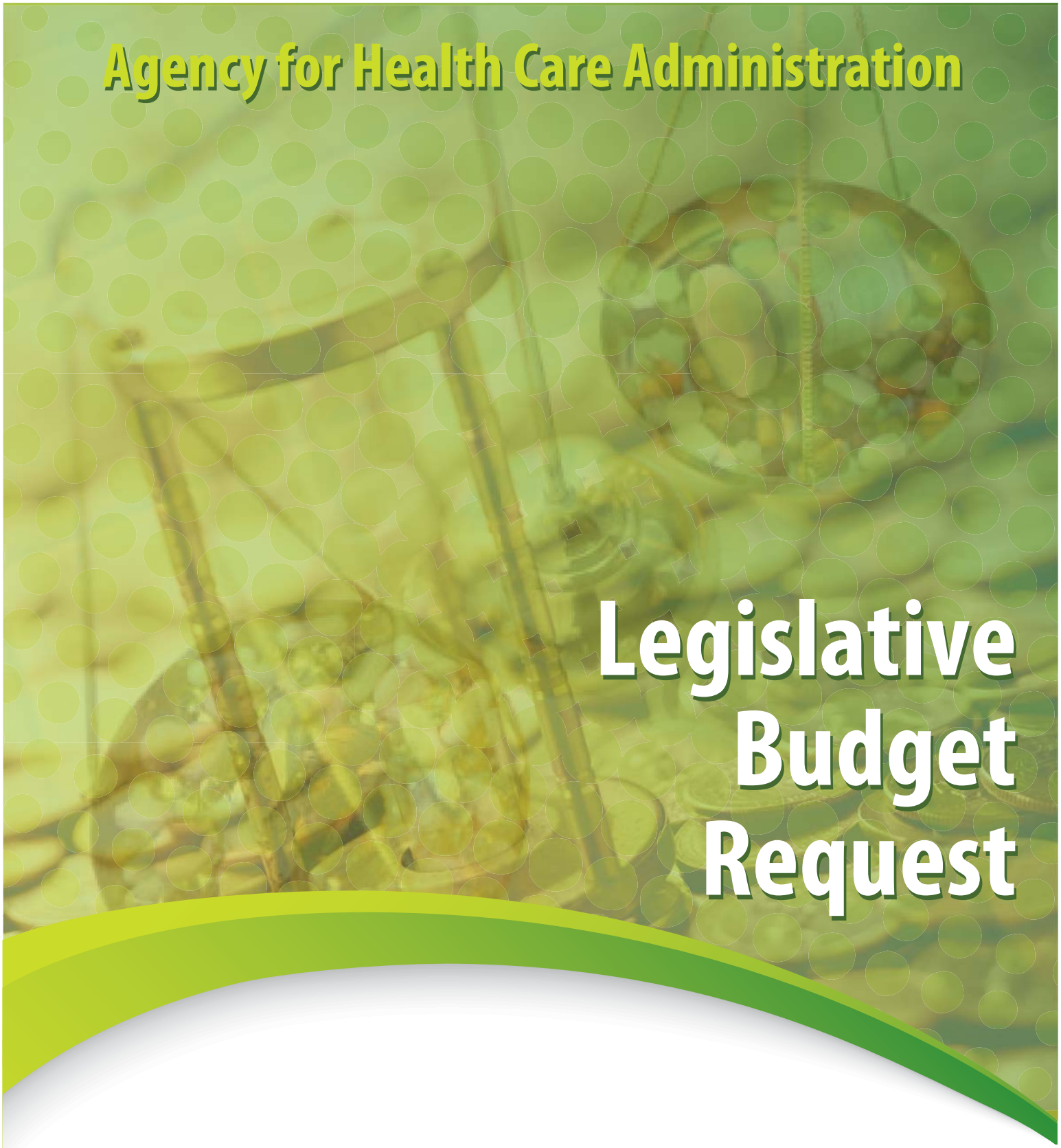


Agency for Health Care Administration

Legislative Budget Request

Fiscal Year 2012-2013

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 15, 2011

Mr. Jerry L. McDaniel, Director
Office of Policy and Budget
Executive Office of the Governor
1701 Capitol
Tallahassee, Florida 32399-0001

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

Mr. Craig Meyer, Staff Director
Senate Budget Committee
201 Capitol
Tallahassee, Florida 32399-1300

Dear Directors:

Pursuant to Chapter 216, Florida Statutes, our Legislative Budget Request for the Agency for Health Care Administration is submitted in the format prescribed in the budget directions. The information provided electronically and contained herein is a true and accurate presentation of our proposed needs for the 2012-13 Fiscal Year. This submission has been approved by Elizabeth Dudek, Secretary.

Sincerely,

Tonya Kidd

Tonya Kidd
Deputy Secretary, Operations

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308

Department Level Exhibits and Schedules

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68200000 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L	CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
13100		UNEXPENDED GENERAL REVENUE RELEASES	
000000		BALANCE BROUGHT FORWARD	71,894.86
31100		ACCOUNTS PAYABLE	
010000		SALARIES AND BENEFITS	26,077.06
010000	CF	SALARIES AND BENEFITS	68,562.62-
030000		OTHER PERSONAL SERVICES	0.00
030000	CF	OTHER PERSONAL SERVICES	304.35-
040000		EXPENSES	0.00
040000	CF	EXPENSES	2,433.39-
100777		CONTRACTED SERVICES	0.00
100777	CF	CONTRACTED SERVICES	70.76-
		** GL 31100 TOTAL	45,294.06-
35300		DUE TO OTHER DEPARTMENTS	
040000		EXPENSES	0.00
040000	CF	EXPENSES	523.74-
		** GL 35300 TOTAL	523.74-
38600		CURRENT COMPENSATED ABSENCES LIABILITY	
010000		SALARIES AND BENEFITS	26,077.06-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	0.00
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68500100 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
13100		UNEXPENDED GENERAL REVENUE RELEASES	
000000		BALANCE BROUGHT FORWARD	9,262,883.75
31100		ACCOUNTS PAYABLE	
100777		CONTRACTED SERVICES	0.00
100777	CF	CONTRACTED SERVICES	544,331.26-
		** GL 31100 TOTAL	544,331.26-
31500		CURRENT INSURANCE LIABILITY	
102340		MEDIKIDS	0.00
102340	CF	MEDIKIDS	999,430.73-
102342		CHILDRENS MED SVCS NETWORK	0.00
102342	CF	CHILDRENS MED SVCS NETWORK	7,719,121.76-
		** GL 31500 TOTAL	8,718,552.49-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	0.00
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68500200 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
11100		CASH ON HAND	
000000		BALANCE BROUGHT FORWARD	43,045.78
001800			0.00
		** GL 11100 TOTAL	43,045.78
13100		UNEXPENDED GENERAL REVENUE RELEASES	
000000		BALANCE BROUGHT FORWARD	8,551,400.17
15100		ACCOUNTS RECEIVABLE	
001801			87,888,840.23
15900		ALLOWANCE FOR UNCOLLECTIBLES	
001801			8,052,944.62-
31100		ACCOUNTS PAYABLE	
010000		SALARIES AND BENEFITS	4,423.13
010000	CF	SALARIES AND BENEFITS	240,742.32-
030000		OTHER PERSONAL SERVICES	0.00
030000	CF	OTHER PERSONAL SERVICES	194,132.45-
040000		EXPENSES	0.00
040000	CF	EXPENSES	2,105.08-
060000		OPERATING CAPITAL OUTLAY	0.00
060000	CF	OPERATING CAPITAL OUTLAY	2,932.70-
100693		CONT NRSNG HOME AUD PRG	0.00
100693	CF	CONT NRSNG HOME AUD PRG	275,789.10-
100777		CONTRACTED SERVICES	32.24
100777	CF	CONTRACTED SERVICES	2,835,627.29-
102086		MEDICAID FISCAL CONTRACT	4,982,660.95-
102086	CF	MEDICAID FISCAL CONTRACT	1,570.67-
102093		MEDICAID PEER REVIEW	0.00
		** GL 31100 TOTAL	8,531,105.19-
31500		CURRENT INSURANCE LIABILITY	
100549		PHARMACEUTICAL EXPENSE ASSISTANCE	0.00
100549	CF	PHARMACEUTICAL EXPENSE ASSISTANCE	15,839.61-
102086		MEDICAID FISCAL CONTRACT	4,982,660.95
102086	CF	MEDICAID FISCAL CONTRACT	4,982,660.95-
		** GL 31500 TOTAL	15,839.61-
32100		ACCRUED SALARIES AND WAGES	
010000		SALARIES AND BENEFITS	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68500200 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
35300	DUE TO OTHER DEPARTMENTS	
040000	EXPENSES	8,290.58-
100777	CONTRACTED SERVICES	32.24-
	** GL 35300 TOTAL	8,322.82-
35600	DUE TO GENERAL REVENUE	
001800		669.99
001801		74,816,260.19-
	** GL 35600 TOTAL	74,815,590.20-
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
010000	SALARIES AND BENEFITS	4,423.13-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	5,055,060.61-
55100	FUND BALANCE RESERVED FOR ENCUMBRANCES	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68501400 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
11100		CASH ON HAND	
000000		BALANCE BROUGHT FORWARD	37,129.59
000500			0.00
001800			0.00
		** GL 11100 TOTAL	37,129.59
13100		UNEXPENDED GENERAL REVENUE RELEASES	
000000		BALANCE BROUGHT FORWARD	311,859,137.74
15100		ACCOUNTS RECEIVABLE	
001800			27,883,539.73
15900		ALLOWANCE FOR UNCOLLECTIBLES	
001800			1,102,182.86-
25400		OTHER LOANS AND NOTES RECEIVABLE	
001800			4,562,688.08
25900		ALLOWANCE FOR UNCOLLECTIBLES	
001800			159,694.08-
31500		CURRENT INSURANCE LIABILITY	
100062		ADULT VISION/HEARING SVCS	0.00
100062	CF	ADULT VISION/HEARING SVCS	848,776.64-
100311		CASE MANAGEMENT	0.00
100311	CF	CASE MANAGEMENT	4,782,971.92-
100436		THERAPEUTIC SVCS - CHILD	0.00
100436	CF	THERAPEUTIC SVCS - CHILD	5,603,981.62-
100616		COMMUNITY MENTAL HEALTH SV	0.00
100616	CF	COMMUNITY MENTAL HEALTH SV	272,454.08-
101240		G/A-RURAL HOSP FIN ASST	0.00
101240	CF	G/A-RURAL HOSP FIN ASST	929,479.56-
101246		FAMILY PLANNING	0.00
101246	CF	FAMILY PLANNING	278,420.51-
101561		HOME HEALTH SERVICES	0.00
101561	CF	HOME HEALTH SERVICES	19,586,842.64-
101575		HOSPICE SERVICES	0.00
101575	CF	HOSPICE SERVICES	28,325,070.69-
101582		HOSPITAL INPATIENT SERVICE	0.00
101582	CF	HOSPITAL INPATIENT SERVICE	123,752,872.26-
101583		REGULAR DISPROP SHARE	0.00
101583	CF	REGULAR DISPROP SHARE	375,120.00-
101584		LOW INCOME POOL	0.00
101584	CF	LOW INCOME POOL	8,600,191.11-
101585		FREESTANDING DIALYSIS CTRS	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68501400 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
101585	CF	FREESTANDING DIALYSIS CTRS	2,338,362.78-
101589		HOSPITAL INSURANCE BENEFIT	0.00
101589	CF	HOSPITAL INSURANCE BENEFIT	23,206,156.06-
101938		RESPIRATORY THERAPY SVCS	0.00
101938	CF	RESPIRATORY THERAPY SVCS	975,747.64-
102212		NURSE PRACTITIONER SERVICE	0.00
102212	CF	NURSE PRACTITIONER SERVICE	1,417,746.43-
102234		BIRTHING CENTER SERVICES	0.00
102234	CF	BIRTHING CENTER SERVICES	218,162.77-
102324		OTHER LAB & X-RAY SERVICES	0.00
102324	CF	OTHER LAB & X-RAY SERVICES	4,720,762.41-
102387		PATIENT TRANSPORTATION	2,020,913.74
102387	CF	PATIENT TRANSPORTATION	7,210,117.17-
102538		PERSONAL CARE SERVICES	0.00
102538	CF	PERSONAL CARE SERVICES	464,624.52-
102540		PHYSICAL REHAB THERAPY	0.00
102540	CF	PHYSICAL REHAB THERAPY	699,114.21-
102681		PRESCRIBED MEDICINE/DRUGS	0.00
102681	CF	PRESCRIBED MEDICINE/DRUGS	22,410,797.25-
102683		MEDICARE PART D PAYMENT	0.00
102683	CF	MEDICARE PART D PAYMENT	35,000,000.00-
102685		PRIVATE DUTY NURSING SVCS	0.00
102685	CF	PRIVATE DUTY NURSING SVCS	17,301,510.38-
103276		RURAL HEALTH SERVICES	0.00
103276	CF	RURAL HEALTH SERVICES	327,521.27-
103529		SPEECH THERAPY SERVICES	0.00
103529	CF	SPEECH THERAPY SERVICES	527,690.89-
103558		MEDIPASS SERVICES	0.00
103558	CF	MEDIPASS SERVICES	1,482,714.79-
103740		OCCUPATIONAL THERAPY SVCS	0.00
103740	CF	OCCUPATIONAL THERAPY SVCS	201,928.14-
		** GL 31500 TOTAL	309,838,224.00-
35300		DUE TO OTHER DEPARTMENTS	
102387		PATIENT TRANSPORTATION	2,020,913.74-
35600		DUE TO GENERAL REVENUE	
000500			10,393.25-
001800			31,028,579.06-
		** GL 35600 TOTAL	31,038,972.31-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	182,508.15-
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68501500 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
13100		UNEXPENDED GENERAL REVENUE RELEASES	
000000		BALANCE BROUGHT FORWARD	41,612,117.81
31500		CURRENT INSURANCE LIABILITY	
101649		ICF/DD COMMUNITY	0.00
101649	CF	ICF/DD COMMUNITY	13,723,187.24-
102233		NURSING HOME CARE	0.00
102233	CF	NURSING HOME CARE	27,888,930.57-
		** GL 31500 TOTAL	41,612,117.81-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	0.00
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68501600 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
13100	UNEXPENDED GENERAL REVENUE RELEASES	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
10 1 000298 68700700 GEN REV--AGENCY FOR HEALTH CARE ADMINSTRATION

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
13100	UNEXPENDED GENERAL REVENUE RELEASES	
000000	BALANCE BROUGHT FORWARD	0.00
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
010000	SALARIES AND BENEFITS	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
55100	FUND BALANCE RESERVED FOR ENCUMBRANCES	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
15 8 100031 68500100 FLA HEALTHY KIDS CORPORATION

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
11200	CASH IN BANK	
000000	BALANCE BROUGHT FORWARD	8,814,545.53
14100	POOLED INVESTMENTS WITH STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	27,565,746.47
15300	INTEREST AND DIVIDENDS RECEIVABLE	
000000	BALANCE BROUGHT FORWARD	629,921.00
16500	DUE FROM OTHER GOVERNMENTAL UNITS	
000000	BALANCE BROUGHT FORWARD	39,288,480.00
19100	PREPAID ITEMS	
000000	BALANCE BROUGHT FORWARD	127,272.00
27400	INFRASTRUCTURE AND OTHER IMPROVEMENTS	
000000	BALANCE BROUGHT FORWARD	49,236.00
27600	FURNITURE AND EQUIPMENT	
000000	BALANCE BROUGHT FORWARD	0.00
27700	ACC DEPR - FURNITURE & EQUIPMENT	
000000	BALANCE BROUGHT FORWARD	0.00
31100	ACCOUNTS PAYABLE	
000000	BALANCE BROUGHT FORWARD	47,034,234.00-
31500	CURRENT INSURANCE LIABILITY	
000000	BALANCE BROUGHT FORWARD	0.00
32100	ACCRUED SALARIES AND WAGES	
000000	BALANCE BROUGHT FORWARD	0.00
32900	ACCRUED INTEREST PAYABLE	
000000	BALANCE BROUGHT FORWARD	67,798.00-
33100	DEPOSITS PAYABLE	
000000	BALANCE BROUGHT FORWARD	0.00
35700	DUE TO COMPONENT UNIT/PRIMARY	
000000	BALANCE BROUGHT FORWARD	277,773.00-

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
15 8 100031 68500100 FLA HEALTHY KIDS CORPORATION

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
000000	BALANCE BROUGHT FORWARD	247,340.00-
38900	DEFERRED REVENUES	
000000	BALANCE BROUGHT FORWARD	15,780,828.00-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	13,067,228.00-
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 003001 68200000 HEALTH CARE TRUST FUND/AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
35400	DUE TO FEDERAL GOVERNMENT	
000700		0.00
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
010000	SALARIES AND BENEFITS	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
55100	FUND BALANCE RESERVED FOR ENCUMBRANCES	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 003001 68500200 HEALTH CARE TRUST FUND/AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 003001 68501400 HEALTH CARE TRUST FUND/AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	12,925,411.38
35300	DUE TO OTHER DEPARTMENTS	
181010	TR/TOBACCO SUR/DOH BIO TF	3,740,459.25-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	9,184,952.13-
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 003001 68501500 HEALTH CARE TRUST FUND/AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 003001 68700700 HEALTH CARE TRUST FUND/AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
11100		CASH ON HAND	
000000		BALANCE BROUGHT FORWARD	410,488.61
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	49,876,553.74
15100		ACCOUNTS RECEIVABLE	
000100			842,047.12
000300			1,926,256.00
001200			6,675,494.77
		** GL 15100 TOTAL	9,443,797.89
15900		ALLOWANCE FOR UNCOLLECTIBLES	
000100			42,059.97-
000300			579,379.20-
001200			3,832,624.12-
		** GL 15900 TOTAL	4,454,063.29-
16200		DUE FROM STATE FUNDS, WITHIN DEPART.	
001500			821,892.88
16300		DUE FROM OTHER DEPARTMENTS	
000200			200.00
001500			2,917,393.83
001600			1,339.21
		** GL 16300 TOTAL	2,918,933.04
16400		DUE FROM FEDERAL GOVERNMENT	
000700			5,716,559.36
25700		ADVANCES TO OTHER FUNDS WITHIN DEPARTM	
000000		BALANCE BROUGHT FORWARD	20,000.00
31100		ACCOUNTS PAYABLE	
010000		SALARIES AND BENEFITS	74,427.45
010000	CF	SALARIES AND BENEFITS	708,588.01-
030000		OTHER PERSONAL SERVICES	0.00
030000	CF	OTHER PERSONAL SERVICES	4,973.62-
040000		EXPENSES	0.00
040000	CF	EXPENSES	210,473.41-
100777		CONTRACTED SERVICES	3,542.00
100777	CF	CONTRACTED SERVICES	428,085.00-
102100		MEDICAID SURVEILLANCE	0.00
102100	CF	MEDICAID SURVEILLANCE	1,526.98-
		** GL 31100 TOTAL	1,275,677.57-

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 003001 68700700 HEALTH CARE TRUST FUND/AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
35300		DUE TO OTHER DEPARTMENTS	
040000		EXPENSES	5,647.82-
040000	CF	EXPENSES	29,963.47-
100777		CONTRACTED SERVICES	3,542.00-
181015		TR/DOH/CERT NURSING ASST	34,500.42-
		** GL 35300 TOTAL	73,653.71-
35600		DUE TO GENERAL REVENUE	
310322		SERVICE CHARGE TO GEN REV	1,104,916.26-
38600		CURRENT COMPENSATED ABSENCES LIABILITY	
010000		SALARIES AND BENEFITS	74,427.45-
38900		DEFERRED REVENUES	
000100			263,995.76-
000300			725,285.71-
001200			2,432,854.65-
		** GL 38900 TOTAL	3,422,136.12-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	58,803,351.12-
55100		FUND BALANCE RESERVED FOR ENCUMBRANCES	
000000		BALANCE BROUGHT FORWARD	0.00
55900		OTHER FUND BALANCE RESERVED	
000100			0.00
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 021010 68200000 ADMINISTRATIVE TRUST FUND--AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
11100		CASH ON HAND	
000000		BALANCE BROUGHT FORWARD	4,542.30
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	3,651,832.38
16400		DUE FROM FEDERAL GOVERNMENT	
000700			2,094,319.96
31100		ACCOUNTS PAYABLE	
010000		SALARIES AND BENEFITS	3,477.87
010000	CF	SALARIES AND BENEFITS	283,398.44-
030000		OTHER PERSONAL SERVICES	0.00
030000	CF	OTHER PERSONAL SERVICES	13,470.09-
040000		EXPENSES	0.00
040000	CF	EXPENSES	105,302.30-
060000		OPERATING CAPITAL OUTLAY	0.00
060000	CF	OPERATING CAPITAL OUTLAY	36,732.04-
100777		CONTRACTED SERVICES	100.44
100777	CF	CONTRACTED SERVICES	363,845.12-
109910		STATE OPERATIONS-ARRA 2009	0.00
109910	CF	STATE OPERATIONS-ARRA 2009	257,882.29-
109911		G/A-CONTRAC SVCS-ARRA 2009	0.00
109911	CF	G/A-CONTRAC SVCS-ARRA 2009	1,786,734.20-
		** GL 31100 TOTAL	2,843,786.17-
35200		DUE TO STATE FUNDS, WITHIN DEPARTMENT	
180200		TR/GENERAL REVENUE-SWCAP	821,892.88-
181011		TR/AGY/PUB HLTH-SOC WLF AG	2,000,000.00-
		** GL 35200 TOTAL	2,821,892.88-
35300		DUE TO OTHER DEPARTMENTS	
040000		EXPENSES	831.30-
040000	CF	EXPENSES	15,526.69-
100777		CONTRACTED SERVICES	6,907.42-
100777	CF	CONTRACTED SERVICES	30,428.75-
210010		TRC - DMS	0.00
210010	CF	TRC - DMS	26,464.78-
		** GL 35300 TOTAL	80,158.94-
35600		DUE TO GENERAL REVENUE	
310322		SERVICE CHARGE TO GEN REV	1,378.78-

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 021010 68200000 ADMINISTRATIVE TRUST FUND--AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
010000	SALARIES AND BENEFITS	3,477.87-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 021010 68500200 ADMINISTRATIVE TRUST FUND--AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
16400	DUE FROM FEDERAL GOVERNMENT	
000700		0.00
31100	ACCOUNTS PAYABLE	
010000	SALARIES AND BENEFITS	0.00
040000	EXPENSES	0.00
040000 CF	EXPENSES	0.00
	** GL 31100 TOTAL	0.00
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
010000	SALARIES AND BENEFITS	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 021010 68700700 ADMINISTRATIVE TRUST FUND--AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
31100	ACCOUNTS PAYABLE	
040000	EXPENSES	0.00
040000 CF	EXPENSES	0.00
	** GL 31100 TOTAL	0.00
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
010000	SALARIES AND BENEFITS	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 122018 68200000 AHCA TOBACCO SETTLEMENT TRUST FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 122018 68500100 AHCA TOBACCO SETTLEMENT TRUST FUND

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	125,016.51
31100		ACCOUNTS PAYABLE	
102342	CF	CHILDRENS MED SVCS NETWORK	0.00
35200		DUE TO STATE FUNDS, WITHIN DEPARTMENT	
100784		G/A-CONTRACT SVCS-FHK ADMN	125,016.51-
35300		DUE TO OTHER DEPARTMENTS	
102342	CF	CHILDRENS MED SVCS NETWORK	0.00
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	0.00
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 122018 68500200 AHCA TOBACCO SETTLEMENT TRUST FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 122018 68501400 AHCA TOBACCO SETTLEMENT TRUST FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
16200	DUE FROM STATE FUNDS, WITHIN DEPART.	
001500		125,016.51
35300	DUE TO OTHER DEPARTMENTS	
181007	TR/DFS/TOBACCO CLEARING TF	125,016.51-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 122018 68501500 AHCA TOBACCO SETTLEMENT TRUST FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 122018 68501600 AHCA TOBACCO SETTLEMENT TRUST FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 126001 68700700 QUALITY OF LONG-TERM CARE FACILITY IMPROVEMT TF

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	3,134,291.78
31100	ACCOUNTS PAYABLE	
100777	CONTRACTED SERVICES	0.00
100777 CF	CONTRACTED SERVICES	253,657.14-
	** GL 31100 TOTAL	253,657.14-
35600	DUE TO GENERAL REVENUE	
310322	SERVICE CHARGE TO GEN REV	128,978.32-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	2,751,656.32-
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 339094 68500100 GRANTS AND DONATION TRUST FUND DEA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	1,583,321.83
31100		ACCOUNTS PAYABLE	
000000		BALANCE BROUGHT FORWARD	0.00
100777		CONTRACTED SERVICES	0.00
100777	CF	CONTRACTED SERVICES	7,931.25-
102342	CF	CHILDRENS MED SVCS NETWORK	0.00
		** GL 31100 TOTAL	7,931.25-
35300		DUE TO OTHER DEPARTMENTS	
102340		MEDIKIDS	0.00
102342		CHILDRENS MED SVCS NETWORK	0.00
102342	CF	CHILDRENS MED SVCS NETWORK	0.00
		** GL 35300 TOTAL	0.00
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	1,575,390.58-
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 339094 68500200 GRANTS AND DONATION TRUST FUND DEA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	193,578.00
15100		ACCOUNTS RECEIVABLE	
000100			0.00
16400		DUE FROM FEDERAL GOVERNMENT	
000700			0.00
31100		ACCOUNTS PAYABLE	
100777		CONTRACTED SERVICES	0.00
100777	CF	CONTRACTED SERVICES	30,608.17-
		** GL 31100 TOTAL	30,608.17-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	162,969.83-
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 339094 68501400 GRANTS AND DONATION TRUST FUND DEA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
11100		CASH ON HAND	
000000		BALANCE BROUGHT FORWARD	12,589,837.20
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	178,491,664.57
15100		ACCOUNTS RECEIVABLE	
000100			374,708.69
000500			338,631.69
001200			360,215.58
001800			149,648,398.95
		** GL 15100 TOTAL	150,721,954.91
15900		ALLOWANCE FOR UNCOLLECTIBLES	
000500			30,364.66-
001200			32,419.40-
001800			1,406,447.08-
		** GL 15900 TOTAL	1,469,231.14-
16300		DUE FROM OTHER DEPARTMENTS	
040000		EXPENSES	11,257.60
25400		OTHER LOANS AND NOTES RECEIVABLE	
001800			1,008,185.59
25900		ALLOWANCE FOR UNCOLLECTIBLES	
001800			45,368.35-
31500		CURRENT INSURANCE LIABILITY	
101240		G/A-RURAL HOSP FIN ASST	0.00
101240	CF	G/A-RURAL HOSP FIN ASST	1,703,397.26-
101582		HOSPITAL INPATIENT SERVICE	0.00
101582	CF	HOSPITAL INPATIENT SERVICE	234,834,202.50-
101583		REGULAR DISPROP SHARE	0.00
101583	CF	REGULAR DISPROP SHARE	31,476,347.50-
101584		LOW INCOME POOL	0.00
101584	CF	LOW INCOME POOL	81,530,323.93-
101596		HOSPITAL OUTPATIENT SVCS	0.00
101596	CF	HOSPITAL OUTPATIENT SVCS	43,348,353.00-
102541		PHYSICIAN SERVICES	0.00
102541	CF	PHYSICIAN SERVICES	271,824.00-
102681		PRESCRIBED MEDICINE/DRUGS	0.00
102681	CF	PRESCRIBED MEDICINE/DRUGS	98,054,022.29-
103742		CLINIC SERVICES	0.00
103742	CF	CLINIC SERVICES	16,396,032.00-
		** GL 31500 TOTAL	507,614,502.48-

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 339094 68501400 GRANTS AND DONATION TRUST FUND DEA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
38900	DEFERRED REVENUES	
000500		246,210.87-
001200		327,796.18-
001800		55,713,700.19-
	** GL 38900 TOTAL	56,287,707.24-
48900	DEFERRED REVENUE - LONG TERM	
001800		962,817.24-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	223,556,726.58
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 339094 68501500 GRANTS AND DONATION TRUST FUND DEA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
11100		CASH ON HAND	
000000		BALANCE BROUGHT FORWARD	31,107.16
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	33,398,322.19
15100		ACCOUNTS RECEIVABLE	
000100			0.00
000300			1,037,609.07
		** GL 15100 TOTAL	1,037,609.07
15900		ALLOWANCE FOR UNCOLLECTIBLES	
000300			280,247.05-
16300		DUE FROM OTHER DEPARTMENTS	
000300			336,755.72
31500		CURRENT INSURANCE LIABILITY	
101649		ICF/DD COMMUNITY	0.00
101649	CF	ICF/DD COMMUNITY	2,048,753.49-
102233		NURSING HOME CARE	0.00
102233	CF	NURSING HOME CARE	99,934,440.34-
		** GL 31500 TOTAL	101,983,193.83-
48800		UNEARNED REVENUE - LONG TERM	
000100			27,292,183.53-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	94,751,830.27
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 474001 68500100 MEDICAL CARE TRUST FUND AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	23,013,541.71
16400		DUE FROM FEDERAL GOVERNMENT	
000700			0.00
31100		ACCOUNTS PAYABLE	
100777		CONTRACTED SERVICES	0.00
100777	CF	CONTRACTED SERVICES	574,192.42-
		** GL 31100 TOTAL	574,192.42-
31500		CURRENT INSURANCE LIABILITY	
102340		MEDIKIDS	0.00
102340	CF	MEDIKIDS	1,197,188.67-
102342		CHILDRENS MED SVCS NETWORK	0.00
102342	CF	CHILDRENS MED SVCS NETWORK	15,840,174.57-
		** GL 31500 TOTAL	17,037,363.24-
35300		DUE TO OTHER DEPARTMENTS	
102342		CHILDRENS MED SVCS NETWORK	77,926.77-
181353		TR/ACHA/CMS-FEDERAL MATCH	1,697,994.94-
		** GL 35300 TOTAL	1,775,921.71-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	3,626,064.34-
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 474001 68500200 MEDICAL CARE TRUST FUND AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	57,180,708.97
16400		DUE FROM FEDERAL GOVERNMENT	
000700			234,582.74
31100		ACCOUNTS PAYABLE	
010000		SALARIES AND BENEFITS	16,711.53
010000	CF	SALARIES AND BENEFITS	535,443.09-
030000		OTHER PERSONAL SERVICES	0.00
030000	CF	OTHER PERSONAL SERVICES	3,261,856.03-
040000		EXPENSES	8,835.63-
040000	CF	EXPENSES	100,445.76-
060000		OPERATING CAPITAL OUTLAY	0.00
060000	CF	OPERATING CAPITAL OUTLAY	1,649.70-
100693		CONT NRSNG HOME AUD PRG	0.00
100693	CF	CONT NRSNG HOME AUD PRG	275,789.10-
100777		CONTRACTED SERVICES	364.56
100777	CF	CONTRACTED SERVICES	9,202,767.77-
102086		MEDICAID FISCAL CONTRACT	0.00
102086	CF	MEDICAID FISCAL CONTRACT	4,712.01-
102093		MEDICAID PEER REVIEW	0.00
102093	CF	MEDICAID PEER REVIEW	11,472.50-
		** GL 31100 TOTAL	13,385,895.50-
31500		CURRENT INSURANCE LIABILITY	
102086		MEDICAID FISCAL CONTRACT	0.00
102086	CF	MEDICAID FISCAL CONTRACT	21,212,531.31-
		** GL 31500 TOTAL	21,212,531.31-
35300		DUE TO OTHER DEPARTMENTS	
010000		SALARIES AND BENEFITS	467.53-
040000		EXPENSES	287.17-
040000	CF	EXPENSES	46,752.00-
100777		CONTRACTED SERVICES	125,921.95-
181011		TR/AGY/PUB HLTH-SOC WLF AG	6,574,842.56-
		** GL 35300 TOTAL	6,748,271.21-
38600		CURRENT COMPENSATED ABSENCES LIABILITY	
010000		SALARIES AND BENEFITS	16,711.53-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	16,051,882.16-
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 474001 68501400 MEDICAL CARE TRUST FUND AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
11100		CASH ON HAND	
000000		BALANCE BROUGHT FORWARD	80,973.67
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	6,681,813,239.58
14300		SPECIAL INVESTMENTS W/STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	8,077,652.88
15100		ACCOUNTS RECEIVABLE	
000000		BALANCE BROUGHT FORWARD	182,378.22
001800			90,711,963.74
		** GL 15100 TOTAL	90,894,341.96
15900		ALLOWANCE FOR UNCOLLECTIBLES	
001800			5,057,827.72-
16200		DUE FROM STATE FUNDS, WITHIN DEPART.	
001500			2,000,000.00
16300		DUE FROM OTHER DEPARTMENTS	
001500			4,390,674.17
25400		OTHER LOANS AND NOTES RECEIVABLE	
001800			9,130,532.51
25900		ALLOWANCE FOR UNCOLLECTIBLES	
001800			335,825.90-
31100		ACCOUNTS PAYABLE	
000000		BALANCE BROUGHT FORWARD	8,085,758.93-
105445		MEDICAID SCHOOL REFINANCE	0.00
105445	CF	MEDICAID SCHOOL REFINANCE	25,489,267.20-
310018		DIST OF DONATE ORG-PASS IT ON LIC PLATE FUN	0.00
		** GL 31100 TOTAL	33,575,026.13-
31500		CURRENT INSURANCE LIABILITY	
100436		THERAPEUTIC SVCS - CHILD	0.00
100436	CF	THERAPEUTIC SVCS - CHILD	4,540,835.65-
100616		COMMUNITY MENTAL HEALTH SV	0.00
100616	CF	COMMUNITY MENTAL HEALTH SV	6,217,615.48-
101240		G/A-RURAL HOSP FIN ASST	0.00
101240	CF	G/A-RURAL HOSP FIN ASST	2,204,294.55-
101246		FAMILY PLANNING	0.00
101246	CF	FAMILY PLANNING	2,491,458.51-

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 474001 68501400 MEDICAL CARE TRUST FUND AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
101405		HEALTHY START SERVICES	0.00
101405	CF	HEALTHY START SERVICES	11,910,070.96-
101561		HOME HEALTH SERVICES	0.00
101561	CF	HOME HEALTH SERVICES	23,835,406.12-
101575		HOSPICE SERVICES	0.00
101575	CF	HOSPICE SERVICES	24,685,510.59-
101582		HOSPITAL INPATIENT SERVICE	0.00
101582	CF	HOSPITAL INPATIENT SERVICE	526,424,595.76-
101583		REGULAR DISPROP SHARE	0.00
101583	CF	REGULAR DISPROP SHARE	39,644,531.50-
101584		LOW INCOME POOL	0.00
101584	CF	LOW INCOME POOL	55,042,628.68-
101585		FREESTANDING DIALYSIS CTRS	0.00
101585	CF	FREESTANDING DIALYSIS CTRS	2,646,059.67-
101589		HOSPITAL INSURANCE BENEFIT	0.00
101589	CF	HOSPITAL INSURANCE BENEFIT	30,490,781.18-
101596		HOSPITAL OUTPATIENT SVCS	0.00
101596	CF	HOSPITAL OUTPATIENT SVCS	195,306,646.88-
101938		RESPIRATORY THERAPY SVCS	0.00
101938	CF	RESPIRATORY THERAPY SVCS	212,079.81-
102212		NURSE PRACTITIONER SERVICE	0.00
102212	CF	NURSE PRACTITIONER SERVICE	2,001,009.43-
102234		BIRTHING CENTER SERVICES	0.00
102234	CF	BIRTHING CENTER SERVICES	268,269.67-
102324		OTHER LAB & X-RAY SERVICES	0.00
102324	CF	OTHER LAB & X-RAY SERVICES	1,414,929.49-
102387		PATIENT TRANSPORTATION	3,430,701.42
102387	CF	PATIENT TRANSPORTATION	3,346,517.48-
102540		PHYSICAL REHAB THERAPY	0.00
102540	CF	PHYSICAL REHAB THERAPY	678,658.07-
102541		PHYSICIAN SERVICES	0.00
102541	CF	PHYSICIAN SERVICES	118,509,586.51-
102681		PRESCRIBED MEDICINE/DRUGS	0.00
102681	CF	PRESCRIBED MEDICINE/DRUGS	3,128,126.98-
102685		PRIVATE DUTY NURSING SVCS	0.00
102685	CF	PRIVATE DUTY NURSING SVCS	17,220,894.98-
103558		MEDIPASS SERVICES	0.00
103558	CF	MEDIPASS SERVICES	838,211.93-
103742		CLINIC SERVICES	0.00
103742	CF	CLINIC SERVICES	6,933,394.42-
		** GL 31500 TOTAL	1,076,561,412.88-
35300		DUE TO OTHER DEPARTMENTS	
102387		PATIENT TRANSPORTATION	3,430,701.42-
181011		TR/AGY/PUB HLTH-SOC WLF AG	357,505.72-
		** GL 35300 TOTAL	3,788,207.14-

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 474001 68501400 MEDICAL CARE TRUST FUND AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
38900	DEFERRED REVENUES	
001800		27,287,367.94-
48900	DEFERRED REVENUE - LONG TERM	
001800		8,794,706.61-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	5,640,987,040.45-
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 474001 68501500 MEDICAL CARE TRUST FUND AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	6,273,394,221.34-
16300		DUE FROM OTHER DEPARTMENTS	
001000			35,982,335.49
001500			28,621,994.21
		** GL 16300 TOTAL	64,604,329.70
25100		ADVANCES TO OTHER FUNDS BETWEEN DEPART	
001500			3,478,978.33
31500		CURRENT INSURANCE LIABILITY	
100602		ASSISTIVE CARE SERVICES	0.00
100602	CF	ASSISTIVE CARE SERVICES	1,590,510.26-
101554		HOME & COMMUNITY BASED SVC	0.00
101554	CF	HOME & COMMUNITY BASED SVC	12,469,057.97-
101557		ALF WAIVER	0.00
101557	CF	ALF WAIVER	7,520,645.84-
101644		ICF/MR - SUNLAND CENTER	0.00
101644	CF	ICF/MR - SUNLAND CENTER	8,867,731.11-
101649		ICF/DD COMMUNITY	0.00
101649	CF	ICF/DD COMMUNITY	33,019,961.04-
102233		NURSING HOME CARE	0.00
102233	CF	NURSING HOME CARE	123,260,130.19-
103556		ST MENTAL HEALTH HOSP PRG	0.00
103556	CF	ST MENTAL HEALTH HOSP PRG	2,421,389.24-
		** GL 31500 TOTAL	189,149,425.65-
48900		DEFERRED REVENUE - LONG TERM	
001500			3,478,978.33-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	6,397,939,317.29
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 474001 68501600 MEDICAL CARE TRUST FUND AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 509001 68700700 FLA ORGAN & TISSUE DONOR, ED & PROCUREMENT TF

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
010000	SALARIES AND BENEFITS	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 522001 68700700 RESIDENT PROTECTION TRUST FUND AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
35200	DUE TO STATE FUNDS, WITHIN DEPARTMENT	
181023	TR/HCTF/EXCESS OF $800,000	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 565006 68501400 PUBLIC MEDICAL ASSISTANCE TRUST FUND AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
11100	CASH ON HAND	
000000	BALANCE BROUGHT FORWARD	772,666.00
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	616,786,226.19
15100	ACCOUNTS RECEIVABLE	
000300		37,249,478.28
001200		5,789.01
	** GL 15100 TOTAL	37,255,267.29
15900	ALLOWANCE FOR UNCOLLECTIBLES	
000300		3,895,879.73-
001200		1,982.00-
	** GL 15900 TOTAL	3,897,861.73-
16300	DUE FROM OTHER DEPARTMENTS	
001500		313,412.04
38900	DEFERRED REVENUES	
000300		11,673,759.49-
001200		3,807.01-
	** GL 38900 TOTAL	11,677,566.50-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	639,552,143.29-
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 579001 68500200 REFUGEE ASSISTANCE TRUST FUND C&F, & AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 579001 68501400 REFUGEE ASSISTANCE TRUST FUND C&F, & AHCA

G-L CAT		G-L ACCOUNT NAME	BEGINNING BALANCE
12100		UNRELEASED CASH IN STATE TREASURY	
000000		BALANCE BROUGHT FORWARD	1,325,712.35
16300		DUE FROM OTHER DEPARTMENTS	
001510			7,101,322.28
31500		CURRENT INSURANCE LIABILITY	
100062		ADULT VISION/HEARING SVCS	0.00
100062	CF	ADULT VISION/HEARING SVCS	179,187.41-
100311		CASE MANAGEMENT	0.00
100311	CF	CASE MANAGEMENT	67,354.05-
100436		THERAPEUTIC SVCS - CHILD	0.00
100436	CF	THERAPEUTIC SVCS - CHILD	2,160.26-
100919		DEVEL EVAL & INTERV/PART C	0.00
100919	CF	DEVEL EVAL & INTERV/PART C	690.50-
101029		EARLY/PERIOD SCREEN/CHILD	0.00
101029	CF	EARLY/PERIOD SCREEN/CHILD	54,915.44-
101246		FAMILY PLANNING	0.00
101246	CF	FAMILY PLANNING	9,503.47-
101596		HOSPITAL OUTPATIENT SVCS	0.00
101596	CF	HOSPITAL OUTPATIENT SVCS	482,575.67-
102324		OTHER LAB & X-RAY SERVICES	0.00
102324	CF	OTHER LAB & X-RAY SERVICES	86,546.26-
102387		PATIENT TRANSPORTATION	0.00
102387	CF	PATIENT TRANSPORTATION	2,123.70-
102541		PHYSICIAN SERVICES	0.00
102541	CF	PHYSICIAN SERVICES	587,409.66-
102673		PREPAID HEALTH PLANS	0.00
102673	CF	PREPAID HEALTH PLANS	4,067,157.82-
102681		PRESCRIBED MEDICINE/DRUGS	0.00
102681	CF	PRESCRIBED MEDICINE/DRUGS	767,900.43-
103276		RURAL HEALTH SERVICES	0.00
103276	CF	RURAL HEALTH SERVICES	192.02-
103529		SPEECH THERAPY SERVICES	0.00
103529	CF	SPEECH THERAPY SERVICES	673.16-
103558		MEDIPASS SERVICES	0.00
103558	CF	MEDIPASS SERVICES	23,365.00-
103742		CLINIC SERVICES	0.00
103742	CF	CLINIC SERVICES	64,587.94-
		** GL 31500 TOTAL	6,396,342.79-
54900		ASSIGNED FUND BALANCE	
000000		BALANCE BROUGHT FORWARD	2,030,691.84-
		*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
20 2 579001 68501600 REFUGEE ASSISTANCE TRUST FUND C&F, & AHCA

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
12100	UNRELEASED CASH IN STATE TREASURY	
000000	BALANCE BROUGHT FORWARD	0.00
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
74 8 680001 00000000 AHCA REVOLVING FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
11200	CASH IN BANK	
000000	BALANCE BROUGHT FORWARD	20,000.00
16800	DUE FROM STATE FUNDS - REVOLVING FUND	
000000	BALANCE BROUGHT FORWARD	0.00
45100	ADVANCES FROM OTHER FUNDS BETWEEN DEPA	
000000	BALANCE BROUGHT FORWARD	0.00
45700	ADVANCES FROM OTHER FUNDS WITHIN DEPAR	
000000	BALANCE BROUGHT FORWARD	20,000.00-
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
80 9 003001 00000000 ADMINISTRATION & HEALTH OWNERSHIP FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
27600	FURNITURE AND EQUIPMENT	
000000	BALANCE BROUGHT FORWARD	9,613,347.01
040000	EXPENSES	341,964.35-
060000	OPERATING CAPITAL OUTLAY	2,542,360.35-
100021	ACQUISITION/MOTOR VEHICLES	213,874.00-
210008	DCF DATA CENTER	60,433.00-
	** GL 27600 TOTAL	6,454,715.31
27700	ACC DEPR - FURNITURE & EQUIPMENT	
000000	BALANCE BROUGHT FORWARD	42,024.96-
040000	EXPENSES	8,639.00-
060000	OPERATING CAPITAL OUTLAY	5,410,480.34-
100021	ACQUISITION/MOTOR VEHICLES	15,737.00-
210008	DCF DATA CENTER	4,613.33-
	** GL 27700 TOTAL	5,481,494.63-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	973,220.68-
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
80 9 021010 00000000 MEDICAID PROPERTY OWNERSHIP FUND

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
27600	FURNITURE AND EQUIPMENT	
040000	EXPENSES	0.00
060000	OPERATING CAPITAL OUTLAY	0.00
	** GL 27600 TOTAL	0.00
27700	ACC DEPR - FURNITURE & EQUIPMENT	
060000	OPERATING CAPITAL OUTLAY	0.00
	*** FUND TOTAL	0.00

680000 AGENCY FOR HEALTH CARE ADMINISTRATION
90 9 680007 00000000 GENERAL LONG TERM DEBT ASSET GROUP

G-L CAT	G-L ACCOUNT NAME	BEGINNING BALANCE
31500	CURRENT INSURANCE LIABILITY	
000000	BALANCE BROUGHT FORWARD	382,464,801.83-
38600	CURRENT COMPENSATED ABSENCES LIABILITY	
000000	BALANCE BROUGHT FORWARD	4,253,081.15-
48500	INSTALLMENT PURCHASE CONTRACTS	
000000	BALANCE BROUGHT FORWARD	0.00
48600	COMPENSATED ABSENCES LIABILITY	
000000	BALANCE BROUGHT FORWARD	14,957,808.77-
49900	OTHER LONG-TERM LIABILITIES	
000000	BALANCE BROUGHT FORWARD	40,273,716.00-
54900	ASSIGNED FUND BALANCE	
000000	BALANCE BROUGHT FORWARD	441,949,407.75
	*** FUND TOTAL	0.00 E

Fund: 2021 Administrative Trust Fund

Budget Entity: 68200000 Administration and Support

Per instructions Administrative Trust Fund is exempt from the reserve computations.

Section III Adjustments Narrative:

September 2010 reversions $80,840 are the result of unexpended certified forward appropriations.

Current Year Adjustments of $1,837,731 are payables not certified forward and due tos and reclass of general ledger codes.

Prior Year Adjustments of $14,788,614 are necessary to record prior year FLAIR adjustments required
by the Department of Financial Services. Due to the trust fund realignment.

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were first adjusted based on
any Legislative Budget Requests being submitted.
Expenditures relating to the administration and support of the Agency are processed in the Administrative Trust Fund.
The expenditures are assigned an Other Cost Accumulator (OCA) code. The code will indicate the source of funding for the expenditures.
The administrative cost pool OCA code is the primary code used.
The methodology for funding the administrative cost pool is based on FTE counts
in each of the three business areas: Division of Health Quality Assurance, Division of Medicaid (less Federal indirect draws), and the Florida Center.
Each of the three business areas contributes their pro rata share of funds.
Other funding sources include the Data Collection and Analysis Assessment, Overpayment, Fraud and Recoupment funds, and Federal administrative draws.

Fund: 2122 Tobacco Settlement Trust Fund

Budget Entity: 68500100 Children's Special Health Care

The Tobacco Settlement Trust Fund is exempt from 5% reserve.

Section III Adjustments Narrative:

September 2010 reversions $756,919 are the result of unexpended certified forward appropriations.

Current Year Adjustments of $(125,017) is an adjustment between budget entities.

Revenue Estimating Methodology Narrative:

Revenue is based on estimating conference.

Fund: 2339 Grants and Donations Trust Fund

Budget Entity: 68500100 Children's Special Health Services

The Grants and Donations Trust Fund in this Budget Entity funds Children's Special Health Care. Per instruction, we have omitted collections from Florida Healthy Kids Corp. from our reserve computations.

Section III Adjustments Narrative:

September 2010 reversions $930,539 are the result of unexpended certified forward appropriations.

Prior Year Adjustments of $(467,911) are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

Revenue is based on the Florida KidCare estimating conference.

Fund: 2474 Medical Care Trust Fund

Budget Entity: 68500100 Children's Special Health Services

The Medical Care Trust Fund in this Budget Entity funds Medicaid Children's Special Health Care. All revenues in this area are involved with Federal funding. Therefore, this activity is exempted from the 5% reserve.

Section III Adjustments Narrative: No Adjustments

September 2010 reversions of $19,275,458 are the result of unexpended certified forward appropriations.

Current year adjustment of $(1,775,922) are recordings of due tos federal government, DCF and DOH.

Prior Year Adjustments of $(12,179,847) are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

Revenue is based on the estimating conference.

Fund: 2339 Grants and Donations Trust Fund

Budget Entity: 68500200 Executive Direction/ Support Services

This Budget Entity in this Fund has revenue subject to the 5% reserve. Per instructions, we have exempted Federal Funds from reserve computations. The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	1,070,535	
Gross Revenue		1,070,535
Less Revenue Exemptions		
General Revenue Service Charge 8%		0
Drug Rebates Federal	355,931	
Non Operating Transfer:		
	0	355,931
Total Non-operating Transfers		0
Total Revenue Exemptions		355,931
Total Revenue Subject to 5% Reserve		714,604
Total 5% reserve for Grants and Donations Trust Fund		**35,730**

Section III Adjustments Narrative:

Current Year Adjustments of $(109,160) is transfer to MCTF and reclass general ledger codes.

Prior Year Adjustments of $52,339,150 are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted.

Fund: 2474 Medical Care Trust Fund

Budget Entity: 68500200 Executive Direction/Support Services

This Budget Entity in this Fund has revenue subject to the 5% reserve. Per instructions, we have exempted Federal Funds from reserve computations. The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	178,225,911	
Gross Revenue		178,225,911
Less Revenue Exemptions		
Federal Funds:		
Title XIX	176,149,942	
Title XXI	853,457	
Total Federal Funds		177,003,399
Other Grants		1,222,512
Non Operating Transfer:		
Transfer to ATF	6,677,069	
Transfer to DOH	24,000,000	
Total Non-operating Transfers		30,677,069
Total Revenue Exemptions		208,902,980
Total Revenue Subject to 5% Reserve		(30,677,069)
Total 5% reserve for Medical Care Trust Fund		**(1,533,853)**

Section III Adjustments Narrative: No Adjustments

September 2010 reversions $20,306,308 are the result of unexpended certified forward appropriations.

Current Year Adjustments of $(22,732,424) are due froms federal government and GDTF. Transfers between budget entities, recording of due tos and reclass general ledger codes.

Prior Year Adjustments of $165,972 are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

The amounts were adjusted based on Legislative Budget Requests being submitted.

Fund: 2579 Refugee Assistance Trust Fund

Budget Entity: 68500200 Executive Direction/Support Services

This Trust Fund in this Budget Entity has no revenues subject to the 5% reserve. Per instructions, we have exempted Federal funds from reserve computations.

Section III Adjustments Narrative: No Adjustments

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted. The Medicaid office prepares a revenue estimate for the Medicaid Services appropriation and that is the estimate that is use to record revenues.

Fund: 2003 Health Care Trust Fund

Budget Entity: 68501400 Medicaid Services - Individuals

Cigarette taxes to fund Medicaid expenditures.

Revenue:		
Total Revenue for FY 11-12	629,300,000	
Gross Revenue		629,300,000
Less Revenue Exemptions		
		0
Non Operating Transfer:		
Transfer to DOH	28,985,225	
Total Non-operating Transfers		28,985,225
Total Revenue Exemptions		28,985,225
Total Revenue Subject to 5% Reserve		600,314,775
Total 5% reserve for Grants and Donations Trust Fund		**30,015,739**

Section III Adjustments Narrative:

Current Year Adjustments of $(2,917,394) due froms.

Prior Year Adjustments of $4,895,312 are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

The revenue estimates are based on the estimating conference.

Fund: 2122 Tobacco Settlement Trust Fund

Budget Entity: 68501400 Medicaid Services - Individuals

The Tobacco Settlement Trust Fund is exempt from 5% reserve.

Section III Adjustments Narrative: No adjustments

Current Year Adjustments of $125,017 is an adjustment between budget entities.

Revenue Estimating Methodology Narrative:

Revenue is based on estimating conference.

Fund: 2339 Grants and Donations Trust Fund

Budget Entity: 68501400 Medicaid Health Services - Individuals

This Budget Entity in this Fund has revenue subject to the 5% reserve. Per instructions, we have exempted Federal Funds from reserve computations. The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	1,543,352,489	
Gross Revenue		1,543,352,489
Less Revenue Exemptions		
Federal Funds:		
Title XIX		
Title XXI	0	
Total Federal Funds		0
Drug Rebates Federal		388,694,965
County contributions		897,791,804
Non Operating Transfer:		
Transfer in From DOH GR	31,560,983	
Transfer to MCTF	14,233,142	
Transfer to ATF	484,031	
		46,278,156
Total Non-operating Transfers		
Total Revenue Exemptions		1,332,764,925
Total Revenue Subject to 5% Reserve		210,587,564
Total 5% reserve for Grants and Donations Trust Fund		**10,529,378**

Section III Adjustments Narrative:

September 2010 reversions of $109,934,770 are the result of unexpended certified forward appropriations.

Current Year Adjustments of $331,886,211 are due from and accrual reversal.
accrual reversal.

Prior Year Adjustments of $(145,647,406) are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted. The Medicaid office prepares a revenue estimate for the Medicaid Services appropriation and that is the estimate that is use to record revenues.

Fund: 2474 Medical Care Trust Fund

Budget Entity: 68501400 Health Services to Individuals

The Medical Care Trust Fund in this Budget Entity funds Medicaid Services to Individuals. This Budget Entity in this Fund has revenue subject to the 5% reserve. Per instructions, we have exempted federal funds from reserve computations. Also, Transfers From Other Agencies in this fund are derived from that Agency's State Match funds and exempt from reserve computations. The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	8,910,051,709	
Gross Revenue		8,910,051,709
Less Revenue Exemptions		
Federal Funds:		
Title XIX	8,598,934,519	
Title XXI		
Total Federal Funds		8,598,934,519
Transfer in From DCF		27,045,302
Transfer in From DOH		3,809,028
Transfer in From DJJ		2,000,000
Refunds-TPL-Federal		38,465,944
Non Operating Transfer:		
Transfer to APD	70,500,000	
Transfer to DCF	82,869,287	
Total Non-operating Transfers		153,369,287
Total Revenue Exemptions		8,823,624,080
Total Revenue Subject to 5% Reserve		86,427,629
Total 5% reserve for Medical Care Trust Fund		**4,321,381**

Section III Adjustments Narrative:

September 2010 reversions of $258,364,511 are the result of unexpended certified forward appropriations.

Prior Year Adjustment of $(209,148,713) are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Current Year Adjustments of $(2,053,458,957)are recording a due to 68501500, reduce due from federal government and transfer between budget entities.

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted. The Medicaid office prepares a revenue estimate for the Medicaid Services appropriation and that is the estimate that is use to record revenues.

Fund: 2565 Public Medical Assistance Trust Fund

Budget Entity: 68501400 Medicaid Health Services - Individuals

The Public Medical Assistance Trust Fund is the Budget Entity that funds Medicaid Services to Individuals. This trust fund has been exempted from the 5% reserve pursuant to Legislative Budget Request instructions.

Section III Adjustments Narrative:

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted. The Medicaid office prepares a revenue estimate for the Medicaid Services appropriation and that is the estimate that is use to record revenues.

Fund: 2579 Refugee Assistance Trust Fund

Budget Entity: 68501400 Medicaid Health Services - Individuals

This Trust Fund in this Budget Entity has no revenues subject to the 5% reserve. Per instructions, we have exempted Federal funds from reserve computations.

Section III Adjustments Narrative: No Adjustments

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted. The Medicaid office prepares a revenue estimate for the Medicaid Services appropriation and that is the estimate that is use to record revenues.

Fund: 2003 Health Care Trust Fund

Budget Entity: 68501500 Medicaid Long Term Care

Cigarette taxes to fund Medicaid expenditures.

Revenue:		
Total Revenue for FY 11-12	270,000,000	
Gross Revenue		270,000,000
Less Revenue Exemptions		
		0
Non Operating Transfer:		
Transfer to DOH		
Total Non-operating Transfers		0
Total Revenue Exemptions		0
Total Revenue Subject to 5% Reserve		270,000,000
Total 5% reserve for Grants and Donations Trust Fund		**13,500,000**

Revenue Estimating Methodology Narrative:

The revenue estimates are based on the estimating conference.

Fund: 2339 Grants and Donations Trust Fund

Budget Entity: 68501500 Medicaid Long Term Care

This Budget Entity in this Fund has revenue subject to the 5% reserve. Per instructions, we have exempted Federal Funds from reserve computations. The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	391,429,797	
Gross Revenue		391,429,797
Less Revenue Exemptions		
Federal Funds:		
Title XIX	0	
Title XXI	0	
Total Federal Funds		0
Quality Assessments		391,429,797
Non Operating Transfer:		
Transfer to ATF	345,955	
Total Non-operating Transfers		345,955
Total Revenue Exemptions		391,775,752
Total Revenue Subject to 5% Reserve		(345,955)
		(17,298)

This Trust Fund in this Budget Entity has no revenues subject to the 5% reserve. Per instructions we have exempted federal funds from reserve computations.

Section III Adjustments Narrative: No Adjustments

September 2010 reversions of $10,740,406 are the result of unexpended certified forward appropriations.

Current Year Adjustments of $100,945,585 are reduction to AP and recording of due from.

Prior Year Adjustments of $(32,729,079) are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted. The Medicaid office prepares a revenue estimate for the Medicaid Services appropriation and that is the estimate that is use to record revenues.

Fund: 2474 Medical Care Trust Fund

Budget Entity: 68501500 Medicaid Long Term Care

The Medical Care Trust Fund in this Budget Entity funds Medicaid Long Term Care Services.
Revenues in this area are involved with Federal funding.
Also, Transfers From Other Agencies in this fund are derived from that Agency's General Revenue fund and exempt from reserve computations. The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	3,301,081,776	
Gross Revenue		3,301,081,776
Less Revenue Exemptions		
Federal Funds:		
Title XIX	2,620,839,630	
Title XXI		
Total Federal Funds		2,620,839,630
Transfers - DCF		37,086,540
Transfers - APD		402,065,161
Transfers - DOEA		231,575,460
Transfers - DOH		9,514,985
Non Operating Transfer:		
Total Non-operating Transfers		0
Total Revenue Exemptions		3,301,081,776
Total Revenue Subject to 5% Reserve		0
Total 5% reserve for Medical Care Trust Fund		**0**

Section III Adjustments Narrative:

September 2010 reversions of $68,157,490 are the result of unexpended certified forward appropriations.

Current Year Adjustments of $3,210,565,917 are recording a due from 68501400 and due from federal government.

Prior Year Adjustment of $(122,586,631) are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were adjusted based on any Legislative Budget Requests being submitted. The Medicaid office prepares a revenue estimate for the Medicaid Services appropriation and that is the estimate that is use to record revenues.

Fund: 2003 Health Care Trust Fund

Budget Entity: 68700700 Health Care Regulation

The Health Care Trust Fund is the primary funding source for the regulatory functions of the Agency for Care Administration. Also collects cigarette taxes to fund Medicaid expenditures.
Per instructions, we have exempted Federal funds from our reserve computations.
The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	94,167,237	
Gross Revenue		94,167,237
Less Revenue Exemptions		
Federal Funds:		
CLIA	2,495,155	
CLIA Indirect	155,112	
Title XVIII	9,671,535	
Title XVIII indirect	1,017,938	
Title XIX	6,918,319	
Title XIX indirect	888,733	
Background Screening Grant	1,734,857	
Total Federal Funds		22,881,649
General Revenue Service Charge 8%		5,702,847
Non Operating Transfer:		
FDLE Level 2 Screening	1,122,000	
DOH Cert Nursing Asst.	225,000	
DOH Local Health Council	1,300,000	
Transfer Section 215.32	12,000,000	
Transfer to ATF	13,619,620	
Total Non-operating Transfers		28,266,620
Total Revenue Exemptions		56,851,116
Total Revenue Subject to 5% Reserve		37,316,121
Total 5% reserve for Health Care Trust Fund		**1,865,806**

Section III Adjustments Narrative:

September 2010 reversions $212,478 are the result of unexpended certified forward appropriations.

Current Year Adjustments of $3,882,291 are due tos, due froms, and reclass of general ledger codes.

Prior Year Adjustments of $(6,675,472) are necessary to record prior year FLAIR adjustments required by the Department of Financial Services.

Revenue Estimating Methodology Narrative:

Calculations began with the previous year requested amount. The amounts were first adjusted based on any Legislative Budget Requests being submitted. Then prior years activity was analyzed to determine if there were upward or downward trends and based on that analysis adjustments were incorporated.

Fund: 2126 Quality Long-Term Care Trust Fund

Budget Entity: 68700700 Health Care Regulation

The Quality Long-Term Care Trust Fund was created to support activities and programs directly related to the improvement of the care of nursing home and assisted living facility residents. This Budget Entity in this Fund has revenue subject to the 5% reserve. Per instructions, we have exempted Federal Funds from reserve computations. The Agency's 5% calculation is presented below.

Revenue:		
Total Revenue for FY 11-12	1,642,555	
Gross Revenue		1,642,555
Less Revenue Exemptions		
General Revenue Service Charge 8%		131,404
Non Operating Transfer:		
Transfer Section 215		
Total Non-operating Transfers		0
Total Revenue Exemptions		131,404
Total Revenue Subject to 5% Reserve		1,511,151
Total 5% reserve for Quality Long-Term Care Trust Fund		**75,558**

Section III Adjustments Narrative:

Revenue Estimating Methodology Narrative:

Calculations were based on historical collections.

Non-Strategic IT Service: **Network Service**

Dept/Agency: **Agency for Health Care Administration**
Prepared by: Scott Ward & Angela Findley
Phone: 850-412-4844

Service Provisioning -- Assets & Resources *(Cost Elements)*		Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2012-13: Number used for this service	Number w/ costs in FY 2012-13	Estimated FY 2012-13 Allocation of Recurring Base Budget *(based on Column G64 minus G65)*
A. Personnel			1.58		$92,723
A-1.1	**State FTE**	1	1.46		$89,610
A-2.1	**OPS FTE**	2	0.12		$3,113
A-3.1	**Contractor Positions** (Staff Augmentation)		0.00		$0
B. Hardware					$46,000
B-1	**Servers**		0	0	$0
B-2	**Server Maintenance & Support**		0	0	$0
B-3	**Network Devices & Hardware** (e.g., routers, switches, hubs, cabling, etc.)	6	120	0	$46,000
B-4	**Online Storage for file and print** *(indicate GB of storage)*		0		$0
B-5	**Archive Storage for file and print** *(indicate GB of storage)*		0		$0
B-6	**Other Hardware Assets** *(Please specify in Footnote Section below)*				$0
C. Software					$0
D. External Service Provider(s)					$688,000
D-1	**MyFloridaNet**	3			$632,000
D-2	**Other** *(Please specify in Footnote Section below)*	4			$56,000
E. Other *(Please describe in Footnotes Section below)*		5			$78,000
F. Total for IT Service					**$904,723**
G. Please identify the number of users of the Network Service					**1,849**
H. How many locations currently host IT assets and resources used to provide LAN services?					**15**
I. How many locations currently use WAN services?					**15**

J. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

#	Footnote
1	[illegible] and Non-Strategic services.
2	There is 1 OPS person/position that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
3	[illegible] provisioned for Data Center Consolidation, & Enterprise email
4	Wireless Air Cards for IT Personnel & DMS STEPS (VoIP) charges paid by IT
5	Colocation Costs - Suncom, Rent, Agency Storage
6	LAN Switch maintenance cost & Wireless Access Points located at AHCA headquarters and Area Offices
7	
8	
9	
10	
11	
12	
13	
14	
15	

Non- Strategic IT Service:

E- Mail, Messaging, and Calendaring Service

Agency: **Agency for Health Care Administration**

Prepared by: Scott Ward & Angela Findley

Phone: 850- 412- 4844

Service Provisioning - - Assets & Resources *(Cost Elements)*		Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2012- 13: Number used for this service	# of Assets & Resources Apportioned to this IT Service in FY 2012- 13: Number w/ costs in FY 2012- 13	Estimated FY 2012- 13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	**Personnel**		1.14		$58,408
A-1	**State FTE**	1	0.94		$53,220
A-2	**OPS FTE**	2	0.20		$5,188
A-3	**Contractor Positions** (Staff Augmentation)		0.00		$0
B.	**Hardware**				$30,000
B-1	**Servers**		0	0	$0
B-2	**Server Maintenance & Support**		0	0	$0
B-3	**Wireless Communication Devices** *(e.g., Blackberries, I-phones, PDAs, etc.)*	3	170	170	$30,000
B-4	**Online Storage** *(indicate GB of storage)*		0		$0
B-5	**Archive Storage** *(indicate GB of storage)*		0		$0
B-6	**Other Hardware Assets** *(Please specify in Footnote Section below)*				$0
C.	**Software**				$0
D.	**External Service Provider(s)**				$280,000
D-1	**Southwood Shared Resource Center**				$0
D-2	**Northwood Shared Resource Center**				$0
D-3	**Northwest Regional Data Center**				$0
D-4	**Other Data Center External Service Provider** *(specify in Footnotes below)*	5			$280,000
E.	**Other** *(Please describe in Footnotes Section below)*				$0
F.	**Total for IT Service**				**$368,408**
G.	**Please provide the number of user mailboxes.**				**1,785**
H.	**Please provide the number of resource mailboxes.**				**289**

I. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	For the total count of FTE there are 7 people/positions that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
2	There is 1 OPS person/position that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
3	Sprint/Nextel for integrated costs of mobile devices and the data services - AHCA has 170 blackberry's of which 25 are used by IT FTE's
4	Estimated Enterprise Email costs
5	
6	
7	
8	
9	

Non- Strategic IT Service: **Desktop Computing Service**

Agency: **Agency for Health Care Administration**

Prepared by: Scott Ward & Angela Findley

Phone: 850- 412- 4844

	Service Provisioning - - Assets & Resources *(Cost Elements)*	*Footnote Number*	*# of Assets & Resources Apportioned to this IT Service in FY 2012- 13* — *Number used for this service*	*Number w/ costs in FY 2012- 13*	Estimated FY 2012- 13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	**Personnel**		6.65		$393,485
A-1	**State FTE**	1, 2	6.35		$385,703
A-2	**OPS FTE**	3	0.30		$7,782
A-3	**Contractor Positions** (Staff Augmentation)		0.00		$0
B.	**Hardware**		2466	2466	$400,764
B-1	**Servers**		0	0	$0
B-2	**Server Maintenance & Support**		0	0	$0
B-3.1	**Desktop Computers**	4, 8	1462	1462	$183,000
B-3.2	**Mobile Computers** (e.g., Laptop, Notebook, Handheld, Wireless Computer)	5, 8	1004	1004	$207,000
B-3.3	**Other Hardware Assets** *(Please specify in Footnote Section below)*	6	0	0	$10,764
C.	**Software**	7			$220,000
D.	**External Service Provider(s)**		0	0	$0
E.	**Other** *(Please describe in Footnotes Section below)*	9			$116,000
F.	**Total for IT Service**				**$1,130,249**
G.	**Please identify the number of users of this service.**				**1,849**
H.	**How many locations currently use this service?**				**15**

I. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	Includes field staff located in 10 area offices. There are a total of 23 positions that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
2	The collective staff has a high level of experience with and knowledge of the many Agency-specific business processes and related information systems. Based on everyone's tenure in Customer Service, we have an average AHCA IT experience of 11.138 years per technician.
3	There is 1 OPS person/position that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
4	Total number of Desktop PCs; Reflects approximately 20% PC replacement (per OPB direction, the planned replacement cycle for desktop PCs extended by 1 year to 5 year target).
5	The figure includes 771 Laptops & Tablets for daily business operations PLUS an additional 233 laptops for COOP/DR/Pandemic. These 233 laptops are no cost items that would have been surplused, but are being retained for COOP/DR
6	Savin Printer/Copier Lease
7	Microsoft EA License
8	Per OPB direction, the planned replacement cycle for desktop and Laptop PCs is extended by 1 year to 5 year target for Desktops and 4 year target for Laptops. Actual replacement rates will be dependent upon available funding.
9	Colocation Costs - Suncom, Rent, Agency Storage
10	
11	
12	
13	
14	
15	

Non- Strategic IT Service: **Helpdesk Service**

Agency: **Agency for Health Care Administration**

Prepared by: Scott Ward & Angela Findley

Phone: 850- 412- 4844

Service Provisioning - - Assets & Resources *(Cost Elements)*	Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2012- 13: Number used for this service	# of Assets & Resources Apportioned to this IT Service in FY 2012- 13: Number w/ costs in FY 2012- 13	Estimated FY 2012- 13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel		3.50		$145,324
A-1 **State FTE**	1	2.50		$112,899
A-2 **OPS FTE**	2	1.00		$32,425
A-3 **Contractor Positions** (Staff Augmentation)		0.00		$0
B. Hardware		2	0	$0
B-1 **Servers**	3	2	0	$0
B-2 **Server Maintenance & Support**		0	0	$0
B-3 **Other Hardware Assets** *(Please specify in Footnote Section below)*		0	0	$0
C. Software				$0
D. External Service Provider(s)		0	0	$0
E. Other *(Please describe in Footnotes Section below)*	4			$22,000
F. Total for IT Service				**$167,324**
G. Please identify the number of users of this service.				**1,849**
H. How many locations currently host IT assets and resources used to provide this service?				**1**
I. What is the average monthly volume of calls/cases/tickets?				**3,400**

J. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	For the total count of FTE there are 8 people/positions that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
2	One full time OPS employee dedicated 100% to helpdesk duties
3	Two physical servers for Magic - fully paid for - no ongoing costs
4	Colocation Costs - Suncom, Rent, Agency Storage; Training & Supplies
5	1,100 calls/network access forms & 3,400 tickets based on the number of calls/network access forms.
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Non- Strategic IT Service:

IT Security/Risk Mitigation Service

Agency: **Agency for Health Care Administration**

Prepared by: **Scott Ward & Angela Findley**

Phone: **850- 412- 4844**

Service Provisioning - - Assets & Resources *(Cost Elements)*		Footnote Number	*# of Assets & Resources Apportioned to this IT Service in FY 2012- 13* Number used for this service	Number w/ costs in FY 2012- 13	Estimated FY 2012- 13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel			3.32		$214,429
A-1	**State FTE**	1	3.32		$214,429
A-2	**OPS FTE**		0.00		$0
A-3	**Contractor Positions** (Staff Augmentation)		0.00		$0
B. Hardware			21	0	$0
B-1	**Servers**	2	1	0	$0
B-2	**Server Maintenance & Support**		0	0	$0
B-3	**Other Hardware Assets** *(Please specify in Footnote Section below)*	3	20	0	$0
C. Software		4			$48,853
D. External Service Provider(s)		5	0	0	$139,980
E. Other *(Please describe in Footnotes Section below)*		6			$12,000
F. Total for IT Service					**$415,262**

G. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	For the total count of FTE there are 38 people/positions that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
2	Camera/Security Monitoring Appliance
3	Security Cameras throughout AHCA Headquarters complex
4	WebStart web-based training ; Ironport
5	Cost for DSM.net disaster recovery, Archives Security, Ft. Knox, Fedex, Emergency Generator maintenance & fuel, Risk Assessment
6	Colocation Costs - Suncom, Rent, Agency Storage; Trainng & Supplies
7	
8	
9	
10	
11	
12	
13	
14	
15	

Non- Strategic IT Service: **Agency Financial and Administrative Systems Support Service**

Agency: **Agency for Health Care Administration**

Prepared by: Scott Ward & Angela Findley

Phone: 850- 412- 4844

Service Provisioning - - Assets & Resources *(Cost Elements)*		Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2012-13: Number used for this service	Number w/ costs in FY 2012- 13	Estimated FY 2012- 13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel			1.75		$127,524
A-1	State FTE	1	0.75		$50,044
A-2	OPS FTE		0.00		$0
A-3	Contractor Positions (Staff Augmentation)	2	1.00		$77,480
B. Hardware			0	0	$0
B-1	Servers		0	0	$0
B-2	Server Maintenance & Support		0	0	$0
B-3	Other Hardware Assets *(Please specify in Footnote Section below)*		0	0	$0
C. Software					$0
D. External Service Provider(s)			0	0	$0
E. Other *(Please describe in Footnotes Section below)*					$0
F. Total for IT Service					$127,524
G. Please identify the number of users of this service.					1,849
H. How many locations currently host agency financial/adminstrative systems?					1

I. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	For the total count of FTE there are 4 people/positions that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Non- Strategic IT Service:

IT Administration and Management Service

Agency: **Agency for Health Care Administration**

Prepared by: Scott Ward & Angela Findley

Phone: 850- 412- 4844

Service Provisioning - - Assets & Resources *(Cost Elements)*	Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2012- 13: Number used for this service	# of Assets & Resources Apportioned to this IT Service in FY 2012- 13: Number w/ costs in FY 2012- 13	C: Estimated FY 2012- 13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel		5.20		$318,942
A-1 **State FTE**	1	4.20		$290,942
A-2 **OPS FTE**	2	1.00		$28,000
A-3 **Contractor Positions** (Staff Augmentation)		0.00		$0
B. Hardware		0	0	$0
B-1 **Servers**		0	0	$0
B-2 **Server Maintenance & Support**		0	0	$0
B-3 **Other Hardware Assets** *(Please specify in Footnote Section below)*		0	0	$0
C. Software				$0
D. External Service Provider(s)		0	0	$0
E. Other *(Please describe in Footnotes Section below)*	3			$40,000
F. Total for IT Service				**$358,942**
G. How many locations currently host assets and resources used to provide this service?				**1**

G. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	For the total count of FTE there are 25 people/positions that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
2	There is an additional OPS position that would be applicable to this service if Agency funding allows the position to be filled.
3	Documentation destruction; Consumables/Office Supplies; Training; Colocation Costs
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Non-Strategic IT Service: **Web/Portal Service**

Dept/Agency: **Agency for Health Care Administration**
Prepared by: Scott Ward & Angela Findley
Phone: 850- 412- 4844

	Service Provisioning -- Assets & Resources *(Cost Elements)*	Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2012-13: Number used for this service	Number w/ costs in FY 2012-13	Estimated FY 2012-13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	**Personnel**		0.75		$45,545
A-1.1	**State FTE**	1	0.75		$45,545
A-2.1	**OPS FTE**		0.00		$0
A-3.1	**Contractor Positions** (Staff Augmentation)		0.00		$0
B.	**Hardware**				$0
B-1	**Servers**	2	22	0	$0
B-2	**Server Maintenance & Support**		0	0	$0
B-3	**Other Hardware Assets** *(Please specify in Footnotes Section below)*		0	0	$0
C.	**Software**	3			$78,000
D.	**External Service Provider(s)**	4	0	0	$2,500
E.	**Other** *(Please describe in Footnotes Section below)*	5			$10,000
F.	**Total for IT Service**				**$136,045**
G.	**Please identify the number of Internet users of this service.**				**Unknown**
H.	**Please identify the number of intranet users of this service.**				**1,849**
I.	**How many locations currently host IT assets and resources used to provide this service?**				**2**

J. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	For the total count of FTE there are 4 people/positions that provide some portion of their time to this service while also shared with other IT Strategic and Non-Strategic services.
2	22 total - 9 Production servers of which 7 are virtual and 2 are physical & 13 virtual Development servers - no cost assocaited with these servers
3	Microsoft Licenses and Nintex licensing & support
4	TZO Support - monitors status off external ESS (Emergency Status System)
5	Training & Supplies
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Non-Strategic IT Service: **Data Center Service**

Dept/Agency: **Agency for Health Care Administration**

Prepared by: Scott Ward & Angela Findley

Phone: 850- 412- 4844

Service Provisioning -- Assets & Resources *(Cost Elements)*	Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2012-13: Number used for this service	Number w/ costs in FY 2012-13	Estimated FY 2012-13 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel *(performing data center functions defined in w. 282.201(2)(d)1.e., F.S.)*		3.76		$243,935
A-1.1 **State FTE**		2.63		$177,619
A-2.1 **OPS FTE**		0.13		$3,916
A-3.1 **Contractor Positions** (Staff Augmentation)		1.00		$62,400
B. Hardware				$38,939
B-1 **Non-Mainframe Servers** *(including single-function logical servers not assigned to another service)*	1	191	0	$0
B-2 **Servers - Mainframe**		0	0	$0
B-3 **Server Maintenance & Support**	2	0	0	$0
B-4 **Online or Archival Storage Systems** *(indicate GB of storage)*	3			$15,500
B-5 **Data Center/ Computing Facility Internal Network**	4			$7,064
B-6 **Other Hardware** *(Please specify in Footnotes Section below)*	5			$16,375
C. Software	6			$313,753
D. External Service Provider(s)				$1,581,053
D-1 **Southwood Shared Resource Center** *(indicate # of Board votes)*	7	0		$7,883
D-2 **Northwood Shared Resource Center** *(indicate # of Board votes)*	8	0		$948,170
D-3 **Northwest Regional Data Center** *(indicate # of Board votes)*		0		$0
D-4 **Other Data Center External Service Provider** *(specify in Footnotes below)*	9			$625,000
E. Plant & Facility				$82,596
E-1 **Data Center/Computing Facilities Rent & Insurance**	10			$78,000
E-2 **Utilities (e.g., electricity and water)**	10			$0
E-3 **Environmentals (e.g., HVAC, fire control, and physical security)**	11			$4,596
E-4 **Other** *(please specify in Footnotes Section below)*				$0
F. Other *(Please describe in Footnotes Section below)*				$0
G. Total for IT Service				**$2,260,276**
H. Please provide the number of agency data centers.				**1**
I. Please provide the number of agency computing facilities.				**0**
J. Please provide the number of single-server installations.				**12**

H. Footnotes - *Please indicate a footnote for each corresponding row above. Maximum footnote length is 1024 characters.*

1	Of the 191 servers, 108 are virtual servers and 83 are physical servers.
2	Most physical servers are under factory warranty. Those that do not have support are in the process of being retired. Therefore, we have no maintenance costs associated with
3	The EVA8100 is the only physical storage system that currently has a maintenance cost ($15,500). All other physical storage systems and backup tape libraries are either under
4	AHCA's primary and failover firewalls, primary and secondary VPN, and IPS are maintained via a Cisco Smartnet contract. This maintenance renewal will be AHCA's responsibility in
5	Includes (a) $8,012 for Ironport, (b) $8,363.10 for APC; These maintenance renewals will be AHCA's responsibility in FY12/13 since they expires 6/30/12.
6	Includes (a) $60,671 Exchange, ISA Server, Windows Datacenter & Server Editions, Project, Sharepoint licenses - Microsoft EA; (b) $37,642 for SQL Server Licenses - Microsoft EA,
7	Southwood Shared Resource Center Billings for Emergency Status System (ESS-HA) $545.45/month totaling $7133 plus an additional estimate of $750 for "Shared Transitional
8	$948,170 - NSRC quote August 2011.
9	DMS network lines (625000) - Network lines also noted on "Network" tab

Agency: Agency for Health Care Administration

	Budget Entity Name	BE Code	Program Component Code	Program Component Name	Identified Funding as % of Total Cost of Service		E-Mail, Messaging, and Calendaring Service	Network Service	Desktop Computing Service	Helpdesk Service	IT Security/Risk Mitigation Service	Agency Financial and Administrative Systems Support Service	IT Administration and Management Service	Web/Portal Service	Data Center Service
					Costs within BE	Funding Identified for IT Service	100.0000%	100.4464%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
							$368,408	$908,762	$1,130,249	$167,324	$415,262	$127,524	$358,942	$136,045	$2,260,276
1	Administration and Support	68200000	1603000000	Information Technology		$5,795,312	$368,408	$908,762	$1,130,249	$167,324	$415,262	$50,044	$358,942	$136,045	$2,260,276
2	Administration and Support	68200000	1603000000	Finance & Accounting		$77,480						$77,480			
3						$0									
4						$0									
5						$0									
6						$0									
7						$0									
8						$0									
9						$0									
10						$0									
11						$0									
12						$0									
13						$0									
14						$0									
15						$0									
16						$0									
17						$0									
18						$0									
19						$0									
20						$0									
21						$0									
22						$0									
23						$0									
24						$0									
25						$0									
26						$0									
27						$0									
28						$0									
29						$0									
30						$0									
					Sum of IT Cost Elements Across IT Services										
	IT Cost Element Data as entered on IT Service Worksheets			State FTE (#)	22.90		0.94	1.46	6.35	2.50	3.32	0.75	4.20	0.75	2.63
			Personnel	State FTE (Costs)	$1,420,011		$53,220	$89,610	$385,703	$112,899	$214,429	$50,044	$290,942	$45,545	$177,619
			Personnel	OPS FTE (#)	2.75		0.20	0.12	0.30	1.00	0.00	0.00	1.00	0.00	0.13
				OPS FTE (Cost)	$80,424		$5,188	$3,113	$7,782	$32,425	$0	$0	$28,000	$0	$3,916
			Personnel	Vendor/Staff Augmentation (# Positions)	2.00		0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	1.00
				Vendor/Staff Augmentation (Costs)	$139,880		$0	$0	$0	$0	$0	$77,480	$0	$0	$62,400
			Hardware		$515,703		$30,000	$46,000	$400,764	$0	$0	$0	$0	$0	$38,939
			Software		$660,606		$0	$0	$220,000	$0	$48,853	$0	$0	$78,000	$313,753
			External Services		$2,691,533		$280,000	$688,000	$0	$0	$139,980	$0	$0	$2,500	$1,581,053
			Plant & Facility (Data Center Only)		$82,596										$82,596
			Other		$278,000		$0	$78,000	$116,000	$22,000	$12,000	$0	$40,000	$10,000	$0
				Budget Total	$5,868,753		$368,408	$904,723	$1,130,249	$167,324	$415,262	$127,524	$358,942	$136,045	$2,260,276
				FTE Total	27.65		1.14	1.58	6.65	3.50	3.32	1.75	5.20	0.75	3.76
						Users	2,074	1,849	1,849	1,849		1,849		#VALUE!	
						Cost Per User	177.6316297	$489.30	$611.28	$90.49		$68.97		#VALUE!	
							(cost/all mailboxes)								

Help Desk Tickets: 3,400
Cost/Ticket: $49

Data Center Consolidation Cost Workbook

Summary Cost Spreadsheet

Agency: Agency for Health Care Administration
Prepared by: Scott Ward & Angela Findley
Contact Info: 850- 412- 4844
Primary Data Center:

Required Cost Elements	Footnote Number	Agency Assets & Resources Identified for Data Center Consolidation: Units in FY 2011- 12	Agency Assets & Resources Identified for Data Center Consolidation: Units in FY 2012- 13	A: (based on Column G64 minus G65) Estimated Allocation of Recurring Base Budget FY2011- 12	B: Deduct Agency Data Center Services Funding FY2012- 13 (D- 3A Issue # 17C01C0)	C: (based on Column G64 minus G65) Add Data Center Services Funding Provided by Primary Data Center Services FY2012- 13 (D- 3A Issue # 17C02C0)	D: Reductions from Data Center Service Consolidations FY2012- 13 (D- 3A Issue 33001C0)	E: Additional Resources Required to Support Consolidation of Data Center Services FY2012- 13 D- 3A Issue 55C01C0
I. Personnel - (Includes Management and Administrative Positions)		3.76		$ 243,935	$ 243,935	$ -	$ 243,935	$ -
I-1 **State FTE** (Filled & Vacant)		2.63		$ 177,619	$ 177,619		$ 177,619	
I-2 **OPS** (Filled & Vacant)		0.13		$ 3,916	$ 3,916		$ 3,916	
I-3 **Contractor Positions** (Staff Augmentation - Filled & Vacant)		1.00		$ 62,400	$ 62,400		$ 62,400	
I-4 **Overtime and On- Call Pay**							$ -	
II. Hardware - Located in Agency Data Center				$ 38,939	$ -	$ -	$ -	$ -
II-1 **Servers** - Mainframe							$ -	
II-2 **Servers** - Other than mainframe	2	191					$ -	
II-3 **Server Maintenance & Support**	3	0					$ -	
II-4 **Storage Systems** (e.g. online & archival tape & disk systems)	4	14		$ 15,500			$ -	
II-5 **Data Center/Computing Facility Internal Network** (e.g., front end processors, routers, switches, etc.)	5	19		$ 7,064			$ -	
II-6 **Other Hardware** (*please specify in Footnotes Section below*)	6			$ 16,375			$ -	
III. Software - Located in Agency Data Center				$ 313,753	$ 49,643	$ -	$ 49,643	$ -
III-1 **Software - Systems Software**	7			$ 60,671			$ -	
III-2 **Software - Database**	8			$ 139,912			$ -	$ -
III-3 **Software - Other** (*please specify in Footnotes Section below*)	9			$ 113,170	$ 49,643		$ 49,643	$ -
IV. Hardware - Not Located in Agency Data Center				$ -	$ -	$ -	$ -	$ -
IV-1 **Servers** - Mainframe				$ -	$ -		$ -	$ -
IV-2 **Servers** - Other than mainframe				$ -	$ -		$ -	
IV-3 **Server Maintenance & Support**				$ -	$ -		$ -	$ -
IV-4 **Storage Systems** (e.g. online & archival tape & disk systems)				$ -	$ -		$ -	$ -
IV-5 **Data Center/Computing Facility Internal Network** (e.g., front end processors, routers, switches, etc.)				$ -	$ -		$ -	$ -
IV-6 **Other Hardware** (*please specify in Footnotes Section below*)				$ -	$ -		$ -	$ -
V. Software - Not Located in Agency Data Center				$ -	$ -	$ -	$ -	$ -
V-1 **Software - Systems Software**				$ -	$ -		$ -	$ -
V-2 **Software - Database**				$ -	$ -		$ -	$ -
V-3 **Software - Other** (*please specify in Footnotes Section below*)				$ -	$ -		$ -	$ -
VI. Contracted Services or External Service Providers				$ 102,144	$ -	$ 948,170	$ -	$ 240,000
VI-1 **Northwood Shared Resource Center Billings**	16			$ -	$ -	$ 948,170	$ -	$ -
VI-2 **Southwood Shared Resource Center Billings**	10			$ 7,883	$ -	$ -	$ -	$ -
VI-3 **Northwest Regional Data Center Billings**				$ -	$ -	$ -	$ -	$ -
VI-4 **Disaster Recovery Services** (*please specify in Footnotes Section below*)	11			$ 94,261	$ -	$ -	$ -	$ -
VI-5 **DMS Network Line Costs**	12						$ -	$ 240,000
VI-6 **Other** (*Please specify in Footnotes Section below*)				$ -	$ -	$ -	$ -	$ -
VII. Administrative Overhead (other personnel & data center/computing facility related costs)				$ 100,787	$ 18,191	$ -	$ 18,191	$ -
VII-1 **Recurring FTE Standard Expense**		2.63		$ 17,240	$ 17,240		$ 17,240	$ -
VII-2 **Recurring Standard HR Assessment (FTE)**		2.63		$ 936	$ 936		$ 936	$ -
VII-3 **Recurring Standard HR Assessment (OPS)**		0		$ 15	$ 15		$ 15	$ -
VII-4 **Data Centers/Computing Facilities - - Rent & Insurance**	13	0		$ 78,000	$ -		$ -	$ -
VII-5 **Data Center/Computing Facility Environmentals** (*e.g. HVAC, fire control, physical security*)	14	2		$ 4,596	$ -		$ -	$ -
VII-6 **Utilities** (*e.g. electricity & water*)	13			$ -	$ -		$ -	$ -
VII-7 **Other** (*please specify in Footnotes Section below*)				$ -	$ -		$ -	$ -
VIII. Other				$ -	$ -	$ -	$ -	$ 591,000
VIII-1 **Training & Travel** (*please specify in Footnotes Section below*)		0				$ -	$ -	$ -
VIII-2 **Other** (*please specify in Footnotes Section below*)	17	0		$ -	$ -	$ -	$ -	$ 591,000
IX. Data Center Consolidation Totals				$ 799,558	$ 311,769	$ 948,170	$ 311,769	$ 831,000
X. Required Cost Elements Funded with Non- Recurring Budget (not included in Column A)	15	0	0	$ 591,000				

Footnotes - *Please be sure to indicate the footnote for the corresponding row above.*

1	
2	Of the 191 servers, 108 are virtual servers and 83 are physical servers.

Footnotes - *Please be sure to indicate the footnote for the corresponding row above.*	
3	Most physical servers are under factory warranty. Those that do not have support are in the process of being retired. Therefore, we have no maintenance costs associated with Server Support.
4	The EVA8100 is the only physical storage system that currently has a maintenance cost ($15,500). All other physical storage systems and backup tape libraries are either under factory warranty or warranty has expired.
5	AHCA's primary and failover firewalls, primary and secondary VPN, and IPS are maintained via a Cisco Smartnet contract.
6	Includes (a) $8,012 for Ironport, (b) $8,363.10 for APC
7	$60,671 Includes Exchange, ISA Server, Windows Datacenter & Server Editions, Project, Sharepoint licenses - Microsoft EA
8	Includes (a) $37,642 for SQL Server Licenses - Microsoft EA, (b) $102,270 for Oracle Database Software
9	##
10	Southwood Shared Resource Center Billings for Emergency Status System (ESS-HA) $545.45/month totaling $7133 plus an additional estimate of $750 for "Shared Transitional Services" throughout the year
11	Includes (a) $89,137 for DSM.net Disaster Recovery Services and ofsite tape storage, (b) $780 for US Storage Center, (c) $4,344 for Archives Security Inc.
12	Column A - DMS Network Line Costs - MFM Common Services lines for Area Offices, 2Gman, extranet, public vrf ($385,000 = FY10/11 costs) Colums E - $120,000 includes the the increased bandwidth and new circuit provisioned at Northwood needed for DCC
13	Utilities, Rent included in the lease, no extra or itemized cost to the agency. This cost remains with the agency whether the data center is on-site or not. Lease for AHCA Headquarters totals $366,537.15 per month and is paid collocated.
14	Includes (a) $1,416 for maintenance of Fire Suppression system, (b) $3180 for maintenance of AHCA's Data Center A/C units
15	Certified movers and consulting expenses are needed for the data center move and will be listed in the FY12/13 LBR for AHCA.
16	$948,170 - NSRC quote from August 2011.
17	For consulting services and certified movers
18	
19	
20	
21	
22	
23	
24	
25	
26	
27	
28	
29	
30	

Org Chart ID #	Position Title	Annual Cost	Personnel Type	FTE/OPS Position # or IT Contractor ID #	If Vacant, Enter Date Vacant	Primary Functional Responsibilties	% Backup & Recovery	Backup & Recovery Cost	% Data Center Management Ops	Data Center Management Ops Cost	% Database Administration	Database Administration Cost	% Disaster Recovery	Disaster Recovery Cost	% Help Desk	Help Desk Cost	% Job Control	Job Control Cost	% Managed Services	Managed Services Cost
Personnel Cost Associated with Data Center Functions:		$ 243,935	3.76				Data Center Functional Responsibilities													
	Chief of Enterprise Infrastructure & Operations	$ 110,812	FTE	53337	7/10/2011	*Infrasturcture Mgmt, Disaster Recovery, Network, Voice over Internet Protocol (VOIP)*	0.00%	$ -	0%	$ -	0%	$ -	5%	$ 5,541	0%	$ -	0%	$ -	0%	$ -
167346	Data Processing Manager - SES	$ 94,016	FTE	63617		*Strategic Database Manager, SQL*	2.00%	$ 1,880	0%	$ -	5%	$ 4,701	3%	$ 2,820	0%	$ -	0%	$ -	0%	$ -
136931	Senior Database Analyst	$ 58,058	FTE	64279		*Strategic Oracle & SQL*	5.00%	$ 2,903	0%	$ -	2%	$ 1,161	0%	$ -	0%	$ -	0%	$ -	0%	$ -
184803	Systems Project Administrator - SES	$ 58,058	FTE	63615	4/18/2011	*Oracle SQL*	8.00%	$ 4,645	0%	$ -	5%	$ 2,903	7%	$ 4,064	0%	$ -	0%	$ -	0%	$ -
903862	Telecommunications Specialist	$ 44,330	FTE	64459		*Network Administration, User account mgmt, Technical Helpdesk Assignments*	20.00%	$ 8,866	5%	$ 2,217	0%	$ -	0%	$ -	10%	$ 4,433	0%	$ -	0%	$ -
676952	Systems Project Administrator - SES	$ 71,656	FTE	34435		*VMWare Specialist, LAN/WAN & FMMIS Infrastructure Management,VoIP Infrastructure, Security*	0.00%	$ -	2%	$ 1,433	0%	$ -	2%	$ 1,433	0%	$ -	0%	$ -	0%	$ -
148315	Systems Programmer III	$ 78,988	FTE	64282		*RAC Server Management, Linux,*	10.00%	$ 7,899	15%	$ 11,848	0%	$ -	5%	$ 3,949	0%	$ -	0%	$ -	5%	$ 3,949
158018	Network Systems Administrator - SES	$ 83,356	FTE	64468		*VMWare Specialist, Network Engineering, LAN/WAN & FMMIS Infrastructure Management, VoIP Infrastructure, Security*	0.00%	$ -	2%	$ 1,667	0%	$ -	5%	$ 4,168	0%	$ -	0%	$ -	0%	$ -
	Systems Programmer III	$ 58,058	FTE	64472		*Back-up Admin, Enterprise Vault Admin., Public Records & Legal Discovery*	25.00%	$ 14,515	2%	$ 1,161	0%	$ -	2%	$ 1,161	0%	$ -	0%	$ -	2%	$ 1,161
874982	Systems Programmer III	$ 64,792	FTE	56680		*IT Asset Management, Security*	0.00%	$ -	2%	$ 1,296	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
OPS	OPS Systems Project Analyst	$ 30,120	OPS		6/30/2011	*User account mgmt, Technical Helpdesk Assignments*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	10%	$ 3,012	0%	$ -	0%	$ -
	Database Administrator	$ 62,400	Contracted Services			*Oracel RAC Management & Support*	0.00%	$ -	0%	$ -	85%	$ 53,040	0%	$ -	0%	$ -	0%	$ -	5%	$ 3,120
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%		0%		0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -

Org Chart ID #	Position Title	Annual Cost	Personnel Type	FTE/OPS Position # or IT Contractor ID #	If Vacant, Enter Date Vacant	Primary Functional Responsibilties	% Backup & Recovery	Backup & Recovery Cost	% Data Center Management Ops	Data Center Management Ops Cost	% Database Administration	Database Administration Cost	% Disaster Recovery	Disaster Recovery Cost	% Help Desk	Help Desk Cost	% Job Control	Job Control Cost	% Managed Services	Managed Services Cost
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
		$ -				*None Provided*	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
							0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
							0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
Total	Cost Identified by Position Title:	$ 814,644						$ 40,707		$ 19,622		$ 61,805		$ 23,137		$ 7,445		$ -		$ 8,231
10	FTE TOTAL	$ 722,124	Personnel Budget Reduction from Tab 1:				FTE	$ 40,707	FTE	$ 19,622	FTE	$ 8,765	FTE	$ 23,137	FTE	$ 4,433	FTE	$ -	FTE	$ 5,111
1	OPS TOTAL	$ 30,120					OPS	$ -	OPS	$ -	OPS	$ -	OPS	$ -	OPS	$ 3,012	OPS	$ -	OPS	$ -
1	Contracted Services TOTAL	$ 62,400					CS	$ -	CS	$ -	CS	$ 53,040	CS	$ -	CS	$ -	CS	$ -	CS	$ 3,120

**** If the amount of the reduction is less than the annual cost of the position, identify the amount of the equivalent position to the nearest .25 fte.**

Personnel Cost Associated with Data Center Functions:		$ 243,935	Data Center Functional Responsibilities																Data Validation			
Org Chart ID #	Position Title	Annual Cost	% Print	Print Cost	% Production Control	Production Control Cost	% Security	Security Cost	% Storage	Storage Cost	% System Administration Cost	System Administration Cost	% System Programming	System Programming Cost	% Technical Support	Technical Support Cost	% Management & Administration	Management & Administration Cost	% Allocated	Cost Allocated by Functional Responsibility	Difference	Position Differences
	Chief of Enterprise Infrastructure & Operations	$ 110,812	0%	$ -	2%	$ 2,216	2%	$ 2,216	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	9%	$ 9,973	$ (100,839)	9% Data Center - 91% Agency Strategic Services
167346	Data Processing Manager - SES	$ 94,016	0%	$ -	0%	$ -	0%	$ -	0%	$ -	3.00%	$ 2,820	1%	$ 940	0%	$ -	0%	$ -	14%	$ 13,162	$ (80,854)	14% Data Center - 86% Agency Strategic Services
136931	Senior Database Analyst	$ 58,058	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	7%	$ 4,064	$ (53,994)	7% Data Center - 93% Agency Strategic Services
184803	Systems Project Administrator - SES	$ 58,058	0%	$ -	0%	$ -	0%	$ -	0%	$ -	7.00%	$ 4,064	3%	$ 1,742	0%	$ -	0%	$ -	30%	$ 17,417	$ (40,641)	30% Data Center - 70% Agency Strategic Services
903862	Telecommunications Specialist	$ 44,330	3%	$ 1,330	0%	$ -	0%	$ -	0%	$ -	5.00%	$ 2,217	0%	$ -	10%	$ 4,433	0%	$ -	53%	$ 23,495	$ (20,835)	53% Data Center - 47% Agency Strategic Services
676952	Systems Project Administrator - SES	$ 71,656	0%	$ -	0%	$ -	5%	$ 3,583	5%	$ 3,583	8.00%	$ 5,732	3%	$ 2,150	0%	$ -	0%	$ -	25%	$ 17,914	$ (53,742)	25% Data Center - 75% Agency Strategic Services
148315	Systems Programmer III	$ 78,988	0%	$ -	0%	$ -	1%	$ 790	2%	$ 1,580	5.00%	$ 3,949	20%	$ 15,798	0%	$ -	0%	$ -	63%	$ 49,762	$ (29,226)	63% Data Center - 37% Agency Strategic Services
158018	Network Systems Administrator - SES	$ 83,356	0%	$ -	0%	$ -	5%	$ 4,168	0%	$ -	5.00%	$ 4,168	5%	$ 4,168	0%	$ -	0%	$ -	22%	$ 18,338	$ (65,018)	22% Data Center - 78% Agency Strategic Services
	Systems Programmer III	$ 58,058	0%	$ -	0%	$ -	0%	$ -	0%	$ -	5.00%	$ 2,903	0%	$ -	0%	$ -	0%	$ -	36%	$ 20,901	$ (37,157)	36% Data Center - 64% Agency Strategic Services
874982	Systems Programmer III	$ 64,792	0%	$ -	0%	$ -	2%	$ 1,296	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	4%	$ 2,592	$ (62,200)	4% Data Center - 96% Agency Strategic Services
OPS	OPS Systems Project Analyst	$ 30,120	3%	$ 904	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	13%	$ 3,916	$ (26,204)	13% Data Center - 87% Agency Strategic Services
	Database Administrator	$ 62,400	0%	$ -	0%	$ -	5%	$ 3,120	0%	$ -	5.00%	$ 3,120	0%	$ -	0%	$ -	0%	$ -	100%	$ 62,400	$ -	100% Data Center
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	

Data Center Consolidation Cost Workbook

Personnel Detail

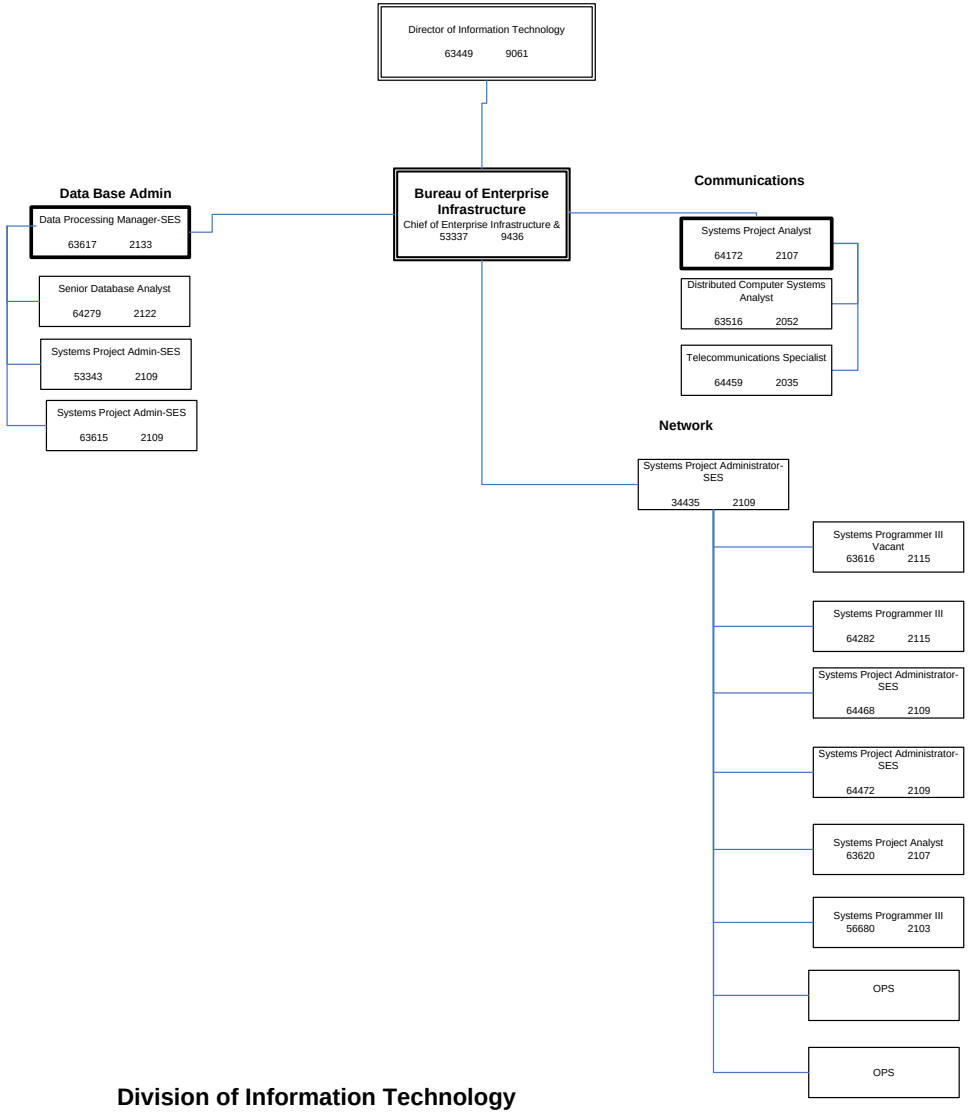
Org Chart ID #	Position Title	Annual Cost	% Print	Print Cost	% Production Control	Production Control Cost	% Security	Security Cost	% Storage	Storage Cost	% System Administration Cost	System Administration Cost	% System Programming	System Programming Cost	% Technical Support	Technical Support Cost	% Management & Administration	Management & Administration Cost	% Allocated	Cost Allocated by Functional Responsibility	Difference	Position Differences
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
		$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
			0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
			0%	$ -	0%	$ -	0%	$ -	0%	$ -	0.00%	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -	$ -	
Total	Cost Identified by Position Title:	$ 814,644		$ 2,234		$ 2,216		$ 15,173		$ 5,163		$ 28,974		$ 24,797		$ 4,433		$ -	3.76	$ 243,935	$ (570,709)	
10	FTE TOTAL	$ 722,124	FTE	$ 1,330	FTE	$ 2,216	FTE	$ 12,053	FTE	$ 5,163	FTE	$ 25,854	FTE	$ 24,797	FTE	$ 4,433	FTE	$ -	2.63	$ 177,619		
1	OPS TOTAL	$ 30,120	OPS	$ 904	OPS	$ -	OPS	$ -	OPS	$ -	OPS	$ -	OPS	$ -	OPS	$ -	OPS	$ -	0.13	$ 3,916		
1	Contracted Services TOTAL	$ 62,400	CS	$ -	CS	$ -	CS	$ 3,120	CS	$ -	CS	$ 3,120	CS	$ -	CS	$ -	CS	$ -	1.00	$ 62,400		

**** If the amount of the reduction is less than the annual cost of the position, identify the amount of the equivalent position to the nearest .25 fte.**

Data Center Consolidation Cost Workbook

FY 2012-13 Cost Breakdown by Funding Categories

	A	B	C	D	E	F	G	H	I	J	K	L	M	P
1														
2														
3										Data Center Consolidation Issues				
4														
5										$ 311,769	$ 948,170	$ 311,769	$ 831,000	
6	Budget Entity Code	Budget Entity Name	Program Component Code	Program Component Title	Appropriation Category Code	Appropriation Category Title	Fund Code	Fund Title	FSI	17C01C0	17C02C0	33001C0	55C001C0	TOTAL
7	68200000	Administration & Support	1603000000	Information Technology	010000	Salaries and Benefits	021010	Administrative Trust Fund	1					$ 1
8	68200000	Administration & Support	1603000000	Information Technology	030000	OPS	021010	Administrative Trust Fund	1					$ 1
9	68200000	Administration & Support	1603000000	Information Technology	040000	Expense	021011	Administrative Trust Fund	1					$ 1
10	68200000	Administration & Support	1603000000	Information Technology	100777	Contracted Services	021010	Administrative Trust Fund	1					$ 1
11														$ -
12														$ -
13														$ -
14														$ -
15														$ -
16														
17														$ -
18														$ -
19														$ -
20														$ -
21														
22														$ -
23														$ -
24														
25														
26														$ -
27														$ -
28														$ -
29														$ -
30														$ -
31														$ -
32														$ -
33														$ -
34														$ -
35														$ -
36														$ -
37														$ -
38														$ -
39	Total									$ -	$ -	$ -	$ -	$ 4



Division of Information Technology
Bureau of Infrastructure Org Chart
07/15/10

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Charles Todd Lee, Rodney Peterson, John Boyd, Clayton L. Griffin, Margaret Washington, and Louise Seymour, on behalf of themselves and all others similarly situated v. Elizabeth Dudek, in her official capacity as Interim Secretary, Florida Agency for Health Care Administration, and Douglas Beach, in his official capacity as Secretary, Florida Department of Elder Affairs
Court with Jurisdiction:	United States District Court in and for the Northern District of Florida
Case Number:	4:08-cv-26-RH-WCS
Summary of the Complaint:	Class action lawsuit alleging that Florida is in violation of Americans with Disabilities Act, 42 U.S.C. §12132 and the Rehabilitation Act of 1973, 29 U.S.C. §794(a)(Section 504) by failing to cover services and support in appropriate, integrated community settings. The Plaintiffs seek declaratory and injunctive relief. They ask the Court for injunctive relief requiring Florida to inform Plaintiffs and class members that they may be eligible for publicly-funded community services and that they have a choice of such services; and ensure coverage of, as appropriate, long-term care services and supports in the most integrated setting appropriate for Plaintiffs and class members and refrain from providing unnecessary and unwanted long-term care only in institutional settings. Plaintiffs ask the court to declare that Florida's failure to provide Plaintiffs and class members with services in the most integrated setting appropriate to their needs violates Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. Plaintiffs also seek attorneys' fees and costs.
Amount of the Claim:	The plaintiffs do not seek monetary damages; however, the monetary impact could exceed $500,000 annually in additional Medicaid payments if the plaintiffs were successful.
Specific Law(s) Challenged:	
Status of the Case:	The Agency was served with a Class Action Complaint on January 15, 2008. On February 19, 2008, the Plaintiffs filed an Amended Class Action Complaint for Declaratory and Injunctive Relief. On March 7, 2008, the Defendants filed a Motion to Dismiss Amended Complaint. On March 21, 2008, the Defendants filed a Response in Opposition to the Plaintiffs' Motion to Certify Class. On June 7, 2008, the Court entered an order denying the Defendants' Motion to Dismiss and Deferring Ruling on Class Certification. On July 7, 2008, the Defendants filed an Answer to the Plaintiffs' Amended Complaint. On September 17, 2008, Plaintiffs filed a Motion for Preliminary Injunction regarding one of the named Plaintiffs.

	On September 30, 2008 the Court orally granted the injunction, followed by a written order on October 14, 2008. Also on October 14, 2008 the Court entered an order certifying the class. Mediation sessions were held on January 5, January 20, February 24, July 7, August 11, August 17, and August 18, 2009. The parties reached a settlement which placed the case in abeyance for one year. On August 20, 2009, the Court held a status conference during which a joint request to stay the proceedings for one year was granted. Telephonic status conference was held on August 26, 2010. Plaintiffs took the position that the defendants had not complied with the settlement. Trail was held February 7 – 11, 2011. Closing arguments were held on February 16, 2011. Awaiting court order.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	**Class was certified on October 14, 2008.** Jodi Siegel with Southern Legal Counsel, Inc. Neil Chonin with Southern Legal Counsel, Inc. Gabriella Ruiz with Southern Legal Counsel, Inc. Stephen F. Gold, P.A. Stacy Canan, D.C. with AARP Foundation Litigation Bruce Vignery, D.C. with AARP Foundation Litigation Sarah Somers, N.C. with National Health Law Program	

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics; Florida Academy of Pediatric Dentistry, Inc.; Ashley Dove, as the next friend of Kaleb Kelley, a minor child; Blanche Spell, as the next friend of Khalillah Spell, a minor child; Eva Carmona, as the next friend of Vanessa and Jennifer Patino, minor children; Amy Torchin, as the next friend of Theeodore Torchin, minor child; and Rita Gorenflo and Lex Gorenflo, as the next friends of Thomas and Nathanial Gorenflo, minor children v. Elizabeth Dudek, in her official capacity as Secretary of the Florida Agency for Health Care Administration; George H. Sheldon, in his official capacity as Secretary of the Florida Department of Children and Family Services; and Ana M. Viamonte Ros, M.D., in her official capacity as the Secretary of the Florida Department of Health
Court with Jurisdiction:	United States District Court for the Southern District of Florida
Case Number:	05-23037-CIV-AJ
Summary of the Complaint:	Class action lawsuit alleging failure of Florida state health officials to provide children in Florida who are enrolled in federally-funded medical assistance with essential medical and dental services as required by Title XIX of the Social Security Act, 42 U.S.C. §1396. The Plaintiffs seek declaratory and injunctive relief. They ask the court for injunctive relief to require the Agency to ensure that payments to providers are sufficient to ensure that Medicaid eligible children have access to care and services at least to the same extent that such care and services are available to other children in the same geographic area, and to assure that such payments are consistent with quality of care.
Amount of the Claim:	The plaintiffs do not seek monetary damages; however, the monetary impact would likely exceed $25 million annually in additional Medicaid payments if the plaintiffs were successful.
Specific Law(s) Challenged:	
Status of the Case:	In 2005, Plaintiffs filed a four count class action complaint, pursuant to 42 U.S.C. §1983, of which three claims remain viable. The first count alleges that Medicaid covered services are not provided to children with reasonable promptness, and alleges violations of 42 U.S.C. 1396a(a)(8) and (10). The second count alleges that the reimbursement rates paid for Florida Medicaid physician and dental services to children are so low that children do not have the same access to services as children who are privately insured have, in violation of 42 U.S.C. §1396a(a)(30)(A). The third count alleges that the Florida Medicaid program does not provide

	adequate outreach to both the uninsured and to Florida Medicaid enrolled children to ensure that all eligible children get the services that are available through the program that they need, in violation of 42 U.S.C. §1396a(43)(A). There are two organizational plaintiffs in the case, the Florida Pediatric Society/the Florida Chapter of the American Academy of Pediatrics, and the Florida Academy of Pediatric Dentistry, and nine individual plaintiffs. Effective July 1, 2011, Medicaid dental reimbursement rates for children were increased by 48.63%. However, Plaintiffs' expert claims that this increase still does not raise the Medicaid dental reimbursement rates high enough to reach the 50th percentile of dentists' charges. He opines that the new rates are about 30% of the 50th percentile of dentists' charges in Florida. After the close of their case in chief, Plaintiffs filed a Motion for Preliminary Injunction by which they sought a preliminary injunction order requiring Defendant Dudek to increase Medicaid reimbursement rates for physician services to children to the level of Medicare rates, and to increase Medicaid reimbursement rates for dental services for children to the 50th percentile of dentists' usual and customary charges. By order entered on July 11, 2011, the Court determined that consideration of the motion should be deferred to completion of Defendants' case-in-chief, at which point, Plaintiffs may argue the motion or present their rebuttal case and then argue the motion. There have been 42 trial days (over 11 segments) since December 7, 2009. Plaintiffs closed their case in chief in February 2011. Agency started its case on April 4, 2011. Another 120 hours is projected for our case-in-chief, followed by Plaintiffs' direct examination. A specific end point cannot be determined, as the Court tries the case in segments, as time becomes available. The Court has indicated in the last two trial sessions that it intends to set aside a longer period of time, as much as 4 weeks, to try to finish the trial in this case.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
	X	Office of the Attorney General or Division of Risk Management
	X	Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	The class was granted a partial certification on September 30, 2009. Boies, Schiller & Flexner, LLP Public Interest Law Center of Philadelphia Miller, Keffer & Bullock, P.C.	

Schedule VII: Agency Litigation Inventory				
Agency:	Agency for Health Care Administration			
Contact Person:	William H. Roberts		Phone Number:	412-3630

Names of the Parties:	K.G., by and through his next friend, Iliana Garrido v. Elizabeth Dudek, in her official Capacity as Secretary, Florida Agency for Health Care Administration	
Court with Jurisdiction:	United States District Court Southern District of Florida	
Case Number:	1:11-cv-20684-JAL	
Summary of the Complaint:	This is a lawsuit where the plaintiff seeks declaratory and injunctive relief regarding services the plaintiff argues should be covered under the state plan.	
Amount of the Claim:	The plaintiffs do not seek monetary damages; however, if plaintiff prevails and the court orders the Agency to cover applied behavior analysis under the state plan, the costs associated with providing the service to every recipient eligible under the state plan would likely exceed $25,000,000.	
Specific Law(s) Challenged:		
Status of the Case:	Plaintiff filed his complaint for declaratory and injunctive relief on February 28, 2011. On March 29, 2011, the Agency filed Defendant's Answer and Affirmative Defenses to Plaintiff's Complaint. On March 10, 2011, Plaintiff filed an Amended Motion for Preliminary Injunction. On March 28, 2011, the Agency filed Defendant's Response and Incorporated Memorandum of Law in Opposition to Plaintiff's Motion for Preliminary Injunction. Mediation is currently set for October 6, 2011.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Joanna Dykes; David Walker, by and through his next friend, Michele Beauregard; Heather young, by and through her next friend Robert Stark; Michelle Congden; Amanda Pivinski; and Disability Rights Florida, Inc., a Florida non-profit corporation v. Elizabeth Dudek in her official capacity as Secretary of the Florida Agency for Health Care Administration, and Brian Vaughan in his official capacity as (Interim) Director of the Florida Agency for Persons with Disabilities, and Rick Scott in his official capacity as Governor of the State of Florida	
Court with Jurisdiction:	United States District Court Northern District of Florida	
Case Number:	4:11-cv-00116-SPM-WCS	
Summary of the Complaint:	This is a class action lawsuit where plaintiff seeks declaratory and injunctive relief to receive Medicaid services which will allow plaintiff to continue to reside in the community and not require institutionalization.	
Amount of the Claim:	The plaintiffs do not seek monetary damages; however, the monetary impact could exceed $25,000,000 annually in additional Medicaid payments if the plaintiffs were successful.	
Specific Law(s) Challenged:		
Status of the Case:	Plaintiffs filed their complaint for declaratory and injunctive relief on March 23, 2011. On June 14, 2011, the Agency filed its Motion to Dismiss for failure to state claim. On July 8, 2011, Plaintiffs filed an Amended Complaint. On July 22, 2011, the Agency filed its Motion to Dismiss Amended Complaint for Failure to State a Claim.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Jonathan Robledo, individually and on behalf of similarly situated persons v. Elizabeth Dudek in her official capacity as Secretary, Florida Agency for Health Care Administration, and Dr. Frank Farmer, in his official capacity as State Surgeon General, Florida Department of Health	
Court with Jurisdiction:	United States District Court Southern District of Florida	
Case Number:	1:11-cv-21997-AJ	
Summary of the Complaint:	This is a class action lawsuit where plaintiff seeks declaratory and injunctive relief to receive Medicaid services which will allow plaintiff to continue to reside in the community and not require institutionalization.	
Amount of the Claim:	The plaintiffs do not seek monetary damages; however, the monetary impact could exceed $25,000,000 annually in additional Medicaid payments if the plaintiffs were successful.	
Specific Law(s) Challenged:		
Status of the Case:	Plaintiffs filed their complaint for declaratory and injunctive relief on June 2, 2011. On June 23, 2011, plaintiffs filed a First Amended Complaint. On July 22, 2011, the Agency filed its Motion to Dismiss Amended Complaint for Failure to State a Claim.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory				
Agency:	Agency for Health Care Administration			
Contact Person:	William H. Roberts		Phone Number:	922-5873
Names of the Parties:	Christine R. Dunham and Robert Bromhall, individually, and on behalf of all others similarly situated v. The State of Florida, Agency for Health Care Administration, by and through its Director, Carlton Dyke Snipes, Carlton Dyke Snipes and Tom Arnold, Individually, Health Management Systems, Inc. a Subsidiary of HMS Holdings Corp., and DOES 1-10			
Court with Jurisdiction:	Circuit Court of the 1st Judicial Circuit in and for Santa Rosa County			
Case Number:	09-612CA01			
Summary of the Complaint:	Class action lawsuit alleging violation of 42 U.S.C. §1396(k) and 1396(p)(a)(1), U.S. Constitutional Amendments V and XIV, Art. X, §6 Florida Constitution and breach of contract. The plaintiffs allege that defendants have asserted liens and received recovery out of workers compensation settlements when no reimbursement of medical expenses was part of such settlement. Plaintiffs seek injunctive relief alleging violation of federal law and the *Ahlborn* Decision. This case is one of several recent actions regarding the Medicaid anti-lien provision that was decided by the United States Supreme Court in *Arkansas Dept of Health & Human Services v. Ahlborn*, 126 S.Ct. 1752 (2006). *Ahlborn* directs that Medicaid liens may be recovered only from the portion of a settlement that applied to reimbursement of medical expenses.			
Amount of the Claim:				
Specific Law(s) Challenged:				
Status of the Case:	The Agency was served with the Class Action Complaint on April 14, 2009. Counsel for the Agency filed a Motion to Dismiss and a Motion to Transfer Venue to Leon County. Plaintiffs agreed to the transfer of venue. Hearing on Motion to Dismiss was held on December 17, 2009. An order dismissing HMS without prejudice was issued on December 22, 2009. On February 7, 2011, the Agency filed a Motion for Summary Judgment. On May 23, 2011, Plaintiffs dismissed the suit. Case closed.			
Who is representing (of record) the state in this lawsuit? Check all that apply.			Agency Counsel	
	X		Office of the Attorney General or Division of Risk Management	
			Outside Contract Counsel	

If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	The class has not been certified to date. Whibbs & Stone, P.A. Burgess & Lamp, P.C.

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	"Karina Smith" and "Elijah Moses", individually and on behalf of others similarly situated v. Jeff Rainey, Sunny Hall, Hillsborough Kids, Inc., a Florida corporation, First Health, the Agency for Health Care Administration, Holly Benson, individually and as Secretary for the Agency for Health Care Administration, the Florida Department of Children and Families, George Sheldon, individually and in his official capacity as Secretary of the Department of Children and Families and Nicholas Cox, individually and in his capacity as Regional Administrator of the Department of Children and Families
Court with Jurisdiction:	United States District Court Middle District of Florida (Tampa) previously filed in Circuit Court of the 13th Judicial Circuit in and for Hillsborough County
Case Number:	8:09-cv-01628-JDW-MAP previously 09-16377
Summary of the Complaint:	Class action lawsuit alleging violation of the Americans with Disabilities Act and breach of statutory duty against the Agency for allowing payment of Medicaid reimbursement for psychotropic medication of children under the care and supervision of The Department of Children and Families and Hillsborough Kids, Inc.
Amount of the Claim:	Plaintiffs sought an unstated amount of monetary damages for a class of plaintiffs.
Specific Law(s) Challenged:	
Status of the Case:	The Agency was served with the Class Action Complaint on July 20, 2009. On August 17, 2009, counsel for the Department of Children and Families filed a Notice of Removal from the 13th Judicial Circuit for the State of Florida to the United States District Court for the Middle District of Florida. On August 19, 2009, counsel for the Agency filed Defendants' Motion to Dismiss Complaint and Memorandum of Law in Support. On October 1, 2009, the Plaintiff filed an Amended Complaint. On October 15, 2009, counsel for the Agency filed Defendants' Motion to Dismiss Amended Complaint. On November 2, 2009, Plaintiffs filed a Response in Opposition to Defendants' Motion to Dismiss. A Motion to Certify Class was filed on April 15, 2010, by defendants. On September 30, 2010 the Court dismissed the First Amended Complaint with leave to amend. The Court further denied without prejudice the plaintiffs Motion for Certification of Class. An Amended Complaint was filed on November 10, 2010. Mediation was held on December 2, 2010. The Agency for Health Care Administration and the Department of Children and Families settled at mediation. The Agency agreed to pay the plaintiffs a total of

	\$10,000 to be distributed equally between the two named plaintiffs. Plaintiffs filed a Motion for Order Approving settlement that was later denied for further clarification of settlement regarding fees and costs. On February 9, 2011, the plaintiffs filed a Renewed Motion for Order Approving Settlement. On March 28, 2011, the Court approved the settlement. The Agency was dismissed from this matter. Case closed.	
Who is representing (of record) the state in this lawsuit? Check all that apply.		Agency Counsel
		Office of the Attorney General or Division of Risk Management
	X	Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	The class has not been certified to date. Gievers, P.A. Wasson & Associates, Chartered	

Schedule VII: Agency Litigation Inventory

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Baptist Hospital Inc., Bay Medical Center, Holmes Regional Medical Center, Inc., Lee Memorial Health System, Lifemark Hospital's of Florida, Inc. d/b/a Palmetto General Hospital, Munroe Regional Medical Center, North Broward Hospital Distric d/b/a Broward Health St. Joseph's Hospital, Inc., South Broward Hospital District d/b/a Memorial Regional Hospital, Tallahassee Memorial Healthcare, Inc. and Wuesthoff Health System v. Agency for Health Care Administration	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	10-2996RX, 10-2997RU, 10-4491RP	
Summary of the Complaint:	Challenges Medicaid reimbursement rate and coverage limitations for care provided in hospital emergency room setting.	
Amount of the Claim:	Monetary impact could exceed $500,000	
Specific Law(s) Challenged:	Florida Administrative Code 59G-4.160	
Status of the Case:	Rule challenge petition filed on June 1, 2010. Discovery has been conducted. Wuestoff Health System filed its voluntary dismissal on August 17, 2010. Hearing set for September 23-24, 2010 was cancelled. Status report was due October 20, 2010. Agency is in the process of filing a Motion for Protective Order.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Jacqueline Jones, on behalf of herself and all others similarly situated v. Thomas Arnold, in his official capacity as Secretary, Florida Agency for Health Care Administration, and Dr. Anna Viamonte Ross in her official capacity as Secretary, Florida Department of Health
Court with Jurisdiction:	United States District Court Middle District of Florida (Jacksonville)
Case Number:	3:09-CV-1 170-J34JRK
Summary of the Complaint:	This is a class action lawsuit where plaintiff seeks declaratory and injunctive relief to receive Medicaid services which will allow plaintiff to continue to reside in the community and not require institutionalization.
Amount of the Claim:	The plaintiffs do not seek monetary damages; however, the monetary impact would likely exceed $20 million annually in additional Medicaid payments if the plaintiff is successful.
Specific Law(s) Challenged:	
Status of the Case:	On December 2, 2009, a Complaint and Motion for Preliminary Injunction were filed by the plaintiff. The Agency was served with the lawsuit on December 3, 2009. On December 15, 2009, the plaintiff filed a Motion for Leave to Amend the Complaint. On December 29, 2009, the defendants filed a Motion to Dismiss Amended Complaint. On January 6, 2010, the plaintiff filed a Motion for Class Certification. On January 12, 2010, the defendants filed an amended motion to stay class certification pending disposition of plaintiff's status and ruling on motion to dismiss, which was denied on January 12, 2010, for technical errors. The defendants filed an Amended Motion to Stay Class Certification on January 12, 2010. On January 27, 2010, the plaintiff filed a Motion to Amend the First Amended Complaint. The defendants filed a response in opposition to plaintiff's Motion for Leave to Amend First Amended Class Action Complaint. On February 23, 2010, the Court issued an order denying plaintiffs' Motion for Preliminary Injunction as moot. On April 12, 2010, the plaintiff filed a request for leave to amend the Second Amended Complaint. On April 15, 2010, the plaintiff filed a Motion for Preliminary Injunction and Expedited Hearing. On May 7, 2010, the Court issued an order denying plaintiffs Motion for Preliminary Injunction. On May 14, 2010, the plaintiffs withdrew their request to file third amended complaint. Motion for Leave to Amend First Amended Complaint was denied on August 13, 2010. The parties requested and were granted an extension of time to complete discovery. The United States has moved the court to intervene on behalf of the plaintiff. Subsequently, the plaintiff received the services. The

	Court dismissed the case on January 3, 2011. Case closed. _____ Michele Haddad v. AHCA and DOH. Jurisdiction is in the United States District Court Middle District of Florida (Jacksonville); Case number 3:10-cv-414-J-34TEM. Plaintiff filed her complaint and motion for preliminary injunction on May 17, 2010. A hearing on the motion for preliminary injunction was held June 15, 2010. The preliminary injunction was granted on June 23, 2010. On April 19, 2011, the Court dismissed the matter with prejudice. Case closed. _____ Luis Cruz and Nigel De La Torre v. AHCA and DOH. Jurisdiction is in the United States District Court Southern District of Florida; Case number 1:10-cv-23048. Plaintiffs filed their complaint and motions for preliminary injunction on August 18, 2010, in the U.S. District Court for the Middle District of Florida. The District Judge transferred the case to the U.S. District Court for the Southern District of Florida on August 23, 2010. The new District Judge referred plaintiffs' motion for preliminary injunction to the Magistrate Judge and a hearing on the motion was held before the Magistrate Judge on September 16, 2010. The Magistrate Judge recommended that the preliminary injunctions be granted. On November 24, 2010, the District Judge entered an Order adopting the Magistrate's recommendation. On April 18, 2011, the Court issued an Order of Voluntary Dismissal. Plaintiff's attorneys are seeking attorneys' fees and costs.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	Class is not certified at this time. Jay M. Howanitz, Esq. Spohrer & Dodd, P.L.	

Schedule VII: Agency Litigation Inventory

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Las Mercedes Home Care Corp. v. Agency for Health Care Administration	
Court with Jurisdiction:	DOAH	
Case Number:	08-5356MPI	
Summary of the Complaint:	This is an action by AHCA and Catapult (a company under contract to federal Center for Medicare and Medicaid Services to assist Medicaid Program Integrity with audits) to collect $879,843.93 in allegedly overpaid claims.	
Amount of the Claim:	$879,843.93	
Specific Law(s) Challenged:	59G-4.130(2), Florida Administrative Code	
Status of the Case:	Defendant received the Agency correspondence dated September 30, 2008, notifying the defendant that the Agency sought reimbursement of overpayment for dates of service during the period July 1, 2004 through June 30, 2006 in the amount of $878,843.73 plus a $1,000 fine. The hearing was scheduled for May 19, 2010 but both parties requested that the case be held in abeyance until the rule challenge case (1D10-4295 previously 10-0860RX) was decided. On July 6, 2011, the DCA issued the Opinion upholding the lower Court's decision. On July 22, 2011, the Mandate was issued. The Division of Administrative Hearings issued an Order Relinquishing on August 9, 2011, as a result of the Agency's Motion to Relinquish based on the DCA ruling in 1D10-4295. Case closed.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	Agency for Health Care Administration v. Las Mercedes Home Care Corp.	
Court with Jurisdiction:	1st District Court of Appeal	
Case Number:	1D10-4295; Lower court case 10-0860RX	
Summary of the Complaint:	This is a challenge to Rule 59G-4.130(2), Florida Administrative Code which states that all home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, July 2008, specifically the part that reads that "home health services are provided by qualified health care professionals who are directly employed by or under contract with a home health agency that is enrolled in the Medicaid home health program." The requirement that such agencies issue either W-2 or 1099 tax forms to individuals on their staffs, is also challenged as an invalid exercise of delegated legislative authority.	
Amount of the Claim:	The plaintiffs do not seek monetary damages; however, the monetary impact could likely exceed $500,000 annually in a loss of Medicaid recoupment if the Appellee is successful.	
Specific Law(s) Challenged:	59G-4.130(2), Florida Administrative Code	
Status of the Case:	Final hearing was held May 19, 2010. Hearing officer entered a final order on July 23, 2010, ruling against the Agency stating that "it is illogical and irrational to suggest that health, safety, and welfare are further ensured, and fraud, waste, and abuse more curbed by the additional requirement that a home health agency only provide Medicaid services through personnel that are directly employed by or under contract with the home health agency, as evidenced by the issuance of W-2's or 1099s." The Agency appealed this decision on August 12, 2010. On July 6, 2011, the Court issued the Opinion upholding the lower Court's decision. On July 22, 2011, the Mandate was issued. Case closed. An unfavorable outcome in this case will prevent the Agency from recouping the overpayment in 08-5356MPI, listed above.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel

If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	

Schedule VII: Agency Litigation Inventory

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3630

Names of the Parties:	James Scott Pendergraft IV, M.D. and on behalf of patients seeking abortions v. State of Florida, its elected and appointed Officials and agencies; and Agency for Health Care Administration, its agents, employees, servants and successors; and Pam Bondi, in her Official Capacity as Attorney General for the State of Florida and her agents and successors, and Laura MacLafferty, Individually and in her Official Capacity; as Unit Manager, Hospital & Outpatient Services Unit, Bureau of Health Facility Regulation of the Administrative Health Care Agency and her agents and successors; and Richard Saliba, Individually and in his Official Capacity as Assistant General Counsel of the Administrative Health Care Agency and his agents and successors	
Court with Jurisdiction:	United States District Court in and for the Middle District of Florida	
Case Number:	6:11-CV-1116-ORL-31KRS	
Summary of the Complaint:	This is a lawsuit where the plaintiff challenges the constitutionality of the Florida Abortion Statutes and rules which denies licensure of an abortion clinic when there is more than one of the same provider type license at the identical physical or street address.	
Amount of the Claim:	$10,000,000.00	
Specific Law(s) Challenged:	Section 390, Florida Statutes and 59A-35, Florida Administrative Code, and in particular 59A-35.100(2), Florida Administrative Code	
Status of the Case:	Plaintiff filed his complaint on July 8, 2011. Service on the Agency has not been perfected.	
Who is representing (of record) the state in this lawsuit? Check all that apply.		Agency Counsel
	X	Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory.				
Agency:	Agency for Health Care Administration			
Contact Person:	William H. Roberts		Phone Number:	412-3630
Names of the Parties:	Denise Williams and on behalf of patients seeking abortions v. State of Florida, its elected and appointed Officials and agencies; and Agency for Health Care Administration, its agents, employees, servants and successors; and Pam Bondi, in her Official Capacity as Attorney General for the State of Florida and her agents and successors, and Laura MacLafferty, Individually and in her Official Capacity; as Unit Manager, Hospital & Outpatient Services Unit, Bureau of Health Facility Regulation of the Administrative Health Care Agency and her agents and successors; and Richard Saliba, Individually and in his Official Capacity as Assistant General Counsel of the Administrative Health Care Agency and his agents and successors			
Court with Jurisdiction:	United States District Court in and for the Middle District of Florida			
Case Number:	6:11-CV-1124-ORL-31KRS			
Summary of the Complaint:	This is a lawsuit where the plaintiff challenges the constitutionality of the Florida Abortion Statutes and rules which denies licensure of an abortion clinic when there is more than one of the same provider type license at the identical physical or street address.			
Amount of the Claim:	Plaintiff has asked for compensatory and punitive damages, but does not specify amount; companion case to Pendergraft.			
Specific Law(s) Challenged:	Section 390, Florida Statutes and 59A-35, Florida Administrative Code, and in particular 59A-35.100(2), Florida Administrative Code			
Status of the Case:	Plaintiff filed her complaint on July 7, 2011, but has not perfected service on the Agency.			
Who is representing (of record) the state in this lawsuit? Check all that apply.		Agency Counsel		
	X	Office of the Attorney General or Division of Risk Management		
		Outside Contract Counsel		
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).				

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS

Budget Period: 2012 - 2013

Department: Agency for Health Care Administration

Chief Internal Auditor: Mary Beth Sheffield

Budget Entity: Inspector General/Internal Audit

Phone Number: 412-3978

(1) REPORT NUMBER	(2) PERIOD ENDING	(3) UNIT/AREA	(4) SUMMARY OF FINDINGS AND RECOMMENDATIONS	(5) SUMMARY OF CORRECTIVE ACTION TAKEN	(6) ISSUE CODE
AUDITS FOR FISCAL YEAR 2010-2011					
10-09	**6/30/2009**	**Aging Out Program, Aged and Disabled Adult Waiver**	**Finding 10-09-01** Control weaknesses were noted for case management services provided to recipients. **Recommendation** 1. Develop monitoring and audit policies and procedures to be utilized by the Program Analyst and the independent case manager. These procedures could include the use of monitoring tools such as compliance checklists and customer satisfaction surveys. 2. Require the Program Analyst, when acting as "case manager", to perform on-site visits of recipients at least annually. **Finding 10-09-02** Providers were reimbursed for more than what was authorized by the Program Analyst via the authorization letters.	1. The Aging Out analyst is in the process of completing the monitoring tool and compliance checklist. The analyst monitors customer satisfaction and service delivery by contacting recipients by phone. The analyst requires case managers to submit monthly case notes and documentation on billable services, including credentialing information. 2. On-site visits have been tentatively scheduled.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation 1. Recoup payments from providers that exceeded authorized amounts, where applicable. The Bureau has been provided a list of providers and potential overpayments. 2. Audit a sample of provider claims quarterly to help ensure that authorized amounts are billed and not the maximum allowable for the Waiver service. 3. Educate providers that additional Waiver services may not be delivered without a revised plan of care or physician approval and authorization from the Bureau. **Finding 10-09-03** Recipients received Waiver services not authorized by the Program Analyst. **Recommendation** 1. Recoup payments from providers, where applicable. The Bureau has been provided a list of providers and potential overpayments. 2. Audit a sample of provider claims quarterly to help ensure that only claims for authorized services are paid. 3. Monitor services received by the recipient to ensure that services are rendered as authorized and included in the written plan of care by conducting a face-to-face visit with the recipient at least annually.	1. The Program is currently working on making referrals to Medicaid Program Integrity (MPI) based on audit findings of overpayments. 2. A sample of claims are monitored quarterly to ensure authorized amounts are not exceeded. Program analyst receives quarterly paid claims data for review and reconciliation. 3. As of January 1, 2011, authorization letters sent to providers specify that services will be authorized based upon medical necessity and physician's orders when applicable. 1. The Program is currently working on making referrals to MPI based on audit findings of overpayments. 2. A sample of claims are monitored quarterly to ensure authorized amounts are not exceeded. Program analyst receives quarterly paid claims data for review and reconciliation. 3. The Aging Out analyst is in the process of completing the monitoring tool and compliance checklist. The analyst reviews client files and monitors customer satisfaction and service delivery by contacting recipients and requiring monthly case notes and documentation on billable services from case managers.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 10-09-04 Attendant care services and personal care services were provided to recipients at the same time, contrary to A/DA Waiver requirements. **Recommendation** In addition to the recommendations under Finding 1: Case Management, we recommend the following: 1. Identify and recoup payments from providers where attendant care services and personal care services were provided to recipients at the same time contrary to Waiver requirements. 2. Continue to educate providers and Independent Case Managers regarding Waiver requirements. 3. Ensure that future authorization letters indicate that personal care services cannot be provided at the same time as attendant care services. **Finding 10-09-05** One provider did not meet the qualifications for supplying attendant care services under the A/DA Waiver. In addition, the Bureau did not follow A/DA Waiver requirements regarding care assessments or monitoring of services delivered by this provider. **Recommendation** In order to meet A/DA Waiver requirements, we recommend the following: 1. Provide the recipient with a new service provider and independent case manager, or either transition the recipient to the CDC+ program. 2. Recoup the $1200 reimbursed to the provider for attendant care services provided while the Program recipient was hospitalized.	1. Home health agencies have been notified in writing as of 3/31/11. 2. The analyst will continue to provide technical assistance by phone and e-mail when necessary. The analyst will continue to assist new providers and existing providers that need periodic reminders. 3. Authorization letters with clarification language are being sent to providers. 1. The referral agreement has been completed and sent to the CDC+ Consulting Agency that will work with this recipient. The Aging Out analyst is working with the CDC+ fiscal agent, DOEA, and the Agency's CDC+ analyst on coordinating training of the consultants and refining areas of the transition that are currently unclear. The provider has completed background screening requirements and is cooperating with the Agency on the transition plan. 2. The $1200 was recouped.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 10-09-06 One provider did not meet the qualifications for supplying consumable medical supplies and specialized medical equipment under the A/DA Waiver. **Recommendation** 1. Verify that the applicable AAA reviewed their CMS provider files to ensure that all consumable medical supply providers met the Waiver requirements. 2. Ensure that only enrolled Medicaid DME providers be authorized to provide specialized medical equipment and supplies to Program recipients. **Finding 10-09-07** Initial authorization letters were either issued after the start of the authorization period or were not issued at all. In addition, reissued authorization letters revising the amount of Waiver services to be provided were incorrectly treated as retroactive by the provider who then resubmitted claims for the revised authorized amount. **Recommendation** 1. Continue to track the authorization letters and their expiration dates in order to issue new authorization letters in a timely manner. Authorization letters issued to consumable providers should also be tracked. 2. Reword authorization letters reissued to providers to specifically include the new effective start date for the revised authorization of waiver services.	1. The provider was disenrolled as a Medicaid provider. The DOEA was contacted and instructed to remind Medicaid Waiver Specialists to research FMMIS prior to enrolling new providers. 2. Authorizations specify that services can be provided only as long as the service provider is enrolled as an Aged and Disabled Adult waiver service provider. The analyst continues to remind recipients, their families, provider enrollment entities (Area Agencies on Aging), and case management service providers about this requirement. 1. Authorizations and renewals are tracked on an Excel spreadsheet and is an ongoing process. The Aging Out program analyst reminds case managers and home health providers to submit applicable documentation in a timely manner. 2. Authorization letters were revised to include new effective dates for authorized services.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 10-09-08 Not all recipient files contained the required Program documentation. **Recommendation** We recommend that the Bureau develop and implement tools that will assist in the administration of the Program. Specifically, a spreadsheet to track receipt of the plan of care, level of care and other required documentation, and a recipient case file log to record recipient/provider activity, capture dates of and nature of phone calls, emerging issues, and other pertinent file information. **Finding 10-09-09** Independent case manager qualifications were not adequately documented in the Bureau's files. **Recommendation** We recommend that the Bureau establish requirements for obtaining documentation supporting a case manager's qualifications. In addition, we recommend that the Bureau ensure that documentation supporting each case manager's qualifications is on file. **Finding 10-09-10** Referral agreements or contracts were not used for providers supplying independent case management services to Aging Out Program recipients. **Recommendation** We recommend that the Bureau use referral agreements or contracts when utilizing case management service providers. We also recommend that the Bureau maintain a spreadsheet to track the use of these referral agreements.	The Aging Out analyst continues to track applicable documentation needs and remind case managers and other service providers about timely submission of required documentation. Case manager qualifications were obtained. The development of referral agreements is currently in progress. The Aging Out analyst is in the process of trying to clarify Agency roles and Program policy for individuals transitioning from the Aging Out Program to other programs while cases remain under the responsibility of the Aging Out analyst. Once completed, the document will route to the Bureau Chief for approval.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
11-18	**5/5/2011**	**Enterprise Wide Audit of Organizational Ethics**	**Finding 11-18-01** The subjects of public records, open meetings, records retention and equal opportunities, along with the proper personnel procedures for each of these subjects, are not covered in all of the Agency's employee training. **Recommendation** 1. We recommend that all the subjects of public records, open meetings, records retention, equal opportunity and the related proper personnel procedures be incorporated into the Agency's required New Employee Orientation and Keep Informed training classes. 2. We also recommend that the Bureau of Human Resources continue to track and send email reminders to employees that have not yet fulfilled their annual training requirements. Only 79% of the employees that responded to our survey state they have received ethics training within the last year. The Agency has however recently implemented a quarterly "Keep Informed" training course to cover required annual training topics which will help ensure that all Agency employees have the opportunity to complete their required annual training.	1. The subjects of public records, open meetings, records retention, equal opportunity and the related proper personnel procedures will be incorporated into the Agency's required New Employee Orientation and Keep Informed training classes. 2. The Bureau of Human Resources will continue to track and send email reminders to all employees who have not completed their annual training requirements. We will also notify the supervisor, via email, if an employee is non-compliant for inclusion on their evaluation. The Division of Information Technology is currently developing a database that will make tracking more efficient and effective.	
OAG #2011-002	**07/2010**	**Operational Audit Prior Audit Follow-up**	**Finding 2011-002-01** The Agency needs to enhance its contract management policies and procedures regarding attestations of independence with respect to contracted entities.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that the Agency's written policies be revised to clearly reflect the specific requirements for completion of the COI questionnaires. Further, since the relationships affecting a contract manager's independence could change over time, we recommend that independence certifications be obtained from contract managers at least annually.	We concur with the recommendation. COI questionnaires are now required of every individual involved in the procurement process, excluding those approving for administrative purposes only. Additionally, contract managers are now required to resubmit independence certifications annually (collected during Contract Administration conducted file reviews). AHCA Policy #4006 will be revised to reflect these requirements.	
			Finding 2011-002-02 Additional actions by the Agency were necessary to ensure that contract monitoring is timely planned and documented.		
			Recommendation We recommend that the Agency enhance policies and procedures to ensure that a monitoring plan is developed and approved during contract scope development. Further, the Agency should consider revising the monitoring plan format to include provision for documenting the date the plan was prepared and approved.	We concur with the recommendation. Contract monitoring plans are now required prior to contract development and execution. The monitoring plan format currently included in policy is provided as an example only. The policy will be revised to delete the form and replace with guidelines for preparing a contract monitoring plan.	
			Finding 2011-002-03 The Agency's Third-Party Liability (TPL) contract monitoring procedures could better assess the TPL contractor's performance by addressing in reports the significance of monitoring findings. The Agency also needs to improve TPL contract procurement processes to minimize the risk of periods of time without TPL services.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that the Agency enhance its monitoring process to ensure that contract monitoring procedures document key compliance issues and the relative impact of any exceptions noted. Also, in the future, the Agency should increase the time allowed for the contract award process to minimize the risk of gaps in the services provided. Finally, the Agency should continue to pursue the collection of amounts forgone during the transition period.	Billings are submitted to ensure collections are realized on a timely basis. The Corrective Action Plan with ACS is now complete. The TPL Unit has now begun to develop checklists in preparation for its formal monitoring process. The TPL unit continues to conduct daily monitoring of the Vendor's activities through document and billings reviews, case reviews and invoice reviews.	
			Finding 2011-002-04 The Agency should periodically review the TPL contractor's list of insurance carriers to evaluate its sufficiency for identifying and locating liable third-parties. The Agency should also request a waiver for modifications to related Federally required processes.		
			Recommendation We recommend that the Agency implement procedures to conduct the required data exchanges or, if determined to be inefficient, request a waiver from the Federal Government related to modified procedures for the identification of liable third parties. We also recommend that the Agency periodically review the TPL contractor's insurance carrier list to evaluate its sufficiency.	The Agency continues to monitor the collections of the Vendor and reports generated regarding data matches with carriers. The Agency and the Vendor will review the results of the federally required data matches that have been conducted by the Vendor and will request a waiver from the Federal Government as appropriate.	
			Finding 2011-002-05 Leads letters are sent to Medicaid recipients for whom claims may identify potential third parties. The Agency should consider the cost effectiveness of sending follow-up letters to Medicaid recipients who do not respond to initial leads letters.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation To increase the leads letters response rate, we recommend that the Agency re-evaluate the process, including the cost-effectiveness of sending follow-up letters to Medicaid recipients who do not respond to the initial request for third-party provider information. As part of the process re-evaluation, the Agency should consider requiring that second request letters be sent to an appropriate sample of recipients and that the usefulness of the related responses be measured and evaluated.	Prior to mailing leads letters, the Vendor runs the recipients through its verification process to identify other insurance. This process typically generates no matches. Since there is a low response to these letters from the recipients and the verification process does not typically generate matched insurance information, it does not appear to be cost – effective for the Vendor to generate a second letter to the recipient. In order to help ensure all available insurance is identified on Medicaid recipients, the Vendor conducts data matches with insurance carriers. The Agency will continue to work with the Vendor to address the leads letter process as the Vendor is required to follow-up with recipients who submit incomplete information. The Vendor has advised it follows-up with providers in order to obtain the recipient's insurance information. The Agency plans to begin tracking this process to determine its effectiveness.	
			Finding 2011-002-06 To ensure that amounts collected by the Agency's TPL Unit are adequately safeguarded and accurately recorded in accounting and other management records, the TPL Unit should record the initial receipt of each amount collected and reconcile amounts collected in the Unit to revenues recorded in the State's accounting records.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that the Agency implement procedures to ensure TPL collections are properly safeguarded and timely and accurately deposited. Such procedures should include the preparation of a listing at the initial point of collection and the performance of a reconciliation of the collections to Agency records of deposit. The reconciliations should be prepared by someone independent of the processing of TPL collections.	The Agency continues to open all mail received at the Agency prior to sending to the Vendor in order to identify any checks received. The Agency logs all checks into a database prior to sending to the Vendor. The Vendor signs for all checks. The Agency verifies the amounts have been deposited by reviewing the Vendor's deposit logs. The Agency has conducted and will continue to conduct on-site reviews of the Vendor's check processing procedure. In addition, the Vendor now has an established lockbox for which checks are directly deposited from payors (carrier billing). This has decreased the number of "live checks" that are received by the Vendor.	
			Finding 2011-002-07 Agency files did not contain sufficient information to document that fees paid for providing NET services were reasonable and did not result in a profit between State entities.		
			Recommendation We recommend that the Agency retain documentation to ensure that NET contract rates are reasonable and do not result in a profit between State agencies. We also recommend that the Agency consider a contract amendment which would limit administrative costs to those which are directly related to Medicaid NET.	The Agency has received unaudited financial reports and will receive the annual audited report (OMB Circular A-133) shortly. Upon receipt, the Agency will review the itemized costs associated with the CTD's claimed administrative expenses. The Agency has clarified with the CTD that Medicaid administrative funds are for Medicaid related expenses only and not for other, non-Medicaid related, programs. The Agency currently has a draft contract amendment, awaiting final CTD approval, that clearly specifies that the CTD only use Medicaid funds for Medicaid related expenses.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2011-002-08 The Agency's monitoring of the NET contract was not sufficient to ensure contractual compliance and evaluate the performance of the contractor and its subcontractors. **Recommendation** To ensure that Medicaid nonemergency transportation services are only provided to eligible recipients and the most cost-effective method is used, we recommend that the Agency enhance contract monitoring procedures. The monitoring efforts and results should be documented in sufficient detail to demonstrate the Agency's evaluation of contractor compliance with key provisions of the contract. **Finding 2011-002-09** The Agency needs to enhance tangible personal property (TPP) policies and procedures to ensure that the annual physical inventory is timely reconciled with property records. **Recommendation** We recommend that the Agency continue efforts to improve the timeliness of reconciliations.	The Agency continues to work with the CTD to develop policies and procedures to ensure contract compliance and to evaluate the services provided. To date, all 35 deliverables have been submitted and 12 have been approved. Among the approved deliverables are the following: Provider Manual, Medicaid Beneficiary Manual, Subcontract, Encounter Data and Performance Measures. The Agency has engaged in on-site surveys of 2 local transportation coordinators and will conduct an on-site survey of the CTD upon completion of all policies and procedures. We concur with this recommendation. Property inventory has been conducted since the audit period. During this process reconciliations for all organizational units were received within the 60 day requirement. We will continue all efforts to improve efficiency and timeliness of reconciliations.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2011-002-10 The Agency needs to improve procedures to ensure TPP is timely and accurately recorded. **Recommendation** To effectively safeguard Agency assets, we recommend that the Agency continue efforts to ensure that property records are accurately and timely updated.	The Agency has reviewed all property records to ensure inclusion of all required information. Additionally, desk procedures have been developed to ensure staff responsible for creating and maintaining data records have a clear understanding of information requirements.	
			Finding 2011-002-11 The Agency has not established rules or written policies and procedures pertaining to the administration and management of the Medicaid nursing home overpayment account (Account), including specification of situations which will result in authorized withdrawals from the Account. As of March 2010, the Account contained approximately $27.3 million. **Recommendation** We again recommend that the Agency establish rules for administration and management of the Account. The Agency should also consider establishing written policies and procedures to guide the annual reviews of the financial viability of the Account.	The policies and procedures were effective June 30, 2010. The Lease Bond Collections and Use spreadsheet is current as of December 31, 2010.	
			Finding 2011-002-12 The Agency submitted an invoice to the Department of Elder Affairs (DOEA) for the Aged/Disabled Adult Services (ADA) and Assisted Living for the Frail Elderly (ALE) waivers that was not supported by information identifying the actual claims paid. According to Agency and DOEA staff this invoice was prepared and paid to prevent unspent General Revenue Fund appropriations from reverting at September 30, 2009.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Agency should ensure that invoices are only prepared after it is determined that valid claims have been paid for which reimbursement is due from applicable agencies.	The Agency has a procedure of producing invoices for paid claims only. This policy was restored January - March 2010 and continues to be the current operation for AHCA.	
OAG #2011-057	**12/2010**	**FMMIS and DSS Information Technology Operational Audit**	**Finding 2011-057-01** Access Control Documentation. The Agency and HP lacked appropriate access control documentation to demonstrate the business justification for access privileges granted within FMMIS, DSS, and the related system software. Similar issues were noted in our report No. 2010-025.		
			Recommendation The Agency, together with HP, should improve its procedures for user account management by maintaining adequate documentation of the authorizations and business justifications for the assignment of user access privileges.	The Security Request form, matrix and associated procedures have been redesigned to provide appropriate access controls across all areas of operation to include technical roles.	
			Finding 2011-057-02 Appropriateness of Access Privileges. The access privileges of some employees and contractors were not appropriate for their job responsibilities. Similar issues were noted in our report No. 2010-025.		
			Recommendation The Agency and HP should review, and adjust as appropriate, the access privileges described in 'Finding Number 2' to limit access privileges to only what is needed to perform job responsibilities.	New security forms were submitted for all personnel and contract staff working on the account. In addition, audit schedules are ongoing for access control reviews, as well as servers and databases.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2011-057-03 Timely Disabling of Access Privileges. Some former contractor access privileges were not timely disabled. Similar issues were noted in our report No. 2010-025. **Recommendation** The Agency should work with HP to ensure that the access privileges of former contractors are timely disabled to minimize the risk that data and IT resources could be misused by the former contractors or others. **Finding 2011-057-04** Access Control Records Retention. Contrary to the requirements of the Department of State General Records Schedule for retention of access control records, the Agency did not retain some FMMIS and DSS access control records for the server operating systems. **Recommendation** The Agency should ensure that access control records are retained as required by the General Records Schedule. **Finding 2011-057-05** Periodic Review of Access Privileges. Except for HP quarterly reviews of application access privileges, neither the Agency nor HP performed periodic reviews of the appropriateness of access privileges. A similar issue was noted in our report No. 2010-025.	The security form and associated procedures define guidelines for terminations and transferred employees within the organization, as well as within departments. All security personnel have been instructed to deactivate accounts rather than deleting accounts in order to comply with record retention periods. This is documented within the security form and associated procedures.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Agency should ensure that periodic reviews are conducted of the ongoing appropriateness of access privileges for the FMMIS and DSS applications, server operating systems, databases, and program change management software to facilitate the timely detection and correction of excessive or unnecessary capabilities.	The Agency has a copy of the fiscal agent's schedule for the review of access privileges regarding the FMMIS and DSS applications, server operating systems, databases, and program change management software. The Agency will review and conduct periodic, unannounced audits to ensure the fiscal agent is performing reviews and taking appropriate action. HP has developed schedules for ongoing periodic access reviews for FMMIS servers and databases.	
			Finding 2011-057-06 User Identification. As also noted in our report No. 2010-025, generic user identifications (IDs) for database administration were being shared by contractor staff. **Recommendation** The Agency should require HP to assign unique user IDs to all individual users authorized to perform database administration functions for FMMIS and DSS.	HP has changed the operational use associated to the IDs and has conducted training to educate the users. These IDs have been included in the ongoing audit procedures to ensure the usage is appropriate, the Agency understands there are currently 17 individuals that have access to these IDs. These individuals make up a core HP team of "floaters," who are assigned to various state accounts on temporary bases to assist with additional or "expert" coding and testing. The Agency has approved this current process. The MCM Systems staff worked with HP to consider alternative measures for the tracking of the "floaters" that align more closely to the Auditor General recommendation. We have not identified any other alternatives and considering that these are leveraged staff, believe the current protocols meet the necessary standards ensure secure database functions.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2011-057-07 Other Security Controls. Certain security controls were deficient in the areas of user authentication, session controls, and logging of system activity. Similar issues were noted in connection with our report No. 2010-025. **Recommendation** The Agency should implement appropriate security controls in the areas of user authentication, session controls, and logging of system activity to ensure the continued confidentiality, integrity, and availability of Agency data and IT resources.	The Agency implemented several of the suggested recommendations of the audit inquiry that was concluded October 2009. These changes were implemented in Mid April 2010. Medicaid Contract Management has prepared a separate response for internal records.	
			Finding 2011-057-08 Program Change Controls. Program and data change controls for FMMIS and DSS needed improvement. Similar issues were noted in our report No. 2010-025. **Recommendation** The Agency, with the assistance of HP as applicable, should accurately document and enforce effective program change controls that provide for appropriate authorization, timely testing, and approval of changes. Additionally, to ensure that only authorized and properly functioning changes are made to FMMIS and DSS and implemented in a consistent manner pursuant to management's expectations, the Agency should log and review program changes that are moved into the production environment.	The Agency will review the Change Control Procedures updating any areas that are not reflective of current change control policy or may not be adequate to ensure proper control authorization and accuracy. The fiscal agent will create a new weekly report of all implemented coding changes. This new report will be compared to the comparable week's promotion to ensure that only those changes approved by the State were promoted (exception for cycle monitor changes) and to ensure that all intended changes were promoted. The change control procedure's review and new audit reporting will be completed by January 31, 2011. The report format automation has been reviewed and approved. However, installation has been delayed with an anticipated completion date of 6/30/11.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2011-057-09 Prioritizing Customer Service Requests. In some instances, customer service requests (CSRs) to correct recipient eligibility processing errors were not analyzed in a timely manner to determine the impact of the processing errors and to ensure that CSRs were effectively prioritized.		
			Recommendation The Agency should ensure that CSRs are adequately researched and prioritized to ensure that recipient eligibility processing errors are resolved in a timely manner.	The Agency has emphasized the need for quantifying the impact regarding processing errors, when submitting a CSR. Not all CSR(s) provide the ability to quantify such an impact; when the capability to assess an impact of an error exists, the extent of the error is quantified and addressed in the CSR to facilitate prioritizing.	
			Finding 2011-057-10 Claims Resolution Quality Reviews. Contrary to the HP Resolutions Procedures Manual, HP was not performing quality control reviews to ensure that claims subject to manual resolution procedures were processed accurately and correctly.		
			Recommendation The Agency should ensure that HP reinstates its claims resolution quality control reviews to provide assurance that claims subject to manual resolution are processed accurately and correctly by the Resolutions Department.	The procedure has been reinstated as documented within the Claims Resolution manual. HP began submitting monthly verification that this task was being completed on 12/1/10.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
OAG #2011-167	**06/2010**	**Summary of State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards**	**Finding FA 10-052** FAHCA did not appropriately allocate salary and benefit costs for an employee who worked on multiple Federal awards. **Recommendation** We recommend FAHCA ensure that salary and benefit costs are allocated appropriately between multiple programs when applicable. FAHCA should maintain personnel activity reports or equivalent documentation to support the allocation to multiple Federal programs. **Finding FA 10-057** Payments made to providers on behalf of clients for medical service claims were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, the payments were for improper amounts or for unallowable services.	We concur with the findings and recommendation. Supervisors are aware that a positon funded by Title XXI must be dedicated to those related functions. If a situation occurs that requires the position to assist in another area, activity reports will be kept for proper funding and reporting. Activity reports were initiated in January, 2011, and reporting adjustments will be made as needed beginning with reports for the quarter ending March 2011.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed, including ensuring that FMMIS is updated timely with current information. Furthermore, we recommend that FAHCA discontinue its practice of instructing Medicaid waiver providers to submit claims that do not accurately reflect the nature or location of services rendered or comply with applicable regulations.	HOME HEALTH - Personal care services provided through the DD waiver (through APD) are currently being transferred to the state plan; the funds previously allocated to APD to provide personal care services under the waiver have been shifted and are now available to AHCA to provide personal care services to these recipients under the Medicaid state plan. The independent unlicensed providers of personal care services were allowed to enroll as Medicaid providers of personal care services. These unlicensed providers were unable to bill for visits, so AHCA decided to change policy to allow home health services providers to be reimbursed for personal care services that are provided in less than two hours. This has no significant fiscal impact. Hence there are FY 09-10 expenditures associated with S9122, but minimal utilization at this 1-hour level. By amending the handbook and instructing the QIO to allow home health providers to bill 1 hour of continuous care only as personal care services for Medicaid recipients under 21, the fiscal impact will not be significant given the current utilization.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				After reviewing a sample of the claims provided on CD, the Agency has determined that the claims paid inappropriately and should have been denied. FMMIS does have edits in place to prevent private duty nursing and personal care services claims from paying without a prior authorization number. It is not clear why the claims identified were able to bypass the prior authorization system requirements. However, we are working with staff in the Bureau of Medicaid Contract Management (MCM) to determine why the claims paid inappropriately. MCM has confirmed that this problem is fixed, and these claims would not be able to bypass this edit if they were processed for payment today. Medicaid services will work with the Bureau of Medicaid Program Integrity to recoup the funds from any claims that paid without a prior authorization number. The plan is to cross reference the claims through the QIO to determine if they actually didn't receive prior authorization. The results of the cross reference will determine the providers that require recoupment of claims.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				DD WAIVER SERVICES - We will change FMMIS to allow place of service codes for DD waiver services to be adjustable, other than the only choice "99", to reflect specific places of service. DENTAL State Agency Response and Corrective Action Plan A quadrant indicator must be submitted with procedure codes D4210, D4211, D4240, D4241, D4260, D4261, D4341, D4342, D7310, and D7320. Medicaid has completed file maintenance to remove all indicators of quadrants except 10, 20, 30, 40, UR, UL, LL, and LR. This prevents same quadrant billing of certain procedure codes that are not allowed on the same date of service, same quadrant, and same recipient. The system now denies as a duplicate quadrant when one of the procedure codes listed above is billed another procedure code listed above for the same quadrant, same recipient, same date of service. CHIROPRACTIC Re: Chiropractic visits paid in excess of 24 per calendar year:	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				A Batch File Maintenance request (Tracking #KS09201001) was completed October 14, 2010, to update the contract billing and reimbursement rules regarding Medicaid policy regarding limitation of visit codes to 24 per calendar year. Reprocessing instructions for the visit claims with dates of service July 1, 2008 (the date of contract implementation for the current Medicaid fiscal agent) through the file maintenance implementation date was also included in the File Maintenance request. The reprocessing procedure (CO 21607) will recoup chiropractic visits that were claimed in excess of the 24 per calendar year maximum, without prior authorization from Medicaid. Re: Reimbursements for chiropractic services provided in exceptional places of service:	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				A Batch File Maintenance Request (Tracking # KS09201005) was submitted in September 2010, with instructions for updating the contract billing and reimbursement rules regarding Medicaid policy regarding the appropriate place of service location codes and places of service considered exceptions to policy. Instructions were given to require referral information on line item 17 of the CMS claim form for all chiropractic claims with an exceptional place of service location code. Instructions include denial of all claims billed with an exceptional place of services location code that do not have the appropriate referral information. The FMMIS file update regarding appropriate and exceptional places of service is progressing but has not been scheduled for implementation. Reprocessing instructions regarding all claims with dates of service January 1, 2010 (the date of adoption for the current Chiropractic Coverage and Limitations Handbook) through the file maintenance implementation date with exceptional places of services and without the required referral information were also included in the File Maintenance Request. The reprocessing	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				INPATIENT - All claims are reviewed by FAHCA's Balanced Budget Act coordinator or physician consultant. Details of the referenced claims were reviewed to ensure adherence to policy related to Balanced Budget Act approved exceptions. In the first instance, a billing error by the provider resulted in the entire 47 days of a claim originating on June 4 2009 being charged to 2008-2009 fiscal year, however 20 of these days should have been charged to 2009 - 2010 fiscal year. The recipient was then transferred to a different hospital on July 21, 2009 for an additional 27 days. The FMMIS system paid the claim for 27 days in the 2009 - 2010 fiscal year. Policy for 45 day limit in one fiscal year was exceeded. FAHCA will recoup the additional two days reimbursement from provider. In the second instance, the Medicaid policy unit approved the claim through the BBA process, Code 20 (patient died) is indicated in status field 17 of the claim form. FAHCA policy is to pay claims in such circumstances. However, claim type 3 should not be approved through the BBA process. New staff member has been trained on the BBA process. FAHCA will [illegible]	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FA 10-059 The Florida Medicaid Management Information System (FMMIS) and the Decision Support System (DSS) were integral to the operations of the Medicaid Program. The FMMIS was used to enroll providers, process Medicaid claims, adjudicate claims, and reimburse providers. FMMIS data was imported into DSS to enable efficient reporting and data analysis. The Medicaid Program is highly dependent on the security, integrity, and proper functioning of FMMIS and DSS. In the Information Technology audit report No. 2011-057, dated December 2010, we disclosed control deficiencies related to access control documentation, access privileges, user identification, security controls, program and data change controls, processing of customer service requests to correct recipient eligibility processing errors, and quality control review of claims subject to manual resolution procedures that, in combination, we consider to be a significant deficiency. Details of the findings and recommendations, as well as, FAHCA management's response are included in that report. **Recommendation** n/a	n/a	
			Finding FA 10-058 Controls were not sufficient to ensure that amounts paid by FAHCA to the Commission for Transportation Disadvantaged (CTD) or amounts paid by CTD to transportation providers under a Medicaid transportation program were reasonable.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that current transportation costs be summarized and used to evaluate the reasonableness of the total contract amount as well as the amounts allocated to STPs and to the CTD for administrative costs. FAHCA should also conduct appropriate monitoring to evaluate CTD and STP compliance with governing laws, regulations, and contract terms.	The Agency will receive administrative costs audit for FY 2009/2010 to determine reasonableness of administrative costs for future contracting purposes. The Agency will receive audits for FY 2009/2010 and FY 2010/2011 in accordance with OMB Circular A-133 and the Florida Single Audit Act. The audits will allow the Agency to determine the reasonableness of funding and if the allocation is sufficient for providing services. On site survey of two transportation providers conducted in July 2010 and an on site survey of the CTD and selected transportation providers to be conducted in the near future.	
			Finding FA 10-060 Contrary to Federal and State requirements, FAHCA funded some current year expenditure obligations using 2008-09 certified forward appropriations. Additionally, expenditures were not always recorded to the correct appropriation categories in the State's accounting records.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that FAHCA ensure that the expenditures are made from the proper funding source and that unspent certified forward funds be allowed to revert as required by law. We also recommend that FAHCA accurately record expenditures in the State's accounting records.	Due to miscommunications, the certified forward appropriations were fully expended. Staff are aware that certified forward expenditures must be supported by the weekly claims financial reports. Unspent certified forward appropriations will be allowed revert. Regarding questioned recording of expenditures to the correct appropriation category (payments April 14, 2010 cited as example), our process is to pay from a few appropriation cateories, then a journal transfer is processed to allocated the charges to the apporpriate categories. For the payment referenced, a journal transfer was processed to move expenditures to the appropriation category under which the claims were paid. The Journal Transfer voucher number is 010149, Statewide Document #D00-0057-8094.	
			Finding FA 10-061 FAHCA could not always properly support salaries and wages charged to the Medicaid Program.		
			Recommendation FAHCA staff indicated that starting with the September 2010 quarter the position will be included in the time and effort records. We recommend that FAHCA strengthen its procedures to ensure that time and effort records are used for all applicable HQA employees whose job duties involve multiple programs.	Florida AHCA staff with multiple duties from multiple funding sources have been educated regarding particular funding sources for their duties. Florida AHCA staff worked with Department of Management Services and Peoples First staff to set up coding time placed on timesheets to attribute that time according to activity and funding source. Florida AHCA office staff are now entering their time into the Florida People's First Time Validation system paying attention to their activities with regard to funding sources.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FA 10-062 In some instances, FAHCA drew funds based on projections that were not supported by a methodology and documentation showing that the funds were for immediate cash needs.		
			Recommendation We recommend FAHCA develop an appropriate methodology for projecting cash needs. Documentation should be maintained to support the calculated cash need.	FAHCA has developed steps that are routinely followed in determining amounts for projected draws. Instructions have been written and worksheets are being maintained. Procedures were put in writing in February 2011. Worksheets have been kept since Fall 2010.	
			Finding FA 10-063 FAHCA did not ensure that amounts were accurately reported on the Cash Management Improvement Act (CMIA) Annual Report to the Florida Department of Financial Services (FDFS).		
			Recommendation We recommend FAHCA develop and implement written procedures for the preparation, review, and submission of the CMIA data to FDFS, including procedures for ensuring that the amounts reported are accurate and complete.	We concur with the recommendation. FAHCA is developing written procedures for the preparation, review, and submission of the CMIA data to FDFS.	
			Finding FA 10-065 Contrary to Federal requirements, FAHCA reported on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program reports expenditures that were not supported by provider claims.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that FAHCA report on the quarterly CMS-64 report only expenditures that are supported by actual claims.	A complete review of Emergency Payments made since July 2008 was made and any payment not supported by claims were reversed in an adjustment to the CMS 64 Report for the quarter ended September 2010. There have been no Emergency Assistance Payments made without claims support since then.	
			Finding FA 10-066 FAHCA procedures were not sufficient to ensure that expenditures reported on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, included only activity pertaining to the applicable reporting period.		
			Recommendation We recommend that FAHCA correct the CMS-64 reports for all subsequent quarters where the expenditures were reported in the incorrect period. We also recommend FAHCA continue its efforts to ensure that expenditures reported on the quarterly CMS-64 report include only payments made to providers during the applicable reporting period.	The prior period adjustments to move claims paid under check date 10/1/2008 from the quarter ending September 30, 2008 to the quarter ending December 31, 2008 was filed in the CMS 64 for the quarter ending September 2010. Adjustments for check date 4/1/2009 and 7/1/2009 will be done in the reports for quarter ending March 31, 2011 and June 30, 2011.	
			Finding FA 10-067 FAHCA procedures were not sufficient to ensure that Medicaid providers receiving payments had a current provider agreement in effect.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that FAHCA ensure that payments are made only to providers with current Provider Agreements in effect. Given that the transition to a new fiscal agent occurred two years ago, FAHCA should work with the fiscal agent to ensure that providers have current provider agreements in place or assess appropriate penalties for nonperformance against the fiscal agent.	The Agency completed installation of an automated reenrollment process in the MMIS in January of 2010 which required over 1200 hours of coding and testing. This automated process runs daily and identifies any provider with a provider agreement end date ninety (90) days in the future; flags the file as needing to reenroll; creates a report for tracking purposes; and sends the reenrollment packet to the provider. The provider has 90 days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who fail to respond within the 90-day window are suspended in the system to prevent claims with dates of service after the agreement end date from processing. This process has been running since February 1, 2010 and guarantees that no provider with a valid agreement will expire and still have claims process and pay. As an automated process, provider reenrollment no longer has to shut down during fiscal agent transitions as in the past. The status for this finding remains partially corrected because the Agency is currently in the process of installing an additional automated job to identify providers with agreement end dates less than the current date; flag the file as needing to reenroll; create a report for tracking purposes; and send the reenrollment packet to the provider.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				The provider will have 90-days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who fail to respond within the 90-day window will be suspended in the system to prevent claims with dates of service after the agreement end date from processing. Senior management will then make a determination if the provider should be terminated. This job will be a one-time cleanup of older provider files and encompasses the providers who were not reenrolled during the fiscal agent transition. Completion of this job will result in a fully corrected status for this finding.	
			Finding FA 10-068 FAHCA had not developed policies and procedures to provide for the timely review and release of cost report audits of Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and nursing homes. Additionally, FAHCA had not resolved issues relating to the cost reports of the ICF-DD facilities for which independent auditors disclaimed an opinion for the 2004-05 fiscal year. **Recommendation** Subsequent to our inquiry, FAHCA completed the development of written policies and procedures pertaining to the release of cost reports. We recommend that FAHCA continue to maintain and enhance written policies and procedures to assist in the review and release of nursing home and ICF-DD audit reports, including time frames for the timely selection of facilities and the timely review and release of the audit reports.	FAHCA has developed written policies and procedures pertaining to the release of cost reports. FAHCA will continue to maintain and revise all written policies and procedures as necessary to assist in the review and release of nursing home and ICF-DD audit reports to ensure timely selection of facilities and timely review and release of audit reports.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FA 10-071 FDCFS did not meet the CMHS maintenance of effort (MOE) requirement for the 2009-10 fiscal year due to the lack of sufficient availability of MOE funds. Additionally, FAHCA did not provide summary records or reports to support the amount of Medicaid expenditures used in the MOE calculation.		
			Recommendation We recommend that FDCFS continue to correspond with SAMHSA regarding the efforts that may be made to comply with the MOE requirements. Additionally, we recommend that FAHCA periodically provide FDCFS with reports of actual expenditures to allow FDCFS to monitor total expenditures incurred and timely identify instances where expenditures may not be sufficient to meet the MOE requirement.	FAHCA will continue to respond to FDCFS requests for actual expenditures to allow FDCFS to monitor total expenditures incurred. The FDCFS typically makes requests to FAHCA via email on an annual basis. Once requests are received from FDCFS, FAHCA provides FDCFS with an extract of actual expenditure data. FAHCA will continue to respond to FDCFS requests in a timely manner.	
			Finding FS 10-001 As previously reported, the FAHCA, Bureau of Finance and Accounting (Bureau), did not record a receivable and deferred revenue to represent its claim on Federal financial resources related to the incurred but not reported (IBNR) Medicaid claims liabilities.		
			Recommendation We again recommend that the Bureau follow established procedures to record net receivables and deferred revenue in recognition of the State's claim on Federal resources related to the IBNR Medicaid claims.	We concur with the recommendation. Management will more closely review the checklist for completion. Additionally, a review meeting is being added to the procedures to review and discuss each item on the checklist.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FS 10-002 FAHCA did not record all drug rebate receivables at fiscal year end. **Recommendation** We recommend the Bureau enhance procedures to include the use of analytical procedures to investigate significant fluctuations in the amount of rebate receivables reported by the vendor at year-end. **Finding FS 10-004** The FAHCA Bureau of Finance and Accounting (Bureau) did not follow established fiscal year-end procedures to record adjustments to accounts payable and expenditure balances which caused material overstatements in the General Fund and the Health and Family Services Fund. Additionally, the Due from Federal government and Grants and donations accounts were also overstated by the amount related to Federal programs of $129,087,314. **Recommendation** We recommend that the Bureau revise its procedures for recording Medicaid accounts payable and the related accounts (expenditures, Federal receivables, and Federal revenue) at year-end. The estimating methodology chosen by the Bureau should allow for a materially accurate amount to be recorded at year-end. For example, the estimate could be based on historical amounts adjusted for factors such as changes in Medicaid enrollment.	We concur with the recommendation. Staff will apply the use of analytics in the review process and management will meet with staff to discuss the analytical procedures that were used. Due to the need to carry forward the budget for Medicaid payments for services provided on or before June 30th and the uncertainty of the totals amount of claims that may be filed, the unexpended budget is established as a payable. The payables and related Federal receivables are adjusted after the final certified forward payment. This final step was overlooked for the FY 09-10 financial statements, but the task has been added to the checklist. We will investigate the feasibility of another methodology for estimating the payables.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
AUDITS FOR FISCAL YEAR 2009-2010					
08-07	**2008/09 FY**	**Medicaid Contract Management**	**Finding 08-07** We noted inefficiencies in the provider change of address process. **Recommendation** We recommend the Bureau of Medicaid Contract Management develop new procedures and technology that would give Medicaid Providers the ability to electronically update their Change of Address. By giving the provider the ability to perform this update, the Agency can hold them solely responsible for ensuring the correct address is maintained in FMMIS. The Medicaid Handbook should be updated to clearly define the timeframe in which providers should notify the Agency of address changes. Additional the Medicaid fiscal agent, Electronic Data Systems, Inc. (EDS) personnel should be assigned to assist with inputting address changes while this technology is being developed to address the backlog of Change of Address requests. We further recommend Medicaid Contract Management (MCM) continue to monitor the fiscal agent and assess penalties as appropriate where contractual requirements are not being met. Should the Bureau choose not to allow providers to input their changes of address directly into FMMIS, then MCM should ensure EDS assigns sufficient personnel to alleviate the change of address backlog and meet contractual requirements going forward.	The fiscal agent has continued to process COAs in the required 48 hour timeframe. There has been no movement, nor will there be any movement toward allowing providers to use the web portal to change addresses as noted in the previously referenced security issues and concerns that online change of address would pose a substantial risk to provider information and result in increased fraud and abuse. MCM will revisit the option to use electronic signatures once the Agency has determined the correct course for use of electronic signatures. As noted in the previous response, the backlog of COAs was eliminated, as of 12/31/09.	
09-10	**1/1/04 to 12/31/2008**	**Medicaid Services**	**Finding 09-10-01** The current design of the Durable Medical Equipment (DME) Prior Authorization (PA) process involves multiple PA request submission points, costly document mailings, and duplicate data entry. This leads to inefficient and inconsistent review and approval of PA requests and creates the potential for lost documents and delays in the approval process.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation - Medicaid Services 1) Require all DME PA requests be sent directly to the fiscal agent, encouraging use of the web portal; 2) Require all PA reviewers to review and approve/deny the PA requests on-line in the Service Authorization module; 3) Develop formal written procedures to help ensure consistency and quality performance in the DME PA review process; 4) Provide FMMIS and DME process training to all DME staff; 5) Discontinue use of the Oracle tracking system; and 6) Amend the DME Handbook to reflect any changes made to the process.	This recommendation encourages Medicaid Services to improve efficiency by taking full advantage of FMMIS' capabilities. We agree completely with this approach, but as there continue to be some system glitches and delays with HP processing and scanning prior authorizations and as Medicaid Services not having the staff nor capacity for our medical consultants to review and post determinations on-line in FMMIS, we have determined that our best approach is to continue to use our current acceptable workaround and continue implementing the audit's alternative recommendations. Separately, we have verified that the Area Office staff are trained in using FMMIS. Please see Alternate Recommendation.	
			Alternate Recommendation - Medicaid Services 1) Develop formal written procedures to help ensure consistency and quality performance in the current DME process; 2) Provide FMMIS and DME process training to all DME staff; and 3) Coordinate with the Bureau of Information Technology to enhance Oracle to capture needed dates.	Medicaid Services developed and routed a policy checklist to distribute to the local area office as a "at a minimum" policy requirement reference. Internal training documents were distributed to the local Area Offices on 03/22/2011. Medicaid Services is currently working with IT and has submitted a Programming Service Order requesting the creation of a new report which will capture prior authorization data when "received" by Medicaid.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation - Medicaid Contract Management 1. Ensure the fiscal agent electronically distributes all DME PA requests to the Agency in a timely manner; 2. Coordinate with the fiscal agent to establish procedures for verifying the availability and legibility of all documents scanned into OnBase; and 3. Enhance FMMIS to capture returned to provider (RTP) dates	Based on Medicaid Services' response to the first part of this recommendation, there is no need for action by Contract Management.	
			Finding 09-10-02 Audits in FMMIS that are designed to verify effective dates, end dates, and utilization limits are not working appropriately.		
			Recommendation - Medicaid Contract Management We recommend the Bureau of Medicaid Contract Management, as outlined in CSR 1239 activate FMMIS Audit criteria to ensure DMEs will not by-pass the prior authorization process. We further recommend that MCM re-process all DME PA claims that have paid incorrectly since July 1, 2008 and recoup all monies owed to the Agency.	CSR 1239 was implemented and closed on 9/18/09. The reprocessing task for all impacted claims (15459) was production-approved on 10/23/09 and completed on 11/03/2009.	
			Finding 09-10-03 Our review disclosed that the average time for completion of a DME PA review exceeded newly established performance goals. We also noted data integrity issues in both FMMIS and the Oracle tracking database that reduce the reliability of any timeliness calculations.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation - Medicaid Contract Management We recommend MCM assist the fiscal agent in establishing procedures to ensure all documents are date stamped upon receipt by EDS, and the date that is stamped on the DME PAs is accurately reflected in the "received date" field in FMMIS. We further recommend MCM assist the fiscal agent in establishing procedures to allow FMMIS to capture Return to Provider (RTP) dates so this timeframe can be taken into consideration when determining the processing time for PAs.	As of February 2010, MCM and the Fiscal Agent updated the current procedures to ensure there is a clearer ability to determine the timeliness of processing.	
			Finding 09-10-04 There is no FMMIS Impact Analysis Environment (Test Box) available to facilitate user testing of the impact of potential process changes or the adequacy of potential programming changes resulting from customer service requests.		
			Recommendation - Medicaid Contract Management We recommend MCM coordinate with the fiscal agent to ensure that an Impact Analysis Environment is available that allows business users to test actual or potential changes to business rules and procedures.	It is not a feasible expectation to have an open test environment for the user testing. The majority of users of the system would not have the technical expertise, time or tools necessary to initialize the test environment for the bulk of the testing, not to mention the challenges required to maintain a viable test environment in such a situation would be overwhelming at best.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				Considering the complexity of the system and the technical expertise required for most of the testing, the current testing approach that we have meets the State's needs (i.e. having the fiscal agent conduct any testing that the State requires under a controlled environment for the State review and approval). It is also significant to note, for the User Interface related testing, we do provide the user with on-line access to a test environment in order to test a User Interface that they are familiar with before production implementation. We also require testing of all rules related changes prior to production implementation to be reviewed and approved by MCM systems staff before production implementation. *Auditor's Response:* *Internal Audit agrees that the fiscal agent should conduct testing on all programming changes prior to promoting the changes into the production environment, and we acknowledge that a level of technical expertise is required when performing integration testing. However, the testing the fiscal agent performs should not be the only testing conducted. When change requests originate outside of Medicaid Contract Management and the fiscal agent, user acceptance testing should be performed by the user group requesting the change subsequent to the fiscal agent's tests. There should be a separate User Acceptance Testing Environment that closely mirrors the FMMIS production environment to facilitate this testing. We feel that this environment is not only feasible, but reiterate that it is a contractual requirement.*	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 09-10-05 The DME Handbook does not provide sufficient criteria for each DME code that requires prior authorization. Approximately one-fifth of the approved DME PAs did not meet the established criteria. **Recommendation - Medicaid Services** We recommend the Bureau of Medicaid Services develop additional criteria necessary for the review of DME PAs and include these criteria in the DME Handbook. We further recommend the Bureau of Medicaid Services develop a criteria checklist for each DME code requiring prior authorization to assist the reviewers in ensuring that PA requests meet the criteria. The checklist could be submitted with the PA documentation for monitoring purposes. If the PA process is revised as recommended above, this criteria checklist could be added to the review screen and completed on-line within the Service Authorization module. **Finding 09-10-06** During our review, we determined that negotiating value for DME trade-ins as outlined in the DME handbook was not occurring.	Medicaid Services created a policy checklist and provider memo for the review of DME PA's. Training documents were distributed to the Area Offices.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation - Medicaid Services We recommend Medicaid Services review the DME Handbook relating to DME trade-ins, and make necessary revisions establishing criteria to specify applicable equipment eligible for trade-in value (Hospital beds, manual or motorized wheelchairs, etc) and a means for determining the depreciated value. One potential solution would be to assign a percentage of residual value based on the age of the chair. For example is a chair is traded in that is less than 3 years old it is worth 30% of its original value, 3 to 5 years old would be worth 20% of its original value, and over 5 years old would be worth 10% of its value. Exceptions could be made for trade-ins that have no actual residual value.	Medicaid is currently promulgating other rules assigned by priority. When the DME handbook is opened it will be a complete update not just one section. An exact completion date can not be determined at this time.	
			Finding 09-10-07 Web Portal submissions are not being processed in a timely fashion, and submitted images of supporting documentation are not always legible.		
			Recommendation - Medicaid Services Identify a criteria checklist for each DME code requiring prior authorization to assist the reviewers in ensuring that PA requests meet the criteria. The checklist could be submitted with the PA documentation for monitoring purposes. Request CSR so that PA Module could be re-engineered for the submission of both the PA data and supporting documentation from the same site. If a checklist is created as suggested in Finding 5, that checklist could be included on the web portal site to help assist providers in submitting the complete set of required documents.	Medicaid Services created a policy checklist and provider memo for the review of DME PA's. Training documents were distributed to the Area Offices.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation - Medicaid Contract Management Make the necessary enhancements to the web portal submission process to ensure the timeliness and legibility of PA requests submitted via the web portal. MCM should also continue to monitor PAs submitted through the web portal to ensure all documents are legible.	Based on Medicaid Services' determination that we will continue using our current process, there is no need for action by Contract Management.	
OAG #2010-25	**2008/09 FY**	**IT Audit of FMMIS/DSS**	**Finding 2010-25-01** The Agency and the Medicaid fiscal agent, EDS, lacked appropriate access control documentation to demonstrate the business justification for access privileges granted within FMMIS, DSS, and the related software. **Recommendation** The Agency, with the assistance of EDS, should develop documentation of user roles and access privileges to guide in the assignment of employee and contractor access. In addition, access authorization records should be consistently maintained to document the access privileges requested, approved, and granted.	1) The roles in MEUPS (FMMIS/DSS application) have been updated with the appropriate clarification to assist in the understanding of the functionality that the role provides. 2) EDS created a Role Definition by Position to help guide the assignment of FMMIS/DSS user roles. 3) EDS updated the Security Access forms and procedures to include a clear justification of the requested roles. However, it is important to note that even though a document was created to guide requesters and reviews in the basic roles for a particular position (job title) there will always be exceptions. There are various functions a user may perform based on skill set and/or assignment; these exceptions are documented on the request form. 4) A refined business process was implemented to maintain the Agency user request forms and approvals in a central location.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2010-25-02 In some instances, system access privileges were inconsistent with employee or contractor job functions. In addition, neither the Agency nor EDS performed periodic reviews of the appropriateness of access privileges. **Recommendation** The Agency, together with EDS, should review, and adjust as appropriate, the above-listed access privileges in question. In addition, the Agency should ensure that periodic reviews are conducted of the ongoing appropriateness of system access privileges to facilitate the timely detection and correction of excessive or unnecessary capabilities.	1) We acknowledge the finding; however there will always be examples outside the norm based on the specialty job functions that are limited to specific users. These exceptions are now being documented on the Security Request form within the business justification section. 2) Access to promote changes is limited to users with Super Users (SU) access. This access has been reviewed and limited to 19 users. Technical Support staff has been briefed on the process and will continue to receive periodic refresher training, as needed. All support staff are required to review the Change Order (CO) Programming Checklist detailing these requirements. Each Systems Manager is responsible for ensuring employees within their areas of responsibility follow these guidelines and documentation requirements. 3) EDS removed the capability of Help Desk users to assign themselves as a System Administrator. 4) EDS has refined the procedures around reviewing the appropriateness of access. Super User access for Databases/ Servers/VCTL is reviewed weekly by the Project Managers. MEUPS (FMMIS application) roles are reviewed quarterly by the Security Officer. EDS has developed a schedule to review all users for all databases and servers.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2010-25-03 Some former contractor access privileges were not removed in a timely manner. **Recommendation** The Agency should work with EDS to ensure that the access privileges of former contractors are promptly removed.	The agency acknowledges all of the documented findings. The NACO's (Network Application Control Online System) identifications (IDs) (i.e. EDS VPN IDs) control all areas. In order to access to the before mentioned areas a VPN connection must be established first. There is a system report card SLA to monitor that all ids are terminated within 4 hours of an employees' termination. However, EDS has implemented procedures improving the timeliness of removal of the terminated users and the database/server levels.	
			Finding 2010-25-04 Generic user identifications (IDs) for database administration were being shared by contractor staff. **Recommendation** The Agency should require EDS to assign unique user IDs to all individual users authorized to perform database administration functions for FMMIS and DSS.	It was discovered that database administration roles have been performed with these three IDs. As a result of this finding EDS is changing the privileges associated to the IDs and educating the users. EDS will include these IDs in their ongoing auditing procedures.	
			Finding 2010-25-05 Certain access controls were deficient in the areas of user authentication, session controls, and logging of system activity.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Agency should implement the appropriate access controls in the areas of user authentication, session controls, and logging of system activity to ensure the continued confidentiality, integrity, and availability of Agency data and IT resources.	We have carefully reviewed the findings and have implemented some of your recommendations. However some of the recommendations will not be implemented because they may be covered via another medium. We are preparing a response for each of the reported findings for internal documentation purposes.	
			Finding 2010-25-06 Program and data change controls for FMMIS and DSS needed improvement.		
			Recommendation The Agency, with the assistance of EDS as applicable, should accurately document and enforce effective program and data change controls that provide for the involvement of the end user; timely testing and approval of changes; and an appropriate separation of duties for programming, testing, approval, and implementation of program and data changes.	1) Cycle Monitoring Procedures, the Customer Service Request (CSR) Process, and the Change Order (CO) Process documentation have been updated and can be found on iTrace. 2) According to procedures, our SE can no longer release code. The Cycle Monitors do this with the Project Manager's approval. There is an exception to this process in order to allow a few selected SE's the ability to promote code in emergency situations normally related to nightly cycles. These special code promotions are tracked in the Florida Interactive Portal (FIP) with the cycle monitoring CO type and ultimately approved by the State, after the fact.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				3) The Agency acknowledges the finding. The code promotion process has been changed, requiring EDS release teams and configuration managers to review all objects for promotion to ensure everything is tied to a CO and the CO has been approved There are reports available to identify what was released for any particular week. 4) The FIP has been modified to prevent this from reoccurring. The defect CO type is no longer available. 5) The CO workflow has now been updated to ensure AHCA approval before a CO can be closed. 6) We acknowledge this finding. The examples provided were during a time period when many procedural changes were occurring. The current promotion process will avoid future occurrences of this finding. 7) This is contrary to our procedures. Management has reemphasized the appropriate procedures to EDS and AHCA staff and further clarified within the promotions procedures. 8) The Agency acknowledges the eight occurrences reported were examples in which business analyst documentation was necessary. However, it is important to note that the various business areas within FMMIS have unique testing requirements regarding the code promotion. Therefore, not all COs will have Business Analyst testing.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				9) The Agency acknowledges the reported examples were not emergency situations. However, there will continue to be situations for which documentation after the fact or limited documentation will occur i.e., cycle monitor promotions and specific coding promotion that do not fit into the normal documentation requirements. 10) The Agency acknowledges the findings. Although the reported examples were not emergency situations, it is important to note that instances of this nature will continue to occur for emergency situations. EDS and the Agency have defined such scenarios when this would be appropriate and also set up a procedure in which the developer is required to perform a walk through with another senior developer prior to promoting the code.	
			Finding 2010-25-07 Agency reconciliation documentation of FFMIS data with DSS data was incomplete and contained discrepancies, limiting the Agency's ability to demonstrate the accuracy and completeness of DSS data. **Recommendation** The Agency should address the inaccuracies in the DSS Claims Balance Reports and maintain appropriate documentation to demonstrate that complete reconciliations of FMMIS data with DSS data are performed.	AHCA acknowledges the finding. The DSS Team created an on-demand report within Business Objects that balances claim payment totals, expenditures, and accounts receivable every week to the corresponding OnBase BAC-Y report. The new balancing report was completed and implemented on November 9, 2009 and directly queries the detailed claims data instead of aggregate tables. This report is also available online as a public report.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
OAG #2010-139	**FYs 2007-2009**	**Medicaid Payments and Related Controls**	**Finding 2010-139-01** Because of claim payment system functionality issues, emergency payments totaling approximately $792 million were made to providers. These payments were made based on estimates rather than specific claims information submitted by the provider. Absent specific claims information and the Agency's preaudit of that information, whether by electronic or other means, the Agency was unable to demonstrate at the time of payment, on a claim-by-claim basis, that the providers were qualified, benefitting recipients were eligible, and the charges for the medical services provided were valid and allowable Medicaid expenditures. **Recommendation** The Agency should continue efforts to ensure that FMMIS payment issues are resolved so that Medicaid claims can be processed by FMMIS and subjected to the controls designed to prevent payment of unallowable claims. Additionally, the Agency should hold the contractor accountable for the timely resolution of the payment issues that are preventing providers from submitting claims through FMMIS. The Agency should also consider inclusion in future State Plans submitted for Federal review and approval, provisions to allow emergency payments to providers on a limited basis under specified circumstances. **Finding 2010-139-02** The Agency had not developed policies or procedures specifically related to the calculation of the amount of emergency payments.	As of August 2010 the Agency has collected 99.33% of all the interim payments made since July 2008. As noted in #4 below, 217 of the Accounts Receivable (AR) balances were turned over to the Agency's Finance and Accounting Bureau for follow-up/ collection. Since February of 2010, the Agency has created only 13 ARs, and collected on all of them as of 7/31/2010, except the AR created 6/24/2010.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Agency should develop written policies and procedures for the calculation of emergency payments. In developing these policies and procedures, the Agency's policies and procedures should detail the methodology to be employed when calculating the payment amount as well as the types of Agency and provider documentation required.	In addition to responses to Auditor General "Memos of Understanding," the Agency provided documents that addressed both in general terms and specific circumstances, the procedures used to derive interim payments. The Agency has since formalized the general procedures used since July 2008 with a set of guidelines for subsequent use.	
			Finding 2010-139-03 The responsibility for the final authorization and approval of emergency payments was assigned to the same Agency staff who initiated and calculated the payments. Also, large payments were not subjected to additional levels of review and approval.		
			Recommendation The Agency should establish policies and procedures regarding the identification, calculation, and authorization of emergency payments. These procedures should provide for adequate separation of duties between persons calculating, authorizing, and approving emergency payments.	Final authorization and approval was performed by the Medicaid Contract Management (MCM) Bureau Chief, with other MCM staff performing the calculations; large payments were reviewed and/or approved by the Assistant Deputy Secretary for Medicaid Finance or the Deputy Secretary for Medicaid.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2010-139-04 After an emergency payment had been issued to a provider, an account receivable was to be established and the provider was to be notified that recoupment of the emergency payment would occur in a recoupment period during which a certain percentage of each claim submitted by the provider would be held back and applied to the account receivable until the balance was offset. The Agency process for recouping emergency payments did not include provisions to timely identify and collect the balances due from those providers that did not file claims during the recoupment period.		
			Recommendation The Agency should enhance procedures to ensure that FMMIS is timely updated to record Medicaid Program provider terminations and that provider recoupment schedules are modified, as needed, to maximize the collection of outstanding receivable balances. Additionally, the Agency should initiate collection efforts for providers with an outstanding receivable balance that have either ceased billing the Medicaid Program or who have been terminated from the Program.	The Agency has continued its collection efforts for these outstanding AR balances. In accordance with Agency policy, after attempting to collect these balances directly by issuing collection letters from the Bureau of Medicaid Contract Management, 217 ARs with uncollected balances that had no payments made were turned over to the Agency's Bureau of Finance & Accounting for collection pursuant to FAC Rule 69I-21.003.	
			Finding 2010-139-05 According to the available performance reports, the Medicaid fiscal agent, Electronic Data Systems, Inc. (EDS) was not performing at contractually required levels. Additionally, the Agency was not timely reviewing and scoring levels of contractor performance.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation In order to effectively monitor contractor performance, the Agency should timely review and score contractually required performance measures and take punitive actions, including the assessment of liquidated damages, for nonperformance. The Agency should also consider requiring the contractor to submit performance measures that address whether claims are accurately processed.	The Agency established a "Report Card" monitoring tool as a component of the Request for Proposal (Contract). Agency staff were involved with fiscal agent transition issues and very intensely monitored the change from the old, outdated FMMIS to the new architecture FMMIS, and the transition between fiscal agent operations and staff. Report card monitoring is an evolving activity, and at present the Agency is now "caught-up" with the monthly report cards.	
			Finding 2010-139-06 Reporting requirements were not sufficient to allow the Agency to effectively monitor subcontractor performance. **Recommendation** The Agency should enhance subcontractor monitoring by requiring that data pertaining to the accuracy of claims processed by the subcontractor's pharmacy benefits system be reported to the Agency at required intervals.	MCM has continuously maintained a Report Card for the Pharmacy Area. MCM staff monitor the statistics for the calls, average speed of answer, blockage, etc., for all the pharmacy call centers; MCM also monitors system down time and listens to calls for accuracy. While there is not an item on the Report Card that monitors accuracy of claims processing, per se, there are many reports generated through On-Base that address the processing results for pharmacy claims. Staff in the Pharmacy, Program Analysis and MPI Bureaus have access to these reports, from "Pay/Deny" reports to a variety of trend reports that would indentify claims accuracy processing questions. Staff in these bureaus also have access to DSS to create unique queries that fine-tune trending issues and examine any anomalies identified on trending reports.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2010-139-07 Controls were not sufficient to ensure that Medicaid claims submitted to the Florida Medicaid Management Information System (FMMIS) were paid in accordance with applicable laws, rules, and regulations. **Recommendation** The Agency should ensure that, in accordance with State law, Medicaid claims are paid only to providers with valid provider agreements in place. Additionally, the Agency should develop Coverage and Limitation Handbooks for all Medicaid service types and improve automated edits and related procedures to ensure that claims are processed in accordance with applicable Medicaid policies and fee schedules.	The Agency has worked with providers of Targeted Case Management for Children At Risk of Abuse and Neglect to revise policy in preparation for promulgating a Coverage and Limitations Handbook for this service. The draft handbook will soon be routed within the Agency in anticipation of entering the Rule Development phase. We expect a promulgation date in early 2011. The Child Health Services Targeted Case Management handbook is entering the Proposed Rule phase and is expected to be promulgated by the end of 2010. Familial Dysautonomia Waiver handbook is under development. It has been delayed by staff turnover. We project it will be promulgated in Spring 2011.	
OAG #2010-165	**FYE 6-30-09**	**Federal Awards Audit**	**Finding FS 09-001** As previously reported, the FAHCA, Bureau of Finance and Accounting (Bureau), did not record a receivable and deferred revenue to represent its claim on Federal financial resources related to the incurred but not reported (IBNR) Medicaid claims liabilities. **Recommendation** We again recommend that the Bureau establish procedures to record net receivables and deferred revenue in recognition of its claim on Federal resources related to the IBNR Medicaid claims.	This item was added to the financial statement checklist, and the receivable and corresponding deferred revenue entries were recorded in the FY 09/10 financial statements.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FS 09-002 Emergency payments to Medicaid providers were recorded and reported as expenditures rather than receivables by the FAHCA, Bureau of Finance and Accounting (Bureau).		
			Recommendation We recommend that the Bureau enhance its procedures to ensure that all appropriate recognition criteria are considered prior to recognizing payments on behalf of Federal programs as expenditures.	In accordance with State statutes and Federal directives, emergency payments have been processed for Medicaid providers. An accounts receivable is established and subsequent claims are processed and posted to the accounts receivable. The Bureau of Medicaid Contract Management provided information to Finance and Accounting and the appropriate entries were recorded in the FY09/10 financial statements.	
			Finding FS 09-003 The FAHCA, Bureau of Finance and Accounting (Bureau), did not fully record amounts due from counties for disproportionate share hospital (DSH), low income pool (LIP), exemptions to ceilings, and other Statewide issue receivables.		
			Recommendation We recommend that the Bureau enhance controls over the use of the spreadsheet to ensure the accurate recording of amounts due, amounts received and amounts receivable from the counties.	Effective for fiscal year beginning July 1, 2009, Finance and Accounting maintained a master copy of the DSH/LIP spreadsheet and updated it based on actual deposits. Medicaid Program Analysis notified Finance and Accounting whenever there was a change in the contract for the amount of receivable due from the counties.	
			Finding FS 09-004 As previously reported, the FAHCA, Bureau of Finance and Accounting (Bureau), did not record an uncollectible allowance related to net receivables for drug rebates.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We again recommend that the Bureau ensure that fiscal year-end procedures are performed to appropriately record all accounts receivable uncollectible allowances.	This item was added to the financial statement checklist, and the allowance for uncollectible entry was recorded in FY 09/10 financial statements.	
			Finding FA 09-055 Payments made to providers on behalf of clients for medical service claims were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, the payments were for improper amounts or for unallowable services.		
			Recommendation We recommend that FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed by FMMIS. Additionally, FAHCA should ensure that FMMIS is updated timely with the proper information.	Waiver section is complete. Issues 1: Home Health - System controls for prior authorization were fixed prior to the publication of this audit. We are working with the Bureau of Medicaid Program Integrity to recoup the overpayments. Issue 2: Private Duty Nursing Claims Paying Less Than The Allowable Amount – The CSR that changes the way the MMIS processes these claims is being tested, through Medicaid Contract Management to determine the impact on other procedure codes for other programs. If testing is successful and the CSR is implemented, PDN claims will not pay unless more than 2 units of service are billed on the claims per day.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				Re: Chiropractic Services overpayment - File maintenance (FM) has been submitted to the Medicaid fiscal agent. This FM requests a FLMMIS system update and includes additional clarification regarding valid and exceptional place of service codes and which chiropractic services codes are included in the 24 visit maximum limit. Instruction is also provided as to how and what combination of codes can be billed and reimbursed without need for prior authorization. The FM also provides instruction to the fiscal agent for recoupment through the reprocessing of claims after the FM is implemented.	
			Finding FA 09-056 Overpayments made to HMO plans on behalf of deceased clients were not timely recouped. **Recommendation** We recommend that FAHCA ensure the timely recoupment of claim overpayments.	The Agency continues to make every effort to ensure overpayments made to HMO plans on behalf of deceased clients are recouped, as timely as possible. The Medicaid Third Party Liability Vendor reviews claims paid after date of death as part of its Medicaid Overpayments Project. This project is conducted on a quarterly basis.	
			Finding FA 09-057 See Information Technology Operational Audit, report No. 2010-025, dated October 2009. Details of the findings and recommendations, as well as, FAHCA management's responses are included in that report.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FA 09-058 See Medicaid Payments and Related Controls Operational Audit, report No. 2010-139, dated March 2010 and Medicaid Facility Reimbursement Rates Operational Audit, report No. 2010-189, dated April 2010. Details of the findings and recommendations, as well as, FAHCA management's responses are included in that report.		
			Finding FA 09-060 Contrary to Federal requirements, FAHCA reported on the CMS-64, Quarterly Medicaid Statement of Expenditures For the Medical Assistance Program reports expenditures that were not supported by provider claims.		
			Recommendation We recommend that FAHCA report on the quarterly CMS-64 report only expenditures that are supported by actual claims.	Finance & Accounting has worked with Medicaid Contract Management to ensure only emergency payments that have claims to support them will be reported on the CMS-64 report.	
			Finding FA 09-061 FAHCA procedures were not sufficient to ensure that expenditures reported on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, included only activity pertaining to the applicable reporting period.		
			Recommendation We recommend FAHCA ensure that expenditures reported on the quarterly CMS-64 report include only payments made to providers during the applicable reporting period. We also recommend FAHCA amend the reports and seek recovery of the additional $47,737,395 of ARRA funds earned for payments made to providers on October 1, 2008.	AHCA will make prior period adjustments to record expenditures for FMMIS run dated September 27, 2008 with state warrant dated October 1, 2008 in Federal fiscal year beginning 10/1/2008. Procedures have been amended to base the reporting periods on the state warrant date.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FA 09-062 FAHCA procedures were not sufficient to ensure that Medicaid providers receiving payments had a current provider agreement in effect. **Recommendation** We recommend that FAHCA ensure that provider agreements are in effect for applicable time periods.	The agency completed installation of an automated reenrollment process in the MMIS in January of 2010 which required over 1200 hours of coding and testing. This automated process runs daily and identifies any provider with a provider agreement end date ninety (90) days in the future; flags the file as needing to reenroll; creates a report for tracking purposes; and sends the reenrollment packet to the provider. The provider has 90 days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who fail to respond within the 90-day window are suspended in the system to prevent claims with dates of service after the agreement end date from processing. Senior management then makes a determination if the provider should be terminated. This process has been running since February 1, 2010 and guarantees that no provider with a valid agreement will expire and still have claims process and pay. As an automated process, provider reenrollment no longer has to shut down during fiscal agent transitions as in the past. The status for this finding remains partially corrected because the agency is currently in the process of installing an additional automated job to identify providers with agreement end dates less than the current date; flag the file as needing to reenroll; create a report for tracking purposes; and send the reenrollment packet to the provider.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				The provider will have 90-days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who fail to respond within the 90-day window will be suspended in the system to prevent claims with dates of service after the agreement end date from processing. Senior management will then make a determination if the provider should be terminated. This job will be a one-time cleanup of older provider files and encompasses the providers who were not reenrolled during the fiscal agent transition. Completion of this job will result in a fully corrected status for this finding.	
			Finding FA 09-063 FAHCA did not always ensure that facilities receiving Medicaid payments met the required health and safety standards.		
			Recommendation We recommend that FAHCA increase its efforts to ensure that staff conduct Life Safety Surveys within the established time frames	Corrective action taken is significantly different from corrective action previously reported: Following a subsequent failure to correct the process to the required timeframes, The Office of Plans and Construction transferred the six staff and approximately 95 percent of the responsibility for fire life safety surveys to the Bureau of Field Operations. Field Operations now conducts all but a very few fire life safety surveys. Those still conducted by the Office of Plans and Construction are scheduled according to the timeframe requirements of Field Operations, which ensures that these surveys are conducted timely.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding FA 09-064 FAHCA had not developed policies and procedures to provide for the timely review and release of cost report audits of Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and nursing homes. FAHCA had not resolved issues relating to ICF-DD facilities for which the independent auditors disclaimed an opinion on the cost reports for the 2003-04 and 2004-05 fiscal years. Additionally, FAHCA had not performed monitoring of the vendor contracted to perform hospital cost report audits. **Recommendation** We recommend that FAHCA develop policies and procedures to assist in the review and release of nursing home and ICF-DD audit reports, including time frames for the timely release of the audit reports. We recommend that FAHCA implement a quality assurance review process in which FAHCA staff review the supporting working papers for a sample of CPA audit reports in lieu of the current practice of reviewing the working papers for all audit reports. We also recommend that FAHCA ensure that procedures established to monitor contractual performance of the hospital cost report auditor (Medicare intermediary) are timely performed.	Medicaid continues to work with Legal staff to address the incomplete audits that were identified in this audit. Medicaid staff strives to complete and review audits as timely as possible. Medicaid completed and in May 2010 issued nine ICF-DD audits for which the independent auditor previously disclaimed an opinion. Medicaid completed the monitoring of the vendor contracted to perform hospital cost report audits for SFYs 08-09 and 09-10. The reports were issued in June 2010.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
OAG #2010-189	**FYs 2007-2009**	**Medicaid Facility Reimbursment Rates**	**Finding 2010-189-01** The Agency did not always calculate Medicaid reimbursement rates for hospitals and intermediate care facilities for the developmentally disabled (ICF-DDs) in accordance with established procedures and instructions. **Recommendation** The Agency should ensure that rates are calculated in accordance with established policy. The Agency should also enhance controls to ensure that calculations are performed correctly and based on complete cost reports submitted by the facility. Furthermore, the Agency should ensure that all manual profile sheets are reviewed by a second person to ensure that reimbursement rates are calculated using accurate information. Any corrections needed should be verified by the reviewer. **Finding 2010-189-02** The Agency calculated Medicaid reimbursement rates for hospitals and ICF-DDs using cost reports accepted after the deadline for cost report submission.	The Agency has and is continuing to ensure that all providers' rates are calculated in accordance with State and Federal policy. The Medicaid Cost Reimbursement Planning Administrator (MCRP Administrator) conducts a review process and signs each rate letter prior to distributing them to the hospital, ICF/DD and the Medicaid Fiscal Intermediary. The review process includes reviewing the manual profile sheet, rate computations, rate letter and the cost report (which produces the manual profile sheet, rate computations and rate letter). The review process has always included the practice that all manual profile sheets are reviewed by a second person (supervisor) to ensure that reimbursement rates are calculated using the reported information. The second reviewer now signs the manual profile sheet. With implementation of the second reviewer signing the manual profile sheets, the development and implementation of a checklist is not necessary to demonstrate that the Agency is in compliance with the rate setting procedures.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Agency should enhance controls to ensure that Medicaid reimbursement rates are calculated using the correct cost report, in accordance with Medicaid policy and Florida law.	The Hospital Reimbursement Plan states each hospital shall submit a cost report 5 months after the close of its cost-reporting year; however, the Plan also states, all cost reports received by AHCA by April 15 and October 15 respectively shall be used to establish the reimbursement ceilings (rates). The Agency disagrees with the finding that ICF/DD cost reports were accepted after the filing deadline. The Agency has confirmed that the original cost reports were submitted prior to the established deadline. The Medicaid policy regarding amended/revised cost report is that the original cost report filing date is the factor for determining if a cost report is late. *The Agency disagreed that the ICF/DD facility cost reports had been accepted after the filing deadline. As noted in our finding, we agree that the original cost reports were received before the filing deadline. However, the rates authorized were based on the revised cost reports rather than the most current acceptable cost report received by the applicable due date.* The SPA requested an effective date of July 1, 2010, and was submitted to CMS prior to September 30, 2010. This SPA contains language regarding the definition of filing deadline and the rate setting deadline. These definitions provide more clarification of the Medicaid policy regarding the deadline for cost report submission and the deadline for cost reports to be used to calculate reimbursement rates.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2010-189-03 The Agency did not always enter reimbursement rates into the Florida Medicaid Management Information System (FMMIS) prior to the effective date of the rate, resulting in claims being reimbursed at the previous rate. In addition, retroactive rate adjustments did not take into consideration required copayments, and overpayments were made. **Recommendation** The Agency should enhance controls to ensure that reimbursement rates are entered into FMMIS prior to the rates' effective dates. The Agency should also ensure that claims adjusted for a new rate are paid in the correct amount, considering any copayments required from the recipient. In addition, the Agency should identify overpayments related to copayments that resulted from retroactive rate adjustments and initiate actions to recoup the applicable amounts from providers. **Finding 2010-189-04** Hospitals, ICF-DDs, and nursing homes did not always submit cost reports to the Agency within the required timeframes.	The Bureau of Medicaid Program Analysis (MPA) has and will continue to ensure that providers' rates are submitted to MCM in a timely fashion in order to ensure that reimbursement rates are entered into FMMIS prior to the rate effective dates. The Agency is aware of issues regarding the overpayment to providers of copayments when retroactive rate adjustments are generated and CSR 1236 was created on July 29, 2009 and implemented into production October 5, 2009. The CSR corrected the business rules used in FMMIS to process retroactive claim adjustments for claims with copayments. The Agency will initiate actions to identify and recoup any overpayments made to providers due to this issue. The Task, Change Order, associated with CSR 1236 has a priority ranking of "2" and will be installed into production in November or early December 2010. When installed overpayments will be recouped.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Agency should revise the Medicaid State Plan to either develop new punitive measures, such as rate reductions, or enforce existing measures to ensure the timely submission of cost reports to the Agency.	The Bureau of Medicaid Program Analysis (MPA) is currently working with the Bureau of Medicaid Program Integrity and Office of the Inspector General to make a rule change to 59G-9.070 to establish punitive fines for providers who are not filing a timely cost report for rate setting. The SPA requested an effective date of July 1, 2010, and was submitted to CMS prior to September 30, 2010. This SPA contains language regarding punitive measures which includes fines for providers who are not filing a timely cost report for rate setting.	
			Finding 2010-189-05 Agency monitoring of the contract with First Coast Service Options, Inc. (FCSO), for hospital cost report audits was not sufficient.		
			Recommendation The Agency should require that FCSO adhere to all contract provisions, including the submission of all required reports. In addition, to gain increased assurance that the audits are performed in accordance with the contract, the Agency should consider increasing the level of detail review employed during annual contract monitoring. Also, prior to entering into another hospital cost reports audit contract, the Agency should consider performing a cost analysis to evaluate the competiveness of proposed rates or competitively procuring the services.	The Agency has amended the FCSO contract to reflect the status reports employed. The contract monitoring for 2009-10 fiscal year was completed and issued in June 2010. The Agency will consider increasing the number of audits for a full working paper review for the next monitoring. The Agency has renewed the contract until March 31, 2011 and intends to competitively procure the services for the next contract.	
			Finding 2010-189-06 Facility reimbursement rate changes resulting from cost report audit adjustments were either not calculated or were calculated but not processed by the Agency.		

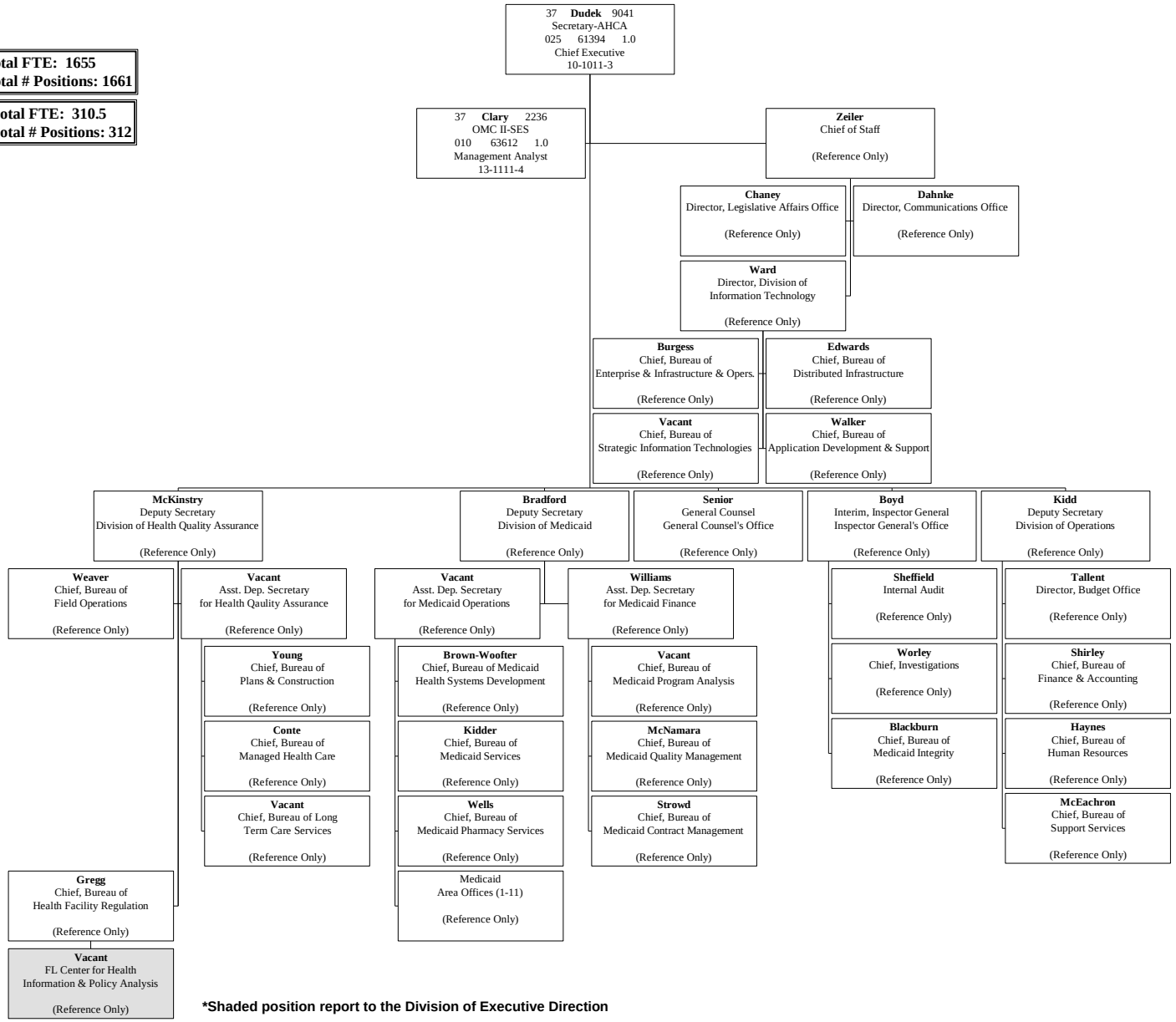
REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Agency should implement procedures to ensure that new ICF-DD rates are calculated when audit reports on ICF-DD cost reports are released. Furthermore, the Agency should enhance policies and procedures to ensure that cost report audits procured by the Agency are timely processed and that any rate changes resulting from cost report audits are timely calculated, entered into FMMIS, and retroactively applied.	Currently, there are procedures in place to ensure that new ICF/DD rates are calculated when audit reports on ICF/DD cost reports are released; however, the delay in processing the current audit is based solely on staff turnover within the unit. We are currently at full staff and the pending audits have been assigned to an analyst. In addition, procedures have been put in place regarding facilities undergoing a change of ownership. For an ICF-DD undergoing a change of ownership, the Licensure process consists of verifying outstanding audits and/or pending rate adjustments based on cost reports. A facility license will not be issued until these outstanding issues have been resolved with the old owner and new owner, with regard to repayment of any outstanding Medicaid liens. The remaining audits have been assigned to an ICF analyst for reviewing and revising the rate, if necessary.	

Effective Date: July 1, 2011
Org. Level: 68-10-00-00-000
FTEs: 2 Positions: 2

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Secretary's Office

Agency Total FTE: 1655
Agency Total # Positions: 1661

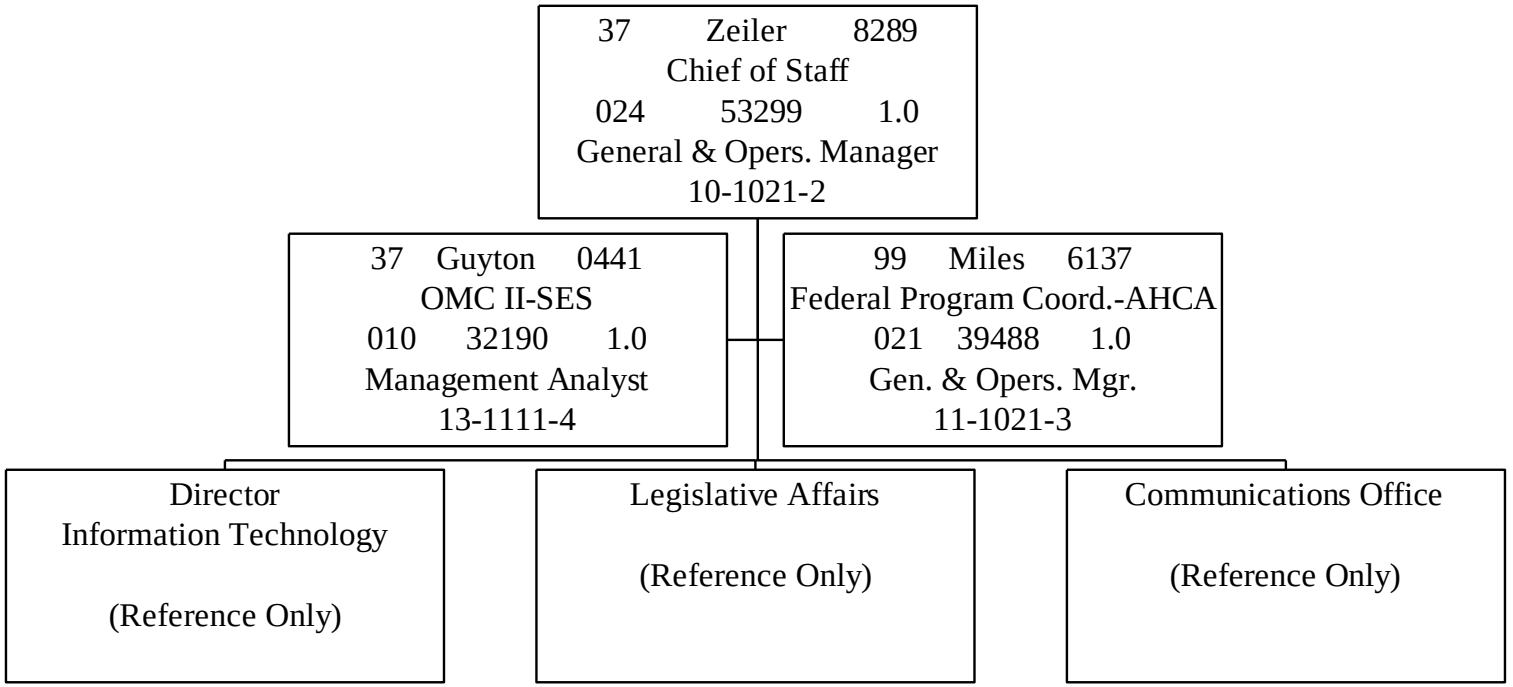
Division Total FTE: 310.5
Division Total # Positions: 312



***Shaded position report to the Division of Executive Direction**

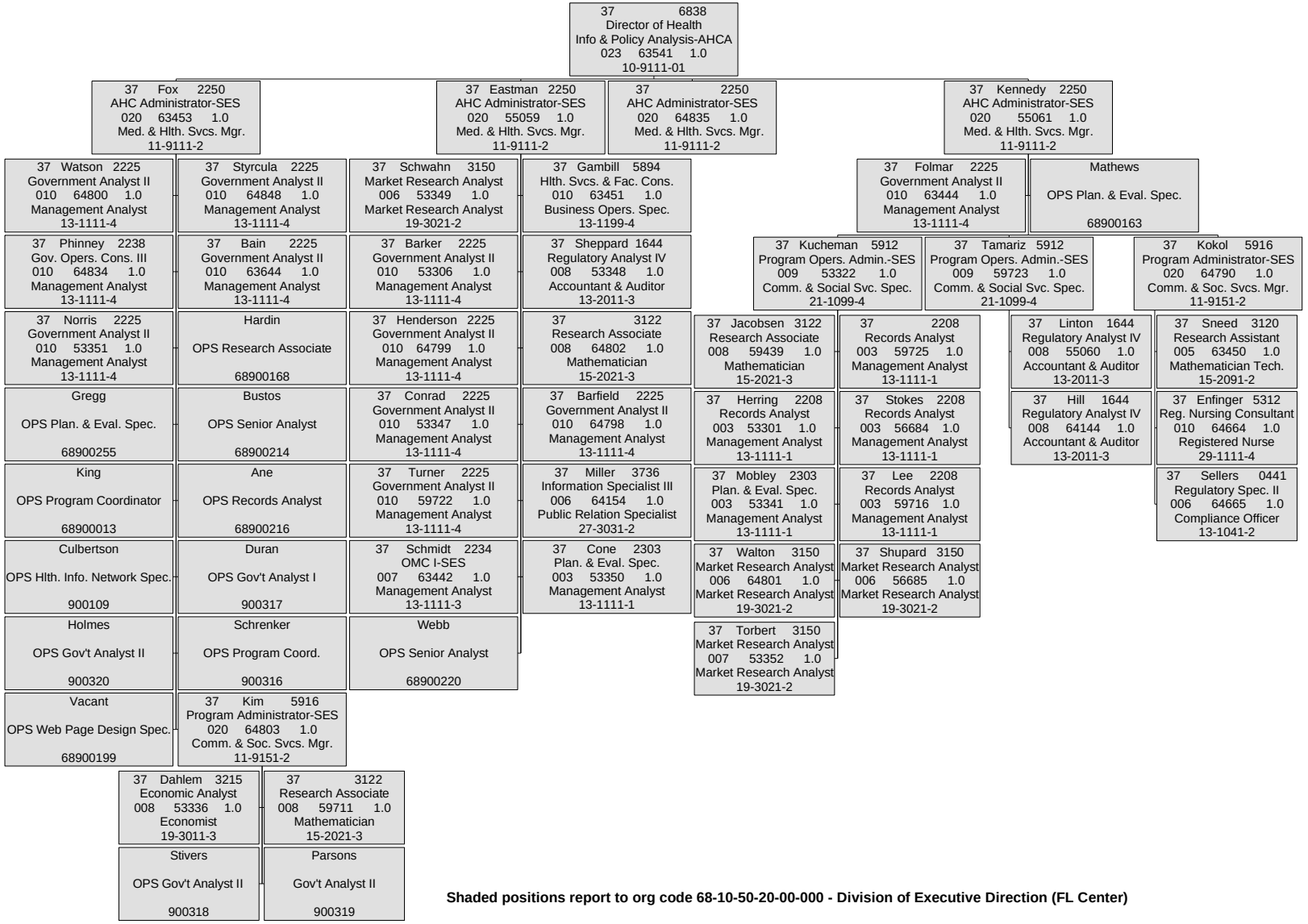
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief of Staff

Effective Date: July 1, 2011
Org Level: 68-10-10-00-00-000
FTEs: 3 Positions: 3



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
HFR - Florida Center for Health Information & Policy Analysis

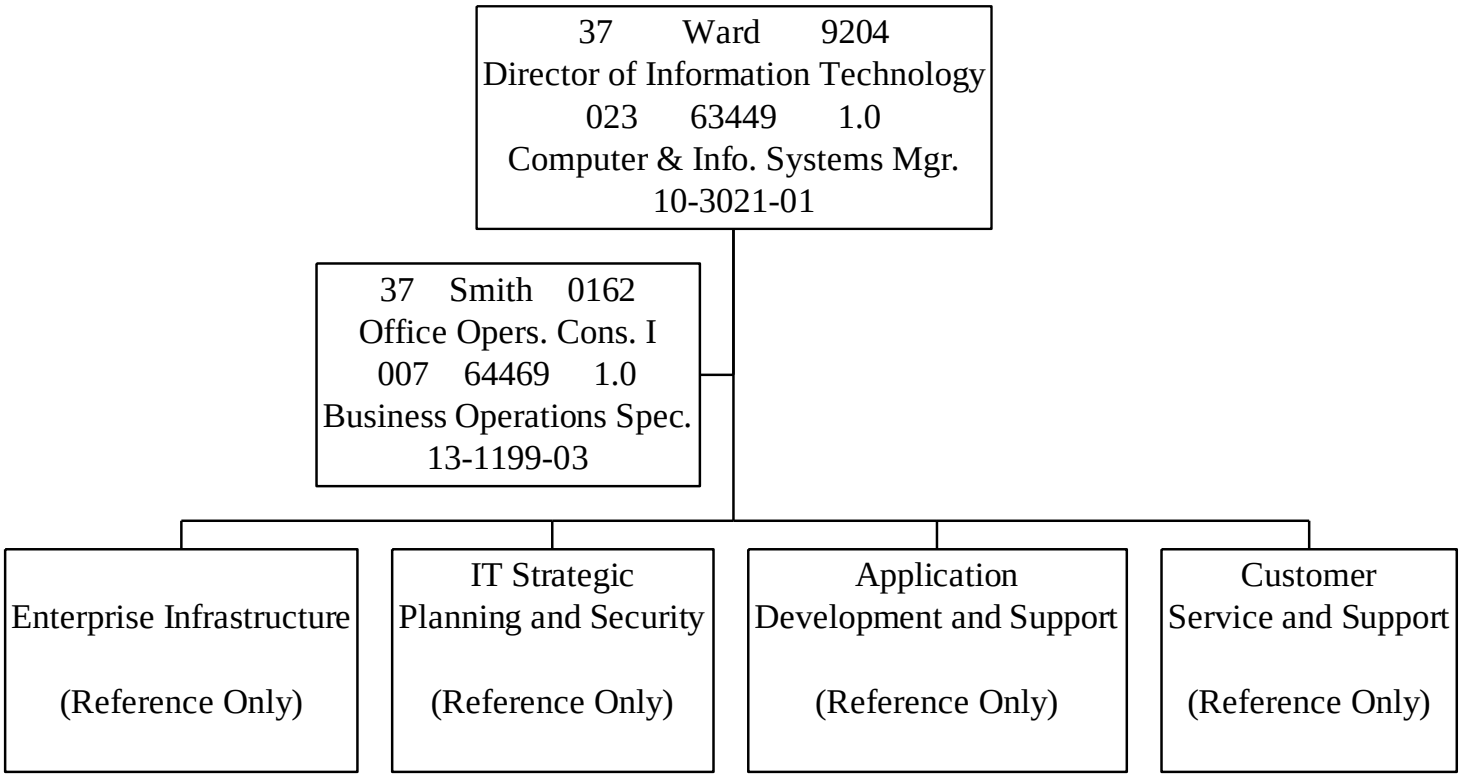
Org. Level: 68-10-50-20-00-000
Revised Date: July 1, 2011
FTEs: 44 Positions: 44



Shaded positions report to org code 68-10-50-20-00-000 - Division of Executive Direction (FL Center)

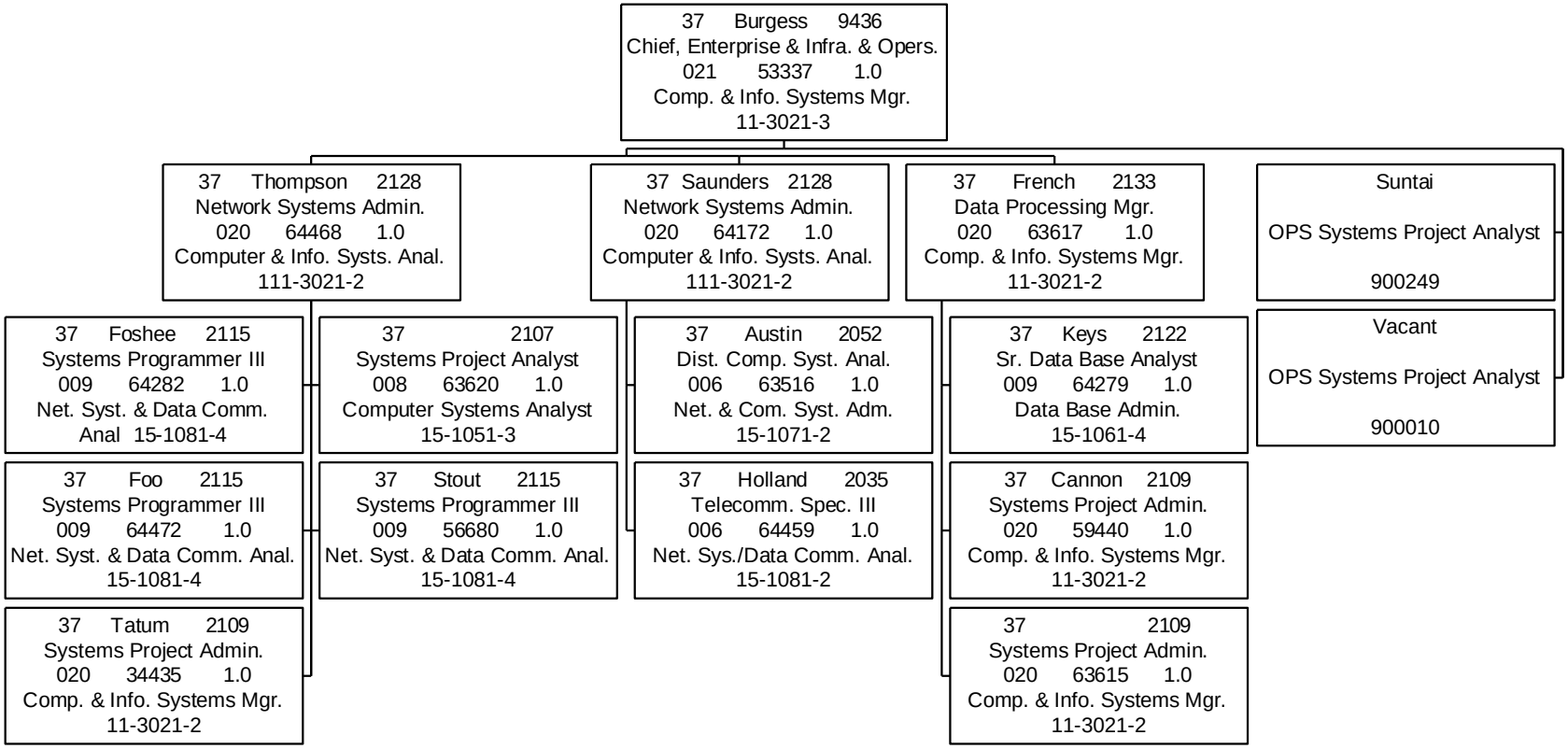
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of Information Technology
Director's Office

Revised Date: July 1, 2011
Org Level: 68-10-10-40-00-000
FTEs: 2 Positions: 2



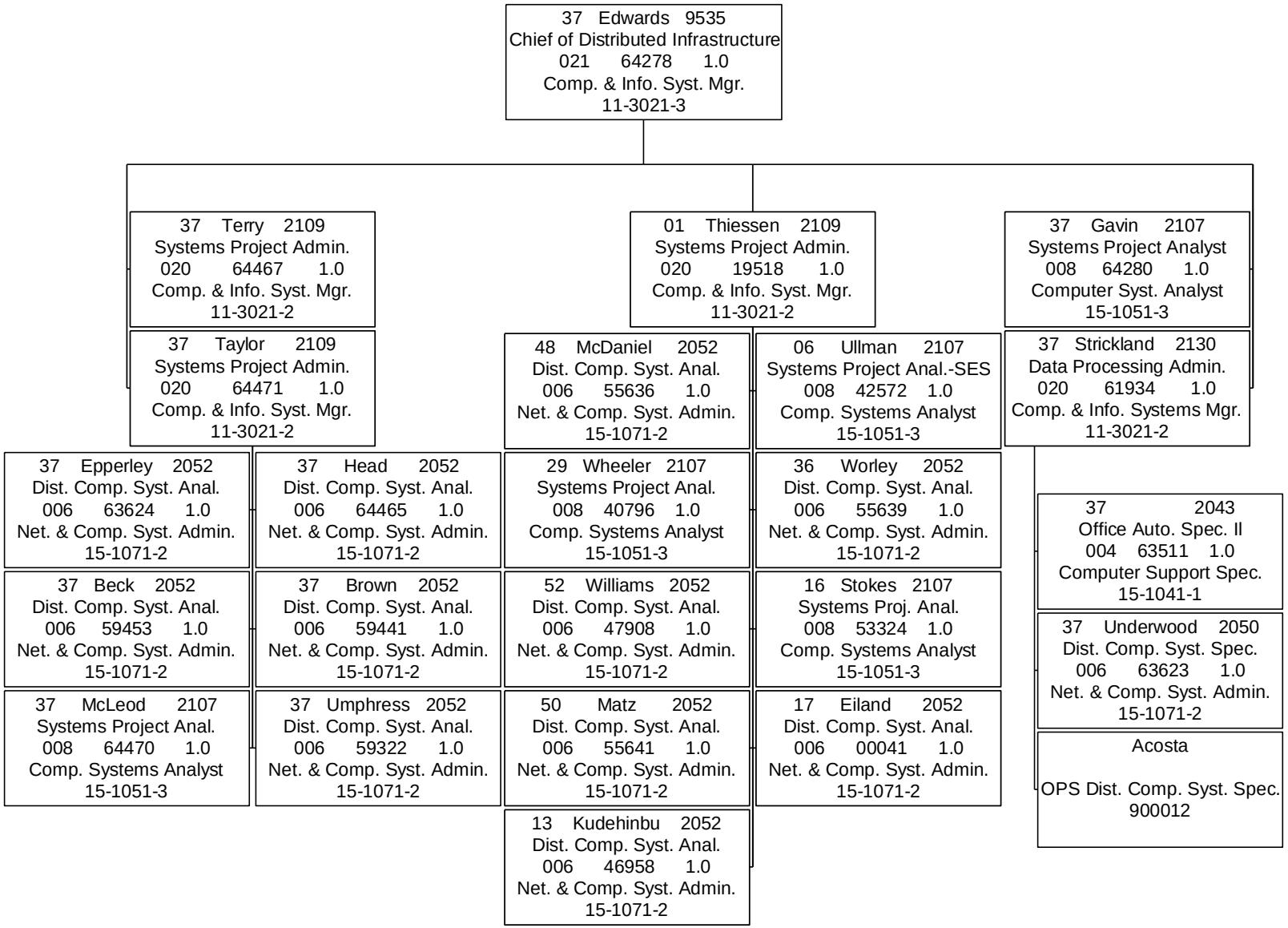
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of Information Technology
Bureau of Enterprise Infrastructure

Org. Level: 68-10-10-40-00-100
Revised Date: July 1, 2011
FTEs: 14 Positions: 14



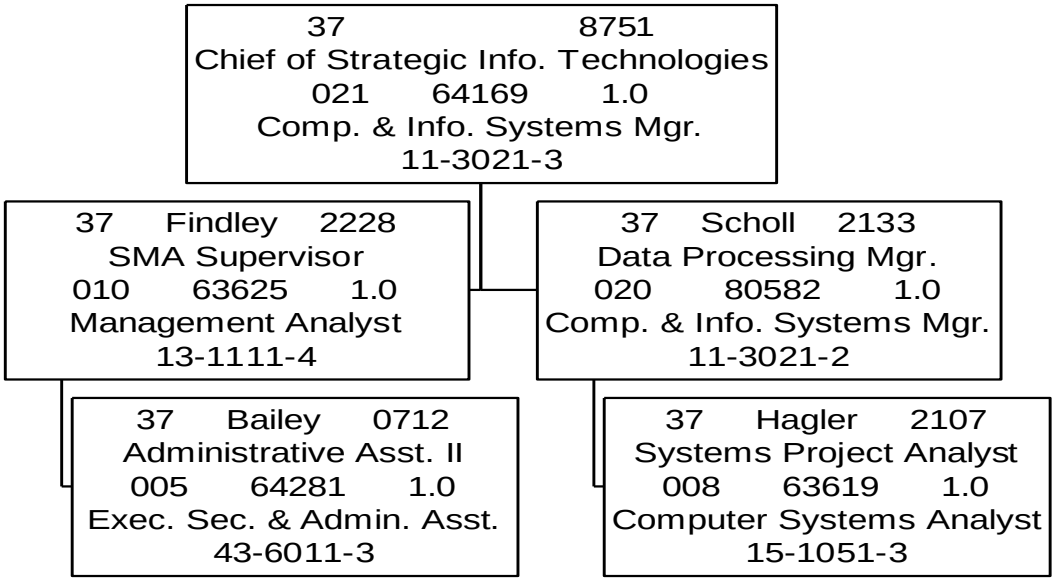
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of InformationTechnology
Bureau of Customer Service and Support

Org. Level: 68-10-10-40-00-200
Revised Date: July 1, 2011
FTEs: 23 Positions: 23



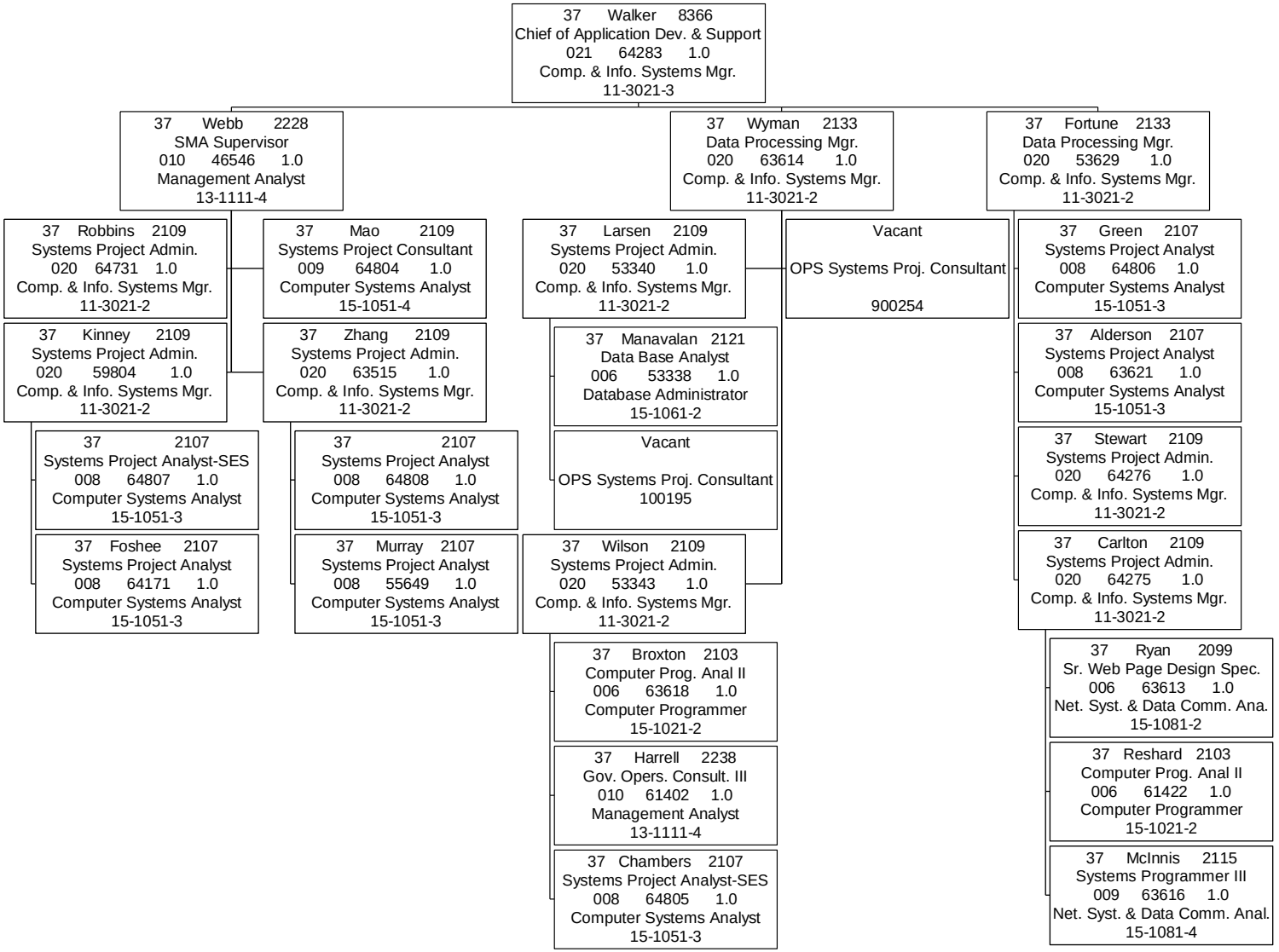
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of Information Technology
Bureau of IT Strategic Planning and Security

Org. Level: 68-10-10-40-00-300
Revised Date: July 1, 2011
FTEs: 5 Positions: 5



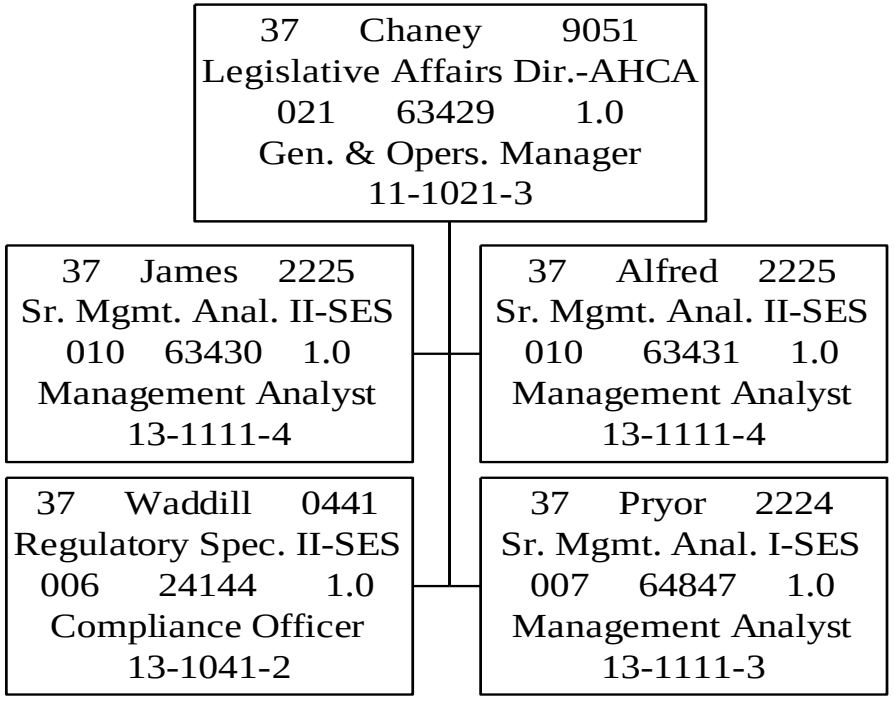
Org. Level: 68-10-10-40-00-400
Revised Date: July 1, 2011
FTEs: 25 Positions: 25

AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of Information Technology
Bureau of Application Development and Support



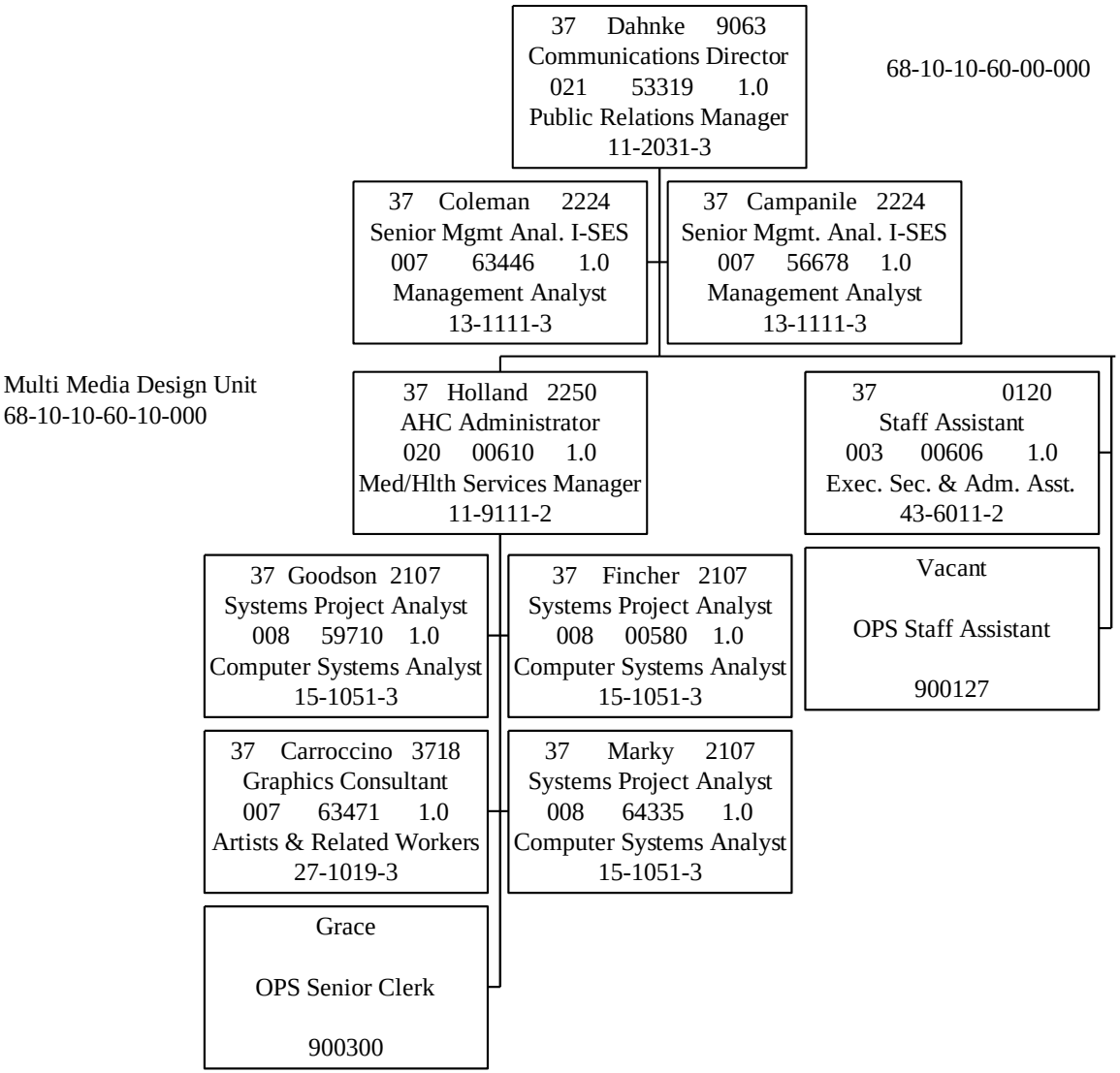
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Legislative Affairs Office

Effective Date: July 1, 2011
Org Level: 68-10-10-50-00-000
FTEs: 5 Positions: 5



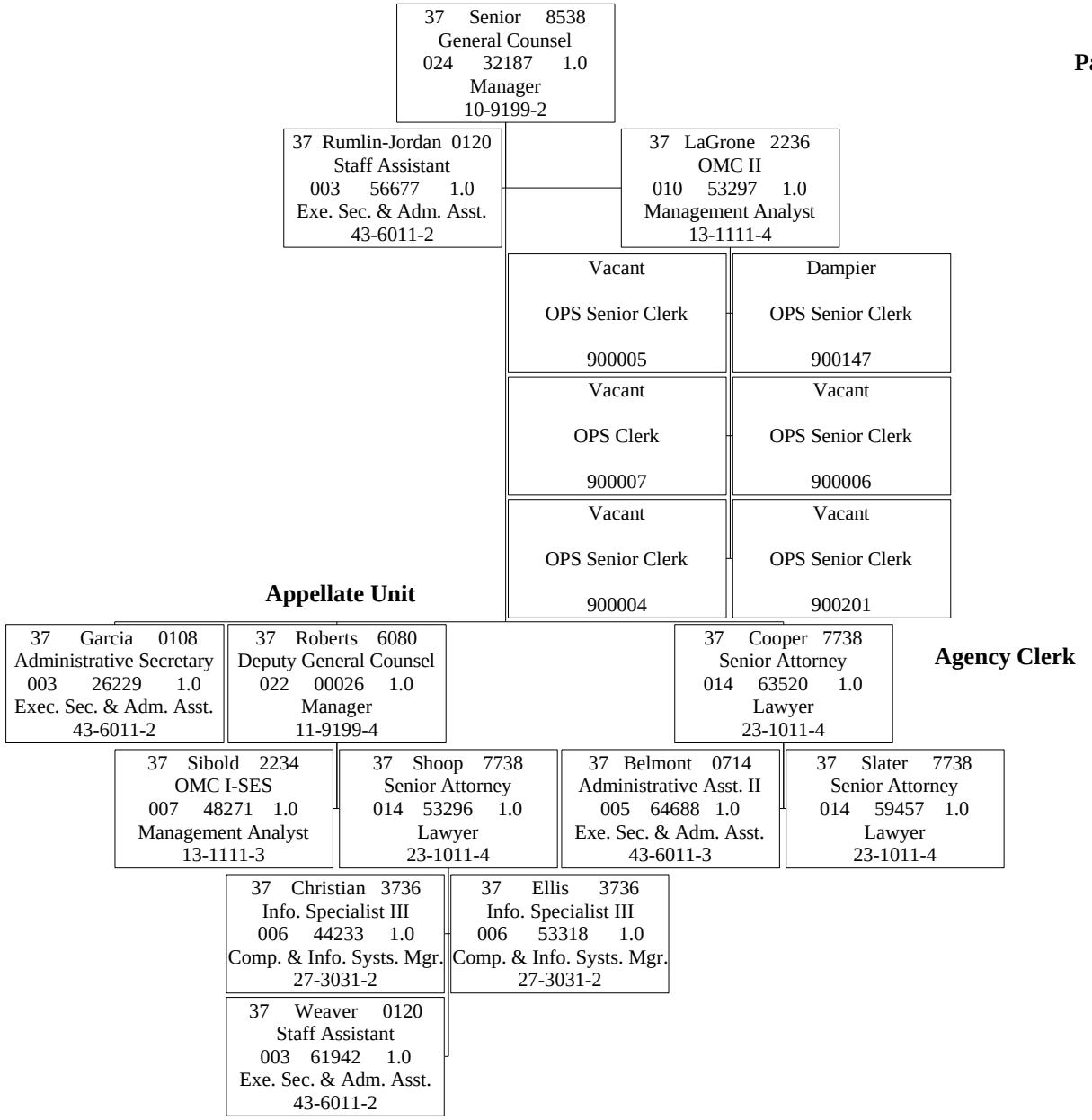
Revised Date: July 1, 2011
FTEs: 9 Positions: 9

AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Communications Office



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

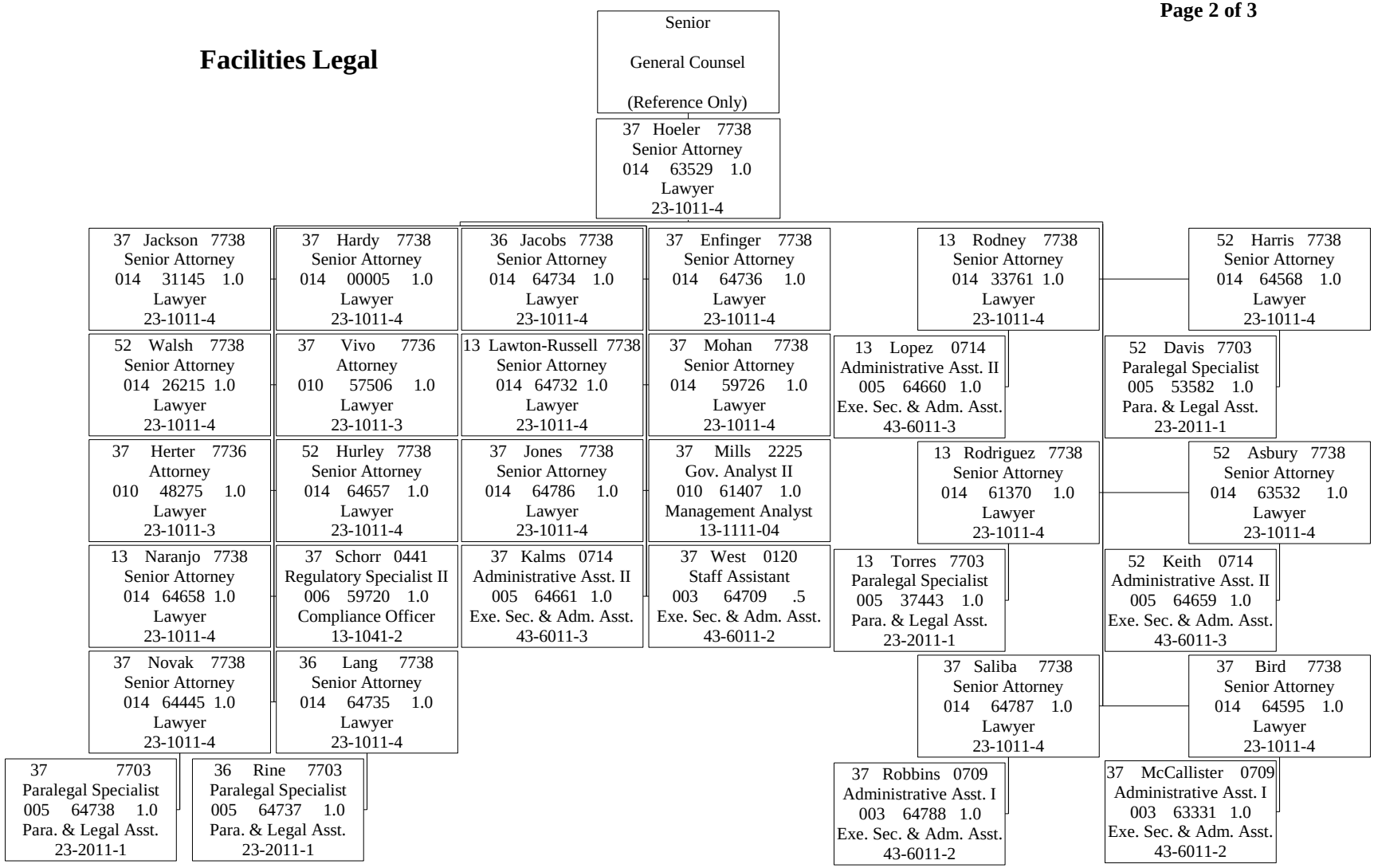
Org. Level: 68 10 20 00 000
Revised Date: July 1, 2011
FTEs: 66.5 Positions: 67



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Org. Level: 68 10 20 00 000
Revised Date: July 1, 2011
FTEs: 66.5 Positions: 67

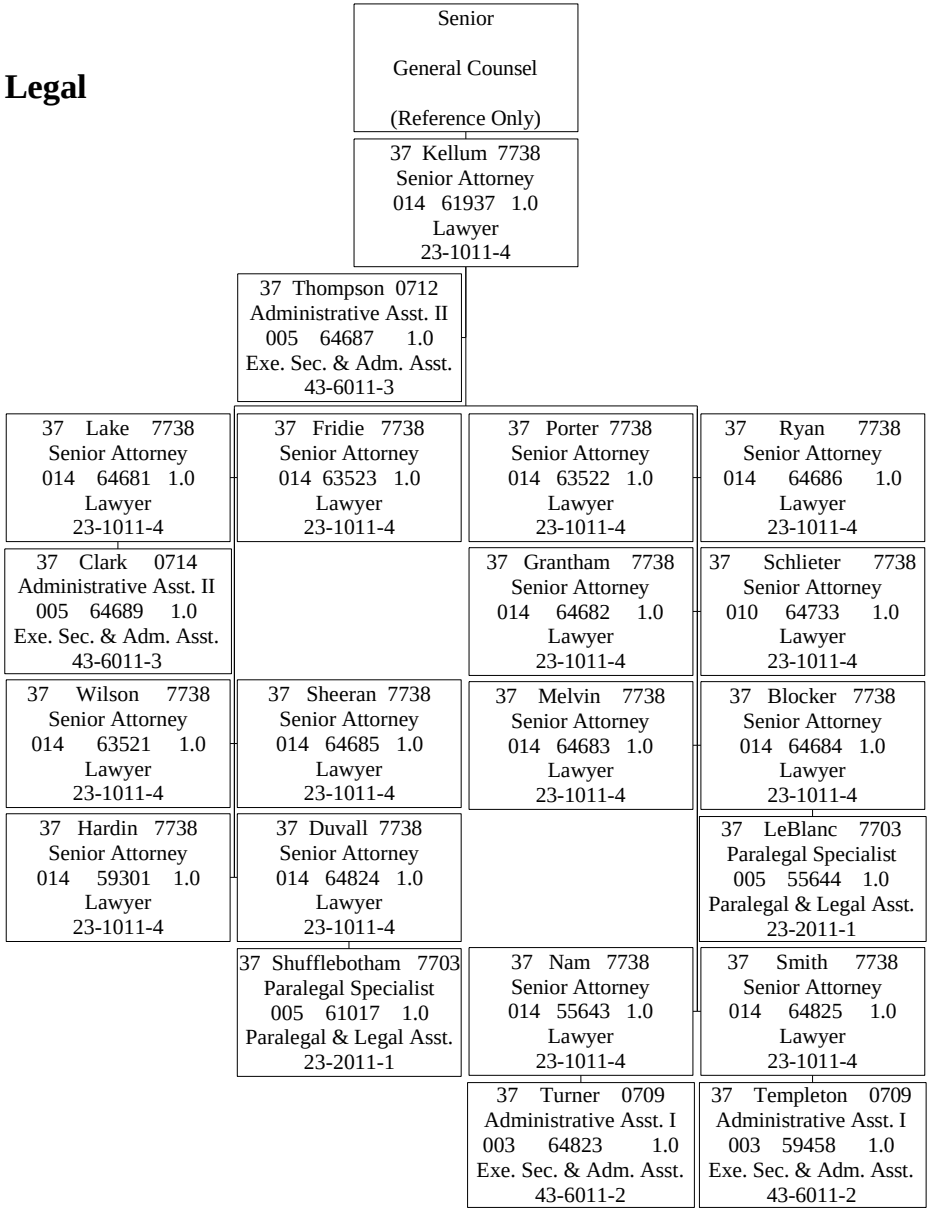
Facilities Legal



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

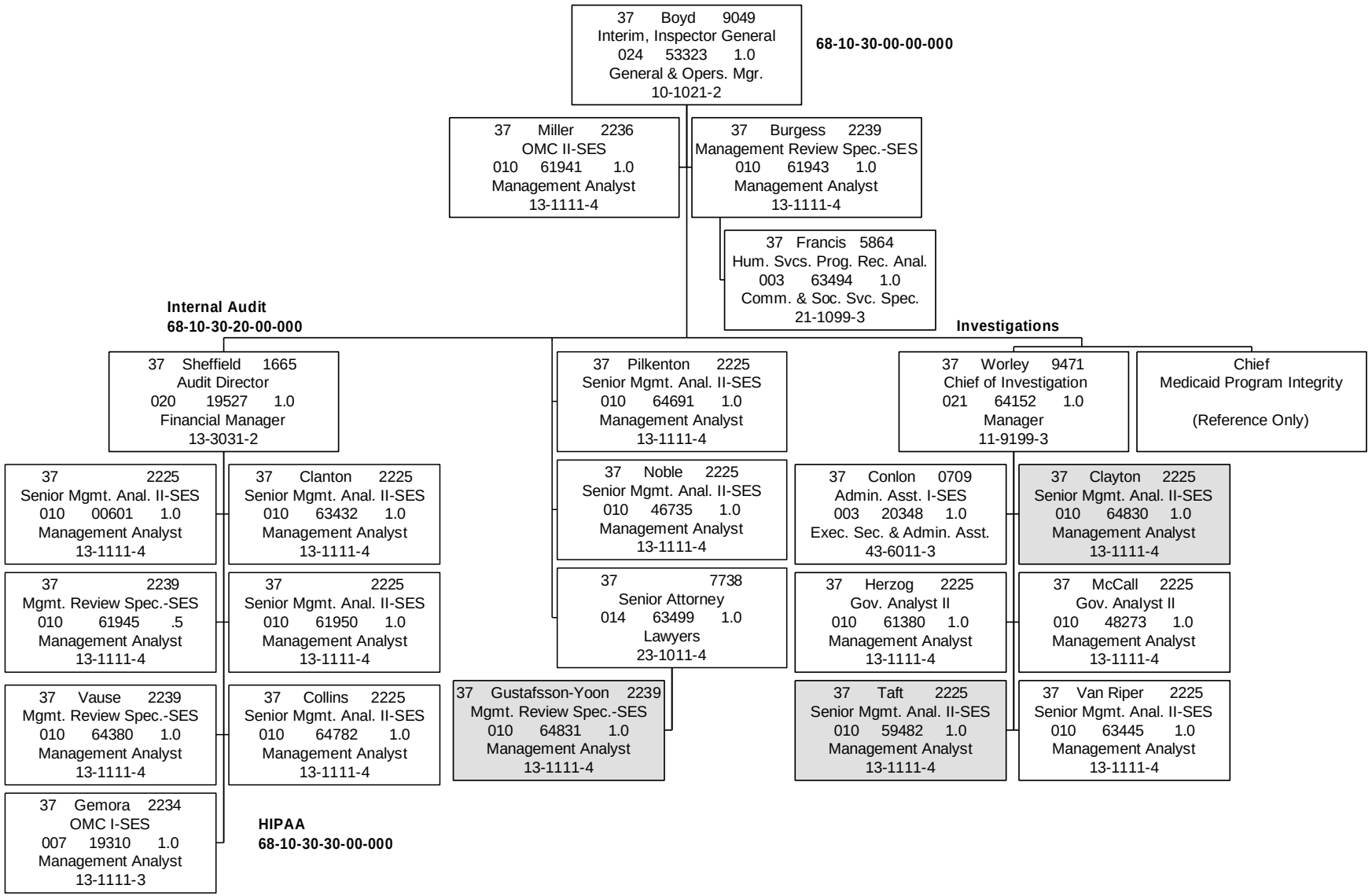
Org. Level: 68 10 20 00 000
Revised Date: July 1, 2011
FTEs: 665 Positions: 67

Medicaid Legal



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General

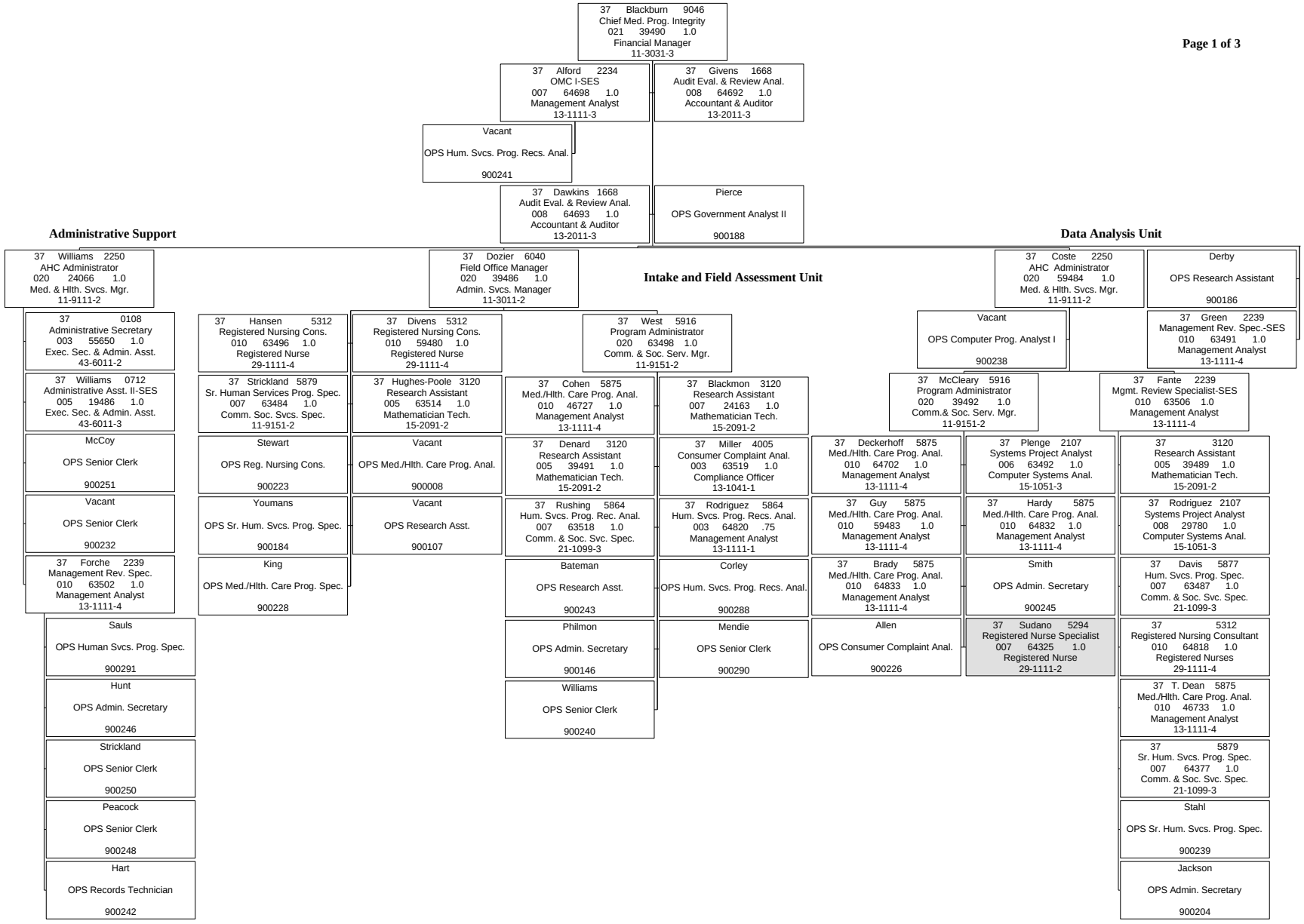
Revised Date: July 1, 2011
FTEs: 19.5 Positions: 20



***Shaded positions report to org code 68-10-30-10-00-000 - Bureau of Medicaid Program Integrity**

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General
Medicaid Program Integrity

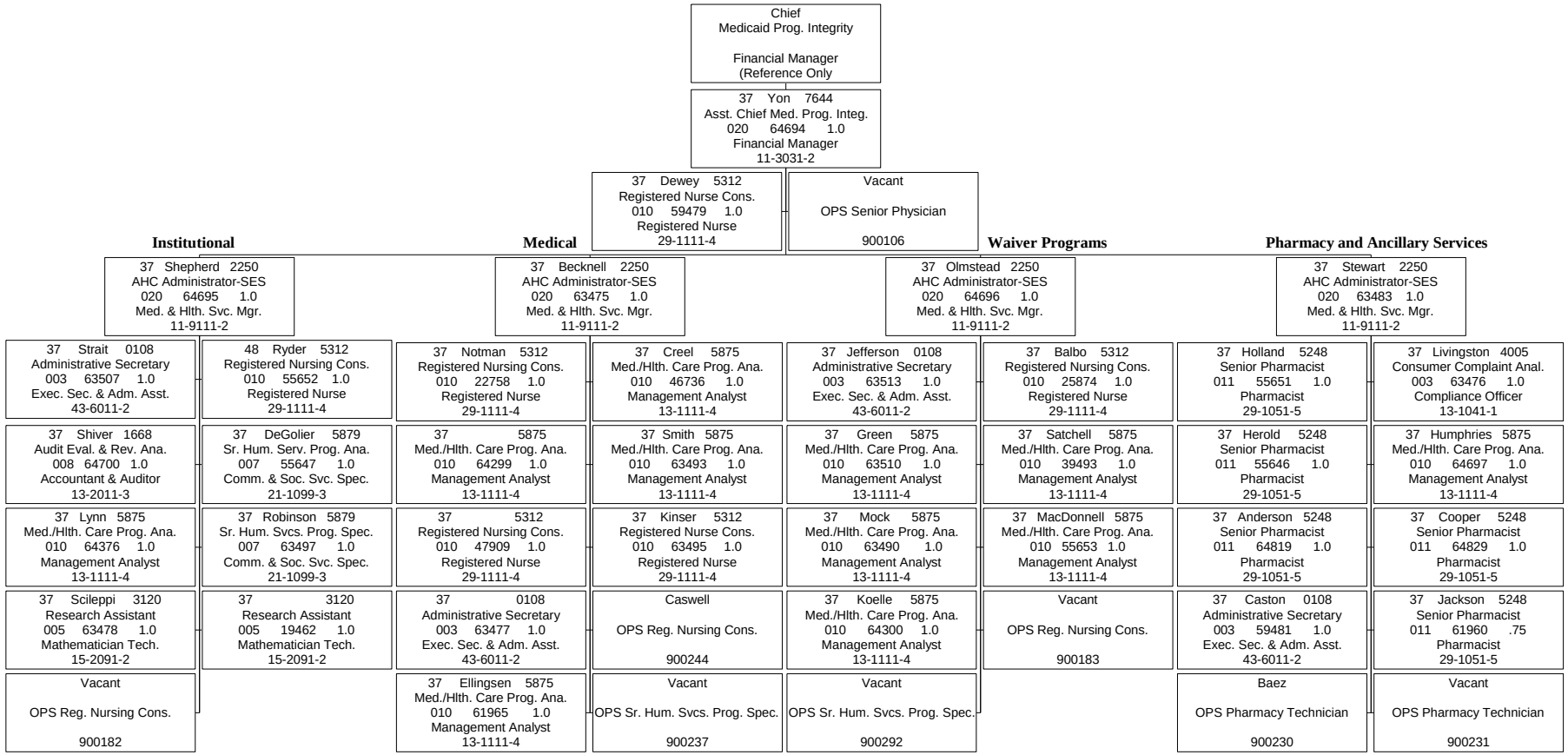
Org. Level: 68-10-30-10-000
Revised Date: July 1, 2011
FTEs: 81.5 Positions: 82



***Shaded position reports to org code 68-10-50-20-00-000 - Florida Center for Health Information & Policy Analysis**

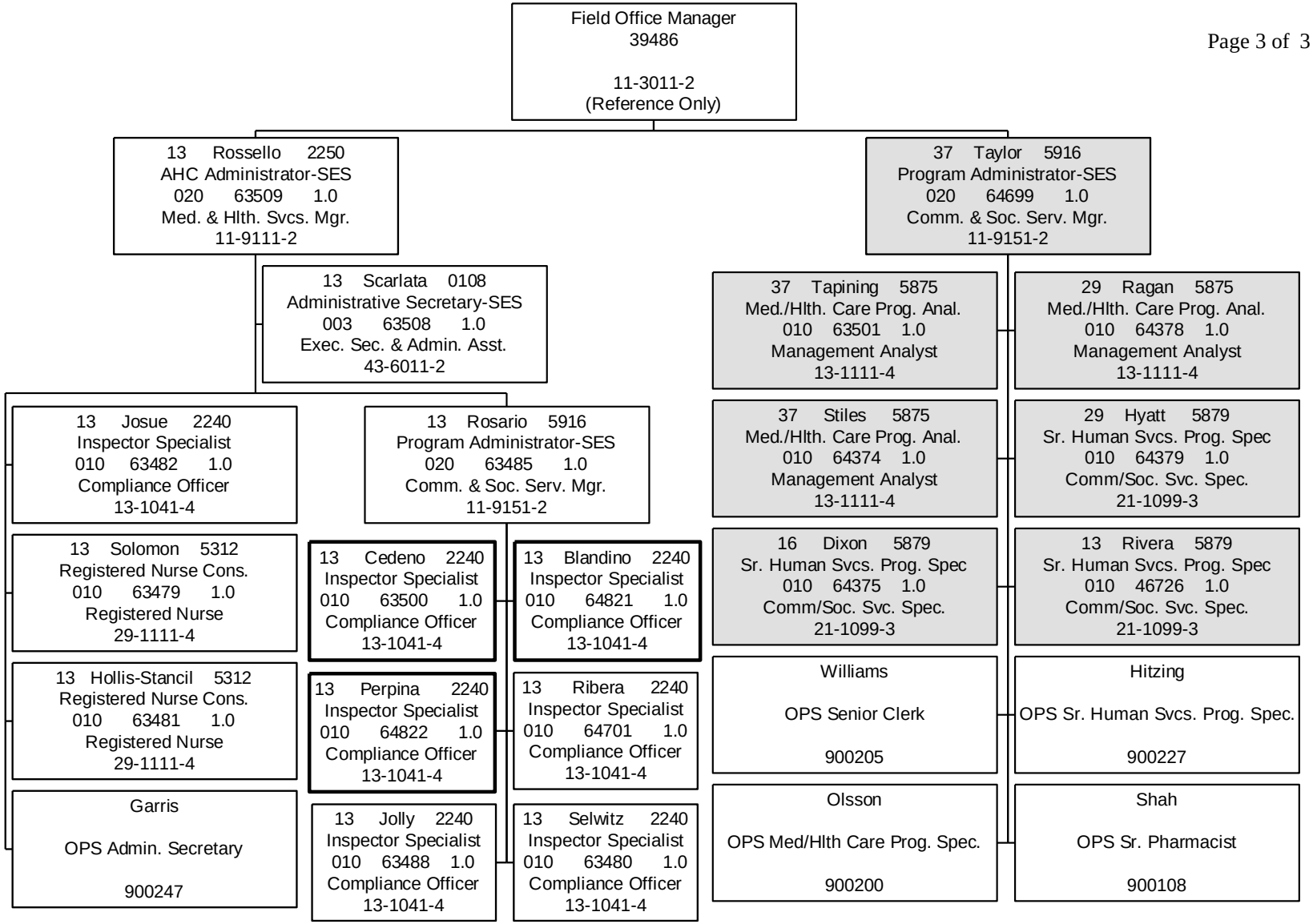
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General
Medicaid Program Integrity

Org. Level: 68-10-30-10-000
Revised Date: July 1, 2011
FTEs: 81.5 Positions: 82



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General
Medicaid Program Integrity - Miami

Org. Level: 68-10-30-10-01-100
Revised Date: June, 2011
FTEs: 12 Positions: 12

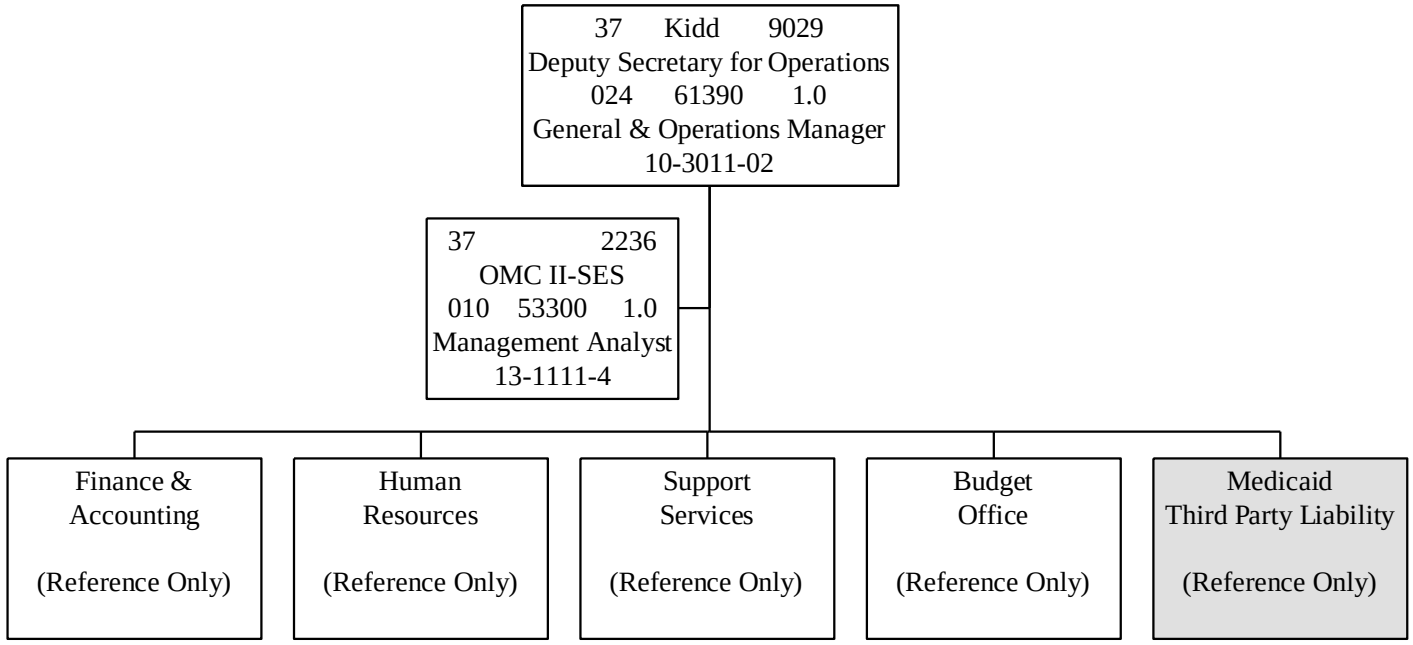


***Shaded positions report to org code 68-10-30-10-00-000 - Bureau of Medicaid Program Integrity**

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Deputy Secretary's Office

Revised Date: July 1, 2011
Org Level: 68-20-00-00-000
FTEs: 2 Positions: 2

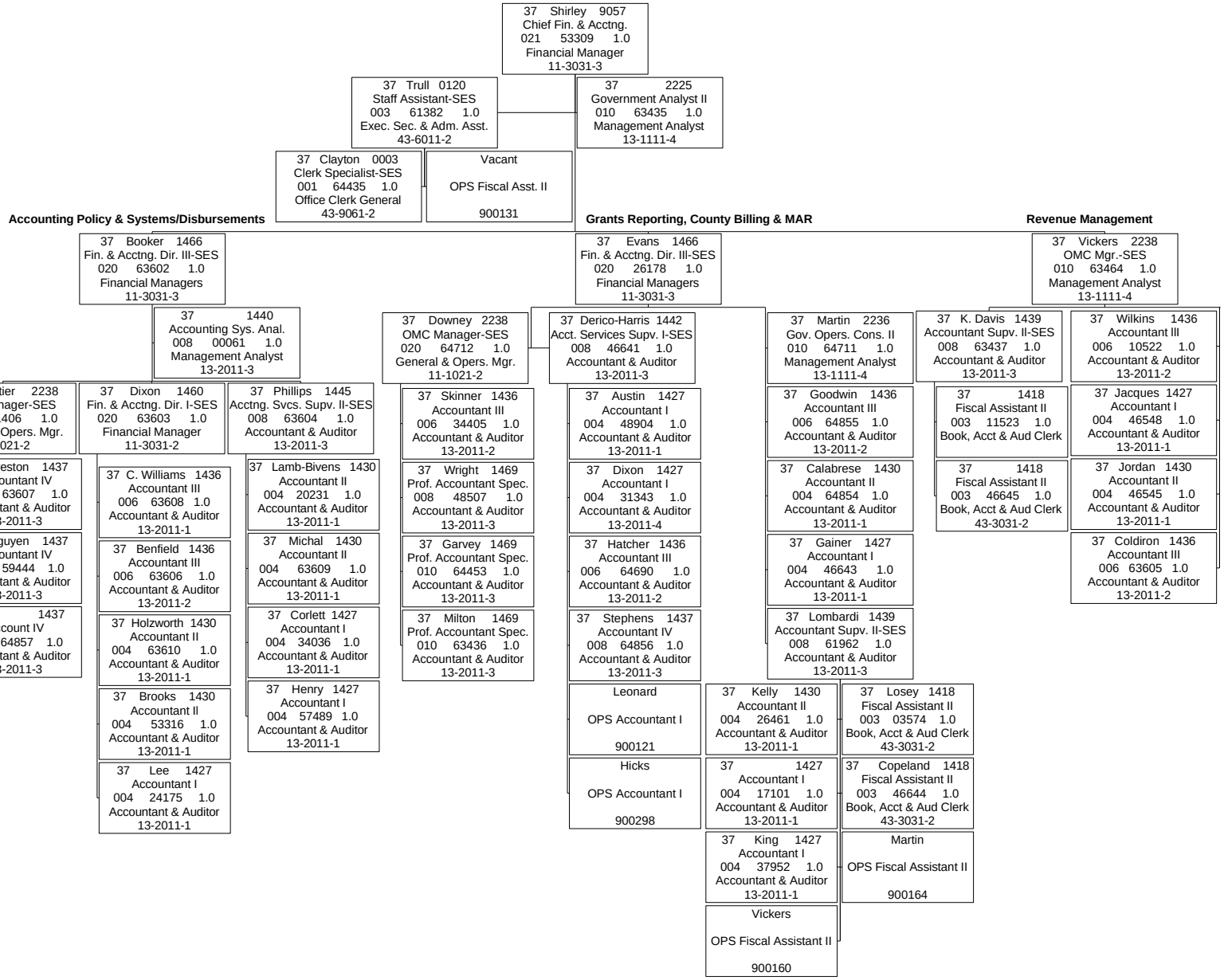
Division of Operations FTE: 86



***Shaded position reports to Division of Medicaid**

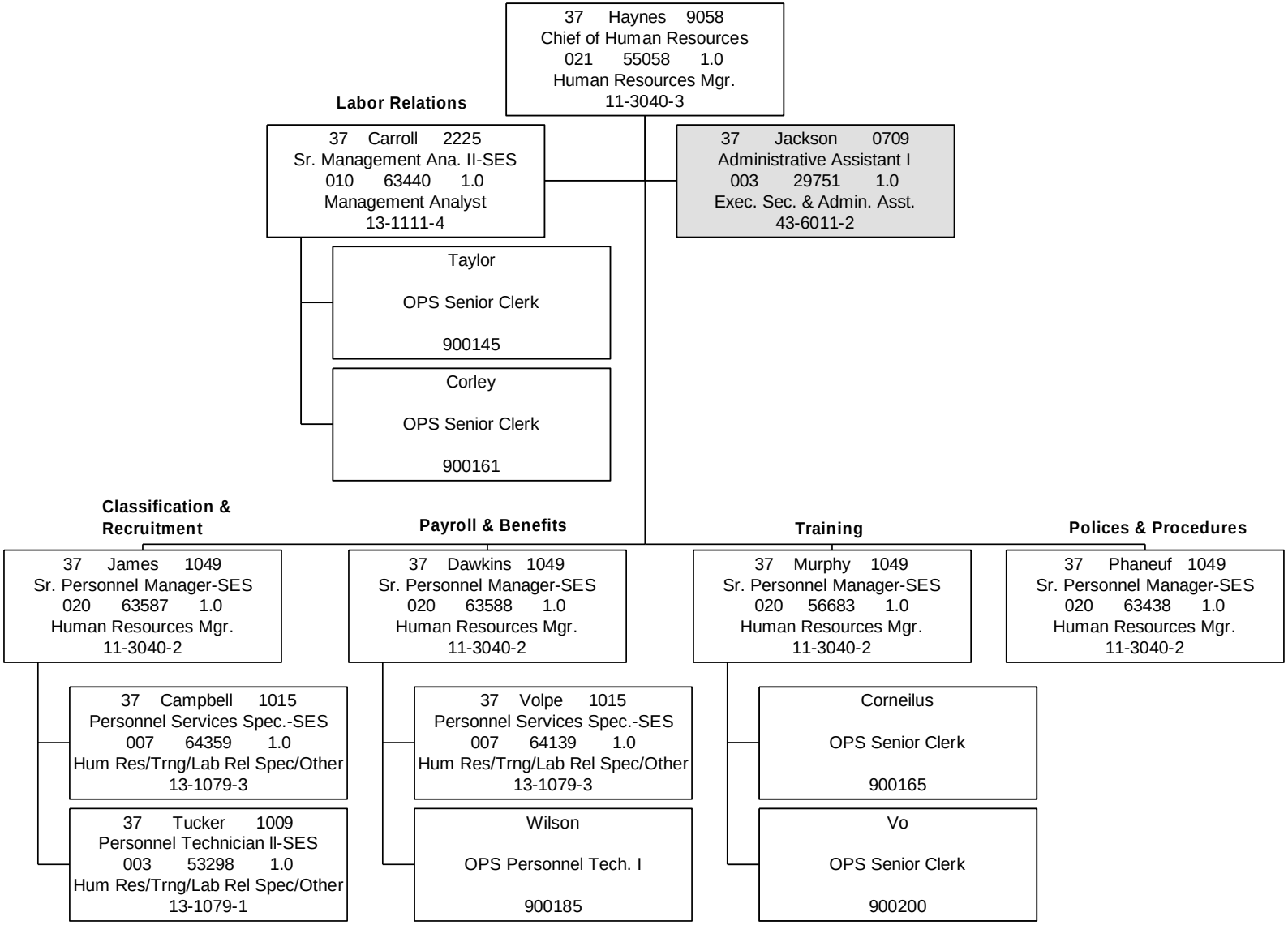
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Finance & Accounting

Org. Level: 68-20-10-00-000
Revised Date: July 1, 2011
FTEs: 50 Positions: 50



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Human Resources

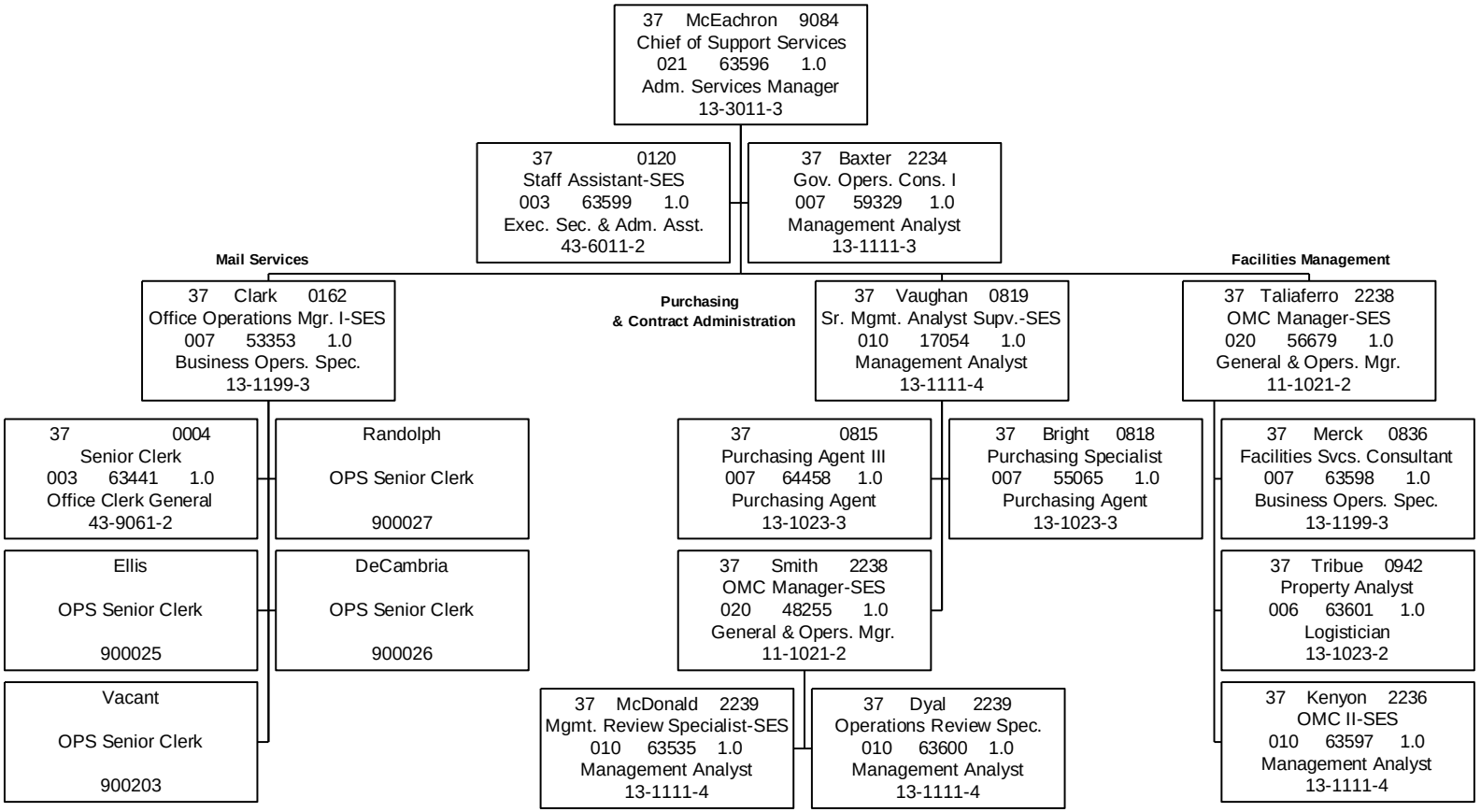
Org. Level: 68-20-20-00-000
Revised Date: July 1, 2011
FTEs: 9 Positions: 9



***Shaded position reports to org code 68-30-30-00-00-000 - HQA Field Operations**

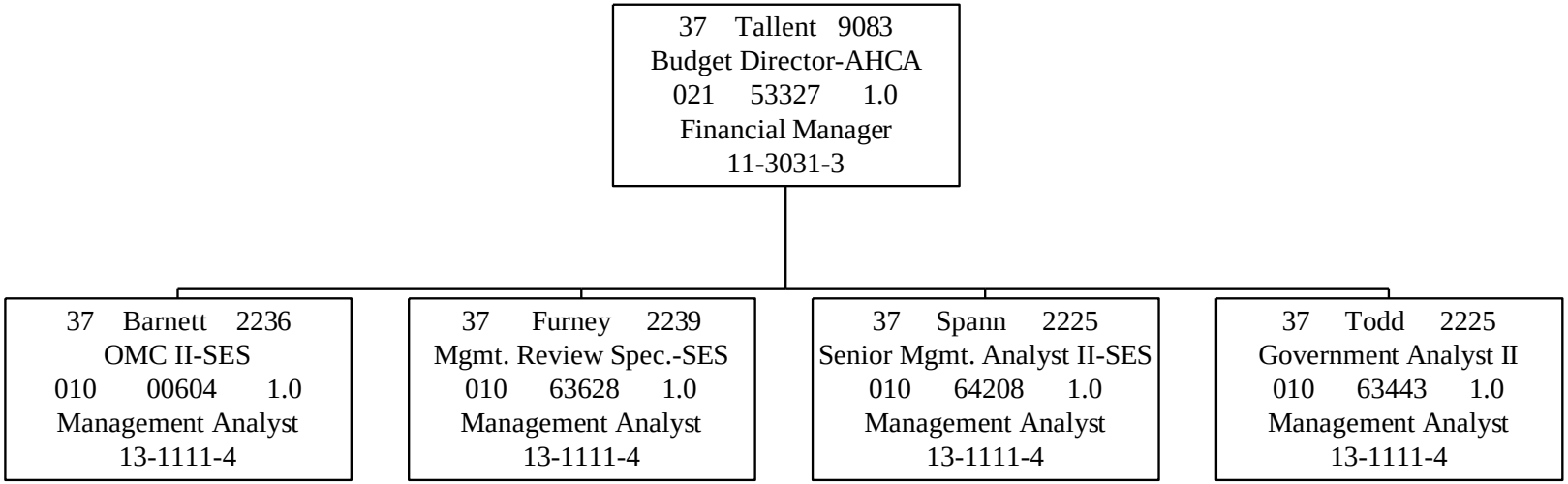
Org. Level: 68-20-40-00-000
Revised Date: July 1, 2011
FTEs: 15 Positions: 15

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Support Services



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Budget Office

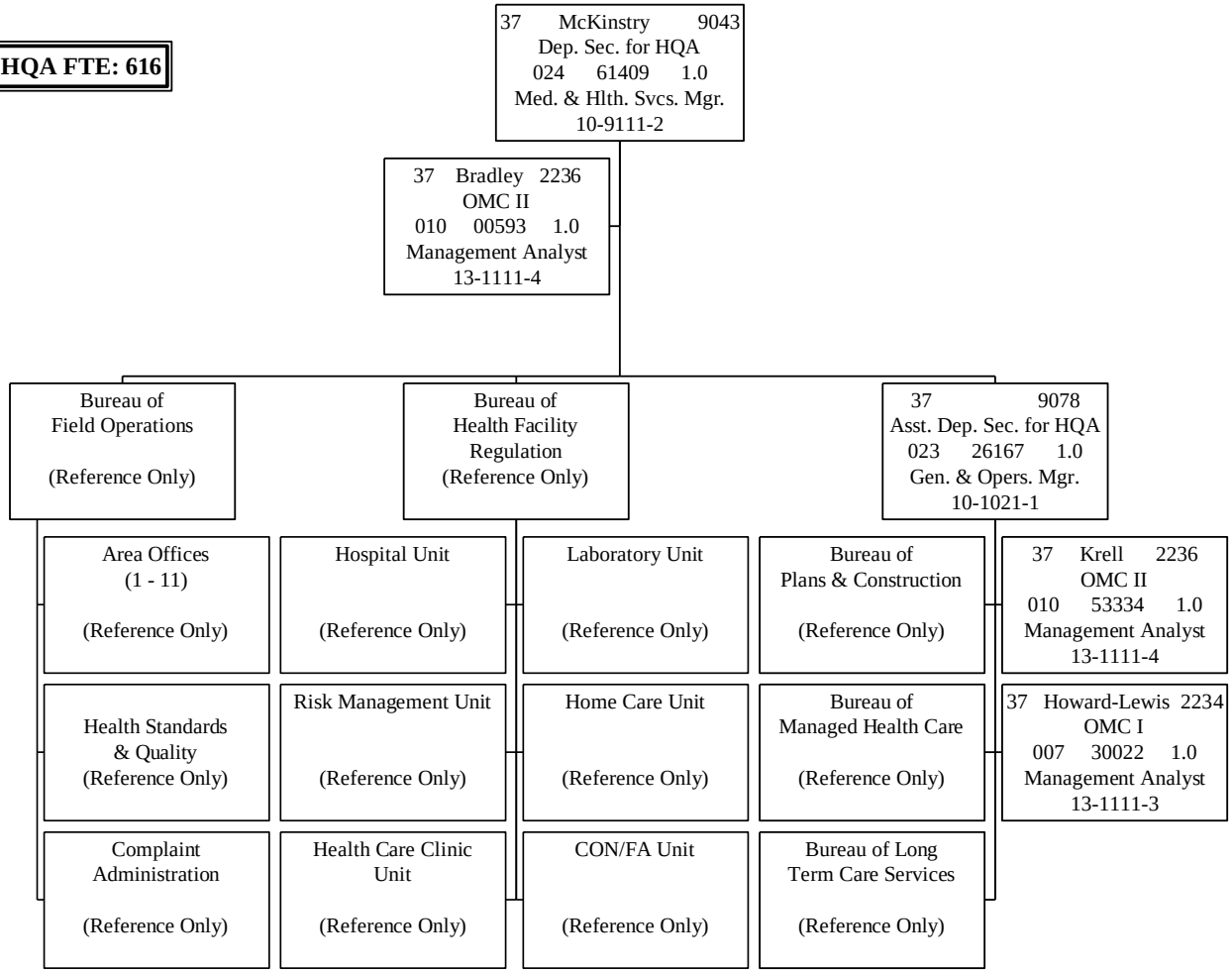
Org. Level: 68-20-70-00-000
Revised Date: July 1, 2011
FTEs: 5 Positions: 5



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance - Deputy Secretary's Office

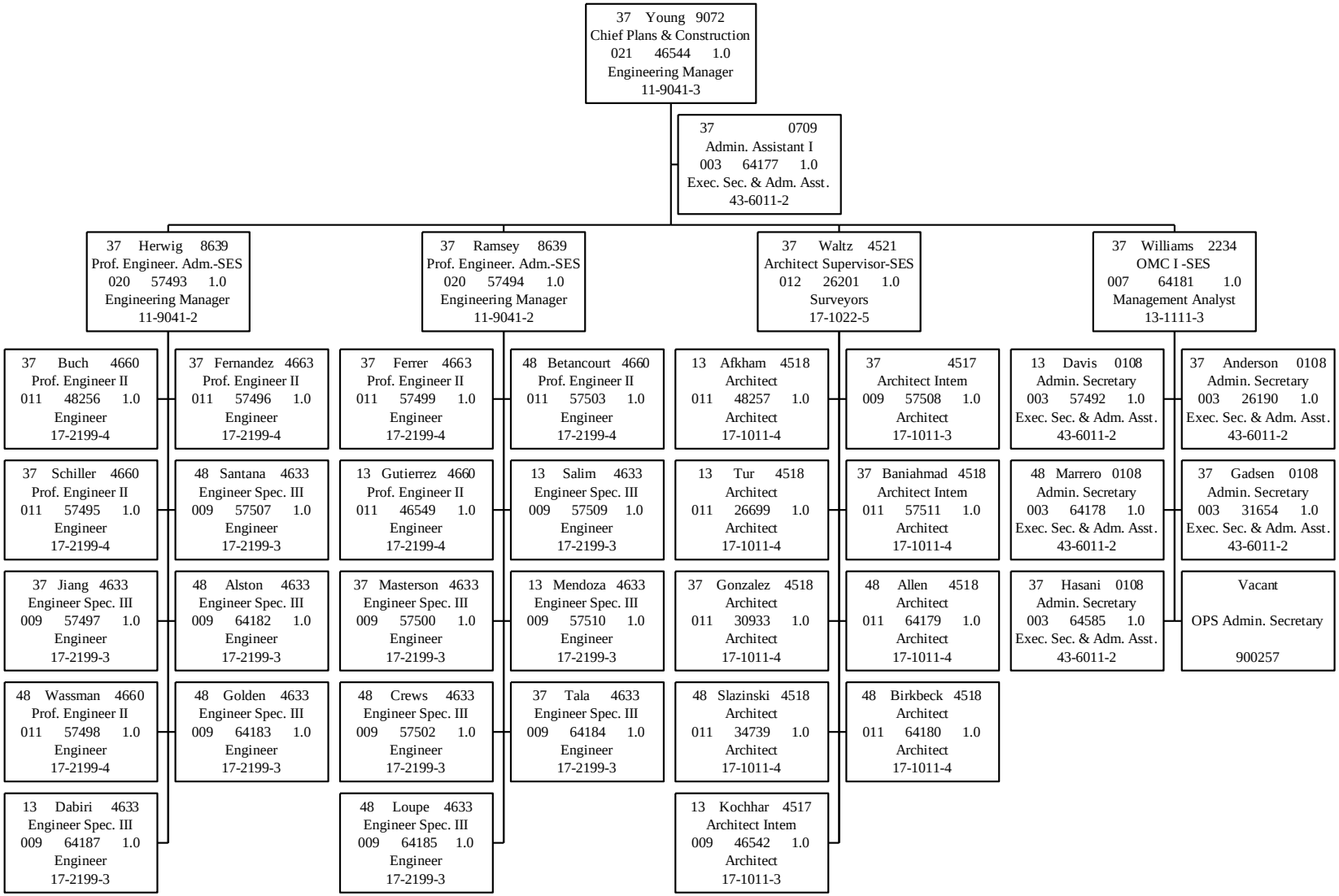
Org. Level: 68-30-00-00-000
Revised Date: July 1, 2011
FTEs: 5 Positions: 5

Division of HQA FTE: 616



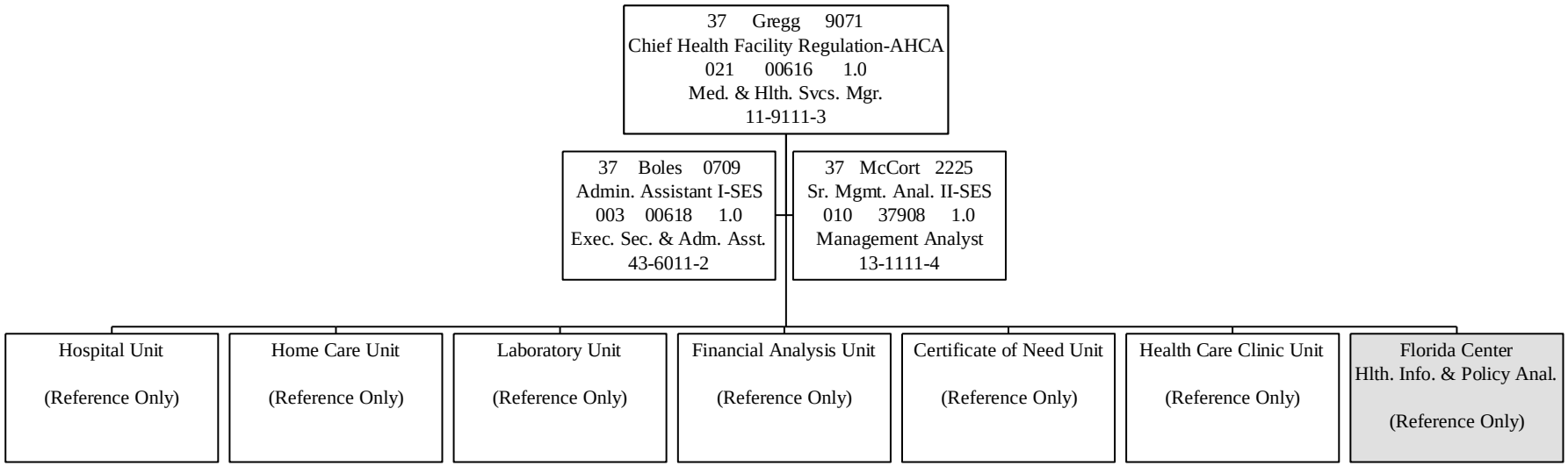
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance - Plans and Construction

Org. Level: 68 30 10 00 000
Revised Date: July 1, 2011
FTEs: 38 Positions: 38



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

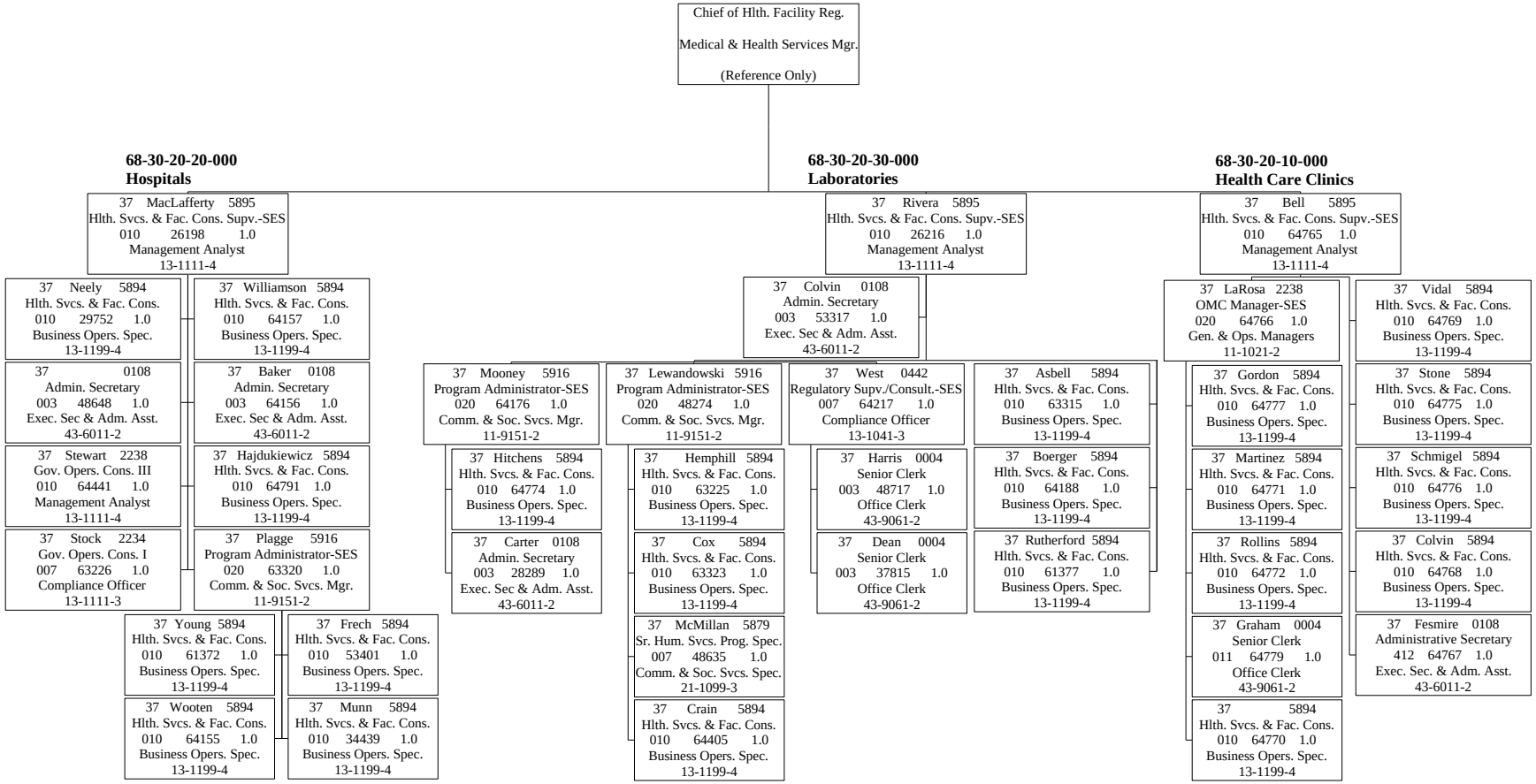
Org. Level: 68 30 20 00 000
Revised Date: July 1, 2011
FTEs 73 Positions: 73



***Shaded positions report to Division of Executive Direction**

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Revised Date: July 1, 2011
FTEs: 73 Positions: 73



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Revised Date: July 1, 2011
FTEs 73 Positions: 73

Chief of Hlth. Fac. Reg.

Medical & Health Services Mgr.

(Reference Only)

Certificate of Need and Financial Analysis
68-30-20-80-000

37 McLemore 5895
Hlth. Svcs. & Fac. Cons. Supv.-SES
020 00643 1.0
Management Analyst
13-1111-4

37 Novak 5894
Hlth. Svcs. & Fac. Cons.
010 48276 1.0
Business Opers. Spec.
13-1199-4

37 Love 5894
Hlth. Svcs. & Fac. Cons.
010 34018 1.0
Business Opers. Spec.
13-1199-4

37 Vice 5894
Hlth. Svcs. & Fac. Cons.
010 00641 1.0
Business Opers. Spec.
13-1199-4

37 Biddle 0108
Admin. Secretary-SES
003 11160 1.0
Exec. Sec. & Adm. Asst.
43-6011-2

37 Fitch 1645
Regulatory Analyst Supv.-SES
010 53310 1.0
Compliance Officer
13-1041-4

37 Bradley 3215
Economic Analyst
008 53326 1.0
Economist
19-3011-3

37 Smith 5894
Hlth. Svcs. & Fac. Cons.
010 55063 1.0
Business Opers. Spec.
13-1199-4

37 Hillman 5894
Hlth. Svcs. & Fac. Cons.
010 53312 1.0
Business Opers. Spec.
13-1199-4

37 Broussard 5894
Hlth. Svcs. & Fac. Cons.
010 00614 1.0
Business Opers. Spec.
13-1199-4

Home Care
68-30-20-50-000

37 Menard 5895
Hlth. Svcs. & Fac. Cons. Supv.-SES
020 48387 1.0
Management Analyst
13-1111-4

37 Lawrence 5916
Program Administrator-SES
020 64558 1.0
Comm. & Soc. Svc. Mgr.
11-9151-2

37 Perry 5894
Hlth. Svcs. & Fac. Cons.
010 64559 1.0
Business Opers. Spec.
13-1199-4

37 Boortz 5894
Hlth. Svcs. & Fac. Cons.
010 58477 1.0
Business Opers. Spec.
13-1199-4

37 Blue 5879
Sr. Hum. Svcs. Prog. Spec.
007 48292 1.0
Comm. & Soc. Serv. Spec.
21-1099-3

37 Hardesty 0108
Administrative Secretary
003 29805 1.0
Ex. Sec. & Adm. Asst.
43-6011-2

37 Benesh 2238
OMC Mgr. -SES
020 53518 1.0
General Opers. Mgr.
11-1021-2

37 Lowry 5894
Hlth. Svcs. & Fac. Cons.
010 26232 1.0
Business Opers. Spec.
13-1199-4

37 Humphries 5875
Med./Hlth. Care Prog. Anal.
010 64402 1.0
Management Analyst
13-1111-4

37 Barnes 5894
Hlth. Svcs. & Fac. Cons.
010 64594 1.0
Business Opers. Spec.
13-1199-4

37 Priest 0108
Administrative Secretary
003 26171 1.0
Ex. Sec. & Adm. Asst.
43-6011-2

37 Glass 5879
Sr. Hum. Svcs. Prog. Spec.
007 47188 1.0
Comm. & Soc. Serv. Spec.
21-1099-3

37 McAleer 0108
Administrative Sec.
003 53346 1.0
Exec. Sec. & Adm. Asst.
43-6011-2

37 Ibrahim 5894
Hlth. Svcs. & Fac. Cons.
010 64773 1.0
Business Opers. Spec.
13-1199-4

37 Williams 0441
Regulatory Specialist II
006 64401 1.0
Compliance Officer
13-1041-2

37 Watkins 5879
Sr. Hum. Svcs. Prog. Spec.
007 26170 1.0
Comm. & Soc. Serv. Spec.
21-1099-3

37 Ross 0440
Regulatory Specialist I
003 57490 1.0
Compliance Officer
13-1041-1

37 Houston 5879
Sr. Hum. Svcs. Prog. Spec.
007 64557 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

Vacant

OPS Regulatory Spec. I

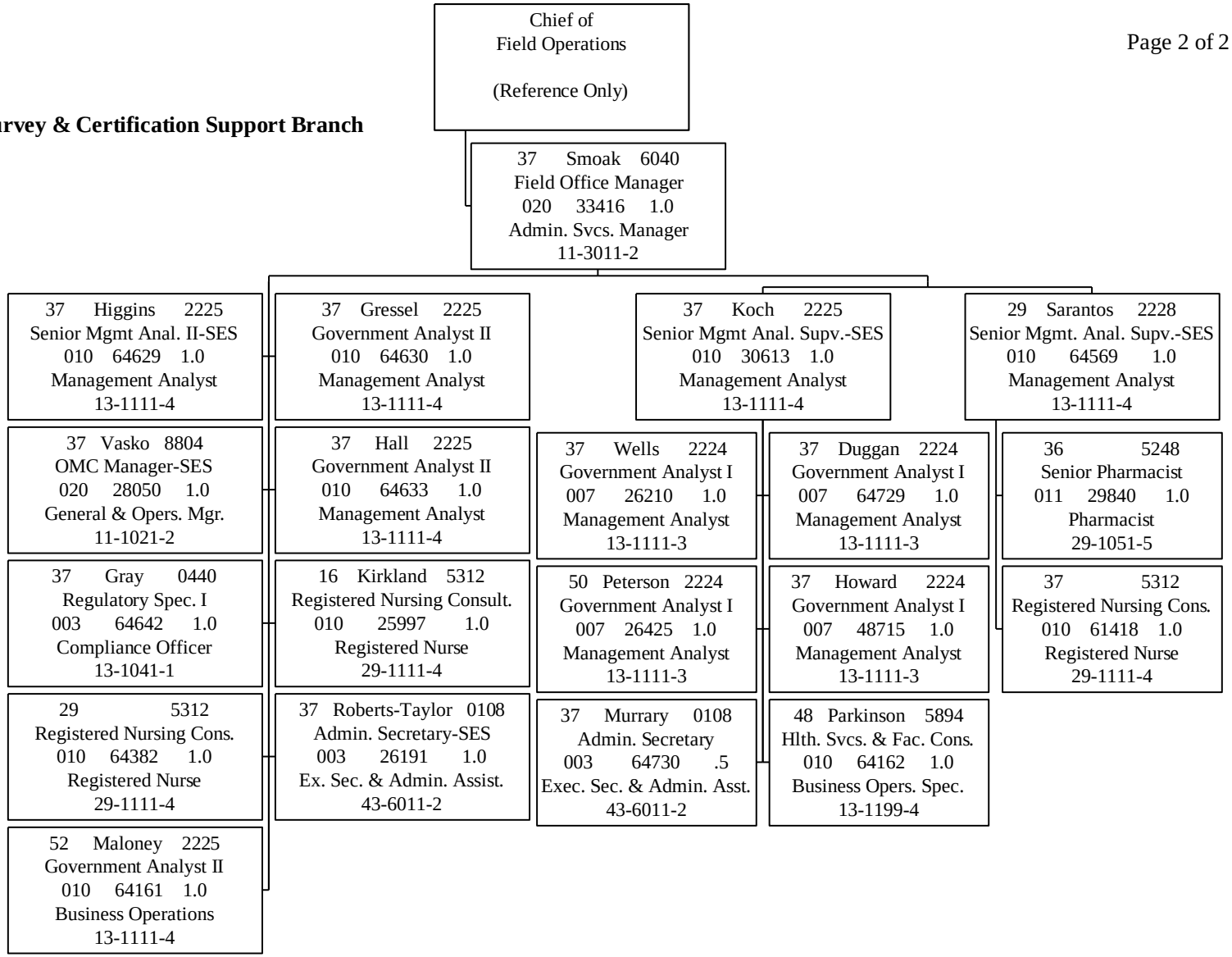
900295

37 Corley 0440
Regulatory Specialist I
003 48727 1.0
Compliance Officer
13-1041-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Field Operations - Health Standards & Quality

Revised Date: July 1, 2011
Org Level: 68-30-30-30-00-000
FTEs: 19.5 Position: 20

Survey & Certification Support Branch

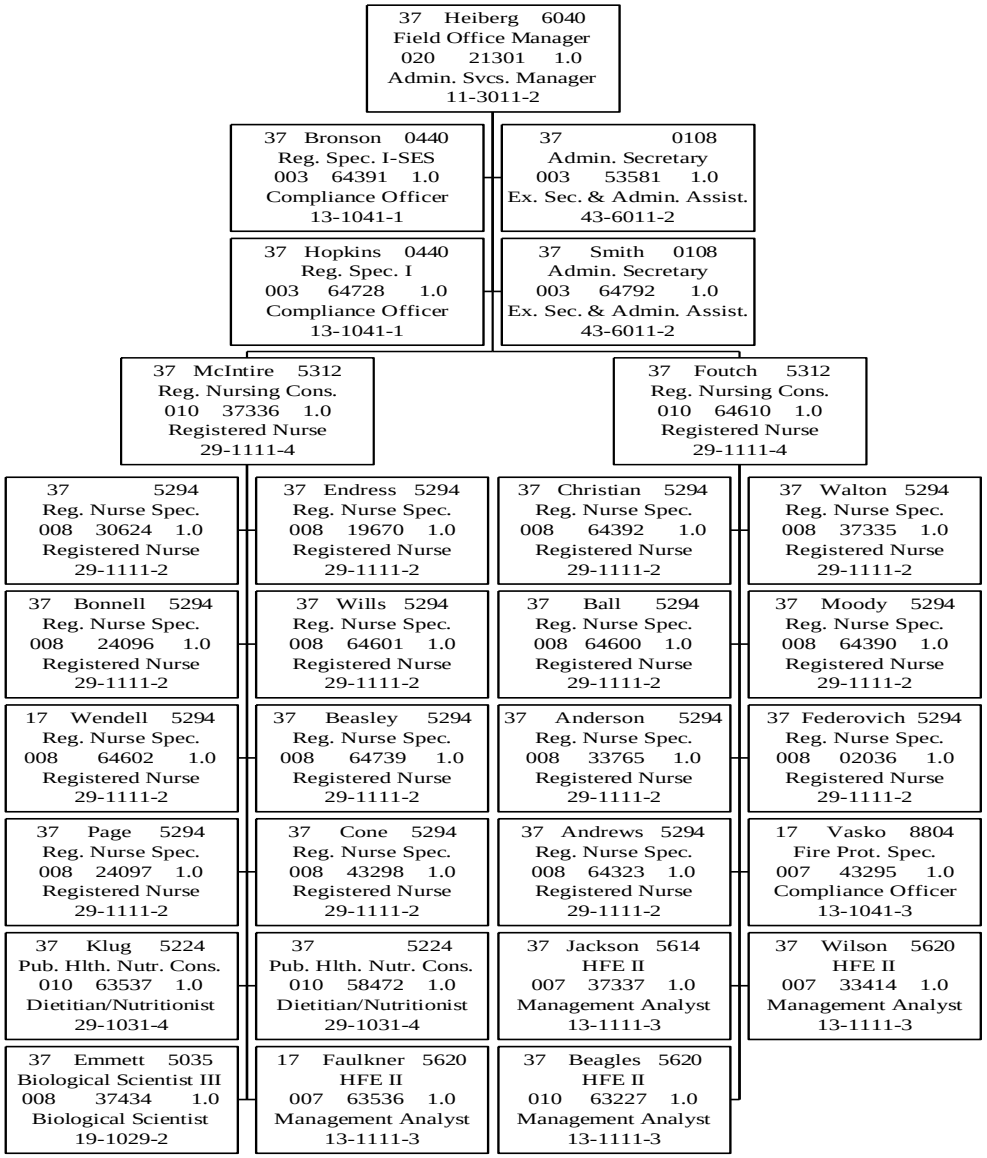


AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 2 - Tallahassee

Org. Level: 68 30 30 02 000
Revised Date: July 1, 2011
FTEs: 30 Positions: 30

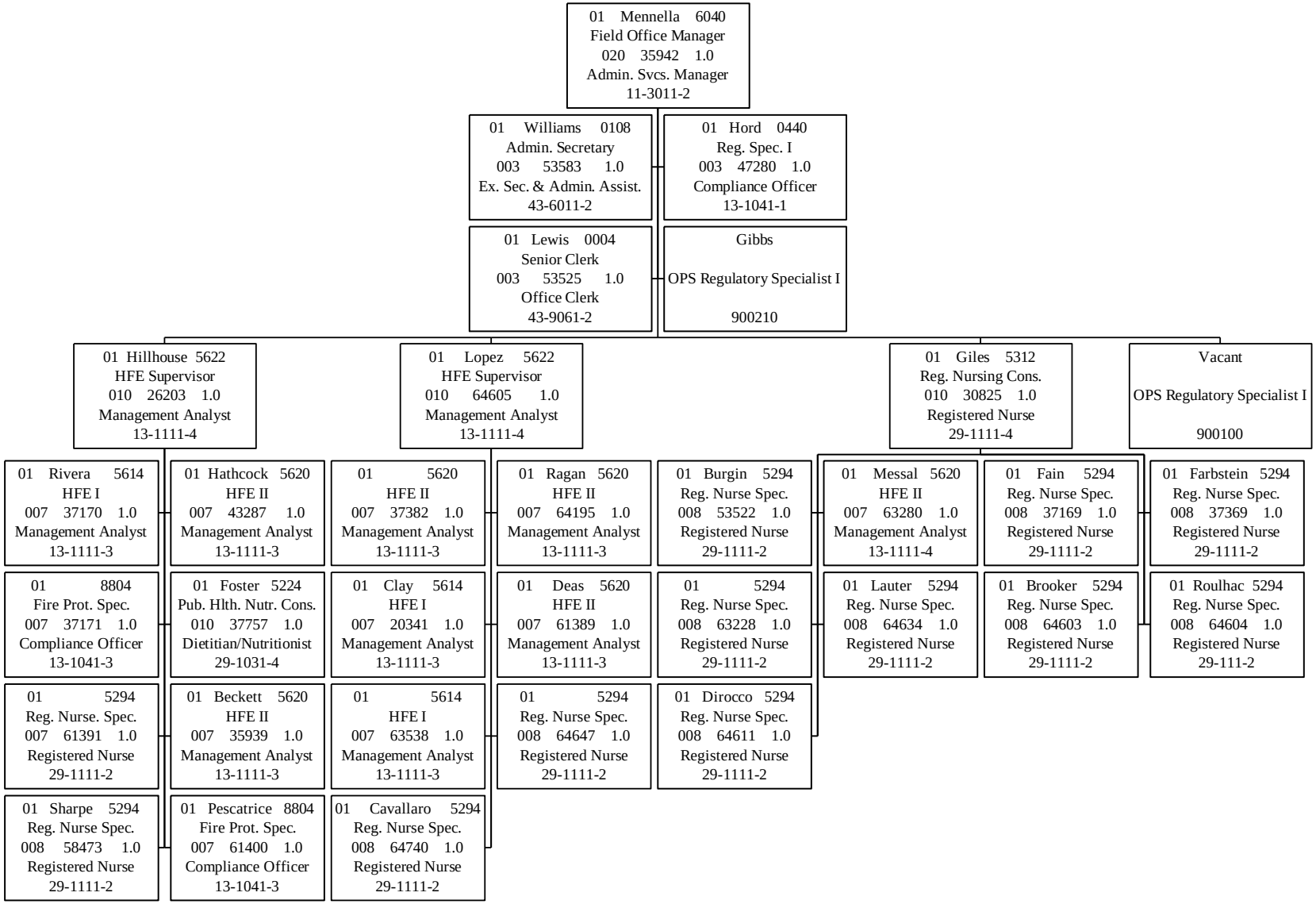


AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 3 Alachua

Org. Level: 68 30 30 03 000
Revised Date: July 1, 2011
FTEs: 31 Positions: 31

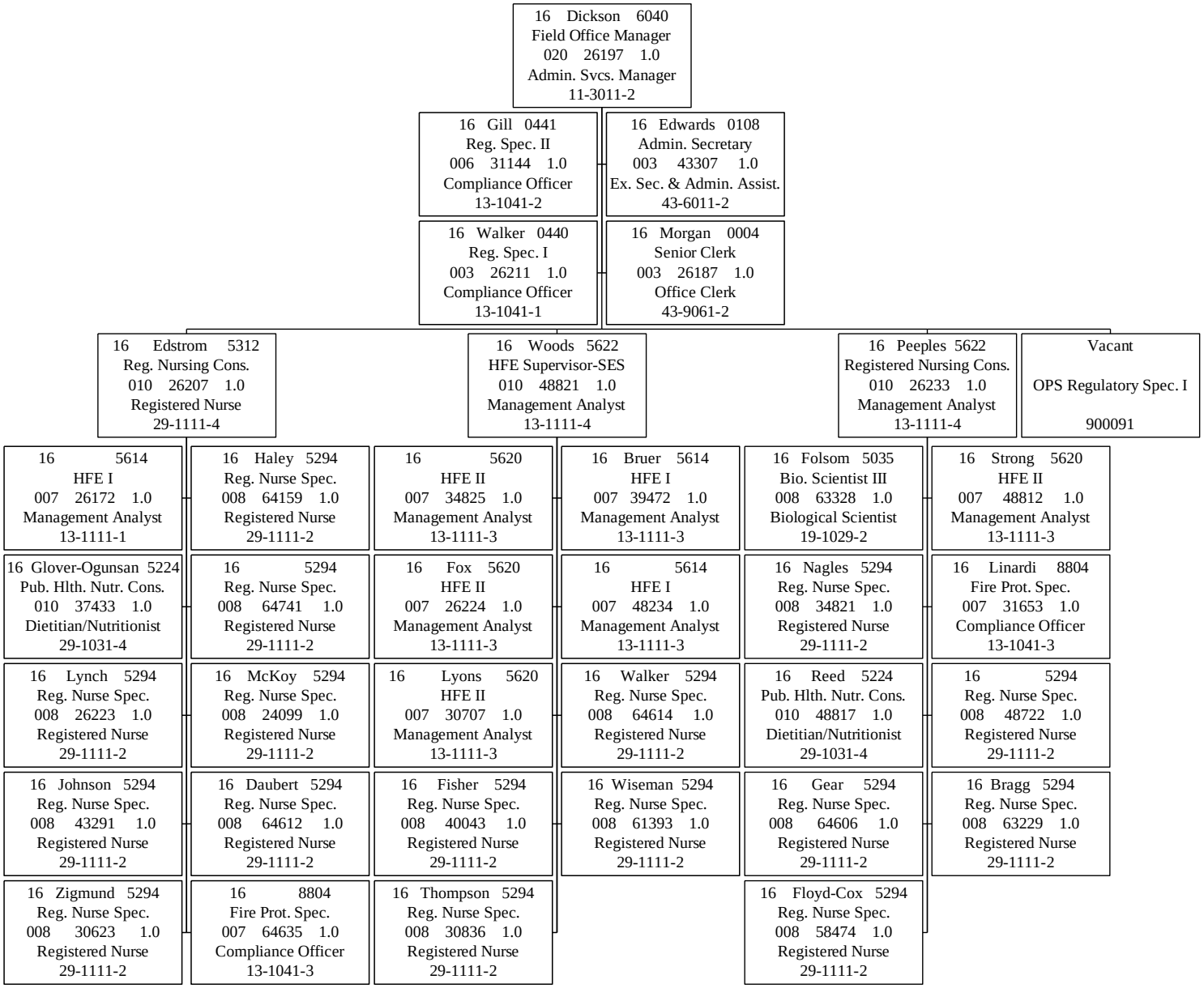


AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 4 - Jacksonville

Org. Level: 68 30 30 04 000
Revised Date: July 1, 2011
FTEs: 36 Positions: 36

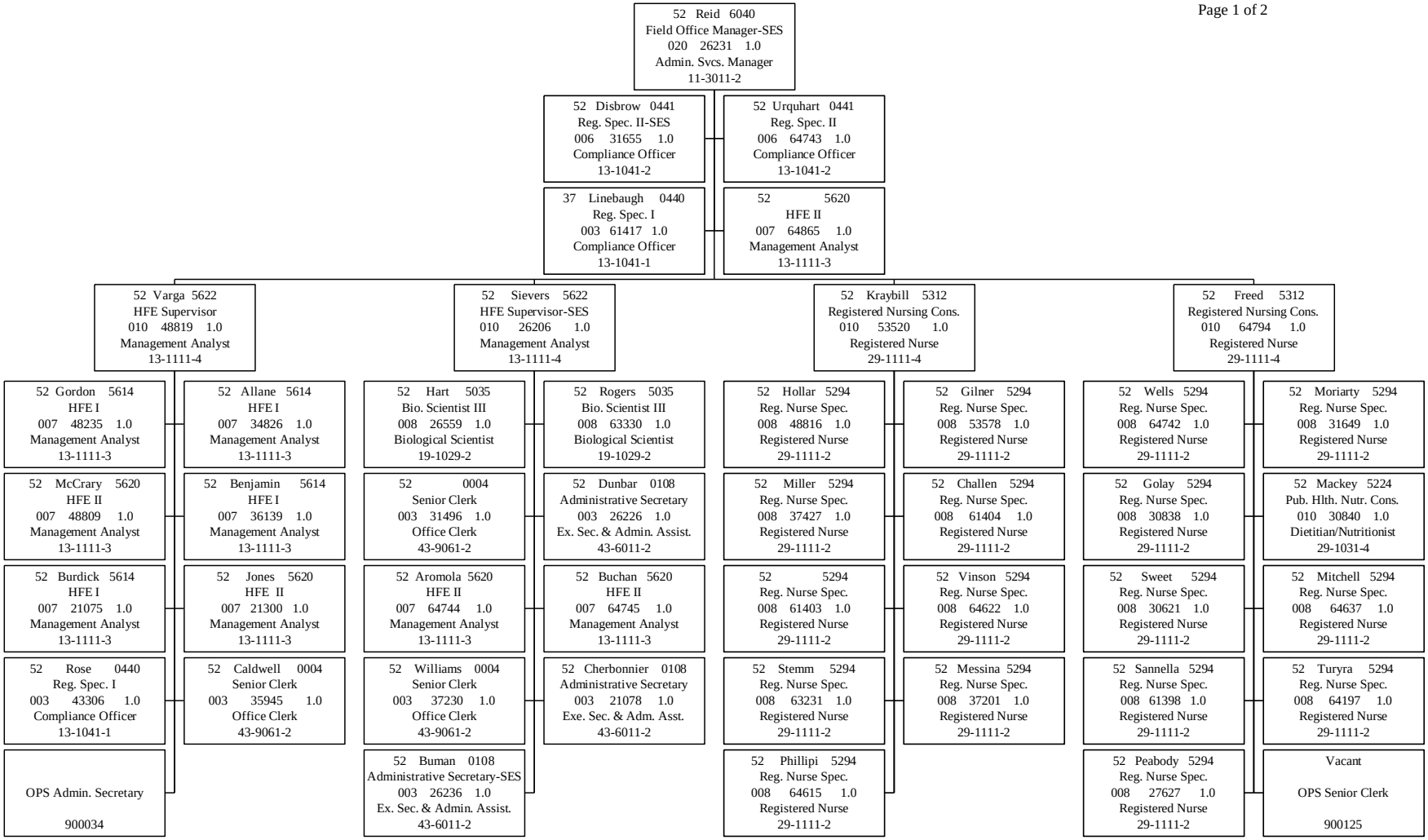


AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

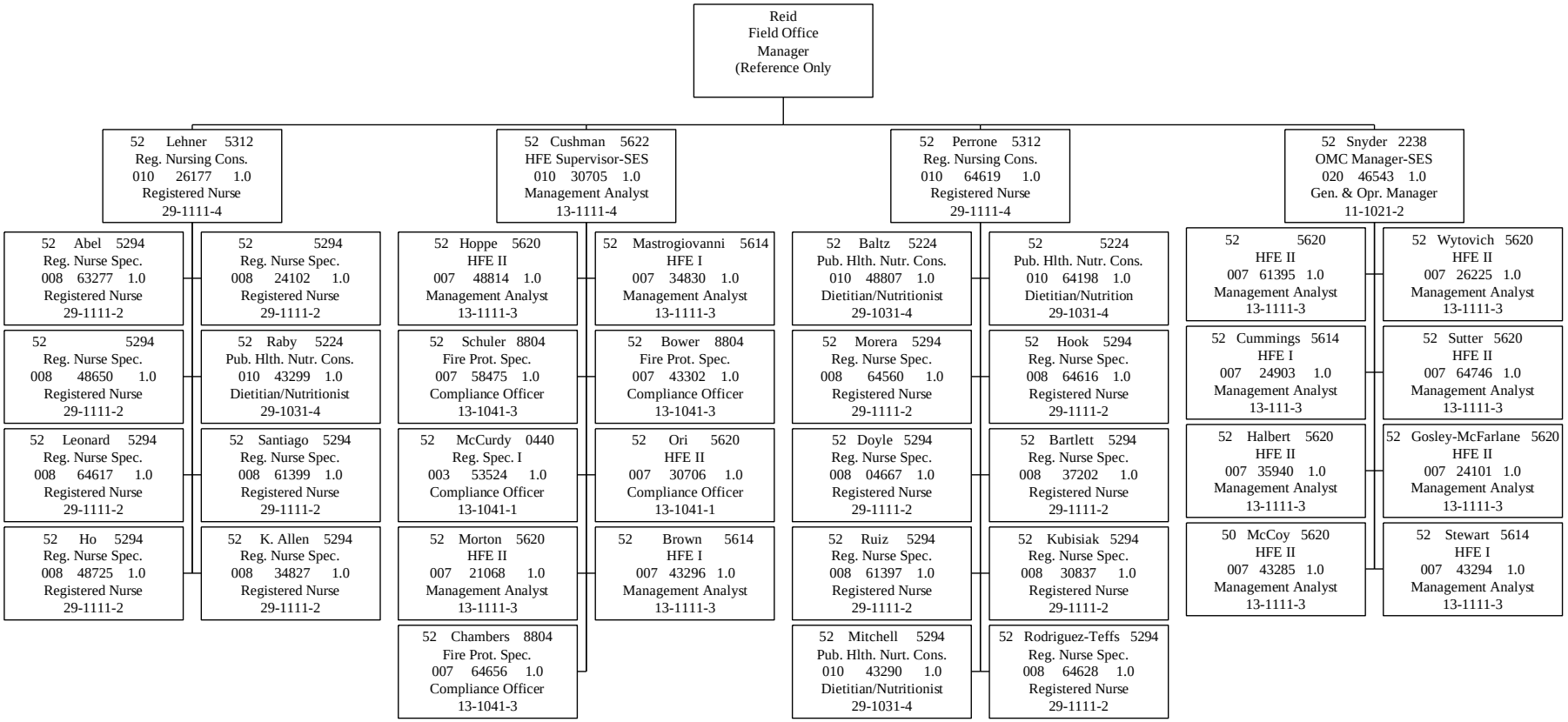
Area 5 - St. Petersburg

Org Level: 68 30 30 05 00
Revised Date: July 1, 2011
FTEs: 83 Positions: 83



AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 5 - St. Petersburg

Org. Level: 68 30 30 05 000
Revised Date: July 1, 2011
FTEs: 83 Positions: 83

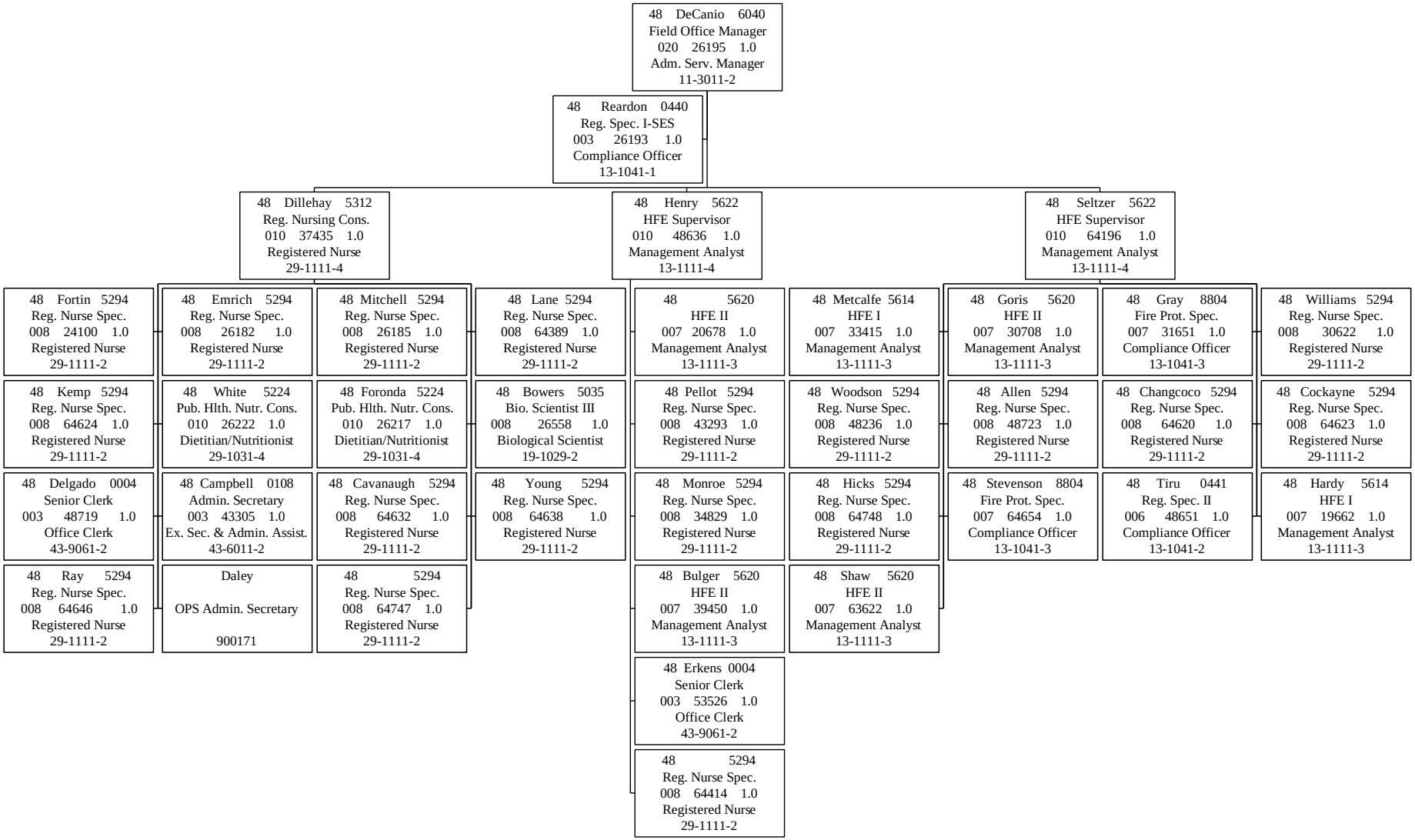


Org. Level: 68 30 30 07 000
Revised Date: July 1, 2011
FTEs: 38 Positions: 38

AGENCY FOR HEALTH CARE ADMINISTRATION

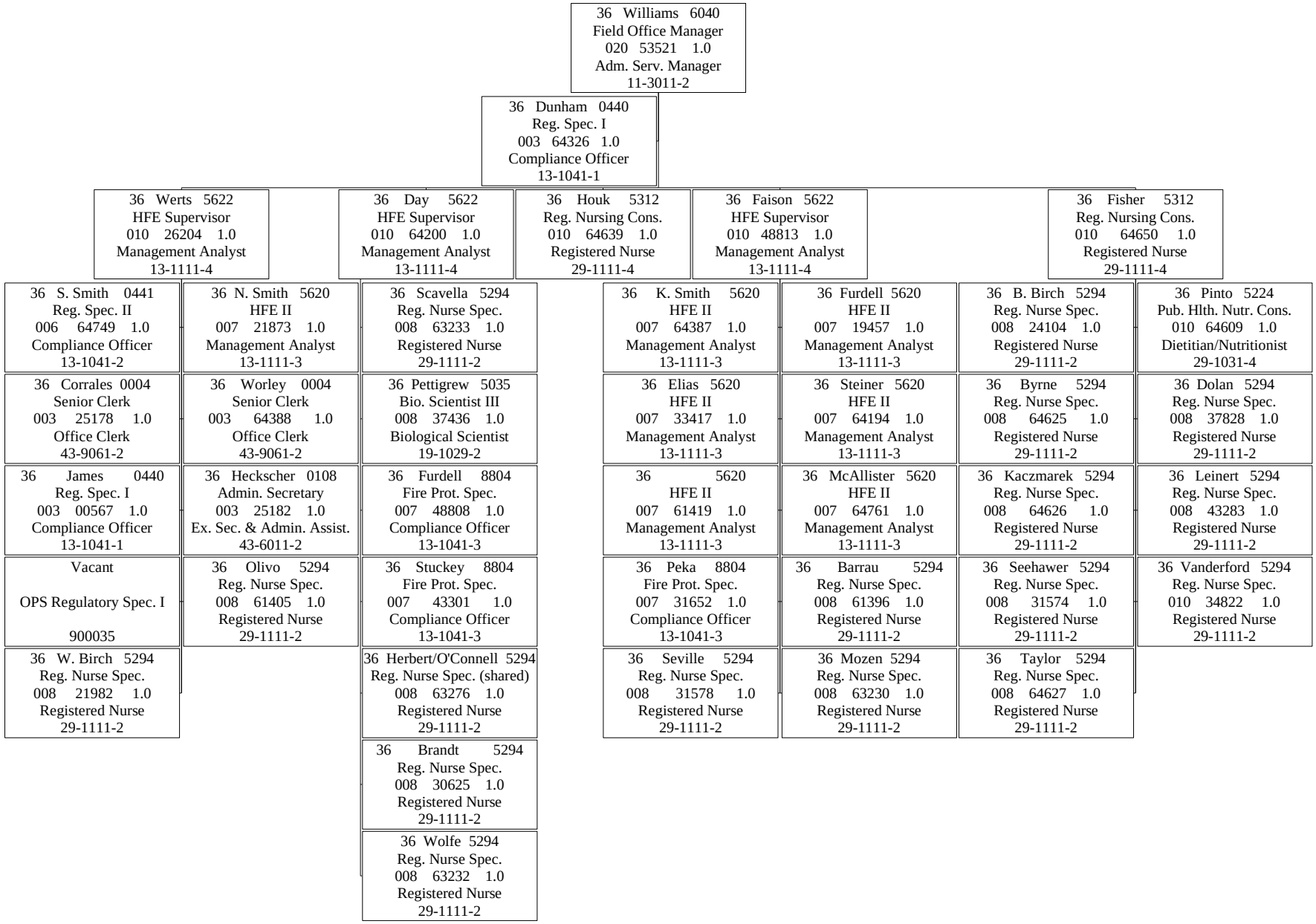
Health Quality Assurance

Area 7 - Orlando



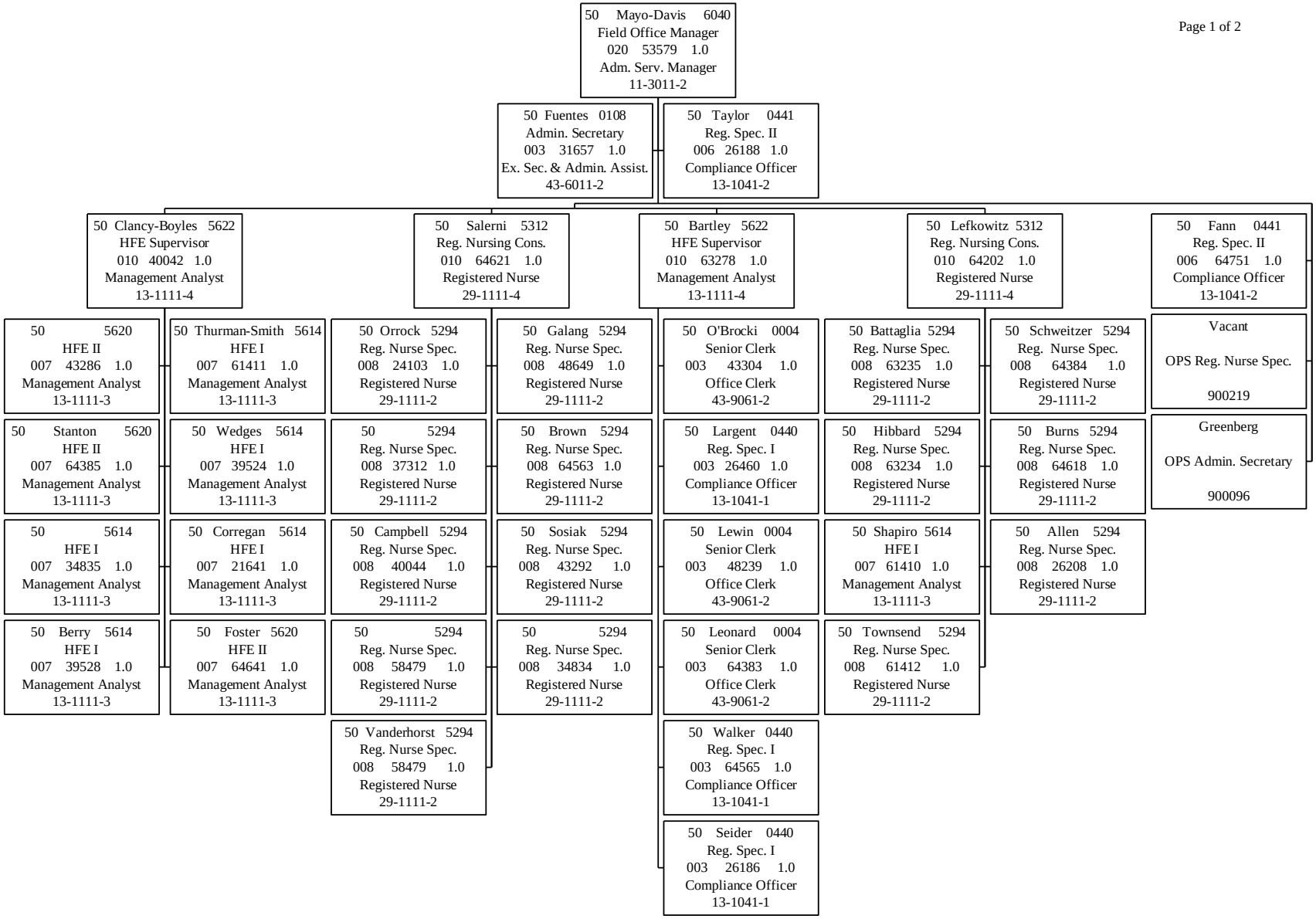
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 8 - Ft. Myers

Org. Level: 68 30 30 08 000
Revised Date: July 1, 2011
FTEs: 41 Positions: 41



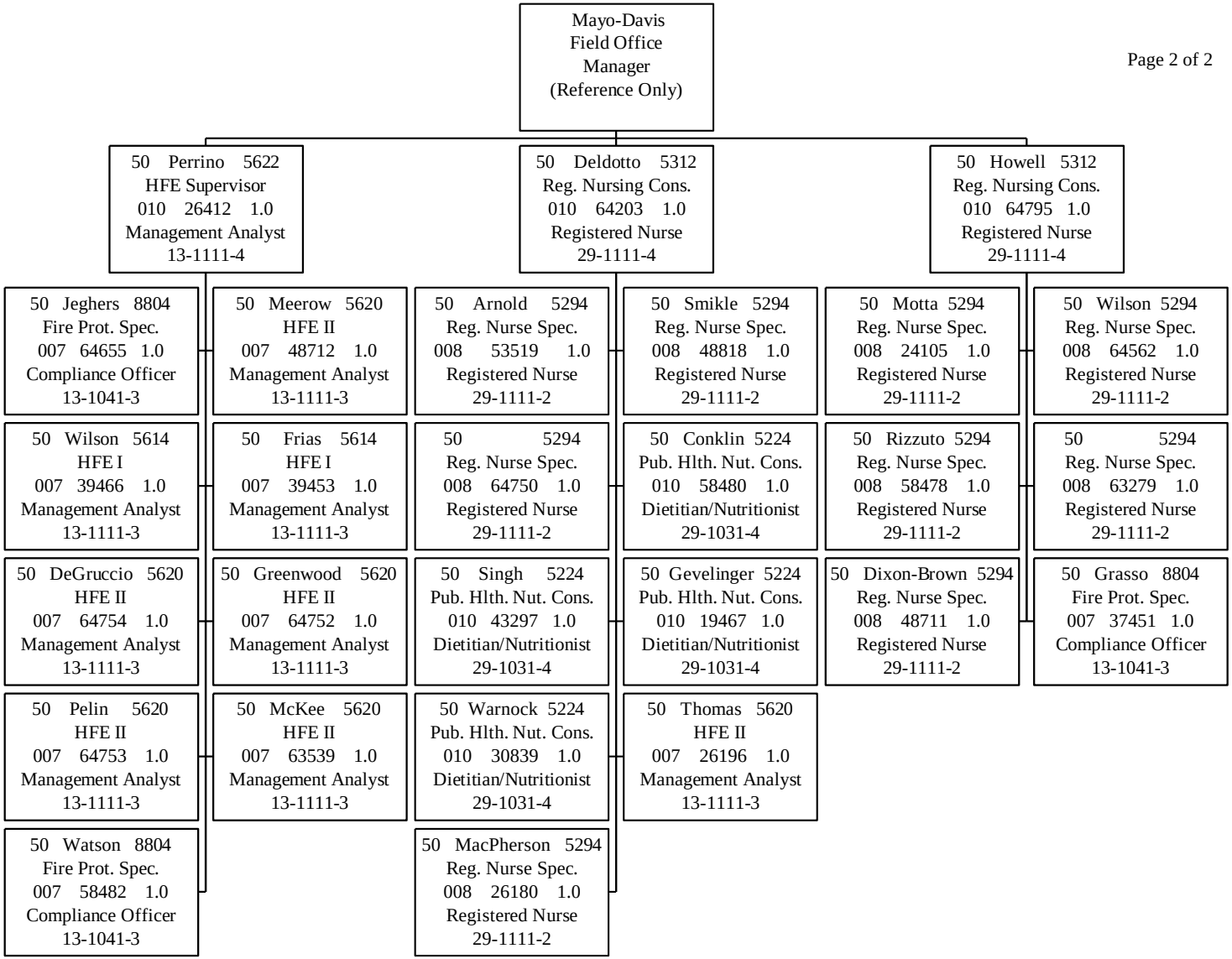
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 9 - West Palm Beach

Org. Level: 68 30 30 09 000
Revised Date: July 1, 2011
FTEs: 65 Positions: 65



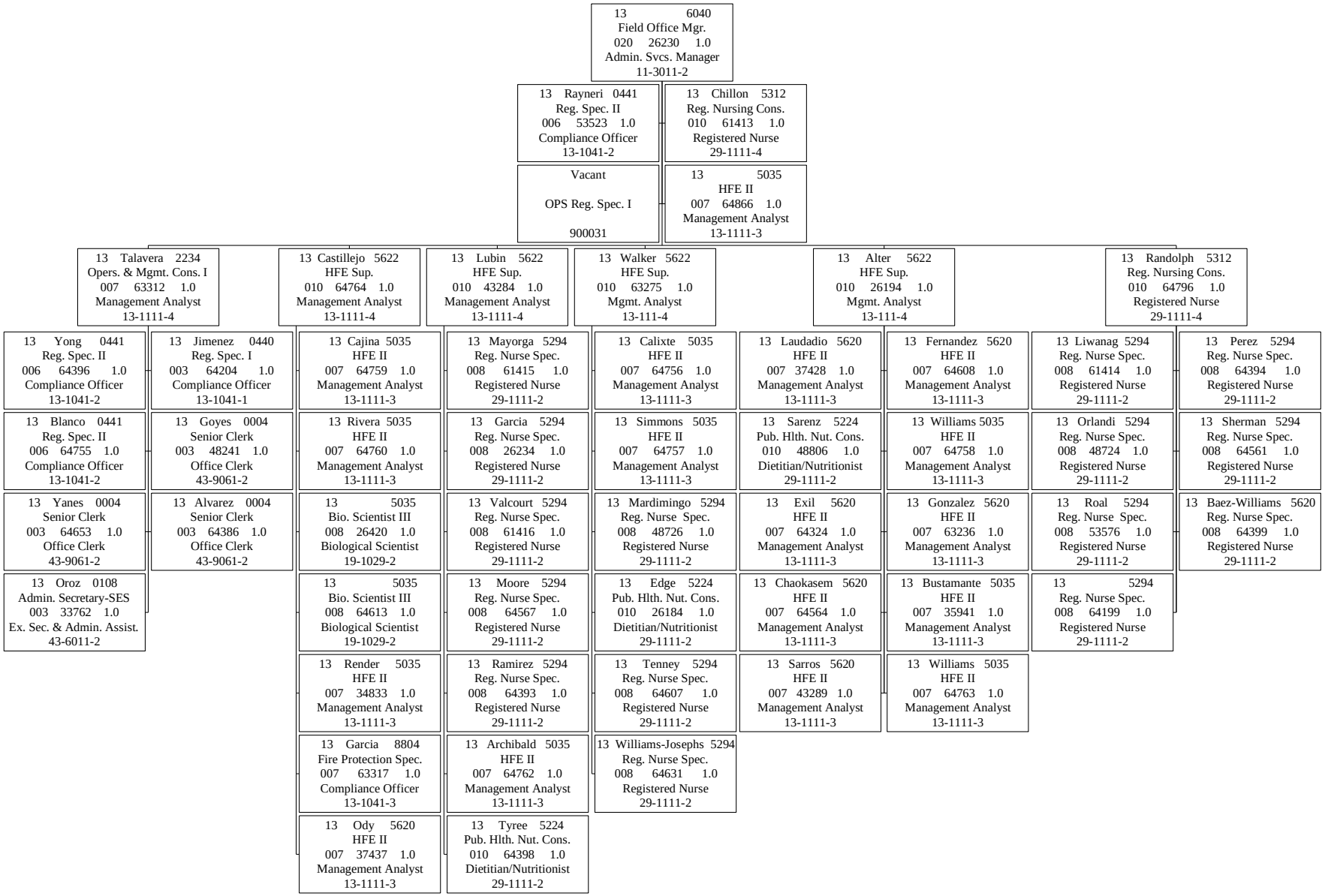
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 9 - West Palm Beach

Org Code: 68 30 30 09 000
Revised Date: July 1, 2011
FTEs: 65 Positions: 65



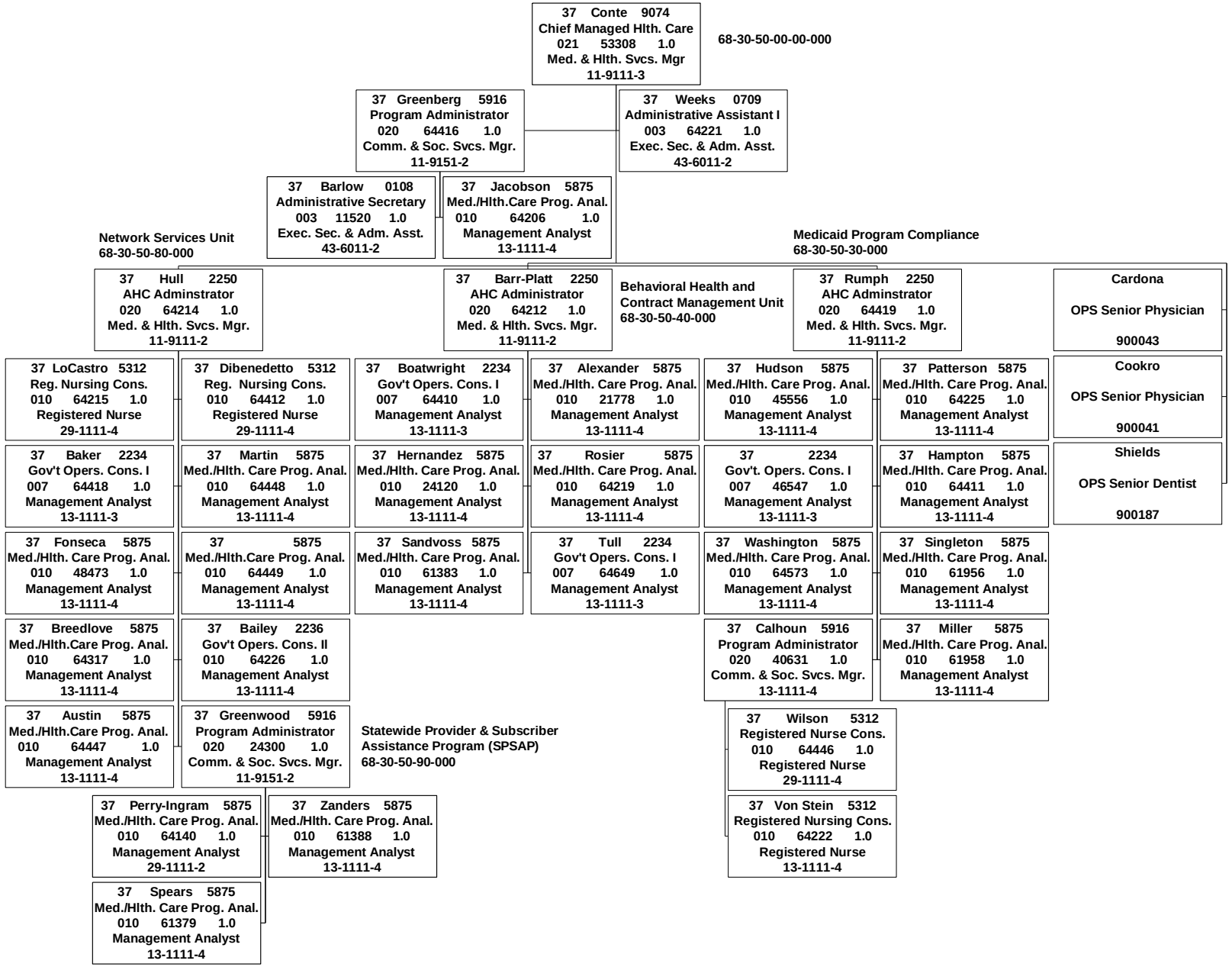
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 11 - Miami

Org. Level: 68 30 30 11 000
Revised Date: July 1, 2011
FTEs: 54 Positions: 54



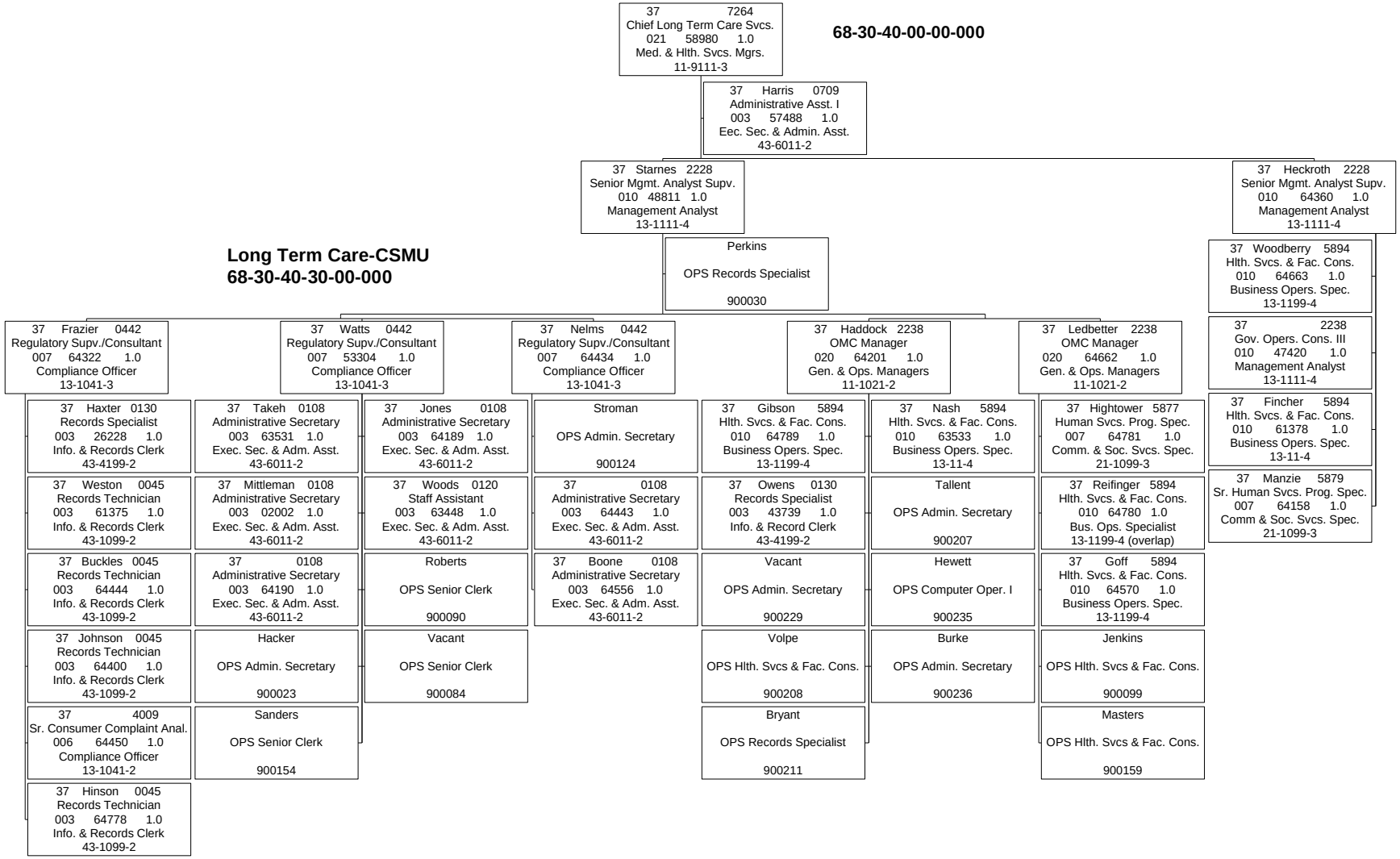
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance - Managed Health Care

Revised Date: July 1, 2011
FTEs: 37 Positions: 37



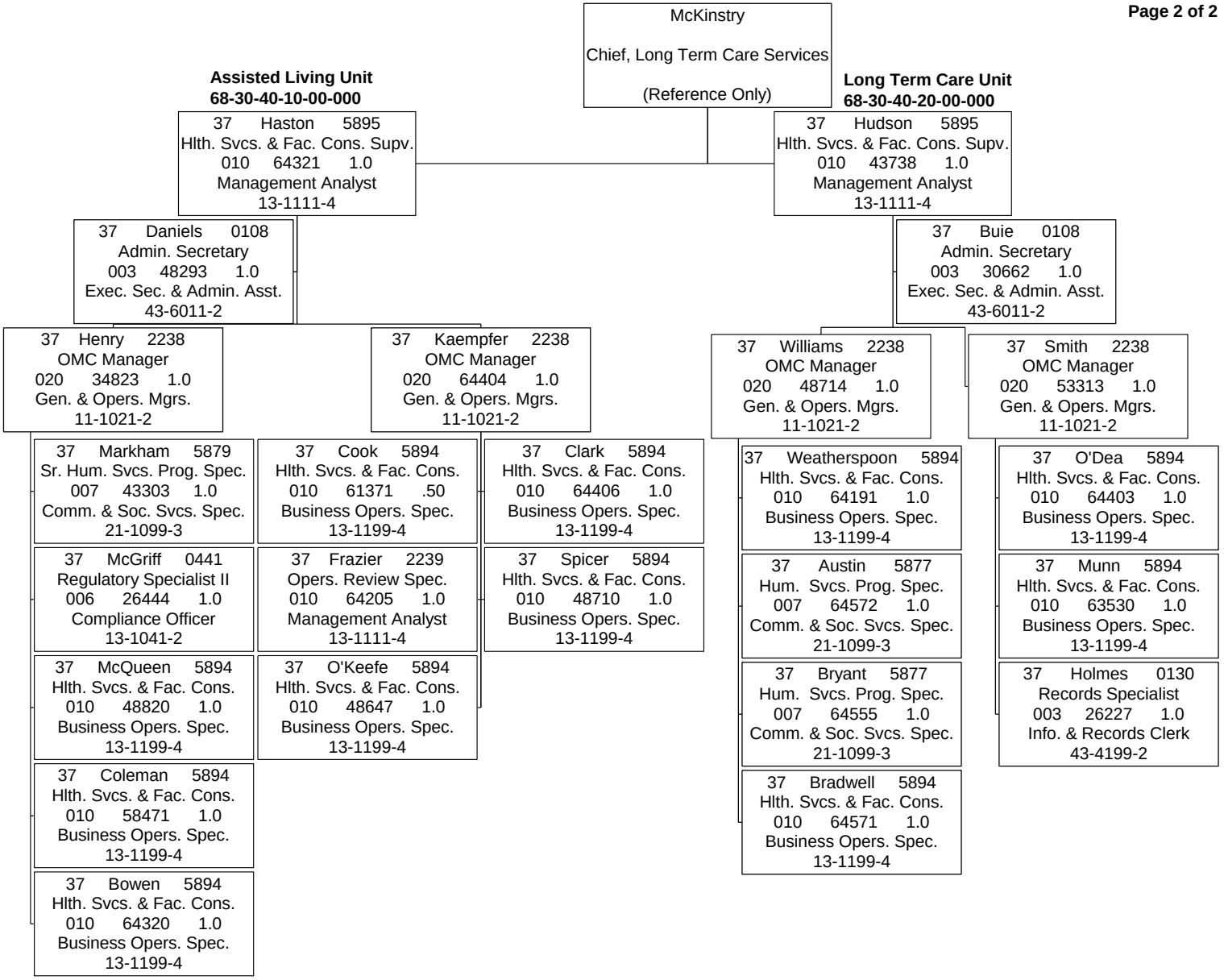
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Bureau of Long Term Care Services

Revised Date: July 1, 2011
FTEs: 56.5 Positions: 57



AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Bureau of Long Term Care Services

Revised Date: July 1, 2011
FTEs: 56.5 Positions: 57



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid - Deputy Secretary's Office

Org. Level: 68500000000
Revised Date: July 1, 2011
FTEs: 21 Positions: 21

Division of Medicaid FTE: 642.5

37 Bradford 9075
Dep. Secretary for Medicaid
024 63629 1.0
Gen. & Opr. Managers
10-1021-2

37 Bush 2236
Opr. & Mgmt. Cons. II-SES
007 19507 1.0
Management Analysts
13-1111-4

Crayton
OPS Program Consultant/Coord.
900321

37 9047
Acting, Asst. Dep. Sec. for Med. Ops.
023 46476 1.0
Gen. & Operations Managers
10-1021-1

37 Williams 9048
Asst. Dep. Sec. for Med. Fin.
023 19253 1.0
Financial Managers
10-3031-1

37 Sims 2225
Sr. Mgmt. Analyst II-SES
010 63439 1.0
Management Analysts
13-1111-4

37 Bennett 2250
AHC Administrator-SES
020 64817 1.0
Management Analyst
13-1111-4

37 Sokoloski 2228
Sr. Mgmt. Analyst Supv.-SES
010 64590 1.0
Management Analysts
13-1111-4

37 Hunter 2234
Oprs. & Mgmt. Cons. I-SES
003 64227 1.0
Management Analysts
13-1111-3

37 Hart 2236
Oprs. & Mgmt. Cons. II-SES
010 64588 1.0
Management Analysts
13-1111-4

37 Guadio 2234
Oprs. & Mgmt. Cons. I-SES
010 03334 1.0
Management Analysts
13-1111-3

37 Britt-Hightower 0108
Adm. Secretary-SES
003 48427 1.0
Ex. Sec. & Adm. Asst.
43-6011-2

29 5879
Sr. HSPS
007 64724 1.0
Comm. & Soc. Svc. Spec.
21-1099-03

48 Phipps 5879
Sr. HSPS
007 64725 1.0
Comm. & Soc. Svc. Spec.
21-1099-03

37 Ryals 2212
Operations Analyst II
007 46253 1.0
13-1111-3
Management Analysts

Bureau of
Health Systems
Development
(Reference Only)

Bureau of
Pharmacy Services
(Reference Only)

Bureau of
Program Analysis
(Reference Only)

37 0108
Adm. Secretary
003 24405 1.0
Ex. Sec. & Adm. Asst.
43-6011-2

37 2225
Gov. Analyst II
010 64859 1.0
Management Analysts
13-1111-4

Strayer
OPS Research Assistant
900221

Wright
OPS Mgmt. Review Spec.
68900169

Bureau of
Medicaid Services
(Reference Only)

Medicaid
Area Offices
(1-11)
(Reference Only)

Bureau of
Medicaid
Quality Management
(Reference Only)

37 Frost 2225
Govt. Analyst II
010 64721 1.0
Management Analysts
13-1111-4

37 Garcia 2228
Sr. Mgmt. Analyst Supv.-SES
010 64860 1.0
Management Analysts
13-1111-4

Bolin
OPS Senior Clerk
900180

Bureau of
Contract Management
(Reference Only)

37 Ingram 2225
Gov. Analyst II
010 64810 1.0
Management Analyst
13-1111-4

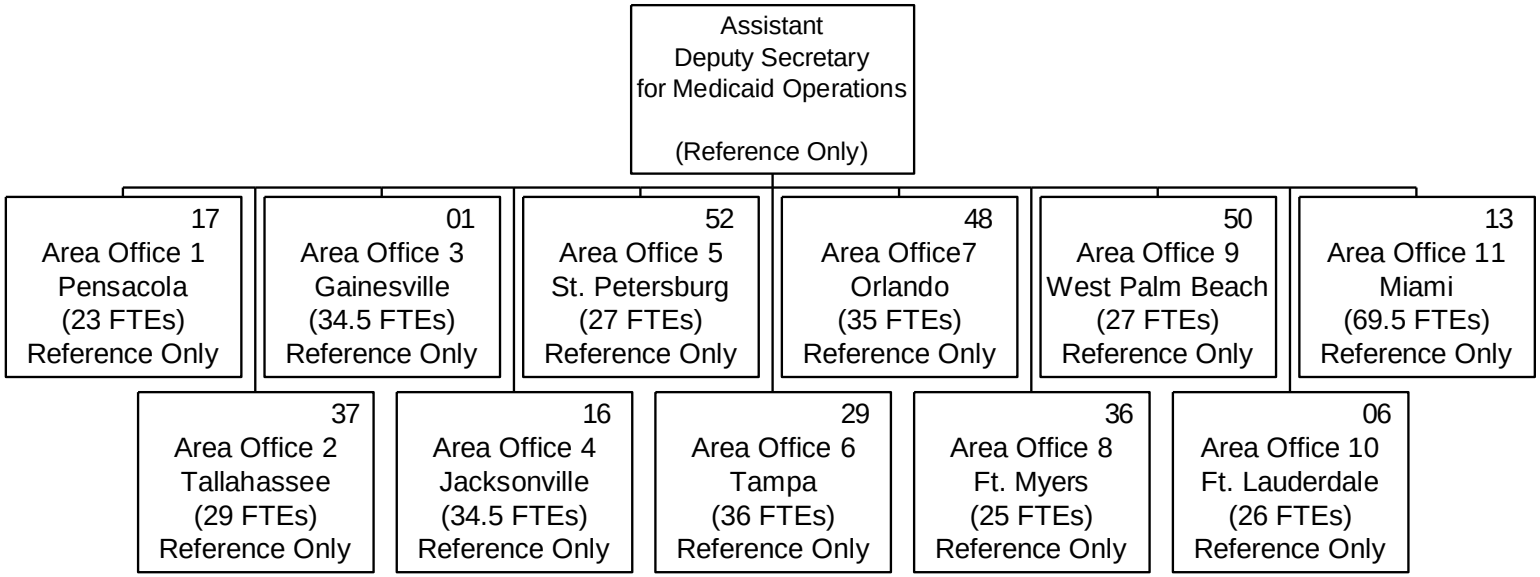
06 Rodriguez 5879
Sr. HSPS
007 64726 1.0
Comm. & Soc. Svc. Spec.
21-1099-03

Newman
OPS Sr. Management Analyst
900044

13 Lanz 5879
Sr. HSPS
007 64727 1.0
Comm. & Soc. Svc. Spec.
21-1099-03

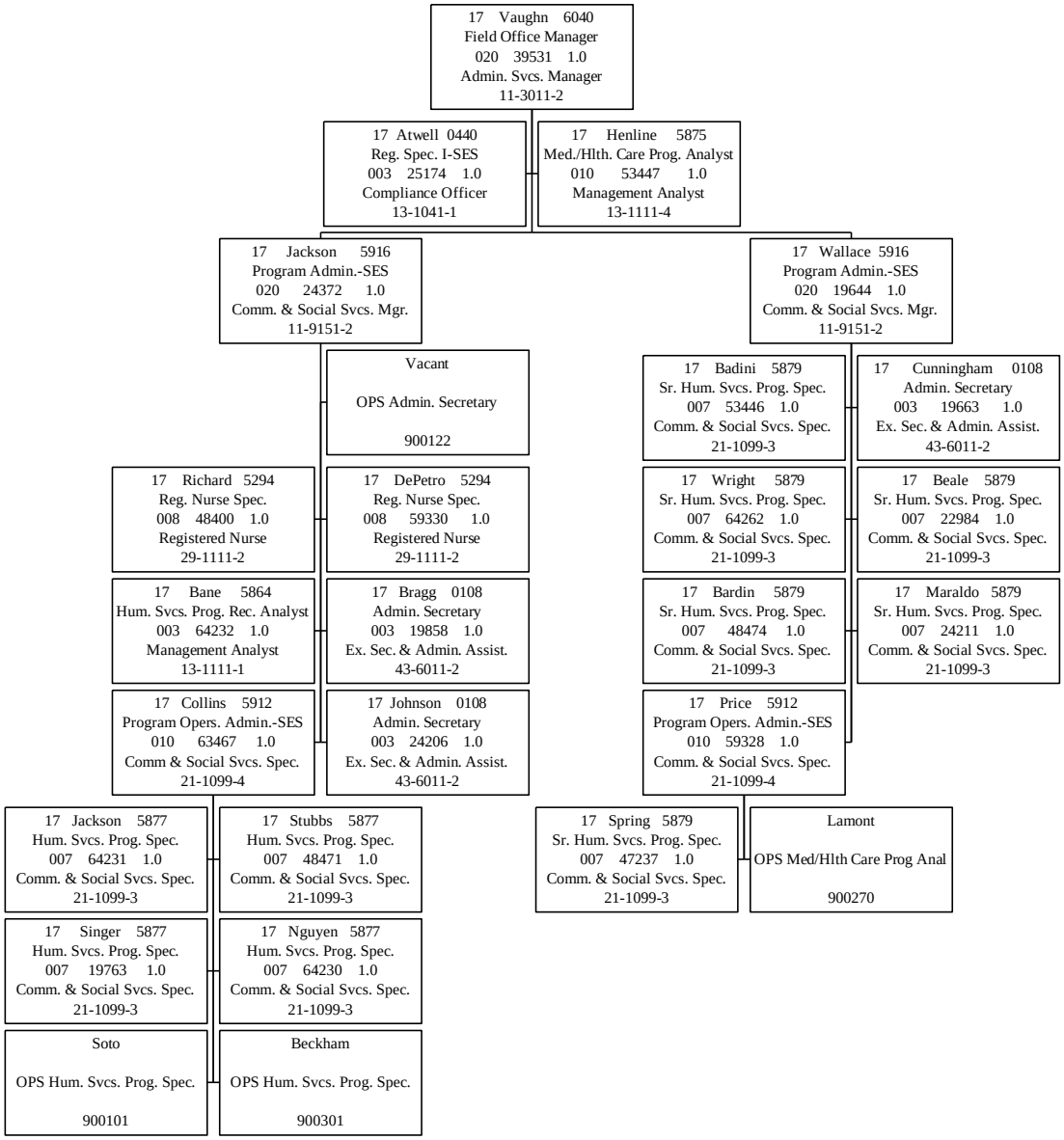
AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID AREA OFFICES

Org. Level: 68 50 10 00 000
Revised Date: July 1, 2011
FTEs: 366.5 Positions: 370



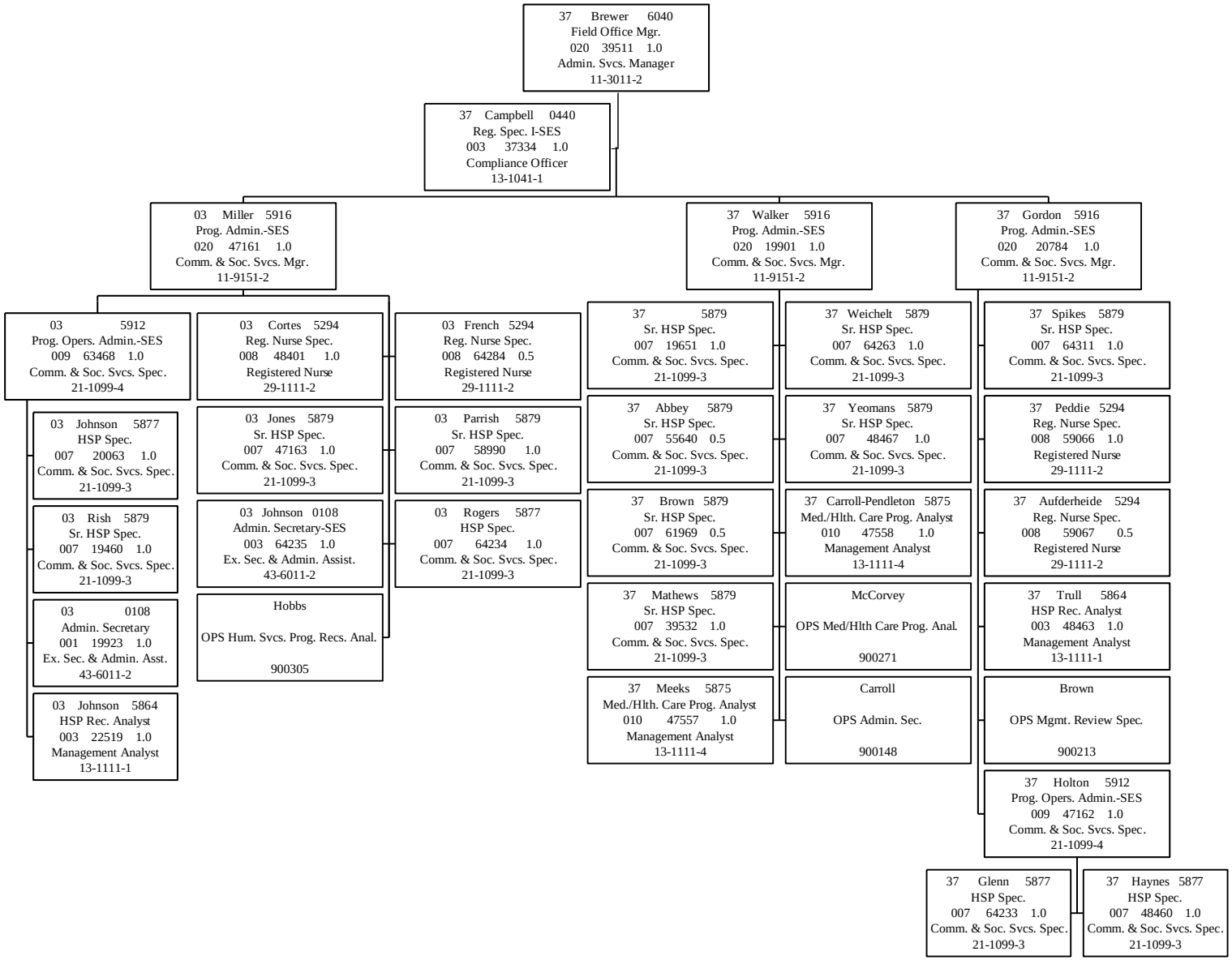
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 1 - Pensacola

Org. Level: 68 50 10 01 000
Revised Date: July 1, 2011
FTEs: 23 Positions: 23



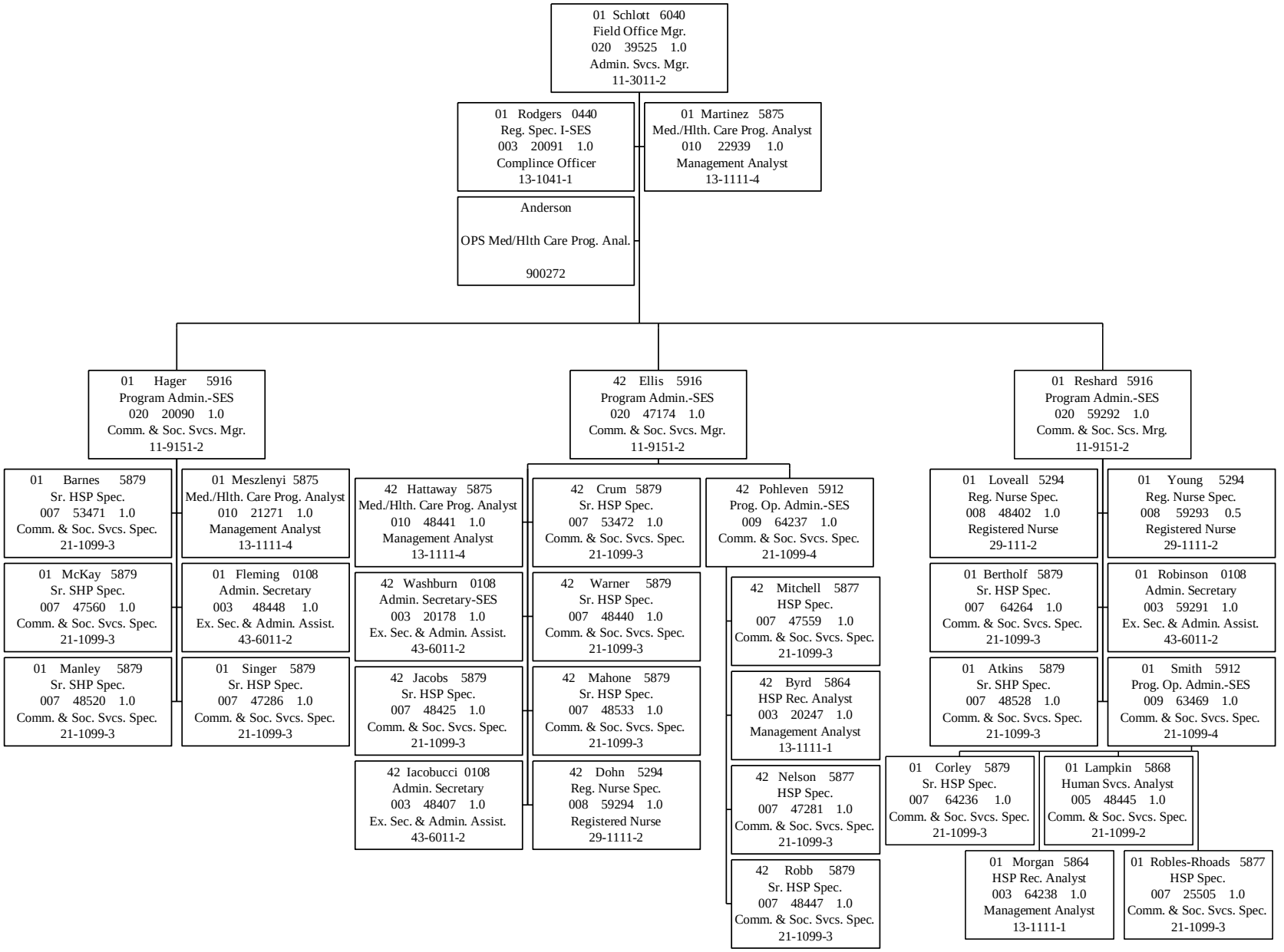
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 2 - Tallahassee

Org. Level: 68 50 10 02 000
Revised Date: July 1, 2011
FTEs: 29 Positions: 31



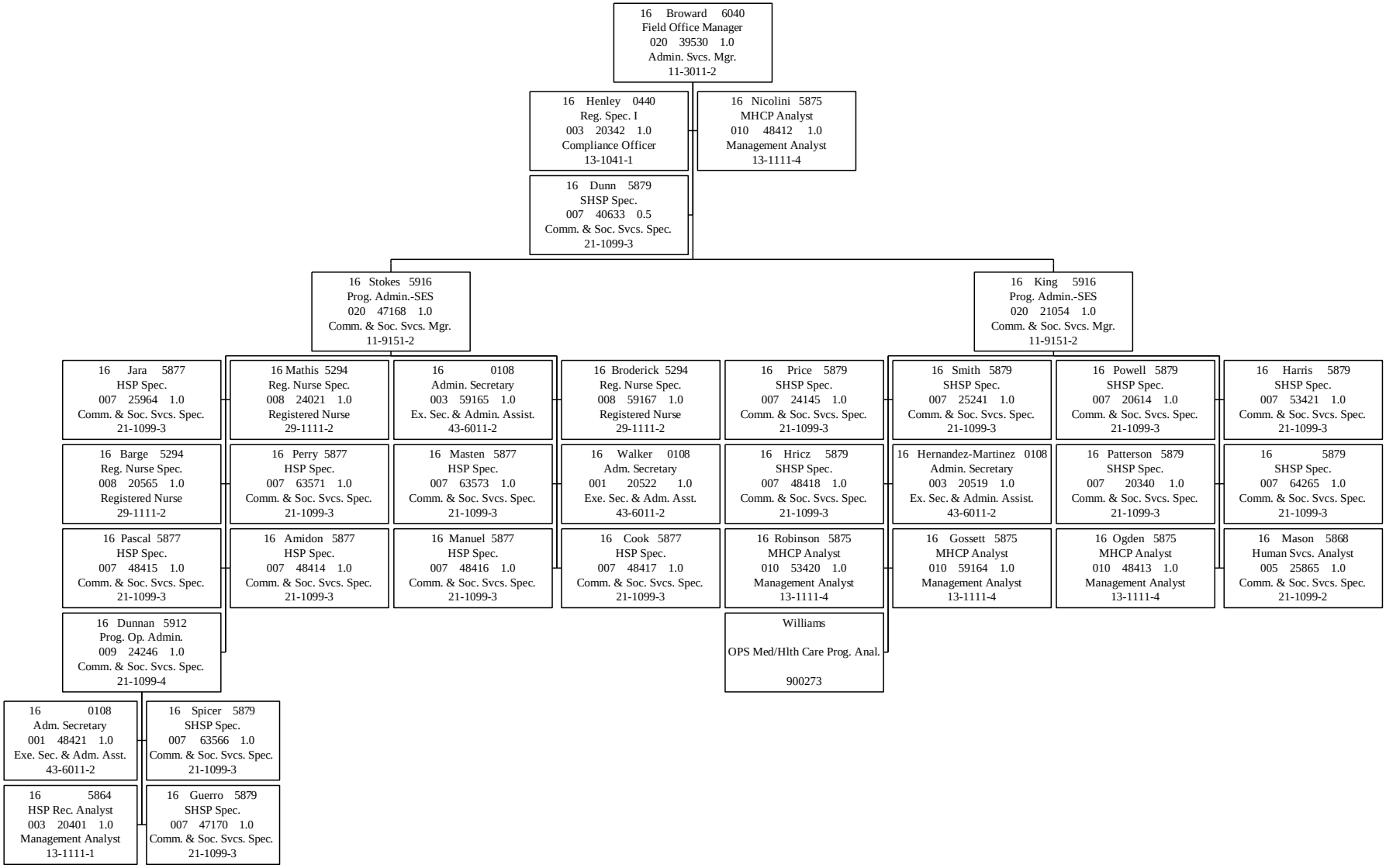
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 3 - Gainesville

Org. Level: 68 50 10 03 000
Revised Date: July 1, 2011
FTEs: 34.5 Positions: 35



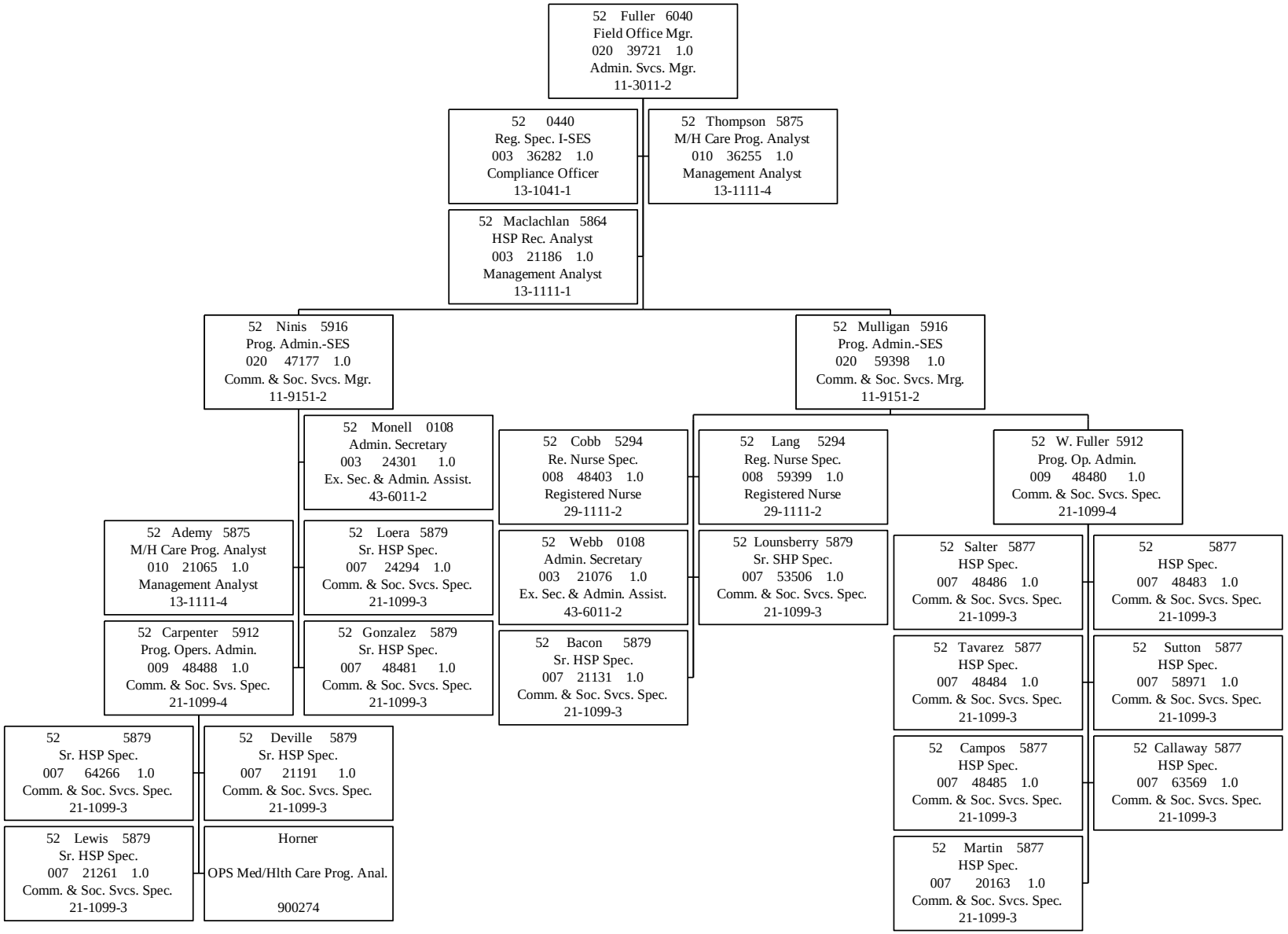
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 4 - Jacksonville

Org. Level: 68 50 10 04 000
Revised Date: July 1, 2011
FTEs: 34.5 Positions: 35



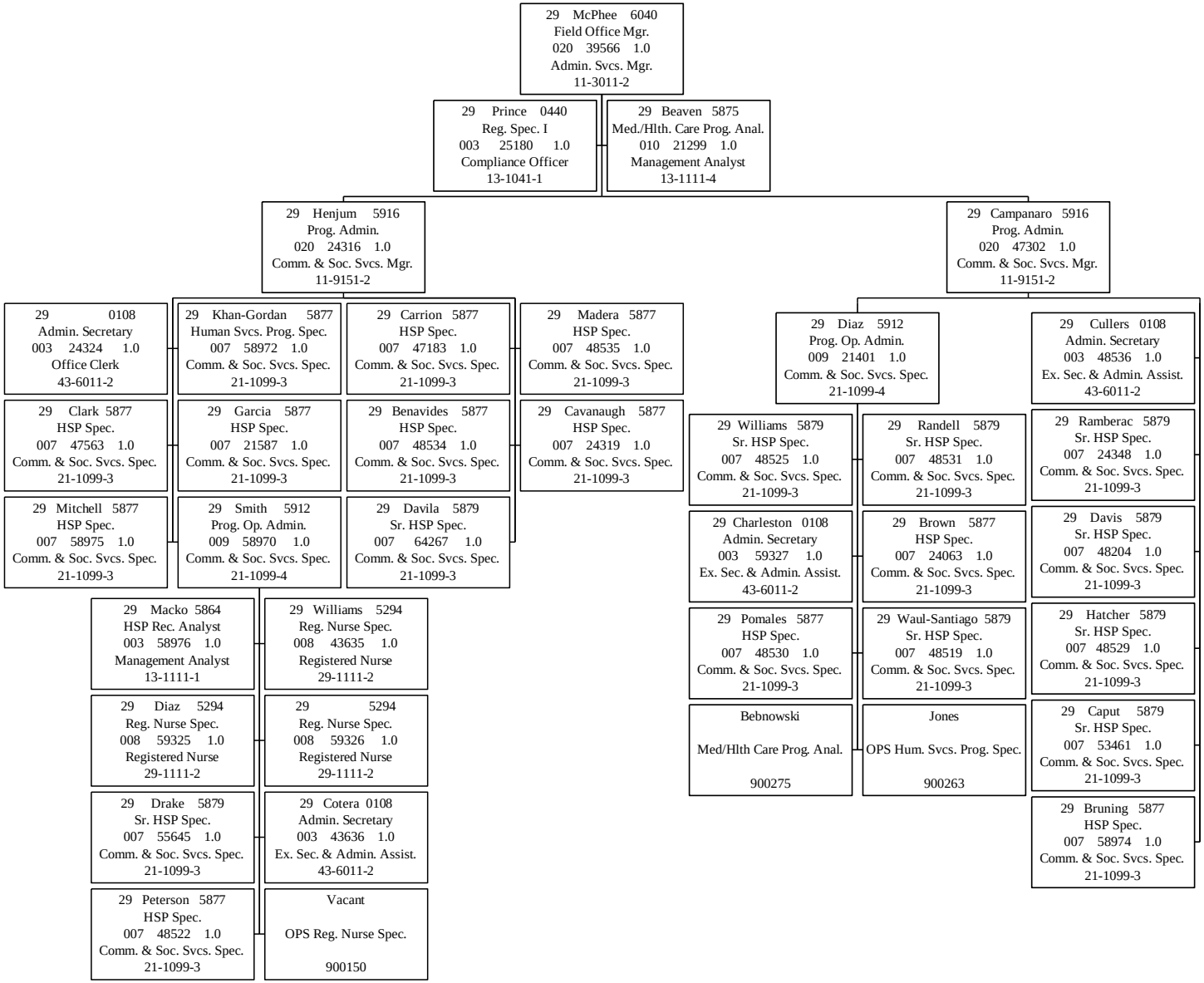
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 5 - St. Petersburg

Org. Level: 68 50 10 05 000
Revised Date: July 1, 2011
FTEs: 27 Positions: 27



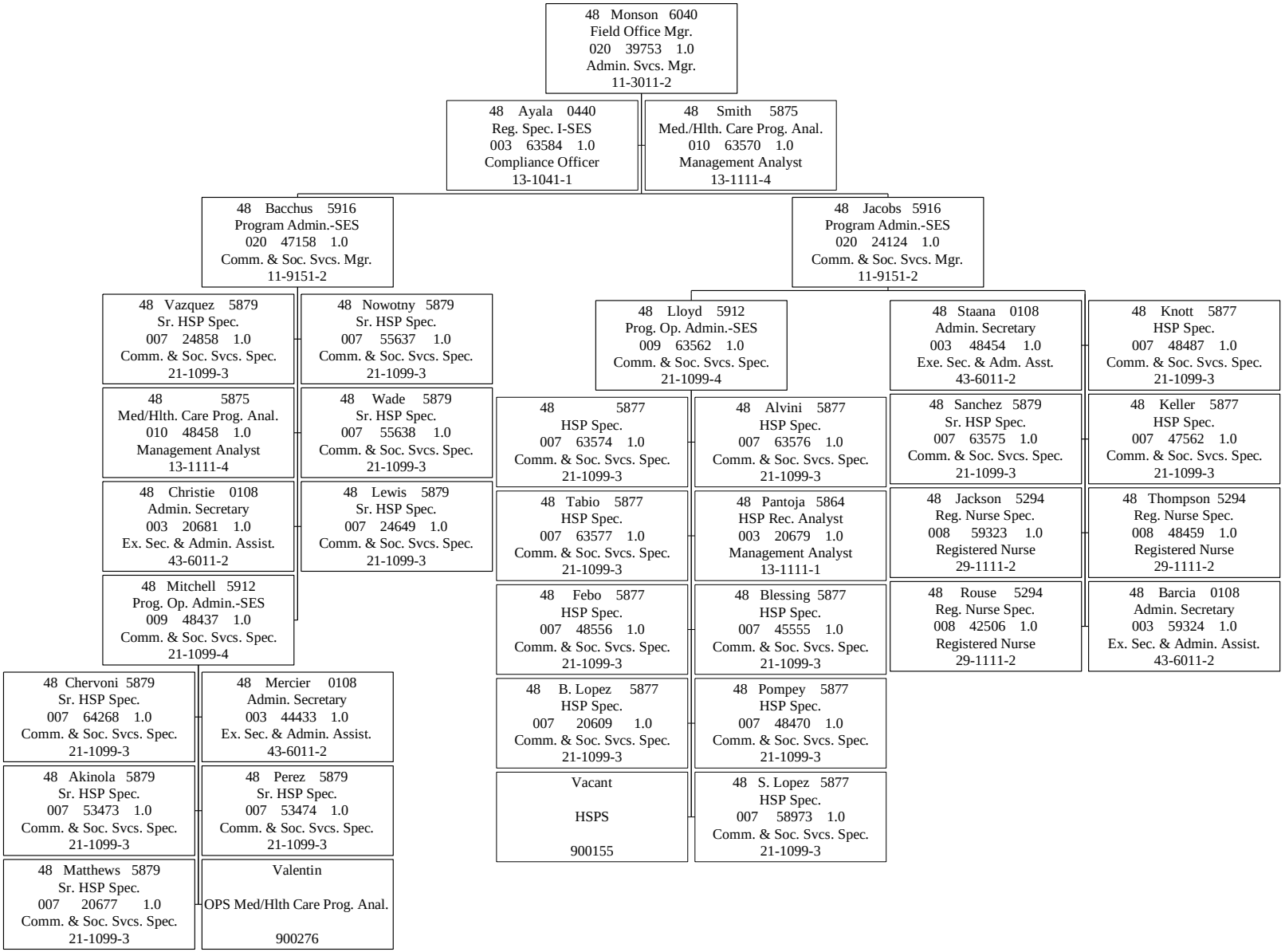
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 6 - Tampa

Org. Level: 68 50 10 06 000
Revised Date: July 1 2011
FTEs: 36 Positions: 36



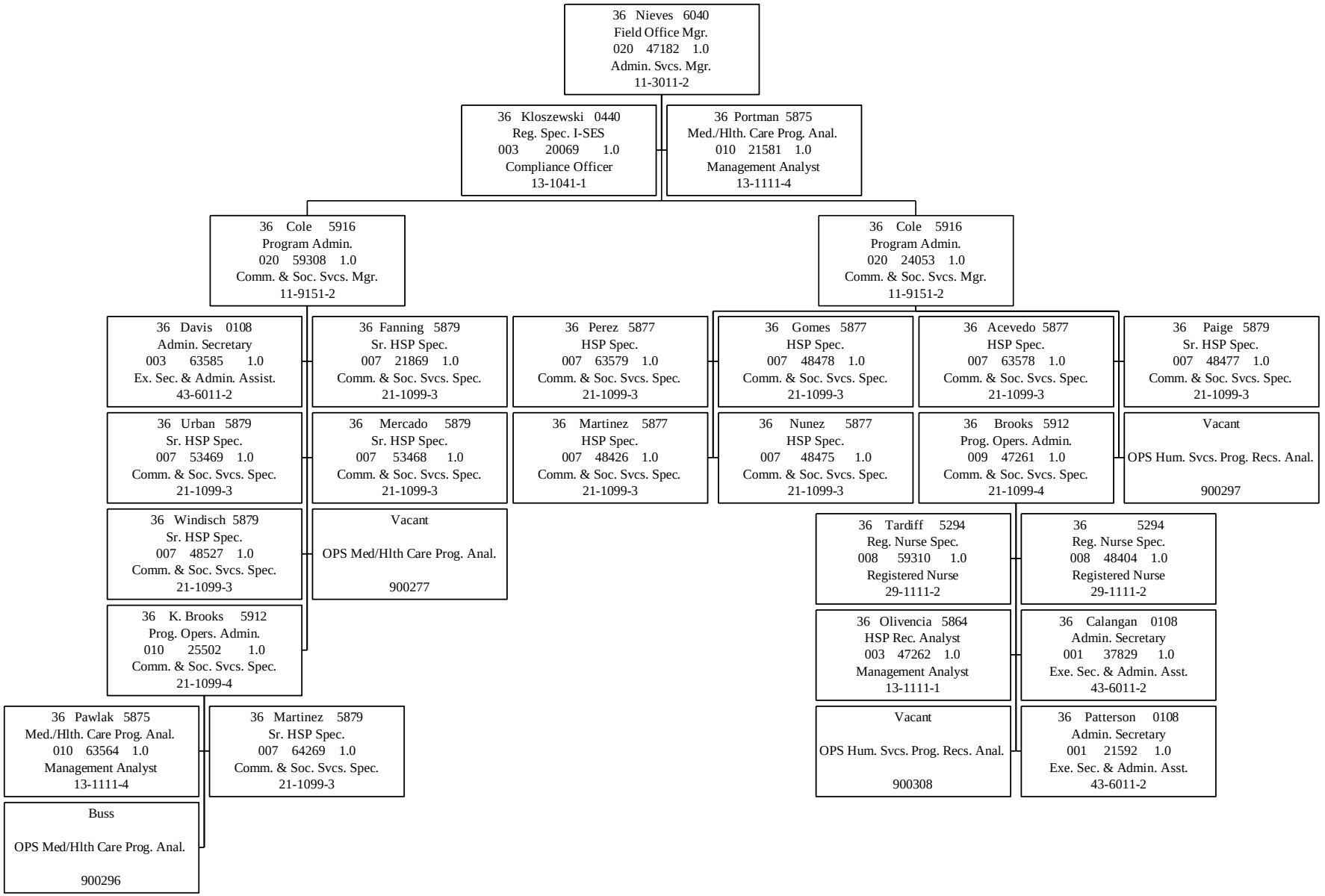
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 7 - Orlando

Org. Level: 68 50 10 07 000
Revised Date: July 1, 2011
FTE: 35 Positions: 35



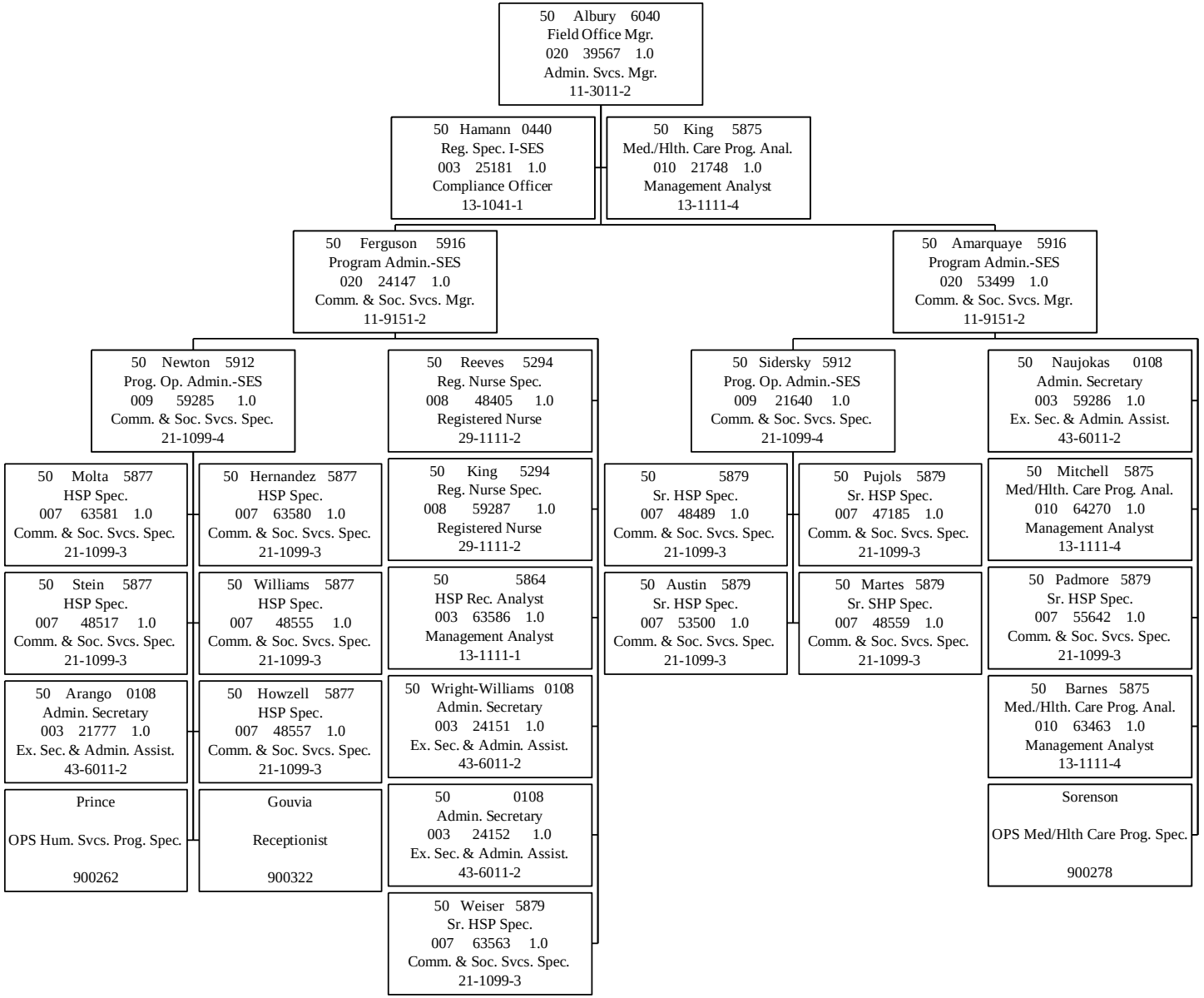
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 8 - Ft. Myers

Org. Level: 68 50 10 08 000
Revised Date: July 1, 2011
FTEs: 25 Positions: 25



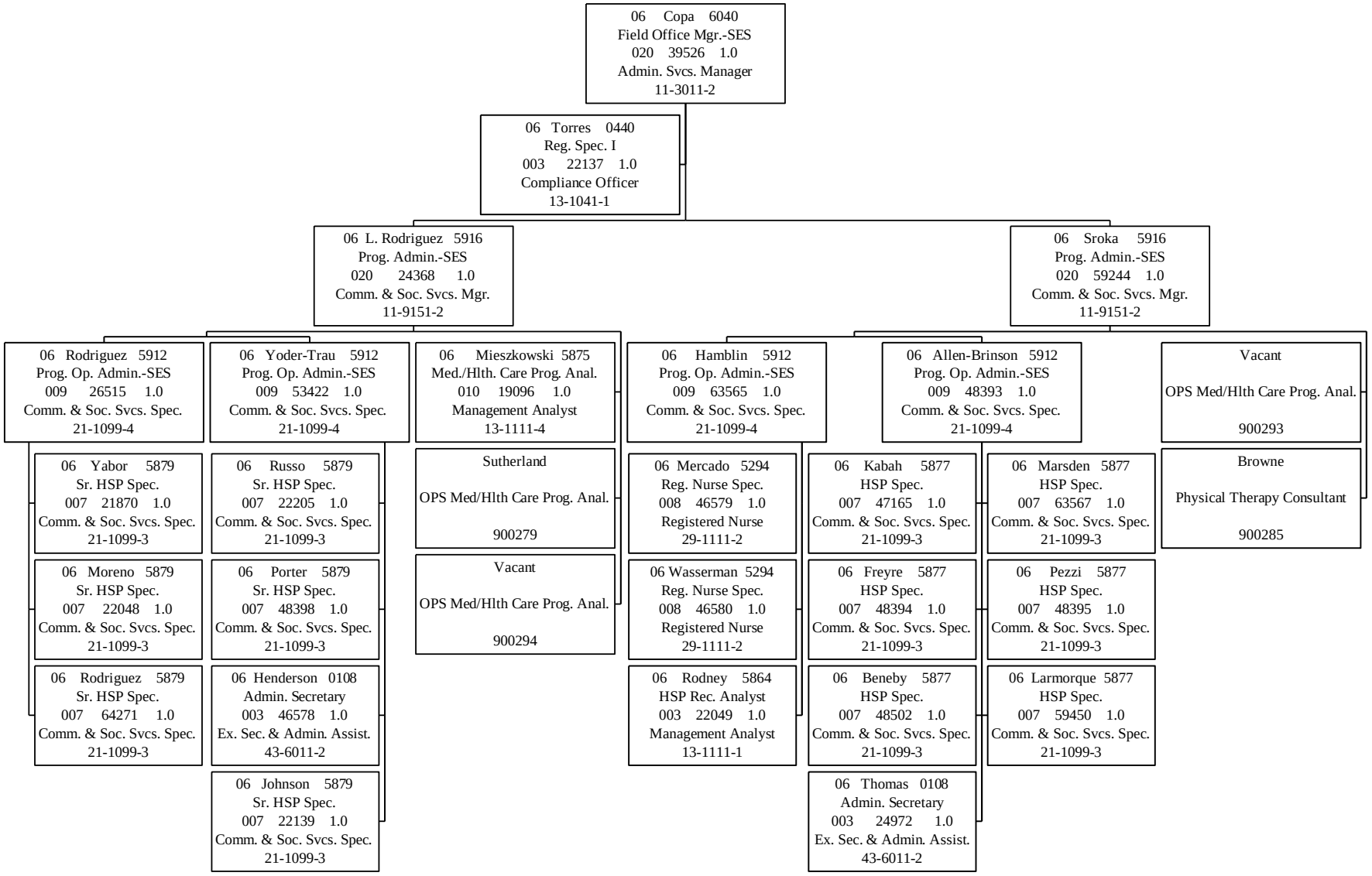
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 9 - West Palm Beach

Org. Level: 68 50 10 09 000
Revised Date: July 1, 2011
FTEs: 27 Positions: 27



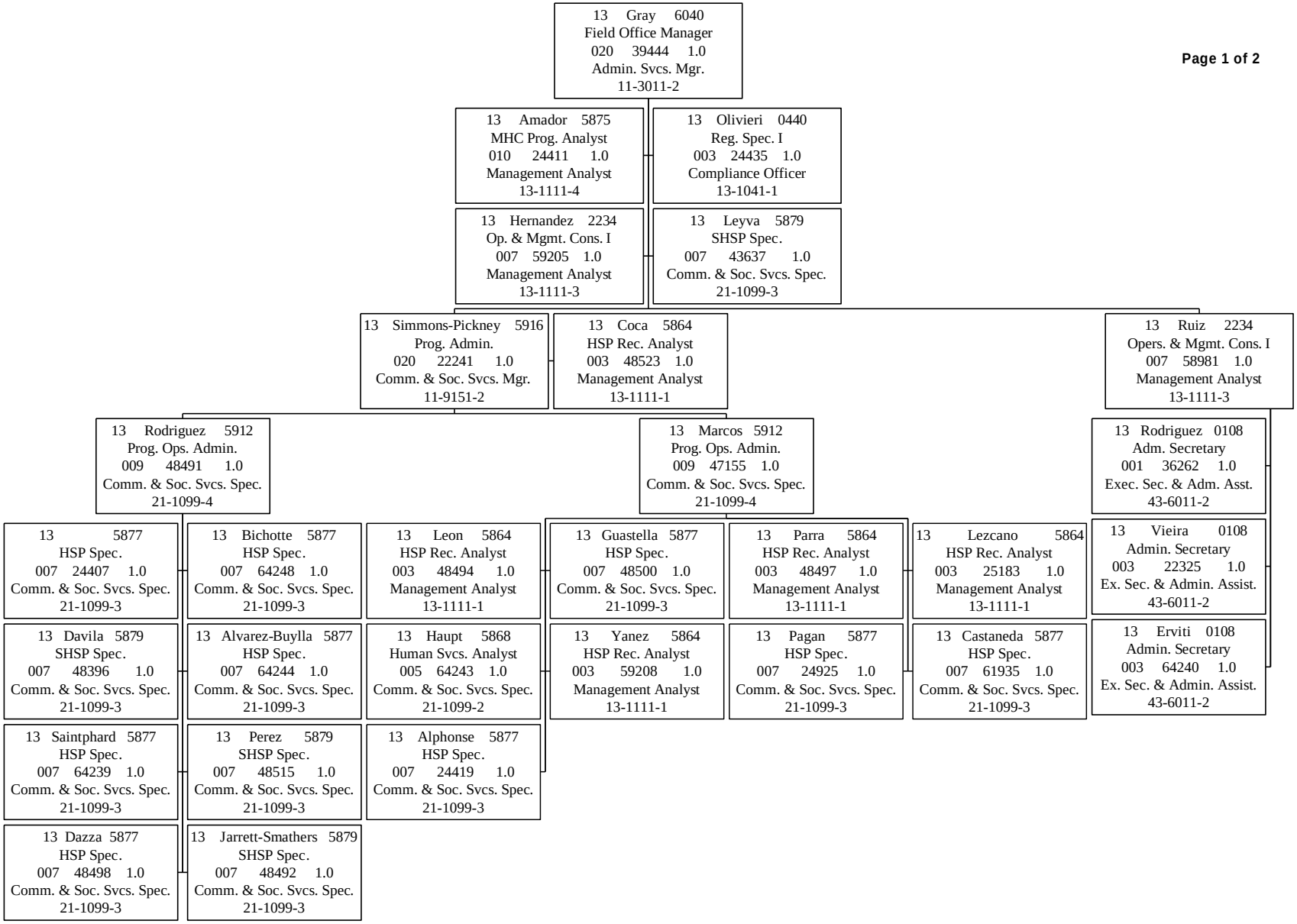
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 10 - Ft. Lauderdale

Org. Level: 68 50 10 10 000
Revised Date: July 1, 2011
FTEs: 26 Positions: 26



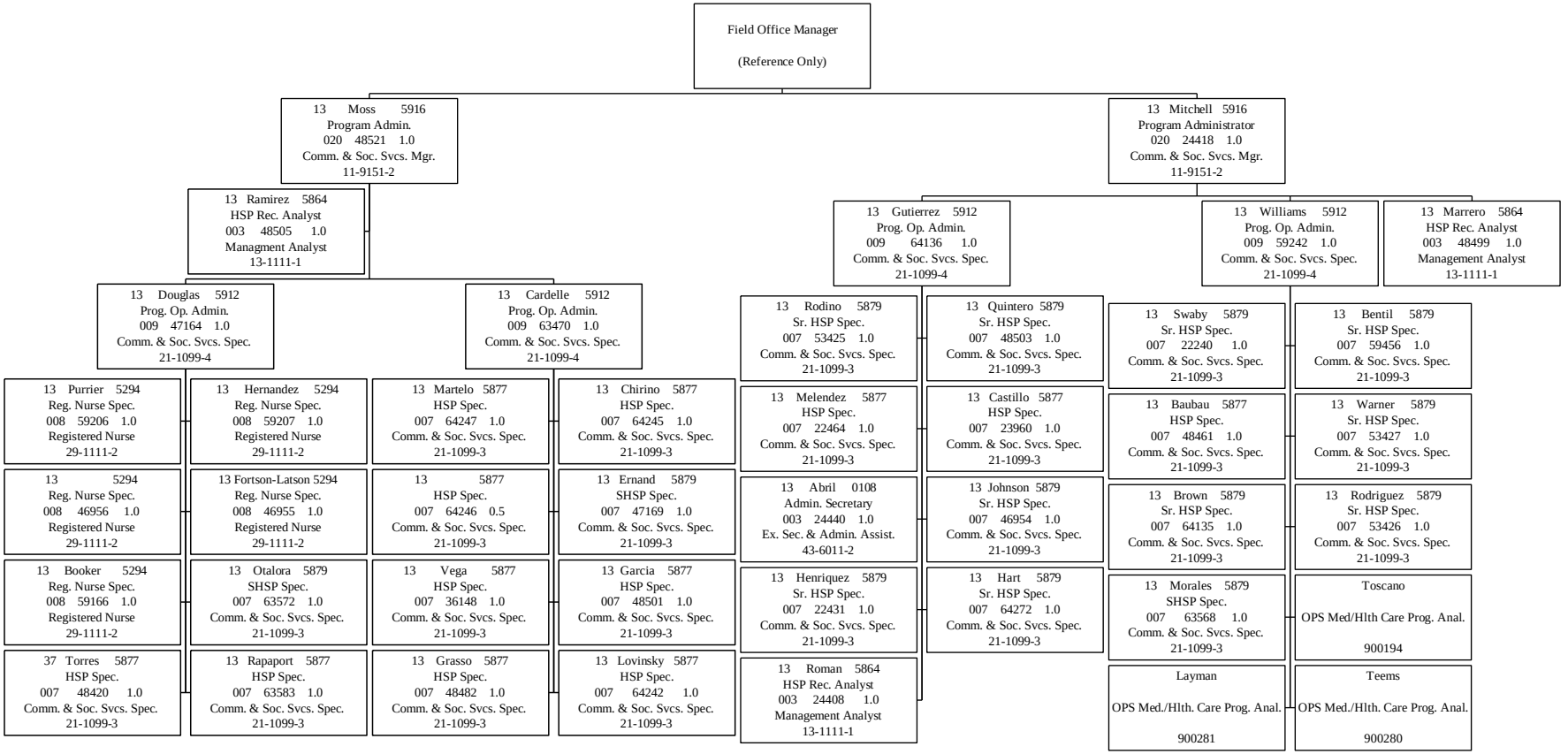
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
AREA 11 - Miami

Org. Level: 68 50 10 11 000
Revised Date: July 1, 2011
FTEs: 69.5 Positions: 70



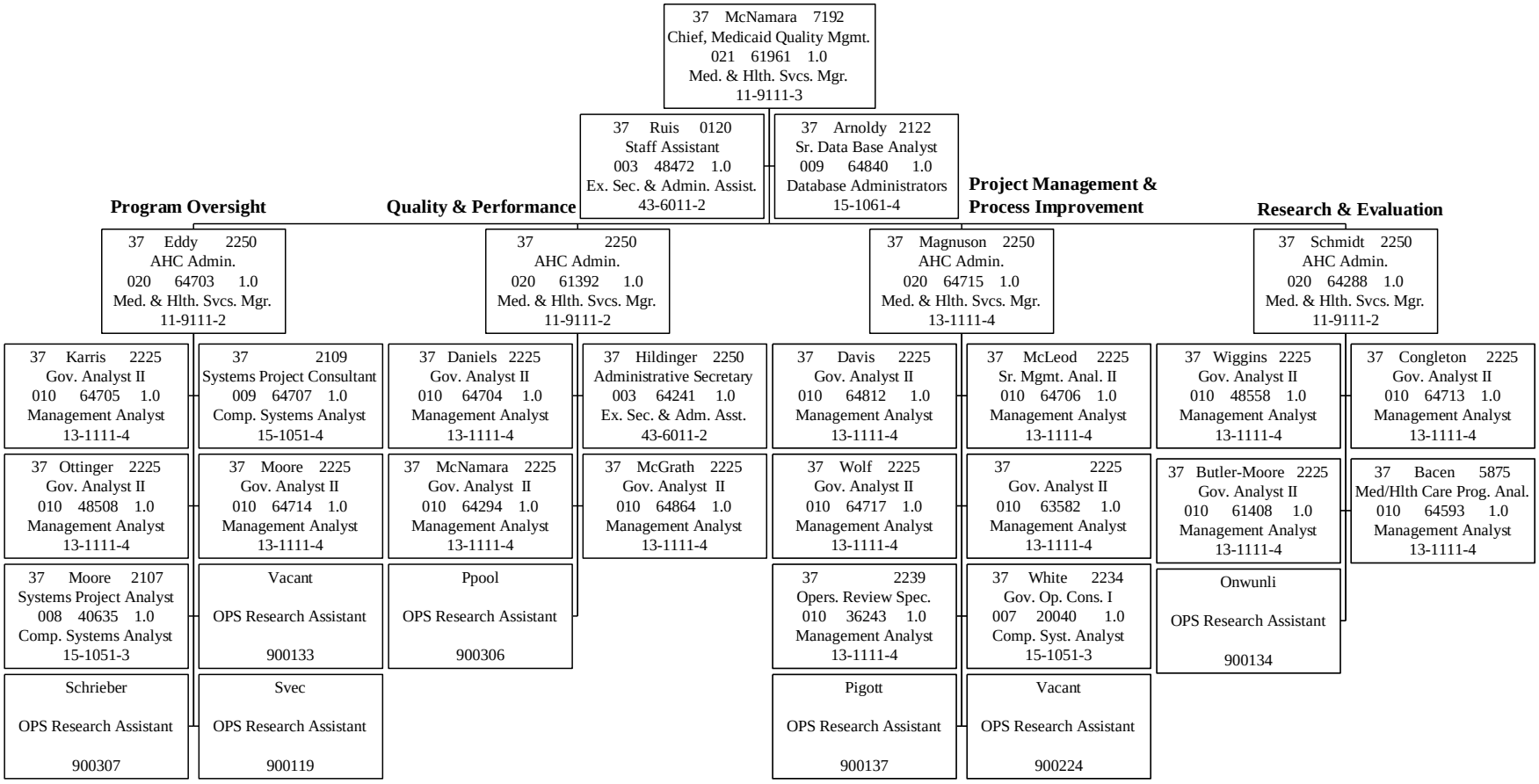
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
AREA 11 - Miami

Org. Level: 68 50 10 11 000
Revised Date: July 1, 2011
FTEs: 69.5 Positions: 70



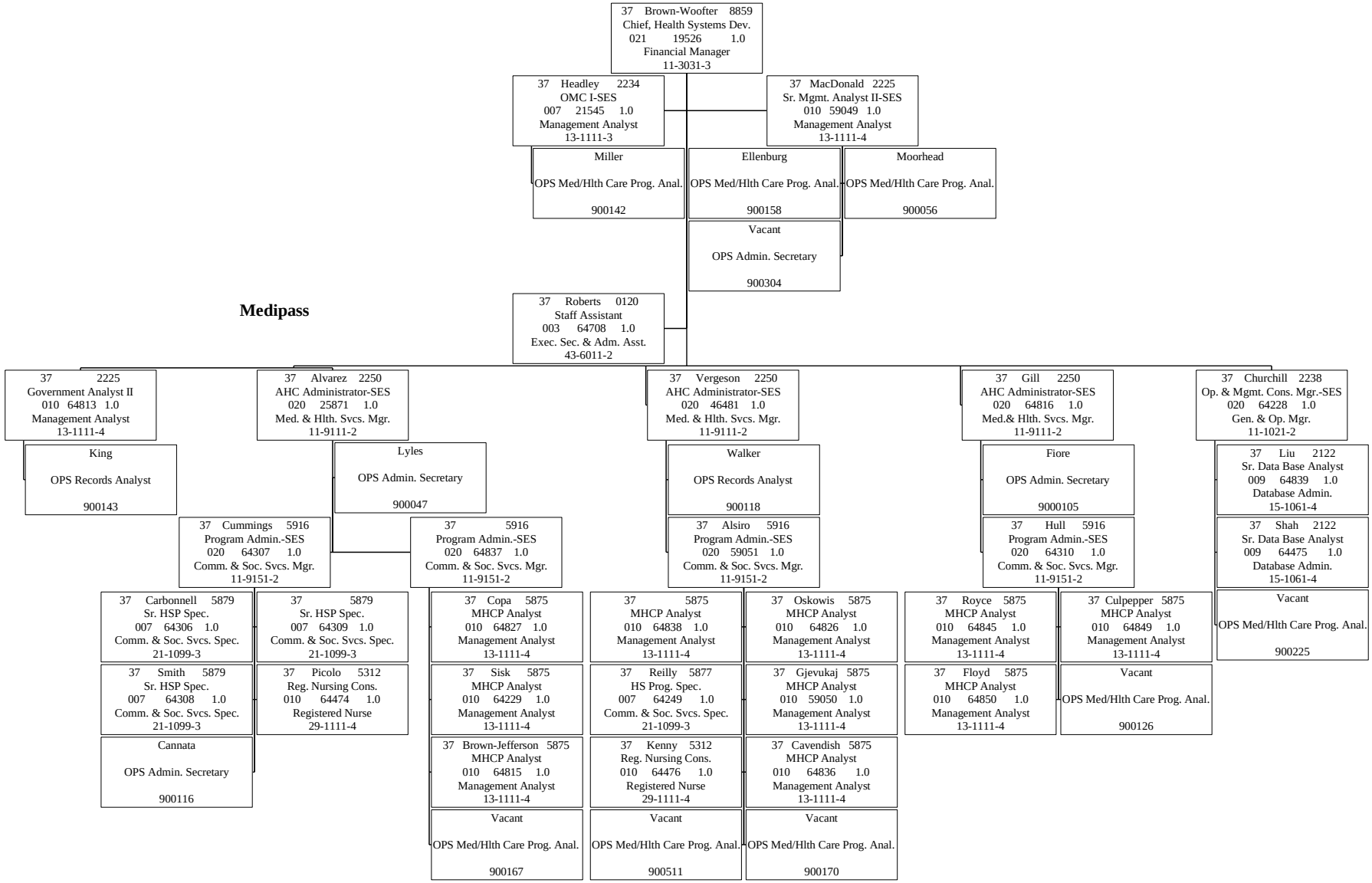
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Medicaid Quality Management

Org Level: 68-50-20-00-000
Revised Date: July 1, 2011
FTE: 26 Positions: 26



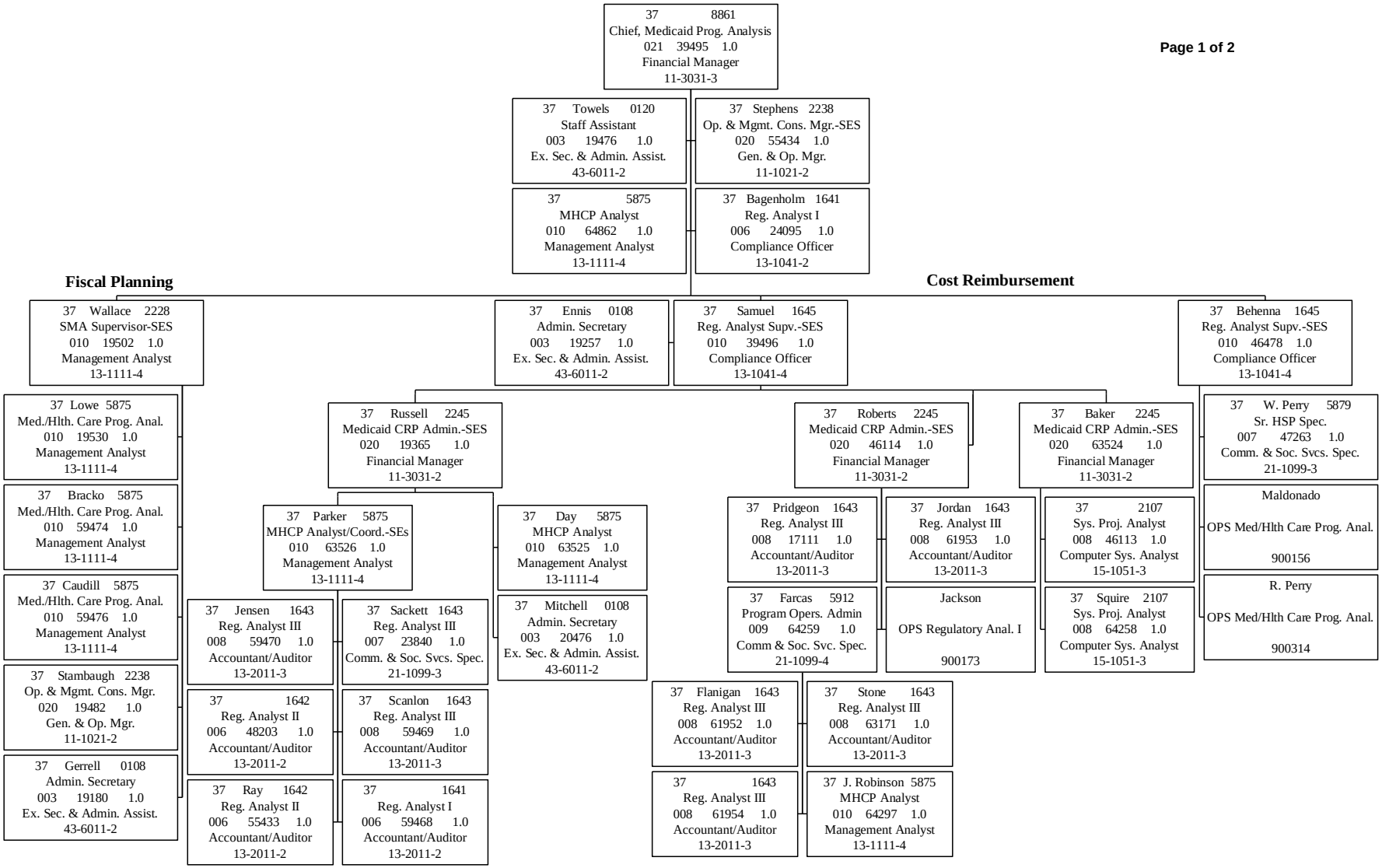
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Health Systems Development

Org. Level: 68 50 40 00 000
Revised Date: July 1, 2011
FTEs: 31 Positions: 31



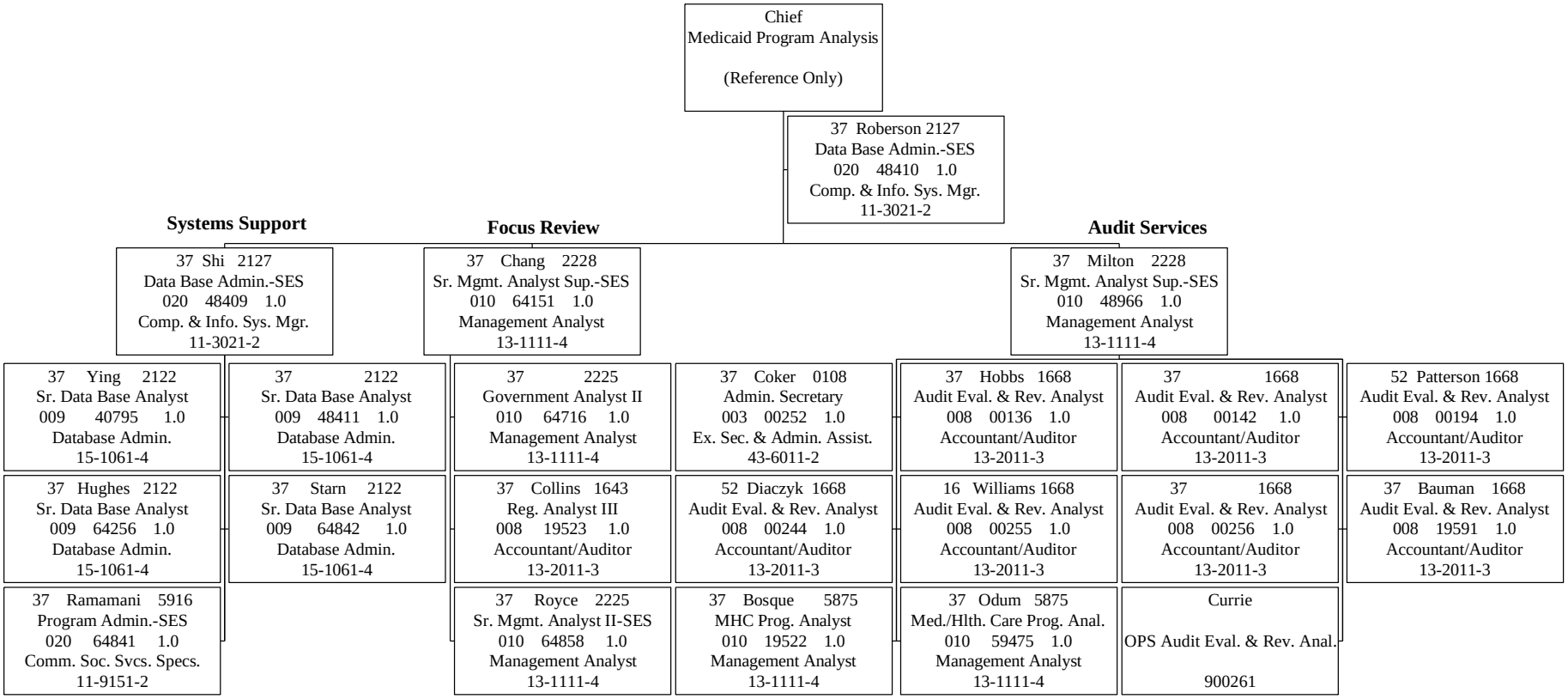
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
PROGRAM ANALYSIS

Org. Level: 68 50 50 00 000
Revised Date: July 1, 2011
FTEs: 58 Positions: 58



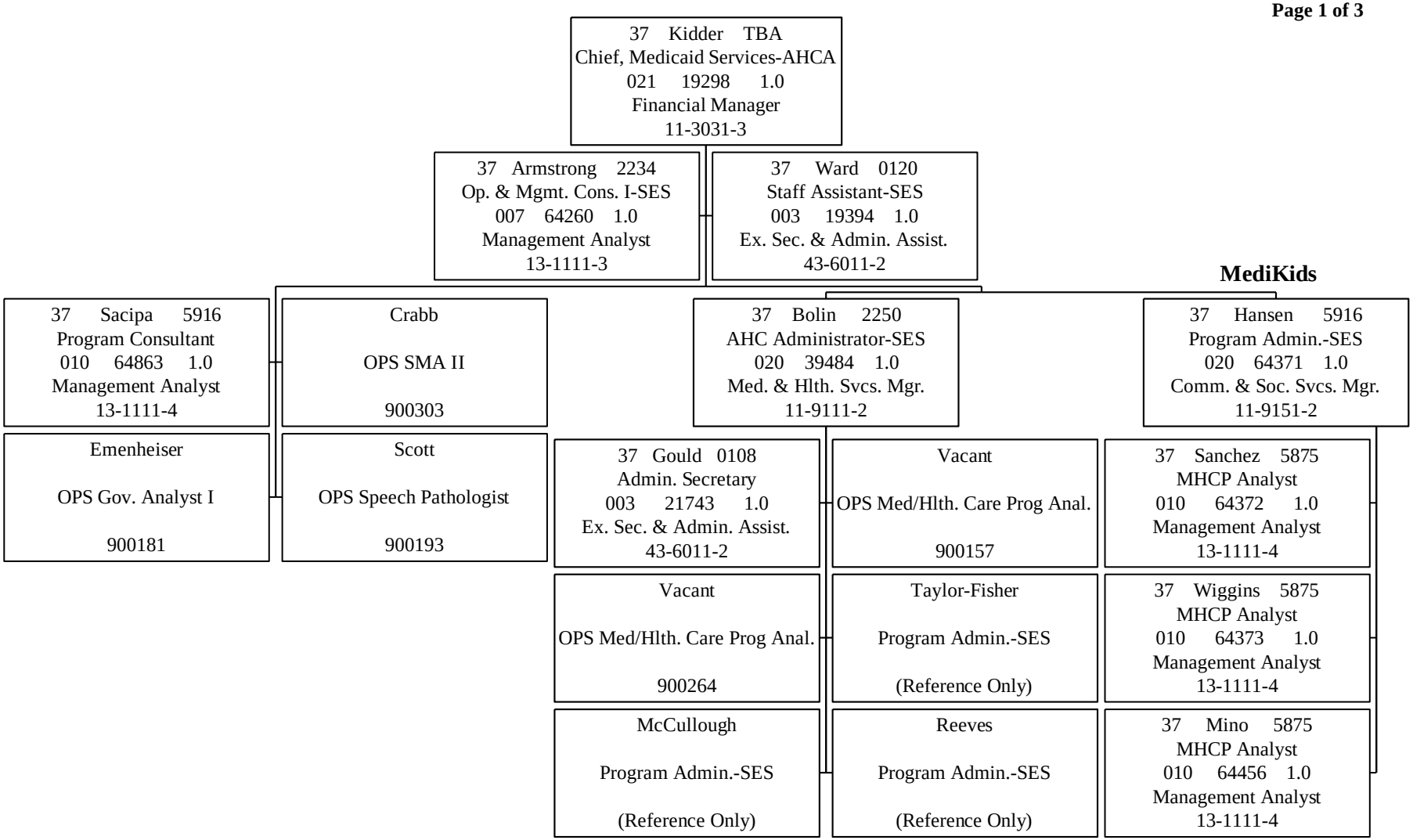
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Program Analysis

Org Level: 68505000000
Revised Date: July 1, 2011
FTE: 58 Positions: 58



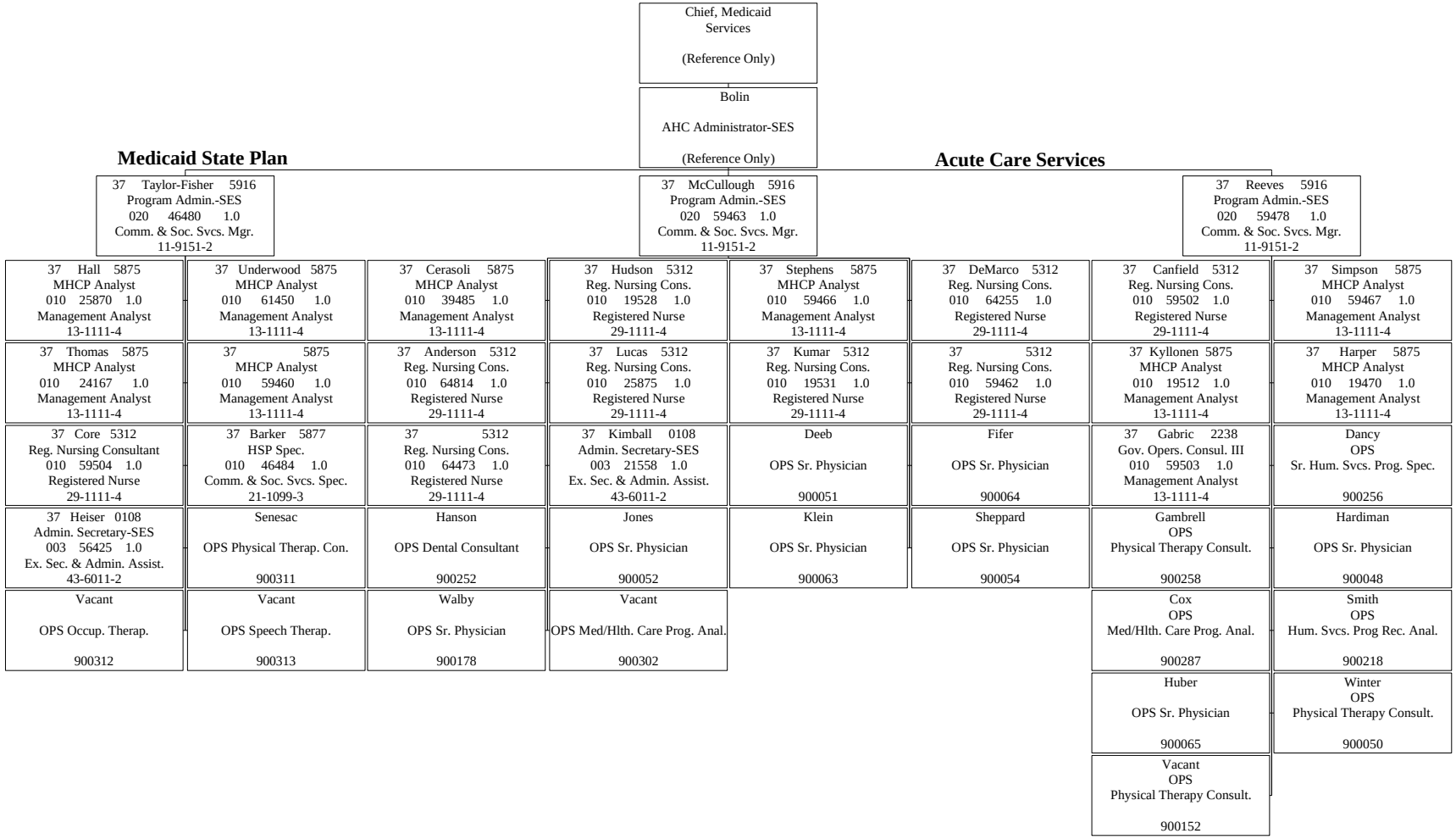
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

Org Level: 68 50 60 00 000
Revised Date: July 1, 2011
FTEs: 68 Positions: 68



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

Org. Level: 68 50 60 00 000
Revised Date: July 1, 2011
FTEs: 68 Positions: 68



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

Org. Level: 68 50 60 00 000
Revised Date: July 1, 2011
FTEs: 68 Positions: 68

**Long Term &
Behavioral Health Care**

Chief, Medicaid Services

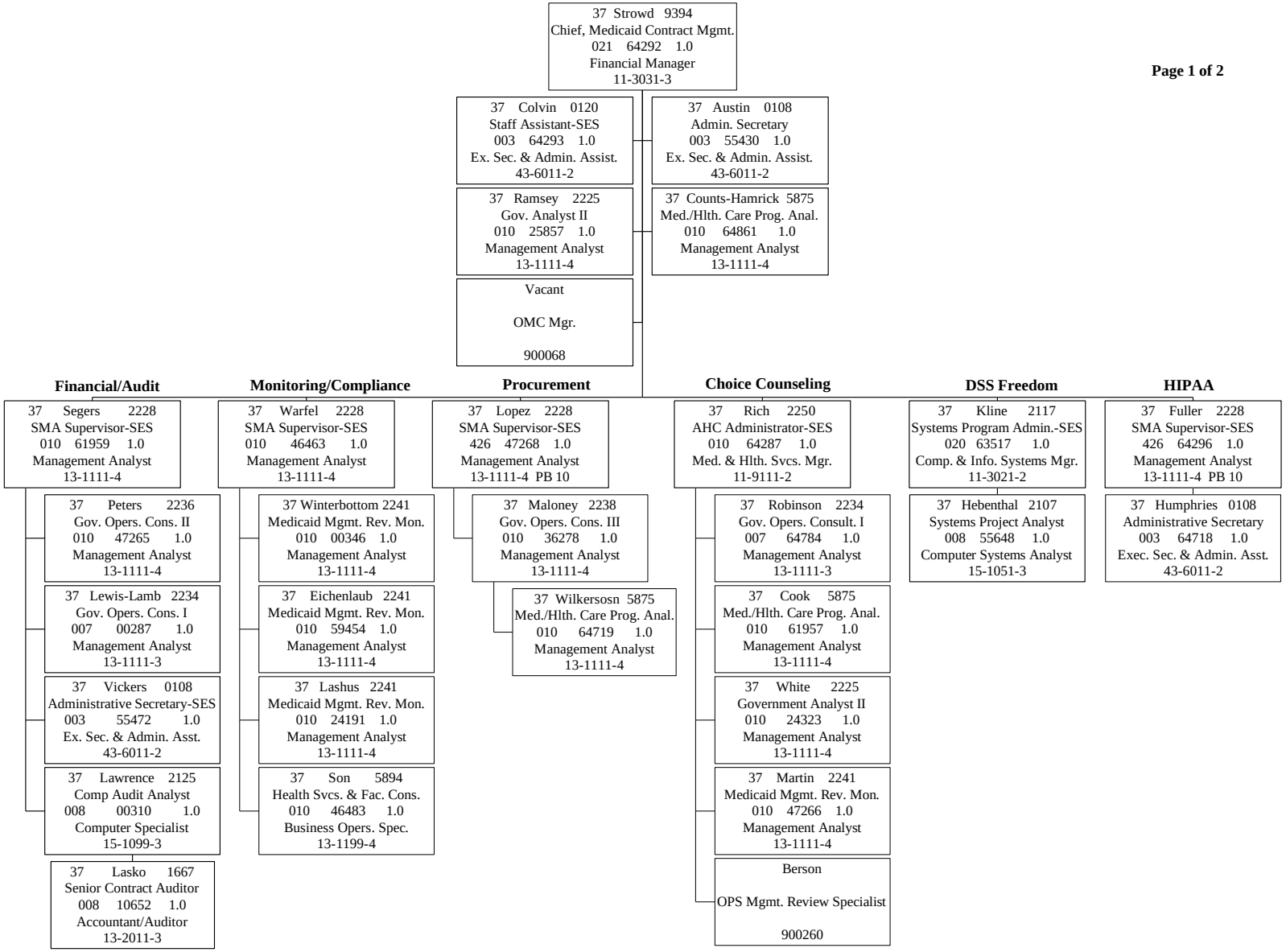
(Reference Only)

37 Abbott 2250
AHC Administrator-SES
020 57053 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

37 Hardin 5916 Program Admin.-SES 020 56423 1.0 Comm. & Soc. Svcs. Mgr. 11-9151-2	37 Smith 5916 Program Admin.-SES 020 24162 1.0 Comm. & Soc. Svcs. Mgr. 11-9151-2	37 Harris 5916 Program Admin.-SES 020 39483 1.0 Comm. & Soc. Svcs. Mgr. 11-9151-2	37 Meadows 5916 Program Admin.-SES 020 64277 1.0 Comm. & Soc. Svcs. Mgr. 11-9151-2	37 Rhodes 2107 Sys. Proj. Analyst 008 61963 1.0 Computer Sys. Analyst 15-1051-3		
29 Daniels 5875 MHCP Analyst 010 64285 1.0 Management Analyst 13-1111-4	37 Muhammad 2238 Govt. Ops. Cons. III 010 64286 1.0 Management Analyst 13-1111-4	37 B. Young 5875 MHCP Analyst 010 63528 1.0 Management Analyst 13-1111-4	37 Mendie 5875 MHCP Analyst 010 22938 1.0 Management Analyst 13-1111-4	37 2238 Gov. Opers Consult III 010 25877 1.0 Management Analyst 13-1111-4	37 Jones-Garrett 5875 MHCP Analyst 010 64274 1.0 Management Analyst 13-1111-4	37 Richardson 0108 Admin. Secretary-SES 003 19525 1.0 Ex. Sec. & Admin. Assist. 43-6011-2
37 Tate 2238 Govt. Ops. Cons. III 020 46732 1.0 Gen. & Op. Mgr. 11-1021-2	37 5875 MHCP Analyst 010 64851 1.0 Management Analyst 13-1111-4	37 Schultz 5875 MHCP Analyst 010 48205 1.0 Management Analyst 13-1111-4	37 Holcomb 5875 MHCP Analyst 010 64843 1.0 Management Analyst 13-1111-4	37 Anthony-Davis 5312 Reg. Nursing Cons. 010 63527 1.0 Registered Nurse 29-1111-4	37 Reatherford 5875 MHCP Analyst 010 57052 1.0 Management Analyst 13-1111-4	Vacant OPS Med/Hlth. Care Prog. Anal. 900059
13 Rawlins 5875 MHCP Analyst 010 64852 1.0 Management Analyst 13-1111-4	37 Brothers 5875 MHCP Analyst 010 64853 1.0 Management Analyst 13-1111-4	37 Rinaldi 5875 MHCP Analyst 010 64844 1.0 Management Analyst 13-1111-4	37 Hengsebeck 5312 Reg. Nursing Cons. 010 19532 1.0 Registered Nurse 29-1111-4	37 Berg 5875 MHCP Analyst 010 64319 0.5 Management Analyst 13-1111-4	37 Debeaugrine 5875 MHCP Analyst 010 63489 1.0 Management Analyst 13-1111-4	Vacant OPS Registered Nurse Consult. 900058
37 Whaley 5875 MHCP Analyst 010 59048 1.0 Management Analyst 13-1111-4	37 Shaperson 0108 Admin. Secretary 003 64295 1.0 Ex. Sec. & Admin. Assist. 43-6011-2	Vacant OPS Senior Clerk 900191	Roberts OPS Senior Clerk 900192	37 Walker 5875 MHCP Analyst 010 64192 1.0 Management Analyst 13-1111-4	37 5875 MHCP Analyst 010 64592 1.0 Management Analyst 13-1111-4	
Dorceus OPS Med/Hlth. Care Prog. Anal. 900282	Vacant OPS Med/Hlth. Care Prog. Anal. 900129	Hermes OPS Med/Hlth. Care Prog. Anal. 900149	Vacant OPS Med/Hlth. Care Prog. Anal. 900135	37 Clarke 5875 MHCP Analyst 010 64828 1.0 Management Analyst 13-1111-4	37 0108 Admin. Secretary 003 46957 1.0 Ex. Sec. & Admin. Assist. 43-6011-2	
Eagle OPS Med/Hlth. Care Prog. Anal. 900233	Vacant OPS Med/Hlth. Care Prog. Anal. 900234	Vacant OPS Med/Hlth. Care Prog. Anal. 900139	Vacant OPS Project Director 900166	Stewart OPS Med/Hlth. Care Prog. Anal. 900283	37 Pinkston 5871 HSP Analyst 007 60627 1.0 Comm & Soc. Svcs. Spec. 21-1099-3	
Fields OPS Med/Hlth. Care Prog. Anal. 900284				Williams OPS Admin. Secretary 900222	37 Cornwell 5875 MHCP Analyst 010 31740 1.0 Management Analyst 13-1111-4	
				Smith OPS Med/Hlth. Care Prog. Anal. 900209		

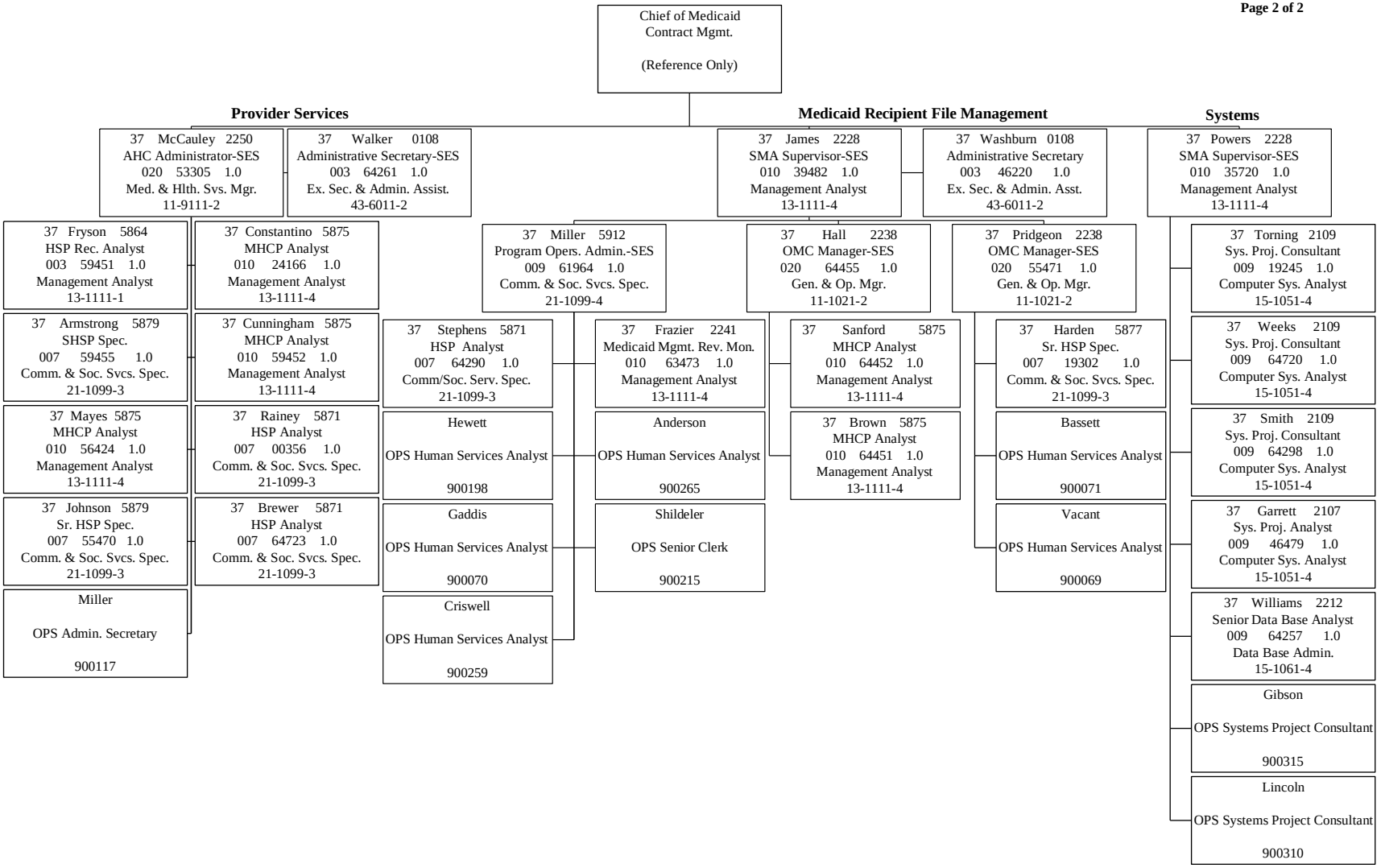
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Contract Management

Org. Level: 68 50 80 00 000
Revised Date: July 1, 2011
FTEs: 54 Positions: 54



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Contract Management

Org. Level: 68 50 80 00 000
Revised Date: July 1, 2011
FTEs: 54 Positions: 54



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Pharmacy Services

Org Level: 68-50-90-00-000
Revised Date: July 1, 2011
FTE: 18 Positions: 18

37 Wells 8951
Chief, Medicaid Pharmacy Svcs.
021 64589 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-3

37 Frost-Penn 0120
Staff Assistant-SES
003 64591 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

Vacant
OPS Pharm. Prog. Manager
900253

37 Elliott 2250
AHCA Administrator-SES
020 19357 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

37 Jones 5248
Sr. Pharmacist
011 61946 1.0
Pharmacist
29-1051-5

37 Craig 5248
Sr. Pharmacist
011 61947 1.0
Pharmacist
29-1051-5

37 Freeman 5879
Sr. Human Serv. Prog. Spec.
007 64289 1.0
Comm./Soc. Serv. Spec.
21-1099-3

37 McKnight 5875
Med./Hlth. Care Prog. Anal.
010 61966 1.0
Management Analyst
13-1111-4

37 Hamilton 2225
Gov. Analyst II
010 64811 1.0
Management Analyst
13-1111-4

37 Aldridge 2225
Gov. Analyst II
010 64783 1.0
Management Analyst
13-1111-4

OPS Administrative Secretary
900113

37 Coley 2250
AHCA Administrator-SES
020 61948 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

37 Fortson 5875
Med./Hlth. Care Prog. Anal.
010 61968 1.0
Management Analyst
13-1111-4

37 Rubin 5248
Sr. Pharmacist
011 64809 1.0
Pharmacist
29-1051-5

37 0108
Administrative Secretary
003 64785 1.0
Exe. Sec. & Admin. Asst.
43-6011-2

37 5248
Sr. Pharmacist
011 61955 1.0
Pharmacist
29-1051-5

37 Hebert 2225
Gov. Analyst II
010 64722 1.0
Management Analyst
13-1111-4

Brown-Blount
OPS Senior Pharmacist
900073

Epelbaum
OPS Senior Pharmacist
900174

Jasper
OPS Senior Pharmacist
900175

Lewis
OPS Senior Clerk
900196

Purvis
OPS Sr. Hum. Svcs. Prog. Spec.
900075

Rizkallah
OPS Senior Pharmacist
900177

Williams
OPS Health Care Pract.
900076

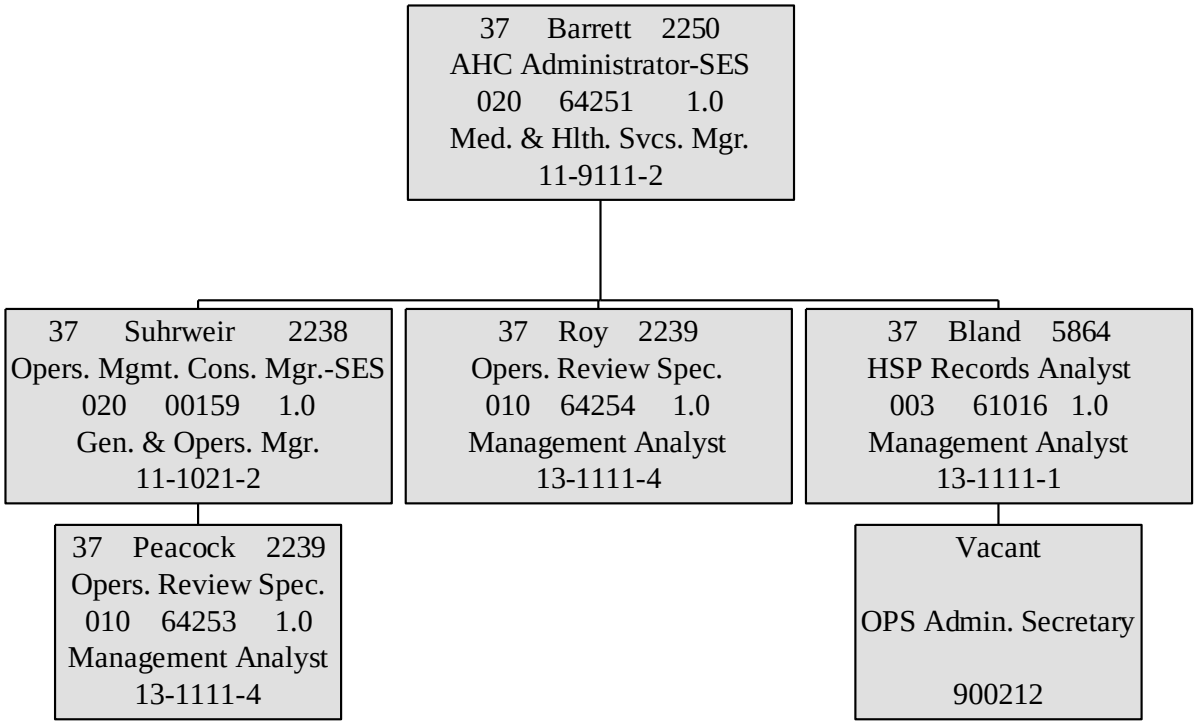
37 Donnelly 2225
Gov. Anal. II
010 64846 1.0
Management Analyst
13-1111-4

37 Moore 2225
Gov. Analyst II
010 61967 1.0
Management Analyst
13-1111-4

37 Alsentzer 5875
Med./Hlth. Care Prog. Anal.
010 19511 1.0
Management Analyst
13-1111-4

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid Third Party Liability

Org. Level: 68-50-70-00-000
Revised Date: July 1, 2011
FTEs: 5 Positions: 5



***Shaded positions report to org code 68-50-70-00-00-000 - Medicaid Third Party Liability**

AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET	FISCAL YEAR 2010-11 OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	20,801,954,676	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)	835,431,392	0
FINAL BUDGET FOR AGENCY	21,637,386,068	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 *	2,153,592	765.36	1,648,272,337	
Prepaid Health Plans - Families *	11,767,452	114.28	1,344,772,523	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	454,007	4,512.60	2,048,754,153	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	454,007	2,036.05	924,381,049	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * **Number of case months Medicaid program services purchased**	454,007	1,068.82	485,251,895	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	454,007	954.88	433,520,768	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	321,901	3,048.83	981,420,508	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	85,598	162.25	13,888,661	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	454,007	148.34	67,347,515	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months Medicaid program services purchased**	454,007	200.59	91,067,350	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	454,007	115.93	52,634,552	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	85,598	218.15	18,673,503	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case months Medicaid program services purchased**	269,038	464.10	124,861,622	
Elderly And Disabled/Fee For Service/Medipass - Hospice * **Number of case months Medicaid program services purchased**	454,007	481.61	218,655,110	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * **Number of case months Medicaid program services purchased**	85,598	2,490.88	213,214,509	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid program services purchased**	454,007	1,398.39	634,878,289	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	974,323	1,475.27	1,437,393,005	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	974,323	279.34	272,164,506	
Women And Children/Fee For Service / Medipass - Physician Services * **Number of case months Medicaid program services purchased**	974,323	616.13	600,313,635	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	974,323	577.40	562,569,317	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	1,037	172,942.85	179,341,734	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	779,578	213.53	166,464,758	
Women And Children/Fee For Service / Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	974,323	66.14	64,444,668	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months Medicaid program services purchased**	974,323	11.38	11,083,752	
Women And Children/Fee For Service / Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	974,323	114.00	111,077,585	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	779,578	71.58	55,804,419	
Women And Children/Fee For Service / Medipass - Clinic Services * **Number of case months and Medicaid program services purchased**	974,323	118.66	115,617,290	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid program services purchased**	974,323	425.54	414,615,149	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid program services purchased**	35,988	7,683.42	276,510,756	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid program services purchased**	35,988	3,308.87	119,079,644	
Medically Needy - Physician Services * **Number of case months Medicaid program services purchased**	35,988	1,790.61	64,440,447	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid program services purchased**	35,988	2,429.73	87,440,956	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	4,466	1,358.60	6,067,514	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	5,999	120.74	724,311	
Medically Needy - Patient Transportation * **Number of case months Medicaid program services purchased**	35,988	67.65	2,434,755	
Medically Needy - Case Management * **Number of case months Medicaid program services purchased**	35,988	45.27	1,629,353	
Medically Needy - Home Health Services * **Number of case months Medicaid program services purchased**	35,988	38.61	1,389,326	
Medically Needy - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	5,999	6.21	37,258	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	35,988	31,258.34	1,124,925,091	
Refugees - Hospital Inpatient * **Number of case months Medicaid program services purchased**	4,400	501.99	2,208,755	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services purchased**	4,400	84,814.87	373,185,441	
Refugees - Physician Services * **Number of case months Medicaid program services purchased**	4,400	588.98	2,591,504	
Refugees - Hospital Outpatient * **Number of case months Medicaid program services purchased**	4,400	362.78	1,596,221	
Refugees - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	540	319.93	172,763	
Refugees - Patient Transportation * **Number of case months Medicaid program services purchased**	4,400	7.49	32,964	
Refugees - Case Management * **Number of case months Medicaid program services purchased**	4,400	19.19	84,456	
Refugees - Home Health Services * **Number of case months Medicaid program services purchased**	4,400	20.38	89,676	
Refugees - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	540	7.81	4,220	
Refugees - Other * **Number of case months Medicaid program services purchased**	4,400	330.80	1,455,503	
Nursing Home Care * **Number of case months Medicaid program services purchased**	75,276	38,116.10	2,869,227,611	
Home And Community Based Services * **Number of case months Medicaid program services purchased**	87,598	12,193.07	1,068,088,204	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * **Number of case months Medicaid program services purchased**	714	163,294.30	116,592,130	
Mental Health Disproportionate Share Program * **Number of case months Medicaid program services purchased**	720	94,023.37	67,696,826	
Long Term Care - Other * **Number of case months Medicaid program services purchased**	29,906	23,321.26	697,445,627	
Purchase Medikids Program Services * **Number of case months**	29,779	1,816.00	54,078,621	
Purchase Children's Medical Services Network Services * **Number of case months**	23,005	6,762.87	155,579,748	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	199,198	1,325.47	264,031,316	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial reviews conducted**	3,761	443.47	1,667,879	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of licensure/certification applications**	23,665	559.67	13,244,641	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys and complaint investigations**	43,506	987.88	42,978,890	
Health Standards And Quality * **Number of transactions**	2,784,324	1.38	3,829,280	
Plans And Construction * **Number of reviews performed**	4,684	1,306.14	6,117,963	
Managed Health Care * **Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys**	165	17,064.58	2,815,656	
Background Screening * **Number of requests for screenings**	209,012	4.60	961,394	
Subscriber Assistance Panel * **Number of cases**	491	1,891.67	928,808	
TOTAL			20,723,869,670	

SECTION III: RECONCILIATION TO BUDGET	
PASS THROUGHS	
TRANSFER - STATE AGENCIES	
AID TO LOCAL GOVERNMENTS	
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS	
OTHER	213,766,310
REVERSIONS	699,750,275
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	21,637,386,255

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

(1) Some activity unit costs may be overstated due to the allocation of double budgeted items.

(2) Expenditures associated with Executive Direction, Administrative Support and Information Technology have been allocated based on FTE. Other allocation methodologies could result in significantly different unit costs per activity.

(3) Information for FCO depicts amounts for current year appropriations only. Additional information and systems are needed to develop meaningful FCO unit costs.

(4) Final Budget for Agency and Total Budget for Agency may not equal due to rounding.

ACTIVITY ISSUE CODES SELECTED:

TRANSFER-STATE AGENCIES ACTIVITY ISSUE CODES SELECTED:

1-8:

AID TO LOCAL GOVERNMENTS ACTIVITY ISSUE CODES SELECTED:

1-8:

THE FOLLOWING STATEWIDE ACTIVITIES (ACT0010 THROUGH ACT0490) HAVE AN OUTPUT STANDARD (RECORD TYPE 5) AND SHOULD NOT:

*** NO ACTIVITIES FOUND ***

THE FCO ACTIVITY (ACT0210) CONTAINS EXPENDITURES IN AN OPERATING CATEGORY AND SHOULD NOT:
(NOTE: THIS ACTIVITY IS ROLLED INTO EXECUTIVE DIRECTION, ADMINISTRATIVE SUPPORT AND INFORMATION TECHNOLOGY)

*** NO OPERATING CATEGORIES FOUND ***

THE FOLLOWING ACTIVITIES DO NOT HAVE AN OUTPUT STANDARD (RECORD TYPE 5) AND ARE REPORTED AS 'OTHER' IN SECTION III: (NOTE: 'OTHER' ACTIVITIES ARE NOT 'TRANSFER-STATE AGENCY' ACTIVITIES OR 'AID TO LOCAL GOVERNMENTS' ACTIVITIES. ALL ACTIVITIES WITH AN OUTPUT STANDARD (RECORD TYPE 5) SHOULD BE REPORTED IN SECTION II.)

BE	PC	CODE	TITLE	EXPENDITURES	FCO
68200000	1602000000	ACT2160	HEALTH POLICY	11,134,684	
68200000	1602000000	ACT2170	STATE CENTER FOR HEALTH STATISTICS	225,901	
68500200	1602000000	ACT5210	MEDICAID FIELD OPERATIONS	30,337,404	
68500200	1602000000	ACT5220	MEDICAID PROGRAM ANALYSIS	7,530,252	
68500200	1602000000	ACT5230	MEDICAID PROGRAM DEVELOPMENT	56,799,061	
68500200	1602000000	ACT5240	THIRD PARTY LIABILITY	10,882,804	
68500200	1602000000	ACT5250	MEDICAID CONTRACTING	15,328,873	
68500200	1602000000	ACT5260	FISCAL AGENT CONTRACT	70,886,443	
68500200	1602000000	ACT5270	MEDICAID PROGRAM INTEGRITY	10,019,910	
68500200	1602000000	ACT5280	MEDICAID CHOICE COUNSELING	272,268	
68500200	1602000000	ACT5290	KIDCARE ADMINISTRATION AND SUPPORT	348,537	
68700700	1204020000	ACT7110	ORGAN AND TISSUE DONOR		
68700700	1205020000	ACT7150	HEALTH FACILITIES AND PRACTITIONER	173	

TOTALS FROM SECTION I AND SECTIONS II + III:

DEPARTMENT: 68	EXPENDITURES	FCO
FINAL BUDGET FOR AGENCY (SECTION I):	21,637,386,068	
TOTAL BUDGET FOR AGENCY (SECTION III):	21,637,386,255	
DIFFERENCE:	187-	
(MAY NOT EQUAL DUE TO ROUNDING)		

Schedule XIV
Variance from Long Range Financial Outlook

Agency: Agency for Health Care Administration **Contact: Michele Tallent**

Article III, Section 19(a)3, Florida Constitution, requires each agency Legislative Budget Request to be based upon and reflect the long range financial outlook adopted by the Joint Legislative Budget Commission or to explain any variance from the outlook.

1) Does the long range financial outlook adopted by the Joint Legislative Budget Commission in September 2011 contain revenue or expenditure estimates related to your agency?

Yes [X] No [ ]

2) If yes, please list the estimates for revenues and budget drivers that reflect an estimate for your agency for Fiscal Year 2012-2013 and list the amount projected in the long range financial outlook and the amounts projected in your Schedule I or budget request.

	Issue (Revenue or Budget Driver)	R/B*	FY 2012-2013 Estimate/Request Amount	
			Long Range Financial Outlook	Legislative Budget Request
a	Medicaid	B	$21.1 Billion ($5,229.7 million GR)	
b				
c				
d				
e				
f				

3) If your agency's Legislative Budget Request does not conform to the long range financial outlook with respect to the revenue estimates (from your Schedule I) or budget drivers, please explain the variance(s) below.

The Medicaid budget is based on the Social Service Estimating Conference and is not included in the LBR.

* R/B = Revenue or Budget Driver

Administration and Support Schedules

Administration and Support

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Administrative Trust Fund
Budget Entity: 68200000
LAS/PBS Fund Number: 2021

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	**3,651,832**	(A)		**3,651,832**
ADD: Other Cash (See Instructions)	**4,542**	(B)		**4,542**
ADD: Investments		(C)		**0**
ADD: Outstanding Accounts Receivable	**2,094,320**	(D)		**2,094,320**
ADD: _____		(E)		**0**
Total Cash plus Accounts Receivable	**5,750,695**	(F)	**0**	**5,750,695**
LESS: Allowances for Uncollectibles		(G)		**0**
LESS: Approved "A" Certified Forwards	**2,919,785**	(H)		**2,919,785**
Approved "B" Certified Forwards		(H)		**0**
Approved "FCO" Certified Forwards		(H)		**0**
LESS: Other Accounts Payable (Nonoperating)	**2,823,272**	(I)		**2,823,272**
LESS: Payables not Certified Forwards	**4,160**			**4,160**
LESS: Current Compensated Absences Liability	**3,478**	(J)		**3,478**
Unreserved Fund Balance, 07/01/11	**0**	(K)	**0**	**0** **

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Administrative Trust Fund
Budget Entity: Department Level
LAS/PBS Fund Number: 2021

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	**3,651,832.38**	(A)		**3,651,832.38**
ADD: Other Cash (See Instructions)	**4,542.30**	(B)		**4,542.30**
ADD: Investments		(C)		-
ADD: Outstanding Accounts Receivable	**2,094,319.96**	(D)		**2,094,319.96**
ADD: _____		(E)		-
Total Cash plus Accounts Receivable	**5,750,694.64**	(F)	-	**5,750,694.64**
LESS: Allowances for Uncollectibles		(G)		-
LESS: Approved "A" Certified Forwards	**2,919,784.70**	(H)		**2,919,784.70**
Approved "B" Certified Forwards		(H)		-
Approved "FCO" Certified Forwards		(H)		-
LESS: Other Accounts Payable (Nonoperating)	**2,823,271.66**	(I)		**2,823,271.66**
LESS: Payables not Certified Forwards	**4,160.41**			**4,160.41**
LESS: Compensated Absences Liability	**3,477.87**	(J)		**3,477.87**
Unreserved Fund Balance, 07/01/11	**(0.00)**	(K)	-	**(0.00)** **

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**

Trust Fund Title: **Administrative Trust Fund (BE 68200000)**

LAS/PBS Fund Number: **2021**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**0.00**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:		(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**0.00**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

Health Care Services Schedules

Children Special Health Care

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: **Agency for Health Care Administration**
Trust Fund Title: **Tobacco Settlement Trust Fund**
Budget Entity: **68500100**
LAS/PBS Fund Number: **2122**

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**125,017**	(A)		**125,017**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)		**0**	
ADD: _____		(E)		**0**	
Total Cash plus Accounts Receivable	**125,017**	(F)	**0**	**125,017**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards		(H)		**0**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**125,017**	(I)		**125,017**	
LESS: Payables not Certified Forwards				**0**	
LESS: Current Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/11	**0**	(K)	**0**	**0**	**

Notes:

***SWFS = Statewide Financial Statement**

****** **This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Tobacco Settlement Trust Fund (68500100)**
LAS/PBS Fund Number:	**2122**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**0.00**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:		(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**0.00**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Grants and Donation Trust Fund
Budget Entity: 68500100
LAS/PBS Fund Number: 2339

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	**1,583,322**	(A)		**1,583,322**
ADD: Other Cash (See Instructions)		(B)		**0**
ADD: Investments		(C)		**0**
ADD: Outstanding Accounts Receivable		(D)		**0**
ADD: _____		(E)		**0**
Total Cash plus Accounts Receivable	**1,583,322**	(F)	**0**	**1,583,322**
LESS: Allowances for Uncollectibles		(G)		**0**
LESS: Approved "A" Certified Forwards	**7,931**	(H)		**7,931**
Approved "B" Certified Forwards		(H)		**0**
Approved "FCO" Certified Forwards		(H)		**0**
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**
LESS: Payables not Certified Forwards				**0**
LESS: Current Compensated Absences Liability		(J)		**0**
Unreserved Fund Balance, 07/01/11	**1,575,391**	(K)	**0**	**1,575,391** **

Notes:

***SWFS = Statewide Financial Statement**

****** **This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Grants and Donation Trust Fund (68500100)**
LAS/PBS Fund Number:	**2339**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**1,575,391**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**1,575,391**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**1,575,391**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Medical Care Trust Fund
Budget Entity: 68500100
LAS/PBS Fund Number: 2474

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**23,013,542**	(A)		**23,013,542**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)		**0**	
ADD: Other Loans and Notes Receivable		(E)		**0**	
Total Cash plus Accounts Receivable	**23,013,542**	(F)	**0**	**23,013,542**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**17,611,556**	(H)		**17,611,556**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**1,697,995**	(I)		**1,697,995**	
LESS: Payables not Certified Forwards	**77,927**			**77,927**	
LESS: Deferred Revenues		(J)		**0**	
Unreserved Fund Balance, 07/01/11	**3,626,064**	(K)	**0**	**3,626,064**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Medical Care Trust Fund (68500100)**
LAS/PBS Fund Number:	**2474**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**3,626,064**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**3,626,064**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**3,626,064**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Executive Direction and Support Services

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Grants and Donation Trust Fund
Budget Entity: 68500200
LAS/PBS Fund Number: 2339

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**193,578**	(A)		**193,578**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)		**0**	
ADD: _____		(E)		**0**	
Total Cash plus Accounts Receivable	**193,578**	(F)	**0**	**193,578**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**30,608**	(H)		**30,608**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards			**162,970**	**162,970**	
LESS: Current Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/11	**162,970**	(K)	**-162,970**	**0**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**
Trust Fund Title: **Grants and Donation Trust Fund (68500200)**
LAS/PBS Fund Number: **2339**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**162,970**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	162,970	(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**0**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**0**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**
Trust Fund Title: **Tobacco Settlement Trust Fund (68500200)**
LAS/PBS Fund Number: **2122**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**0.00**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:		(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**0.00**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Medical Care Trust Fund
Budget Entity: 68500200
LAS/PBS Fund Number: 2474

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**57,180,709**	(A)		**57,180,709**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**234,583**	(D)	**5,539,894**	**5,774,476**	
ADD: Other Loans and Notes Receivable		(E)		**0**	
Total Cash plus Accounts Receivable	**57,415,292**	(F)	**5,539,894**	**62,955,185**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**34,653,419**	(H)		**34,653,419**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**6,574,843**	(I)	**21,591,776**	**28,166,618**	
LESS: Payables not Certified Forwards	**118,436**			**118,436**	
LESS: Compensated Absences Liability	**16,712**	(J)		**16,712**	
Unreserved Fund Balance, 07/01/11	**16,051,882**	(K)	**(16,051,882)**	**0**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

Office of Policy and Budget - July, 2011

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Medical Care Trust Fund (68500200)**
LAS/PBS Fund Number:	**2474**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**16,051,882**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From	5,539,894	(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
Other Accounts Payable (Nonoperating)	21,591,776	(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**0**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**0**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

AGENCY FOR HEALTH CARE ADMINISTRATION
SCHEDULE IV-B
FOR
MONEY FOLLOWS THE PERSON (MFP) INFORMATION TECHNOLOGY SYSTEM

FOR

FISCAL YEAR 2012-13

State of Florida

The Florida Legislature *Governor's Office of Policy and Budget*

September 15, 2011

Table of Contents

I. Schedule IV-B Cover Sheet

Schedule IV-B Cover Sheet and Agency Project Approval	
Agency: Agency For Health Care Administration	**Schedule IV-B Submission Date:**
Project Name: Money Follows the Person (MFP) Grant	**Is this project included in the Agency's LRPP?** **___ Yes _X__ No**
FY 2012-13 LBR Issue Code: 3000120	**FY 2012-13 LBR Issue Title:** Money Follows the Person (MFP) Rebalancing Demonstration Grant
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): **GP Mendie, (850) 412-4252, gp.mendie@ahca.myflorida.com**	
AGENCY APPROVAL SIGNATURES	
I am submitting the attached Schedule IV-B in support of our legislative budget request. I have reviewed the estimated costs and benefits documented in the Schedule IV-B and believe the proposed solution can be delivered within the estimated time for the estimated costs to achieve the described benefits. I agree with the information in the attached Schedule IV-B.	
Agency Head: **Printed Name: Elizabeth Dudek**	**Date:**
Agency Chief Information Officer (or equivalent): **Printed Name: Scott Ward**	**Date:**
Budget Officer: **Printed Name: Michele Tallent**	**Date:**
Planning Officer: **Printed Name: GP Mendie**	**Date:**
Project Sponsor: **Printed Name: Beth Kidder**	**Date:**

Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	N/A
Cost Benefit Analysis:	N/A
Risk Analysis:	Scott Ward, Mike Magnuson, GP Mendie
Technology Planning:	Ken Walker, Mike Magnuson, GP Mendie
Project Planning:	Mike Magnuson, GP Mendie

II. Schedule IV-B Business Case (Under $2 million)

III. Schedule IV-B Cost Benefit Analysis (Under $2 million)

IV. Major Project Risk Assessment Component

The Major Project Risk Assessment Component identifies the risks faced by the project so the agency can enact appropriate mitigation strategies for managing those risks. **This Feasibility Study Component is required for *all* IT projects.**

A. Risk Assessment Tool
See Appendix E
Please note: Answers to questions in Appendix E regarding workload activities only represent efforts conducted in submitting the grant application.

Eight major project risk assessment areas:
- Strategic - Medium
- Technology - Medium
- Change Management - Low
- Communication - Medium
- Fiscal - Medium
- Project Organization - High
- Project Management - High
- Project Complexity - High

B. Risk Assessment Summary
The assessment determined the project to have a medium to high level of risk. This is likely due to the level of inter-agency and stakeholder coordination required for successful implementation. The results of the Project Risk Assessment tool can be viewed in Appendix E.

As presented in Appendix B, the grant funds awarded to the State required the submission of an operational protocol to the Centers for Medicare and Medicaid Services (CMS) for the administration of the program prior to the award. This included letters of support from many stakeholders.

This project is to build a system, which would allow for the tracking and reporting of the participants in the program. This will enable providers and other stakeholders the ability to communicate and ultimately reduce the same program risk by providing a standard infrastructure; thereby reducing program complexity.

Further, the Agency's Division of Medicaid has operated on a standard project management methodology for several years and has successfully implemented large-scale projects, such as implementation of the Medicaid Reform Pilot done in 2006. This methodology is complimented by the Division of Information Technology's Information System Development Methodology (ISDM), which has been in use since Fiscal Year (FY) 2009-10. Agency project management staff with

experience managing projects involving multiple area offices, such as the 2006 Medicaid Reform Pilot, will help mitigate some of the risk due to project complexities.

V. Technology Planning Component

Technology Planning Section	$1-1.99M	$2 – 10 M		> $10 M
		Routine upgrades & infrastructure	Business or organizational change	
Current Information Technology Environment		X	X	X
Proposed Solution Description	X	X	X	X
Capacity Planning	X	X	X	X
Analysis of Alternatives	X	X	X	X

A. Proposed Solution Description

1. Summary description of proposed system

The proposed information technology infrastructure will assist the State in streamlining data collection and tracking, fostering accountability, and monitoring program operations. This infrastructure will benefit the State in working with Managed Care Organizations (MCO's) on encounter data reports for the services delivered to MFP individuals under the managed care long term care program. The system will integrate and communicate with multiple State agencies (Department of Elder Affairs, Department of Health, Department of Children and Families) databases and assist in increasing data driven quality monitoring capabilities and quality improvement activities.

The infrastructure benefits include, but are not limited to the following:

- Ability to track and generate an alert regarding a resident's length of nursing home stay (Medicaid & non-Medicaid) to facilitate the identification of each eligible individual's funding source (60 days-Proviso; 90 Medicaid days-MFP)
- Tracking individuals at every transition phase (such as number of individuals identified for transition during the month) for efficient program operations
- Ability to generate programmatic and financial reports required for the federally approved grant
- Availability of access from any authorized computer terminal, with secure web-based capabilities. This will be critical for managed care organizations to submit transition information to AHCA for tracking.
- Possibility of enabling electronic submission and approval of invoices, tracking and paying for MFP supplemental services (e.g. utility deposits)
- Efficient tracking of savings from moving recipients to a less costly care setting
- The Agency and Department of Elder Affairs are co-defendants in a Federal class action lawsuit (Lee v. Dudek) that alleges the State has unfairly institutionalized Medicaid recipients in nursing homes. The State

is continuing to vigorously defend this lawsuit. It is critical that the State be able to document, with data, the successes in moving recipients to less restrictive settings.

2. Resource and summary level funding requirements for proposed design and development of the MFP information technology system is presented below:

   FY 2012-13 Non-Recurring IT Cost Estimate: $1,384,387
   Source of Funds: Medical Care Trust Fund

3. The system will integrate and communicate with multiple State partner agencies (Department of Elder Affairs, Department of Health, Department of Children and Families) databases and assist in increasing data driven quality monitoring capabilities and quality improvement activities. This information technology system will greatly enhance Florida's operation of the MFP program and the achievement of the Agency's long term care rebalancing goals, compliance with grant reporting requirements as well as assistance in quality improvement, cost effectiveness efforts and evidence-based best practices. The system is also intended to facilitate the following:
   - A web-based infrastructure that supports streamlining and coordinated point of entry functions;
   - The identification, assessing, and tracking of potential transition candidates as well as individuals who have transitioned in the community across service providers (while meeting Federal privacy and confidentiality requirements);
   - Support financing and efficient budgetary tracking structure for MFP operations;
   - A web-based system with applications to support the program processes that are individual-centered and allow for measurement of participant outcomes;
   - An integrated system that accommodates the business needs of multiple organizations that provide services to the same target populations.

B. Capacity Planning
   - The system is expected to track approximately 3,000 individuals and/or transactions annually.
   - It is expected to be used by multiple partner agencies and numerous stakeholders with limited access.
   - The Agency will administer and maintain the system and it will be used by more than a dozen Agency staff managing designated MFP proposed waivers.
   - The infrastructure will be beneficial to the State in working with MCO's on encounter data reports for the services delivered to MFP individuals.

C. Analysis of Alternatives
   - Currently, this is not a function of the fiscal agent, Florida Medicaid Management Information System (FMMIS).

- Current system of tracking Nursing Home Transition program is manual (Excel spreadsheets) and not a viable alternative for increased volume and need for coordination for efficient program operations.
- Too specialized for off-the-shelf solution and requires input through web services from partnering agencies and stakeholders.
- Two meetings were held in the Fall of 2010 with partner agencies responsible for much of the data to be input into the new solution. During these meetings, the sources of data were diagramed and a list of common fields and specifications identified. This diagram can be seen in Appendix A. Coordination with Versa Regulation, which harbors the licensure information on Long-Term Care facilities, was later considered as necessary and budgeted in the solution.

VI. Project Management Planning Component

Project Management Section	$1-1.99 M	$2 – 10 M		> $10 M
		Routine upgrades & infrastructure	Business or organizational change	
Project Charter	X	X	X	X
Work Breakdown Structure	X	X	X	X
Project Schedule	X	X	X	X
Project Budget	X	X	X	X
Project Organization			X	X
Project Quality Control			X	X
External Project Oversight			X	X
Risk Management			X	X
Organizational Change Management			X	X
Project Communication			X	X
Special Authorization Requirements			X	X

A. Project Charter
The Money Follows the Person grant received from the US Department of Health and Human Services - Centers for Medicare and Medicaid Services (CMS) required the submission of a grant operational protocol, which defines the relationships between the Agency and its stakeholders. See Appendix B.

B. Work Breakdown Structure
See Appendix C

C. Resource Loaded Project Schedule
See Appendix C and D

D. Project Budget
See Appendix D for the breakdown of estimated contractual needs for the technical solution design and development.

E. Project Organization
The Agency operates with two levels of project initiation governance and will develop a project specific governance committee upon approval of funds. This body will also act as the final tier for change control.

VII. Appendices

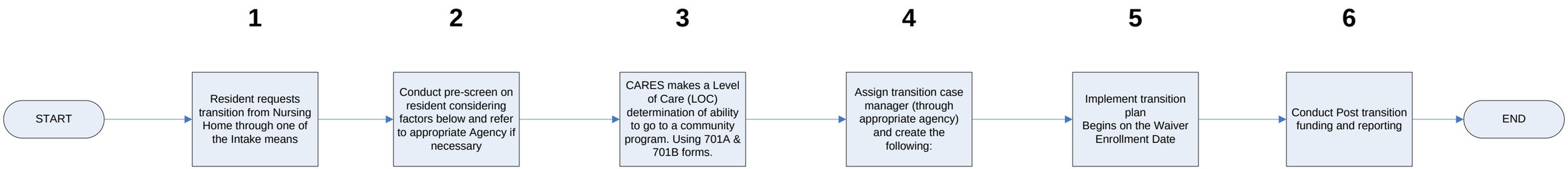
Number and include all required spreadsheets along with any other tools, diagrams, charts, etc. chosen to accompany and support the narrative data provided by the agency within the Schedule IV-B.

Appendix A: Nursing Home Transition Process and Databases
Appendix B: MFP Grant Operational Protocol
Appendix C: Project Milestone Schedule
Appendix D: Project Budget Estimates – Design and development of the technical solution.
Appendix E: Risk Assessment Tool

Date Prnted: Thursday, September 15, 2011

Nursing Home Transition
High Level Process
11/9/2010

Draft



Intake Avenues
- Self, friend or family (MDS)
- Advocacy groups/community organizations
- Long-Term Care Ombudsman
- Centers for Independent Living (CIL)
- Aging Resource Centers
- Elder Helpline
- Lead Agencies
  - DOEA (CIRTS)
  - DCF (ASIS)
  - DOH (RIMS)
- Nursing home discharge planners
- CARES
- Clearinghouse on Disability Information

Prescreen Considerations
- NH Date of Admission
- Length of stay in NH
- Medicaid enrollment status
- Community resource assessment
- Resident demographics

TCM Tasks
- Create needs assessment
- Develop care plan of services
- Conduct client consultation to explain services and verify plan
- Complete 2515 form and submit
- Receive DCF approval (FL System)

Implementation Triggers
- DCF approval
- Waiver enrollment date determined
- NH Discharge date determined

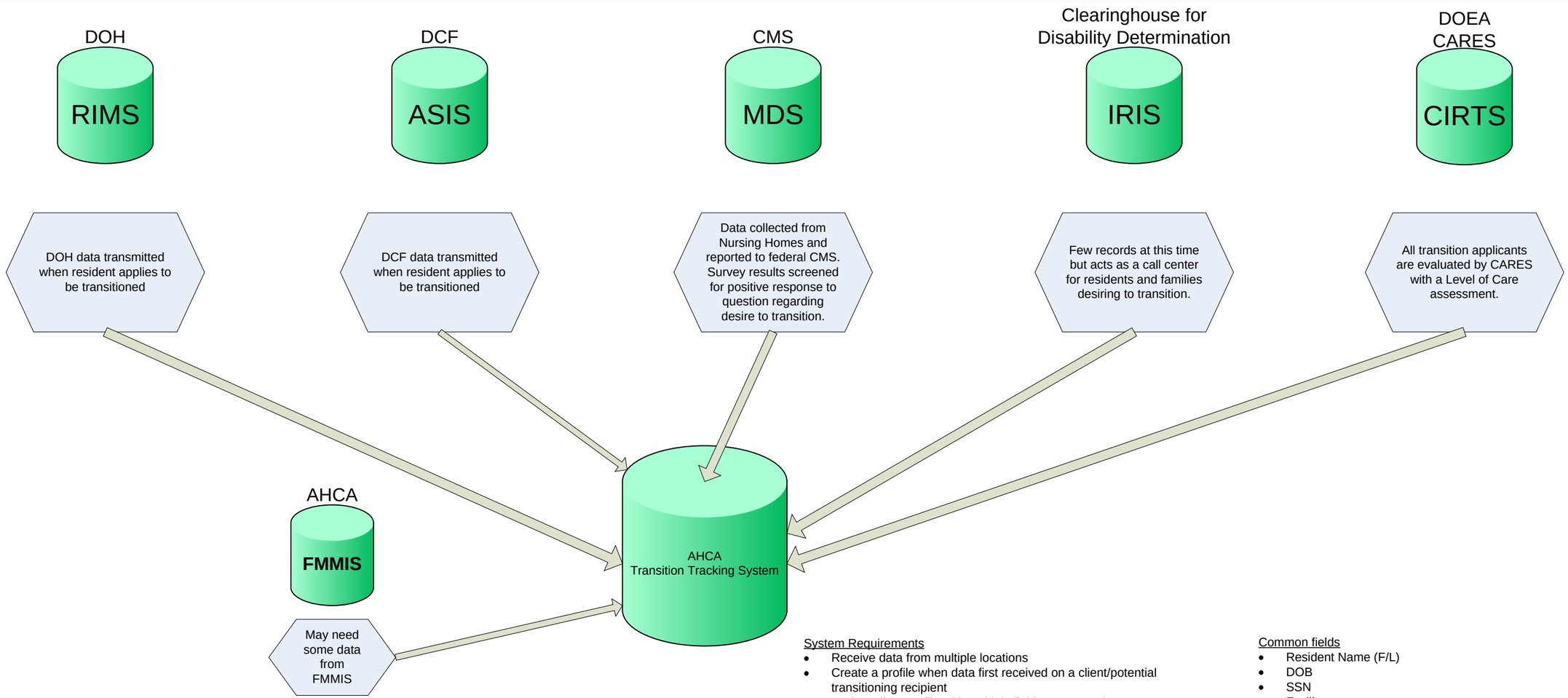
Post transition activities/needs
- Reimbursement of supplemental services from Medicaid
- Quarterly Reporting to CMS
- Funding/Reimbursement from CMS

Acronyms

MFP - Money Follow the Person
TCM - Transition Case Manager
CIL - Center for Independent Living
TBI - Traumatic Brain Injury
DOEA – Elder Affairs
DCF – Dept. Children and Families
DOH – Dept. of Health
LOC - Level of Care
CARES
2515 – form for NH transition waiver approval
D/C - Discharge
MDS - Minimum Data Set

Transition Tracker
Contributing Data Systems & basic functionality

Draft



Outstanding items:
- All data fields not available at this time. Each system must be enhanced for additional data fields.
- Review of Data Use Agreements
- Decision needs to be made on frequency of data push

System Requirements
- Receive data from multiple locations
- Create a profile when data first received on a client/potential transitioning recipient
- Update client profile with multiple fields, status updates, etc
- Ability to accept daily feeds from each source database
- Some reconciliation logic may need to be built for proper sequencing of data coming in but the team opts for all data to be stored and no overrides of data
- Not a billing system

Reporting/Querying
- Ad hoc query capabilities
- Canned report creation/sharing

Security/Access
- HIPPA Compliance
- Ability to create different access levels to different data
- Accessibility from all data feed (less Clearinghouse and MDS) organizations (all within state system)
- Ability for outside users to run reports
- AHCA Administrator overrides of data

Common fields
- Resident Name (F/L)
- DOB
- SSN
- Facility
- Medicaid ID
- Clinical and Social Assessment Information
- Dates of applications, assessments, transitions, discharge, etc.

MONEY FOLLOWS THE PERSON DEMONSTRATION
FLORIDA OPERATIONAL PROTOCOL

TABLE OF CONTENTS

PROJECT ABSTRACT

FLORIDA MONEY FOLLOWS THE PERSON GRANT APPLICATION

Florida's MFP Nursing Home Transition Initiative is the voluntary transfer of eligible Medicaid beneficiaries from a nursing home to a community setting. Through the MFP Rebalancing Grant Demonstration, the Agency for Health Care Administration (AHCA) and its partners estimate annual transition of 1,703 elders and disabled adults to community settings of their choice. To achieve our MFP goals and benchmarks, Florida seeks $44,211,067.91 over five years for waiver and transition services and administrative costs.

In addition to comprehensive services through its transition-designated 1915(c) home and community based waiver, Florida proposes to provide certain MFP demonstration and supplemental services to increase opportunities for individuals to transition and live safely in the community. Also, the state will provide an online searchable database to assist with locating affordable housing options and develop a comprehensive web-based infrastructure for data collection, tracking and reporting. The system will integrate and communicate with multiple state agency databases and help increase data driven quality monitoring capabilities and quality improvement activities

Partnering with AHCA in this demonstration are the Department of Elder Affairs, Department of Health, Department of Children and Families, Supportive Housing Coalition, and Florida Housing Finance Corporation. The effort is supported by stakeholder organizations. Florida Medicaid, a division of AHCA, will serve as the lead organization for administering the demonstration program.

A. Project Introduction
1. Organization and Administration
a. Part #1 - Systems Assessment and Gap Analysis

Florida has been working since the 1980s to shift the emphasis from institutional care to community care for its most vulnerable populations. Initial focus was on closing the Florida Sunland centers, which served individuals with developmental disabilities. Subsequent efforts have focused on diversion--working to prevent institutional placement in favor of community-based care for elders, adults with disabilities, and children. Florida's proposed transition project takes on a more challenging population--individuals who have been living in institutional settings for at least 90 days, as specified in the Money Follows the Person Rebalancing Demonstration project requirements.

Florida has been a leader in community-based initiatives. In 1982, the state implemented its Developmental Services waiver, the Aged and Disabled Adult waiver and the Channeling waiver for frail elders. These were followed by the Frail Elder Project in 1987, the Assisted Living for the Elderly (ALE) waiver in 1995, and the Nursing Home Diversion program in 1998.

Florida's strategy related to nursing home care has included controlling the growth and use of nursing home beds, tort reform, and a phased increase of nursing home staffing ratios that exceed federal requirements. Since 2001, Florida has had a moratorium on granting new certificates of need for nursing facilities. This has contributed to higher occupancy rates in existing facilities and to the overall leveling off in growth of the nursing facility population.

In 2000-01 Medicaid served 81,116 people in institutions and 50,167 in home and community-based settings. In 2009-10 the number being served in the community is at 81,754 versus 79,109 in institutional settings. Figures include nursing homes and intermediate care facilities for the developmentally disabled (ICF/DD). The number of people served in community care exceeded the number served in institutional care for the first time in 2008-09. (See chart in Attachment A.)

Florida has a large assisted living component. There are three add-on licenses for assisted living facilities (ALF) seeking to provide higher levels of care: extended congregate care, limited nursing care, and limited mental health care. Home and community-based services provided under various waivers are currently available to ALF residents over age 60. In addition, the 2010 legislature provided authority to lower the ALE waiver age requirement to age 18. Florida is working on a waiver amendment and administrative rule update to implement that change. The state has supported expanded assisted living opportunities for elders and individuals with disabilities, community-based care for individuals with developmental disabilities, a variety of managed care options, and a consumer-directed care program for all populations.

When Florida originally began moving people from institutions into the community, its human service agencies were housed in a single, integrated entity, the Department of Health and Rehabilitative Services. Beginning in the late 1980s, that department was disassembled to create the following separate entities: Department of Health-DOH (brain/spinal cord injury); Department of Children and

Families-DCF (mental health, economic services, and adult protective services); Department of Elder Affairs-DOEA; Agency for Health Care Administration-AHCA (Medicaid and facility regulation); Agency for Persons with Disabilities-APD (developmental disabilities). Vocational Rehabilitation-VR was moved to the Department of Education.

Florida uses its Comprehensive Assessment and Review for Long Term Care Services (CARES) program through the DOEA to perform level of care determinations for individuals seeking Medicaid nursing home and waiver services. DOEA also operates a Client Information Registration and Tracking System (CIRTS) that includes certification and recertification data for a wide array of services. The two databases are used in concert with Medicaid claims data to provide information about consumer characteristics and use of services. Developmental services assessments are performed separately through contracts with APD.

Between 2001 and 2004, Florida received $3.7 million in funding through Real Choice System Change grants. The 2001 grant focused on operational linkages among state agencies and service providers, streamlining service delivery, creating a single contact point for the public, and developing community networks. Other grants have gone to DCF, which received an Independence Plus Award for the Florida Freedom Initiative, to APD for a quality assurance and quality improvement initiative, and to DOEA for aging and disability resource center development.

Today Florida Medicaid has fourteen 1915(c) waivers related to home and community-based care. As required, participants are served first by Medicaid State

Plan services and then by waiver services. Each waiver has a different set of services tailored to the needs of the waiver participants.

New home and community based waiver programs and state plan services authorized by the Legislature since 2000 include:

- Adult Cystic Fibrosis Waiver – 2001
- Adult Day Health Care Waiver – 2002
- Familial Dysautonomia Waiver – 2005
- Assistive Care Services (state plan) – 2001
- Program of All-inclusive Care for the Elderly (PACE) (state plan) – 2002:

In addition to the original PACE site authorized by the 2002 Florida legislature, authority and funding have been received to expand the numbers of individuals served by three additional PACE providers.

Florida's 14 HCBS waivers are funded through specific line items in the state's budget. Five state agencies serve as operating entities for the waivers. Sometimes the general revenue portion of the waiver is budgeted to the operating agency, while the federal matching share is budgeted to AHCA. Specific line items also exist for each State Plan service. It is possible to move funds between line items through a budget amendment process, although a number of rules govern what may be transferred, and it is not commonly done among long-term care programs. However, the 2009 and 2010 Florida Legislature provided authority for AHCA to transfer funds from the nursing home line item to four HCBS waivers to pay for HCBS waiver services necessary to transition individuals from nursing homes and maintain them in their homes or the community.

Since 2008, AHCA has worked with DOEA, DOH, DCF, and the Clearinghouse for Disability Information to improve Florida's nursing home transition process. An interagency workgroup meets monthly to discuss ways to increase transition opportunities. The workgroup developed a draft nursing home transition plan and recommended adding a nursing home transition case management service to the ADA, ALE, the Nursing Home Diversion (NHD), and the Traumatic Brain and Spinal Cord Injury (TBI/SCI) waivers. Waiver amendments have been approved by the Centers for Medicare and Medicaid Services (CMS) to add transition case management services to all four waivers. In addition, a special transition home modification service was approved for the TBI/SCI waiver.

During 2009, AHCA obtained a data use agreement (DUA) with CMS to help Florida identify individuals who have indicated on the minimum data set (MDS) survey that they would like to transition to the community. Florida is using this information to supplement the information the waiver state operating agencies have on individuals who have already contacted them to seek assistance with transition.

Florida offers a statewide program under a 1915(j) Self-Directed Personal Assistance Services State Plan Amendment. The program, called Consumer Directed Care Plus (CDC+), gives participants the opportunity to hire their own workers and vendors to help with daily needs such as bathing, dressing, housecleaning, home repairs, pest control, yard work and cooking. Other services are available if needed. To be eligible for CDC+, the consumer must be receiving services under one of the following HCBS waivers: Aged/Disabled Adult, Traumatic Brain and Spinal Cord Injury, or Developmental Disabilities. Funding for each consumer's individual

monthly CDC+ budget is based on the cost of services that consumer receives under the waiver program. This funding "follows" the consumer and provides the basis of the CDC+ budget plan. The monthly plan lists the workers, vendors and services the consumer has hired to provide for his/her needs. The consumer's paid workers may be family members, friends or commercial entities. Under CDC+ the consumer may also purchase certain items with cash or have a savings plan for larger purchases.

Under the program, a fiscal/employer agent (F/EA) holds the consumer's monthly Medicaid funds in an individual account. The F/EA pays the employees and vendors according to the rates listed in the consumer's budget plan. The F/EA also pays the required federal and state taxes. Each consumer chooses a trained consultant to assist with the program, but the consumer may also choose a family member or friend as representative to manage the budget plan and help with decisions. CDC+ is operated by the DOEA, APD, and DCF as partners.

There are 2,023 people participating in CDC+, and it is estimated that one to two institutional residents a year will transition to CDC+. Experience shows that people usually receive waiver services for a period before attempting self-directed care. Detailed information about Florida's CDC+ program is available at the DOEA web site at www.elderaffairs.state.fl.us and at the APD web site at http://www.apd.myflorida.com/cdcplus.

Through the MFP grant, individuals transitioning from institutions into home and community-based settings will have the choice to self-direct by enrolling in CDC+ through the participating waiver programs. Each transitioning recipient will

be choice counseled on options available in the community setting, and CDC+ will be part of those options.

If awarded the Money Follows the Person grant, Florida will continue to meet regularly with its waiver operating partners to ensure that the demonstration project is being implemented according to the requirements of the grant. Florida is in the process of enrolling the Centers for Independent Living (CIL) as transition case managers for the ADA waiver program. AHCA and its partner agencies will continue to meet regularly with the CILs to receive feedback on what is needed for a successful transition program. The feedback received from the CILs to date has contributed significantly to Florida's decision to add supplemental services such as security deposits and moving-related expenses to the grant proposal. Florida will continue to hold periodic public meetings to solicit input from provider organizations, advocacy groups, consumers and families, and other stakeholders throughout the implementation of the MFP grant. AHCA has recently begun holding regular meetings with affordable housing, ALF, and nursing home provider organizations to maintain open communication and address any challenges related to nursing home transition. See Section C-4 for more detail on stakeholder involvement.

AHCA has established a nursing home transition web site that contains information about nursing home transition opportunities and the MFP demonstration. During this past year, Florida established that a toll-free number staffed by the Clearinghouse on Disability Information is available for individuals requesting information and referral for nursing home transition. Letters were sent

to administrators of all Medicaid-enrolled nursing homes, notifying them of nursing home transition opportunities and the toll-free number. Posters and brochures were developed and distributed to individuals in nursing homes by CARES, the Long Term Care Ombudsman, the Aging and Disability Resource Centers, and AHCA's 11 Medicaid area offices.

Based on MDS data for the period April 1-September 30, 2010, Florida nursing homes assessed 128,010 individuals using the MDS survey. Of those, 7,291 met three criteria: they were admitted to the nursing home during this time period, they were not discharged during this period, and they expressed interest n returning to the community. Of the 7,291, only 1,595 had been in the nursing home for 90 days or longer, and 723 were Medicaid recipients. The state will make further determinations to exclude Medicare rehabilitation days before determining eligibility for MFP participation.

In the past 10 years Florida has transitioned an average of 390 people per year. This number represents people who lived in a nursing home for 60 days or more and were enrolled in a home and community-based waiver within 60 days of discharge from the nursing home.

Over the grant period Florida estimates it will transition 1,703 people who meet MFP requirements.

No additional legislation is needed to implement MFP in Florida beyond obtaining spending authority for the grant funds. No new Medicaid programs are needed to implement MFP.

Manuals for Florida Medicaid programs are available on the Internet at http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport.

b. Part #2 - Description of the Demonstration's Administrative Structure

The Agency for Health Care Administration (AHCA) is Florida's single state Medicaid agency. AHCA will oversee the MFP demonstration and will partner with DOEA, DOH, DCF, the Florida Supportive Housing Coalition (FSHC), and the Florida Housing Finance Corporation (Florida Housing) to offer additional services and supports to Medicaid recipients and enroll the people being transitioned into specific HCBS waiver programs. While APD is unable to participate as a full partner in the grant, all transition opportunities will be available to Medicaid beneficiaries living in APD-related institutions. Special memorandums of agreement will be developed to provide AHCA with authority for oversight of its partner agencies' operations related to the MFP grant.

The AHCA Secretary and the heads of its partner agencies are appointed by the Florida Governor. The AHCA Secretary has three deputies, one each for Administration, Health Quality Assurance, and Medicaid. The Deputy Secretary for Medicaid oversees six administrative bureaus and 11 field offices. Each bureau is headed by a chief responsible for the following:

- Contract Management – fiscal agent activities
- Health Systems Development – managed care and innovation in health care delivery systems
- Pharmacy Services – Medicaid's prescription drug program

- Program Analysis – financial planning, audit, and cost reimbursement
- Quality Management – project management and quality assurance
- Medicaid Services – State Plan and waiver programs

The Chief of the Bureau of Medicaid Services will oversee the MFP project, and the project director will work in a full-time position for AHCA.

The AHCA Bureau of Finance and Accounting will work with fiscal staff from partner agencies to track expenditures necessary to meet grant-reporting requirements. A work group is already meeting to establish a common database into which existing data collection and reporting systems will feed information related to MFP program operation.

See Attachment B for organization charts and the links to partner agencies.

2. Benchmarks

Florida is adopting the following annual benchmarks:

1. Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.
2. Increase the proportion of state Medicaid enrollment for HCBS to institutional care during each calendar year of the demonstration program.
3. Increase available and accessible supportive services for individuals who transition from nursing homes.
4. Increase the use of transition coordinators used to assist individuals in Medicaid find appropriate services and supports in the community.

5. Expansion to and improvement in health information technology. (See Attachment J for information on Florida's health information technology initiatives.)

B. Demonstration Implementation Policies and Procedures

1. Participant Recruitment and Enrollment

Florida's target MFP population is nursing home residents 18 years of age or older who have lived in the nursing facility a minimum of 90 days not including rehabilitation days. Nursing home placement in Florida requires a CARES assessment that determines whether the applicant actually needs nursing home care or can be served in a different environment. (See Attachment C for the assessment tool.) Included are questions designed to indicate whether the person is a potential candidate for transition to the community. In addition, outreach and recruitment materials will be developed to make people aware of transition opportunities. These may include posters, brochures, public service announcements, and group and individual consultation.

Service providers will be selected based on the age of the individual being transitioned and on the specific waiver program into which the individual is transitioning. The CILs are enrolling as Medicaid waiver providers and will be providing transition case management services.

Candidates for transition may be identified through referrals from any source, including:

- Self, friend or family

- Advocacy groups/community organizations
- Long-Term Care Ombudsman
- Centers for Independent Living (CIL)
- Aging Resource Centers
- Elder Helpline
- Lead Agencies
- Nursing home discharge planners
- CARES

Candidates may also be identified through analysis of databases containing information about nursing home and other institutional residents, including MDS section Q data.

Once potential transition candidates are identified, transition workers will arrange meetings with the candidates and their families/caregivers to discuss the possibility of transition and what is involved. Transition workers may be representatives from any of the partner agencies or their contractors, depending on how the process is structured among the partners. All materials used will be prior approved by the MFP project director.

Information provided will focus on:

- Educating and increasing awareness among nursing home residents and stakeholders about community alternatives to nursing home care.
- Providing persons interested in returning to the community with the appropriate contacts for obtaining additional information on what resources are available.

- Providing state agencies, advocacy groups, providers, and provider associations with program information via the AHCA website or training sessions/workshops.
- Publishing outreach materials in English, Spanish and Haitian Creole.
- Providing brochures to nursing homes through the Long-Term Care Ombudsman and made available for download on the AHCA website.
- Placing posters on bulletin boards in nursing homes, CILs, senior centers and other locations used by transition candidates and their families/caregivers. Posters will also be available for download on the AHCA website.
- Sending informational letters to nursing home administrators.
- Providing a central information website with links from partner agency sites that describe the nursing home transition program, frequently asked questions, links to partner agencies, contact information, program brochures and other informational materials.
- Airing public service announcements in broadcast and print media.
- Working with local media to get feature stories on the transition program.
- Sending information to stakeholder publications for use in newsletters and on web pages.

AHCA will make outreach materials available to the following entities for distribution:

- Long-Term Care Ombudsman (distribution of transition program materials to nursing home residents)

- Aging Resource Centers (ARC)/Area Agencies on Aging
- Lead Agencies
- Nursing Homes
- Centers for Independent Living
- Medicaid Field Offices
- CARES

The following entities are the primary contacts for information, referral and enrollment:

- Adults with disabilities, age 18-59 – DCF Adult Protective Services and DOH Brain and Spinal Cord Injury Program
- Elders, age 60 or older – DOEA, ARC, Elder Helpline, and CARES

The qualified institutional settings that individuals will be transitioning from are primarily nursing homes statewide. Florida will work with eligible individuals who express the desire to leave the nursing home, and will include individuals with mental illness, developmental disabilities, and dementia as nursing home transition candidates.

Transition case managers are responsible for assuring that transition candidates have been eligible for Medicaid at least one day before transition to the community. Transition case managers can assist with the Medicaid application, if necessary, and monitoring the eligibility date on FMMIS, the Florida Medicaid management information system and the 2515 waiver enrollment form.

As noted previously, Florida already uses a level-of-care determination for nursing home placement through the Department of Elder Affairs CARES team. This

tool will also be used to assess eligibility for transition. (See the assessment form in Attachment C.)

Individuals who complete 12 months of demonstration services and are readmitted to an institution for 90 consecutive days not counting rehabilitation days will be eligible for another 12 months of demonstration services depending on their circumstances and whether any barriers to a successful transition can be resolved. The transition case manager will identify and address any existing conditions that led to re-institutionalization in order to assure a sustainable transition.

During the plan of care development, the case manager will inform the client or representative about abuse, neglect and exploitation reporting. Florida has a statutorily required process for reporting and investigating abuse and neglect at all age levels. Residential facilities must post information on how to report allegations of abuse, neglect or exploitation to Florida's toll-free abuse reporting hotline operated by the DCF. The hotline telephone number on the information posters is: 1-800-96-ABUSE.

As mandated in Chapter 415, Florida Statutes, the DCF Adult Protective Services Office is responsible for providing services to detect and correct abuse, neglect, and exploitation of vulnerable adults who, because of their age or disability may be unable to adequately provide for their own care or protection. (Florida Statutes are available online at www.leg.state.fl.us/Statutes/index.) Everyone in the State of Florida is a mandatory reporter for abuse, neglect and exploitation. Florida law requires any person who knows or who has reasonable cause to suspect any abuse of vulnerable adults to report that information to the Florida Abuse Hotline. The following are ways in which a report may be made:

1. REPORT ONLINE
   - http://www.dcf.state.fl.us/programs/aps/Reporting.shtml
2. TELEPHONE: 1-800-962-2873
3. TDD (Telephone Device for the deaf): 1-800-453-5145
4. FAX: 1-800-914-0004

The Florida Abuse Hotline screens allegations of child and adult abuse and neglect to determine whether the information meets the criteria of an abuse report. If the criteria are met, a protective investigation is initiated to confirm whether there is evidence that abuse, neglect, or exploitation occurred; whether there is an immediate or long-term risk to the victim; and whether the victim needs additional services to safeguard his/ her well being.

In addition, Adult Protective Services helps vulnerable adults to live dignified and reasonably independent lives in their own homes or in the homes of relatives or friends so that they may be assured the least restrictive environment suitable to their needs (See section 410.602, Florida Statutes.).

Waiver case managers are responsible for providing information and training on accessing Florida's abuse, neglect and exploitation hotline. An informational letter is provided to clients or representatives during the plan of care development. Because the case manager is in at least monthly contact with the client or representative, information and training is ongoing, and clients may contact their case manager at any time. Case management agencies providing services to HCBS waiver clients must maintain a 24-hour, 7-day-a-week on-call staff with the capability for emergency services referrals, including those from Adult Protective Services workers.

2. Informed Consent and Guardianship

Clients and caregivers/ representatives are counseled on long-term care options and services available during the CARES assessment. This assessment is mandatory for

any individual enrolling in any program based on institutional policy or the Medicaid Institutional Care Program (ICP). ICP covers nursing home care; hospice; and home and community-based service programs. The CARES assessor provides the Informed Consent form when the client or designee selects a waiver program. The form is executed and maintained in the CARES program files and the individual's case file. The client's case manager again discusses the meaning of the form with the client or designee when the plan of care is developed. (See Attachment D for the Informed Consent form.)

For the majority of participants the state's criteria for who can provide informed consent is based on the client's own decision. In the waiver programs, the competent individual may determine who will make the program decisions, with them or for them. It is generally a family member who is in the care-giving role. If the client is legally incompetent, the client's designated guardian must sign the informed consent and plan of care. A copy of the legal guardianship paperwork is maintained in the client's case file.

The CARES assessor is responsible for providing all information to the client regarding the transition process, program options and waiver services available to the client. The case manager also discusses the various program options with the client. All clients found to need the institutional level of care have the right to choose between receiving services in an institutional setting or receiving services through a waiver program. Clients also have the right to request a copy of any completed assessment forms.

In Florida legal guardianship is governed under the rules and processes in Chapter 744, Florida Statutes. The basis for the guardianship and the type of guardianship for a client are noted on the paperwork provided by the court, or attorney representing the

client, and maintained in the client file. The case manager is aware of the guardianship arrangements and knows the relationship and interaction the guardian has with the client. The case manager informs the guardian on health and welfare issues of the client and keeps in close contact.

Informal representatives or designees of the client are not covered by a formal policy in the waiver programs. The informal designee provides day-to-day care giving and is in constant interaction with the client. The case manager works with the informal representative or designee on services and issues regarding the client.

3. Outreach/Marketing/Education

Information communicated to enrollees, providers and staff will focus on:

- Educating and increasing awareness among nursing home residents and stakeholders about community alternatives to nursing home care.
- Providing persons interested in returning to the community with the appropriate contacts for obtaining additional information on what resources are available.
- Providing state agencies, advocacy groups, providers, and provider associations with program information via the Agency's website or training sessions/workshops.

Types of media to be used will include:

- Brochures: Provided to nursing home residents by Long-Term Care Ombudsman and available for download on the AHCA website.
- Posters: Placement on bulletin boards in nursing homes, CILs, and senior centers. Posters will also be available for download on the AHCA website.

- Letters: An informational letter will be sent to nursing home administrators.
- Website: An AHCA website with links to and from all partner agencies. It will include a description of the nursing home transition program, frequently asked questions, links to partner agencies, contact information, program brochures and other informational materials.
- Stakeholder Publications: Transition articles published in newsletters or on web pages of stakeholder groups.
- Media Relations: Work with local media to get print and electronic coverage of transition opportunities.
- Public Service Announcements: Print and electronic public service ads to encourage people to seek information about transition.

Outreach will be provided statewide since all eligible nursing home residents will be eligible for consideration for transition. The MFP project director will approve all materials before use and will submit them to CMS for approval.

AHCA will make outreach materials available to the following entities for distribution:

- Long-Term Care Ombudsman headquarters and regional offices (distribution of transition program materials to nursing home residents)
- Aging Resource Centers (ARC)/Area Agencies on Aging
- Lead Agencies
- Nursing Homes

- Centers for Independent Living
- Medicaid Field Offices
- CARES
- DOH Brain and Spinal Cord Injury Program
- Department of Children and Families
- Agency for Persons with Disabilities

Staff at partner agencies will be trained on MFP transition through on-site meetings in the agencies' field offices, webinars, and other web-based tools. Partner agencies also will offer training specific to hiring caregivers, as appropriate. Staff also will be available to speak at civic organizations, faith-based groups, and other venues to provide program information.

Florida routinely provides material to the public in English, Spanish and Haitian Creole. The Clearinghouse on Disability Information toll free line has access to bilingual staff.

Any cost sharing required for State Plan services is discussed with the participant at the time of enrollment. Florida's waiver programs do not include cost sharing.

4. Stakeholder Involvement

Florida will work cooperatively with the Governor's Commission on Disabilities and the Clearinghouse on Disability Information, as they continue to provide information and referral services to individuals interested in transitioning from nursing homes into the community. The Clearinghouse on Disability Information maintains a large database of community resources, and is able to

provide referrals for necessary community services, including referrals to the state agencies responsible for operating the home and community-based waiver programs. The Clearinghouse actively participates in monthly meetings with AHCA and its partner agencies, as all partners work to improve their nursing home transition programs and processes. The Clearinghouse is part of the Governor's Commission on Disabilities, which was created by Executive Order to be a policy and advisory body to collect and analyze data, advocate, and advise the Governor on issues involving persons with disabilities. One of its major issues has been access to and participation in community life for disabled people.

Florida will work with the Florida Association of Centers for Independent Living, which is the state association that provides support and resource development to the CILs throughout Florida. Many of the CILs are in the process of applying to become Medicaid Nursing Home Transition Case Managers for the ADA waiver program, where they will specifically reach out to adults with physical disabilities residing in nursing homes and provide the coordination and support necessary to effect a successful transition to the community. The CILs have entered into cooperative agreements with DCF to provide HCBS waiver case management to individuals with physical disabilities.

The 11 Aging Resource Centers (ARC), operated through the Area Agencies on Aging (AAA) are very actively involved in the nursing home transition process. The Department of Elder Affairs maintains cooperative agreements with the ARCs to administer services to people age 60 and older in all areas of the state. The ARCs contract with lead agencies in each area of the state to provide home and

community based services for elder programs, including HCBS waiver services. The ARCs and their contracted lead agencies will be a significant resource to the state in identifying and working with individuals eligible to access services under the MFP demonstration grant. Each ARC houses Medicaid Waiver Specialists that are responsible for oversight and monitoring of Medicaid waiver policies, provider and recipient enrollment activities, and provider reimbursement. The Department of Elder Affairs and AHCA meet regularly with the Medicaid Waiver Specialists to provide technical assistance and training. These individuals will receive training on the MFP demonstration and will be tasked with assisting AHCA and DOEA in ensuring that all Medicaid providers within the aging network are providing appropriate services to individuals transitioning from nursing homes into HCBS waivers.

The Agency for Health Care Administration works closely with the nursing home, assisted living, and affordable housing provider organizations to share information about current and future initiatives and to work together to ensure that all Floridians have access to the most appropriate level of care. The Florida Health Care Association (FHCA) is the advocacy organization for long-term care providers and the individuals they serve. The FHCA represents facilities that provide skilled nursing, post-acute and sub-acute care, short-term rehabilitation, assisted living and other services to frail elderly and individuals with disabilities in Florida. The Florida Association of Homes and Services for the Aging (FAHSA) provides leadership, advocacy, and education for retirement housing and nursing home communities that serve the needs of Florida's retirees. The Florida Assisted Living

Affiliation (FALA) represents the owners and operators of assisted living communities. The Florida Housing Coalition, Inc. is a nonprofit organization whose mission is to act as a catalyst to bring together housing advocates and resources so that all Floridians have a quality affordable home and suitable living environment. The Florida Housing Coalition provides professional consultation services through training and technical assistance on affordable housing and related issues; supports community-based partnerships in leveraging resources; and advocates for policies, programs and use of funding resources that maximize the availability and improve the quality of affordable housing in Florida.

The Florida Housing Finance Corporation (Florida Housing) is a partner in the MFP demonstration. It was created by the Florida Legislature more than 25 years ago to help Floridians obtain affordable housing that might otherwise be unavailable to them. Florida Housing continues its mission by increasing affordable housing opportunities and ensuring that its programs are well matched to the needs of the individuals they serve. It maintains a searchable statewide database of available housing. For MFP the database will be enhanced to target specific housing opportunities for MFP participants. See the section on housing for additional information.

The Florida Supportive Housing Coalition also is an MFP partner. This statewide organization is dedicated to fostering the development of housing for various special needs populations, including: the elderly, certain veterans returning from service abroad, young people aging out of the foster care system, persons with a disability, those at risk or suffering from homelessness, ex-offenders, people with

mental illnesses, and others. It will develop training and resource material for use by transition case managers and caregivers. This will include six webinars and a Florida housing resource guide covering Section 8 vouchers, rental assistance, HUD 800, HUD 211, HUD/McKinney, Shelter Plus Care, and low income housing credits as well as information on how to advocate for housing for special populations. Detailed information about the coalition is available on its web site at http://www.flshc.net.

The Agency for Health Care Administration will continue to work with its stakeholders to design and implement the MFP demonstration program through regular meetings and other forms of communications. The MFP staff members will be tasked with maintaining open, ongoing communication with all stakeholders, including consumers, family members, community and institutional provider organizations, and other state agencies.

See Attachment E for a chart showing relationships with stakeholders.

5. Benefits and Services

a. Service Delivery System

Florida will deliver services to elder and disabled adults participating in the MFP demonstration through the state's current waiver programs: the Aged/Disabled Adult (ADA) Waiver, the Assisted Living for the Elderly (ALE) Waiver, the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver and the Nursing Home Diversion Waiver (NHD) programs.

The ADA waiver serves elders age 60 and older and disabled adults age 18 to 59. The ADA waiver is a fee-for-service program, based on 15-minute service increments with maximum service limitations.

The ALE waiver provides services in an assisted living facility to individuals age 60 and over. ALE waiver services are reimbursed at a daily rate and a capped monthly rate. The ALE waiver provides three services: case management, assisted living services, and incontinence supplies, if needed. The components of the assisted living services are: an attendant call system, attendant care, behavior management, chore, companion services, homemaker, intermittent nursing, medication administration, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services. The costs of the services are: case management $100 per month; assisted living services $32.20 per client per day; and, incontinence supplies $125 per month.

The ADA and ALE waivers provide approximately 40 services to help people live in the least restrictive environment within the community.

The TBI/SCI waiver allows individuals with a traumatic brain or spinal cord injury to live in their homes or in community-based settings rather than in a nursing facility. The individual must be age 18 or over to participate. Services include: adaptive health and wellness, assistive technologies, attendant care, behavioral programming, companion services, community support coordination, consumable medical supplies, environmental accessibility adaptations, life skills training, personal adjustment counseling, personal care, and rehabilitation engineering evaluation. Costs are paid on a fee-for service basis.

The NHD waiver is a combination 1915(a) (c) program that provides frail elders age 65 and older who are eligible for both Medicare and Medicaid with an

alternative to nursing facility placement. Under this managed care program, elders can choose to continue living in their own homes or a community setting such as an assisted living facility where they receive coordinated acute and long-term care services. Besides the services of a case manager, NHD long-term care services include: adult companion, adult day health, assisted living, case management, chore, consumable medical supplies, environmental accessibility and adaptation, escort, family training, financial assessment and risk reduction, home delivered meals, homemaker, nutritional assessment and risk reduction, personal care, personal emergency response systems, respite care, occupational, physical and speech therapies, home health, and nursing facility services

The NHD managed care providers are responsible for Medicare co-payments and deductibles for services to all individuals enrolled in this program. The costs of services under NHD are reimbursed at a capitated rate, which is set for each NHD provider based on an actuarially sound rate methodology.

When MFP eligibility ends, participants may continue receiving services under the waiver program with the costs covered by the waiver. If the client wishes to look at other options, the case manager and CARES staff will discuss other programs appropriate to the individual's health and service needs.

b. Service Package

Florida Medicaid uses State Plan and home and community-based (HCBS) waiver fee-for-service and managed care services to meet the needs of individuals transitioning from qualified institutions to a community setting. To be eligible for transition under a HCBS waiver, these individuals must:

- Meet nursing home level of care as determined by CARES
- Meet Medicaid ICP income and asset limits
- Satisfy any additional criteria such as diagnosis, age or level of impairment
- Accept waiver services in lieu of institutional placement

Florida's MFP demonstration will transition individuals into existing 1915(c) home and community-based-waivers designated for transition, as outlined in section 5..a. above. A separate demonstration 1915(c) waiver is not needed and will not be created for the MFP demonstration. After the 12-month demonstration period, transitioned individuals will continue to be served in the same 1915(c) waiver program as long as they meet the eligibility requirements for the program or until they choose to enroll in another waiver.

Below are tables describing services under the four 1915(c) transition/MFP designated home and community-based waivers.

Table 1

Aged and Disabled Adult waiver qualified services, unit and cost

Service	**Procedure Code**	**Maximum Reimbursement Per Unit**	**Maximum Limit**
Adult Companion Services	S5135	$5.25 per 15-minute unit	32 units (8 hours) per day
Adult Day Health Care	S5100	$2.50 per 15-minute unit	40 units (10 hours) per day

Attendant Care Services	S5125	$10.00 per 15-minute unit	40 units (10 hours) per day
Caregiver Training/ Support–Individual	97537	$9.25 per 15-minute unit	16 units (4 hours) per day with maximum monthly total of 80 units (20 hours) per month
Caregiver Training/ Support–Group	S5110	$2.00 per 15-minute unit	16 units (4 hours) per day with maximum monthly total of 80 units (20 hours) per month
Case Aide	G9002	$5.25 per 15-minute unit	16 units (4 hours) per day
Case Management	G9002	$11.25 per 15-minute unit	32 units (8 hours) per day
Case Management Aging Out—Enhanced	T2022	$145.00 per month	Flat fee per client per month.
Chore	S5120	$4.50 per 15-minute unit	32 units (8 hours) per day
Chore–Enhanced	S5120	$6.50 per 15-minute unit	32 units (8 hours) per day
Consumable Medical Supplies	S5199	$500.00 in total purchases per month	No limit on number of purchases up to dollar amount
Consumable Medical Supplies–Enhanced	S5199	$5,000.00 in total purchases per month	No limit on number of purchases up to dollar amount
Counseling	H0004	$15.00 per 15-minute unit	32 units (8 hours) per day with maximum monthly total of 80 units (20 hours) per month
Emergency Alert Response Installation	S5160	$95.00 per installation	3 installations per lifetime
Emergency Alert Response Maintenance	S5161	$1.30 per day	31 days per month

Escort	T2001	$5.25 per 15-minute unit	32 units (8 hours) per day
Financial Assessment/ Risk Reduction	H2011	$8.75 per 15-minute unit	16 units (4 hours) per day with maximum monthly total of 32 units (8 hours) per month
Financial Maintenance/ Risk Reduction	H2011	$5.00 per 15-minute unit	16 units (4 hours) per day with maximum monthly total of 64 units (16 hours) per month
Home Delivered Meals	S5170	$7.00 per Home Delivered Meal unit	2 meals per day
Home Modifications	S5165	$1,000.00 per job	5 jobs per year
Home-manager/ Homemaker	S5130	$4.50 per 15-minute unit	32 units (8 hours) per day
Nutritional Risk Reduction	97802	$12.00 per 15-minute unit	16 units (4 hours) per day with maximum monthly total of 64 units (16 hours) per month
Occupational Therapy	97530	$16.69 per 15-minute unit	8 units (2 hours) per day
Personal Care	T1019	$5.00 per 15-minute unit	48 units (12 hours) per day
Pest Control–Initial Visit	G9004	$65.00	1 initial visit per client
Pest Control–Maintenance	G9005	$50.00 per month	1 service per month
Physical Risk Reduction	99412	$6.25 per 15-minute unit	16 units (4 hours) per day with maximum total of 64 units (40 hours) per year
Physical Therapy	97110	$16.69 per 15-minute unit	16 units (4 hours) per day

Rehabilitation Engineering Evaluation	T1028	$85.00 per evaluation	Number of evaluations will coincide with limits set for the assistive technologies/ adaptive equipment services
Respiratory Therapy–Evaluation	S5180	$45.00 per evaluation	1 per day
Respiratory Therapy–Treatment	99503	$20.00 per 15-minute unit	1 per day
Respite–In-Home	S5150	$4.50 per 15-minute unit	96 units per day (24 hours) with maximum 60 full days per year
Respite–Facility-Based	T1005	$2.50 per 15-minute unit	96 units per day (24 hours) with maximum 60 full days per year
Skilled Nursing–RN, LPN	T1001	$25.00 per visit.	2 visits per day
Skilled Nursing–BSN	T1001	$35.00 per visit	2 visits per day
Specialized Medical Equipment And Supplies	E1399	$1,000.00 per purchase	1 purchase per month
Speech-Language Pathology Therapy	92507	$10.00 per 15-minute unit	16 units (4 hours) per day

Table 2

Assisted Living for the Elderly waiver qualified services, unit and cost

Description of Service	Procedure Code	Unit	Maximum Unit	Reimbursement Rate
Case Management	G9012	Monthly	1	$100
Assisted Living	T1020	Daily	1	$32.20

Incontinence Supplies	S5199	Monthly	1	$125
Transition Case Management	T2024	Monthly	1 Unit Per Month/6 Units Per Six Month Transition Period	$100 ($600 maximum)

Table 3

Traumatic Brain and Spinal Cord Injury waiver qualified services, unit and cost

Service	Procedure Code	Reimbursement	Maximum Limit
Adaptive Health and Wellness	S9970	$50 per month	Not to exceed $600 per year
Assistive Technologies	E1399	Variable	Not to exceed $7500 per year
Attendant Care	S5125	$11.00 per 15-minute unit	12 units (3 hours) per day
Behavior Programming	96152	$15.00 per 15-minute unit	8 units (2 hours) per day
Community Support Coordination	G9012	$160 per month	1 unit ($160) per month
Companion Care	S5135	$4.00 per 15-minute unit	24 units (6 hours) per day
Consumable Medical Supplies	S5199	$300 per month	Not to exceed $300 per month
Environmental Accessibility Adaptations	S5165	Variable	Not to exceed $10,000 per year
Life Skills Training	H2014	$7.50 per 15-minute unit	8 units (2 hours) per day
Personal Adjustment Counseling	H2019	$12.00 per 15-minute unit	8 units (2 hours) per day
Personal Care	T1019	$6.00 per 15-minute unit	16 units (4 hours) per day

Rehabilitation Engineering Evaluation	T1028	$600 per evaluation	2 units ($600) per recipient per year
Transition Case Management	T2024	$160.00 per month	6 units ($160) per year
Transition Environmental Accessibility Adaptations	T2038	Variable	Not to exceed $15,000 per year

Nursing Home Diversion waiver

The Nursing Home Diversion (NHD) waiver is a managed care program that serves dually eligible individuals age 65 and older. NHD waiver providers receive a monthly capitation payment ranging from $1,230.74 to $1,656.70. The NHD program has no service limits except for the following related to transition case management: (1) service recipients must have resided in a nursing facility for at least 60 days or more; (2) transition services can be provided up to 180 consecutive days prior to nursing facility discharge; (3) payment for the service must be made after the recipient enrolls in the waiver.

Acute care services are not included because participants are Medicare-eligible. The NHD waiver covers Medicare cost sharing. The waiver offers the following services

- Case Management Services: contribute to the coordination and integration of care delivery through the ongoing monitoring of services as prescribed in each enrollee's care plan. Case management services help enrollees access needed medical, social, and educational services regardless of the funding source for the services. Services are provided directly, and the ratio of

enrollees to case managers is set at a level appropriate to support the needs of the enrollees.

- Transition case management services are reimbursed fee-for-service and are specific to Medicaid waiver-eligible recipients who reside in a nursing home and wish to transition to a less restrictive and more integrated environment within the community. These services will be used to evaluate, plan and access the services needed by potential transition candidates. The objective of the transition case manager is to facilitate the transfer of individuals into a safe community setting of their choice and ensure the recipient receives the appropriate home and community-based services available in this waiver program.
- Adult Companion Services: Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation, light housekeeping or laundry and shopping but do not perform these activities as discrete services. The service does not entail hands-on nursing care.
- Adult Day Health Services: Services are furnished in an outpatient setting and include both the health and social services needed to ensure optimal functioning of an enrollee. This includes social services to help with personal and family problems, and planned group therapeutic activities as well as nutritional meals served at the center. Adult day health care provides medical screening emphasizing prevention and continuity of care including routine blood pressure checks and diabetic maintenance checks; physical,

occupational and speech therapies indicated in the enrollee's plan of care; and nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene,

- Assisted Living Services: Personal care services, homemaker services, chore services, attendant care, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in a licensed assisted living facility. This service does not include the cost of room and board furnished in conjunction with residing in the facility.
- Assistive care services are covered under the managed care contract and cannot be billed separately by the ALF. This includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Individualized care is furnished in the person's own living unit (which may include dual occupied units when both occupants consent to the arrangement). The living unit may or may not include kitchenette and/or living rooms and does contain bedrooms and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing that the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. The facility must have a central dining room,

living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Assisted living services may also include: physical therapy, occupational therapy, speech therapy, medication administration, and periodic nursing evaluations. The residence operator may arrange for other authorized service providers to deliver care to residents in the same manner as those services would be delivered to a person in his/her own home.

- Chore Services: Services needed to maintain the home as a clean, sanitary and safe living environment. This includes heavy household chores such as washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe entry and exit; and pest control.
- Consumable Medical Supply Services: The provision of disposable supplies used by the enrollee and caregiver, which are essential to adequately care for the needs of the enrollee. These supplies enable the enrollee to perform activities of daily living or stabilize or monitor a health condition. Not included are items covered under the Medicaid home health service;

personal toiletries; household items such as detergents, bleach, and paper towels; or prescription drugs.

- Environmental Accessibility Adaptation Services: Physical adaptations to the home required by the enrollee's care plan that are necessary to ensure the health, welfare and safety of the enrollee or that enable the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the needed medical equipment and supplies. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair, or central air conditioning. Adaptations that add to the total square footage of the home are not included. All services must be provided in accordance with applicable state and local building codes.
- Escort Services: Personal escort for enrollees to and from service providers. An escort may provide language interpretation for people who have hearing or speech impairments or who speak a language different from that of the provider. Escort providers assist enrollees in gaining access to services. This service does not include transportation.
- Family Training Services: Training and counseling services for the families of enrollees. For purposes of this service, "family" is defined as the individuals

who live with or provide care to a person and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include persons who are employed to care for the enrollee. Training includes instruction and updates about treatment regimens and use of equipment specified in the plan of care to safely maintain the enrollee at home.

- Financial Assessment/Risk Reduction Services: Assessment and guidance to the caregiver and enrollee with respect to financial activities. This service provides instruction for and/or actual performance of routine, necessary, monetary tasks for financial management such as budgeting and bill paying. In addition, this service also provides financial assessment to prevent exploitation by sorting through financial papers and insurance policies and organizing them in a usable manner. This service provides coaching and counseling to enrollees to: (1) avoid financial abuse; (2) maintain and balance accounts that directly relate to the enrollee's living arrangement at home; or (3) lessen the risk of nursing home placement due to inappropriate money management.
- Home-Delivered Meals: Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. Each meal is designed to provide 1/3 of the Recommended Dietary Allowance (RDA). Home-delivered meals may be hot, cold, frozen, dried, canned or a combination with a satisfactory storage life.
- Homemaker Services: General household activities such as meal preparation and routine household care provided by a trained homemaker.

- Nutritional Assessment/Risk Reduction Services: An assessment, hands-on care, and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications that are essential to the enrollee's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and food preparation.
- Nursing Facility Services: Services furnished in a health care facility licensed under Chapter 395 or Chapter 400, F. S. A person entering a nursing facility would be disenrolled from the MFP demonstration but could be considered again for transition after meeting program requirements.
- Personal Care Services: Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.
- Personal Emergency Response Systems (PERS): The installation and service of an electronic device that enables enrollees at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The enrollee may also wear a portable "help" button to allow for mobility. PERS services are generally limited to those

enrollees who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.

- Respite Care Services: Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility, or assisted living facility.
- Occupational Therapy: Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the enrollee's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
- Physical Therapy: Treatment to restore, improve or maintain impaired functions by using activities and chemicals with heat, light, electricity or sound, and by massage and active, resistive, or passive exercise when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
- Speech Therapy: The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that effect oral motor functions. Therapy services include the evaluation and treatment of

problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

Demonstration and Supplemental Service Packages

Florida's MFP demonstration and supplemental services are detailed below in Tables 4, 5 and 6.

Table 4

MFP demonstration services for:

- **Aged and Disabled Adult waiver population – ages 18 and older**
- **Assisted Living for the Elderly waiver population**

Demonstration Services	Description	Max Cost	Service Utilization Limits	Provider Qualifications
Transition Home Modification	Provides physical adaptations to the recipient's residence, as described in the plan of care. Must demonstrate the recipient would require more in-home service or institutionalization. May include ramps, grab-bars, interior modifications to accommodate a wheelchair or other necessary medical equipment. Must be performed by licensed contractor and meet all building codes. Cannot be billed until the resident transitions	$10, 000 for all modifications	One per transition	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government health care program; and • signs an agreement with Medicaid.
Transition Vehicle Accessibility Modifications	Adaptations or alterations to an automobile or van that is the recipient's primary	$7,500		Any willing Medicaid waiver provider or entity who: • meets the waiver

	means of transportation, are necessary to ensure the health, welfare and safety of the recipient, and enable the recipient to integrate more fully into the community. The adapted vehicle must be owned by the participant or by a family member or non-relative with whom the recipient lives or has consistent and on-going contact. The recipient is responsible for ongoing maintenance of the modification. Specifically excluded are: 1. General utility adaptations or improvements to the vehicle that are not of direct remedial benefit to the participant; 2. Purchase or lease of a vehicle; and 3. Regularly scheduled upkeep and maintenance of a vehicle and the modifications.			qualifications to provide the specific service; • is not terminated from any government health care program; and • signs an agreement with Medicaid.
Transitional Assistive Technology	An item, piece of equipment or product system used to increase, maintain, or improve functional capabilities of participants. Includes both the device and the evaluation, interventions, and training necessary to use the device effectively.	$3,000	Per transition	Any willing Medica waiver provider or entity who: • Meets the waiver qualifications to provide the device • Is not terminated from any government health care program, and • Signs an agreement with

Comment [CR1]: Beth wants to describe any other specialized equipment or supplies that might be included here.

				Medicaid.
Transition Behavioral Programming	Behavioral programming is individualized strategies to decrease a recipient's maladaptive behaviors that interfere with the ability to remain in the community. It is provided to assist in learning new behavior, increase existing acceptable behavior, reduce existing maladaptive behavior, and to promote appropriate behavior under precise environmental conditions.	$12 per 15 minute unit	8 units a day (52-day max)	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government health care program; and • signs an agreement with Medicaid.
Transition Enhanced Chore Services	Chore Services are provided to recipients in nursing homes whose community residence is not suitable for occupancy for cleanliness or safety reasons. The service provides heavy-duty cleaning such as removal of debris, cleaning roofs and gutters, correcting code violations, cleaning carpet, washing floors, windows and walls, moving heavy items of furniture to provide safe access and egress, as well as renting dumpsters, carpet cleaning machines and	$2,000 per job	One job per transition	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government health care program; and • signs an agreement with Medicaid.

	protective clothing for the provider. Transitional Chore services performed on the exterior of the recipient's dwelling are limited to promoting safe access and egress to the dwelling such as lawn mowing, shrub trimming, and tree and tree-limb removal. This service can be authorized only when neither the recipient nor anyone else in the household is capable of performing or hiring the service and when no third party is responsible for providing the service.			
Transition Enhanced Pest Control	Enhanced Pest Control services are provided to transitioning recipients to eliminate insects, rodents and other potential disease carriers in the community residence. Transition Pest Control is provided before the recipient is discharged from the nursing home but billed after the discharge. This service is authorized only if no other third party is responsible for the providing the service.	$100.00/ visit	One visit per transition	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government health care program; and • signs an agreement with Medicaid.

Table 5

MFP Demonstration Service Package for the TBI/SCI Population

Demonstration Services	Description	Max Cost	Service Utilization Limits	Provider Qualifications
Transition Physical Therapy	Physical Therapy is a specifically prescribed program to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. Physical Therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities. The Physical Therapist must be currently licensed under Chapter 486, Florida Statutes.	$16.50/15 minute unit of service	12 units a week (52-week max)	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government health care program; and • signs an agreement with Medicaid.
Transition Speech Therapy	Speech-Language Pathology services involve the evaluation and treatment of speech-language disorders.	$10/unit	12 units/ week (52-week max)	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government health care

				program; and • signs an agreement with Medicaid.
Transition Occupational therapy	Occupational Therapy services address the functional needs of the individual related to self-help skills; adaptive behavior; and sensory, motor and postural development. Occupational Therapy services include evaluation and treatment to prevent or correct physical and cognitive deficits or to minimize the disabling effect of these deficits. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.	$16.50/unit	12 units/ week (26-week max)	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government health care program; and • signs an agreement with Medicaid.
Transition Nutritional Risk Reduction	Nutritional Risk Reduction services provide assessment and guidance to the recipient or caregiver in the planning and preparation of nutritionally appropriate meals for the purpose of promoting better health through improved nutritional status.	$12/15-min unit	8 units/day (12-week max)	Any willing Medicaid waiver provider or entity who: • meets the waiver qualifications to provide the specific service; • is not terminated from any government

				health care program; and • signs an agreement with Medicaid.

Table 6

MFP supplemental services for the following HCBS waiver populations

- **Aged and Disabled Adult– ages 18 and older**
- **Assisted Living for the Elderly**
- **Traumatic Brain and Spinal Cord Injury**

Supplemental Services	Description	Max Cost	Service Utilization Limits
One-time Expenditure	One-time expenses associated with transitioning: Allowable expenditures include: • renting a van/truck to move the recipient; • deposits for housing, power, water, phone; • kitchen appliances such as refrigerator, microwave, toaster oven; • home furnishings including bed, sofa, dining table and chairs; • household items, including sheets and towels, pots and pans, dishes, glasses and silverware; and clothing. All items must be specified in the care plan. *The following are not covered expenditures: rent; entertainment equipment such as televisions, stereos, recording devices, cable, and satellite dishes; artwork; other appliances such as washers and	3,300.00	One-time per transition

	dryers, and freezers.		

6. Consumer Supports

Case managers in the waiver programs are responsible for addressing recipient needs, and they are the recipient's first contact in the event there is a crisis or a problem with services. The case manager must be accessible and provide the recipient with an emergency back-up telephone number. For elders in the waiver programs, DOEA provides the Elder Helpline: 1-800-96-ELDER (1-800-963-5337) 8 a.m. to 5 p.m. weekdays. DCF operates the Abuse Hotline: 1-800-96-ABUSE (1-800-962-2873) 24 hours a day, 7 days a week. The Abuse Line contact information is widely distributed throughout the elder care community. For those participating in the TBI/SBI waiver, each participant is regularly instructed to contact the community support coordinator (CSC) to discuss any concerns related to service delivery or health and safety. Additionally, each recipient is aware of the roles and responsibilities of the Medicaid waiver specialist covering that geographic area. If the recipient is unable to contact the CSC, the Medicaid waiver specialist serves as the backup contact for all concerns. Field staff also are instructed to contact the waiver administrator located in the DOH headquarters office for additional assistance with resolution of issues. The abuse hotline also is required to accept calls reporting abuse, neglect, or exploitation of disabled adults, and all field staff have been instructed on their role as "mandated reporters."

When the abuse call center receives information on abuse, neglect or exploitation, the information is reported to Florida's Adult Protective Services Office. Adult Protective Services is required to investigate the incident and if verified, remove the recipient from the situation if no alternative is available. The case management staff must be able to assess and initiate services within 72 hours, or in accordance with local protocols, if a recipient is determined by Adult Protective Services workers to be in need of immediate services to prevent harm.

Individuals aged 18 to 59 in the waiver programs may call Adult Protective Services in case of critical incidents or the absence of an expected service worker. However, recipients are instructed to first contact the case manager/support coordinator or Medicaid waiver specialist in an effort to resolve any service-related concerns.

The case manager provides this information and telephone numbers to the recipients in the waiver programs at the time of waiver enrollment and provides reminders during the required monthly contact.

Transportation

Non-emergency transportation to medical appointments for Florida Medicaid enrollees, both waiver and non-waiver, is provided through the Medicaid contract with the Commission for the Transportation Disadvantaged. The vehicles used depends on the individual's medical limitations and can involve mass/public transit (bus); multiple passenger van; taxi cab; wheelchair van; or stretcher van. A recipient may access non-emergency transportation by

contacting the Commission for the Transportation Disadvantaged at: 1-866-374-3368, extension 5700 or through the website: http:/ /www.dot.state.fl.us/ctd/contacts/ctcsbycounty.htm . The Medicaid Area Offices also are able to help arrange transportation. The case manager provides each participant with the telephone number of the appropriate Medicaid Area Office. The recipient may also access the Area Office website at: www.ahca.myflorida.com/Medicaid/Areas/index.shtml . In case of emergency, the recipient is advised to contact 911 for emergency transportation.

Direct Service Workers

As noted above, case managers and community support coordinators in the waiver programs are responsible for addressing recipient needs and are the recipient's first contact in the event there is a crisis or a problem with services. The case manager must be accessible and provide the recipient with an emergency back-up telephone number. The client notifies the case manager if the service worker does not appear at the scheduled time. The case manager contacts the provider and arranges for another worker to substitute and provide the necessary services. This is the procedure that has been in place for many years and provides the assurance of back-up services for the client.

Equipment Repair/Replacement

Durable medical equipment providers, as private businesses, may offer 24-hour backup service for their equipment. It is at the business's discretion. Under Florida's State Plan Durable Medical Equipment/Medical Supply Services program (DME), individuals using oxygen or ventilators and associated parts, must be

provided 24-hour backup services from the provider. Life-sustaining equipment must be provided, and the DME company is expected to service these clients at all times. Loan equipment is also provided at the business's discretion. The client would work with the case manager to obtain equipment, if necessary, in the case of a needed repair to the client's own equipment.

Access to Medical Care

The client works with the case manager to arrange medical appointments and to address all issues relating to medical care. The case manager may also discuss and resolve issues with the physician's office if the client has given permission.

During the monthly contact under the TBI/SCI waiver, CSCs are required to ask the recipient a series of questions. One is about medical appointments and timely receipt of prescription medications. If the recipient requires assistance making appointments or arranging transportation, the CSC can assist with this.

Complaint Resolution**.**

TBI/SCI waiver recipients are instructed on how to file a grievance with the Brain/Spinal Cord Injury Program. In all waivers the recipient always has the option to request a Medicaid fair hearing. A copy of the Notice of Decision and procedures for requesting a fair hearing are found in the TBI/SCI Medicaid Waiver Coverage and Limitations Handbook. See below for further details about the hearing process.

DOEA, the operational agency for the ADA and ALE waivers, provides a grievance procedure for waiver participants. ADA and ALE waiver participants may file a grievance with DOEA concerning any action taken by DOEA or its service

provider network affecting service provision. The recipient must contact the case manager for assistance with the grievance. The case manager must assist and represent the recipient or the designated representative with preparation and presentation of the grievance to the appropriate entity. The case manager mediates the grievance with the source of the complaint and attempts to provide a solution for the recipient. This is a less formal process than the Medicaid Fair Hearing procedures and is not referenced through state rules, regulations, or policies. Participation in the DOEA grievance process does not affect a recipient's right to a fair hearing. DOEA reviews the explanation of the grievance process to the recipient when monitoring the case file.

Medicaid participants enrolled in managed care may grieve problems associated with their medical care. The first level is through the managed care organization's grievance process. If the complaint is not resolved to the enrollee's satisfaction, the grievance may be appealed to one of two Assistance Panels operated by the state to hear such appeals.

None of these grievance resolution tools replaces or precludes the enrollee from using the Medicaid Fair Hearing process to resolve service issues. The Medicaid Fair Hearing policy and process is detailed in Rule 65-2.042, Florida Administrative Code. The individual is informed of the right to a Fair Hearing when action has been taken regarding Medicaid services or eligibility. Actions related to decisions regarding Medicaid eligibility include determinations that an applicant does or does not meet Medicaid financial, clinical, or technical criteria or failure to

act in a timely manner for eligibility determination. The individual receives a Notice of Case Action (HRS-AA Form 2266) from which contains the following statement:

> *"If you have reason to believe this action is incorrect, your eligibility specialist will be glad to discuss it with you. You also have the right to request a hearing before a State Hearing Officer. A request for a hearing should be made within 90 days from the date at the top of this notice. You can bring with you or be represented at the hearing by a lawyer, relative, or person designated by you."*

Fair Hearings may be requested orally or in writing. No specific form is required. To request a Fair Hearing for financial or clinical eligibility determinations, individuals are directed to contact the DCF office in their geographic area. The telephone number for the local DCF office is included on the notice.

Fair Hearings are conducted by the Office of Public Assistance Appeals at DCF. DOEA Form 203A documents the recipient's acknowledgement of the right to a fair hearing. (See Attachment F.) Waiver recipients must be informed in writing 10 days in advance of a planned change in benefits. This includes a reduction, suspension or termination of services. Services cannot be reduced or terminated during the 10 days' advance notice of the planned change. If a fair hearing is requested within this 10-day advance notice period, waiver services must continue as provided until a hearing is held and a final decision is issued. The case manager must be familiar with fair hearing procedures and assist the beneficiary during the entire process.

The case manager provides the grievance and fair hearing information to the recipient when developing the plan of care, after enrollment into the waiver

program. The information is also available in the waiver handbooks, which may be found at: http://mymedicaid-florida.com/.

7. Self-Direction (See Appendix A)

Choosing to Leave Self-Direction

All Consumer Directed Care Plus (CDC+) participants are funded through a HCBS waiver program. Participants are served by a case manager who is funded through the waiver program and has additional training on the state's self-direction program. That case manager conducts assessments, re-assessments, and care plan reviews according to the policies, procedures, and timetables of the waiver program. Once a person selects the self-directed option, funds associated with the waiver services care plan are available for the client's self-direction budget. All clients who transition to self-direction begin self-directing on the first of the month, after all enrollment processes are completed in the prior month. Case managers/consultants ensure that waiver services continue until self-direction begins, and it is also the responsibility of case managers/consultants to ensure that self-directed services are in place on the first day of the month in which the client transitions. A client who chooses to leave self-direction reverts to the regular waiver program. This process has been in place in Florida since the inception of self-direction and is highly effective at maintaining continuity of services.

Involuntary Termination of Self-Direction

Involuntary disenrollment is rarely imposed. Such action would be a last resort if clients consistently overspend their budget and refuse to cooperate with the terms of a negotiated corrective action plan to reduce spending over a period of

months to correct a negative account balance. Typically, clients who overspend opt to cooperate with corrective action making it unnecessary to initiate disenrollment. Corrective action plans to temporarily reduce spending are negotiated between case manager/consultants and the client or representative. Case manager/consultants ensure that spending can be reduced temporarily without endangering the client's health and safety. Additionally, clients may be disenrolled if their participation in the program were deemed to place them at risk (*e.g.*, client is incapable of acting as an employer and no representative is available).

In all cases of disenrollment, voluntary or otherwise, the client remains a participant in the waiver. The client is returned to waiver services immediately upon disenrollment from CDC+. It is the responsibility of the case manager/consultant to coordinate services under the waiver to ensure a seamless transition back to home and community-based services. This process has been in place since the inception of Florida's self-direction program and has proven highly effective at maintaining continuity of services.

Goal for Self-Direction in Demonstration

Based on Florida's experience in the nursing home transition program, it is estimated that one to two clients per year may decide to opt for self-direction opportunities immediately upon returning to the community. Because the CDC+ program is designed for people who have been active under the HBCS services waiver prior to transitioning to CDC+, we anticipate very few if any clients will transition directly into self-direction. However, some clients, once transitioned, may eventually select the self-directed option.

8. Quality

Florida will use existing service delivery systems to serve individuals through the MFP demonstration. Florida has over a quarter century of experience with Medicaid HCBS waiver service delivery to frail elders and individuals with disabilities. The depth of systems in place will allow existing programs to seamlessly incorporate expanded service delivery in the community for individuals with increasingly complex health care needs. The state will use four of its established HCBS 1915(c) waiver programs, previously described, and their mature networks of service providers to further expand services to Florida citizens through the MFP demonstration program. Quality assurance requirements for waiver services are reviewed and updated on a continuous basis as determined by the existing individual waiver renewal schedules.

Although MFP participants will be in a unique demonstration project, oversight of service delivery for these individuals will meet each waiver program's requirements for quality, quantity, and appropriateness. While specific details differ with each waiver program's unique design, all recipients will receive a full reassessment at least every 12 months, which includes a full review of services for appropriateness and adjustment if necessary. Reassessment will occur more often if the individual is found to have experienced a significant change in physical or mental condition or if service delivery has been affected by a change in the individual's community and social support system. Contact is required at least once a month between the recipient, the caregiver/legal representative (if appropriate) and the individual's case manager. In addition, recipients and their caregivers/legal

representatives have the ability to contact the case management agency (or their case managers) if an emergency situation warrants.

Oversight of waiver service delivery is provided on a continuous basis by the State Medicaid Agency and the approved State Operating Agencies. Each program has an established system of on-site and desktop program monitoring. The findings of these monitoring activities result in remediation and improvement activities appropriate to the identified issues. Education activities are conducted for all providers regarding systemic programmatic operational issues, or are provided on an individual basis to address specific provider shortcomings. The State Medicaid Agency and its partner State Operating Agencies will monitor MFP demonstration program recipients to ensure standards meet or exceed existing waiver requirements.

Florida does not intend to use State Plan amendment or 1915(b) or 1115 waiver authorities to provide MFP demonstration services. All services will be provided through existing 1915(c) HCBS waiver programs.

Each of the four 1915(c) HCBS waivers that will be participating in the MFP demonstration project addresses the six waiver assurances and sub-assurances. Oversight of waiver service provision is provided with numerous redundancies through the combined efforts of the State Medicaid Agency and the State Operating Agency at both the central and field offices.

Level of care determinations, service plan descriptions, and the associated sub-assurances are monitored though both on-site and desktop review of case files. Representative samples are selected for review. Qualifications of Medicaid

providers are monitored through the provider enrollment process and by continuous review of provider qualifications by waiver contract managers and policy analysts. The health and welfare of waiver recipients are monitored continuously through the efforts of the case managers and the field offices of the State Medicaid Agency and the State Operating Agencies. The central offices of the State Medicaid Agency and the State Operating Agencies maintain open communications with the field staff to further ensure the health and welfare of the recipients. Both the State Medicaid Agency and the State Operating Agencies share administrative authority and financial accountability as appropriate under state and federal laws.

9. Housing

a. Defining and Documenting Qualified Residences

Information on the type of qualified residence that a MFP transitioned individual chooses is determined during the transition process prior to the individual's discharge from the institutional setting and enrollment in a designated 1915(c) waiver.

Participants can choose among three types of qualified residences:

- A home owned or leased by the individual or the individual's family member - For this type of community residence, Florida waivers put no requirements other than the home must be a safe and healthy environment that will meet the needs of the transitioned individual.

- An apartment with an individual lease - with lockable access and doorway over which the individual or the individual's family has domain and control. A residential apartment is a living unit that is a private space with connected sleeping, kitchen, and bathroom areas and adequate storage space. The bedroom must be suitable for double occupancy. The living unit must have private kitchen and bathroom facilities.
- An alternative residence, in a community-based residential setting, in which no more than four unrelated individuals reside – this type of residence includes Adult Family Care Homes (AFCH). An AFCH is a full-time, family-type living arrangement, in a private home, under which a person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives. Adult family care homes are defined in Chapter 429, Part III, Florida Statutes; related regulations are located in Rule 58A-.014, Florida Administrative Code.

Assisted Living Facility

Chapter 429, Florida Statutes, which governs assisted living facilities, states that "…this act is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decision-making ability of such persons, to provide for the health, safety, and welfare of residents of assisted living facilities in the state…". It further states,

To the maximum extent possible, appropriate community-based programs must be available to state-supported residents to augment the services provided in assisted living facilities. The Legislature recognizes that assisted living facilities are an important part of the continuum of long-term care in the state. In support of the goal of aging in place, the Legislature further recognizes that assisted living facilities should be operated and regulated as residential environments with supportive services and not as medical or nursing facilities. The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible. Regulations governing these facilities must be sufficiently flexible to allow facilities to adopt policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences.

Assisted living facilities are a viable option for individuals transitioning from institutions while providing an independent and less restrictive environment.

Florida's assisted living facilities are surveyed and licensed according to Chapter 429, Florida Statutes (F.S.). Specifically, s. 429.07, F.S., gives examples of types of licenses and the requirements for each. License types include standard; limited nursing services; extended congregate care; or limited mental health. The Agency for Health Care Administration completes the surveys for licensure and issues the license for the facility type. Surveys for ALFs are conducted every two years unless circumstances dictate a more frequent schedule.

Contracts in assisted living facilities (ALFs) are considered private and between the client and the facility. The contract must be executed at the time the

client is admitted into the ALF or before the client moves into the apartment. The contract must contain all the provisions and services agreed to between the facility and the client. The transition case manager, working with the client moving from the institution into the ALF, will assist the client by discussing the necessary protections that should be a part of the contract. Section 429.24, F.S. discusses the protections, rules and regulations regarding contracts between clients and facilities. A lease may be substituted for a contract if it meets the disclosure requirements of section 429.24, F.S.

According to Florida statute, an ALF "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory. Transition case managers will ensure the apartment is equipped with these areas for the transition client.

The ALF chosen by a transition client will respect the individual's personal dignity, individuality, and the need for privacy by ensuring the apartment will have lockable access and egress.

Florida statutes ensure there is a grievance procedure available to all ALF residents. The facility must post a written notice of the rights, obligations, and prohibitions of the client. The notice includes the name, address, and telephone numbers of the local ombudsman council and central abuse hotline, and when applicable, the Advocacy Center for Persons with Disabilities and the Florida local advocacy council, where complaints may be lodged. A telephone must be accessible to the resident to report complaints.

Any differences regarding the care plan process are a part of the formal grievance procedures. However, if the client believes there is a problem with the

care plan, the case manager will be called to assist the client in resolving the issue. The case manager will work with the client, facility and physician to develop a care plan acceptable in protecting the health, safety and welfare of the individual.

Chapter 429, Florida Statutes, includes the Resident Bill of Rights, which provides for the rights, benefits and privileges of the client living in the ALF. A copy of this document is in Attachment G.

The transition case manager will discuss what type of living arrangements within the community is appropriate to the transition client. If choices are available, the transition case manager will develop a list of the specific living arrangements, and the client may chose from the available living arrangements. The transition case manager will discuss service providers with the client and offer choices from those available.

Under the Assisted Living waiver, the ALF will ask for notification of absence in order to ensure Medicaid is not billed on the days services were not provided. Absences are discussed with the facility to ensure the care plan is followed and health and safety of the resident are not compromised. However, the client is free to leave the facility to visit friends and family at any time without fear of termination of the contract or lease.

Aging in place is the goal of the transition program, regardless of the type of living arrangements made by the transition client. By developing the plan of care to include needed support services, it is hoped that the client will be able to stay in their choice of residence and remain as independent as possible. ALFs participating in the Assisted Living waiver must have an extended congregate care (ECC) license

or a limited nursing service license (LNS). These license types ensure there will be more intensive services available in the facility if needed by the resident.

Case management will ensure this provision is followed for the transition client and request this issue be a part of the client's contract. As stated in the "Resident Bill of Rights" under Chapter 429, Florida Statutes, the facility must give 45 days' written notice for any relocation. The client has a right to file a grievance with the facility and request assistance with the grievance from an advocacy group such as the Ombudsman.

b. Supplying Qualified Residences

Florida is partnering with the Florida Housing Finance Corporation and the Supportive Housing Coalition to identify housing options for MFP participants and to train partner agency staff members in housing issues.

Florida Housing is the state's housing finance agency that provides funding and low income housing tax credits to qualified affordable housing developers that make a long-term commitment to set aside a percentage of units in a funded multi-family rental development for households that qualify as extremely low to low income. It supports the development of family, elderly, and special needs household rental housing. Florida Housing funded rental developments generally consisting of between 60 and 150 units and serve a mixed income population. Florida Housing requires and incentivizes the developers to include amenities related to energy efficiency, proximity to public transportation and community services, accessibility and universal design, as well as resident programs that are relevant to a development's family, elderly and/or special needs households. Its funds and

resources may be used for the construction, acquisition, rehabilitation and/or preservation of affordable rental housing developments.

In 2009 Florida Housing implemented a long-term, statewide initiative to enhance the ability of extremely low income households with special needs to access affordable rental units funded by Florida Housing. This initiative called the Link to Permanent Housing Initiative offers incentives to affordable rental housing developers that reserve or set aside a significant portion of a funded development's extremely low income (ELI) units for households with special needs referred by supportive services providers. Link to Permanent Housing serves people with physical, mental and/or developmental disabilities, youth aging out of foster care, homeless people and their families, frail elders, and survivors of domestic violence.

Florida Housing estimates that 250 ELI rental units will be made available in affordable housing developments across Florida each year. The goal is to have more than 1500 ELI units set aside for special needs households by the end of 2014. With the assistance of APD, DCF, the Department of Veterans Affairs and members of the Supportive Housing Coalition, Florida Housing has recruited more than 200 local and regional supportive services providers statewide to identify, pre-screen and refer eligible and interested special needs households to Link to Permanent Housing units. These stakeholders also have agreed to support the tenancy of the referred households through community based case management and services. As a MFP partner, Florida Housing will work with AHCA and the Florida Supportive Housing Coalition to consider approaches to enhance the access of transition consumers with extremely low-incomes to the Link to Permanent Housing units.

Florida Housing offers a statewide searchable housing database at www.FloridaHousingSearch.org, that allows landlords, including providers of critically needed affordable and special needs housing, to advertise their properties free of charge while helping renters find a property that fits their needs, including accessibility. Through a partnership with DOEA, the site also includes a separate search engine for locating assisted living facilities and adult family care homes. The site, which is updated daily, has more than 150,000 affordable rental units in its database, with about 10,000 listed as available on an average day. The site also includes over 2,000 licensed assisted living facilities accounting for more than 90,000 ALF beds.

Florida Housing's executive director, Steve Auger, says, "We want the locator to serve as an invaluable tool for families, persons with disabilities, elderly persons or households with special needs that are searching for affordable housing in their communities."

People can search for available properties online 24 hours a day or by contacting the toll-free, bilingual search support call center at 877-428-8844 (TTD/TTY: 7-1-1) weekdays from 9 a.m. to 8 p.m. eastern time. The call center staff helps with conducting searches and provides affordable housing resource information and referral services. Both the web site and the call center serve English and Spanish speakers.

The database is searchable by city, county, street address, and/or zip code; number of bedrooms/bathrooms; leasing agent phone number; rent amount; HUD Section 8 voucher acceptance; proximity to public transit; utilities inclusion; target

populations; accessible units and accessibility features; and map links and pictures. There is also an affordability calculator, rental checklist, and renter rights and responsibilities information. Non-Profit Industries of Charlotte, NC, maintains the database for Florida Housing and will enhance it as part of the MFP demonstration to provide MFP-specific search criteria available to case managers. The annual fee of $12,000 will include the development and ongoing operations of a unique FloridaHousingSearch.org portal for transition caseworkers to search for general rental housing and assisted living options, as well as those specifically identified and registered in the database to serve MFP consumers. The annual fee will include outreach activities to landlords, ALF administrators and supportive housing providers to identify and register units for MFP consumers, as well as the registration and training of transition caseworkers in using the general FloridaHousingSearch.org features and MFP portal that is accessible only to registered transition caseworkers. In addition to the $12,000 annual fee for systems support, Florida Housing has requested $9,000 per year during the grant period to support its costs related to landlord registration and updating the database of affordable rental units, ALF beds, as well as web-based search engine and call center operations fees. The annual cost to Florida Housing for providing the existing search site and call center to the public is over $200,000 per year, including administrative costs, that it funds with its own revenues, not state or federal funding.

10. Continuity of Care Post Demonstration

a. Managed Care/Freedom of Choice – Not applicable to Florida's MFP demonstration.

b. Capacity and Waiver Authority

Nursing home transition clients are a priority for waiver enrollment so it will not be necessary at this time to create a new waiver or reserve capacity through a waiver amendment. AHCA, in collaboration with the program partners who operate the ADA, ALE, NHD and TBI/SCI waivers, can access capacity and make the decision to amend the waivers if it becomes necessary to accommodate the transition population.

c. Research and Demonstration – Not applicable to Florida's MFP demonstration.

d. State Plan and Amendments

The Agency does not have an optional State Plan amendment for home and community-based services. An individual who has an income at 300% of the Federal Poverty Level qualifies for all State Plan programs and for enrollment into the waiver programs, based on medical necessity.

C. Project Administration

1. Organization:

AHCA, Florida's single state Medicaid agency, will manage the MFP demonstration grant. AHCA administers the four home and community-based waiver programs that provide special opportunities for nursing home transition. DOEA is the state operating agency for the ALE and the ADA waiver programs for the age 60 and older population, and the NHD waiver program for dually eligible individuals age 65 and older. DCF is the state operating agency for the ALE and ADA waiver programs for the age 18-59 population. DOH is the state operating agency

for the TBI/SCI waiver program. APD is the state operating agency for the waiver programs that serve individuals with developmental disabilities. Each of AHCA's waiver operating partners manages the day-to-day operations of these HCBS waiver programs through cooperative agreements. Monitoring of the waiver services, including quality of care, is the responsibility of the waiver operating agencies in cooperation with AHCA, which is responsible for monitoring its waiver operating partners to ensure that all waivers are operated according to federal and state requirements. AHCA will provide oversight, technical assistance, and monitoring of the MFP demonstration, and will be responsible for coordination of all required reporting for the MFP grant.

2. Staffing:

The Project Director for the Money Follows the Person demonstration will be a full-time position, dedicated to management and oversight of the grant. The Project Director will be supervised by the Program Administrator for the Long Term Care Waivers and Institutional Unit within the AHCA Bureau of Medicaid Services, who will be responsible for the assessment of performance of this staff member. Although the MFP Project Director will not directly supervise the positions dedicated to the MFP grant, the Project Director will be responsible for providing coordination and support to all dedicated MFP staff members. The Project Director will coordinate the scheduling of meetings and other regular communications with all MFP dedicated staff members to ensure that policies and procedures are being implemented consistently across all participating agencies and waiver programs. The Project Director will be responsible for making sure that all required reports

are timely completed and submitted to the Centers for Medicare and Medicaid Services. The Project Director will assume the lead role in coordinating communication and outreach efforts to all MFP stakeholders, including other state agencies, advocacy groups, nursing home organizations, assisted living and housing provider organizations, Centers for Independent Living, the Governor's Commission for Persons with Disabilities, families and consumers.

The Assistant Project Director will be a full-time position, dedicated to the Money Follows the Person demonstration. The Assistant Project Director will provide support and coverage for the Project Director. The Assistant Project Director must be prepared at any time to step in for the MFP Project Director during times when the Project Director is out of the office or if the position becomes vacant. In addition to support and coverage functions, the Assistant Project Director will serve as the quality and housing specialist. The Money Follows the Person grant will require that Florida expand its quality assurance and reporting efforts. Although AHCA plans to contract with qualified state universities to conduct the required quality of life surveys and provide an independent evaluation of the MFP project, AHCA will supervise the contract(s) and provide oversight to its partner agencies on all additional quality assurance activities and reports. AHCA and its partner agencies have been meeting with the affordable housing organizations to improve the lines of communication and develop a collaborative working relationship. This position will continue to coordinate with these organizations to develop resources for individuals transitioning to the community who need affordable housing. The Assistant Project Director will be supervised by the Program Administrator for the

Long Term Care Waivers and Institutional Unit within the AHCA Bureau of Medicaid Services, who will be responsible for the assessment of performance of this staff member.

The third full time position to be housed at AHCA will be responsible for oversight of all research and data activities. This position also will work with systems and data staff at each waiver operating agency to ensure that necessary information and data are transmitted among agencies to allow accurate and up-to-date reporting of individuals identified for transition. This position will be supervised by the Program Administrator for the Long Term Care Waivers and Institutional Unit within AHCA's Bureau of Medicaid Services, who will be responsible for the assessment of performance of this staff member.

The fourth AHCA position will be a project manager to oversee development and implementation of the MFP database. This will be a contracted position. The incumbent will bring in short-term contractors as needed to complete the various phases of system development to construct a system that will incorporate data already being gathered by the partner agencies, the additional MFP required data, and case file information to support claims payment/auditing and federal and state reporting.

The three waiver operating agencies managing the different populations for Money Follows the Person will each house full-time staff dedicated to the MFP demonstration as follows: DOH one position, DCF two positions, and DOEA five positions. Work done by Florida Housing and the Housing Coalition will be done by contract.

These staff members will be directly supervised by the state agencies where they work. The MFP Project Director will serve as the coordinator to schedule regular meetings (monthly or more often if needed) and other opportunities for communication, to ensure that all dedicated MFP staff members are consistently following guidelines specified by the grant and to provide an opportunity to share information on best practices.

AHCA plans to contract with a qualified state university to administer the Quality of Life surveys and submit data to the MFP National Evaluator. AHCA currently contracts with a qualified state university using a different funding source to conduct an independent evaluation of existing long-term care programs in Florida. This contractor can also assist the state in determining whether the MFP demonstration program is meeting its goals to increase the number and proportion of Medicaid enrollees who have successfully transitioned from institutions into the community, and to rebalance the state's long-term care system by developing the required infrastructure and increasing opportunities for home and community-based services. The independent evaluation can determine what services were most valuable to the project and what other variables contributed to a successful transition and helped to maintain an individual in the community.

Florida's MFP Project Director will be hired once spending authority is authorized. The position has been advertised. A job description is included with the resumes in Attachment H.

AHCA consultant, Connie Ruggles, has assisted Florida in developing the grant application and is available to assist with implementation. In addition,

consultants from Florida State University are willing to offer their expertise and assistance during the grant implementation phase as needed.

The remainder of the MFP administrative staff will be in place on or about July 1, 2011. Once the demonstration grant award is received by the state, AHCA will be required to obtain legislative authority during the regular session of the 2011 Florida Legislature to spend the funds. The session is scheduled for March 8 through May 6, 2011. Once the Legislature provides spending authority to AHCA, Florida will move forward in using the funding. It is expected that the legislative authority will be effective at the start of the state fiscal year, which begins July 1, 2011. See Attachment B for organization charts.

Staff	Title	% of Time	Role / Responsibility
AHCA Money Follows the Person Demonstration Program Staff			
TBA	Money Follows the Person Project Director (Government Operations Consultant III)	100%	Project Director for the Money Follows the Person Demonstration. Provides oversight, coordination, and program management of all demonstration project activities.
TBA	Money Follows the Person Assistant Project Director (Medical Health Care Program Analyst)	100%	Assistant Project Director for the Money Follows the Person Demonstration. Provides support and coverage for the Project Director. Responsible for coordination and oversight of all housing and quality-related grant requirements.
TBA	Money Follows the Person Research and Data Specialist (Medical Health Care Program Analyst)	100%	Money Follows the Person dedicated staff member responsible for coordination and oversight of all research and data requirements.

TBA	Money Follows the Person IT Project Manager (contracted)	100% first year	Responsible for development and implementation of MFP database and reporting system.
Department of Elder Affairs Money Follows the Person Demonstration Program Staff			
TBA	Money Follows the Person Coordinator for the Elder population. This staff member will be housed and supervised by the waiver operating agency. (Medical Health Care Program Analyst)	100%	Money Follows the Person dedicated staff member responsible for outreach, communication, resource development, and monitoring of individuals age 60 and over transitioning into waiver programs.
3 TBA year one 2 additional beginning year two	MFP Transition Coordinators to work with field staff on identifying and transitioning people (Medical Health Care Program Analysts)	100%	Staff will partner with CARES, DCF, DOH, Aging Resource Centers and housing partners on identification, screening, referral, and outreach activities.
Department of Children and Families Money Follows the Person Demonstration Program Staff			
TBA	Money Follows the Person Coordinator for individuals age 18-59 with physical disabilities. This staff member will be housed and supervised by the waiver operating agency.	100%	Money Follows the Person dedicated staff member responsible for outreach, communication, resource development, and monitoring of individuals age 18-59 and over transitioning into the Aged and Disabled Adult and Assisted Living waiver programs.
TBA	MFP Transition Coordinator to work with field staff on identifying and transitioning elders (Medical Health Care Program Analyst)	100%	Staff will partner with CARES, DOEA, DOH, Aging Resource Centers and housing partners on identification, screening, referral, and outreach activities.
Department of Health Money Follows the Person Demonstration Program Staff			

TBA	Money Follows the Person Coordinator for adults with traumatic brain or traumatic spinal cord injuries. This staff member will be housed and supervised by the waiver operating agency.	100%	Money Follows the Person dedicated staff member responsible for outreach, communication, resource development, and monitoring of individuals age 18 and over transitioning into the Traumatic Brain and Spinal Cord Injury waiver program.
AHCA Key Project Support			
Beth Kidder	Bureau Chief, AHCA Medicaid Services	5%	Bureau Chief responsible for supervision of all Medicaid Services staff members. Responsible for implementation and over all coordination of the demonstration project.
Darcy Abbott	AHC Administrator, AHCA Medicaid Services, Long Term and Behavioral Health Care Section	5%	Supervisor, Long Term Care and Behavioral Health Program Administrators and staff responsible for coordinating HCBS policy to directly support the demonstration project activities.
Wendy Smith	Program Administrator, AHCA Medicaid Services, Long Term Care Waivers and Institutional Unit	20%	Administration of Medicaid long-term care HCBS waivers and State Plan services for elders and individuals with physical disabilities. Will be responsible for supervision of AHCA Money Follows the Person program staff. Supervises waiver analysts responsible for the Aged and Disabled Adult, Assisted Living, and Nursing Home Diversion waiver programs.
Shevaun Harris	Program Administrator, AHCA Medicaid Services, Quality Assurance Improvement and Long-Term Care Unit	5%	Supervises waiver analyst responsible for the Traumatic Brain and Spinal Cord Injury waiver and State Plan Home Health Services. Supports policy

			development, management and coordination for the demonstration project.
Carol Schultz	Medical Health Care Program Analyst, AHCA Medicaid Services, Long Term Care Waivers and Institutional Unit	5%	Waiver analyst responsible for the Aged and Disabled Adult and Assisted Living waivers. Will work cooperatively with staff dedicated to the MFP demonstration to provide technical assistance and policy clarification.
Keith Young	Medical Health Care Program Analyst, AHCA Medicaid Services, Long Term Care Waivers and Institutional Unit	5%	Waiver analyst responsible for the Nursing Home Diversion waiver. Will work cooperatively with staff dedicated to the MFP demonstration to provide technical assistance and policy clarification.
Arlene Walker	Medical Health Care Program Analyst, AHCA Medicaid Services, Quality Assurance Improvement and Long-Term Care Unit	5%	Waiver analyst responsible for the Traumatic Brain and Spinal Cord Injury waiver. Will work cooperatively with staff dedicated to the MFP demonstration to provide technical assistance and policy clarification.
Karen Chang	AHCA Medicaid Program Analysis	5%	Responsible for tracking and reporting financial expenditures for services provided under the MFP demonstration. Will work with dedicated MFP staff members to ensure that financial reporting requirements for the grant are tracked and reported accurately and timely.
Neal Garvey	Professional Accountant Specialist, AHCA Finance and Accounting	5%	Responsible for tracking and reporting financial expenditures related to administrative funding. Will work with dedicated MFP staff members to ensure that

			financial reporting requirements for the grant are tracked and reported accurately and timely.
Chinonye Onwunli	Contract Manager, AHCA Bureau of Quality Management	5%	Contract manager for Dr. Glenn Mitchell at Florida State University for the independent evaluation of Florida's long term care services.
Contracted Project Consultants			
Connie Ruggles	AHCA Consultant	10%	Provide assistance with grant-related policy development and training modules. Assist MFP dedicated staff with program design and implementation of the demonstration.
Dr. Glenn Mitchell	Florida State University	10%	Assist with program design and implementation. .
TBA	State University Consultant	10%	Administer the Quality of Life surveys.

3. Billing and Reimbursement

Billing and reimbursement for MFP activities will be handled by AHCA's Bureau of Finance and Accounting. State Plan services and those routinely paid either through capitation or fee-for-service to enrolled Medicaid providers will be handled through Florida's Medicaid Management Information System. All others will be done through monthly invoice and voucher processing at AHCA.

Medicaid has an active fraud and abuse prevention program operating under the Deputy Secretary for Medicaid and a Bureau of Program Integrity operating under the AHCA Inspector General that conducts reviews and data mining to recover overpayments and billing errors. The AHCA Office of Internal Audit, also

under the Inspector General, conducts routine reviews of financial transactions to ensure prompt payment and appropriate documentation. Information about program integrity and internal audit activities is available on the AHCA web site at http://www.ahca.myflorida.com.

D. Evaluation

Florida does not plan to conduct its own project evaluation and will participate fully in the national evaluation.

E. Budget

1. Administrative Budget (see electronic form)

Maintenance of Effort

Florida Medicaid has fourteen 1915(c) waivers offering home and community-based care. Participants are served first by Medicaid State Plan services and then by waiver services. Each waiver has a different set of services tailored to meet the needs of the targeted waiver populations. Florida's fourteen HCBS waivers are funded through specific line items in the state's budget. Five state agencies serve as operating entities for the waivers.

Since 2008, AHCA has worked in cooperation with the Department of Elder Affairs, the Department of Health, the Department of Children and Families, and the Clearinghouse for Disability Information to improve Florida's nursing home transition process. An interagency workgroup meets at least monthly to discuss ways to increase transition opportunities. The workgroup developed a draft nursing home transition plan and recommended adding a nursing home transition case management service to the Aged and Disabled Adult waiver, the Assisted Living for the Elder waiver, the Nursing Home Diversion waiver, and the Traumatic Brain and Spinal Cord Injury waiver. Waiver amendments have been approved by the Centers for Medicare and Medicaid Services to add transition case management services to all four waivers. In addition, a special transition home modification service was approved for the Traumatic Brain and Spinal Cord Injury waiver.

Florida Medicaid has three PACE providers offering services in six approved PACE sites. Florida Medicaid is currently reviewing applications for two additional sites, which if approved, should be operational sometime during the first half of 2011, and includes the approval of a new PACE provider.

Comment [CR2]: We said eight sites earlier; which is it?

Florida's strategy related to nursing home growth has included controlling the number of nursing home beds through a moratorium on certificate of need expansion, tort reform, and a phased increase of staffing ratios for nursing homes that exceed federal requirements. Since 2001, Florida has had a moratorium on granting new certificates of need for nursing facilities. This has contributed to higher occupancy rates in existing facilities and to the overall leveling off in growth of the nursing facility population.

Florida plans to focus its Money Follows the Person Rebalancing Demonstration efforts on identifying individuals who wish to leave nursing homes and work with them to develop the supports necessary for them to return safely to the community. Florida will work with individuals to try and locate suitable housing or assisted living facilities appropriate for each individual. Individuals will be assessed for state plan and waiver services, as well as other non-Medicaid services that can best meet their needs in the community. If individuals need additional care and supervision to remain safely in the community, Florida will work with nursing home transition candidates to try and locate interested family members or friends willing to provide this assistance. The additional resources provided by the Money Follows the Person grant would enable Florida to hire dedicated staff members for this project and to develop demonstration services that will assist more individuals to transition from nursing homes, and help them to live safely in the community. The added resources will allow Florida to significantly enhance its current nursing home transition efforts and increase the availability of home and community-based services to its Medicaid population.

Florida's Maintenance of Effort (MOE) Form includes actual expenditures for all fourteen HCBS waiver programs and all non-institutional State Plan services for State Fiscal Year 2009-2010. The MOE Form includes only the non-institutional expenditures for PACE and the Nursing Home Diversion capitated HCBS programs.

(See electronic form for data)

APPENDIX A.

Self-Direction Submittal Form

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development**. Specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
➢	Case Manager. *Specify qualifications*:
	Four year degree in a human services field or equivalent experience, certification and training as a case manager, additional one-day training certification on the consumer-directed program.
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

➢	Entities and/or individuals that have responsibility for service plan development *may not provide* other services to the participant. Note— representatives may not provide other paid services to the participant, but they do provide ongoing, *unpaid* assistance to participants.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Participants are provided with a detailed program manual, a trained case manager/consultant, and a toll-free number staffed by central office CDC+ staff who are prepared to provide additional

technical assistance. The participant has choice of case management providers (in areas of the state where multiple providers are available) and has authority to request a trusted friend or family member to act as representative, when needed.

d. Service Plan Development Process In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The participant-directed service plan is developed by the participant or representative, with assistance as-needed from the case manager/consultant. The participant-directed plan is developed as part of the enrollment process, in the month prior to beginning program participation. The allocation is derived directly from the participant's care plan for the traditional waiver. Specifically, the assessment and care planning process is identical to that employed for traditional waiver participants. The aging network utilizes a standardized comprehensive assessment, administered by trained and certified assessors, that forms the basis of the care planning process. Client choice with regard to programs as well as providers is intrinsic to the process,

For self-directing clients, an additional instrument, the Scripps Personal Goal Setting (PGS) instrument is used to help participants identify their personal goals that are then linked to the participant-directed budget.

The self directed services will be coordinated by the consultant and the participant. The services provided will be those available under Medicaid State Plan and the specific participating 1915(i) waiver program the participant is enrolled in. The responsibility to implement services belongs to the participant, with assistance of the consultant, and the consultant provides the monitoring and oversight of the program.

Case managers/consultants are required to ensure that participants retain a copy of their self-directed plan budget plan.

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks (such as a need for an emergency alert response) are identified as part of the overall assessment and care planning process, and case managers/consultants ensure that mitigation of risks is addressed in the participant-directed budget. Case managers/consultants contact clients at least monthly, and perform annual re-assessments and semi-annual assessment updates. Through scheduled as well as unscheduled contacts, case managers/consultant provide ongoing monitoring for risks that may arise. As employees of case management agencies, case managers/consultants have knowledge of and access to the full range of available community resources for elders, including those who self-direct. For clients who self-direct, emergency backup workers are required for critical services. Emergency backup workers may be directly hired employees or agencies. Emergency backup workers are prepared to work at a moment's notice, and are fully registered as employees including fulfilling background screening requirements.

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

Participants have access to both Medicaid enrolled and non-Medicaid enrolled providers. Case managers/consultants provide information, as needed, regarding agency services. Most self-directing clients choose to employ directly hired workers, very often friends and family members.

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency**. Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

Area Agencies on Aging sign off on the budget plan, and CDC+ staff also review budget plans and Special Purchase Requests for appropriateness.

h. **Maintenance of Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three

years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
➢	Operating agency
➢	Case manager
☐	Other (*specify):*

II. Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers/consultants provide ongoing oversight and "monitoring" of the service plan implementation. In addition to twice-yearly home visits, case managers/consultants are required to contact clients monthly and to track monthly account statements and receipts for cash purchases. The operating agency (Department of Elder Affairs) additionally, per 1915(j) state plan requirements, monitors a sample of approximately 40% of program participant files annually, including reviewing a sample of timesheets, invoices, and cash receipts.

b. Monitoring Safeguards. *Select one:*

➢	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

III. Overview of Self-Direction

a. Description of Self-Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

Participants will have the opportunity to enroll in the state's existing self-directed program. This program offers participants the ability to "cash out" all funds (except for case management) allocated in their traditional services care plan. These funds may be used flexibly to hire directly-hired workers, vendors, or independent contractors. Goods such as consumable medical supplies and nutritional supplements may be purchased either through regular vendors or via monthly cash checks. Additionally, clients may save for special purchases such as environmental modifications, and may even purchase needed items that are not normally funded through the Waiver, such as service animals.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
➢	**Both Authorities.** The demonstration provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

➢	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.

☐	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
➢	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:
	The only criteria is that the client must be capable of directing their own care, with available supports, or must have a representative who is capable of assisting with directing care, with available supports.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Case managers are required to describe the participant-directed option to clients, and offer this option. Case managers must document their discussion of the participant direction option in their case notes.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of demonstration services by a representative *(select one)*:

○	The State does not provide for the direction of demonstration services by a representative.
➢	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct

	demonstration services: *(check each that applies)*:	
	➢	Demonstration services may be directed by a legal representative of the participant.
	➢	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		The representative may not be a paid employee, and the client and caregiver are monitored by the case manager/consultant on an ongoing basis. Florida is currently phasing in Level 2 background screening for all representatives.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities), available for each demonstration service. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Demonstration Service	**Employer Authority**	**Budget Authority**
Individuals electing self direction under the 1915(i) CDC+ program will be receiving the services available through the participating waivers.	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform

necessary financial transactions on behalf of the demonstration participant.
Select one:

➢ ✠	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	➢	Governmental entities—the state functions as a government fiscal employer agent with subagent.
	➢	Private entities—the state contracts with a subagent to perform check writing, EFTs, and tax reporting services. The state provides the remainder of FEA functions.
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. S*elect one*:

○	FMS are covered as a Demonstration service		Fill out i. through iv. below:
➢	FMS are provided as an administrative activity. Fill out i. through iv. below*:*		
	i	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
		Government fiscal employer agent with subagent provides services statewide.	
	ii. S	**Payment for FMS**. Specify how FMS entities are compensated for the activities that they perform:	
		Staffed by state workers funded through Medicaid Administration funds.	
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
		Supports furnished when the participant is the employer of direct support workers:	
		➢ ✠	Assist participant in verifying support worker citizenship status
		➢ ✠	Collect and process timesheets of support workers
		➢ ✠	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
			Other *(specify):*
		Supports furnished when the participant exercises budget authority:	
		➢ ✠	Maintain a separate account for each participant's self-directed budget
		➢ ✠	Track and report participant funds, disbursements and the balance of

			participant funds
		➢ ☒	Process and pay invoices for goods and services approved in the service plan
		➢ ☒	Provide participant with periodic reports of expenditures and the status of the self-directed budget
		➢ ☒	Other services and supports *(specify)*:
			Toll-free customer service line with staff available to assist with payment/budget or programmatic questions.
		Additional functions/activities:	
		➢ ☒	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
		☐	Other *(specify):*
	iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
		The subagent provides regular reports including cash balance and expenditures. Client statements showing all account activity are monitored monthly by the client and case manager/consultant.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

➢	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:*
☐	**Demonstration Service Coverage**. Information and assistance in support of participant direction are provided through the

	demonstration service coverage (s) entitled:
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
➢	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The case manager/consultant arranges for traditional services to resume immediately upon voluntary termination of participant-directed services. Because all consultants are also case managers and can continue to serve the client through their agency, and because all CDC+ participants have a traditional care plan in place at all times (because the self-directed budget is derived from the traditional care plan), transitions back to traditional services, which are rare, are seamless.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination is a very rare event, as most problems can be resolved through corrective action plans. In cases in which the client chronically overspends and refuses to cooperate with a corrective action plan, or in cases in which the client cannot safely self-direct, termination is

initiated by the case manager/consultant. Traditional services are arranged as described in item l above, to ensure immediate resumption of agency-based care.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

Table E-1-n

	Employer Authority Only
Demonstration Year	**Number of Participants**
Year 1	2
Year 2	2
Year 3	2
Year 4	2
Year 5	2

Participant Employer

a. Participant – Employer Authority *(Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)*

Participant Employer Status. Specify the participant's employer status under the demonstration. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
➢	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

	Supports are available to assist the participant in conducting employer-related functions.

Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

➢	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
➢	Hire staff (common law employer)
➢	Verify staff qualifications
➢	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	Note, the state receives Level 2 background screening results and shares with the employer whether the potential worker or representative is authorized to work based on the results of the screening.
➢	Specify additional staff qualifications based on participant needs and preferences
➢	Determine staff duties consistent with the service specifications
➢	Determine staff wages and benefits subject to applicable State limits
➢	Schedule staff
➢	Orient and instruct staff in duties
➢	Supervise staff
➢	Evaluate staff performance
➢	Verify time worked by staff and approve time sheets
➢	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)*

1. **Participant Decision Making Authority**. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

➢	Reallocate funds among services included in the budget
➢	Determine the amount paid for services within the State's established limits
➢	Substitute service providers

➢	Schedule the provision of services
➢	Specify additional service provider qualifications
➢	Specify how services are provided,
➢	Identify service providers and refer for provider enrollment
➢	Authorize payment for demonstration goods and services
➢	Review and approve provider invoices for services rendered
	Other *(specify):*
	Request special purchases that are not already on the budget plan, such as assistive technology, service animals, or home modifications.

2. **Participant-Directed Budget**. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

All budgets are based on the standardized, well-established assessment and care planning processes used for traditional waiver participants. This ensures that CDC+ participant budgets are equivalent to those of clients with similar needs and available informal supports participating in the traditional waiver, and also contributes towards the program achieving cost-neutrality with traditional services. Furthermore, this process ensures that an accurate and adequate care plan is in place should a client return to traditional services.

3. **Informing Participant of Budget Amount**. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The budget is based completely on a care plan developed using the assessment and care planning process of the traditional services waiver. The consultant shares budget information with the client as an early step in the enrollment process. If additional funds are needed, or if the client specifically requests additional funds, the case manager/consultant must update the assessment and care plan under the traditional waiver protocols. If additional funding would be approved under these protocols, then they may be added to the participant directed budget. Additional funds may be added if service needs change, not for reasons such as a desire to give workers a raise.

4. **Participant Exercise of Budget Flexibility. Select one:**

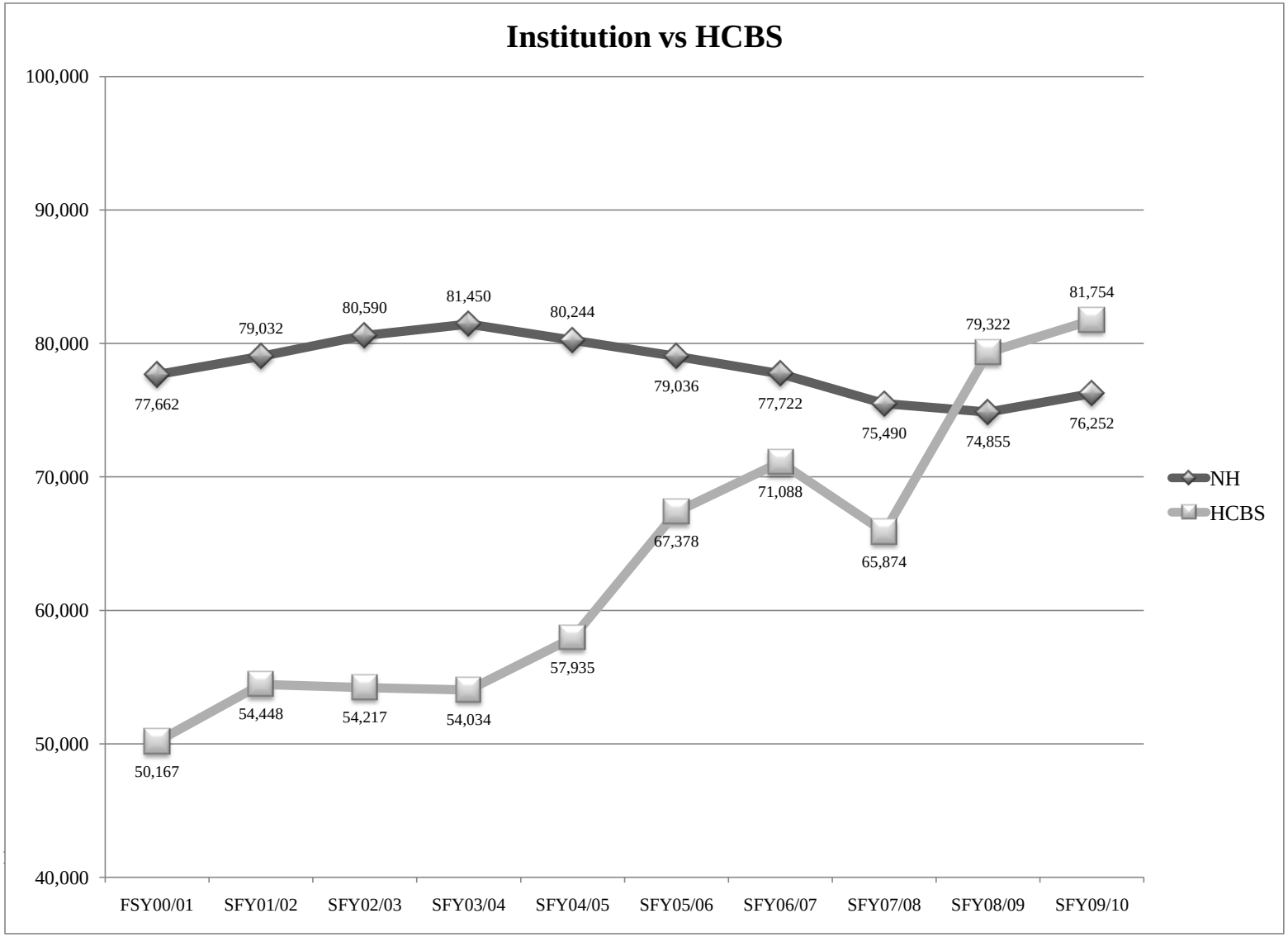
	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	All updates to the participant directed budget must be approved by the case manager/consultant. However, participants may vary somewhat from the service plan, for example, as long as their budget permits, they may receive more of a specific service than budgeted. Specifically, the system does not limit timesheets to the pre-approved weekly number of hours. Special purchases are requested through a "Request for Special Purchase" form, on which the client and consultant describe how this purchase will enhance the participant's health or independence, or substitute for human assistance. The CDC+ office has final approval authority for special purchase requests.
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

5. **Expenditure Safeguards**. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

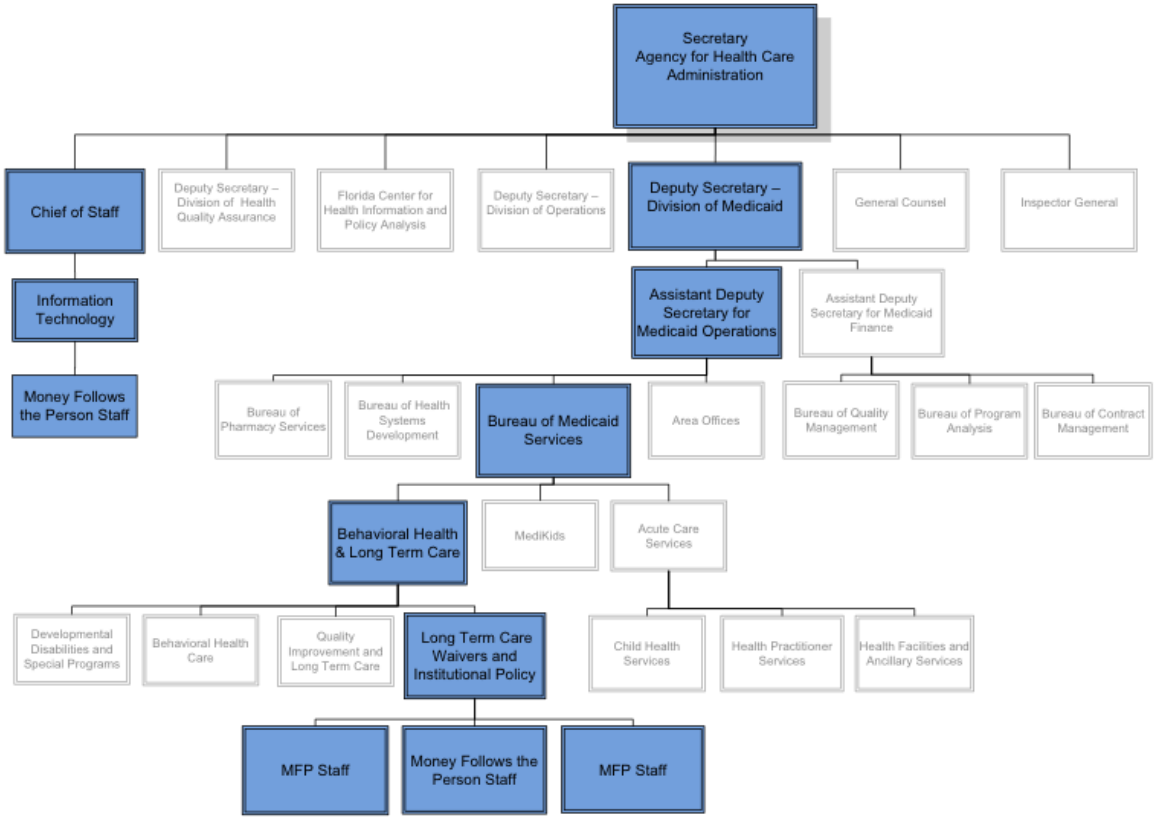
Consultants and state (FEA) staff monitor statement balances on a monthly basis to detect overspending. Initially, clients are contacted and alerted of the need to reduce spending through a written corrective improvement plan. If overspending continues, a formal corrective action plan is implemented. As a last resort, clients may be returned to traditional services. Consultants monitor service adequacy through monthly phone contacts as well as through availability for assistance upon client request, between scheduled contacts.

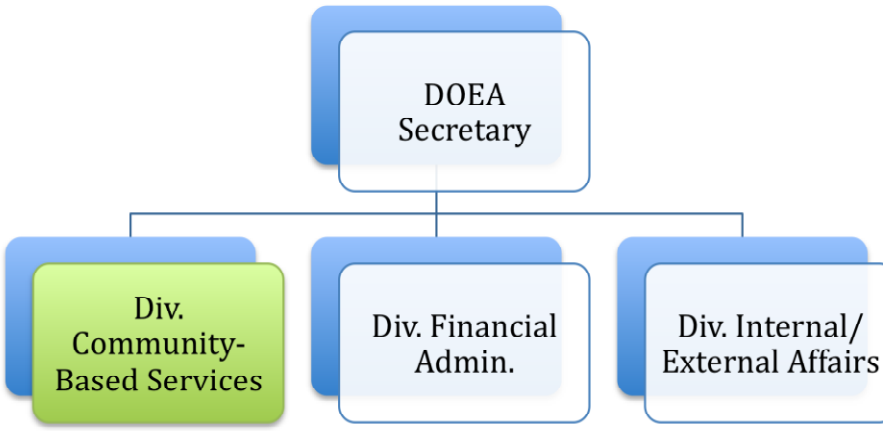
ATTACHMENT A – Institutional vs. HCBS Services 2000-2010

Comment [CR3]: Need to change NH to "Institution" on legend; how to do that?

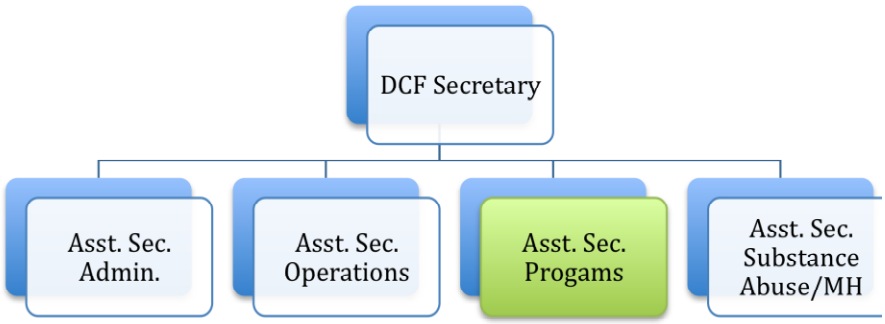

Institution vs HCBS
100,000
90,000
80,000
70,000
60,000
50,000
40,000
77,662
79,032
80,590
81,450
80,244
79,036
77,722
75,490
74,855
76,252
50,167
54,448
54,217
54,034
57,935
67,378
71,088
65,874
79,322
81,754
NH
HCBS
FSY00/01
SFY01/02
SFY02/03
SFY03/04
SFY04/05
SFY05/06
SFY06/07
SFY07/08
SFY08/09
SFY09/10

ATTACHMENT B – ORGANIZATION CHARTS

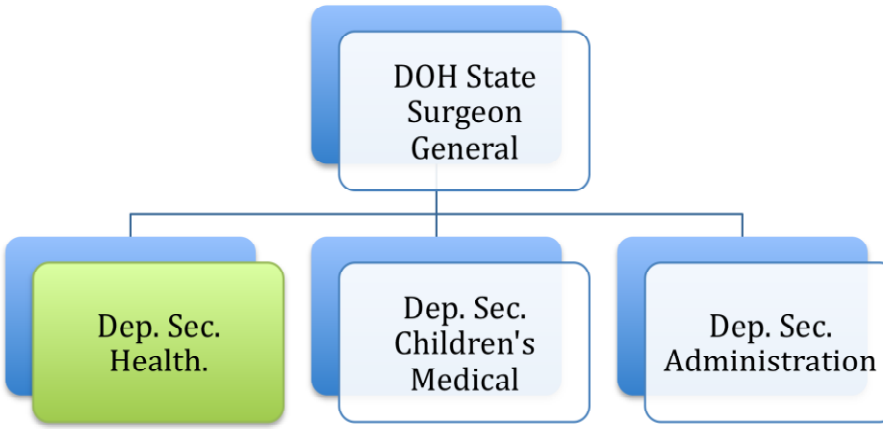

Secretary
Agency for Health Care Administration
Chief of Staff
Deputy Secretary – Division of Health Quality Assurance
Florida Center for Health Information and Policy Analysis
Deputy Secretary – Division of Operations
Deputy Secretary – Division of Medicaid
General Counsel
Inspector General
Information Technology
Money Follows the Person Staff
Assistant Deputy Secretary for Medicaid Operations
Assistant Deputy Secretary for Medicaid Finance
Bureau of Pharmacy Services
Bureau of Health Systems Development
Bureau of Medicaid Services
Area Offices
Bureau of Quality Management
Bureau of Program Analysis
Bureau of Contract Management
Behavioral Health & Long Term Care
MediKids
Acute Care Services
Developmental Disabilities and Special Programs
Behavioral Health Care
Quality Improvement and Long Term Care
Long Term Care Waivers and Institutional Policy
Child Health Services
Health Practitioner Services
Health Facilities and Ancillary Services
MFP Staff
Money Follows the Person Staff
MFP Staff



- Community & Support Services
- CARES
- Long-Term Care & Support (Oropallo)
  - 2 MFP Program Staff
  - 2 Additional MFP Staff (beginning year 2)



- Child Care Services
- Family Safety
- Economic Self Sufficiency
- Refugee Services
- Homelessness
- Domestic Violence
- Adult Protective Services (Anderson)
  - 2 MFP Program Staff



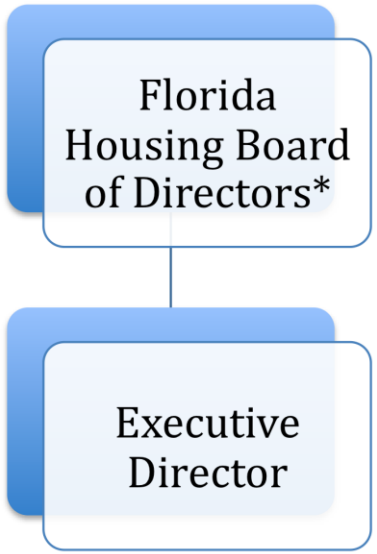
Div. Emergency Medical Operations

- Emergency Medical Services
- Preparedness & Response
- Trauma
- Injury Prevention
- Brain/Spinal Cord Injury (Russell)
  - 1 MFP Program Staff

ATTACHMENT B – Organization

Charts

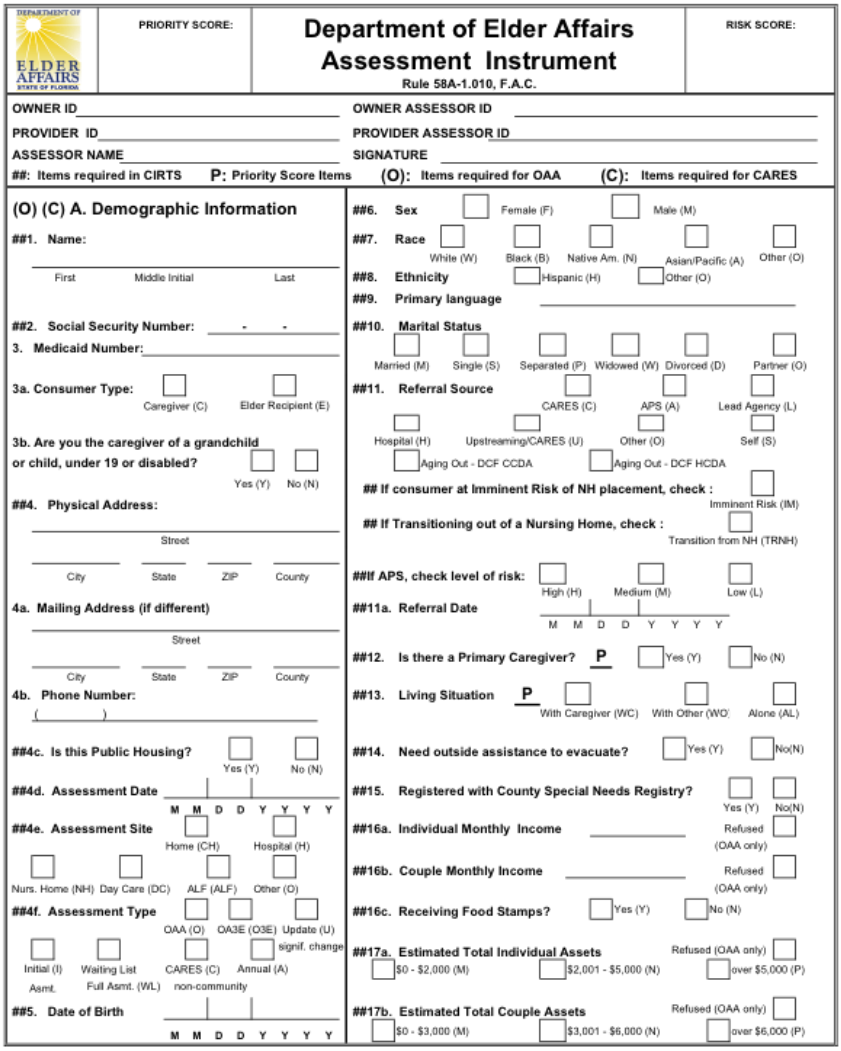
Comment [CR4]: Beth wants changes in Agency and bureau org charts; discuss



- Multi-Family Loan Programs
- Multi-Family Bonds
- Single Family Programs
- Chief Technology Officer
- Human Resources/Operations
- Chief Information Officer
- Communications
- Policy and Special Programs (Aldinger)
  - FloridaHousingSearch.org

*Florida Housing is a public corporation within the Florida Department of Community Affairs (DCA). It is a separate budget entity governed by a nine-member board. The DCA Secretary is and ex officio and voting board member and appoints the Florida Housing Executive Director.

Attachment C – Assessment tools



PRIORITY SCORE:

Department of Elder Affairs Assessment Instrument

Rule 58A-1.010, F.A.C.

RISK SCORE:

OWNER ID _____ OWNER ASSESSOR ID _____

PROVIDER ID _____ PROVIDER ASSESSOR ID _____

ASSESSOR NAME _____ SIGNATURE _____

##: Items required in CIRTS **P:** Priority Score Items **(O):** Items required for OAA **(C):** Items required for CARES

(O) (C) A. Demographic Information

##1. Name:
First Middle Initial Last

##2. Social Security Number: - -

3. Medicaid Number:

3a. Consumer Type: ☐ Caregiver (C) ☐ Elder Recipient (E)

3b. Are you the caregiver of a grandchild or child, under 19 or disabled? ☐ Yes (Y) ☐ No (N)

##4. Physical Address:
Street
City State ZIP County

4a. Mailing Address (if different)
Street
City State ZIP County

4b. Phone Number: ( )

##4c. Is this Public Housing? ☐ Yes (Y) ☐ No (N)

##4d. Assessment Date M M D D Y Y Y Y

##4e. Assessment Site ☐ Home (CH) ☐ Hospital (H) ☐ Nurs. Home (NH) ☐ Day Care (DC) ☐ ALF (ALF) ☐ Other (O)

##4f. Assessment Type ☐ OAA (O) ☐ OA3E (O3E) ☐ Update (U) signif. change ☐ Initial (I) Asmt. ☐ Waiting List Full Asmt. (WL) ☐ CARES (C) non-community ☐ Annual (A)

##5. Date of Birth M M D D Y Y Y Y

##6. Sex ☐ Female (F) ☐ Male (M)

##7. Race ☐ White (W) ☐ Black (B) ☐ Native Am. (N) ☐ Asian/Pacific (A) ☐ Other (O)

##8. Ethnicity ☐ Hispanic (H) ☐ Other (O)

##9. Primary language _____

##10. Marital Status ☐ Married (M) ☐ Single (S) ☐ Separated (P) ☐ Widowed (W) ☐ Divorced (D) ☐ Partner (O)

##11. Referral Source ☐ CARES (C) ☐ APS (A) ☐ Lead Agency (L) ☐ Hospital (H) ☐ Upstreaming/CARES (U) ☐ Other (O) ☐ Self (S) ☐ Aging Out - DCF CCDA ☐ Aging Out - DCF HCDA

If consumer at Imminent Risk of NH placement, check : ☐ Imminent Risk (IM)

If Transitioning out of a Nursing Home, check : ☐ Transition from NH (TRNH)

##If APS, check level of risk: ☐ High (H) ☐ Medium (M) ☐ Low (L)

##11a. Referral Date M M D D Y Y Y Y

##12. Is there a Primary Caregiver? P ☐ Yes (Y) ☐ No (N)

##13. Living Situation P ☐ With Caregiver (WC) ☐ With Other (WO) ☐ Alone (AL)

##14. Need outside assistance to evacuate? ☐ Yes (Y) ☐ No(N)

##15. Registered with County Special Needs Registry? ☐ Yes (Y) ☐ No(N)

##16a. Individual Monthly Income _____ ☐ Refused (OAA only)

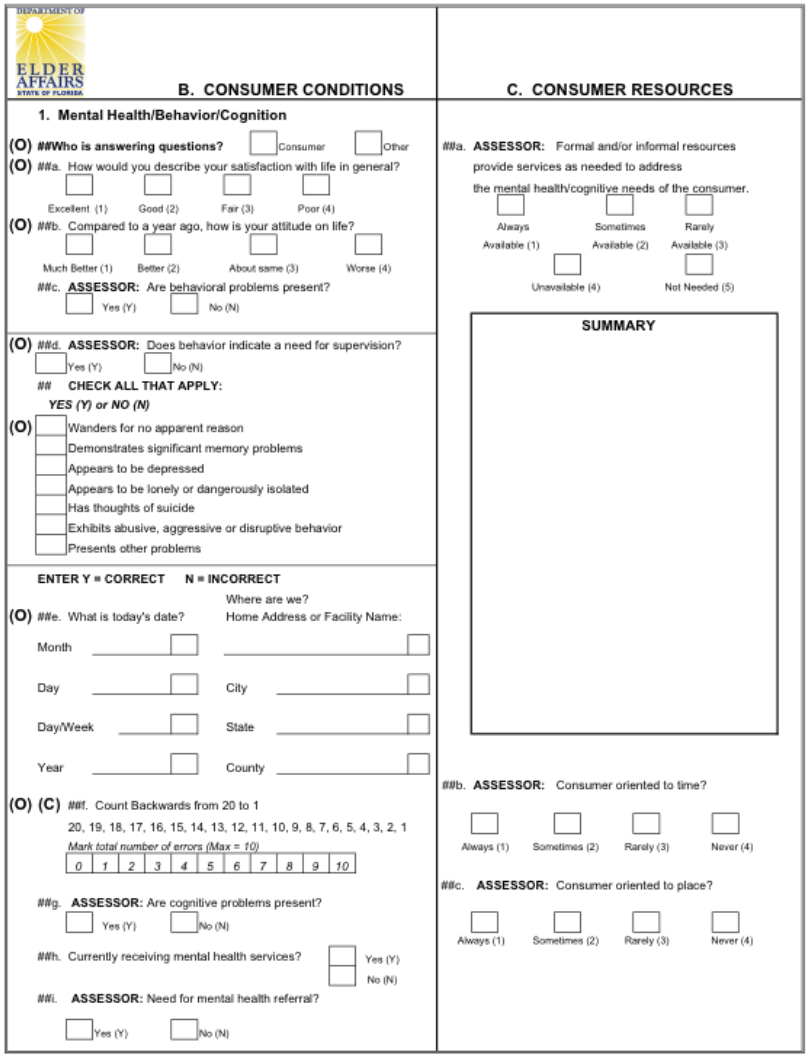
##16b. Couple Monthly Income _____ ☐ Refused (OAA only)

##16c. Receiving Food Stamps? ☐ Yes (Y) ☐ No (N)

##17a. Estimated Total Individual Assets ☐ Refused (OAA only) ☐ $0 - $2,000 (M) ☐ $2,001 - $5,000 (N) ☐ over $5,000 (P)

##17b. Estimated Total Couple Assets ☐ Refused (OAA only) ☐ $0 - $3,000 (M) ☐ $3,001 - $6,000 (N) ☐ over $6,000 (P)

DOEA FORM 701B, September 2008 1



DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

B. CONSUMER CONDITIONS

1. Mental Health/Behavior/Cognition

(O) **##Who is answering questions?** ☐ Consumer ☐ Other

(O) ##a. How would you describe your satisfaction with life in general?

☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

(O) ##b. Compared to a year ago, how is your attitude on life?

☐ Much Better (1) ☐ Better (2) ☐ About same (3) ☐ Worse (4)

##c. **ASSESSOR:** Are behavioral problems present?

☐ Yes (Y) ☐ No (N)

(O) ##d. **ASSESSOR:** Does behavior indicate a need for supervision?

☐ Yes (Y) ☐ No (N)

CHECK ALL THAT APPLY:

YES (Y) or NO (N)

(O)
- ☐ Wanders for no apparent reason
- ☐ Demonstrates significant memory problems
- ☐ Appears to be depressed
- ☐ Appears to be lonely or dangerously isolated
- ☐ Has thoughts of suicide
- ☐ Exhibits abusive, aggressive or disruptive behavior
- ☐ Presents other problems

ENTER Y = CORRECT N = INCORRECT

(O) ##e. What is today's date?

Month ☐ Day ☐ Day/Week ☐ Year ☐

Where are we?

Home Address or Facility Name: ☐

City ☐ State ☐ County ☐

(O) (C) ##f. Count Backwards from 20 to 1

20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1

Mark total number of errors (Max = 10)

0	1	2	3	4	5	6	7	8	9	10

##g. **ASSESSOR:** Are cognitive problems present?

☐ Yes (Y) ☐ No (N)

##h. Currently receiving mental health services?

☐ Yes (Y) ☐ No (N)

##i. **ASSESSOR:** Need for mental health referral?

☐ Yes (Y) ☐ No (N)

C. CONSUMER RESOURCES

##a. **ASSESSOR:** Formal and/or informal resources provide services as needed to address the mental health/cognitive needs of the consumer.

☐ Always Available (1) ☐ Sometimes Available (2) ☐ Rarely Available (3) ☐ Unavailable (4) ☐ Not Needed (5)

SUMMARY

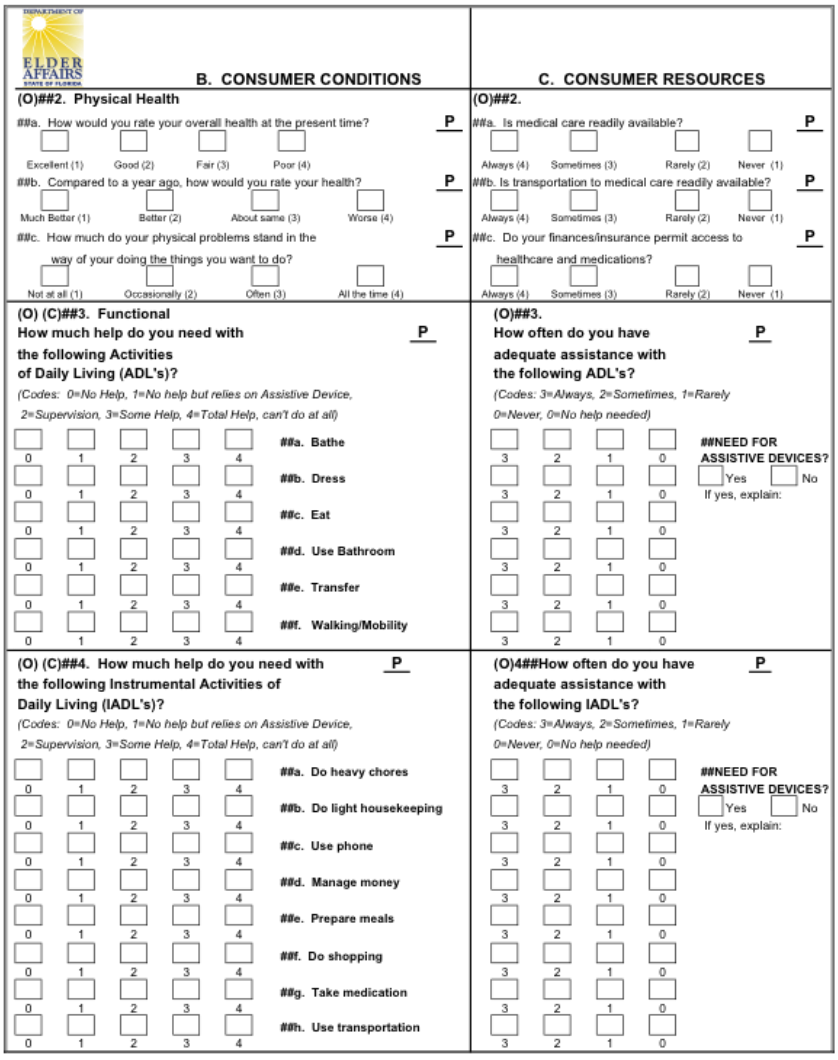
##b. **ASSESSOR:** Consumer oriented to time?

☐ Always (1) ☐ Sometimes (2) ☐ Rarely (3) ☐ Never (4)

##c. **ASSESSOR:** Consumer oriented to place?

☐ Always (1) ☐ Sometimes (2) ☐ Rarely (3) ☐ Never (4)

DOEA FORM 701B, September 2008 2



B. CONSUMER CONDITIONS

(O)##2. Physical Health

##a. How would you rate your overall health at the present time? P
☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

##b. Compared to a year ago, how would you rate your health? P
☐ Much Better (1) ☐ Better (2) ☐ About same (3) ☐ Worse (4)

##c. How much do your physical problems stand in the way of your doing the things you want to do? P
☐ Not at all (1) ☐ Occasionally (2) ☐ Often (3) ☐ All the time (4)

(O) (C)##3. Functional
How much help do you need with the following Activities of Daily Living (ADL's)? P

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##a. Bathe**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##b. Dress**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##c. Eat**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##d. Use Bathroom**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##e. Transfer**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##f. Walking/Mobility**

(O) (C)##4. How much help do you need with the following Instrumental Activities of Daily Living (IADL's)? P

(Codes: 0=No Help, 1=No help but relies on Assistive Device, 2=Supervision, 3=Some Help, 4=Total Help, can't do at all)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##a. Do heavy chores**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##b. Do light housekeeping**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##c. Use phone**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##d. Manage money**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##e. Prepare meals**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##f. Do shopping**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##g. Take medication**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	**##h. Use transportation**

C. CONSUMER RESOURCES

(O)##2.

##a. Is medical care readily available? P
☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

##b. Is transportation to medical care readily available? P
☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

##c. Do your finances/insurance permit access to healthcare and medications? P
☐ Always (4) ☐ Sometimes (3) ☐ Rarely (2) ☐ Never (1)

(O)##3.
How often do you have adequate assistance with the following ADL's? P

(Codes: 3=Always, 2=Sometimes, 1=Rarely 0=Never, 0=No help needed)

☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	

##NEED FOR ASSISTIVE DEVICES? ☐ Yes ☐ No
If yes, explain:

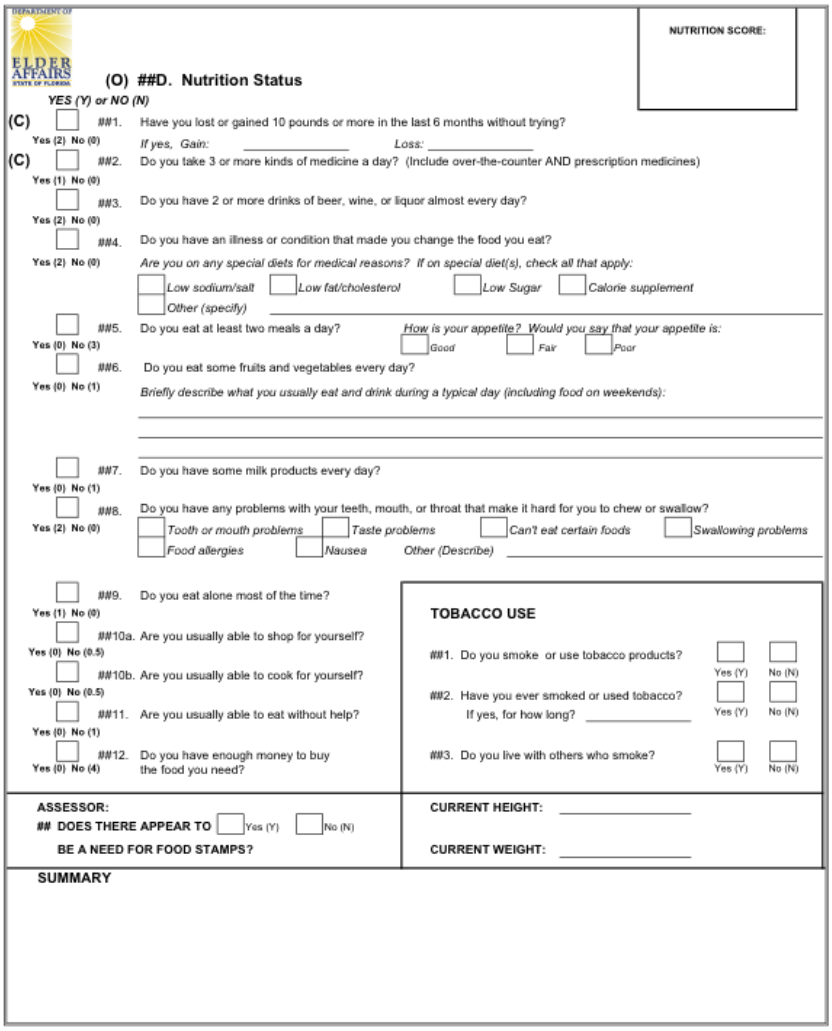
(O)4##How often do you have adequate assistance with the following IADL's? P

(Codes: 3=Always, 2=Sometimes, 1=Rarely 0=Never, 0=No help needed)

☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	
☐ 3	☐ 2	☐ 1	☐ 0	

##NEED FOR ASSISTIVE DEVICES? ☐ Yes ☐ No
If yes, explain:

DOEA FORM 701B, September 2008 3



DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

NUTRITION SCORE:

(O) ##D. Nutrition Status

YES (Y) or NO (N)

(C) ☐ ##1. Have you lost or gained 10 pounds or more in the last 6 months without trying?
Yes (2) No (0)
If yes, Gain: _____ *Loss:* _____

(C) ☐ ##2. Do you take 3 or more kinds of medicine a day? (Include over-the-counter AND prescription medicines)
Yes (1) No (0)

☐ ##3. Do you have 2 or more drinks of beer, wine, or liquor almost every day?
Yes (2) No (0)

☐ ##4. Do you have an illness or condition that made you change the food you eat?
Yes (2) No (0)
Are you on any special diets for medical reasons? If on special diet(s), check all that apply:
☐ *Low sodium/salt* ☐ *Low fat/cholesterol* ☐ *Low Sugar* ☐ *Calorie supplement*
☐ *Other (specify)* _____

☐ ##5. Do you eat at least two meals a day?
Yes (0) No (3)
How is your appetite? Would you say that your appetite is:
☐ *Good* ☐ *Fair* ☐ *Poor*

☐ ##6. Do you eat some fruits and vegetables every day?
Yes (0) No (1)
Briefly describe what you usually eat and drink during a typical day (including food on weekends):
_____
_____
_____

☐ ##7. Do you have some milk products every day?
Yes (0) No (1)

☐ ##8. Do you have any problems with your teeth, mouth, or throat that make it hard for you to chew or swallow?
Yes (2) No (0)
☐ *Tooth or mouth problems* ☐ *Taste problems* ☐ *Can't eat certain foods* ☐ *Swallowing problems*
☐ *Food allergies* ☐ *Nausea* *Other (Describe)* _____

☐ ##9. Do you eat alone most of the time?
Yes (1) No (0)

☐ ##10a. Are you usually able to shop for yourself?
Yes (0) No (0.5)

☐ ##10b. Are you usually able to cook for yourself?
Yes (0) No (0.5)

☐ ##11. Are you usually able to eat without help?
Yes (0) No (1)

☐ ##12. Do you have enough money to buy the food you need?
Yes (0) No (4)

TOBACCO USE

##1. Do you smoke or use tobacco products? ☐ Yes (Y) ☐ No (N)

##2. Have you ever smoked or used tobacco? ☐ Yes (Y) ☐ No (N)
If yes, for how long? _____

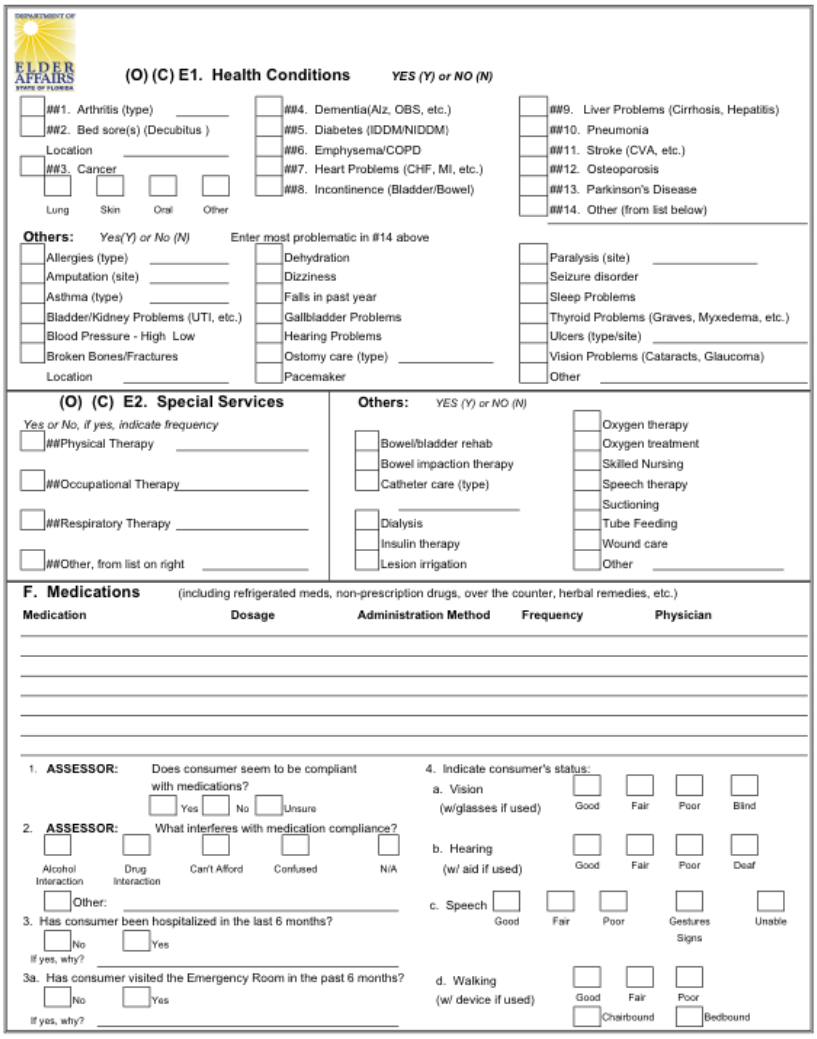
##3. Do you live with others who smoke? ☐ Yes (Y) ☐ No (N)

ASSESSOR:
DOES THERE APPEAR TO ☐ Yes (Y) ☐ No (N)
BE A NEED FOR FOOD STAMPS?

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

SUMMARY



(O) (C) E1. Health Conditions

YES (Y) or NO (N)

- ##1. Arthritis (type) _____
- ##2. Bed sore(s) (Decubitus) Location _____
- ##3. Cancer — Lung, Skin, Oral, Other
- ##4. Dementia(Alz, OBS, etc.)
- ##5. Diabetes (IDDM/NIDDM)
- ##6. Emphysema/COPD
- ##7. Heart Problems (CHF, MI, etc.)
- ##8. Incontinence (Bladder/Bowel)
- ##9. Liver Problems (Cirrhosis, Hepatitis)
- ##10. Pneumonia
- ##11. Stroke (CVA, etc.)
- ##12. Osteoporosis
- ##13. Parkinson's Disease
- ##14. Other (from list below) _____

Others: *Yes(Y) or No (N)* Enter most problematic in #14 above

- Allergies (type) _____
- Amputation (site) _____
- Asthma (type) _____
- Bladder/Kidney Problems (UTI, etc.)
- Blood Pressure - High Low
- Broken Bones/Fractures Location _____
- Dehydration
- Dizziness
- Falls in past year
- Gallbladder Problems
- Hearing Problems
- Ostomy care (type) _____
- Pacemaker
- Paralysis (site) _____
- Seizure disorder
- Sleep Problems
- Thyroid Problems (Graves, Myxedema, etc.)
- Ulcers (type/site) _____
- Vision Problems (Cataracts, Glaucoma)
- Other _____

(O) (C) E2. Special Services

Yes or No, if yes, indicate frequency

- ##Physical Therapy _____
- ##Occupational Therapy _____
- ##Respiratory Therapy _____
- ##Other, from list on right _____

Others: *YES (Y) or NO (N)*

- Bowel/bladder rehab
- Bowel impaction therapy
- Catheter care (type) _____
- Dialysis
- Insulin therapy
- Lesion irrigation
- Oxygen therapy
- Oxygen treatment
- Skilled Nursing
- Speech therapy
- Suctioning
- Tube Feeding
- Wound care
- Other _____

F. Medications

(including refrigerated meds, non-prescription drugs, over the counter, herbal remedies, etc.)

Medication	Dosage	Administration Method	Frequency	Physician

1. **ASSESSOR:** Does consumer seem to be compliant with medications? Yes, No, Unsure

2. **ASSESSOR:** What interferes with medication compliance? Alcohol Interaction, Drug Interaction, Can't Afford, Confused, N/A, Other: _____

3. Has consumer been hospitalized in the last 6 months? No, Yes — If yes, why? _____

3a. Has consumer visited the Emergency Room in the past 6 months? No, Yes — If yes, why? _____

4. Indicate consumer's status:

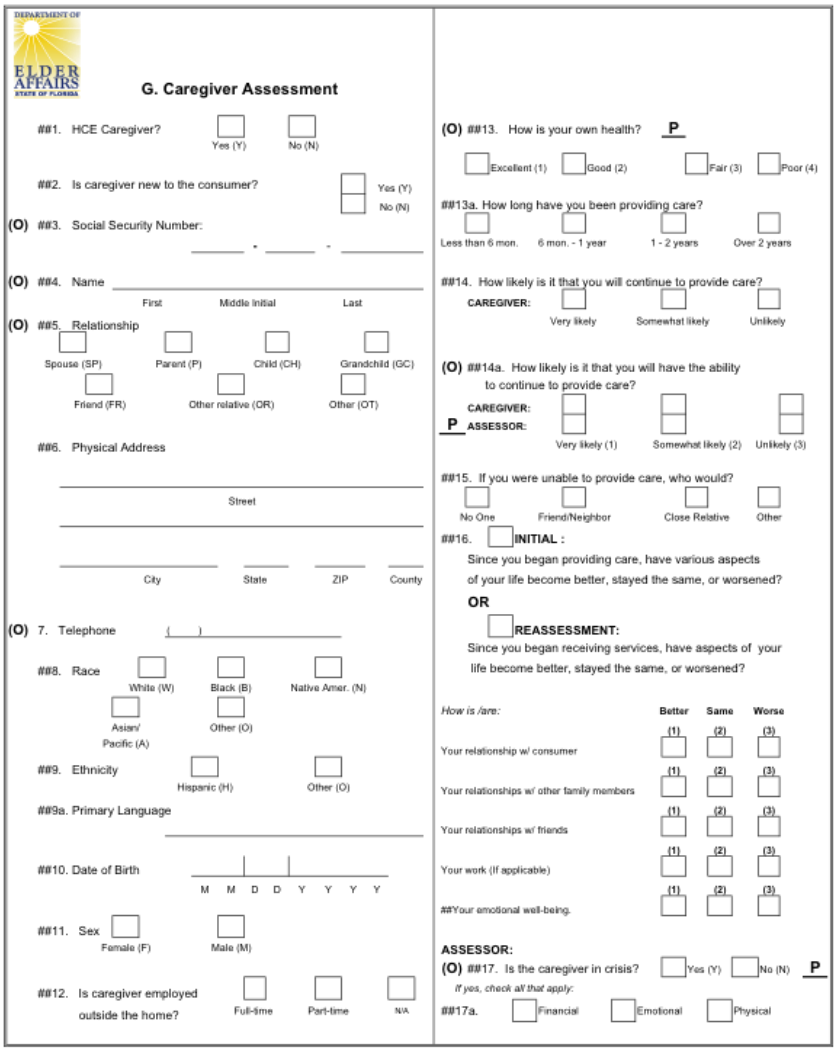
a. Vision (w/glasses if used) — Good, Fair, Poor, Blind

b. Hearing (w/ aid if used) — Good, Fair, Poor, Deaf

c. Speech — Good, Fair, Poor, Gestures Signs, Unable

d. Walking (w/ device if used) — Good, Fair, Poor, Chairbound, Bedbound

DOEA FORM 701B, September 2008 5



DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

G. Caregiver Assessment

##1. HCE Caregiver? ☐ Yes (Y) ☐ No (N)

##2. Is caregiver new to the consumer? ☐ Yes (Y) ☐ No (N)

(O) ##3. Social Security Number: ___ - ___ - ___

(O) ##4. Name _____ (First, Middle Initial, Last)

(O) ##5. Relationship
☐ Spouse (SP) ☐ Parent (P) ☐ Child (CH) ☐ Grandchild (GC)
☐ Friend (FR) ☐ Other relative (OR) ☐ Other (OT)

##6. Physical Address
_____ (Street)
_____
_____ (City) _____ (State) _____ (ZIP) _____ (County)

(O) 7. Telephone ( ) _____

##8. Race ☐ White (W) ☐ Black (B) ☐ Native Amer. (N) ☐ Asian/ Pacific (A) ☐ Other (O)

##9. Ethnicity ☐ Hispanic (H) ☐ Other (O)

##9a. Primary Language _____

##10. Date of Birth ___ ___ (M M D D Y Y Y Y)

##11. Sex ☐ Female (F) ☐ Male (M)

##12. Is caregiver employed outside the home? ☐ Full-time ☐ Part-time ☐ N/A

(O) ##13. How is your own health? P
☐ Excellent (1) ☐ Good (2) ☐ Fair (3) ☐ Poor (4)

##13a. How long have you been providing care?
☐ Less than 6 mon. ☐ 6 mon. - 1 year ☐ 1 - 2 years ☐ Over 2 years

##14. How likely is it that you will continue to provide care?
CAREGIVER: ☐ Very likely ☐ Somewhat likely ☐ Unlikely

(O) ##14a. How likely is it that you will have the ability to continue to provide care?
CAREGIVER:
P ASSESSOR:
☐ Very likely (1) ☐ Somewhat likely (2) ☐ Unlikely (3)

##15. If you were unable to provide care, who would?
☐ No One ☐ Friend/Neighbor ☐ Close Relative ☐ Other

##16. ☐ INITIAL :
Since you began providing care, have various aspects of your life become better, stayed the same, or worsened?
OR
☐ REASSESSMENT:
Since you began receiving services, have aspects of your life become better, stayed the same, or worsened?

How is /are:	Better (1)	Same (2)	Worse (3)
Your relationship w/ consumer	☐	☐	☐
Your relationships w/ other family members	☐	☐	☐
Your relationships w/ friends	☐	☐	☐
Your work (If applicable)	☐	☐	☐
##Your emotional well-being.	☐	☐	☐

ASSESSOR:
(O) ##17. Is the caregiver in crisis? ☐ Yes (Y) ☐ No (N) P
If yes, check all that apply:
##17a. ☐ Financial ☐ Emotional ☐ Physical

DOEA FORM 701B, September 2008 6

H. Social Resources

1. Does consumer live alone? ☐ Yes (6) ☐ No (0) If no, with whom? _____

##1a. Does consumer care for grandchildren on a permanent basis? ☐ Yes ☐ No

##2. If needed, could you stay with someone, or they stay with you? ☐ Yes (Complete below) (0) ☐ No (6)

Name: _____ Relationship to consumer: _____

Address: _____ Phone: _____

##3. Do you have someone you can talk to when you have a problem (other than caregiver)? ☐ Yes (0) ☐ No (4)

Name: _____ Relationship to consumer: _____

##4. About how many times do you talk to friends, relatives, telephone reassurance volunteers or others on the telephone in a week, either they call you or you call them?

☐ Once a day or more (0) ☐ 2-6 times a week (2) ☐ Once a week (2) ☐ Not at all (4) ☐ No phone (4)

##5. How many times during a week do you spend time with someone who does not live with you - you go see them, they come to visit, or you do things together? ☐ Once a day or more (0) ☐ 2-6 times a week (2) ☐ Once a week (2) ☐ Not at all (4)

6. Are you able to participate in activities such as day care, senior center, church or other interests that you enjoy? ☐ Yes ☐ No If no, why not? _____

7. Do you own a pet? ☐ Yes ☐ No If yes, specify _____

Can you feed your pet? ☐ Yes ☐ No Clean up after your pet? ☐ Yes ☐ No Exercise your pet? ☐ Yes ☐ No

8. If consumer is the caregiver/guardian of a grandchild or child, under 19 years old or disabled, (section A. #3a. & 3b.) complete information on the child:

Child's name: _____ Child's date of birth: ___ - ___ - _____

Child's relationship to the consumer: _____ Is child disabled? _____ (Yes or No)

SUMMARY

##I. Environmental Assessment (Enter Risk below in CIRTS)

Case Manager: Please indicate the specific area(s) where there are potential safety or accessibility problems for the client.

☐ Building in need of repairs	☐ Refrigerator not working	☐ Grab bars/handrails needed
☐ Furniture in need of repairs	☐ Telephone not working	☐ Bathtub/shower unsafe
☐ Inadequate/insufficient plumbing	☐ No telephone	☐ Commode unsafe
☐ No/insufficient heat	☐ Flooring/rugs loose	☐ Electrical hazards
☐ No/insufficient hot water	☐ Lighting inadequate	☐ Insect or other pests present
☐ No air conditioning	☐ Stairs/railings unsafe	☐ Unsanitary conditions or odors
☐ Stove not working	☐ Ramp needed/unavailable	☐ Other - specify in comments

COMMENTS:

☐ **No Risk:** The physical environment is generally well equipped and supportive. This includes building, neighborhood and necessary furnishings.

☐ **Low Risk:** The physical environment has few negative aspects. The few negative aspects are minor or within acceptable living standards and are not hazardous to the consumer's well-being.

☐ **Moderate Risk:** The physical environment is negative. Many aspects are substandard or hazardous. The consumer may not be able to remain in the current dwelling.

☐ **High Risk:** The physical environment is strongly negative or hazardous. The consumer should change dwellings or is very likely to need to change dwellings unless immediate corrective action is taken to address the negative or hazardous aspects.

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

ASSESSMENT SUMMARY

PROBLEMS	LIABILITIES/ CHALLENGES/BARRIERS	RESOURCES/ASSETS	GAPS WHICH NEED TO BE MET IN CARE PLAN
B. CONSUMER CONDITIONS			
D. NUTRITION			
E. HEALTH			
F. MEDICATIONS			
G. CAREGIVER			
H. SOCIAL RESOURCES			
I. ENVIRONMENTAL			

Florida Department of Children and Families

ADULT SERVICES CLIENT ASSESSMENT

Client Name:_____ **Client ID:**_____

Information Source / Relationship to Client:_____ / _____

I. HEALTH ASSESSMENT

SUBJECTIVE EVALUATION OF HEALTH: Overall, do you consider your health as excellent, good, fair, poor or serious?

_____ Excellent (0) _____ Good (5) _____ Fair (10) _____ Poor (15) _____ Serious (20)

SUBJECTIVE EVALUATION OF HEALTH SCORE ☐

HEALTH PROBLEMS

1. Do you have any health problems, and how do they affect you? For instance, has your doctor told you that you have any of the following health problems or symptoms?

Health Condition	Present	Interferes with Living	Condition Not Under Treatment
Allergies (Type) (Drug/skin/etc.)	____	____	____
Amputation	____	____	____
Anemia (Type)	____	____	____
Arthritis (Type)	____	____	____
Asthma (Type)	____	____	____
Bladder/Kidney Problems (UTI, etc)	____	____	____
Broken Bones (Type; Site)			
Cancer (Type)	____	____	____
Cerebral Palsy			
Decubitus	____	____	____
Dehydration			
Dementia (Type) (Alz., OBS, etc)	____	____	____
Dialysis (Type)			
Diabetes (Type)	____	____	____
Dizziness			
Emphysema (COPD, etc)	____	____	____
Head Trauma	____	____	____
Hearing Problems	____	____	____
Heart Problems (CHF, MI, etc)	____	____	____
High Blood Pressure (Type)	____	____	____
Liver Problems (Cirrhosis/Hepatitis)	____	____	____
Lupus	____	____	____
Multiple Sclerosis	____	____	____
Muscular Dystrophy	____	____	____
Osteoporosis	____	____	____
Paralysis (Site)	____	____	____
Parkinson's Disease	____	____	____
Pneumonia	____	____	____
Potassium/Sodium Imbalance	____	____	____
Seizure Disorders (Epilepsy, etc)	____	____	____
Shingles (Herpes Zoster)	____	____	____
Sleep Problems	____	____	____
Spina Bifida			
Spinal Injury	____	____	____
Stroke (CVA, etc)			
Tuberculosis	____	____	____
Ulcers			
Vision Problems (Type)	____	____	____
Thyroid Problems (Graves, etc)			
Other:_____	____	____	____
Other:_____	____	____	____

Describe concerns regarding health problems:

HEALTH ASSESSMENT SCORE ☐

0 = No Health Conditions, 5 = Minor Health Conditions, 10 = Moderate Health Conditions
15 = Substantial Health Conditions, 20 = Serious Heal

Incorporated by reference in 59G-13.030, F.A.C., CF-AA 3019, PDF 10/2005

I. HEALTH ASSESSMENT

MEDICAL TREATMENTS AND THERAPIES (Place a ✓ mark next to any of the following medical treatments received by the client)

☐ Aseptic dressing	☐ Insulin therapy	☐ Physical therapy
☐ Bedsores treatment	☐ Lesion irrigation	☐ Occupational therapy
☐ Bowel/bladder rehab	☐ Ostomy care (type:)	☐ Speech therapy
☐ Catheter care (type:)	☐ Oxygen	☐ Respiratory therapy
☐ Dialysis (type:)	☐ Respiratory treatment	☐ Radiation
☐ IV fluids	☐ Suctioning	☐ Chemotherapy
☐ IV medicines	☐ Tube feeding	☐ Other (specify below)

NOTE ANY SPECIAL EQUIPMENT OR PROVIDERS USED OR NEEDED BY THE CLIENT:

MEDICATIONS (List current prescription and non-prescription medications)

Name of Medication	Dosage	Frequency	Physician	Name of Medication	Dosage	Frequency	Physician

What pharmacy does client use?

Describe concerns regarding medication use:

NUTRITION

(Enter scores below)

1. How is your appetite? Would you say that your appetite is good, fair or poor?
   ____ Good (0) ____ Fair (2) ____ Poor (6)

2. Current weight and height? Weight:_____ Height:_____

3. Have you gained or lost significant (10% change) amount of weight in the last 6 months? ____ Yes (4) ____ No (0)
   Describe gain or loss: _____ Gain _____ Loss
   Note: If significant gain or loss of weight was recommended by a physician, a "Yes" response receives no score.

4. Do you have difficulty eating? Why?

	Yes	No		Yes	No
Tooth or mouth problems?	____ (4)	____ (0)	Taste problems?	____ (0)	____ (0)
Swallowing Problems?	____ (4)	____ (0)	Problems eating certain foods?	____ (0)	____ (0)
Nausea/Vomiting?	____ (4)	____ (0)	Any food allergies?	____ (0)	____ (0)

   Any other problems with eating (describe below)? ____ Yes (0) ____ No (0)

5. Are you on any special diets for medical reasons? ____ none (0) ____ 1 diet (4) ____ 2 or more diets (6)
   ____ Low sodium (salt) ____ Low fat/cholesterol ____ Low sugar ____ Calorie supplement ____ Other (describe below)

6. Describe concerns regarding nutrition problems:

NUTRITION SCORE ☐

II. FUNCTIONAL ASSESSMENT

FUNCTIONAL ASSESSMENT

Do you need someone to assist you with:

Activities of Daily Living (ADLs)	No Help	Some Help/Supervision	Total Assistance
1. Dressing. Includes getting out clothes and putting them on and fastening them, and putting on shoes.	0	2	3
2. Grooming. Includes combing hair, washing face, shaving, and brushing teeth.	0	2	3
3. Bathing. Includes running the water, taking the bath or shower and washing all parts of the body, including hair.	0	2	3
4. Eating. Includes eating, drinking from a cup and cutting foods.	0	2	3
5. Transferring. Includes getting in and out of a bed or chair.	0	2	3
6. Walking/Mobility. Includes walking. Independence in walking refers to the ability to walk short distances at home. (Does not include climbing stairs.)	0	2	3
7. Climbing Stairs. Ability to climb stairs.	0	2	3
8. Toileting. Includes ability to manage use of toilet.	0	2	3
9. Bladder/Bowel Control ____ Never have accidents (0) ____ Occasionally have accidents (2) ____ Often have accidents (3) ____ Always have accidents (4) (enter score)			
10. Does client wear special briefs for incontinence? ____ Yes ____ No (If no, skip next question)			
11. How well do you manage changing them?	0	2	3

ADL SCORE (sum of circled 2's, 3's & Bladder Control Score) ____

ADL IMPAIRMENT COUNT (# of 2's & 3's circled) ____

CF-AA 3019, PDF 10/2005

III. CLIENT SUPPORT ASSESSMENT Page 3

CLIENT SUPPORT

What help are you receiving? (detail who, what, how often) What equipment would aid in the performance of these activities?	Is Amount of Help Adequate?
1.	☐ Yes ☐ No
2.	☐ Yes ☐ No
3.	☐ Yes ☐ No
4.	☐ Yes ☐ No
5.	☐ Yes ☐ No
6.	☐ Yes ☐ No
7.	☐ Yes ☐ No
8.	☐ Yes ☐ No
9.	☐ Yes ☐ No
10.	
11.	☐ Yes ☐ No

II. FUNCTIONAL ASSESSMENT

III. CLIENT SUPPORT ASSESSMENT Page 4

FUNCTIONAL ASSESSMENT Do you need someone to assist you with:	No Help	Some Help/Supervision	Total Assistance
Instrumental Activities of Daily Living (IADLs)			
12. Answering the Telephone. Includes the use of an amplifier or special equipment.	0	2	3
13. Making Telephone Calls. Includes ability to call another party on the telephone.	0	2	3
14. Shopping. Includes shopping for food and other things, but does not include transportation.	0	2	3
15. Transportation Ability. Includes using local transportation or driving to places beyond walking distance.	0	2	3
16. Preparing Meals. Includes preparing meals for yourself including sandwiches, cooked meals and TV dinners.	0	2	3
17. Laundry. Includes doing laundry; putting clothes in the washer or dryer, starting and stopping the machine, and drying clothes.	0	2	3
18. Light Housekeeping. Includes dusting, vacuuming, sweeping, etc., but does not include laundry.	0	2	3
19. Heavy Chores. Includes yard work, windows, moving furniture, but does not include laundry.	0	2	3
20. Taking Medication. Includes ability to take own medication.	0	2	3
21. Handling Money. Includes managing own money, such as paying bills, and/or balancing checkbook.	0	2	3

CLIENT SUPPORT What help are you receiving? (detail who, what, how often) What equipment would aid in the performance of these activities?	Is Amount of Help Adequate?
12.	☐ Yes ☐ No
13.	☐ Yes ☐ No
14.	☐ Yes ☐ No
15.	☐ Yes ☐ No
16.	☐ Yes ☐ No
17.	☐ Yes ☐ No
18.	☐ Yes ☐ No
19.	☐ Yes ☐ No
20.	☐ Yes ☐ No
21.	☐ Yes ☐ No

IADL SCORE (Sum of circled 2's & 3's in IADL section) ☐

IADL IMPAIRMENT COUNT (# of 2's & 3's circled) ☐

CLIENT SUPPORT SCORE (includes Client Support Items 1 - 21) ☐

0 = No need, 5 = Low need, 10 = Moderate need,

CLIENT SUPPORT COUNT(# N's) (includes Client Support Items 1 - 21) ☐

Comments / Functional and Client Support Assessment Sections:

CF-AA 3019, PDF 10/2005

IV. ENVIRONMENTAL ASSESSMENT

SUBJECTIVE EVALUATION OF ENVIRONMENT

1. Are you concerned about your safety in your home or neighborhood? ____ Yes ____ No (If yes, explain)

POTENTIAL SAFETY/ACCESSIBILITY PROBLEMS

1. (Check all of the following areas that apply)

Area		Comments
Structural damage/dangerous floors	____	
Barriers to access	____	
Electrical hazards	____	
Fire hazards	____	
Unsanitary conditions/odors	____	
Insects or other pests	____	
Poor lighting	____	
Insufficient hot water/water	____	
Insufficient heat/air conditioning	____	
Inaccessible shopping	____	
Inaccessible transportation	____	
Inaccessible telephone	____	
Unsafe neighborhood	____	
Inability to evacuate in emergency	____	
Other (describe)	____	

ENVIRONMENTAL COUNT(# of √'s) ☐ **ENVIRONMENT SCORE** ☐

0 = No need, 5 = Low need, 10 = Moderate need
15 = Substantial need, 20 = Serious need

V. INDICATION OF OTHER PROBLEMS

Is there any indication of cognitive functioning problems? ..... ____ Yes ____ No **(If yes, complete Page 6)**

Is there any indication of mental health/substance abuse problems? ..... ____ Yes ____ No **(If yes, complete Page 7)**

Is caregiver assessment warranted?..... ____ Yes ____ No **(If yes, complete Page 8)**
(Check yes for HCDA, and others as warranted)

CLIENT ASSESSMENT SCORING MATRIX

DOMAIN	LEVEL 1		LEVEL 2		LEVEL 3		LEVEL 4		LEVEL 5		
	Range	Score	Range	Score	Range	Score	Range	Score	Range	Score	Count
Subjective Evaluation of Health	0		5		10		15		20		
Health Assessment	0		5		10		15		20		
Nutrition	≤4		6-10		12-16		18-22		24-28		
Functional - ADLs	≤5		6-11		12-17		18-24		25-31		
Functional - IADLs	≤5		6-11		12-17		18-24		25-30		
Client Support	0		5		10		15		20		
Environment	0		5		10		15		20		
Total Ranges (L1 - L5)	≤14		15-52		53-90		91-130		131-169		
TOTAL CLIENT SCORE: (Does not include Count)											

Signature of Assessor _____ Program/Unit _____ Date _____

Signature of Assessor _____ Program/Unit _____ Date _____

CF-AA 3019, PDF 10/2005

VI. COGNITIVE ASSESSMENT

(Complete only if indication(s) of cognitive functioning problems)

COMMUNICATION ABILITY

1. Rate the client's speaking and communication ability based on performance in the interview:

Speaking	Communication
____ Speaks clearly with others of the same language	____ Transmits/receives information
____ Some defect in speech--usually gets message across	____ Limited ability
____ Unable to speak clearly/does not speak	____ Nearly or totally unable

2. Assessor's rationale and concerns regarding indication(s) of cognitive impairment:

(The following mental status exam may be used to document assessor's concerns.)

MENTAL STATUS QUESTIONNAIRE (MSQ) Orientation-Memory-Concentration Test (Katzman et al., 1983)

Now I'm going to read you a list of questions. These are questions that are often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Items	Maximum Errors	Score	Weight	Weighted Score
What year is it now?	1	_____	x 4 =	_____
What month is it now?	1	_____	x 3 =	_____

(Tell the client you are giving them a man's name and address to memorize.)

Memory phrase: John Brown, 42 Market Street, Chicago

(Elicit 3 correct repetitions from the client, phrase by phrase or word by word, if necessary, before continuing.)

Without looking at a clock, about what time is it? (Within 1 hour) ..... 1 _____ x 3 = _____

Count backwards from 20 to 1. (Check missed/out of order numbers in boxes.) ..... 2 _____ x 2 = _____

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

Say the months in reverse order. Hint: For ease in scoring, start with the month of December.
(Check missed/out of order months in boxes.) ..... 2 _____ x 2 = _____

Dec.	Nov.	Oct.	Sept.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.

Ask the client to repeat the memory phrase. Prompt the client if necessary: "It was John Brown..."
(Write the client's response on the line below to score.) ..... 5 _____ x 2 = _____

	John	Brown,	42	Market Street,	Chicago
Error Points:	(1)	(1)	(1)	(1)	(1)

weighted risk score: (0-4 = Low) (5-9 = Moderate) (10-28 High)

Total Weighted Error Score: _____

VII. MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

(Complete only if indication(s) of mental health/substance abuse problems)

Are you currently or have you previously received mental health services or counseling? ____ Yes ____ No

What is your mental health diagnosis? _____

Name of provider:_____. Describe services:

EMOTIONAL WELL BEING: Now I have some questions about how you have been feeling during the past month.

	Yes	No
Are you satisfied with life?	____	____
Have you been depressed or very unhappy?	____	____
Have you been very anxious or nervous?	____	____
Have you had difficulty sleeping?	____	____
Have you seen or heard things that other people didn't see or hear?	____	____
Have you become physically aggressive, or made threats to harm anyone?	____	____
Have you had a serious thought about harming or killing yourself?	____	____
Is anyone plotting against you?	____	____

MEMORY ASSESSMENT: I'd like to ask you some questions about your memory and ability to find things. In the past month have you:

	Yes	No
Had problems with your memory?	____	____
Frequently lost items such as your purse/wallet or glasses?	____	____
Failed to recognize family members or friends?	____	____
Lost your way around the house; can't find the bedroom or bathroom?	____	____
Forgotten to turn the stove off?	____	____
Wandered away from home for no apparent reason?	____	____

ALCOHOL/SUBSTANCE USE

Do you drink alcoholic beverages including beer and wine? ____ Yes ____ No (If no, skip next question.)

On average, counting beer, wine, and other alcoholic beverages, how much do you drink? (Describe frequency.)

Do you have a history of substance abuse? ____ Yes (Describe) ____ No

Do you smoke or use tobacco? ____ Yes ____ No (If no, skip next question.)

On average, how much do you smoke per day? (Describe frequency.)

Assessor's rationale and concerns regarding indication(s) of mental health issues/substance abuse:

VIII. CAREGIVER ASSESSMENT

(Complete for all HCDA clients and for other client's if there is an indication of caregiver issues.)
(Address to caregiver only)

1. Name:_____ Relationship:_____

2. How long have you given care to (Name of client)? _____ Years _____ Months

3. How often do you give care to (Name of client)? Would you say you give care:
   ____ Every day
   ____ Several times a week
   ____ At least once a week
   ____ Less than once a week
   ____ Don't know

4. Are you employed full-time, part-time, or not working at all?
   ____ Full-time ____ Part-time ____ Not working

5. If you were suddenly unable to provide care, who would take your place?
   ____ No one ____ Other (specify):_____

6. How is your own health? Would you say it is excellent, good, fair or poor?
   ____ Excellent ____ Good ____ Fair ____ Poor

7. Considering the care you provide for (Name of client), I would like to ask you if various aspects of your life have become better, the same, or worse. Let's start with...

	Better	Same	Worse	Don't Know
Relationship with (Name of client)	____	____	____	____
Relationship with other family members	____	____	____	____
Relationship with friends	____	____	____	____
Your health	____	____	____	____
Your work (if applicable)	____	____	____	____
Your emotional well-being	____	____	____	____

8. Is there anything else we need to know that makes it difficult for you to manage care? ____ Yes (explain) ____ No

9. Do you (caregiver) need training or services? ____ Yes (describe) ____ No

10. Assessor's concerns regarding caregiver's ability to provide care:

CF-AA 3019, PDF 10/2005

FLORIDA MEDICAID

MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME- AND COMMUNITY-BASED SERVICES FORM (MCNF/HCBS)

(Replaces Patient Transfer and Continuity of Care Form)

(A) FACILITY INFORMATION

Facility From _____

Admission Date	Discharge Date
____/____/____	____/____/____

(B) DEMOGRAPHIC INFORMATION

Individual's DOB ____/____/____ Sex _____ Race _____

Individual's Last Name First Name I

Individual's Address Phone

Nearest Relative/Health Care Surrogate Phone N

PHYSICIAN INFORMATION

Name

Will you care for individual in NF? ☐ Yes ☐ No

If no, referred to

Principal Diagnosis

Secondary Diagnosis

Discharge Diagnosis

(Problem List may be attached)

Date ____/____/____

Allergy/Drug Sensitivity

MEDICATION AND TREATMENT ORDERS (copies may be attached)

(C) PREADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION

1. Is dementia the primary diagnosis? ☐ Yes ☐ No
2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years? ☐ Yes ☐ No
3. Is there an indication of, or diagnosis of serious mental illness (MI), such as (check all that ap
   - ☐ Schizophrenia
   - ☐ Mood disorder
   - ☐ Somatoform disorder
   - ☐ Paranoia
   - ☐ Panic or severe anxiety disorder
   - ☐ Personality disorder
   - ☐ Other psychotic or mental disorder leading to chronic disability
4. Has the individual received MI services within the past two years? ☐ Yes ☐ No
5. Is the individual a danger to self or others? *(If yes, please attach expla* ☐ Yes ☐ No
6. Is the individual on any medication for the treatment of a serious menta ☐ Yes ☐ No illness or psychiatric diagnosis?
7. If yes, is the MI or psychiatric diagnosis controlled with medication? ☐ Yes ☐ No
8. Is the individual being admitted from a hospital after receiving acute inpatient care? ☐ Yes ☐ No
9. Does the individual require nursing facility services for the condition for he/she received care in the hospital? ☐ Yes ☐ No
10. Has the physician certified the individual is likely to require less than 3 of nursing facility services? ☐ Yes ☐ No

(D) ADDITIONAL ORDERS (Orders may be attached)

(E) HISTORY & PHYSICAL AND LABS

1. PHYSICAL EXAM (History & Physical may be attached)

Head Ears Eyes Nose & Throat (HEENT)

Neck

Cardiopulmonary

Abdomen

GU

Rectal

Extremities

Neurological

Other

Free from communicable diseases ☐ Yes ☐ No

2. LABORATORY FINDINGS (Reports may be attached)

TB Test ☐ Yes ☐ No Date ____/____/____

Results

Chest X-Ray ☐ Yes ☐ No Date ____/____/____

Results

(F) IMMUNIZATIONS GIVEN

- ☐ Pneumococcal Vaccine Date ____/____/____
- ☐ Influenza Vaccine Date ____/____/____
- ☐ Tetanus and Diphtheria Vaccine Date ____/____/____
- ☐ Herpes Zoster Vaccine Date ____/____/____

(G) PHYSICAL THERAPY (Attach Orders)

☐ New Referral ☐ Continuation of Therapy

FREQUENCY OF THERAPY

INSTRUCTIONS

- ☐ Stretching
- ☐ Passive Range of Motion (ROM)
- ☐ Active assistive
- ☐ Active
- ☐ Progressive resistive

- ☐ Coordinating Activities
- ☐ Non-weight bearing
- ☐ Partial weight bearing
- ☐ Full weight bearing

- ☐ Progress bed to wheelchair
- ☐ Recovery to full function
- ☐ Wheelchair independent
- ☐ Complete ambulation

Sensation Impaired: ☐ Yes ☐ No

Restrict Activity: ☐ Yes ☐ No

PRECAUTIONS

- ☐ Cardiac
- ☐ Other

ADDITIONAL THERAPIES (Attach Orders)

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Respiratory Therapy
- ☐ Other

(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)

- ☐ Catheter Care
- ☐ Changing Feeding Tube
- ☐ Dressing Changes
- ☐ Ostomy Care
- ☐ Wound Care
- ☐ Suctioning
- ☐ Trach Care
- ☐ Diabetic Care
- ☐ Monitor Blood Sugar/Frequency
- ☐ Administer Insulin
- ☐ Tube Feeding
- ☐ Oxygen *(Select from below)*
  - ☐ PRN
  - ☐ Continuous @L/min

Instructions

(I) SPECIAL DIET ORDERS (Orders may be attached)

(J) TYPE OF CARE RECOMMENDED

☐ Skilled Nursing Extended Care Facility (ECF), Duration _____ Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

☐ Intermediate Care: Duration _____ Admission Date to Nursing Facility ____/____/____ Effective Date of Medical Condition ____/____/____

☐ I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization.

☐ I certify that this individual is in need of Medicaid Waiver Services in lieu of Institutional placement.

Print Physician's Name

Address

Phone Number **Fax**

Email Contact Address

FOR ONLINE APPLICANT USE ONLY

IF APPLYING FOR MEDICAID, PLEASE INCLUDE

Physician's Signature **Date** ____/____/____

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

Notification of Level of Care

1. From CARES PSA/Worker: _____ To District: _____ C&F Unit/Other: _____

Case Mgr: _____ Case Mgt Agency: _____

2. Client Name: _____ DOB: _____ SSN: _____

Current Location: _____

3. Level of Care:

☐ Skilled ☐ Intermediate I ☐ Withhold LOC

☐ Risk of Hospital ☐ Intermediate II ☐ Does Not Meet LOC

4. Meets Program Requirements For:

☐ PAC ☐ Aged & Disabled Adults ☐ Assisted Living

☐ Channeling ☐ Elder Care

☐ Cystic Fibrosis

☐ Model Waiver ☐ Brain and Spinal Cord Injury ☐ LTCCDPP

☐ PACE ☐ Does Not Meet Waiver Criteria ☐ Other Program

Specify: _____

5. Placement Recommendation:

☐ Community ☐ Nursing Facility ☐ Temporary Nursing Facility

☐ Swing Bed ☐ State Mental Health Hospital

☐ Other Placement

Specify: _____

☐ Hospital Based Nursing
Bed for Rehab Care

6. OBRA Screen: ☐ MI Level I ☐ MR Level I ☐ MI Level II

☐ MR Level II

7. LOC Effective Date: _____

8. Comments: _____
_____
_____
_____
_____

9. Approval Signature: _____ Date: _____

DOEA-CARES form 603 (Revised, March 2003), Incorporated by reference in 59G-13.030, F.A.C.

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Request for Approval of Care Plan Services Increase

Part I: Recipient Information

Name: Last name, first name, middle name or initial	Date of birth:
Social security number:	Medicaid/Medicare Medical assistance number:
Current Address: County:	Address where services will be received: County:
Status (Transfer/Existing): If individual is a transfer, indicate originating district/agency: If individual is an existing consumer with your agency, indicate current monthly authorized units of service by service type(s):	Describe reason for service funding increase. An Adult Services client reassessment was completed on _____ by _____ and respective revised care plan revisions made on _____ by _____ , to reflect that this Recipient is justifiably in need of increased Service(s) based on (check all situations which apply): ☐ Failing Support System ☐ Decrease in Functional Capacity ☐ Rapidly Deteriorating Health
Medicaid waiver eligibility date: _____	

Provider Information

Agency name:	Agency contact person:
Agency address:	Phone:_____ Fax:_____ E-mail address:

Part II: Summary of Recipient's Presenting Situation. (Refer to form instructions for details about the type of information required here. Use the space below or include attachment.)

Part III: Proposed New Service Request. (Please indicate the new care plan services being requested and the corresponding, anticipated service start dates.)

Service	Anticipated start date	Service	Anticipated start date

Incorporated by reference in 59G-13.030, F.A.C., CF-AA 1116, PDF 05/2004

Part IV: Specific Description of Proposed New Service(s) As Tailored To Meet Recipient's Need. (Refer to the form instructions for details about the type of information required here. Use the space below or include attachment.)

Part V: Cost Detail for Proposed New Care Plan Service(s).

A. Attach a Cost Detail page for each service requested in Part III. Each Cost Detail page should reflect the total annual cost of serving the consumer for that service type.

Part VI: Care Plan Modification of Number of Service Units. The Budget Entity Team will not consider authorization to increase service unit quantity of an authorized service on a Recipient's care plan for any of the following documented reasons unless this section is accurately and fully completed.

[To justify unit service rates, please present comparative information: unit rate quotes from a minimum of three other service agencies providing this same service within a ten mile radius; reasons for choosing this specific vendor; a statement attesting to the fact that selected vendor is a sole source provider of this service in this geographic area, etc. Attach information as necessary (e.g., agency administrative costs, your agency salary scale, etc.). Refer to the form instructions.]

☐ Failing Support System: List proposed add-on number of monthly service units by service component with annualized service costs projected to safely maintain Recipient at home and to ameliorate this risk factor.

☐ Decrease in Functional Capacity: List proposed add-on number of monthly service units by service component with annualized service costs projected to safely maintain Recipient at home and to ameliorate this risk factor.

☐ Rapidly Deteriorating Health: List care plan add-on number of monthly service units by service component with annualized service costs projected to safely maintain Recipient at home and to ameliorate this risk factor.

Part VII. Signatures. (Please note: Final approval of all requests for Care Plan increases rest with the Budget Entity Team. Providers will receive an Award Letter from the Budget Entity Team (or one of its members) when the plan has been approved.)

Provider: (Signature indicates that the information presented in this Request for Care Plan Services Increase and attachments is accurate and complete.)	Date:
Provider Agency Waiver program Coordinator: (Signature indicates that the agency program coordinator has reviewed the Request for Care Plan Services Increase and attachments.)	Date:
Recipient/Representative: (Signature indicates that the Recipient/Representative has reviewed the Request for Care Plan Services Increase and attachments.)	Date:
District/Regional Program Staff: (Signature indicates that the district/regional program staff and provider have agreed upon the services to be funded.)	Date:
District/Regional Adult Services Program Director: (Signature indicates district/regional approval of the Service Funding Plan.)	Date:

ATTACHMENT D – Informed Consent Form

STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)
DEPARTMENT OF ELDER AFFAIRS (DOEA)

INFORMED CONSENT FORM

CLIENT'S NAME: _____

DATE OF BIRTH: _____

An assessment is required for all persons applying for or receiving assistance for long-term care. This includes the Institutional Care Program (ICP) and Home and Community-Based Services (HCBS) waiver programs.

In order to evaluate my needs, I am giving my consent to the following:

- **I agree to an assessment to identify my need for long-term care, and to determine if my needs can be met in the community instead of a nursing facility.**
- **I authorize DOEA staff to access my medical records. I understand and agree that DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview my family members, close friends and social services professionals about my situation.**

_____
Individual or Representative

_____
Relationship (if representative signs)

_____
Date

AHCA-Med Serv 2040, May 2009, Incorporated by reference in 59G-4.200, F.A.C.

ESTADO DE LA FLORIDA
AGENCIA DE ADMINISTRACIÓN PARA EL CUIDADO DE LA SALUD (AHCA)
DEPARTAMENTO DE LAS PERSONAS MAYORES (DOEA)

CONSENTIMIENTO Y DECLARACIÓN DE QUE HA ENTENDIDO LO QUE FIRMA

NOMBRE DEL CLIENTE:_____

FECHA DE NACIMIENTO:_____

Es necesario que las personas que estén solicitando o recibiendo ayuda de cuidado a largo plazo pasen por una evaluación. Se incluyen los programas de exoneración (waiver) del Programa de Cuidado Institucional *(ICP,* del inglés *Institutional Care Program)* y los Servicios Domésticos y Comunitarios *(CSB,* del inglés *Home and Community Based Services).*

A fin de evaluar mis necesidades, consiento...

- ... a que se evalúe mi necesidad de cuidado a largo plazo, y se determine si en lugar de internarme en un asilo, mis necesidades pueden satisfacerse dentro de la comunidad, y
- Autorizo al DOEA (Departamento de las Personas Mayores) a tener acceso a mis expedientes médicos. Entiendo y estoy de acuerdo que dichos departamentos pudieran necesitar hablar con mi médico y otros profesionales médicos. También entiendo que pudieran tener que entrevistar a familiares, amigos íntimos y profesionales de servicios sociales sobre mi estado.

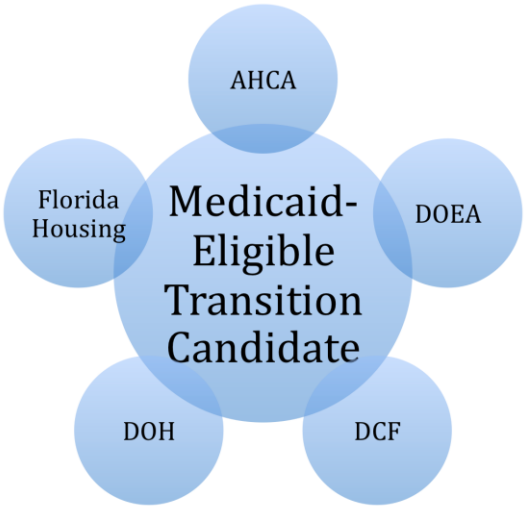
_____
Persona o representante

_____
Relación (si firmase un representante)

_____
Fecha

AHCA-Med Serv 2040, May 2009, Incorporated by reference in 59G-4.200, F.A.C.

ATTACHMENT E – Stakeholder/Relationship Chart



Stakeholders

Advocacy Organizations
Caretakers
Family Members
Landlords
Providers

CARE PLAN

PAGE ____ OF ____ CONSUMER: _____ SOCIAL SECURITY NUMBER: _____ CASE MANAGER: _____ PROVIDER: _____ WORKER ID: _____	CARE PLAN DATE: _____	DESIRED OUTCOMES: ____ Prevent acute episode or nursing home placement. Short Term(ST), Long Term (LT) PROVIDER: Non-DOEA Funded Source: (1) Family and Friends, (2) Local Government, (3) Faith Based, (4) Other Non-profit Association DOEA Funded Source: (1) OAA, (2) NW, (3) ALW, (4) CCE, (5) HCE, (6) ADI, (7) SHINE, (8) Other (Specify) ANTICIPATED SERVICE IMPACT ON HEALTH CONDITIONS: (1) Improve (2) maintain (3) decline (4) unknown	DOEA-FUNDED MONTHLY CARE PLAN COST: ANNUALIZED DOEA-FUNDED CARE PLAN COST: NON-ANNUALIZED DOEA-FUNDED CARE PLAN COST: CO-PAY MONTHLY AMOUNT (circle CCE or ADI): ANNUALIZED CO-PAY AMOUNT: ANNUALIZED NON-DOEA RESOURCE: NON-ANNUALIZED NON-DOEA RESOURCE: Care Plan Total:
HEALTH CONDITIONS AND SERVICE IMPACT: (a) (b) (c) (d)	CARE PLAN REVIEW: _____ _____ _____ _____ _____ _____		

#	Date	Problems/Gaps	Service/Activity	Frequency & Duration Needed: Began (B) Ended (E)	Non-DOEA (ND) / DOEA (D) Planned	Provider: Non-DOEA (ND) DOEA (D)	Date Service: Began (B) Ended (E) Problem: Resolved (RS) Revised (RV)	Unit Cost/ Individual Purchase	Monthly Cost/ Value

I have participated in developing this care plan through discussions regarding my assessed needs, and the services and service providers available to help meet those needs. I understand that the amount of assistance I receive is dependent upon my ability and preference. I understand I am entitled to a grievance review if my services are reduced, changed, or terminated. For Medicaid Waiver services, I accept the services from my choice of enrolled providers, instead of nursing home placement. I understand under Medicaid Waiver, in addition to a grievance review, I am further entitled to a fair hearing. I authorize the provider to release information concerning the services I receive under all programs in the Florida Department of Elder Affairs.

CONSUMER/RESPONSIBLE PARTY: CAREGIVER:	DATE:	CASE MANAGER:	DATE:

ATTACHMENT G – Resident Bill of Rights

Florida Statutes

429.28 Resident bill of rights.

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.

(g)Share a room with his or her spouse if both are residents of the facility.

(h)Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

(k)At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. This notice shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline and, when applicable, the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council, where complaints may be lodged. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council.

(3)(a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents' rights as a prerequisite to initial licensure or licensure renewal.

(b) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.

(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.

(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.

(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.

(4) The facility shall not hamper or prevent residents from exercising their rights as specified in this section.

(5) No facility or employee of a facility may serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, inside or outside the facility.

(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.

(6) Any facility which terminates the residency of an individual who participated in activities specified in subsection (5) shall show good cause in a court of competent jurisdiction.

(7) Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or criminal liability therefor, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justifiable issue of either law or fact raised by the losing party.

ATTACHMENT H. – Resumes and Job Descriptions

PROJECT DIRECTOR – AHCA

% of Time	*Duties and Responsibilities*
	This is a highly responsible administrative and professional position in the Bureau of Medicaid Services. The incumbent in this position will have primary responsibility for the Money Follows the Person (MFP) Demonstration Grant. The incumbent shall be responsible for planning, implementing, and evaluating development activities related to the grant, including goal development, review and resolution of programmatic issues, the development of legislative proposals and legislative budget requests; completion of federal reporting requirements; and coordination with staff from the Agency, partner agencies, and external vendors to meet grant requirements. The incumbent will also act as a contract manager for contracts related to the grant, and shall participate in the any procurement, contract development, and contract management activities related to this grant. The incumbent is responsible for ensuring that these activities comply with applicable federal, state and Agency policies.
10%	**General Knowledge** • Maintain up-to-date knowledge concerning state and federal requirements/regulations related to the MFP Grant, Medicaid, nursing home transition, Medicaid waivers and Health Information Technology.
30%	**Project Management** • Assist in the implementation of and updates to the grant operating plan. • Monitor project activities for completeness and accuracy. • Assign tasks to project staff and track completion. • Coordinate MFP activities among partners. • Coordinate communication and outreach activities. • Track and be responsible for reporting requirements and other federal requirements related to the MFP grant. • Coordinate workgroups and project teams related to MFP grant activities. • Manage project using Medicaid Project Management Methodology and templates.
10%	**Reporting** • Ensure completion and submission all reports related to the MFP Demonstration Grant no later than the specified due dates. • Ensure completion of all public records requests and other requests for ad hoc reports in a timely manner.
10%	**Contract Management** • Ensure that contract operations are consistent with Medicaid policies and procedures; • Participate in the procurement and development of needed contract, including preparing solicitations, assisting in the selection of the contractor, participating in contract negotiations, and coordinating internal review and approval; • Prepare all contract related documents, including amendments and extensions on a timely basis; • Maintain active agency contract manager certification; • Adhere to established agency and state procurement policies and procedures; • Oversee the day-to-day administrative, programmatic, and financial operations of assigned contract; • Enforce performance of assigned contract terms and conditions; • Perform contract monitoring of vendor performance at least annually; • Maintain appropriate and up-to-date contract files; • Process, review, and approve deliverables; • Serve as liaison with assigned contract vendor(s); and • Track contract expenditures, and process invoices within 5 working days of an acceptable completed invoice.
10%	**Program Planning and Analysis** • Perform strategic planning activities for the MFP Demonstration Grant. • Work with other AHCA units, partner agencies, other executive agencies, the Legislature, the federal Centers for Medicare and Medicaid Services, other federal agencies, and other appropriate entities. • Analyze proposed state and federal legislation, rules, regulations and policies to determine the programmatic and fiscal impact on the MFP Demonstration Grant; • Assist in the development of legislative budget requests and substantive legislative proposals.
10%	**Agency Representation** • Represent the agency in local, state, and national meetings, conferences, workshops, and seminars related to the MFP Demonstration Grant. In addition, as assigned, deliver speeches and present programs on MRP to local and state organizations, represent the Medicaid office on health care committees and task forces; work with the executive and legislative branches of government with regard to the Medicaid program.
10%	**Program Monitoring and Evaluation** • Plan, organize, and coordinate monitoring and evaluation for assigned program and contract activities to ensure compliance and efficiency with federal regulations, state statutes, and Medicaid policies to assess the achievement of goals, objectives, and priorities of the Medicaid and MFP programs. • Oversee technical assistance and training activities necessary for quality improvement. • Monitor corrective action plans and follow-up activities as needed. • Design models to collect, assimilate, and report program information. • Develop and implement a system for review of program budgets and expenditures.

5%	**Quality of Work** • Prioritize workload to ensure that assignments are completed by the due date. • Ensure that all work products are accurate, complete and of professional quality. Documents produced are consistent with guidelines established by the supervisor, the Agency Correspondence Manual, and established rules of style and grammar.
5%	**Other duties as assigned**

ASSISTANT PROJECT DIRECTOR – AHCA

% of Time	*Duties and Responsibilities*
	This is a highly responsible administrative and professional position in the Bureau of Medicaid Services. The incumbent in this position will assist the Project Director, who has primary responsibility for the Money Follows the Person (MFP) Demonstration Grant. The incumbent shall be responsible for assisting in planning, implementing, and evaluating development activities related to the grant, including goal development, review and resolution of programmatic issues, the development of legislative proposals and legislative budget requests; completion of federal reporting requirements; and coordination with staff from the Agency, partner agencies, and external vendors to meet grant requirements. The incumbent will be prepared to take over the Project Director's duties if necessary and to assist with contract management for the MRP grant, ensuring that all activities comply with applicable federal, state and Agency policies.
10%	**General Knowledge** • Maintain up-to-date knowledge concerning state and federal requirements/regulations related to the MFP Grant, Medicaid, nursing home transition, Medicaid waivers and Health Information Technology.
30%	**Project Management** • Assist in the implementation of and updates to the grant operating plan. • Monitor project activities for completeness and accuracy. • Assign tasks to project staff and track completion. • Coordinate MFP activities among partners. • Ensure the quality of all grant-related activities and take prompt corrective action when needed. • Work with housing partner(s) to provide appropriate housing options for MFP participants. • Track and be responsible for reporting requirements and other federal requirements related to the MFP grant. • Coordinate workgroups and project teams related to MFP grant activities in quality management and housing. • Maintain current knowledge of all grant activities as back-up for Project Director
10%	**Reporting** • Assist in completion and submission all reports related to the MFP Demonstration Grant no later than the specified due dates. • Assist in completion of all public records requests and other requests for ad hoc reports in a timely manner.
10%	**Contract Management** • Assist with contract issues related to the MFP demonstration grant. • Maintain active agency contract manager certification; • Oversee the day-to-day administrative, programmatic, and financial operations of assigned contract; • Enforce performance of assigned contract terms and conditions; • Maintain appropriate and up-to-date contract files;
10%	**Program Planning and Analysis** • Assist with strategic planning activities for the MFP Demonstration Grant. • Work with other AHCA units, partner agencies, other executive agencies, the Legislature, the federal Centers for Medicare and Medicaid Services, other federal agencies, and other appropriate entities. • Analyze proposed state and federal legislation, rules, regulations and policies to determine the programmatic and fiscal impact on the MFP Demonstration Grant; • Assist in the development of legislative budget requests and substantive legislative proposals.
10%	**Agency Representation** • Represent the agency in local, state, and national meetings, conferences, workshops, and seminars related to the MFP Demonstration Grant. In addition, as assigned, deliver speeches and present programs on MRP to local and state organizations, represent the Medicaid office on health care committees and task forces; work with the executive and legislative branches of government with regard to the Medicaid program.
10%	**Program Monitoring and Evaluation** • Assist in planning, organizing, and coordinating monitoring and evaluation for assigned program and contract activities to ensure compliance and efficiency with federal regulations, state statutes, and Medicaid policies to assess the achievement of goals, objectives, and priorities of the Medicaid and MFP programs. • Oversee technical assistance and training activities necessary for quality improvement. • Monitor corrective action plans and follow-up activities as needed. • Design models to collect, assimilate, and report program information. • Assist in developing and implementing a system for review of quality and housing initiatives.
5%	**Quality of Work** • Prioritize workload to ensure that assignments are completed by the due date. • Ensure that all work products are accurate, complete and of professional quality. Documents produced are consistent with guidelines established by the supervisor, the Agency Correspondence Manual, and established rules of style and grammar.
5%	**Other duties as assigned**

DATA AND RESEARCH POSITION - AHCA

% of Time	*Duties and Responsibilities*
	This is a highly responsible administrative and professional position in the Bureau of Medicaid Services. The incumbent in this position will be responsible for data and research functions related to the Money Follows the Person (MFP) Demonstration Grant. The incumbent shall be responsible for assisting in planning, implementing, and evaluating development activities related to the grant, including data gathering, information technology and data exchange, and research related to the MFP program.
10%	**General Knowledge** • Maintain up-to-date knowledge concerning state and federal requirements/regulations related to the MFP Grant, Medicaid, nursing home transition, Medicaid waivers, data analysis and Health Information Technology.
30%	**Project Management** • Assist in the implementation of and updates to the grant operating plan. • Monitor data and research-related project activities for completeness and accuracy. • Coordinate MFP data and research activities among partners. • Ensure the quality of all grant-related data and research activities and take prompt corrective action when needed. • Track and be responsible for reporting requirements and other federal requirements related to the MFP grant. • Coordinate workgroups and project teams related to data and research activities of the MFP grant. • Maintain current knowledge of all grant activities.
10%	**Reporting** • Assist in completion and submission all reports related to the MFP Demonstration Grant no later than the specified due dates. • Assist in completion of all public records requests and other requests for ad hoc reports in a timely manner.
10%	**Contract Management** • Assist contractors and partners with data and research related to the MFP demonstration grant. • Work with IT contractors in development of MFP data system. • Enforce performance of assigned contract terms and conditions; • Maintain appropriate and up-to-date contract files;
10%	**Program Planning and Analysis** • Assist with strategic planning activities on data and research for the MFP Demonstration Grant. • Work with other AHCA units, partner agencies, other executive agencies, the Legislature, the federal Centers for Medicare and Medicaid Services, other federal agencies, and other appropriate entities on issues related to data and research. • Analyze proposed state and federal legislation, rules, regulations and policies to determine the programmatic and fiscal impact on the MFP Demonstration Grant; • Assist in the development of legislative budget requests and substantive legislative proposals.
10%	**Agency Representation** • Represent the agency in providing data and research information to people within the Agency, in partner agencies, and to other interested parties.
10%	**Program Monitoring and Evaluation** • Assist in planning, organizing, and coordinating monitoring and evaluation for assigned program and contract activities to ensure compliance and efficiency with federal regulations, state statutes, and Medicaid policies to assess the achievement of goals, objectives, and priorities of the Medicaid and MFP programs. • Oversee technical assistance and training activities necessary for gathering accurate data and conducting valid research. • Monitor corrective action plans and follow-up activities as needed. • Design models to collect, assimilate, and report program information..
5%	**Quality of Work** • Prioritize workload to ensure that assignments are completed by the due date. • Ensure that all work products are accurate, complete and of professional quality. Documents produced are consistent with guidelines established by the supervisor, the Agency Correspondence Manual, and established rules of style and grammar.
5%	**Other duties as assigned**

INFORMATION TECHNOLOGY PROJECT MANAGER - AHCA

% of Time	*Duties and Responsibilities*
	This is a highly responsible administrative and professional position in the Office of Information Technology. The incumbent in this position will have primary responsibility for developing and implementing the data system for the Money Follows the Person (MFP) Demonstration Grant. The incumbent will also act as a contract manager for contracts related to the grant, and shall participate in the any procurement, contract development, and contract management activities related to this grant. The incumbent is responsible for ensuring that these activities comply with applicable federal, state and Agency policies.
10%	**General Knowledge** • Maintain up-to-date knowledge concerning state and federal requirements/regulations related to information technology and its applicability to the MFP Grant, Medicaid, nursing home transition, Medicaid waivers and Health Information Technology.
35%	**Project Management** • Direct the development and implementation of a data system to support the MFP grant. • Coordinate the system development with partner agencies that will provide input to the system • Contract with programmers and other information systems specialists to complete the required phases of system development and implementation. • Meet with system users to ensure development conforms to their needs. • Secure necessary hardware and software to implement system within grant requirements. • Manage project using Medicaid Project Management Methodology and templates.
10%	**Reporting** • Ensure completion and submission all reports related to the MFP Demonstration Grant no later than the specified due dates. • Ensure completion of all public records requests and other requests for ad hoc reports in a timely manner.
10%	**Contract Management** • Ensure that contract operations are consistent with Medicaid policies and procedures; • Participate in the procurement and development of needed contract, including preparing solicitations, assisting in the selection of the contractor, participating in contract negotiations, and coordinating internal review and approval; • Prepare all contract related documents, including amendments and extensions on a timely basis; • Maintain active agency contract manager certification; • Adhere to established agency and state procurement policies and procedures; • Oversee the day-to-day administrative, programmatic, and financial operations of assigned contract; • Enforce performance of assigned contract terms and conditions; • Perform contract monitoring of vendor performance at least annually; • Maintain appropriate and up-to-date contract files; • Process, review, and approve deliverables; • Serve as liaison with assigned contract vendor(s); and • Track contract expenditures, and process invoices within 5 working days of an acceptable completed invoice.
10%	**Program Planning and Analysis** • Perform strategic planning activities for MFP Demonstration Grant IT system. • Work with other AHCA units, partner agencies, other executive agencies, the Legislature, the federal Centers for Medicare and Medicaid Services, other federal agencies, and other appropriate entities. • Analyze proposed state and federal legislation, rules, regulations and policies to determine the programmatic and fiscal impact on the MFP Demonstration Grant; • Assist in the development of legislative budget requests and substantive legislative proposals.
10%	**Program Monitoring and Evaluation** • Plan, organize, and coordinate monitoring and evaluation for assigned program and contract activities to ensure compliance and efficiency with federal regulations, state statutes, and Medicaid policies to assess the achievement of goals, objectives, and priorities of the Medicaid and MFP programs. • Oversee technical assistance and training activities necessary for quality improvement. • Monitor corrective action plans and follow-up activities as needed. • Design models to collect, assimilate, and report program information. • Develop and implement a system for review of program budgets and expenditures.
10%	**Quality of Work** • Prioritize workload to ensure that assignments are completed by the due date. • Ensure that all work products are accurate, complete and of professional quality. Documents produced are consistent with guidelines established by the supervisor, the Agency Correspondence Manual, and established rules of style and grammar.
5%	**Other duties as assigned**

,MFP STAFF – DCF (2 positions)

% of Time	*Duties and Responsibilities*
	This is a highly responsible professional position in Adult Protective Services. The incumbent in this position will oversee MFP and transition activities for one or more planning and service areas under the Money Follows the Person (MFP) Demonstration Grant.
10%	**General Knowledge** • Maintain up-to-date knowledge concerning state and federal requirements/regulations related to the MFP Grant, Medicaid, nursing home transition, Medicaid waivers and Health Information Technology.
40%	**Project Management** • Develop and maintain coordination efforts with local CARES, ADRC and MFP partner agencies in addition to community providers and other organizations to support grant activities. • Review, process and analyze data to provide timely identification and screening of potential MFP participants. • Standardize and make consistent outreach efforts to ensure public awareness of MFP and how to access the service. • Assist in developing materials to inform people about MFP. • Serve as liaison with MFP Project Director and local stakeholders and providers. • Research community services such as housing and other local services and share information with those who need it. • Build relationships with and educate service providers, professional entities and others to facilitate referrals and increase awareness of MFP. • Meet with and train providers on access points and increase awareness of resources.
10%	**Reporting** • Prepare program reports, surveys and related materials on MFP.
10%	**Contract Management** • Assist participants in finding contracted services and in resolving problems with services. • Maintain working relationships with Medicaid-contracted providers.
10%	**Program Planning and Analysis** • Perform program monitoring, serve on interdisciplinary staff teams to develop optimum solutions, implement those solutions. • Advise central office and Project Director on operational problems and issues affecting grant performance and recommend solutions.
5%	**Agency Representation** • Represent the program in local meetings, conferences, workshops, and seminars.
5%	**Program Monitoring and Evaluation** • Oversee technical assistance and training activities necessary for quality improvement. • Monitor corrective action plans and follow-up activities as needed. •
5%	**Quality of Work** • Prioritize workload to ensure that assignments are completed by the due date. • Ensure that all work products are accurate, complete and of professional quality. Documents produced are consistent with guidelines established by the supervisor, and established rules of style and grammar.
5%	**Other duties as assigned**

MFP STAFF – DOEA (3 positions year one; 2 additional positions year two)

% of Time	*Duties and Responsibilities*
	This is a highly responsible professional position in the Long-Term Care and Support. The incumbent in this position will oversee MFP and transition activities for one or more planning and service areas under the Money Follows the Person (MFP) Demonstration Grant.
10%	**General Knowledge** • Maintain up-to-date knowledge concerning state and federal requirements/regulations related to the MFP Grant, Medicaid, nursing home transition, Medicaid waivers and Health Information Technology.
40%	**Project Management** • Develop and maintain coordination efforts with local CARES, ADRC and MFP partner agencies in addition to community providers and other organizations to support grant activities. • Review, process and analyze data to provide timely identification and screening of potential MFP participants. • Standardize and make consistent outreach efforts to ensure public awareness of MFP and how to access the service. • Assist in developing materials to inform people about MFP. • Serve as liaison with MFP Project Director and local stakeholders and providers. • Research community services such as housing and other local services and share information with those who need it. • Build relationships with and educate service providers, professional entities and others to facilitate referrals and increase awareness of MFP. • Meet with and train providers on access points and increase awareness of resources.
10%	**Reporting** • Prepare program reports, surveys and related materials on MFP.
10%	**Contract Management** • Assist participants in finding contracted services and in resolving problems with services. • Maintain working relationships with Medicaid-contracted providers.
10%	**Program Planning and Analysis** • Perform program monitoring, serve on interdisciplinary staff teams to develop optimum solutions, implement those solutions. • Advise central office and Project Director on operational problems and issues affecting grant performance and recommend solutions.
5%	**Agency Representation** • Represent the program in local meetings, conferences, workshops, and seminars.
5%	**Program Monitoring and Evaluation** • Oversee technical assistance and training activities necessary for quality improvement. • Monitor corrective action plans and follow-up activities as needed. •
5%	**Quality of Work** • Prioritize workload to ensure that assignments are completed by the due date. • Ensure that all work products are accurate, complete and of professional quality. Documents produced are consistent with guidelines established by the supervisor, and established rules of style and grammar.
5%	**Other duties as assigned**

MFP STAFF – DOH (1 POSITION)

% of Time	*Duties and Responsibilities*
	This is a highly responsible professional position in the Brain and Spinal Cord Injury Program. The incumbent in this position will oversee MFP and transition activities for one or more planning and service areas under the Money Follows the Person (MFP) Demonstration Grant.
10%	**General Knowledge** • Maintain up-to-date knowledge concerning state and federal requirements/regulations related to the MFP Grant, Medicaid, nursing home transition, Medicaid waivers and Health Information Technology.
40%	**Project Management** • Develop and maintain coordination efforts with local and MFP partner agencies in addition to community providers and other organizations to support grant activities. • Review, process and analyze data to provide timely identification and screening of potential MFP participants. • Standardize and make consistent outreach efforts to ensure public awareness of MFP and how to access the service. • Assist in developing materials to inform people about MFP. • Serve as liaison with MFP Project Director and local stakeholders and providers. • Research community services such as housing and other local services and share information with those who need it. • Build relationships with and educate service providers, professional entities and others to facilitate referrals and increase awareness of MFP. • Meet with and train providers on access points and increase awareness of resources.
10%	**Reporting** • Prepare program reports, surveys and related materials on MFP.
10%	**Contract Management** • Assist participants in finding contracted services and in resolving problems with services. • Maintain working relationships with Medicaid-contracted providers.
10%	**Program Planning and Analysis** • Perform program monitoring, serve on interdisciplinary staff teams to develop optimum solutions, implement those solutions. • Advise central office and Project Director on operational problems and issues affecting grant performance and recommend solutions.
5%	**Agency Representation** • Represent the program in local meetings, conferences, workshops, and seminars.
5%	**Program Monitoring and Evaluation** • Oversee technical assistance and training activities necessary for quality improvement. • Monitor corrective action plans and follow-up activities as needed. •
5%	**Quality of Work** • Prioritize workload to ensure that assignments are completed by the due date. • Ensure that all work products are accurate, complete and of professional quality. Documents produced are consistent with guidelines established by the supervisor, and established rules of style and grammar.
5%	**Other duties as assigned**

MFP Staff Performance Standards

1. Employee demonstrates, models and reinforces the mission of the agency and the MFP program and the fundamental values of fairness, cooperation, respect, commitment, excellence, honesty, and teamwork.

2. Employee uses knowledge acquired through education, training or experience to accomplish and complete responsibilities.

3. Employee demonstrates cooperative and productive working relationships within and across departments.

4. Employee uses creativity, innovation, and persistence to achieve positive results.

5. Employee effectively communicates in a variety of ways that exhibit the ability to clearly and accurately provide information. Employee also exhibits good listening skills.

6. Employee completes all assignments in a timely and professional manner. Employee prioritizes workload to ensure that 95% of all assignments are completed by the assigned due date. Employee ensures that all work products are accurate, complete and of professional quality. Employee tracks applicable expenditures and processes invoices within five working days of an acceptable completed invoice.

7. Employee plans, organizes, and coordinates program monitoring and evaluation activities to ensure compliance with assigned contracts, federal regulations, state statutes, administrative rules, the Medicaid State Plan and waiver policies, and Medicaid policies in general. Employee monitors corrective actions, oversees technical assistance and training activities necessary for quality improvement.

8. Employee meets position-related goals and objectives related to the Money Follows the Person Demonstration Grant.

Individual Performance Rating Scale

Rating	Numeric Scale	Definition and Examples
Exceptional	5	Consistently exceeds the performance expectation of the position. Examples include, but are not limited to: Requires little or no supervision from management in accomplishing tasks and seeks opportunities to enhance the organization. Possesses highly advanced job knowledge. Is relied upon to solve complex problems and applies creativity and innovative approaches to formulating solutions.
Above Expectation	4	Consistently meets and often exceeds the performance expectation of the positions. Examples include, but are not limited to: Requires minimal supervision from management in accomplishing tasks. Possesses a thorough knowledge of the job, and often solves or assists in solving complex problems.
Meets Expectation	3	Consistently meets and may occasionally exceed the performance expectation of the position. Examples include, but are not limited to: Requires moderate supervision from management in accomplishing tasks. Possesses sufficient knowledge and/or initiative to execute duties and responsibilities.
Below Expectation	2	Exhibits inconsistent job performance but has the capacity to improve to meet the performance expectation of the position. Examples include, but are not limited to: At times requires close supervision where he/she should be operation on own. Sometimes lacks the initiative and/or job knowledge to execute duties and responsibilities.
Unacceptable	1	Consistently fails to meet the designated performance expectation. Examples include, but are not limited to: Requires close supervision and the work requires continual correction. Job knowledge is insufficient to meet daily requirements.
N	None Given	No longer applicable or unable to determine.

Overall Performance Rating Scale

Numeric Range	Overall Rating
4.50 – 5.00	Outstanding
3.50 - 4.49	Commendable
3.00 – 3.49	Satisfactory
2.50 - 2.99	Needs Improvement
2.49 and below	Unsatisfactory

Performance Improvement Plan

Working with the employee, the supervisor will construct a detailed plan for improving performance that falls below expectation. The plan will include specific targets and dates, and a date will be set for re-evaluation of the employee's performance. Both parties will sign the plan.

Darcy A. Abbott, M.S.W., L.C.S.W.

1138 Green Hill Trace, Tallahassee, Florida, 32317, 850-942-0303 (Res.), 850-412-4236 (Bus.), 850-766-6667 (Cell).
Darcy.abbott@ahca.myflorida.com (Bus.) darcy.abbott@gmail.com (Res.)

EXPERIENCE

Agency for Health Care Administrator, Florida Agency for Health Care Administration. Medicaid Services, Long-Term Care and Behavioral Health Policy Section, Tallahassee, Florida, 9/05 to present.

Description: Agency for Health Care Administrator for the Medicaid Services Long-Term Care and Behavioral Health Policy Section of Medicaid Services. Responsible for administrative management of four unit managers that are responsible for the following Medicaid policy sections: Community Behavioral Health Care Services Unit, Long-Term Care Waivers and Institutions Unit, Developmental Disabilities ands Special Programs Unit and the Quality Assurance and Long-Term Care Unit. Programmatic responsibilities include policy development for long-term care and behavioral health Medicaid service. Administrative management of waivers, contract management, programmatic monitoring, development of managed care initiatives, management of prior authorization contracted providers, programmatic evaluation, budget development, development and implementation of legislation and administrative rules and data reporting. Represents the agency on statewide workgroups, task forces, and interagency initiatives such as the Governor's Commission on Disabilities, Florida Substance Abuse and Mental Health Corporation, Criminal Justice, Mental Health & Substance Abuse Reinvestment Policy Council, Florida's Returning Veterans and their Families Grant team, and Supreme Court Task Force on Substance Abuse and Mental Health Issues in the Court.

Program Administrator, Florida Agency for Health Care Administration, Medicaid Services, Behavioral Health Care Policy Unit, Tallahassee, Florida, 8/02 to 9/05.

Description: Program Administrator for the Medicaid Services Behavioral Health Care Policy Unit. Responsible for supervising unit that manages community behavioral health care services policy, prepaid mental health managed care plans, psychiatric inpatient services for children and targeted case management. Programmatic responsibilities of the unit include policy development for the Medicaid Services Community Behavioral Health Services Coverage and Limitations Handbook, training and support to Florida Medicaid providers. Contract management responsibilities include community behavioral health prior authorization services, University research and grant facilitation, prepaid mental health managed care plans, and management of the Statewide Inpatient Psychiatric Program for children. This unit is also responsible for programmatic and contact monitoring and evaluation, workgroup development, legislation and rule development, legislative budget requests and program development. Represents the Agency as an ad hoc member of the legislatively authorized Substance Abuse and Mental Health Corporation.

Senior Management Analyst II-Coordinator, Florida Department of Children and Families, Office of Family Safety-Child Protection Policy Unit, Tallahassee, Florida, 11/01 to 7/02.

Description: Management analyst for the Office of Family Safety-Child Protection Policy Unit. Responsible for inter-program and inter-departmental policy development and coordination. Primarily interfaces with the Offices of Mental Health and Substance Abuse and Departments of Juvenile Justice, Education, Health and the Agency for Health Care Administration. This function targets the integration of program services with the state's child welfare population. Representative for the Office of Family Safety with other organizations and workgroups including SEDNET, State Mental Health Planning Council, Fetal Alcohol Syndrome Task Force and Behavioral Health Services Integration Workgroup. Evaluates research, bill analysis and quality assurance reports and evaluations related to program services for the child welfare population. Accomplishments: Manages ongoing development of the Behavioral Health Overlay Services program for dependent children in residential group homes. Develops administrative rules, policy and operational procedures related to the integration of mental health, health, substance, and juvenile justice services to support the ongoing development of the child protection system.

Senior Management Analyst II-Coordinator, Florida Department of Children and Families, Office of Family Safety, Tallahassee, Florida, 12/98 to 11/01

Description: Supervisor within the Office of Family Safety. Responsible for promoting the safety, well-being, stability and permanency of children and families served by Office of Family Safety through the direct supervision of staff (4 professional and 2 clerical) who are responsible for the management of grants, contracts and other funding sources for services, the development of model attachments, program planning and evaluation, outcome measures, and the development and implementation of statewide operating procedures, policies and other activities necessary to comply with state and federal laws and the identification of national and other state initiatives that have the potential to improve Florida's child protection system.
Accomplishments: Serves as the state liaison to the districts for technical assistance and policy support in implementing the Promoting Safe and Stable Families: Child and Family Services state five-year plan. Serves as state liaison with federal representatives for family preservation and support services. Assists in the writing of grant applications to fund prevention, family preservation, family support, time–limited family reunification, adoption promotion and support services, and collaborative system change initiatives. Plans, organizes and assists in facilitating district, inter-agency and inter-program representatives to obtain feedback and input on the planning and implementation of family preservation and family support services. Responsible for ongoing coordination and collaboration of work activities at state and local levels for the purpose of preparing, updating annually, and implementing the Promoting Safe and Stable Families five-year plan that is annually submitted to the Florida Legislature and the federal Department of Health and Human Services. Coordinated the development of a web-based reporting system for district grant activities reporting. Coordinates planning and reviews contract development related to programmatic services. Functions as a contract manager for several statewide service providers and initiatives. Collaborates in the development of tracking statewide and district performance measures and targets. Directs, supervises and coordinates the collection and analysis of pertinent information related to district performance, including federal funding compliance reviews, quality assurance reports, budget reviews, contract reviews, customer surveys, performance on outcome and process measures. Assists with and supports programmatic and training support activities for the district community facilitators. Developed statewide initiative "Adoption Summer School" through a contract with the University of South Florida that provided a forum for communities to address the needs of adopted children and adoptive parents. Initiated contract development with Florida State University to develop a project that researched the needs of adopted children an their parents through a focus group format. Collaborates with other community partners to coordinate Child Abuse Prevention Month activities and the Governor's press release agenda. Co-chairs the TEAM Florida Partnership quarterly meetings and the Coordinating Committee. Serves as a liaison to the Office of Mental health, Office of Substance Abuse and the Florida Mental Health Planning Council, Infant Mental Health Workgroup, Substance Exposed Newborn Workgroup, Fetal Alcohol Syndrome Workgroup and the Florida Mental Health and Substance Abuse Commission including the Children's Workgroup. Attends federal meetings related to the Promoting Safe and Stable Families, Child Abuse and Neglect and Community Based Family Resource and Support federal grants. Personnel activities related to the creation of position descriptions, annual performance reviews, interviewing, hiring, training, communicating and meeting regularly with staff, workload planning, workflow, deadlines, purchasing, travel schedules, attendance schedules, tracks assignments and bill analysis, and coordinates special assignments.

Associate in Social Work Services, University of South Florida Consultant to the Florida Department of Health-Division of Family Health Services, Tallahassee, Florida, 4/90 to 12/98.

Description: Provided consultation and technical assistance using public health social work knowledge and skills in the area of system wide issues on a statewide basis to County Health Departments (CHD), administrators, direct line staff and coalitions.
Accomplishments: State Coordinator of Public Health Social Work Services. Maintained contact with all maternal and child health social workers placed in CHDs across the state by providing technical assistance, site visits, writing newsletters, correspondence and maintaining phone contact. Developed and conducted an annual statewide conference and orientation training for CHD social workers. Created a new career service classification, "Social Work Services Program Manager", continues to be available to all state agencies. Represented public health social work issues at national/regional public health social work director meetings. Developed a proposal for the standardization and re-professionalization of public health social workers that was implemented. Administered a specialized project to establish new positions, recruit and train master's prepared social workers to provide specialized program development, prevention strategies and psychosocial services for Healthy Start families. Addressed maternal and child health psychosocial issues in program and health care policy development including legislative bill analysis, grant writing and budget requests. Provided consultation, technical assistance and training on issues related to social work, prevention, care coordination, crisis intervention, enhanced services and Family Support Plan development including integration with Part H for the Healthy Start initiative. Assisted in the development and pilot evaluation of psychosocial screening and assessments tool for at-risk families that is in use state-wide. Supervised graduate School of Social Work internships. Served as the Department of Health

representative to the Association of State and Territorial Public Health Social Workers. Participated as a member of the Department of Health: Quality Improvement Training Team, to provide training on psychosocial aspects of the Problem Oriented Record system and ongoing evaluation of Healthy Start services in select counties. Assisted public health responders and victims of Hurricane Andrew in Dade County during September 1992. Provided disaster response training to public health social workers at state and National conferences in Florida, Alabama, Mississippi and North Carolina. Designed and implemented Domestic Violence Intervention Technical Assistance Guidelines for use in all CHDs. Domestic violence liaison for the Department of Health to the Governor's Task Force on Domestic and Sexual Violence. Member of the Family Violence Prevention Fund National Health Care Initiative on Domestic Violence--Florida Leadership Team, Florida Pregnancy Associated Mortality Review Team, State WAGES Family Violence Committee, and Department of Health Professional Staff Council.

Senior Human Services Program Specialist, Florida Department of Health and Rehabilitative Services, Family Health Services - Special Health Services, Tallahassee, Florida, 11/89 to 4/90.
Description: Provided coordination and administration for the legislatively mandated, Governor's Task Force on Epilepsy.
Accomplishments: Formulated innovative family support systems, interdisciplinary design for the provision of clinical and related support services throughout Florida. Conducted survey research and data analysis on all aspects of associated policy, legislation, financial need, and service delivery structures. Developed a published report establishing policy and program development initiatives for presentation to the Governor and the State Legislature.

Social Worker II, Craig Developmental Disabilities Service Office: Elmira DDSO,
Elmira Heights, New York, 6/84 to 11/89.
Description: Provided social work services to developmentally disabled adult residents of four Intermediate Care Facilities (ICF).
Accomplishments: Provided individual therapy to ICF residents to assist them in coping with community living. Conducted weekly group therapy sessions that focused on improving social skills, self-assertiveness, and making appropriate choices. Developed, implemented, provided clinical supervision of therapists for on-going Human Enrichment and Relationship Training Skills (HEARTS) program. Completed comprehensive quarterly and annual computerized social work assessments on all ICF residents. Participated as a member of the interdisciplinary treatment team. Made referrals for changes in residential and vocational/day treatment programming. Maintained and integrated regular contact with family members of ICF residents. Provided social work in-service training to ICF staff. Participated as a member of the Client Self-Advocacy Committee for Craig DDSO. Supervised graduate social work student internship. Utilized microcomputer for clinical program development and assessments. Involved in development of the Client's Rights and Responsibilities video production.

M.S.W. Social Work Internship, Children and Youth Services, Elmira Psychiatric Center,
Elmira, New York, 6/83 to 5/84.
Description: Provided case management, individual and group therapy to both children and adolescents utilizing a interdisciplinary team approach.
Accomplishments: Provided individual and group therapy to both children and adolescents. Participated in joint school consultation screenings with other mental health agencies. Worked with community mental health agencies to screen potential impatient and outpatient admissions. Provided clinical linkage between treatment planning and recreational therapy programs. Participated as a member of the interdisciplinary treatment team. Conducted extensive social assessments with youths and their and family members. Prepared and maintained medical records utilizing a uniform case recording system. Participated in monthly social work discipline training.

Caseworker, Child Protective Services, Chemung County Department of Social Services,
Elmira, New York, 10/79 to 9/82.
Description: Provided child protection case management services to families and children with indicated child abuse and/or neglect.
Accomplishments: Advocate and liaison for individuals and families within the human services system. Provided support structure for families. Managed children in foster care, group homes and in institutional placements. Investigated and documented reported cases of suspected child abuse and neglect. Representative of the Department of Social Services in the family court system. Maintained a specialized case load of families involved with sexual abuse. Developed and implemented living skills and parenting skills training. Member of a multidisciplinary community agency team providing referrals for specialized services. Responsible for

the management, and maintenance of uniform case recording system state pilot project for caseload. Experienced in usage of statewide Client Data Recording System.

Welfare Examiner, Chemung County Department of Social Services, Elmira, New York, 4/79 to 10/79.
Description: Pre-screened applicants for Emergency Food Stamp program and Medicaid eligibility.

Caseworker, Department of Program Evaluation, Elmira Psychiatric Center, Elmira, New York, 11/78 to 4/79.
Description: Conducted research studies for the New York State Department of Mental Hygiene.

SOCIAL WORK CONSULTING

Children's Home Society, Tallahassee, Florida, 8/96 to 12/96.
Description: Provided a series of 12 workshops to community agencies on behalf of the Pregnancy and Adoption Counseling Services provided through Children's Home Society.

Healthdesigns Counseling Center, Tallahassee, Florida, 5/94 to 6/95.
Description: Provided private psychotherapy services to children, families, couples and individuals.

STARS (Southern Tier Alcoholism Rehabilitation Services), St. Joseph's Hospital, Elmira, New York, 7/86 to 11/89.
Description: Group therapist for adults recovering from alcoholism and substance abuse. Provided psychosocial-educational services to recovering group members. Participated in treatment planning with primary therapist and clinical staff. Implemented a group specifically designed to address women's issues in recovery.

CHOICE Program (Alternatives to Child Sexual Abuse), Family Service Society of Corning, New York, 1/87 to 3/88.
Description: Group therapist for non-offending mothers of sexually abused children. Provided psychosocial-educational services and support to facilitate the recovery and prevention of future sexual abuse. Interdisciplinary treatment team planning to assure therapeutic treatment of individual family members.

VOLUNTEER WORK

Tallahassee Community Crisis Response Team, 1990 to 2002.
American Red Cross Mental Health Disaster Responder/ National Registry, 1993 to present.

CERTIFICATION

Facilitative Leadership Certification, June,1996.
American Red Cross-Disaster Mental Health Responder, April, 1993.
Denver II Developmental Screening Certified Master Trainer, April, 1993.
Certified Family Support Plan Trainer, June, 1992.
Florida State University Faculty Fellow - Social Work Field Instructor, August, 1991.
Florida Licensed Clinical Social Worker (LCSW effective 3/30/91).
Community Crisis Response Team Certified for Responses, 1990.
New York State Certified Social Worker (CSW effective 11/22/85).
New York State Qualified Mental Retardation Professional (QMRP), 1984.

EDUCATION

Master of Social Work (MSW), Marywood College, Graduate School of Social Work, Certified Social Work Education, Scranton, Pennsylvania, 1984.

Bachelor of Science in Social Work (BSW with Honors), Rochester Institute of Technology, Department of Social Work, Certified Social Work Education, Student internship as a medical social worker in the Emergency Department at Genesee Hospital, Rochester, New York, 1978.

Disaster Mental Health Services, provided by American Red Cross. Sixteen hours of intervention training, 1994.
Morita Therapy: Counseling Victims of Crime, provided by Brian Ogawa, D.Min. Fifteen hours of specialized intervention training. 1993.
Disaster Response Training for Mental Health Professionals, provided by Grady Bray, Ph.D. 15 hours of specialized intervention training. 1992.
Tallahassee Community Crisis Response Team Training. 1991.
Specialized training and supervision in substance abuse leading toward certification in alcoholism counseling. 1986 to 1989.
Specialized training in Human Development and Family Studies and Program Development in Human Services, Cornell University - Training includes graduate courses and more than twenty specialized multi-day workshops. 1980 through 1983.

PROFESSIONAL MEMBERSHIPS

Association of State and Territorial Public Health Social Work (**National President** 1996 and 1997 and Past President--Board Member)
Florida Public Health Association (Past Chairperson for Social Work Section and Member-at-Large)
Florida Perinatal Association (Past Board Member)
Team Florida Partnership: (Past Co-Chairperson)

PRESENTATIONS

A Personal and Professional Perspective on Domestic Violence: Florida's Integration of Domestic Violence Services into Maternal and Child Health Services: Partners in Perinatal Health-Sharing Solutions annual conference. Keynote address with book author Connie May Fowler, co-speaker, (Orlando, Florida) November 1998.

Teen Dating Violence and Violence Directed Against Pregnant Teens: James and Jennifer Harrell Center for the Study of Domestic Violence--Satellite Training, University of South Florida (Statewide Broadcast) August 1998.

Opportunities to Improve Women's Health Through Maternal and Child Health: The Integration of Domestic Violence Screening, The Association of Maternal and Child Health Programs 1998 National Meeting, (Washington, D.C.) March 1998.

"The Changing Tide Of Public Health Social Work: A Most Excellent Adventure," Annual Conference for Public Health Social Workers, (St. Petersburg Beach, Florida) October 1997.

Managed Care and Other Systems Changes: Challenges to Social Work: Practice Responder, Public Health Social Work Institute, University of Pittsburgh, (Pittsburgh, Pennsylvania) May 1997.

The Impact of Domestic Violence on Women, Children and Adolescents, Sharing Solutions Conference, (Orlando, Florida) December 1996.

"The Changing Tide Of Public Health Social Work: A Most Excellent Adventure," Annual Conference of the Association of State and Territorial Public Health Social Work, (Myrtle Beach, South Carolina) October 1996.

"Domestic Violence And Children: The Impact And Negative Consequences," Florida School Health Association, 1996 Biennial Conference, (Orlando, Florida) May 1996.

"Community Crisis: Public Health Social Work Response," Mississippi Public Health Social Work Conference, (Lake Tiak-O'Khata, Mississippi) April 1996.

"Domestic Violence," AHEC statewide audio-teleconference for Florida health care providers, (Florida) January 1996.

"Fighting The Darkness: Bringing The Light Of Healing In Times Of Crisis," North Carolina Annual Public Health Social Work Conference, (Winston-Salem, North Carolina) November 1995.

"Preventing Violence: A Public Health Approach," Bi-Regional Conference For Public Health Social Workers, (Atlanta, Georgia) May 1995.

"**Crisis Reactions: Helping Children Cope With Disasters,**" WJEB Radio Broadcast: for victims of flooding in Albany, Georgia, (Thomasville, Georgia) 1994.

"Community Crisis Response Teams - A Preventative Technique For Post-Traumatic Stress And Violence," Florida School Health and Full Service Schools, Second Annual Joint Conference, (St. Petersburg Beach , Florida) June 1994.

"Community Crisis Response Teams And Compassion Fatigue," Alabama Conference of Social Work, (Mobile, Alabama) April 1994.

"Implementation Of The "Tell Us About Yourself" Psychosocial Screening Questionnaire," Sharing Solutions II: Building Systems of Supports and Services for Families, (Orlando, Florida) January 1994.

"Prevention Of Violence: A Public Health Perspective," Social Work '93, National Association of Social Worker's Meeting of the Profession, (Orlando, Florida) November 1993.

"Making A Difference In The Community: Community Crisis Response Teams," 20th Annual Regional Conference on Maternal and Child Health, Family Planning, and Services for Children with Special Needs: From Debate to Action, (Chapel Hill, North Carolina) May 1993.

"Healthy Start--The Social Worker's Role," Social Work Month Conference - Vital Signs of a Healthy Nation: Tampa General Hospital, (Tampa, Florida) March 1993.

"Interdisciplinary Team Work," School Health Orientation for Nurses, Social Workers and Health Support Aides, (Miami, Florida) January 1993.

"Florida's Healthy Start Initiative," 1992 BiRegional Public Health Social Work Conference, (Columbia, South Carolina) May 1992.

TRAINING FOR
DEPARTMENT OF HEALTH AND COMMUNITY SERVICE PERSONNEL

The Impact of Domestic Violence on Women, Children and Adolescents, Building Skills for Better Services Workshop, (Tampa) 1996.

Developing Family Support Plans, Interdisciplinary/Interagency Video Teleconference for Families and Providers, Statewide Video Teleconference Series, 1995, 1996.

When Violence And Disaster Hit Your Community, 1995 Annual Public Health Social Work Conference, (Tallahassee) 1995.

Domestic Violence, Health Promotion and Wellness Statewide Audio Teleconference, 1994.

Healthy Start Implementation, Statewide Video and Audio Teleconference Series, 1994.

The Family Support Planning Process, Statewide Video Teleconference, 1994.

Orientation To Public Health Social Work, (Tallahassee) 1994, 1995, 1996.

Denver II Developmental Screening Training, (Ft. Lauderdale, Ft. Myers (2x), Miami, Green Cove Springs, Tallahassee, Tampa (3x), Jacksonville, Ft. Walton Beach) 1993-1997.

Problem Oriented Record Training: Psychosocial Issues, (Orlando, Palatka, West Palm Beach, St. Petersburg) 1991-1993.

Healthy Start Case Management Training For HRS County Public Health Unit Nurses And Social Workers: Communication And Psychosocial Issues, (Tampa, Orlando, Miami, Ft. Myers) 1992.

The Tracy Brown Story, Healthy Start Training Video. 1992

Family Support Plan Training And Healthy Start (Gainesville) 1992.

Healthy Start: Community And Health and Rehabilitative Services County Public Health Unit Forums (Miami, Orlando, Ft. Lauderdale, St. Augustine) 1991-1992.

PUBLICATIONS

Abbott, D., (1997). A Community Crisis Response Team Approach to Disasters and Violence in the Community: A Public Health Perspective (pg. 26-36). Kelly-Lewis, Change and Challenge: Maternal/Child Health Social Workers Make the Difference: Proceedings, National Maternal and Child Health Clearinghouse Publication.

Abbott, D., (May 1995). "Fallen Stars: Assessment for Family Violence," Association of State and Territorial Public Health Social Workers Newsletter.

Tribley, D., (October/November 1992). "Critical Incident Stress Debriefing," and "Homestead: Public Health Social Work," Health and Rehabilitative Services - Florida Public Health Advisor.

Mann, P., Robbins, C., **Tribley, D.,** (January 1992) "Reducing the Impact of Violent Events: Public Health's Responsibilities," Association of State and Territorial Public Health Social Workers Newsletter.

COMPUTER SOFTWARE EXPERIENCE

Microsoft Office Products

William L. Aldinger, M.A.
3041 Fermanagh Drive
Tallahassee, FL 32309

Job Qualifications

- 26 years professional experience managing programs and services for the elderly, adults with special needs and their families;
- Advanced degrees and specialty education and training in the areas of aging, mental health, long-term care, supportive services, and affordable housing;
- Significant experience in the development and implementation of policy and new programs and services, as well as enhancing existing ones;
- Recognized ability to develop and maintain effective collaborative relationships with co-workers, professional colleagues, organizations, service providers and community groups;
- Knowledge of and experience working with aging, long-term care/supportive services and housing providers, associations, non-profit and private organizations, funding entities, coalitions and universities;
- Strong background and continued work in the areas of long-term care/supportive services, senior and supportive housing, community development planning, policy making, service provision, regulation and information dissemination;
- Extensive experience in coordinating, facilitating and participating in interagency committees and workgroups, issue specific task forces and community meetings;

Work Experience

2006 – Present Florida Housing Finance Corporation – Supportive Housing Coordinator

Coordinate the Florida Housing's activities related to supportive housing and special needs households in the areas of policy making, program development, stakeholder collaboration and information dissemination. Represent the organization on statewide councils, task forces, workgroups and at meetings relevant to the corporation's objectives in serving persons with special needs and very low incomes.

2005 – 2006 Florida Department of Elder Affairs, Elderly Housing Unit, Director

Managed the development and implementation of the newly established Elderly Housing Unit and was a team leader for the Communities for a Lifetime initiative. Coordinated the department's elderly housing planning, policy and consumer information activities.

2002 – 2005 Florida Department of Elder Affairs, Coming Home Program, Director

Administered the Robert Wood Johnson Foundation' s grant program activities related to facilitating affordable assisted living and senior housing in Florida's rural and underserved areas through research, advocacy, policymaking, regulation, funding development and access, technical assistance and support, information dissemination, community partnerships and project demonstrations. Worked closely with housing, supportive services and long-term care providers.

1999 – 2002 Florida Department of Elder Affairs, Assisted Living Program, State Administrator

Directed the Programs' operations at department headquarters and the 11 satellite offices statewide, as well as managed its 22 staff persons who trained and provided technical assistance to more than 10,000 persons and handled more than 25,000 assisted living inquiries annually. Assisted in the development and analysis of assisted living policy, as well as, had an active role in developing, writing, and promulgating Florida administrative code for assisted living facilities, adult family care homes, hospice, and adult day care.

1997 – 1999 Pennsylvania Department of Aging, Senior Policy Analyst and Program Manager

Managed the Pennsylvania Family Caregiver Support Program and Domiciliary Care Program, which annually served more than 15,000 long-term care and supportive housing consumers. Oversaw the policy, program development and regulatory activities of each Program, as well as, assisted with the contract management of the Programs' local operations, provided statewide by 52 Area Agencies on Aging;

1994 – 1997 Dauphin County Area Agency on Aging
Director of Community Services and Contracts

Directed the Agency's direct care, clinical operations and contracted services. Managed approximately 45 staff who provided services to more than 50,000 elderly and disabled adults and their families, annually, in the areas of information and referral, consumer needs assessment, care planning , program eligibility determination, care management, protective services investigation, ombudsman, adult day care, in-home services, meals on wheels, senior centers, domiciliary care, preventative health, and volunteering.

Other Related Work Experience

1992 – 1994 Dauphin County Area Agency on Aging
Case Mangement and Protective Services Supervisor

1989 – 1991 Davidson-Peterson Associates Strategic Planning and Research
Mature Adult Market Specialist

1988 – 1989 American Association of Retired Persons, National Headquarters
Research Analyst – Member Services

1984 – 1988 Department of Aging and Mental Health, University of South Florida
Unit Director, Older Adult Day Treatment and Outpatient Counseling

BETH KIDDER

HIGHLIGHTS

- 15 years in public policy arena, primarily in administration of health care programs
- Non-profit and public sector experience
- Recognized leadership in policy and management
- Strong written and verbal communication skills

EXPERIENCE

Agency for Health Care Administration Tallahassee, FL

Chief, Bureau of Medicaid Services June 2005 to present

Manager for an 80-person Medicaid bureau responsible for policy development and implementation for SCHIP and all Medicaid acute, primary, mental health and long-term care services. Oversee utilization management programs and quality improvement projects.

Key duties and skills:

- Develop and implement policies and programs for Medicaid and SCHIP services;
- Manage limited resources to achieve rapidly shifting policy priorities in response to the Legislature, federal government, recipients, and service providers;
- Represent Medicaid to Legislature, advocates, partner agencies, and recipients;
- Problem-solve complex health and long-term care issues;
- Strengthen and maintain relationships with partners including Medicaid service providers, state agencies, and federal Centers for Medicare and Medicaid Services.

Program Administrator and AHC Administrator March 2003 to June 2005

Manager for Medicaid units responsible for policy development for behavioral health and long term care services.

Medical/Health Care Program Analyst October 2001 to March 2003

North Carolina Department of Health and Human Services Raleigh, NC

Human Services Planner/Evaluator II July 1998 to October 2001

Developed Medicaid long term care initiatives by researching and writing policy papers and analyzing statistical data on

elderly and disabled recipients.

- Developed successful Real Choice Systems Change grant proposal to move nursing facility residents back home by integrating diverse community supports;
- Re-designed LTC utilization review and quality improvement process using data from the nursing facility Minimum Data Set (MDS).

Florida Public Interest Research Group Tallahassee, FL
Advocate, Campus Organizer, Canvass Director August 1993 to July 1996

- Lobbied the Florida Legislature and U.S. Congress for environmental and consumer protections.
- Recruited and trained student leaders to create community service projects, educational events, and public interest campaigns designed to address pressing social problems.
- Directed grassroots campaigns in Tallahassee, Tampa, and Miami.

EDUCATION

Duke University, Sanford Institute of Public Policy Durham, NC
Master of Public Policy May 1998

University of Florida Gainesville, FL
Bachelor of Arts with Highest Honors, Sociology June 1993

Ellen Z. Piekalkiewicz
8327 Inverness Drive
Tallahassee, Florida 32312
ellenzp@yahoo.com
(850)241-2051

Qualifications Summary

Human Services Executive with over 20 years experience in association, legislative, governmental, and federal nonprofit environments. Expertise in identifying needs, devising pragmatic solutions to complex issues, facilitating substantive changes, and achieving ambitious goals in high–profile arenas.

- Detailed knowledge of best practices in community based treatment, including housing options, peer support and employment programs
- Leadership involvement in systemic mental health, substance abuse and Medicaid issues
- Proven ability in successful non-profit administration including Board development
- Successful legislative and public policy advocate
- Skilled at budget development and financial management
- Known for ability to partner successfully with all levels of stakeholders
- Adept at strategizing and implementing plans to secure funding including foundation and federal grants
- Ability to initiate projects with strong follow-through
- Strong supervisory skills

Highlights of Accomplishments

Served as the first Executive Director of the statutorily established Florida Substance Abuse and Mental Health Corporation, an advisory council to the Florida Legislature and Governor. Ensured family members and consumers were appointed to the Board of Directors. Established the Corporation in strong statewide role. Secured private foundation support and grant funding for the Corporation. Co-wrote three federal grants with the Florida Department of Children and Families.

Initiated statewide coalition, which renewed interest in a Medicaid initiative for people with disabilities who want to work competitively.

Produced six comprehensive annual reports with recommendations to the Governor and Legislature on the publicly funded mental health and substance abuse system with sections on community-based

funding, criminal justice, housing and employment.

Implemented $3.8 million statewide grant program to counties established by the Criminal Justice, Mental Health and Substance Abuse Reinvestment Act of 2007.

Served as member of the Florida Advocacy Center for Persons with Disabilities negotiating team during the final phase of the *Brown vs. Bush* litigation that resulted in the closure of two state institutions for people with developmental disabilities.

Professional Experience

President, Capital Health Strategies July 2010-present
Tallahassee, FL

Serves as President of Capital Health Strategies which provides consulting and management services to state and l governments and private non-profit organizations. Current projects include provision of management services to Florida Supportive Housing Coalition and a research project for the National Council on Disabilities deinstitutionalization.

Special Assistant
Florida Department of Children and Families July 2010 – present
Tallahassee, FL

Special assistant to the Assistant Secretary for Substance Abuse and Mental Health. Managing $3 million Crim Justice Mental Health and Substance Abuse Reinvestment Grant which has been awarded to 14 counties. Staffing Secretary's Advisory Council on Substance Abuse and Mental Health.

Executive Director, April 2004 – June 2010
Florida Substance Abuse and Mental Health Corporation
Tallahassee, FL

Served at the pleasure of the Board of Directors of the Corporation as the Chief Executive Officer of the Corporation, a non-profit corporation. Serves as staff to the Board of Directors of the Corporation, created by the Florida Legislature to oversee the state's publicly funded substance abuse and mental health services. Responsible for daily operations, development of policy and procedure, and administration.

The Corporation was charged by the Legislature with making recommendations annually to the Governor and the Legislature on policies designed to improve coordination and effectiveness of the state's publicly funded mental health and substance abuse systems. Responsible for producing annual report and promoting the recommendations with the Governor, gubernatorial cabinet and staff, members of the Florida Legislature and their staff.

Acting Chief Executive Officer, January 2004 – April 2004

Advocacy Center, Florida's Protection and Advocacy Programs
Tallahassee, FL
Chief Executive Officer of the fourth largest federal/state protection and advocacy program for people with disabilities. Oversaw programmatic, budget and litigation operations. Managed the eight federal grants that fund the Center.

Deputy Director of Operations, 2001-2003
Advocacy Center, Florida's Protection and Advocacy Programs
Tallahassee, FL
Responsible for human resources, staff development, and general operations of the fourth largest federal/state protection and advocacy program for people with disabilities with a staff of 56. Director of all cross-programmatic teams of the eight federally mandated programs of the agency; annual goal setting and strategic planning; supervision of the Center's Information and Referral function; leadership involvement in systemic mental health and Medicaid issues; and advocating for systemic reforms to ensure voting access for people with disabilities.

Director of Policy and Planning, 1993-2001
Association of Community Mental Health Centers
Topeka, KS
Responsible for planning and coordinating the public policy agenda of the Association of Community Mental Health Centers. Included directing the legislative program of the Association and ensuring that the Association policy positions were communicated to the state agency overseeing community mental health programs.

Senior Fiscal Analyst, 1990-1993
Kansas Legislative Research Department, Topeka, KS
Conducted in-depth research and situational analysis for members of the Kansas Legislature. Networked with national, regional, and state policy members. Budget development and analysis. Interfaced with state agency officials, the press, and the general public. Staffed House Appropriations Committee.

Education
University of Kansas, Masters of Arts
Grinnell College, Bachelors of Arts

Connie Ruggles
Communications Consulting
2318 Hampshire Way
Tallahassee, FL 32309
850-893-3518 – phone
850-893-3807 – fax
conrug@aol.com - e-mail

Experience

1987-Present — Solo practitioner in communications consulting. Prepare business presentations, advise clients on internal and external communications planning, assist clients with preparation of business documents including proposals, business plans, and publications. Write and/or edit reports, proposals, and other business documents. Since 2006 working under contract with the Division of Medicaid, Florida Agency for Health Care Administration. Other clients in the past have included Access Behavioral Health, Pensacola, Florida; Larry Overton and Associates; Health Management Associates; Unisys; and the Florida State University Foundation,

1993-2005 — Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Senior management analyst for Florida's agency in charge of Medicaid, health planning, and health facility regulation. Served as part of leadership in establishing Community Health Purchasing Alliances, created by the Legislature to help small businesses offer health coverage to their employees. Performed oversight functions for a variety of Medicaid activities, including procurements and contracting. Participated in developing and implementing communication strategies. Served as vice chair of Subscriber Assistance Panel, which hears grievance appeals from members of health maintenance organizations in Florida. Served on a variety of task forces, work groups, and special project teams.

1991-1993 — Florida Department of Education
Turlington Building
Tallahassee, FL 32399

Supervised a unit in the Office of Student Financial Assistance that administered scholarship programs for vocational students, foreign students, minorities, and science and math scholars.

1987-1991 — Solo practitioner in communications consulting (full-time; see above).

1976-1987 Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, FL 32399

Public information director for two years for the state's largest agency, which administered programs for children, the elderly, Medicaid, mental health, developmental services, juvenile services, social services (temporary assistance for needy families and food stamps), and vocational rehabilitation. Other assignments in the Office of the Secretary involving public relations and communications, including speech writing.

1974-1976 Florida Press Association
Tallahassee, Florida

Managed the Florida Press Center, wrote and produced the monthly association newspaper, worked with association membership, planned seminars and annual conventions.

1964-1974 The University of Oklahoma
Norman, Oklahoma

- Executive assistant to the vice president for development, working with donors and potential donors to the university.
- Editor of the university's alumni publications, including a magazine and a newspaper.
- Writer and editor in the university's public information office.
- Editor of publications for the university foundation.

1962-1964 Columbus Ledger-Enquirer
Columbus, Georgia

Reporter for daily newspaper

Education

1962 Bachelor's degree in journalism, University of Oklahoma

KRISTEN M. RUSSELL

445 S. Waukeenah Street
Monticello, FL 32344
(850) 294-1473
Russellk47@hotmail.com

PROFESSIONAL EXPERIENCE

Florida Department of Health

Program Administrator, Traumatic Brain/Spinal Cord Injury Medicaid Waiver and Adult Cystic Fibrosis Medicaid Waiver, 2004 to present

- Developed policies and operating procedures based on best practices for programs serving two unique populations of disabled adults.
- Improved oversight of programs by developing a team of Medicaid Waiver Specialists who supervise support coordinators, monitor service provision, and train providers.
- Currently supervise professional staff of eleven Medicaid Waiver Specialists serving all 67 Florida counties.
- Manage $12 million service budget through diligent monitoring and approval of all service plans.
- Serve on the Nursing Home transition work group organized by Florida's Medicaid agency which has successfully developed a program allowing revenue from the state nursing home budget to be utilized for the transition from skilled nursing facilities to the community.
- Responsible for creating annual legislative budget requests to be presented for consideration by the Florida Legislature.
- Represented the programs in appearances before the state's Legislative Budget Committee during negotiations for nursing home transition funding.
- Honored to receive the Department's Employee of the Year Award in 2009

Medical Health Care Program Analyst, Florida Agency for Health Care Administration, 2001-2004

- Oversight of several Medicaid Waiver Program operated by FL Department of Health
- Developed Coverage and Limitation Handbooks for three Medicaid Waiver programs and the Nursing Home program and successfully steered them all through the rule promulgation process.
- Responsible for oversight of CARES, Florida's pre-admission screening program during the re-emphasis on PASRR requirements.
- Submitted annual report on CARES activities to Florida Legislature resulting in additional staffing for this critical component of Medicaid.

Operations Manager, Florida Department of Elder Affairs 1994-2000

- Responsible for operation of the Aged/Disabled Adult as well as the Assisted Living for the Elderly Medicaid waiver programs.
- Coordinated with the Agency for Health Care Administration to ensure adherence to federal requirements
- Developed monitoring format which is still utilized by DOEA staff to measure quality assurance.

- Provided training to statewide network of providers and case managers.
- Responsible for making recommendations to senior management regarding appropriate transfer of funds within the various areas of the state.
- Developed legislative budget requests and conducted analyses of various legislative bills and initiatives during my tenure.
- Received two leadership awards and my team was nominated for Florida's prestigious Davis Productivity Award.

Humans Services Program Specialist, Area Agency on Aging for North Florida 1991-1994

- Participated in the development and execution of a comprehensive area plan to provide services to elders located in 14 rural counties in North Florida.
- Primarily responsible for implementation of Community Care for the Elderly and Alzheimer's Disease Initiative programs through contracts with the state unit on aging.
- Provided training and technical assistance to designated lead agencies in each of the counties.
- Conducted monitoring and quality assurance surveys to ensure adherence to contractual obligations and customer satisfaction.

Case Manager. Elder Care Services 1988-1991

- Maintained active caseload of 80-90 frail elders participating in Community Care for the Elderly and Alzheimer's Disease Initiative programs. Completed assessments and developed plans of care to address needs of participants and their caregivers.
- Supervised and trained eleven Senior Companions providing in-home care. Training emphasized recommended hands-on care techniques as well as communications methods to be used with non-verbal participants.

Social Services Director Several skilled nursing facilities in Pennsylvania 1978-1986

- Serving in this capacity provided insight into the need to provide in-home services to frail elders in order to allow them to safely remain in their own homes and delay or prevent institutionalization. I was pleased to find such programs when I relocated to Florida.

EDUCATION

BA Sociology E Stroudsburg College 1971

MARY SCHRENKER

Experience:

3/01 to present **Florida Department of Children and Families, Tallahassee, FL**

5/09 to present *Operations Review Specialist, Adult Protective Services*

- Manage the budget and statewide waiting list for the Aged and Disabled Adults Home and Community Based Services Medicaid Waiver for disabled adults aged 18 to 59.
- Develop policy and provide technical support for all Medicaid Waiver services provided or coordinated by the Department.

9/06 to 5/09 *Government Operations Consultant II, Florida Abuse Hotline*

- Responsible for developing and updating policies and pre-service training job aids based on changes to statute, administrative rule or policy.
- Developed and maintained a web based resource for staff with job aids, policies, referrals for callers, links to statutes and administrative rule and questions and answers.

1/04 to 9/06 *Abuse Registry Supervisor, Florida Abuse Hotline*

- Supervised a unit of eight to ten Abuse Registry Counselors. Responsible for hiring decisions, continuing training after new counselors completed pre-service training, day to day supervision and performance evaluations.

3/01 to 1/04 *Abuse Registry Counselor, Florida Abuse Hotline*

- Assess calls for abuse/neglect/exploitation of children and vulnerable adults and determine if allegations meet criteria for a report. Complete abuse reports and other documentation.

12/91 to 7/00 **Children's Home Society of Florida, Central Florida Division, Orlando FL**

12/99-7/00 *Counselor IV*

- Utilization management for TANF dollars. Worked in collaboration with Human Services Associates, the agency that was contracted fiscal responsibility for the funding.
- Assisted with developing policies and procedures, developing provider network, and training providers.

6/97 to 12/99 *Program Director*, Family Support and Visitation Center

- Developed program which provided supervised visitation for families with children in foster care or other substitute care. Managed operations and budget. Wrote several grants.
- Trained all staff and volunteers.
- Participated in the Florida Chapter of Supervised Visitation Network, International. Chaired several committees including the conference committee.

12/91 to 6/97 *Program Director*

- Developed three programs.
- Managed operations and budgets for several programs that provided in home counseling for families involved with the Department of Children and Families and/or case management for children with serious emotional disturbances and mental health diagnoses.
- Developed fiscal tracking and auditing systems; responsible for hiring, training, disciplinary action, Medicaid billing, grant writing.

9/90 to 12/91 **Orange County Board of County Commissioners, Department of Children, Youth and Family Services, Orlando, FL,**

Children's Services Counselor

- Provided individual, family and group counseling for residents ages 11-17.
- Provided case management and discharge planning, networked with community resources.

Education:

12/91 University of Central Florida, Orlando, FL, M. S., Clinical Psychology

5/85 Belmont Abbey College, Belmont, NC, B. A., Business Administration

WENDY L. SMITH, LCSW

EDUCATION:

Master of Clinical Social Work
Florida State University
Tallahassee, Florida
April 1986

Bachelor of Arts in Psychology
State University of New York
Fredonia, New York
May 1978

CERTIFICATIONS / LICENSES:

Licensed Clinical Social Worker:
State of Florida (Expiration 3/11)

Certificate in Gerontology:
Florida State University - April 1990

HONORS:

Graduated Magna Cum Laude in 1986 from Florida State University
Graduated Cum Laude in 1978 from S.U.N.Y. at Fredonia
New York State Regents Scholarship recipient, 1974 – 1978

PROFESSIONAL EXPERIENCE:

Florida Agency for Health Care Administration
Medicaid Services
Tallahassee, FL

Program Administrator — February 2005 – Present
Long-Term Care Waivers and Institutional Unit

Responsible for policy development and oversight of Medicaid programs for elders and adults with physical disabilities in the state of Florida, including: the Aged and Disabled Adult Waiver, Assisted Living Waiver, Assistive Care Services, Nursing Home Diversion Waiver, Channeling Waiver, Adult Day Health Care Waiver, Program of All-Inclusive Care for the Elderly (PACE), Nursing Home Reimbursement Policy, Hospice Reimbursement Policy, Nursing Home Transition Services, CARES, PASRR, and the Long-Term Care Insurance Partnership Program. Responsible for the supervision of eight professional and data entry staff members within the Bureau of Medicaid Services.

HealthSouth Rehabilitation Hospital
Columbia and Charleston, SC
Kingsport, TN

Case Manager — October 2001 – December 2004
and October 1991 – August 1993

Case manager and discharge planner in an inpatient physical rehabilitation hospital. Responsible for coordinating and integrating each patient's individualized rehabilitation plan in cooperation with all other hospital disciplines. Responsible for working with patients, families and insurance providers to communicate patient progress and insure appropriate delivery of services. Responsible for working with community resources to arrange for nursing home placement, in-home services, home health or outpatient therapies, medical appointments, and durable medical equipment.

Florida Agency for Health Care Administration
Medicaid Services
Tallahassee, FL

Program Administrator — July 1996 – August 2001
Behavioral Health Care Unit

Managed behavioral health care specialist for the Bureau of Medicaid Services. Contract manager for the Medicaid Prepaid Mental Health Plan (PMHP) waiver project in Medicaid Area Six, and for the Sub-Acute Inpatient Psychiatric Program (SIPP) waiver in Medicaid Areas Four and Eight. Clinical coordinator for the Florida Medicaid Behavioral Health Care Utilization Management Program. Responsible for developing and monitoring mental health and substance abuse policies and programs for the Florida Medicaid program. Responsible for supervision of professional and clerical staff, and a mental health consumer advocate.

Florida State Hospital
Chattahoochee, FL

Mental Health — September 1993 – July 1996
Program Analyst

Qualified mental health professional (QMHP), or single point of accountability for coordination of clinical treatment for mental health patients in a major state institution. Served as treatment team coordinator and primary patient advocate. Responsible for scheduling and chairing treatment team meetings and ensuring that all treatment decisions were appropriately documented. Monitored implementation of treatment services, patient participation and progress. Member of the unit management team, responsible for developing unit policy and monitoring unit compliance with hospital and state policies.

Medfield Hospital
Largo, FL

Clinical Social Worker — September 1990 - August 1991

Provided individual, family, and group therapy to adults in a 65-bed private psychiatric hospital. Responsible for patient case management, completion of social service admission assessments, coordination of social, legal, financial resources, and discharge planning. Served as member of a psychiatric evaluation team on call for the purpose of making assessments for hospitalization when a potential need was identified. Additionally responsible for contacting local service providers and encouraging utilization of services offered by the facility, as a member of the hospital marketing team.

Aging and Adult Services
Tallahassee, FL

Senior Human Services — April 1989 - September 1990
Program Specialist

Responsible for coordination of all quality assurance activities for the Aging and Adult Services Program Office. Provided technical assistance to each of the eleven district program offices and eleven area agencies on aging related to the administration of Older Americans Act programs, Senior Center Projects, Home Care for the Elderly, Community Care for the Elderly, and Emergency Home Energy Assistance for the Elderly Program. Coordinated preparation of annual quality assurance standards for the office, and served as team leader in monitoring each district once every fiscal year. Completed detailed reports of findings after each review, and coordinated completion of annual statewide report at the end of each fiscal year. Provided oversight on revisions to monitoring chapters in state program manuals. Responsible for tracking monitoring reports from all aging and adult services providers statewide and coordinated tracking of corrective actions by program office specialists.

Florida State Hospital
Chattahoochee, FL

Mental Health Program — November 1985 - April 1989
Analyst Coordinator – Office of Quality Assurance

Responsible for the collection of data from clinical programs for evaluation of the effectiveness of mental health programs and service delivery in a major state institution. Assisted treatment units in maintaining compliance with standards set forth in internal and external requirements. Performed spot check validation for accuracy of unit reporting for Health Care Quality Assurance and Departmental Performance Review monitoring. Coordinated the establishment of unit level quality assurance programs hospital-wide. Worked in conjunction with the Office of Program Planning in the analysis and reporting of data gathered during internal survey activities. Served as a liaison between the treatment units, administration, and external monitoring groups during hospital surveys. Assisted units in ongoing corrective action process.

Clinical Social Worker — May 1985 - October 1985
Forensic Services

Responsible for providing individual and group therapy. Functioned as a co-leader of an interdisciplinary treatment team. Participated in diagnostic and technical staff conferences regarding admissions, releases, transfers, and psychiatric reviews. Completed required admission documents, wrote patient progress reports, and prepared clinical summaries for administrative hearings. Provided information for competency evaluations, coordinated referrals to treatment programs inside the hospital, and made recommendations for aftercare services as appropriate. Served as liaison between the forensic patient, Florida State Hospital, and the courts.

Clinical Social Worker — May 1983 - May 1985
Long Term Care Facility

Responsible for all aspects of discharge planning, including coordination and completion of required discharge documents. Maintained contact with families, encouraging support and involvement in treatment and discharge planning. Contacted community resources for the development of placement options. Completed clinical summaries, social history updates, periodic progress reports, and treatment reviews. Testified at commitment/recommitment, guardianship, and consent for treatment hearings. Provided individual and group therapy, and served as an advocate for skilled and intermediate level of care patients in a major mental health institution.

Clinical Social Worker — August 1982 - May 1983
Psychiatric/Geriatric Services

Completed admission assessments, social history updates, progress reports, and offered recommendations for patient treatment as a member of an interdisciplinary treatment team. Responsible for all aspects of discharge planning, including coordination and completion of discharge documents. Maintained contact with families and developed community resources for the purpose of aftercare planning. Assisted patients and families in applying for financial assistance, including the State of Florida Institutional Care Program. Completed clinical summaries and participated in court proceedings on patients scheduled for guardianship hearings, consent for treatment, and recommitment under the Baker Act. Provided individual and group therapy.

Department of Health and Rehabilitative Services
Fort Pierce, FL 33450

Social Worker — August 1982 - May 1983
Aging and Adult Services

Coordinated the provision of medical, legal, and psychiatric services for abused, neglected, exploited, or at-risk adults. On call 24 hours daily for second party abuse, exploitation, or neglect complaints. Coordinated placements in adult foster homes, adult congregate living facilities, or nursing homes, when remaining in the home was no longer possible. Certified foster homes as alternative living facilities. Determined client eligibility for participation in Home Care for the Elderly, Optional State Supplement Program, and Institutional Care Program. Served as case manager, providing ongoing supervision and advocacy for clients in these programs. Arranged for legal services in guardianship, mental health or substance abuse commitment hearings, and assisted in Adult Protective Service Act placements.

Eligibility Specialist — December 1978 - August 1979
Economic Services

Determined continued financial eligibility for public assistance, Medicaid, and Food Stamps. Made referrals to the work incentive program and child support investigation as appropriate. Updated client records on the automated statewide client information system. Received six weeks of specialized training in policies and procedures for state economic services programs.

ATTACHMENT I – List of Acronyms and Abbreviations

AAA – Area Agencies on Aging

AFCH – Adult Family Care Home

AHCA – Agency for Health Care Administration

ALE – Assisted Living for the Elderly

ALF – Assisted Living Facility

APD – Agency for Persons with Disabilities

ARC – Aging Resource Center

CARES – Comprehensive Assessment and Review for Long Term Care Services

CDC+ - Consumer Directed Care Plus

CIL – Center for Independent Living

CIRTS – Client Information Registration and Tracking System

CMS – Centers for Medicare and Medicaid Services

CSC – Community Support Coordinator

DCF – Department of Children and Families

DOEA – Department of Elder Affairs

DOH – Department of Health

ECC **–** Extended Congregate Care

DUA – Data Use Agreement

FAHSA – Florida Association of Homes and Services for the Aging

FALA – Florida Assisted Living Affiliation

F/EA – Fiscal/Employer Agent

FHCA – Florida Health Care Association

FSHC – Florida Supportive Housing Coalition

HCBS – Home and Community-Based Services

ICP – Institutional Care Program

LNS – Limited Nursing Services

MDS – Minimum Data Set

NHD – Nursing Home Diversion

PACE – Program of All-Inclusive Care for the Elderly

PERS – Personal Emergency Response System

TBI/SCI – Traumatic Brain Injury/Spinal Cord Injury

VR – Vocational Rehabilitation

ATTACHMENT J – Florida's Health Information Technology Initiative

Florida is participating in a broad range of HIT activities. At its base is the Florida Health Information Exchange Cooperative Agreement Program (HIE), which received federal funding in March 2010 to support a four-year effort in its statewide health information exchange. Responses to an invitation to negotiate for design, development, implementation and ongoing operation and maintenance of the HIE were received in September, and on November 30 AHCA announced its intent to award a $20 million four-year contract to the Florida-based company Harris Healthcare Corporation. Two respondents filed notices of intent to protest, and the contract award is on hold until resolution of the protests.

Significant planning work must occur. This includes determining the technical specifics to support the HIE services; the legal policy and approach to ensure appropriate levels of privacy, achieve maximum participation, and keep administrative burden to a minimum; and long-term financial sustainability approaches for maintaining the HIE services.

AHCA is committed to engaging stakeholders in the planning and implementation of statewide HIE. In June 2010 AHCA held an HIE kickoff meeting that included health care providers and consumers, regional health information organizations, medical associations, regional extension centers, government agencies and other stakeholders to discuss how to move HIE forward in Florida. The goal is to develop and improve the ability of health care providers to exchange health information, ensure adequate oversight of data sharing, and support and

measure the meaningful use of HIE in order to improve coordination of care and public health.

Already, Florida providers are able to access patient-specific Medicaid claims-based data, along with patient eligibility and benefit look-up. After receiving patient authorization and registering with the project site, providers can access prescription and lab event history, hospital visits, diagnoses and any other paid Medicaid claims information retroactive 18 months. Patient consent specifies that the provider has permission to access all information regarding health history, hospitalization, tests and outpatient care and that it may contain sensitive health information including, but not limited to, drug, alcohol or substance abuse, mental health or developmental disabilities (excluding psychotherapy notes), Sickle Cell Anemia, birth control and family planning, sexually transmitted disease, HIV/AIDS, tuberculosis, and genetic diseases or tests.

AHCA is now reaching out to providers to encourage them to implement an electronic health record program. This outreach includes incentives for provider participation with payments scheduled to begin in August 2011. Professionals eligible are non-hospital based physicians, dentists, nurse-midwives, nurse practitioners and physician assistants practicing in a federally qualified health center or rural health clinic that is directed by a physician assistant. They must also meet certain Medicaid patient volume thresholds. Eligible professionals can receive up to $63,750 over six years for adopting and meaningfully using EHR technology. Hospitals eligible for incentive payments are acute care, critical access, and children's hospitals. Acute care and critical access facilities must have a Medicaid

patient volume of at least 10% to be eligible. All participants are required to use certified EHR technology.

Detailed information about all of Florida's HIT initiatives is available on the web at http://www.fhin.net.

ATTACHMENT K – Florida Housing Information

A SUMMARY OF FLORIDA HOUSING'S PROGRAMS

227 North Bronough Street, Suite 5000 • Tallahassee, FL 32301 • 850.488.4197 • www.floridahousing.org

HOMEOWNERSHIP PROGRAMS

First-Time Homebuyer Program

Florida Housing's First Time Homebuyer (FTHB) program offers 30-year, fixed-rate first mortgage loans originated by trained and approved lenders throughout the State of Florida. The program is offered to all borrowers who meet income, purchase price and other program guidelines, and can otherwise qualify for a loan. Borrowers who qualify for this first mortgage program are automatically qualified for one of Florida Housing's down payment assistance programs.

Down Payment Assistance Programs

In an effort to assist low- to moderate-income individuals achieve homeownership, the FTHB program offers borrowers an assortment of down payment assistance options. The assistance comes in the form of a grant, or a 0% interest or low, fixed-rate second mortgage. Only one Florida Housing down payment program can be used by the borrower and only in conjunction with the FTHB program first mortgage products.

• ***Florida Assist Program***

Up to $7,500 is available through the HAP to assist first time homebuyers with down payment and closing costs. HAP loans are 0% interest, non-amortizing second mortgage loans, which means the homebuyer does not make any monthly payments. Instead, the loan is repaid if the homebuyer sells the home, transfers ownership, satisfies or refinances the first mortgage, or ceases to occupy the home. This program targets applicants whose incomes are at or below 100% of the area median income (AMI), adjusted for family size.

• ***Homeownership Assistance for Moderate Income (HAMI)***

Up to $5,000 is available to assist first time homebuyers with down payment and closing costs through the HAMI program. This program enables borrowers with moderate incomes to receive down payment and closing cost assistance. Unlike the HAP, HAMI is an amortized loan that is offered at a low, fixed interest rate with level monthly payments for a 10-year term. First time homebuyers may be eligible for this loan if their incomes exceed the limits of the HAP, but do not exceed the maximum annual income limits for the FTHB program.

Homeownerhip Pool Program

Florida Housing's Homeownership Pool (HOP) program is designed to be a non-competitive and ongoing program, with developers reserving funds for eligible homebuyers to provide down payment assistance on a first-come, first-served basis.

Eligible Participants

• ***Developers:*** The HOP program is available to non-profit and for-profit organizations, Community Housing Development Organizations (CHDOs), and counties and eligible municipalities that are recipients of SHIP funding and United States Department of Agriculture - Rural Development (USDA-RD) funding. HOP funds are available for use in conjunction with new construction, and also may be used in conjunction with substantial rehabilitation by eligible local governments that are recipients of SHIP funding.

• ***Homebuyers:*** Eligible homebuyers are those whose adjusted income does not exceed 80% AMI. Through this program, they can receive a 0% deferred second mortgage loan for the lesser of 25% of the purchase price of the home or $70,000, or the amount necessary to meet underwriting criteria (with the exception of eligible homebuyers with disabilities and eligible homebuyers at 50% AMI or below, who may receive the lesser of up to

35% of the purchase price or $80,000).

MULTIFAMILY DEVELOPMENT PROGRAMS

State Apartment Incentive Loan Program
The State Apartment Incentive Loan (SAIL) program provides low-interest loans on a competitive basis each year to developers of affordable rental housing. SAIL funds provide gap financing that allows developers to obtain the full financing needed to construct affordable multifamily units. SAIL dollars are available to public entities, and non-profit and for-profit organizations for the construction or substantial rehabilitation of multifamily units. Special consideration is given to properties that target specific demographic groups such as the elderly, the homeless, farmworkers and commercial fishing workers.

Elderly Housing Community Loan
A portion of SAIL funds is set aside to fund the Elderly Housing Community Loan (EHCL) program. This program provides loans of up to $750,000 to make substantial improvements to existing affordable elderly rental housing. The EHCL program generally has one competitive funding cycle each year and the application period is open for a minimum of 45 days. These funds are available for the purpose of making sanitation repairs or improvements required by federal, state or local regulation codes, and for life-safety or security-related improvements.

Multifamily Mortgage Revenue Bonds
The Multifamily Mortgage Revenue Bond (MMRB) program uses both taxable and tax-exempt bonds to provide below market rate loans to non-profit and for-profit developers who set aside a certain percentage of their apartment units for low-income families. Proceeds from the sale of these bonds are used to construct, or acquire and rehabilitate, multifamily rental properties. The MMRB program's application scoring and ranking criteria encourage increased set-asides for low-income households. Special consideration is given to properties that target specific geographic areas.

Florida Affordable Housing Guarantee
The Florida Affordable Housing Guarantee program encourages affordable housing lending by issuing guarantees on mortgages of bond-financed affordable housing, thereby, creating a security mechanism that allows issuers of mortgage revenue bonds to sell affordable housing loans in the primary and secondary markets. It also encourages affordable housing lending activities that would not otherwise have taken place. Most of the transactions in this portfolio are partially guaranteed by the U.S. Department of Housing and Urban Development (HUD) Risk-Sharing Program. In light of current adverse market conditions, Florida Housing has suspended the issuance of additional guarantees.

HOME Investment Partnerships
The HOME Investment Partnerships (HOME) program provides non-amortizing, low-interest rate loans to developers of affordable housing who acquire, rehabilitate or construct housing for low-income families. Loans are offered through the annual Universal Cycle at the simple interest rate of 0% to non-profit applicants and 1.5% to for-profit applicants. Florida Housing's HOME program is designed for smaller developments.

Low Income Housing Tax Credits
The competitive (9%) and non-competitive (4%) Low Income Housing Tax Credit program provides for-profit and non-profit organizations with equity based on a dollar-for-dollar reduction in federal tax liability for investors in exchange for the acquisition, rehabilitation and new construction of affordable rental housing. Special consideration is given to properties that target specific demographic groups, such as the elderly, the homeless and farmworkers. Consideration also is given to properties that target specific geographic areas, such as the Florida Keys, rural areas and urban infill areas.

SPECIAL PROGRAMS

State Housing Initiatives Partnership
The State Housing Initiatives Partnership (SHIP) program provides funds to local governments on a population-based formula as an incentive to produce and preserve affordable housing for very low-, low-, and moderate-income families. These funds are derived from the collection of documentary stamp tax revenues, which are deposited into the Local Government Housing Trust Fund. SHIP funds are distributed on an entitlement basis to all 67 counties and 52 Community Development Block Grant (CDBG) entitlement cities in Florida. The minimum allocation per county is $350,000. SHIP dollars may be used to fund emergency repairs, new construction, rehabilitation, down payment and closing cost assistance, impact fees, construction and gap financing, mortgage buy-downs, acquisition of property for affordable housing, matching dollars for federal housing grants and programs, and homeownership counseling. Each participating local government may use up to 10% of its SHIP funds for administrative expenses.

Predevelopment Loan Program
The Predevelopment Loan Program (PLP) assists non-profit and community-based organizations, local governments, and public housing authorities with planning, financing and developing affordable housing. Eligible organizations may apply for a three-year loan of up to $750,000 for predevelopment activities, such as rezoning, title searches, legal fees, administrative costs, soil tests, engineering fees, appraisals, feasibility analyses, audit fees, earnest money deposits, insurance fees, commitment fees, administrative costs, marketing expenses, and acquisition expenses. Technical assistance is also provided at no charge.

Affordable Housing Catalyst Program
The Affordable Housing Catalyst Program provides on-site and telephone technical assistance and training on the SHIP program, the HOME program, and other affordable housing programs. This technical assistance is targeted to non-profits and government entities, and includes training on forming local and regional public/private partnerships, working effectively with lending institutions, implementing regulatory reform, training for boards of directors, implementing rehabilitation and emergency repair programs, developing volunteer programs, assisting with the design and establishment of fiscal and program tracking systems, and compliance requirements of state and federally funded housing programs. Workshops are conducted throughout the year at locations around the state.

Homeownership Assistance for Local Governments that Reduce or Waive Impact Fees
The 2008-09 Legislature made $10 million in one-time funds for homeownership assistance available to counties and municipalities that have reduced impact fees by a minimum of 25% for at least 18 months, or which impose no impact fees for homeownership. The objective of the funding is to incentivize a jurisdiction to reduce impact fees on new construction to stimulate construction and to reduce the amount of excess housing stock in the state. The appropriation is intended to be expended for homeownership assistance within a short time frame. Florida Housing is to administer the funds through the framework of the SHIP program. Local governments were given an opportunity to submit a request for funding, and seven (7) counties and two (2) cities will receive funds.

Preservation Bridge Loan Program
The 2008-09 Legislature made available $5 million for a preservation rehabilitation pilot program in Pasco, Palm Beach, and Orange counties targeting rental housing that receives or has received funding from any federal or state housing funding program. The legislative proviso dictated that, to the maximum extent feasible, the funding shall be leveraged by intermediaries at least 4:1. Florida Housing determined that, as part of a comprehensive multifamily preservation effort, the funding should be used to create a preservation bridge loan program. The program will offer three-year bridge loans to provide acquisition financing, as well as the time to stabilize and position a property for more favorable permanent financing. Florida Housing expects to have contracts signed with an intermediary, and the pilot up and running in mid-2009; this funding will be available to projects in these three counties at that time.

FloridaHousingSearch.org—Florida Housing's Online Affordable Rental Housing Locator
FloridaHousingSearch.org is Florida Housing's free online affordable rental housing locator for Florida. It serves

as clearinghouse for affordable rental properties for people who earn up to 120 percent of an area's median income (AMI) in the State of Florida. Landlords throughout the state are encouraged to register their affordable properties on the site, as this site serves as an important resource as the state continues to face the challenges of the foreclosure crisis and the effects of hurricane seasons that can leave thousands of people searching for available and affordable housing. Anyone can search online 24 hours a day or contact a toll-free, bilingual call center at 1-(877) 428-8844 for searching support, Monday through Friday, 9:00 a.m. to 6:00 p.m. EST.

HURRICANE RECOVERY

Hurricane Housing Recovery

The Hurricane Housing Recovery Program (HHRP) was established to enable 28 local governments impacted by the 2004 hurricanes to develop and implement long-term affordable housing strategies for their communities. Local governments developed and submitted hurricane housing assistance plans to Florida Housing that outlined how their funding would be expended; the program is much like the SHIP program. Local governments were scheduled to complete the expenditure of the HHRP funds in 2008. However, some local governments have requested expenditure extensions to complete developments.

HOME Again

In response to the devastating 2004 hurricane season, Florida Housing created the HOME Again program, providing funding statewide to help hurricane-impacted homeowners with the repair, reconstruction or replacement of their damaged homes. The allocation focused on the most intensively storm-impacted areas of the state, and provided local governments and non-profit organizations home repair or replacement funding—on a reimbursement basis—on behalf of homeowners in communities that were declared state or federal disaster areas. The program provided up to $50,000 per home to homeowners whose gross annual incomes did not exceed 80% of AMI, living in single-family detached housing, a condominium unit or townhome, or manufactured housing. In 2008, final funding was awarded to successful applicants, many of whom also have provided rehabilitation assistance to homeowners in their local communities.

Tenant-Based Rental Assistance

Florida Housing set aside nearly $22 million from its Federal HOME program toward temporary rental assistance for emergency housing in response to the devastation caused by hurricanes Charley, Frances, Ivan and Jeanne. HOME funds were granted to qualifying public housing authorities (PHAs) that administer the HUD Section 8 Housing Choice Voucher Program. Eligible households have included those who have incomes at or below 80% of AMI, adjusted for family size, as established by HUD. For each fiscal year, at least 90 percent of the eligible households assisted through HOME TBRA must be at or below 60% of AMI. Rental assistance is limited to an initial 12-month period, but in no event will assistance be extended beyond an additional one year.

WORKFORCE HOUSING

Community Workforce Housing Innovation Pilot Program

In 2006 and 2007, the Florida Legislature passed housing bills focused on addressing some of the affordable housing challenges the state faced during that time frame. A total of $112.4 million was appropriated for an affordable housing pilot program—the Rep. Mike Davis Community Housing Workforce Innovation Pilot (CWHIP) program. The purpose of CWHIP was to promote the creation of public-private partnerships to finance, build and manage workforce housing, and required the coordinated efforts of all levels of government, as well as private sector developers, financiers, business interests, and service providers. CWHIP was funded for two years (2006 and 2007) and these funds were awarded through a competitive process to public-private entities seeking to build affordable housing for Florida's workforce.

ATTACHMENT L – Support Letters

Name	Title	Affiliation
Shannon Nazworth	Executive Director	Ability Housing of Northeast Florida
Bryan Scott Funk, Esq.	Attorney	Advocacy Center for Persons with Disabilities
Jack D. Humburg	Director of Housing Development	Boley Centers
Kelly Greene	Executive Director	Center for Independent Living of South Florida, Inc.
Larry Polivka, Ph.D	Executive Director	The Claude Pepper Center
Susan Ventura, M.S.	President & CEO	Easter Seals Disability Services
Mark Fontaine	Executive Director	Florida Alcohol & Drug Abuse Association
Margaret Lynn Duggar	Executive Director	Florida Association of Aging Services Providers
Martina Schmid-Brawer	Executive Director	Florida Association of Centers for Independent Living
Janegale Boyd	President & CEO	Florida Association of Homes and Services for the Aging
Leah Cook	Program Director	Florida Coalition for the Homeless
Bob Carter	President	Florida Council on Aging
George Sheldon	Secretary	Florida Department of Children and Families
Bill Palmer	Director, Division of Vocational Rehabilitation	Florida Department of Education
Stephen P. Auger	Executive Director	Florida Housing Finance Corporation
Molly Gosline	Executive Director	Florida Independent Living Council, Inc.
Gail D. Cordial	Executive Director	Florida Partners in Crisis
Ellen Piekalkiewicz	Program Director	Florida Supportive Housing Coalition
Nestor Plana	President	Independent Living Systems
Debra Shade	President & CEO	Neighborly Care Network

Donna Wyche	Manager	Orange County Health and Family Services
Deborah J. Linton	Executive Director	The Arc of Florida
Pat Wear	Senior Vice President	Wilson Resources, Inc.

ABILITY HOUSING
OF NORTHEAST FLORIDA

November 29, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

Ability Housing of Northeast Florida, Inc. is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The mission of Ability Housing is to provide quality, community-inclusive housing for adults with a disability. As such, we are committed to increasing the independent housing options of adults with disabilities. The Money Follows the Person Rebalancing Demonstration Grant will expand the state's efforts to transition individuals from overly-restrictive facility settings to community-based housing of their choice.

As a Florida nonprofit, our organization supports the Agency for Health Care Administration's in Florida's application for the MFP grant. During the last several months, our staff has participated in meetings with AHCA staff; providing with input on housing component of the grant application. AHCA has identified quality, affordable housing as one of the greatest challenges for implementation of the grant.

MFP will require a concerted, coordinated effort between multiple state agencies: Agency for Healthcare Administration, Department of Elder Affairs, Agency for Person with Disabilities, Department of Children and Families, and Florida Housing Finance Corporation, as well as many community stakeholders, including local Public Housing Authorities (PHAs) and the Florida Supportive Housing Coalition.

As an agency concerned with the community-based option provided to adults with disabilities, Ability Housing will support AHCA's implementation of the grant in whatever way it can; including providing technical assistance concerning the housing component of the grant.

Sincerely,

Shannon Nazworth
Executive Director
Board Chair, Florida Supportive Housing Coalition

126 W. Adams St.
Suite 502
Jacksonville, FL 32202

904.359.9650 phone
904.359.9653 fax

www.abilityhousing.org

OPENING DOORS TO INDEPENDENCE

Advocacy Center
for Persons with Disabilities, Inc.
Florida's Protection and Advocacy System

November 8, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308
Re: Support for *2011 Money Follows the Person Rebalancing Demonstration Grant*

Deputy Secretary Bradford:

The Advocacy Center for Persons with Disabilities, Inc. (the Advocacy Center)---the official protection and advocacy system for Florida's citizens with disabilities as designated by Executive Order of the Governor--- submits this recommendation in support of the Agency's application for the *2011 Money Follows the Person Rebalancing Demonstration Grant,* FON CMS-1LI-11-001.

The Advocacy Center's recommendation affirms that the *Money Follows the Person Rebalancing Demonstration Grant,* as offered by the Centers for Medicare and Medicaid Services, will engender a focused impetus within the Agency to move Agency clients out of institutional settings and into the community. This focus should create the framework for future efforts to transition institutionalized populations into the community, both fulfilling the mandate created by the *Olmstead* decision and, most importantly, improving quality of life for many Florida's citizens with disabilities. Because deinstitutionalization is one of the Advocacy Center's overarching goals, it is gratifying that the Agency and the State of Florida have been provided with this opportunity.

The Advocacy Center also affirms that this *Money Follows the Person Rebalancing Demonstration Grant* will enable the Agency to shift available funding into enhancing existing Medicaid State Plan and home and community-based waiver services to Florida's citizens with disabilities. This shift in funding may foster a renewed drive to reduce lengthy waitlist times for individuals in need of waiver services.

The Advocacy Center, therefore, strongly supports the Agency for Health Care Administration in its application for this 2011 *Money Follows the Person Rebalancing Demonstration Grant,* and is confident that it will significantly benefit many of our clients. Finally, as one of Florida's stakeholder groups, the Advocacy Center is committed to working closely with the Agency in implementing this grant and improving Florida's long term care system.

Sincerely,

/S/

Bryan Scott Funk, Esq.

www.advocacycenter.org

2728 Centerview Drive, Suite 102
Tallahassee, Florida 32301

800.342.0823 or 850.488.9071
Fax 850.488.8640
TDD 800.346.4127

November 29, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

Boley Centers is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's efforts with this grant. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Jack D. Humburg
Director of Housing Development
& ADA Services

445 31st Street North, St. Petersburg, Florida 33713
Telephone (727) 821-4819 • Fax (727) 822-6240
www.boleycenters.org

CENTER FOR INDEPENDENT LIVING OF SOUTH FLORIDA, INC.

October 5, 2010

Nicole Nicholson
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Re: Money Follows the Person Rebalancing Grant Demonstration
Funding Opportunity Number: CMS-1LI-11-001
Competition ID Number: CMS-1LI-11-001-011751
CFDA 93.791

Dear Ms. Nicholson:

The Center for Independent Living of South Florida applauds AHCA's initiative to apply for the Money Follows the Person Demonstration grant project, which will enable Florida to provide the most integrated setting and community supports for people with disabilities based on personal choice to live in the community rather than an institution. We are eager to be considered for a partnership opportunity should this proposal be awarded funds.

We began institutional transition in the same year that President Bush issued his New Freedom Initiative and have continued to assist people with disabilities to leave nursing homes and mental health facilities, and relocate to the community. We have also diverted individuals who are being steered to nursing homes as they leave hospitals. We do this by informing them of other options and resources and providing the necessary assistance to return to their own home or to an apartment in the community. Sometimes the only reason a person is sent from hospital to nursing home is because the individual cannot afford to have a ramp built. Our solution was to provide a portable ramp. Our deinstitutionalization project has grown little by little each year as we have become more adept at searching for housing in the community and expanding our network of community resources to provide furniture, house wares, rent/security/utility deposits, moving expenses and minor home renovations.

This demonstration project will enable our center to reach out to the large number of individuals who wish to leave institutions but have been prevented from doing so by the historic lack of funding for community supports in comparison to nursing home beds. It also promises to give people of diverse age and disability Real Choice about living in the least restrictive setting in compliance with the Olmstead decision.

CIL of South Florida
3660 Biscayne Blvd.
Miami, FL 33138
www.soflacil.org
www.cilatie.blog.org

Voice: 305-751-8025
TTY: 305-751-8691
Fax: 305-751-8944
Toll-free: 800-854-7981

Funded by the U.S. Department of Education, Rehabilitation Services Administration; Florida Department of Education, Division of Vocational Rehabilitation; Miami-Dade County Office of Grants Coordination, foundations and private donations.

We believe this demonstration grant will also remove the historical bias in the design of state Medicaid programs whereby institutional placement is considered the first option and community placement not considered at all, even when the person has a home to return to but can't get inside without a ramp for access.

This year, we participated in the efforts of the Hialeah and Miami-Dade Housing Agencies to seek Section 8 vouchers for individuals transitioning from nursing homes. We are hopeful that one or both of these applications to HUD will be funded in our county.

If this demonstration grant is funded, it will allow Centers for Independent Living statewide to greatly expand their efforts to deinstitutionalize the huge population of people with disabilities languishing in nursing homes across the state.

CMS has already made strides to eliminate many of the barriers to community living so that states will be successful in their efforts to deinstitutionalize people with disabilities and return them to the community. By joining forces, we will be able to achieve our mutual goals of reducing the state's budget for nursing home care and increasing community living, while improving the overall quality of life for people with disabilities in our state.

AHCA is to be commended for its foresight in taking the leadership role by applying for this demonstration project. We feel sure that together we will be able to accomplish so much more together than we have been able to do alone.

Sincerely,

Kelly Greene
Executive Director

THE CLAUDE PEPPER CENTER
at Florida State University
636 West Call Street
Tallahassee, FL 32306-1124

December 15, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The *Claude Pepper Data Center* is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant. FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's efforts with this grant. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Larry Polivka, Ph.D.
Executive Director

Phone (850) 644 9311 ◆ Fax (850) 644-9301
claudepeppercenter.fsu.edu

[redacted]

Easter Seals Florida, Inc

Susan Ventura, M.S.
President and Chief Executive Officer

2010 Mizell Ave
Winter Park, Florida 32792
407-629-7881 phone
407-629-4764 fax
e-mail: sventura@fleasterseals.com
www.fleasterseals.com

October 27, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

Easter Seals Florida is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's efforts with this grant. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Susan Ventura, M.S.
President and Chief Executive Officer

Remember Easter Seals Florida in your will.

FADAA
FLORIDA ALCOHOL & DRUG ABUSE ASSOCIATION

November 30, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Florida Alcohol and Drug Abuse Association (FADAA) is pleased to provide this letter to the Agency for Health Care Administration (AHCA) in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services will enable AHCA and its partners to offer services that will enhance the Medicaid State Plan and home and community-based services to individuals with disabilities and the elderly.

The proposed services will enhance the state's current efforts to transition individuals from institutions to the community setting of their choice and provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, FADAA supports the Agency for Health Care Administration's application for the MFP grant and as a member of the Florida Supportive Housing Coalition. FADAA recognizes that locating safe, affordable, accessible housing is expected to be one of the biggest challenges facing individuals in the implementation of Florida's MFP program.

We are supportive of this worthy initiative to improve Florida's long term care system

Sincerely,

Mark Fontaine
Executive Director

2668 MAHAN DRIVE, SUITE 1, TALLAHASSEE, FL 32308 • 850-878-2196 • WWW.FADAA.ORG

Florida Association of Aging Services Providers

Received

NOV 03 2010

Medicaid

"Serving Florida's Elderly"

November 1, 2010

248635

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Florida Association of Aging Services Providers is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's efforts with this grant. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Margaret Lynn Duggar

Margaret Lynn Duggar
Executive Director

1018 Thomasville Rd. #110 • Tallahassee, FL 32303 • 850-222-3624 • Fax: 850-222-2575 • FASPHeadquarters@fasp.net • www.FASP.net

325 John Knox Rd, Bldg C, Ste 132 Tallahassee, FL 32303 • Ph: 850-575-6004 • Fax: 850-575-6093
Email: facilmartina@earthlink.net • Web Site: www.floridacils.org

Florida Association of
Centers for Independent Living

October 28, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

Over the past two years the Florida Agency for Health Care Administration, the Department of Elder Affairs and the Department of Children and Families have been working tirelessly to develop a nursing home transition initiative in Florida. They have developed policies and procedures that will allow community agencies such as the Centers for Independent Living to transition people with disabilities out of nursing homes into the community. The Florida Association of Centers for Independent Living is pleased to support the Agency for Health Care Administration's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services is critical to the success of Florida's efforts to move people out of nursing homes. The funds will allow the Agency and its partners to offer demonstration and supplemental services that are not provided by the Medicaid State Plan or the home and community-based waiver, but, are necessary for the transition of elders and individuals with disabilities into the community.

AHCA has worked hard to gain legislative funding and also leverage the support of Florida's community based agencies, which in turn leverage the support of their communities; we now poised for a monumental change in the way in which we will provide long term care for people with disabilities and elders. The Money Follows the Person grant is the final piece that will set this program in motion and allow it to be sustainable after the MFP funding runs out.

As a Florida stakeholder, we look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Martina Schmid-Brawer
Executive Director

The Florida Association of Centers for Independent Living facilitates collaboration among member Centers for Independent Living and other stakeholders, resulting in a unified statewide voice advocating for equal rights for people with disabilities.

Florida Association of Homes and Services for the Aging

Terri Cunliffe, Chair **Janegale Boyd,** President/CEO

November 18, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford,

The Florida Association of Homes and Services for the Aging (FAHSA) is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

FAHSA is the leading statewide association representing mission-driven providers of quality elder care services, affordable housing communities, continuing care retirement communities, nursing homes, assisted living facilities and home and community-based providers. We represent more than 400 facilities statewide, 160 of which are affordable senior housing communities. FAHSA members currently serve the needs of more than 80,000 seniors.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's efforts to pursue this grant. Some of our members, most of which are non-profit, hope to be involved in the program through the provision of respite, adult day and home health services. We are also hopeful that the program will benefit frail seniors who live in HUD affordable housing properties by reducing the possibility of permanent nursing home placement after what is intended as a short-term admission.

We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Janegale Boyd

Janegale Boyd
President and CEO

1812 Riggins Road ■ Tallahassee, Florida 32308 ■ www.fahsa.org
Telephone: 850.671.3700 ■ Fax: 850.671.3790
Central Florida Office: 2303 Pin Oak Drive, Deland, FL 32720 ■ Telephone: 386.738.0503 ■ Fax: 386.738.1428

November 29, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Florida Coalition for the Homeless is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Coalition understands that the Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. This grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

The Florida Coalition for the Homeless is a dynamic organization whose membership and Board of Directors include homeless advocates, service providers, members of the faith-based community, formerly homeless persons, educators, attorneys, mental health professionals and many others statewide who are committed to putting an end to homelessness and improving the conditions of persons living without shelter.

The Florida Coalition for the Homeless also strives to make homelessness one of the state's priorities. We accomplish this through providing education on homelessness issues; advocating for initiatives that help homeless people and against laws and ordinances that may harm them; networking with advocates throughout Florida on federal, state and local issues; promoting unification, involvement and leadership of local coalitions, service providers, homeless people, religious leaders, units of government and others in the development and implementation of a statewide agenda.

The Florida Coalition for the Homeless is pleased to support Florida's MFP application. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Please feel free to contact me in the future if you have any questions.

Sincerely,

Leah Cook
Program Director

Leah Cook, Program Director
P.O. Box 3764 • Tallahassee, FL 32315
Phone 850-412-0021 • Toll Free 1-877-205-0021
Email leah@fchonline.org • www.fchonline.org

September 22, 2010

Elizabeth Dudek, Interim Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Dudek:

The Florida Council on Aging is pleased to offer its support to the Agency for Health Care Administration (AHCA), and other partners in the State of Florida's application to the Centers for Medicare and Medicaid Services' (CMS) Money Follows the Person Grant.

We strongly support the efforts of AHCA and its grant partners and will work collaboratively to accomplish the goals of the Money Follows the Person Grant. We are committed to sharing grant updates with the FCOA membership and learning more about how we may be a partner of this worthwhile project.

Money Follows the Person grant funding will build upon and enhance Florida's capacity to identify and support individuals transitioning from institutions back into the community. We look forward to this statewide transformation and the positive changes to the quality of life of Floridians.

Sincerely,

Robert Carter, President

1018 Thomasville Road, Suite 110, Tallahassee, FL 32303-6236 (850) 222-8877 Fax: (850) 222-2575 www.fcoa.org

State of Florida
Department of Children and Families

Charlie Crist
Governor

George H. Sheldon
Secretary

November 29, 2010

Ms. Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive Mail Stop #8
Tallahassee, FL 32308

Dear Deputy Secretary Bradford:

The Florida Department of Children and Families is pleased to provide this letter in support of the Agency for Health Care Administration's application for the 2011 *Money Follows the Person Rebalancing Demonstration Grant.*

As the operational agency responsible for administering the Aged and Disabled Adult Home and Community Based Services Medicaid Waiver for persons with disabilities ages 18 to 59, the Department is proud of our current efforts with the Nursing Home Transition Program. Our Nursing Home Transition Program is in its first year of implementation. As our partnerships with the individual Centers for Independent Living (CIL) expand, we are seeing an increase in the number of persons with disabilities that are choosing to transition from nursing homes back to the community.

Through our Aged and Disabled Adult Medicaid Waiver, the Department is committed to assisting adults with disabilities to be cared for in their homes and preserving their independence and ties to family and friends. As you are aware, we have a greater need than our current resources provide and this demonstration grant gives people with disabilities more resources to allow them to live in the community.

The Department is committed to continue the Nursing Home Transition Program to serve people with disabilities. The *Money Follows the Person Rebalancing Demonstration Grant* will assist the Department and our partner CILs in expanding choices for Medicaid recipients in nursing homes.

The Department looks forward to working with the Agency to make this grant a success. If we may be of further assistance, please let us know.

Sincerely,

George H. Sheldon
Secretary

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

FLORIDA DEPARTMENT OF EDUCATION

Dr. Eric J. Smith
Commissioner of Education

Just Read, Florida!

248637

November 1, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, Florida 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Florida Department of Education Division of Vocational Rehabilitation is pleased to provide this letter in support of the Agency for Health Care Administration's application for the 2011 Money Follows the Person (MFP) Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The MFP Demonstration Program reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to "person-centered," consumer directed and delivered in community-based settings of choice. The recent extension of this program will give states additional resources and program flexibilities to remove barriers and improve people's access to community supports and independent living for elders and persons with disabilities.

As a Florida stakeholder, the Division supports your efforts with this grant. I look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration Project a success.

Sincerely,

Bill Palmer

BILL PALMER
Director, Division of Vocational Rehabilitation
2002 Old Saint Augustine Road, Building A • Tallahassee, FL 32301-4862
Toll Free: 1-800-451-4327 (Voice or TTY) • In Tallahassee: 850-245-3399 (Voice or TTY) • FAX: 850-245-3382
Florida Relay Service: 1-800-955-8771 (TTY) • 1-800-955-8770 (Voice) • www.rehabworks.org

we make housing affordable™
Florida Housing
Finance Corporation
227 North Bronough Street, Suite 5000 • Tallahassee, Florida 32301
850.488.4197 • Fax 850.488.9809 • www.floridahousing.org

November 30, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

Florida Housing is pleased to partner with and support the Agency for Health Care Administration in the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As the State's Housing Finance Agency, Florida Housing's support of Florida's Demonstration Grant will include:

- Dedicating staff with expertise in the areas of affordable rental housing and supportive housing to participate in relevant planning, development and implementation meetings;
- Working with stakeholders to increase the Demonstration's transition coordinators and their consumers awareness of and knowledge about community based housing options;

Roberta K. Bradford
November 30, 2010
Page Two

- Facilitating the participation of other rental and supportive housing stakeholders in addressing challenges and developing strategies related to accessible and affordable housing options that meet the needs and preferences of the Demonstration's consumers; and
- Utilizing its Affordable Housing Locator's web-based and call center services to facilitate the Demonstration's consumers' search for available rental housing, assisted living facilities and adult family care homes in their communities.

We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Stephen P. Auger
Executive Director

FLORIDA INDEPENDENT LIVING COUNCIL, INC.

1416 N. Adams Street
Tallahassee, FL 32303
877-822-1993 Toll Free
850-488-5624 Voice/TDD
850-488-5281 FAX
mg@pilaris.net
www.filc.org

November 4, 2010

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

The Florida Independent Living Council, Inc. is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant. FONCMS- 11 2-001.

As a Florida stakeholder, we are convinced of the enhancement of the existing Medicaid State Plan and community-based waiver services to Florida's elders and individuals with disabilities which will be realized should the agency be awarded this grant.

The Money Follows the Person Grant will aid to Florida's efforts, already in place, to transition individuals from institutions to the community settings they choose. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and for expanding choices for Florida's Medicaid population.

The Florida Independent Living Council, Inc. shares the goal of and anticipates working with the Agency for Health Care Administration to achieve more balance in our long term care system and making the making the Money Follows the Person Demonstration a success.

Sincerely,

Molly Gosline
Executive Director

Florida Partners in Crisis

JUSTICE | TREATMENT | SAFETY

249310

Received

DEC 02 2010

Medicaid

November 29, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Dear Deputy Secretary Bradford:

On behalf of the Board of Directors and members of Florida Partners in Crisis, I am pleased to provide you with this letter of support for the Agency's 2011 Money Follows the Person (MFP) Rebalancing Demonstration Grant.

Florida Partners in Crisis is the only organization of its kind in Florida that brings together government leaders, law enforcement officials, health care professionals and concerned citizens to advocate for people with mental illnesses and substance use disorders. A significant amount of our efforts are geared toward the recovery and wellness of individuals with mental illnesses and substance use disorders and helping them live successfully in their communities. Accessible and affordable housing is one of the major challenges these individuals face when re-entering their community.

The Money Follows the Person Rebalancing Demonstration Grant will provide an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance the existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities.

The grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. It will also provide valuable assistance to improve Florida's infrastructure for transition services and expanding choices for our Medicaid population.

We are pleased to support the Agency's MFP grant application and your efforts to improve and expand available housing options for individuals transitioning to community based living. We look forward to partnering with you to achieve these goals and toward making the Money Follows the Person Demonstration a success for so many individuals in need of safe, accessible housing.

Sincerely,

Thanks for all your work!

Gail D. Cordial
Executive Director

175 Marlin Drive • Merritt Island, FL 32952 • 321-453-8825 • www.fpic.org

Florida Supportive Housing Coalition
P.O. Box 11242 • Tallahassee, Florida 32308
(850) 241-2051 • www.flshc.net

249248

Received
NOV 23 2010
Medicaid

November 22, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Florida Supportive Housing Coalition is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's in Florida's application for the MFP grant. During the last several months, we have met with AHCA staff to provide them with input on housing. AHCA staff has agreed that locating safe, affordable, accessible housing is expected to be one of the biggest challenges facing individuals in the implementation of Florida's MFP program since transitioning to a community residence will be dependent on having a sufficient supply of qualified residences in the service area of the potential participant.

MFP will require a concerted effort between the Agency for Healthcare Administration, Department of Elder Affairs, the Agency for Person with Disabilities, the Department of Children and Families, the Florida Housing Finance Corporation, Public Housing Authorities (PHAs), the Florida Supportive Housing Coalition and other related organizations. We have suggested to AHCA that they establish a Housing Task Force to facilitate a high level conversation in Florida about housing for individuals transitioning to community based living. We also have suggested to AHCA that the agency should fund a housing resource guide and training on housing resources for waiver case managers.

In regard to MFP participants, we have indicated to AHCA that the MFP Grant must include funding for housing subsidies, security and utility deposits, furniture and appliance purchases, and home modifications.

The Florida Supportive Housing Coalition as a partner is pleased to support Florida's MFP application and hopes to partner with AHCA in linking MFP participants to supportive housing resources in the State. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Ellen Piekalkiewicz
Program Director

INDEPENDENT
Living Systems

NESTOR PLANA
President

November 1, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, Florida 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

Independent Living Systems, LLC and Independent Living Community Services, Inc. (a not for profit company) are pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant. FOA CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance the existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

We believe that with Florida's significant infrastructure of assisted living and other community based service providers, there is opportunity for significant rebalancing and controlling of costs, as well as the opportunity to reduce or eliminate waiting lists and serve many more individuals through programs aimed at nursing home diversion and nursing home transition, such as the Money Follows the Person program.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As Florida stakeholders, our organizations support the Agency for Health Care Administration's efforts with this grant. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

NP/cmg

Received

NOV 0 3 2010

Medicaid

13943 Evergreen Avenue
Clearwater, Florida 33762
727-573-9444 | www.Neighborly.org

Health, Wellness and Independent Living

October 28, 2010

248634

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Neighborly Care Network is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant. FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's efforts with this grant. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Debra Shade

Debra Shade, CPA, MBA, CRM
President/CEO

NOV 0 3 2010

Neighborly Care Network is partially funded by:

ORANGE COUNTY GOVERNMENT FLORIDA

HEALTH AND FAMILY SERVICES DEPARTMENT
MENTAL HEALTH & HOMELESS ISSUES DIVISION
DONNA WYCHE, Manager
2100 East Michigan Street • Orlando, Florida 32806-4914
407-836-7606 • FAX 407-836-7589 • Donna.Wyche@ocfl.net

249423

November 22, 2010

Received
DEC 8 2 2010
Medicaid

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr, Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Orange County/Mental Health & Homeless Issues Division are pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The MFP Grant provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The MFP grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

MFP will require a concerted effort between the Agency for Healthcare Administration, Department of Elder Affairs, the Agency for Person with Disabilities, the Department of Children and Families, the Florida Housing Finance Corporation, Public Housing Authorities (PHAs), the Florida Supportive Housing Coalition and other related organizations. We have suggested to AHCA that they establish a Housing Task Force to facilitate a high-level conversation in Florida about housing for individuals transitioning to community based living. We also have suggested to AHCA that the agency should fund a housing resource guide and training on housing resources for waiver case managers.

In regards to MFP participants, we have indicated to AHCA that the MFP Grant must include funding for housing subsidies, security and utility deposits, furniture and appliance purchases, and home modifications.

The Orange County/Mental Health & Homeless Issues Division, as a partner, is pleased to support Florida's MFP application and hopes to collaborate with AHCA in linking MFP participants to supportive housing resources in the State. We look forward to working with the Agency in its goal of achieving more balance in the long-term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Donna Wyche
Manager

October 28, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr. Mail Stop #8
Tallahassee, FL 32308

Re: Letter of Support for 2011 Money Follows the Person Rebalancing Demonstration Grant

Dear Deputy Secretary Bradford:

The Arc of Florida is pleased to provide this letter to the Agency for Health Care Administration in support of the Agency's application for the 2011 Money Follows the Person Rebalancing Demonstration Grant, FON CMS-1LI-11-001.

The Money Follows the Person Rebalancing Demonstration Grant offered by the Centers for Medicare and Medicaid Services provides an excellent opportunity for the Agency and its partners to offer demonstration and supplemental services that will enhance existing Medicaid State Plan and home and community-based waiver services to elders and individuals with disabilities in the State of Florida.

The Money Follows the Person grant will add to the state's current efforts to transition individuals from institutions to the community setting of their choice. The grant will provide valuable assistance to the State in improving its infrastructure for transition services and expanding choices for Florida's Medicaid population.

As a Florida stakeholder, our organization supports the Agency for Health Care Administration's efforts with this grant. We look forward to working with the Agency in its goal of achieving more balance in the long term care system and making the Money Follows the Person Demonstration a success.

Sincerely,

Deborah J. Linton
Executive Director, The Arc of Florida

Cc: Beth Kidder

2898 Mahan Drive Suite 1, Tallahassee, Florida 32308
850-921-0460, Fax 850-921-0418
arcflorida@gmail.com

October 19, 2010

Roberta K. Bradford
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Dear Ms. Bradford:

I am writing in enthusiastic support of the Florida Agency for Health Care Administration's application for round two of the CMS Money Follows the Person (MFP) grants.

As former commissioner of Mental Health for the Commonwealth of Kentucky, I was responsible for submittal of Kentucky's application in the initial round of MFP funding to the states. I am thoroughly familiar with and highly supportive of the grants' intent.

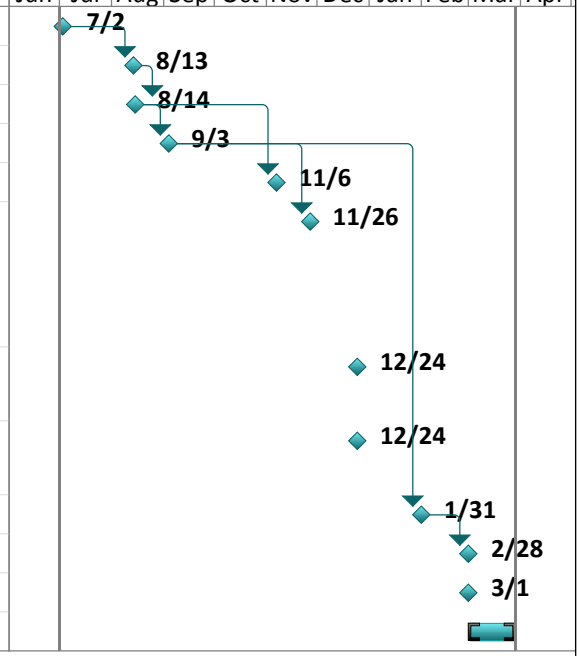
Florida has demonstrable experience with nursing home diversion programs, which has helped to lay the groundwork for a thoughtful MFP proposal. As the last "large state" to participate, I believe it is critical that Florida join the rest of the states in this initiative. Florida continues to have a significant Medicaid imbalance of expenditures for community vs. institutional services. A Florida MFP grant would favorably affect this imbalance and save considerable state funds in the first year of individuals' transition.

I urge your approval of Florida's application.

Sincerely,
Pat Wear, II, M.S.
Senior Vice President
Email: patw@wilres.com

1747 Amberwynd Circle West, Palmetto, Florida 34221 Phone: 941-729-9673; Fax: 941-729-6707

ID	Mileston	Task Name	Duration	Start	Finish	Predecessors
1	Yes	Receive Budget Authority	1 day	Mon 7/2/12	Mon 7/2/12	
2	Yes	Procure project resources	30 days	Tue 7/3/12	Mon 8/13/12	1
3	Yes	Kickoff Project with team	1 day	Tue 8/14/12	Tue 8/14/12	2
4	Yes	Develop WBS for Project	14 days	Wed 8/15/12	Mon 9/3/12	3
5	Yes	Design and deploy new databases	60 days	Wed 8/15/12	Tue 11/6/12	3
6	Yes	Manage security of application and user access/ acquire needed software hardware to manage identities. Eg. Forefront Identity Manager	60 days	Tue 9/4/12	Mon 11/26/12	4
7	Yes	Integrate with FLMMIS for data from that system	80 days	Tue 9/4/12	Mon 12/24/12	
8	Yes	Integrate with Versa for data from that system	80 days	Tue 9/4/12	Mon 12/24/12	
9	Yes	Develop actual application	108 days	Tue 9/4/12	Thu 1/31/13	4
10	Yes	Testing Phase	20 days	Fri 2/1/13	Thu 2/28/13	9
11	Yes	Implementation	0 days	Fri 3/1/13	Fri 3/1/13	
12	No	Project Closure	20 days	Fri 3/1/13	Thu 3/28/13	



Project: Project1
Date: Mon 9/12/11

Task	External Milestone	Manual Summary Rollup	
Split	Inactive Task	Manual Summary	
Milestone	Inactive Milestone	Start-only	
Summary	Inactive Summary	Finish-only	
Project Summary	Manual Task	Deadline	
External Tasks	Duration-only	Progress	

Appendix D - Schedule IV-B

Preliminary Money Follows Patient System Estimates for IT only	*Issue*	*Type*	*Count*	*Rate*	*Time-Hours*	*Amount*	*Est cost*	*Time in Months*	*Notes*	
	Design and deploy new databases							1		
DBA		DBA	1	125	160	$20,000.00				
Develolper		DEV	2	100	160	$32,000.00				
							$52,000.00			
Develolper	Manage security of application and user access/ acquire needed software hardware to manage identities. Eg. Forefront Identity Manager	DEV	1	100	80	$8,000.00		0.5	Depending on other Agency projects,	
FIM Consultant		CONS	1	130	80	$10,400.00				
Software/Hardware Acquisition						$100,000.00				
							$118,400.00			
	Integrate with FLMMIS for data from that system									
DBA		DBA	2	125	320	$80,000.00		2	**High risk due to historical problems connecting to Medicaid data**	
Develolper		DEV	4	100	320	$128,000.00				
							$208,002.00			
	Integrate with Versa for data from that system									
DBA		DBA	1	125	160	$20,000.00		1		
Develolper		DEV	1	100	160	$16,000.00				
							$36,001.00			
	Develop actual application							9	**High risk due to lack of information about specifics on the application, therefore timeframe may be inaccurate**	
Web Designer		DEV	1	100	1440	$144,000.00				
Web Developrr		DEV	4	100	1440	$576,000.00				
							$720,000.00			
DBA		DBA	1	125	160	$20,000.00		1		
Develolper		DEV	2	100	160	$32,000.00				
							$52,000.00			
DOEA Web Service Creation		DEV	1	100	160	$16,000.00		1		
AHCA Web Service Connectivity		NETWK	1	125	80	$10,000.00			**Risk due to unknown systems at other agency**	
AHCA Web Service Consumption		DEV	1	100	160	$16,000.00				
							$42,000.00			
DOH Web Service Creation		DEV	1	100	160	$16,000.00		1		
AHCA Web Service Connectivity		NETWK	1	125	80	$10,000.00			**Risk due to unknown systems at other agency**	
AHCA Web Service Consumption		DEV	1	100	160	$16,000.00				
							$42,000.00			
DCF Web Service Creation		DEV	1	100	160	$16,000.00		1		
AHCA Web Service Connectivity		NETWK	1	125	80	$10,000.00			**Risk due to unknown systems at other agency**	
AHCA Web Service Consumption		DEV	1	100	160	$16,000.00				
							$42,000.00			
External application		USER		30	160	$4,800.00	$4,800.00	1	Cannot apply cost, since this is based upon user testing across many agencies/entities. Per further conversation with Ken, we are estimating the cost & hours presented in colunms E54, E55, F54 & F55 for testing by all agencies involved	
Inter Agency Connectivity		USER		30	480	$14,400.00	$14,400.00			
Maintenance							$52,784.00			
Grand Total							**$ 1,384,387.00**			$1,384,387.00

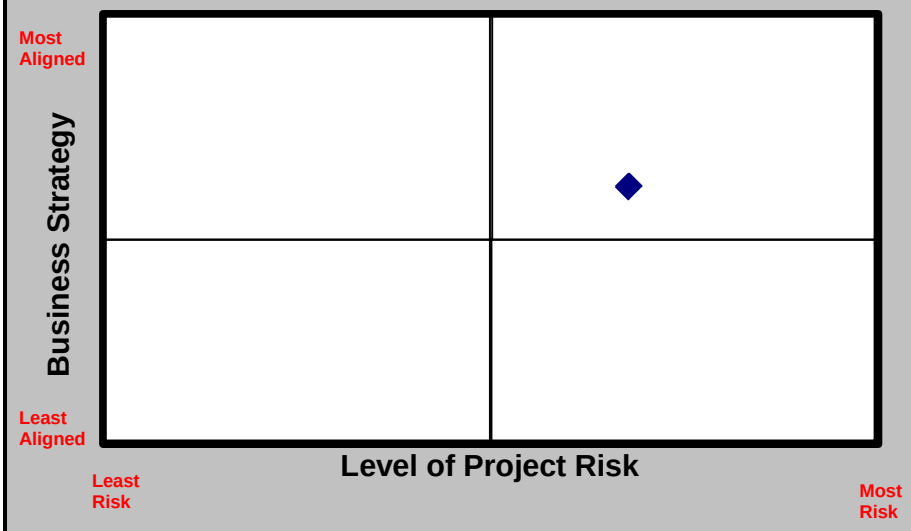
IT Project Risk Assessment Tool **Schedule IV-B** **Fiscal Year 2011-2012**

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 1 -- Strategic Area			
#	**Criteria**	**Values**	Answer
1.01	Are project objectives clearly aligned with the agency's legal mission?	0% to 40% -- Few or no objectives aligned	81% to 100% -- All or nearly all objectives aligned
		41% to 80% -- Some objectives aligned	
		81% to 100% -- All or nearly all objectives aligned	
1.02	Are project objectives clearly documented and understood by all stakeholder groups?	Not documented or agreed to by stakeholders	Documented with sign-off by stakeholders
		Informal agreement by stakeholders	
		Documented with sign-off by stakeholders	
1.03	Are the project sponsor, senior management, and other executive stakeholders actively involved in meetings for the review and success of the project?	Not or rarely involved	Most regularly attend executive steering committee meetings
		Most regularly attend executive steering committee meetings	
		Project charter signed by executive sponsor and executive team actively engaged in steering committee meetings	
1.04	Has the agency documented its vision for how changes to the proposed technology will improve its business processes?	Vision is not documented	Vision is completely documented
		Vision is partially documented	
		Vision is completely documented	
1.05	Have all project business/program area requirements, assumptions, constraints, and priorities been defined and documented?	0% to 40% -- Few or none defined and documented	81% to 100% -- All or nearly all defined and documented
		41% to 80% -- Some defined and documented	
		81% to 100% -- All or nearly all defined and documented	
1.06	Are all needed changes in law, rule, or policy identified and documented?	No changes needed	Changes are identified and documented
		Changes unknown	
		Changes are identified in concept only	
		Changes are identified and documented	
		Legislation or proposed rule change is drafted	
1.07	Are any project phase or milestone completion dates fixed by outside factors, e.g., state or federal law or funding restrictions?	Few or none	Some
		Some	
		All or nearly all	
1.08	What is the external (e.g. public) visibility of the proposed system or project?	Minimal or no external use or visibility	Minimal or no external use or visibility
		Moderate external use or visibility	
		Extensive external use or visibility	
1.09	What is the internal (e.g. state agency) visibility of the proposed system or project?	Multiple agency or state enterprise visibility	Multiple agency or state enterprise visibility
		Single agency-wide use or visibility	
		Use or visibility at division and/or bureau level only	
1.10	Is this a multi-year project?	Greater than 5 years	1 year or less
		Between 3 and 5 years	
		Between 1 and 3 years	
		1 year or less	

Project	*Money Follows the Person*	
Agency	*Agency for Health Care Administration*	
FY 2012-13 LBR Issue Code:	**FY 2012-13 LBR Issue Title:**	
3000120	*Money Follows the Person (MFP)*	
Risk Assessment Contact Info (Name, Phone #, and E-mail Address):		
GP Mendie, (850) 412-4252, GP.Mendie@ahca.myflorida.com		
Executive Sponsor	*Beth Kidder*	
Project Manager	*Mike Magnuson*	
Prepared By	*Mike Magnuson & GP Mendie*	*9/12/2011*

Risk Assessment Summary



Project Risk Area Breakdown

Risk Assessment Areas	*Risk Exposure*
Strategic Assessment	MEDIUM
Technology Exposure Assessment	MEDIUM
Organizational Change Management Assessment	LOW
Communication Assessment	MEDIUM
Fiscal Assessment	MEDIUM
Project Organization Assessment	HIGH
Project Management Assessment	HIGH
Project Complexity Assessment	HIGH
Overall Project Risk	HIGH

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 2 -- Technology Area			
#	Criteria	Values	Answer
2.01	Does the agency have experience working with, operating, and supporting the proposed technology in a production environment?	Read about only or attended conference and/or vendor presentation	Installed and supported production system more than 3 years
		Supported prototype or production system less than 6 months	
		Supported production system 6 months to 12 months	
		Supported production system 1 year to 3 years	
		Installed and supported production system more than 3 years	
2.02	Does the agency's internal staff have sufficient knowledge of the proposed technology to implement and operate the new system?	External technical resources will be needed for implementation and operations	External technical resources will be needed through implementation only
		External technical resources will be needed through implementation only	
		Internal resources have sufficient knowledge for implementation and operations	
2.03	Have all relevant technology alternatives/ solution options been researched, documented and considered?	No technology alternatives researched	Some alternatives documented and considered
		Some alternatives documented and considered	
		All or nearly all alternatives documented and considered	
2.04	Does the proposed technology comply with all relevant agency, statewide, or industry technology standards?	No relevant standards have been identified or incorporated into proposed technology	Proposed technology solution is fully compliant with all relevant agency, statewide, or industry standards
		Some relevant standards have been incorporated into the proposed technology	
		Proposed technology solution is fully compliant with all relevant agency, statewide, or industry standards	
2.05	Does the proposed technology require significant change to the agency's existing technology infrastructure?	Minor or no infrastructure change required	Minor or no infrastructure change required
		Moderate infrastructure change required	
		Extensive infrastructure change required	
		Complete infrastructure replacement	
2.06	Are detailed hardware and software capacity requirements defined and documented?	Capacity requirements are not understood or defined	Capacity requirements are defined only at a conceptual level
		Capacity requirements are defined only at a conceptual level	
		Capacity requirements are based on historical data and new system design specifications and performance requirements	

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 3 -- Organizational Change Management Area			
#	Criteria	Values	Answer
3.01	What is the expected level of organizational change that will be imposed within the agency if the project is successfully implemented?	Extensive changes to organization structure, staff or business processes	Minimal changes to organization structure, staff or business processes structure
		Moderate changes to organization structure, staff or business processes	
		Minimal changes to organization structure, staff or business processes structure	
3.02	Will this project impact essential business processes?	Yes	No
		No	
3.03	Have all business process changes and process interactions been defined and documented?	0% to 40% -- Few or no process changes defined and documented	81% to 100% -- All or nearly all processes defiined and documented
		41% to 80% -- Some process changes defined and documented	
		81% to 100% -- All or nearly all processes defiined and documented	
3.04	Has an Organizational Change Management Plan been approved for this project?	Yes	Yes
		No	
3.05	Will the agency's anticipated FTE count change as a result of implementing the project?	Over 10% FTE count change	Less than 1% FTE count change
		1% to 10% FTE count change	
		Less than 1% FTE count change	
3.06	Will the number of contractors change as a result of implementing the project?	Over 10% contractor count change	Less than 1% contractor count change
		1 to 10% contractor count change	
		Less than 1% contractor count change	
3.07	What is the expected level of change impact on the citizens of the State of Florida if the project is successfully implemented?	Extensive change or new way of providing/receiving services or information)	Minor or no changes
		Moderate changes	
		Minor or no changes	
3.08	What is the expected change impact on other state or local government agencies as a result of implementing the project?	Extensive change or new way of providing/receiving services or information	Minor or no changes
		Moderate changes	
		Minor or no changes	
3.09	Has the agency successfully completed a project with similar organizational change requirements?	No experience/Not recently (>5 Years)	Recently completed project with similar change requirements
		Recently completed project with fewer change requirements	
		Recently completed project with similar change requirements	
		Recently completed project with greater change requirements	

Agency: Agency Name Project: Project Name

Section 4 -- Communication Area			
#	Criteria	Value Options	Answer
4.01	Has a documented Communication Plan been approved for this project?	Yes	Yes
		No	
4.02	Does the project Communication Plan promote the collection and use of feedback from management, project team, and business stakeholders (including end users)?	Negligible or no feedback in Plan	Routine feedback in Plan
		Routine feedback in Plan	
		Proactive use of feedback in Plan	
4.03	Have all required communication channels been identified and documented in the Communication Plan?	Yes	Yes
		No	
4.04	Are all affected stakeholders included in the Communication Plan?	Yes	Yes
		No	
4.05	Have all key messages been developed and documented in the Communication Plan?	Plan does not include key messages	Some key messages have been developed
		Some key messages have been developed	
		All or nearly all messages are documented	
4.06	Have desired message outcomes and success measures been identified in the Communication Plan?	Plan does not include desired messages outcomes and success measures	Plan does not include desired messages outcomes and success measures
		Success measures have been developed for some messages	
		All or nearly all messages have success measures	
4.07	Does the project Communication Plan identify and assign needed staff and resources?	Yes	Yes
		No	

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 5 -- Fiscal Area			
#	Criteria	Values	Answer
5.01	Has a documented Spending Plan been approved for the entire project lifecycle?	Yes	Yes
		No	
5.02	Have all project expenditures been identified in the Spending Plan?	0% to 40% -- None or few defined and documented	81% to 100% -- All or nearly all defined and documented
		41% to 80% -- Some defined and documented	
		81% to 100% -- All or nearly all defined and documented	
5.03	What is the estimated total cost of this project over its entire lifecycle?	Unknown	Between $500K and $1,999,999
		Greater than $10 M	
		Between $2 M and $10 M	
		Between $500K and $1,999,999	
		Less than $500 K	
5.04	Is the cost estimate for this project based on quantitative analysis using a standards-based estimation model?	Yes	Yes
		No	
5.05	What is the character of the cost estimates for this project?	Detailed and rigorous (accurate within ±10%)	Detailed and rigorous (accurate within ±10%)
		Order of magnitude – estimate could vary between 10-100%	
		Placeholder – actual cost may exceed estimate by more than 100%	
5.06	Are funds available within existing agency resources to complete this project?	Yes	No
		No	
5.07	Will/should multiple state or local agencies help fund this project or system?	Funding from single agency	Funding from single agency
		Funding from local government agencies	
		Funding from other state agencies	
5.08	If federal financial participation is anticipated as a source of funding, has federal approval been requested and received?	Neither requested nor received	Requested and received
		Requested but not received	
		Requested and received	
		Not applicable	
5.09	Have all tangible and intangible benefits been identified and validated as reliable and achievable?	Project benefits have not been identified or validated	All or nearly all project benefits have been identified and validated
		Some project benefits have been identified but not validated	
		Most project benefits have been identified but not validated	
		All or nearly all project benefits have been identified and validated	
5.10	What is the benefit payback period that is defined and documented?	Within 1 year	Within 1 year
		Within 3 years	
		Within 5 years	
		More than 5 years	
		No payback	
5.11	Has the project procurement strategy been clearly determined and agreed to by affected stakeholders?	Procurement strategy has not been identified and documented	Stakeholders have reviewed and approved the proposed procurement strategy
		Stakeholders have not been consulted re: procurement strategy	
		Stakeholders have reviewed and approved the proposed procurement strategy	
5.12	What is the planned approach for acquiring necessary products and solution services to successfully complete the project?	Time and Expense (T&E)	Time and Expense (T&E)
		Firm Fixed Price (FFP)	
		Combination FFP and T&E	

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 5 -- Fiscal Area			
#	Criteria	Values	Answer
5.13	What is the planned approach for procuring hardware and software for the project?	Timing of major hardware and software purchases has not yet been determined	Timing of major hardware and software purchases has not yet been determined
		Purchase all hardware and software at start of project to take advantage of one-time discounts	
		Just-in-time purchasing of hardware and software is documented in the project schedule	
5.14	Has a contract manager been assigned to this project?	No contract manager assigned	No contract manager assigned
		Contract manager is the procurement manager	
		Contract manager is the project manager	
		Contract manager assigned is not the procurement manager or the project manager	
5.15	Has equipment leasing been considered for the project's large-scale computing purchases?	Yes	No
		No	
5.16	Have all procurement selection criteria and outcomes been clearly identified?	No selection criteria or outcomes have been identified	No selection criteria or outcomes have been identified
		Some selection criteria and outcomes have been defined and documented	
		All or nearly all selection criteria and expected outcomes have been defined and documented	
5.17	Does the procurement strategy use a multi-stage evaluation process to progressively narrow the field of prospective vendors to the single, best qualified candidate?	Procurement strategy has not been developed	Multi-stage evaluation and proof of concept or prototype planned/used to select best qualified vendor
		Multi-stage evaluation not planned/used for procurement	
		Multi-stage evaluation and proof of concept or prototype planned/used to select best qualified vendor	
5.18	For projects with total cost exceeding $10 million, did/will the procurement strategy require a proof of concept or prototype as part of the bid response?	Procurement strategy has not been developed	Not applicable
		No, bid response did/will not require proof of concept or prototype	
		Yes, bid response did/will include proof of concept or prototype	
		Not applicable	

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 6 -- Project Organization Area			
#	Criteria	Values	Answer
6.01	Is the project organization and governance structure clearly defined and documented within an approved project plan?	Yes	Yes
		No	
6.02	Have all roles and responsibilities for the executive steering committee been clearly identified?	None or few have been defined and documented	All or nearly all have been defined and documented
		Some have been defined and documented	
		All or nearly all have been defined and documented	
6.03	Who is responsible for integrating project deliverables into the final solution?	Not yet determined	Agency
		Agency	
		System Integrator (contractor)	
6.04	How many project managers and project directors will be responsible for managing the project?	3 or more	2
		2	
		1	
6.05	Has a project staffing plan specifying the number of required resources (including project team, program staff, and contractors) and their corresponding roles, responsibilities and needed skill levels been developed?	Needed staff and skills have not been identified	Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented
		Some or most staff roles and responsibilities and needed skills have been identified	
		Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented	
6.06	Is an experienced project manager dedicated fulltime to the project?	No experienced project manager assigned	No experienced project manager assigned
		No, project manager is assigned 50% or less to project	
		No, project manager assigned more than half-time, but less than full-time to project	
		Yes, experienced project manager dedicated full-time, 100% to project	
6.07	Are qualified project management team members dedicated full-time to the project	None	None
		No, business, functional or technical experts dedicated 50% or less to project	
		No, business, functional or technical experts dedicated more than half-time but less than full-time to project	
		Yes, business, functional or technical experts dedicated full-time, 100% to project	
6.08	Does the agency have the necessary knowledge, skills, and abilities to staff the project team with in-house resources?	Few or no staff from in-house resources	Few or no staff from in-house resources
		Half of staff from in-house resources	
		Mostly staffed from in-house resources	
		Completely staffed from in-house resources	
6.09	Is agency IT personnel turnover expected to significantly impact this project?	Minimal or no impact	Minimal or no impact
		Moderate impact	
		Extensive impact	
6.10	Does the project governance structure establish a formal change review and control board to address proposed changes in project scope, schedule, or cost?	Yes	Yes
		No	
6.11	Are all affected stakeholders represented by functional manager on the change review and control board?	No board has been established	No board has been established
		No, only IT staff are on change review and control board	
		No, all stakeholders are not represented on the board	
		Yes, all stakeholders are represented by functional manager	

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 7 -- Project Management Area			
#	Criteria	Values	Answer
7.01	Does the project management team use a standard commercially available project management methodology to plan, implement, and control the project?	No Project Management team will use the methodology selected by the systems integrator Yes	Yes
7.02	For how many projects has the agency successfully used the selected project management methodology?	None 1-3 More than 3	More than 3
7.03	How many members of the project team are proficient in the use of the selected project management methodology?	None Some All or nearly all	All or nearly all
7.04	Have all requirements specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	41 to 80% -- Some have been defined and documented
7.05	Have all design specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	41 to 80% -- Some have been defined and documented
7.06	Are all requirements and design specifications traceable to specific business rules?	0% to 40% -- None or few are traceable 41 to 80% -- Some are traceable 81% to 100% -- All or nearly all requirements and specifications are traceable	81% to 100% -- All or nearly all requirements and specifications are traceable
7.07	Have all project deliverables/services and acceptance criteria been clearly defined and documented?	None or few have been defined and documented Some deliverables and acceptance criteria have been defined and documented All or nearly all deliverables and acceptance criteria have been defined and documented	None or few have been defined and documented
7.08	Is written approval required from executive sponsor, business stakeholders, and project manager for review and sign-off of major project deliverables?	No sign-off required Only project manager signs-off Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables	Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables
7.09	Has the Work Breakdown Structure (WBS) been defined to the work package level for all project activities?	0% to 40% -- None or few have been defined to the work package level 41 to 80% -- Some have been defined to the work package level 81% to 100% -- All or nearly all have been defined to the work package level	0% to 40% -- None or few have been defined to the work package level
7.10	Has a documented project schedule been approved for the entire project lifecycle?	Yes No	No

Agency: Agency for Health Care Administration Project: Money Follows the Person

Section 7 -- Project Management Area			
#	Criteria	Values	Answer
7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints), critical milestones, and resources?	Yes No	No
7.12	Are formal project status reporting processes documented and in place to manage and control this project?	No or informal processes are used for status reporting Project team uses formal processes Project team and executive steering committee use formal status reporting processes	Project team and executive steering committee use formal status reporting
7.13	Are all necessary planning and reporting templates, e.g., work plans, status reports, issues and risk management, available?	No templates are available Some templates are available All planning and reporting templates are available	No templates are available
7.14	Has a documented Risk Management Plan been approved for this project?	Yes No	No
7.15	Have all known project risks and corresponding mitigation strategies been identified?	None or few have been defined and documented Some have been defined and documented All known risks and mitigation strategies have been defined	None or few have been defined and documented
7.16	Are standard change request, review and approval processes documented and in place for this project?	Yes No	No
7.17	Are issue reporting and management processes documented and in place for this project?	Yes No	No

Section 8 -- Project Complexity Area			
#	Criteria	Values	Answer
8.01	How complex is the proposed solution compared to the current agency systems?	Unknown at this time	Similar complexity
		More complex	
		Similar complexity	
		Less complex	
8.02	Are the business users or end users dispersed across multiple cities, counties, districts, or regions?	Single location	More than 3 sites
		3 sites or fewer	
		More than 3 sites	
8.03	Are the project team members dispersed across multiple cities, counties, districts, or regions?	Single location	More than 3 sites
		3 sites or fewer	
		More than 3 sites	
8.04	How many external contracting or consulting organizations will this project require?	No external organizations	1 to 3 external organizations
		1 to 3 external organizations	
		More than 3 external organizations	
8.05	What is the expected project team size?	Greater than 15	9 to 15
		9 to 15	
		5 to 8	
		Less than 5	
8.06	How many external entities (e.g., other agencies, community service providers, or local government entities) will be impacted by this project or system?	More than 4	More than 4
		2 to 4	
		1	
		None	
8.07	What is the impact of the project on state operations?	Business process change in single division or bureau	Statewide or multiple agency business process change
		Agency-wide business process change	
		Statewide or multiple agency business process change	
8.08	Has the agency successfully completed a similarly-sized project when acting as Systems Integrator?	Yes	Yes
		No	
8.09	What type of project is this?	Infrastructure upgrade	Combination of the above
		Implementation requiring software development or purchasing commercial off the shelf (COTS) software	
		Business Process Reengineering	
		Combination of the above	
8.10	Has the project manager successfully managed similar projects to completion?	No recent experience	Similar size and complexity
		Lesser size and complexity	
		Similar size and complexity	
		Greater size and complexity	
8.11	Does the agency management have experience governing projects of equal or similar size and complexity to successful completion?	No recent experience	Similar size and complexity
		Lesser size and complexity	
		Similar size and complexity	
		Greater size and complexity	

Medicaid Services to Individuals

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Health Care Trust Fund
Budget Entity: 68501400
LAS/PBS Fund Number: 2003

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**12,925,411**	(A)		**12,925,411**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)		**0**	
ADD: Advance		(E)		**0**	
Total Cash plus Accounts Receivable	**12,925,411**	(F)	**0**	**12,925,411**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards		(H)		**0**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**3,740,459**	(I)		**3,740,459**	
LESS: Payables not Certified Forwards				**0**	
LESS: Deferred Revenue		(J)		**0**	
Unreserved Fund Balance, 07/01/11	**9,184,952**	(K)	**0**	**9,184,952**	**

Notes:

***SWFS = Statewide Financial Statement**

****** **This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Health Care Trust Fund (68501400)**
LAS/PBS Fund Number:	**2003**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**9,184,952**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
Other Accounts Payable (Nonoperating)		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**9,184,952**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**9,184,952**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Tobacco Settlement Trust Fund
Budget Entity: 68501400
LAS/PBS Fund Number: 2122

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance		(A)		**0**
ADD: Other Cash (See Instructions)		(B)		**0**
ADD: Investments		(C)		**0**
ADD: Outstanding Accounts Receivable	**125,017**	(D)		**125,017**
ADD: _____		(E)		**0**
Total Cash plus Accounts Receivable		(F)	**0**	**125,017**
LESS: Allowances for Uncollectibles		(G)		**0**
LESS: Approved "A" Certified Forwards		(H)		**0**
Approved "B" Certified Forwards		(H)		**0**
Approved "FCO" Certified Forwards		(H)		**0**
LESS: Other Accounts Payable (Nonoperating)	**125,017**	(I)		**125,017**
LESS: Payables not Certified Forwards				**0**
LESS: Current Compensated Absences Liability		(J)		**0**
Unreserved Fund Balance, 07/01/11		(K)	**0**	**0** **

Notes:

***SWFS = Statewide Financial Statement**

****** **This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**

Trust Fund Title: **Tobacco Settlement Trust Fund (68501400)**

LAS/PBS Fund Number: **2122**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**0.00**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:		(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**0.00**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Grants and Donation Trust Fund
Budget Entity: 68501400
LAS/PBS Fund Number: 2339

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**178,491,665**	(A)		**178,491,665**	
ADD: Other Cash (See Instructions)	**12,589,837**	(B)		**12,589,837**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**150,733,213**	(D)	**242,065,430**	**392,798,643**	
ADD: Other Loans and Notes Receivable	**1,008,186**	(E)		**1,008,186**	
Total Cash plus Accounts Receivable	**342,822,900**	(F)	**242,065,430**	**584,888,330**	
LESS: Allowances for Uncollectibles	**1,514,599**	(G)		**1,514,599**	
LESS: Approved "A" Certified Forwards	**507,614,502**	(H)		**507,614,502**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards			**(89,809,523)**	**(89,809,523)**	
LESS: Deferred Revenues	**57,250,524**	(J)		**57,250,524**	
Unreserved Fund Balance, 07/01/11	**(223,556,727)**	(K)	**331,874,953**	**108,318,226**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**
Trust Fund Title: **Grants and Donation Trust Fund (68501400)**
LAS/PBS Fund Number: **2339**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**-223,556,727**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From	242,065,430	(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	-89,809,523	(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**108,318,226**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**108,318,226**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Medical Care Trust Fund
Budget Entity: 68501400
LAS/PBS Fund Number: 2474

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**6,681,813,240**	(A)		**6,681,813,240**	
ADD: Other Cash (See Instructions)	**80,974**	(B)		**80,974**	
ADD: Investments	**8,077,653**	(C)		**8,077,653**	
ADD: Outstanding Accounts Receivable	**97,285,016**	(D)	**21,594,776**	**118,879,792**	
ADD: Other Loans and Notes Receivable	**9,130,533**	(E)		**9,130,533**	
Total Cash plus Accounts Receivable	**6,796,387,415**	(F)	**21,594,776**	**6,817,982,191**	
LESS: Allowances for Uncollectibles	**5,393,654**	(G)		**5,393,654**	
LESS: Approved "A" Certified Forwards	**1,105,481,382**	(H)		**1,105,481,382**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**357,506**	(I)		**357,506**	
LESS: Payables not Certified Forwards	**8,085,759**		**5,389,234,761**	**5,397,320,520**	
LESS: Deferred Revenue	**36,082,075**	(J)		**36,082,075**	
Unreserved Fund Balance, 07/01/11	**5,640,987,040**	(K)	**(5,367,639,985)**	**273,347,056**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

Office of Policy and Budget - July, 2011

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Medical Care Trust Fund (68501400)**
LAS/PBS Fund Number:	**2474**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**5,640,987,040**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From	21,594,776	(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	5,389,234,761	(D)
Other Accounts Payable (Nonoperating)		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**273,347,056**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**273,347,056**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Public Medical Assistance Trust Fund
Budget Entity: 68501400
LAS/PBS Fund Number: 2565

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**616,786,226**	(A)		**616,786,226**	
ADD: Other Cash (See Instructions)	**772,666**	(B)		**772,666**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**37,568,679**	(D)		**37,568,679**	
ADD: Advance		(E)		**0**	
Total Cash plus Accounts Receivable	**655,127,572**	(F)	**0**	**655,127,572**	
LESS: Allowances for Uncollectibles	**3,897,862**	(G)		**3,897,862**	
LESS: Approved "A" Certified Forwards		(H)		**0**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards				**0**	
LESS: Deferred Revenue	**11,677,567**	(J)		**11,677,567**	
Unreserved Fund Balance, 07/01/11	**639,552,143**	(K)	**0**	**639,552,143**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**

Trust Fund Title: **Public Medical Assistance Trust Fund (68501400)**

LAS/PBS Fund Number: **2565**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**639,552,143**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
Other Accounts Payable (Nonoperating)		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**639,552,143**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**639,552,143**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Refugee Assistance Trust Fund
Budget Entity: 68501400
LAS/PBS Fund Number: 2579

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**1,325,712**	(A)		**1,325,712**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**7,101,322**	(D)		**7,101,322**	
ADD: Advance		(E)		**0**	
Total Cash plus Accounts Receivable	**8,427,035**	(F)	**0**	**8,427,035**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**6,396,343**	(H)		**6,396,343**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards				**0**	
LESS: Deferred Revenue		(J)		**0**	
Unreserved Fund Balance, 07/01/11	**2,030,692**	(K)	**0**	**2,030,692**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Refugee Assistance Trust Fund (68501400)**
LAS/PBS Fund Number:	**2579**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**2,030,692**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
Other Accounts Payable (Nonoperating)		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**2,030,692**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**2,030,692**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Medicaid Long Term Care

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Health Care Trust Fund
Budget Entity: 68501500
LAS/PBS Fund Number: 2003

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**0**	(A)		**0**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)		**0**	
ADD: Advance		(E)		**0**	
Total Cash plus Accounts Receivable	**0**	(F)	**0**	**0**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards		(H)		**0**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards				**0**	
LESS: Deferred Revenue		(J)		**0**	
Unreserved Fund Balance, 07/01/11	**0**	(K)	**0**	**0**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Grants and Donation Trust Fund
Budget Entity: 68501500
LAS/PBS Fund Number: 2339

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**33,398,322**	(A)		**33,398,322**	
ADD: Other Cash (See Instructions)	**31,107**	(B)		**31,107**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**1,374,365**	(D)	**27,979,540**	**29,353,905**	
ADD: Other Loans and Notes Receivable		(E)		**0**	
Total Cash plus Accounts Receivable	**34,803,794**	(F)	**27,979,540**	**62,783,334**	
LESS: Allowances for Uncollectibles	**280,247**	(G)		**280,247**	
LESS: Approved "A" Certified Forwards	**101,983,194**	(H)		**101,983,194**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards			**(72,966,045)**	**(72,966,045)**	
LESS: Deferred Revenues	**27,292,184**	(J)		**27,292,184**	
Unreserved Fund Balance, 07/01/11	**(94,751,830)**	(K)	**100,945,585**	**6,193,754**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Grants and Donation Trust Fund (68501500)**
LAS/PBS Fund Number:	**2339**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**-94,751,830**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From	27,979,540	(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	-72,966,045	(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**6,193,754**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**6,193,754**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Medical Care Trust Fund
Budget Entity: 68501500
LAS/PBS Fund Number: 2474

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**(6,273,394,221)**	(A)		**(6,273,394,221)**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**64,604,330**	(D)	**6,397,939,317**	**6,462,543,647**	
ADD: Advance	**3,478,978**	(E)		**3,478,978**	
Total Cash plus Accounts Receivable	**(6,205,310,913)**	(F)	**6,397,939,317**	**192,628,404**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**189,149,426**	(H)		**189,149,426**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards				**0**	
LESS: Deferred Revenue	**3,478,978**	(J)		**3,478,978**	
Unreserved Fund Balance, 07/01/11	**(6,397,939,317)**	(K)	**6,397,939,317**	**0**	**

Notes:

***SWFS = Statewide Financial Statement**

****** **This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**
Trust Fund Title: **Medical Care Trust Fund (68501500)**
LAS/PBS Fund Number: **2474**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**-6,397,939,317**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From	6,397,939,317	(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
Other Accounts Payable (Nonoperating)		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**0**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**0**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Health Facility Regulation Schedules

Health Facility Regulation

Schedule I Series

SCHEDULE 1A: DETAIL OF FEES AND RELATED PROGRAM COSTS

Department: 68 Health Care Administrati **Budget Period: 2012-13**
Program: 68700700 Health Care Regulation
Fund: 2003 Health Care Trust Fund

Specific Authority: Various Sections of the following Chapters 112, 383, 390, 394, 395, 400, 4
483, 641, 765, F.S.
Purpose of Fees Collected: The fees are necessary to enable the Agency to administer its regulat
responsibilities.

Type of Fee or Program: (Check **ONE** Box and answer questions as indicated.)

X	Regulatory services or oversight to businesses or professions (Complete Sections I, II, and III and attach **Examination of Regulatory Fees** Form - Part I and II.)
	Non-regulatory fees authorized to cover full cost of conducting a specific program or service. (Complete Sections I, II, and III only.)

SECTION I - FEE COLLECTION	**ACTUAL FY 2010 - 11**	**ESTIMATED FY 2011 - 12**	**REQUEST FY 2012 - 13**
Receipts:			
Abortion Clinic	26,416	25,142	25,142
AFCH	64,692	78,129	78,129
ALF Facility	3,904,961	3,931,452	3,931,452
ADC Facility	9,559	23,398	23,398
Amb. Surgical Center	463,113	436,693	436,693
Birth Center	8,280	7,523	7,523
Crisis Stabilization Units	164,989	137,189	137,189
Diagnostic imaging	0	0	0
Forensic Lab	67,337	113,962	113,962
HMO	1,643,382	1,994,775	1,994,775
HMO-WC	0	218,872	218,872
H, C, & Ss	91,217	135,688	135,688
Health Care Clinics	2,912,994	2,752,012	2,752,012
Health Care Services Pool	215,761	223,629	223,629
Home Health	3,299,757	4,580,318	4,580,318
Home Medical Equipment	345,372	418,239	418,239
Home Spec. Service	713	2,346	2,346
Hospice	38,792	34,357	34,357
Hospital	1,503,724	1,337,457	1,337,457
ICF/DD	279,671	347,752	347,752
Laboratory	1,268,216	1,542,312	1,542,312
Multiphasic Center	3,746	3,496	3,496
Nurse Registry	346,274	507,246	507,246

Organ & Tissue Donor	73,622	89,215	89,215
Organ Procurement	517,400	390,169	390,169
PPECS	46,073	32,347	32,347
Radiation Therapy	0	0	0
Residential Treatment	276,870	239,214	239,214
Risk Management	97,375	147,562	147,562
SNF Home	4,846,231	4,171,901	4,171,901
Trans. Living	26,174	43,591	43,591
UTIL Review	87	965	965
Plans Review	4,178,725	3,483,458	3,483,458
Total Fee Collection to Line (A) - Section III	26,721,524	27,450,409	27,450,409

SECTION II - FULL COSTS

Direct Costs:			
Salaries and Benefits			
Other Personal Services			
Expenses			
Operating Capital Outlay			
Direct Cost Allocation	21,315,391	22,082,958	22,082,958
Indirect Costs Charged to Trust Fund	7,434,002	7,701,700	7,701,700
Total Full Costs to Line (B) - Section III	28,749,393	29,784,659	29,784,659

Basis Used:

SECTION III - SUMMARY

TOTAL SECTION I	(A)	26,721,524	27,450,409	27,450,409
TOTAL SECTION II	(B)	28,749,393	29,784,659	29,784,659
TOTAL - Surplus/Deficit	(C)	(2,027,869)	(2,334,250)	(2,334,250)

EXPLANATION of LINE C:

The deficits cover by 408.20 F.S Assessments, Health Care Trust Fund.

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Health Care Trust Fund
Budget Entity: 68700700
LAS/PBS Fund Number: 2003

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**49,876,554**	(A)		**49,876,554**	
ADD: Other Cash (See Instructions)	**410,489**	(B)		**410,489**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**18,901,183**	(D)		**18,901,183**	
ADD: Advance	**20,000**	(E)		**20,000**	
Total Cash plus Accounts Receivable	**69,208,226**	(F)	**0**	**69,208,226**	
LESS: Allowances for Uncollectibles	**4,454,063**	(G)		**4,454,063**	
LESS: Approved "A" Certified Forwards	**1,383,610**	(H)		**1,383,610**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**1,139,417**	(I)		**1,139,417**	
LESS: Payables not Certified Forwards	**-68,780**		**50,596**	**-18,184**	
LESS: Current Compensated Absences	**74,427**			**74,427**	
LESS: Deferred Revenue	**3,422,136**	(J)		**3,422,136**	
Unreserved Fund Balance, 07/01/11	**58,803,351**	(K)	**(50,596)**	**58,752,755**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Health Care Trust Fund (68700700)**
LAS/PBS Fund Number:	**2003**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**58,803,351**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment Due From		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	50,596	(D)
Other Accounts Payable (Nonoperating)		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**58,752,755**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**58,752,755**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2012-2013

Department Title: Agency for Health Care Administration
Trust Fund Title: Quality of Long-Term Care Facility Improvement Trust Fund
Budget Entity: 68700700
LAS/PBS Fund Number: 2126

	Balance as of 6/30/2011		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**3,134,292**	(A)		**3,134,292**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)		**0**	
ADD: _____		(E)		**0**	
Total Cash plus Accounts Receivable	**3,134,292**	(F)	**0**	**3,134,292**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**253,657**	(H)		**253,657**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**128,978**	(I)		**128,978**	
LESS: Payables not Certified Forwards				**0**	
LESS: Current Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/11	**2,751,656**	(K)	**0**	**2,751,656**	**

Notes:

***SWFS = Statewide Financial Statement**

**** This amount should agree with Line I, Section IV of the Schedule I for the most recent completed fiscal year and Line A for the following year.**

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2012 - 2013

Department Title: **Agency for Health Care Administration**

Trust Fund Title: **Quality of Long-Term Care Facility Improvement Trust Fund (68700700)**

LAS/PBS Fund Number: **2126**

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/11 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**2,751,656**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**2,751,656**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line I)	**2,751,656**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

AGENCY FOR HEALTH CARE ADMINISTRATION
SCHEDULE IV-B
FOR
ONLINE LICENSING AND RECONCILIATION SYSTEM

FOR

FISCAL YEAR 2012-13

State of Florida

The Florida Legislature *Governor's Office of Policy and Budget*

September 15, 2011

Table of Contents

I. Schedule IV-B Cover Sheet

Schedule IV-B Cover Sheet and Agency Project Approval	
Agency: Agency for Health Care Administration	**Schedule IV-B Submission Date: September 15, 2011**
Project Name: Licensing System Upgrade	**Is this project included in the Agency's LRPP?** **_X__ Yes ____ No**
FY 2012-13 LBR Issue Code: 36375C0	**FY 2012-13 LBR Issue Title: Online Licensing and Reconciliation System**
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): **Kay Heckroth, (850) 412-4723, Kay.Heckroth@ahca.myflorida.com**	
AGENCY APPROVAL SIGNATURES	
I am submitting the attached Schedule IV-B in support of our legislative budget request. I have reviewed the estimated costs and benefits documented in the Schedule IV-B and believe the proposed solution can be delivered within the estimated time for the estimated costs to achieve the described benefits. I agree with the information in the attached Schedule IV-B.	
Agency Head: **Printed Name: Elizabeth Dudek**	**Date:**
Agency Chief Information Officer: **Printed Name: Scott Ward**	**Date:**
Budget Officer: **Printed Name:**	**Date:**
Planning Officer: **Printed Name:**	**Date:**
Project Sponsor: **Printed Name: Molly McKinstry**	**Date:**

Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Kay Heckroth/Molly McKinstry
Cost Benefit Analysis:	
Risk Analysis:	
Technology Planning:	Scott Ward
Project Planning:	

II. Project Risk Assessment

The inability to complete this project would result in the loss of an opportunity to improve service delivery and communication with citizens and the health care community. An assessment of overall risk incurred by the project will improve the likelihood of project success.

A. Risk Assessment Tool

1. Strategic Area - Medium Risk

Nbr	Criteria	Answer
1.01	Are project objectives clearly aligned with the agency's legal mission?	81% to 100% -- All or nearly all objectives aligned
1.02	Are project objectives clearly documented and understood by all stakeholder groups?	Informal agreement by stakeholders
1.03	Are the project sponsor, senior management, and other executive stakeholders actively involved in meetings for the review and success of the project?	Most regularly attend executive steering committee meetings
1.04	Has the agency documented its vision for how changes to the proposed technology will improve its business processes?	Vision is partially documented
1.05	Have all project business/program area requirements, assumptions, constraints, and priorities been defined and documented?	81% to 100% -- All or nearly all defined and documented
1.06	Are all needed changes in law, rule, or policy identified and documented?	No changes needed
1.07	Are any project phase or milestone completion dates fixed by outside factors, e.g., state or federal law or funding restrictions?	All or nearly all
1.08	What is the external (e.g. public) visibility of the proposed system or project?	Extensive external use or visibility
1.09	What is the internal (e.g. state agency) visibility of the proposed system or project?	Multiple agency or state enterprise visibility
1.10	Is this a multi-year project?	Between 1 and 3 years

2. Technology Assessment - Low Risk

Nbr	Criteria	Answer
2.01	Does the agency have experience working with, operating, and supporting the proposed technology in a production environment?	Installed and supported production system more than 4 years
2.02	Does the agency's internal staff have sufficient knowledge of the proposed technology to implement and operate the new system?	Internal resources have sufficient knowledge for implementation and operations
2.03	Have all relevant technology alternatives/ solution options been researched, documented and considered?	All or nearly all alternatives documented and considered
2.04	Does the proposed technology comply with all relevant agency, statewide, or industry technology standards?	Proposed technology solution is fully compliant with all relevant agency, statewide, or industry standards
2.05	Does the proposed technology require significant change to the agency's existing technology infrastructure?	Moderate infrastructure change required
2.1	Are detailed hardware and software capacity requirements defined and documented?	Capacity requirements are based on historical data and new system design specifications and performance requirements

3. Change Management - Medium Risk

Nbr	Criteria	Answer
3.01	What is the expected level of organizational change that will be imposed within the agency if the project is successfully implemented?	Moderate changes to organization structure, staff or business processes structure
3.02	Will this project impact essential business processes?	Yes
3.03	Have all business process changes and process interactions been defined and documented?	41% to 80% -- Some process changes defined and documented
3.04	Has an Organizational Change Management Plan been approved for this project?	No

3.05	Will the agency's anticipated FTE count change as a result of implementing the project?	1% to 10% FTE count change
3.06	Will the number of contractors change as a result of implementing the project?	Less than 1% contractor count change
3.07	What is the expected level of change impact on the citizens of the State of Florida if the project is successfully implemented?	Extensive change or new way of providing/receiving services or information
3.08	What is the expected change impact on other state or local government agencies as a result of implementing the project?	Moderate changes
3.09	Has the agency successfully completed a project with similar organizational change requirements?	Recently completed project with similar change requirements

4. Communication - Medium Risk

Nbr	Criteria	Answer
4.01	Has a documented Communication Plan been approved for this project?	No
4.02	Does the project Communication Plan promote the collection and use of feedback from management, project team, and business stakeholders (including end users)?	Proactive use of feedback will be included in Plan
4.03	Have all required communication channels been identified and documented in the Communication Plan?	No. A Communications Plan will be developed if funding received.
4.04	Are all affected stakeholders included in the Communication Plan?	Yes
4.05	Have all key messages been developed and documented in the Communication Plan?	Plan does not include key messages
4.06	Have desired message outcomes and success measures been identified in the Communication Plan?	The Agency's LRPP includes an outcome of **at least 50%** of the licenses completed through an online system within 5 years. This will be identified in the communication plan.

4.07	Does the project Communication Plan identify and assign needed staff and resources?	No

5. Fiscal Area - Medium Risk

Nbr	Criteria	Answer
5.01	Has a documented Spending Plan been approved for the entire project lifecycle?	The Spend Plan has been drafted, but has not received final approval due to staff augmentation rate determination.
5.02	Have all project expenditures been identified in the Spending Plan?	Yes
5.03	What is the estimated total cost of this project over its entire lifecycle?	Between $2 M and $ 10 M
5.04	Is the cost estimate for this project based on quantitative analysis using a standards-based estimation model?	No
5.05	What is the character of the cost estimates for this project?	Detailed and rigorous (accurate within 10%)
5.06	Are funds available within existing agency resources to complete this project?	No
5.07	Will/should multiple state or local agencies help fund this project or system?	Funding from single agency
5.08	If federal financial participation is anticipated as a source of funding, has federal approval been requested and received?	Neither requested nor received
5.09	Have all tangible and intangible benefits been identified and validated as reliable and achievable?	All or nearly all project benefits have been identified and validated
5.10	What is the benefit payback period that is defined and documented?	Within 3 years
5.11	Has the project procurement strategy been clearly determined and agreed to by affected stakeholders?	Stakeholders have reviewed and approved the proposed procurement strategy
5.12	What is the planned approach for acquiring necessary products and solution services to successfully complete the project?	Agency FTE resources and staff augmentation services

5.13	What is the planned approach for procuring hardware and software for the project?	Purchase all hardware and software at start of project to take advantage of one-time discounts
5.14	Has a contract manager been assigned to this project?	Yes
5.15	Has equipment leasing been considered for the project's large-scale computing purchases?	Yes
5.16	Have all procurement selection criteria and outcomes been clearly identified?	All or nearly all section criteria and expected outcomes have been defined and documented.
5.17	Does the procurement strategy use a multi-stage evaluation process to progressively narrow the field of prospective vendors to the single, best qualified candidate?	As the development will be in-house, using Agency FTE resources and staff augmentation resources, the stages of evaluation are related to review of resumes and interviews.
5.18	For projects with total cost exceeding $10 million, did/will the procurement strategy require a proof of concept or prototype as part of the bid response?	Not applicable

6. Project Organization Area - Medium Risk

Nbr	Criteria	Answer
6.01	Is the project organization and governance structure clearly defined and documented within an approved project plan?	No, The project organization and governance structure has been finalized and approved. A high-level project plan has been drafted and the detailed project plan (WBS) has been started. The WBS will be finalized after the final approval of the high-level project plan.
6.02	Have all roles and responsibilities for the executive steering committee been clearly identified?	Some have been defined and documented

6.03	Who is responsible for integrating project deliverables into the final solution?	The Agency's Division of Information Technology
6.04	How many project managers and project directors will be responsible for managing the project?	1
6.05	Has a project staffing plan specifying the number of required resources (including project team, program staff, and contractors) and their corresponding roles, responsibilities and needed skill levels been developed?	Some or most staff roles and responsibilities and needed skills have been identified.
6.06	Is an experienced project manager dedicated fulltime to the project?	Yes
6.07	Are qualified project management team members dedicated full-time to the project	Mixed; staff augmentation resources are dedicated full-time and Agency FTE resources are dedicated more than half-time, but less than full-time.
6.08	Does the agency have the necessary knowledge, skills, and abilities to staff the project team with in-house resources?	No, the project team is a mixture of Agency FTE resources and staff augmentation resources (by head count, approximately 50/50 including subject matter experts).
6.09	Is agency IT personnel turnover expected to significantly impact this project?	Moderate impact
6.10	Does the project governance structure establish a formal change review and control board to address proposed changes in project scope, schedule, or cost?	Yes
6.11	Are all affected stakeholders represented by functional manager on the change review and control board?	Yes, all stakeholders are represented by functional manager

7. Project Management Area - Medium Risk

Nbr	Criteria	Answer
7.01	Does the project management team use a standard commercially available project management methodology to plan, implement, and control the project?	Yes, Microsoft Project
7.02	For how many projects has the agency successfully used the selected project management methodology?	More than 3
7.03	How many members of the project team are proficient in the use of the selected project management methodology?	All or nearly all. Project Management Professionals (PMP) are available within the agency, both in the business unit areas and Bureau of Information Technology to coordinate and assist. Additionally, the Project Manager is PMP certified.
7.04	Have all requirements specifications been unambiguously defined and documented?	41% to 80% -- Some have been defined
7.05	Have all design specifications been unambiguously defined and documented?	41% to 80% -- Some have been defined
7.06	Are all requirements and design specifications traceable to specific business rules?	81% to 100% -- All or nearly all requirements and specifications are traceable
7.07	Have all project deliverables/services and acceptance criteria been clearly defined and documented?	Some deliverables and acceptance criteria have been defined and documented
7.08	Is written approval required from executive sponsor, business stakeholders, and project manager for review and sign-off of major project deliverables?	Yes, review and sign-off from the executive sponsor, business stakeholders, and project manager are required on all major project deliverables.
7.09	Has the Work Breakdown Structure (WBS) been defined to the work package level for all project activities?	41 to 80% -- Some have been defined to the work package level
7.10	Has a documented project schedule been approved for the entire project lifecycle?	No, a high-level project plan has been drafted and the detailed project plan (WBS) has been started. The WBS will be finalized after the final

		approval of the high-level project plan.
7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints), critical milestones, and resources?	The finalized project schedule will specify the elements.
7.12	Are formal project status reporting processes documented and in place to manage and control this project?	Project team and executive steering committee use formal status reporting processes
7.13	Are all necessary planning and reporting templates, e.g., work plans, status reports, issues and risk management, available?	Yes
7.14	Has a documented Risk Management Plan been approved for this project?	No
7.15	Have all known project risks and corresponding mitigation strategies been identified?	Some have been defined and documented
7.16	Are standard change request, review and approval processes documented and in place for this project?	Yes
7.17	Are issue reporting and management processes documented and in place for this project?	Yes

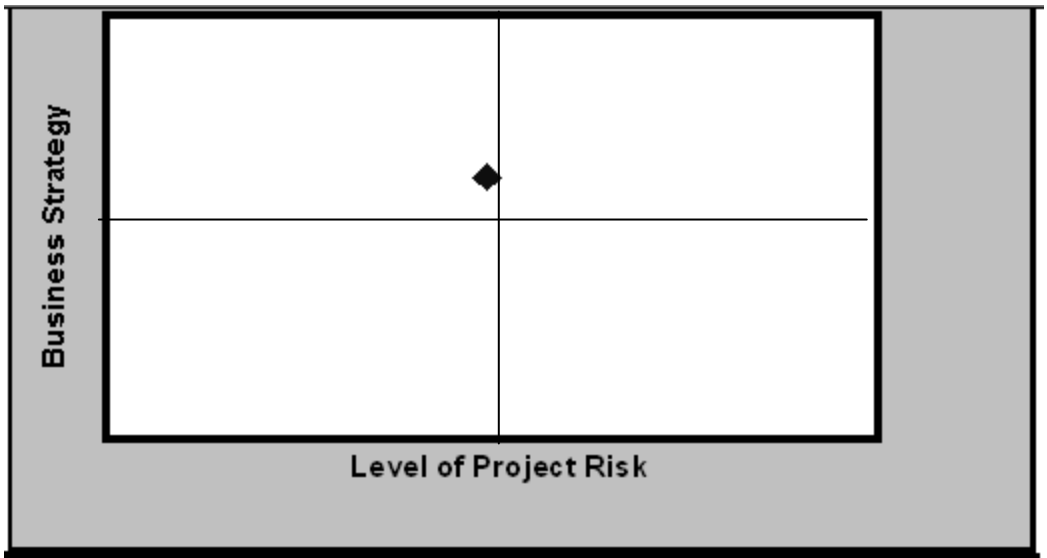
8. Complexity Area - Medium Risk

Nbr	Criteria	Answer
8.01	How complex is the proposed solution compared to the current agency systems?	More complex
8.02	Are the business users or end users dispersed across multiple cities, counties, districts, or regions?	More than 3 sites
8.03	Are the project team members dispersed across multiple cities, counties, districts, or regions?	Single location
8.04	How many external contracting or consulting organizations will this project require?	1 to 3 external organizations

8.05	What is the expected project team size?	10-15
8.06	How many external entities (e.g., other agencies, community service providers, or local government entities) will be impacted by this project or system?	35,000 regulated health care providers
8.07	What is the impact of the project on state operations?	Agency-wide business process change
8.08	Has the agency successfully completed a similarly-sized project when acting as Systems Integrator?	Yes
8.09	What type of project is this?	Online application and system integration
8.10	Has the project manager successfully managed similar projects to completion?	Yes
8.11	Does the agency management have experience governing projects of equal or similar size and complexity to successful completion?	Similar size and complexity

B. Risk Assessment Summary

The Agency believes the risk of implementing an online licensing and reconciliation system which uses established technology will be LOW. However, the overall risk assessment is MEDIUM due mainly to the significant changes in internal and external business processes related to the online services available to the public.



Project Risk Area Breakdown	
Risk Assessment Areas	*Risk Exposure*
Strategic Assessment	MEDIUM
Technology Exposure Assessment	LOW
Organizational Change Management Assessment	MEDIUM
Communication Assessment	MEDIUM
Fiscal Assessment	MEDIUM
Project Organization Assessment	MEDIUM
Project Management Assessment	MEDIUM
Project Complexity Assessment	MEDIUM
Overall Project Risk	MEDIUM

III. Technology Planning

Technology Planning Section	$1-1.99M	$2 – 10 M		> $10 M
		Routine upgrades & infrastructure	Business or organizational change	
Current Information Technology Environment		X	X	X
Proposed Solution Description	X	X	X	X
Capacity Planning	X	X	X	X
Analysis of Alternatives	X	X	X	X

A. Proposed Solution Description

1. The following list of benefits will be realized with the online licensing and reconciliation project.

- Streamline application process
- Integrate stand-alone systems
- Keep up with shift in corporate structure/ownership in health care industry
- Enhance ability to track and report on Anti-Fraud Effort
- Eliminate write-offs and lost interest due to delinquent payment
- Use corporate ownership structure to identify and collect money due
- Utilize electronic payment
- Reduce costs related to mail and collection
- Staff shift/reduction due to workload changes

2. The following shows the summary level funding requirements, by fiscal year (FY), for proposed system upgrade to Versa Regulation:

FY 2011-12 - Non-Recurring Contracted Services: $1,751,600
Source of Funds: Health Care Trust Fund

FY 2012-13 - Non-Recurring Contracted Services: $2,322,800
Source of Funds: Health Care Trust Fund and Quality of Care Trust Fund

FY 2013-14 - Non-Recurring Contracted Services: $1,087,200
Source of Funds: Health Care Trust Fund

3. The Agency is scheduled to use a state primary data center, Northwood Shared Resource Center (NSRC). Service Level Agreements (SLA) will be negotiated to support the proposed system. All network system availability and capacity requirements will be agreed to in the SLA.

B. Capacity Planning

1. Summary

This issue requests funding for full implementation of online licensing for 29 provider types in the Division of Health Quality Assurance, including online payment, integration with document management, web portal for providers to submit applications, check status, and update licensure information between license renewals. The project will provide single sign-on capability to providers to have one user account for multiple online systems, email notifications for reminders and deadlines, requests for additional information (omissions)and will integrate with all Agency fees, assessments, overpayments, fines to facilitate full collection before licenses are issued.

The total number of providers under the jurisdiction and authority of the Division of Health Quality Assurance and the total number of applications processed for these providers continues to increase. Agency staff process initial and renewal applications for licensure and/or certification and required inspections for these providers. To date, the Agency has been able to meet the needs of this caseload growth without requiring additional resources; however, the ability to continue to stretch existing resources to meet growing needs can only be accomplished through the development of efficiencies such as electronic automation of paper-and-labor-intensive processes.

Improvements in regulations governing disclosure of ownership for licensure and the liability of controlling interests significantly improves AHCA's authority to collect overpayments if our system can support connecting the owner/controlling interest relationships between providers and our accounts receivable are retained in an integrated system that allows easy connection to the licensing process.

Major efficiencies to be gained from upgrading the current licensing system include:

- Enabling online licensure applications for health care providers; thus reducing application processing time, increasing accuracy, and providing transparency. A recent survey of Agency licensees found that 81.2% of 335 respondents would prefer to submit the renewal application online. 81.6% would prefer to check the status of the application online rather than making a phone call to the Agency.

- Interfacing with other agency data systems which reduces duplicative data entry, allows for sharing of data and provides interface with electronic documents.
- Enhancing the ability to track ownership interest relationships by connecting people and entities to all related health care providers. This will improve the Agency's ability to identify new applicants that may have a poor regulatory history or outstanding sanctions even if they apply for licensure as another type of health care provider.

Project Update

A pilot application has been developed and is scheduled to be released in November, 2011. This pilot provides initial functionality for single sign-on and license renewal processing for Nursing Home licenses.

The team for the full project is currently being assembled with the project manager, systems architect, and database administrator already on board. Business analysts are scheduled to join the team in September, 2011 and the developers will be added after detailed requirements have been clarified to a testable level.

The detailed project plan is in draft status and the project manager is working within the Agency's ISDM process to complete planning phase.

2. Scope of the Plan

The scope of the plan includes the following areas of functionality:

- **Online Licensing**
  Create online licensing for all Health Quality Assurance (HQA) licensure applications: Initial, Renewal, Change of Ownership, etc.
  Enable intermittent reports of changes in licensure information between licensure renewal periods.

- **Online Payments**
  Acceptance of money.
  Interface with Treasury Deposit.
  Pay licensure fees, fines, and outstanding money required before license is issued.
  Feedback to Licensure when fees are deposited (cleared).
  Bad Check Communication (restrict license issuance).

- **Integration with Document Management**
  Accept attachments with Application.
  Retain copy of online application in document management system.
  Interface with Web DM – push documents to the web – copies of license, application, supporting documents etc – utilize existing interface with Web Document Management and Florida Health Finder front end.

- **External Interface (Provider View)**
  Utilize Single Sign-On – building on Background Screening Systems Single

Sign-On (being developed with a Federal Grant)
Manage Applications.
Provide Status View on users "page", Requests for additional information, Issuance of license, Reminder / Due Dates

- **Accounts Receivable (AR) Reconciliation**

Fox Pro Applications
All Lists / Systems that track Money Due, including:
Florida Medicaid Management Information System (FMMIS)
Versa Regulation
Fraud and Abuse Case Tracking System (FACTS)
Misc Lists (Excel, etc.) – 17 known
Invoicing Process - expand existing system that IT built to interface with Receipts and Accounts Receivable Application (RARA).
Assessments e.g.: Public Medical Assistance Trust Fund (PMATF), Annual Assessments

3. Methods Used

Costing, scaling, and scoping were collaboratively performed by the Agency Division of IT, Division of Health, Quality, and Assurance, and the Division of Operations in producing the amounts shown in the section above.

4. Assumptions & Constraints

- Success of the project depends largely on the ability to provide online services to the public
- The project will receive continued support from upper management
- There are sufficient resources to complete the project and to implement changes required for integrating with other systems/applications
- There is sufficient budget to fund the project
- The Division of Health Quality Assurance will act as business leaders for the project
- Staff will be heavily involved in establishing and conducting test scenarios
- Business system standards and change management will be centralized
- IT staff will receive specific system training

There is no direct change in the regulatory function nor on other state or federal agencies.

C. Analysis of Alternatives

During a limited pilot in FY 2008-09, focusing on a relatively small number of nursing homes, manual staff research and collection efforts resulted in collection of $1,248,989 in nursing home overpayments/money due to relationships to other providers and the threat of licensure actions if payments were not made. It is not feasible to manually research and collect every overpayment/money due without an automated system for doing so.

IV. Project Management Planning

Project Management Section	$1-1.99 M	$2 – 10 M		> $10 M
		Routine upgrades & infrastructure	Business or organizational change	
Project Charter	X	X	X	X
Work Breakdown Structure	X	X	X	X
Project Schedule	X	X	X	X
Project Budget	X	X	X	X
Project Organization			X	X
Project Quality Control			X	X
External Project Oversight			X	X
Risk Management			X	X
Organizational Change Management			X	X
Project Communication			X	X
Special Authorization Requirements			X	X

A. Project Charter

The Agency for Health Care Administration seeks to provide better health care for all Floridians. In support of this mission, the Agency seeks to implement online licensing for HQA for 29 provider types, including online payment, integration with document management, web portal for providers to submit applications, check status, and update licensure information between license renewals. Solution will provide single sign-on capability to providers to have one user account for multiple online systems, email notifications for reminders and deadlines, requests for additional information (omissions). Integration with all Agency fees, assessments, overpayments, fines to facilitate full collection before licenses are issued.

To ensure that the system deliverables fulfill both functional and technical requirements and to ensure that the project itself is operating successfully, the project team will develop and follow plans. These plans will address:

- Review of the deliverables to ensure the project meets the business goals and functional requirements of the system
- Review of deliverables to ensure the technical approach utilized to meet goals is valid.
- Review project status to ensure that the project's resources are being managed appropriately.
- Communication with executive sponsors, program areas and the project team to discuss status, resolve issues and avoid project delays.
- Creation of a disciplined environment for proactive decision making

- Establishment of a change control strategy to address design changes and modifications throughout the project
- Performance of stress/performance testing, system integration testing and user acceptance testing.
- Approach and methodology to be used to conduct training on the operations, maintenance and use of the upgraded system.

B. Resource Loaded Project Schedule

Purpose: To indicate the planned timetable for all project-related work and estimate the appropriate staffing levels necessary to accomplish each task, produce each deliverable, and achieve each milestone.

Task & IT Resources	*Resource Type*	*Count*	*Estimated Rate*	*Time-Hours*	*Estimated Amount for Staffing*	*Est. cost*	*Time in Weeks*
Use VR Web Services - Build Core Application (have Core form); Create applications for all licensed provider types -29 Provider types – begin with Nursing Homes							
Project Manager (PM)	PM	1	85	2080	$176,800.00		12 Mos.
Business Analyst (BA)	BA	2	75	1040	$156,000.00		**July 2011 - June 2012**
Database Administration Developer	DBA	2	125	1040	$260,000.00		
Developers	DEV	3	100	1040	$312,000.00		
Network Engineer - Internal to AHCA		1	50	80	$4,000.00		
Dev - Internal to AHCA - Review		***2***	***50***	80	$8,000.00		
					$916,800.00	$916,800.00	
Online Payments - Acceptance of money (F&A); Interface with Treasury Deposit; Pay licensure fees; Pay fines and any outstanding money required before license is issued including assessments, NFQA/ ICFQA, delinquent ; Fees for other AHCA programs (e.g.: OPC) and Medicaid ARs; Feedback to Licensure when fees are deposited (cleared); Bad Check Communication (restrict license issuance)							
Project Manager (PM)	PM	1	85	2080	$176,800.00		12 Mos.
Business Analyst (BA)	BA	2	75	1040	$156,000.00		**July 2012 - June 2013**
Database Administration Developer	DBA	2	125	2080	$520,000.00		
Developer	DEV	3	100	1040	$312,000.00		
DBA - Internal AHCA - Review		1	50	80	$4,000.00		
Network Engineer - Internal to AHCA		1	50	80	$4,000.00		
Dev - Internal to AHCA - Review		***1***	***50***	80	$4,000.00		
				80	$1,176,800.00	$1,176,800.00	
Integration with Document Management - Accept attachments with Application; Retain copy of online application in document management system; Interface with Web DM – push documents to the web – copies of license, application, supporting documents etc – utilize existing interface with Web DM and Florida Health Finder front end							
Project Manager (PM)	PM	1	85	2080	$176,800.00		12 Mos.
Business Analyst (BA)	BA	3	75	1040	$234,000.00		**July 2012 - June 2013**
DBA	DBA	2	125	1040	$260,000.00		
Developer	DEV	3	100	2080	$624,000.00		
Network Engineer - Internal to AHCA		1	50	80	$4,000.00		
DBA - Internal AHCA review		1	50	160	$8,000.00		
Developer - Internal AHCA review		2	50	160	$16,000.00		

					$1,146,000.00	$1,146,000.00	
External Interface (Provider View) - **Utilize Single Sign-On – building on BGS Single Sign-On (Federal Grant); Enable same account for multiple systems / licensee manages their users based on the application/ access; Manage Applications; Ability to begin an application (save) and return to complete later; Status View/ Email notices – trigger notification plus post to status on users "page"; Requests for additional information; Issuance of license; Reminder / Due Dates**							
Project Manager (PM)	PM	1	85	2080	$176,800.00		12 Mos.
Business Analyst (BA)	BA	3	75	1040	$234,000.00		**July 2011 - June 2012**
Database Administrator	DBA	2	125	800	$200,000.00		
Developer	DEV	2	100	1040	$208,000.00		
Network Engineer - Internal to AHCA	NW	1	50	80	$4,000.00		
DBA - Internal AHCA Review		1	50	80	$4,000.00		
Developer - Internal AHCA review		2	50	80	$8,000.00		
					$834,800.00	$834,800.00	
Account Receivable (AR) Reconciliation - **Fox Pro Applications-All Lists / Systems that track $ Due; FMMIS, Versa Reg, FACTS, Misc. Lists (Excel, etc.) – 17 known; Invoicing Process (expand existing system that IT built to interface with RARA); Assessments e.g.: PMATF, Annual Assessments**							
Project Manager (PM)	PM	1	85	3120	$265,200.00		18 Months
Business Analyst (BA)	BA	3	75	1040	$234,000.00		**January 2013- July 2014**
Developer	DEV	3	100	1040	$312,000.00		
DBA - Staff Aug	DBA	2	125	1040	$260,000.00		
Network Engineer- Internal to AHCA	DBA	1	50	80	$4,000.00		
DBA - Internal to AHCA	DBA	1	50	80	$4,000.00		0.25 Mos.
Developer - Internal to AHCA	Dev	2	50	80	$8,000.00		
					$1,087,200.00	$1,087,200.00	
Total						**$5,161,600.00**	

Fiscal Year 2012-13 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Adminstration / Administration and Support

Agency Budget Officer/OPB Analyst Name: Michele Tallent / Kate West

A "Y" indicates "YES" and is acceptable, an "N/J" indicates "NO/Justification Provided" - these require further explanation/justification (additional sheets can be used as necessary), and "TIPS" are other areas to consider.

		Program or Service (Budget Entity Codes)				
	Action	68200000				
1. GENERAL						
1.1	Are Columns A01, A02, A04, A05, A36, A90, A91, A92, A93, A94, A95, IA1, IA4, IA5, IP1,V1, IV3 and NV1 set to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for both the Budget and Trust Fund columns? Are Columns A06, A07, A08 and A09 for Fixed Capital Outlay (FCO) set to TRANSFER CONTROL for DISPLAY status only? **(CSDI)**	Y				
1.2	Is Column A03 set to TRANSFER CONTROL for DISPLAY and UPDATE status for both the Budget and Trust Fund columns? **(CSDI)**	Y				
AUDITS:						
1.3	Has Column A03 been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y				
1.4	Has security been set correctly? **(CSDR, CSA)**	Y				
TIP	The agency should prepare the budget request for submission in this order: 1) Lock columns as described above; 2) copy Column A03 to Column A12; and 3) set Column A12 column security to ALL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status.					
2. EXHIBIT A (EADR, EXA)						
2.1	Is the budget entity authority and description consistent with the agency's LRPP and does it conform to the directives provided on page 56 of the LBR Instructions?	Y				
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y				
2.3	Are the issue codes and titles consistent with *Section 3* of the LBR Instructions (pages 15 through 30)? Do they clearly describe the issue?	Y				
2.4	Have the coding guidelines in *Section 3* of the LBR Instructions (pages 15 through 30) been followed?	Y				
3. EXHIBIT B (EXBR, EXB)						
3.1	Is it apparent that there is a fund shift and were the issues entered into LAS/PBS correctly? Check D-3A funding shift issue 340XXX0 - a unique deduct and unique add back issue should be used to ensure fund shifts display correctly on the LBR exhibits.	N/A				
3.2	Are the 33XXXX0 issues negative amounts only and do not restore nonrecurring cuts from a prior year or fund any issues that net to a positive or zero amount? Check D-3A issues 33XXXX0 - a unique issue should be used for issues that net to zero or a positive amount.	Y				

	Program or Service (Budget Entity Codes)				
Action	68200000				

AUDITS:						
3.3	Negative Appropriation Category Audit for Agency Request (Columns A03 and A04): Are all appropriation categories positive by budget entity at the FSI level? Are all nonrecurring amounts less than requested amounts? **(NACR, NAC - Report should print "No Negative Appropriation Categories Found")**	Y				
3.4	Current Year Estimated Verification Comparison Report: Is Column A02 equal to Column B07? **(EXBR, EXBC - Report should print "Records Selected Net To Zero")**	Y				
TIP	Generally look for and be able to fully explain significant differences between A02 and A03.					
TIP	Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.					
TIP	Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, the Special Categories appropriation category (10XXXX) should be used.					
4. EXHIBIT D (EADR, EXD)						
4.1	Is the program component objective statement consistent with the agency LRPP, and does it conform to the directives provided on page 62 of the LBR Instructions?	Y				
4.2	Is the program component code and title used correct?	Y				
TIP	Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.					
5. EXHIBIT D-1 (ED1R, EXD1)						
5.1	Are all object of expenditures positive amounts? (This is a manual check.)	Y				
AUDITS:						
5.2	Do the fund totals agree with the object category totals within each appropriation category? **(ED1R, XD1A - Report should print "No Differences Found For This Report")**	Y				
5.3	FLAIR Expenditure/Appropriation Ledger Comparison Report: Is Column A01 less than Column B04? **(EXBR, EXBB - Negative differences need to be corrected in Column A01.)**	Y				
5.4	A01/State Accounts Disbursements and Carry Forward Comparison Report: Does Column A01 equal Column B08? **(EXBR, EXBD - Differences need to be corrected in Column A01.)**	Y				

	Program or Service (Budget Entity Codes)				
Action	68200000				

TIP	If objects are negative amounts, the agency must make adjustments to Column A01 to correct the object amounts. In addition, the fund totals must be adjusted to reflect the adjustment made to the object data.					
TIP	If fund totals and object totals do not agree or negative object amounts exist, the agency must adjust Column A01.					
TIP	Exhibit B - A01 less than B04: This audit is to ensure that the disbursements and carry/certifications forward in A01 are less than FY 2009-10 approved budget. Amounts should be positive.					
TIP	If B08 is not equal to A01, check the following: 1) the initial FLAIR disbursements or carry forward data load was corrected appropriately in A01; 2) the disbursement data from departmental FLAIR was reconciled to State Accounts; and 3) the FLAIR disbursements did not change after Column B08 was created.					
6. EXHIBIT D-3 (ED3R, ED3) (Not required in the LBR - for analytical purposes only.)						
6.1	Are issues appropriately aligned with appropriation categories?	Y				
TIP	Exhibit D-3 is no longer required in the budget submission but may be needed for this particular appropriation category/issue sort. Exhibit D-3 is also a useful report when identifying negative appropriation category problems.					
7. EXHIBIT D-3A (EADR, ED3A)						
7.1	Are the issue titles correct and do they clearly identify the issue? (See pages 15 through 30 of the LBR Instructions.)	Y				
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See page 65 of the LBR Instructions.)	Y				
7.3	Does the narrative for Information Technology (IT) issue follow the additional narrative requirements described on pages 66 through 70 of the LBR Instructions?	Y				
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	Y				
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E-4 and E-5 of the LBR Instructions.)	Y				
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	Y				
7.7	Does the issue narrative thoroughly explain/justify all Salaries and Benefits amounts entered into the Other Salary Amounts transactions (OADA/C)? Amounts entered into OAD are reflected in the Position Detail of Salaries and Benefits section of the Exhibit D-3A.	Y				

		Program or Service (Budget Entity Codes)				
	Action	68200000				
7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A				
7.9	Does the issue narrative reference the specific county(ies) where applicable?	N/A				
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #12-009?	Y				
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A				
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A				
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A				
7.14	Do the amounts reflect appropriate FSI assignments?	Y				
7.15	Do the issues relating to *salary and benefits* have an "A" in the fifth position of the issue code (XXXXAXX) and are they self-contained (not combined with other issues)? (See page 29 and 88 of the LBR Instructions.)	Y				
7.16	Do the issues relating to *Information Technology (IT)* have a "C" in the sixth position of the issue code (36XXXCX) and are the correct issue codes used (361XXC0, 362XXC0, 363XXC0, 17C01C0, 17C02C0, 17C03C0, 24010C0, 33001C0 or 55C01C0)? Have the correct issue codes been used for the Statewide Email Consolidation (17C10C0, 17C11C0, 17C14C0, 33015C0 and 55C04C0)	Y				
7.17	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A				
AUDIT:						
7.18	Are all FSI's equal to '1', '2', '3', or '9'? There should be no FSI's equal to '0'. **(EADR, FSIA - Report should print "No Records Selected For Reporting")**	Y				
7.19	Does the General Revenue for 160XXXX (Adjustments to Current Yeer Expenditures) issues net to zero? **(GENR, LBR1)**	N/A				
7.20	Does the General Revenue for 180XXXX (Intra-Agency Reorgaznizations) issues net to zero? **(GENR, LBR2)**	N/A				
7.21	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? **(GENR, LBR3)**	N/A				

		Program or Service (Budget Entity Codes)				
	Action	68200000				
7.22	Have FCO appropriations been entered into the nonrecurring column A04? **(GENR, LBR4 - Report should print "No Records Selected For Reporting" or a listing of D-3A issue(s) assigned to Debt Service (IOE N) or in some cases State Capital Outlay - Public Education Capital Outlay (IOE L))**	N/A				
TIP	Salaries and Benefits amounts entered using the OADA/C transactions must be thoroughly justified in the D-3A issue narrative. Agencies can run **OADA/OADR** from STAM to identify the amounts entered into OAD and ensure these entries have been thoroughly explained in the D-3A issue narrative.					
TIP	The issue narrative must completely and thoroughly explain and justify each D-3A issue. Agencies must ensure it provides the information necessary for the OPB and legislative analysts to have a complete understanding of the issue submitted. Thoroughly review pages 67 through 71 of the LBR Instructions.					
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.					
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).					
TIP	If an appropriation made in the FY 2011-12 General Appropriations Act duplicates an appropriation made in substantive legislation, the agency must create a unique deduct nonrecurring issue to eliminate the duplicated appropriation. Normally this is taken care of through line item veto.					
8. SCHEDULE I & RELATED DOCUMENTS (SC1R, SC1 - Budget Entity Level *or* SC1R, SC1D - Department Level)						
8.1	Has a separate department level Schedule I and supporting documents package been submitted by the agency?	Y				
8.2	Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y				
8.3	Have the appropriate Schedule I supporting documents been included for the trust funds (Schedule IA, Schedule IB, Schedule IC, and Reconciliation to Trial Balance)?	Y				
8.4	Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs?	Y				
8.5	Have the required detailed narratives been provided (5% trust fund reserve narrative; method for computing the distribution of cost for general management and administrative services narrative; adjustments narrative; revenue estimating methodology narrative)?	Y				

	Program or Service (Budget Entity Codes)				
Action	68200000				
8.6 Has the Inter-Agency Transfers Reported on Schedule I form been included as applicable for transfers totaling $100,000 or more for the fiscal year?	Y				
8.7 If the agency is scheduled for the annual trust fund review this year, have the Schedule ID and applicable draft legislation been included for recreation, modification or termination of existing trust funds?	Y				
8.8 If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to *section 215.32(2)(b), Florida Statutes* - including the Schedule ID and applicable legislation?	Y				
8.9 Are the revenue codes correct? In the case of federal revenues, has the agency appropriately identified direct versus indirect receipts (object codes 000700, 000750, 000799, 001510 and 001599)?	Y				
8.10 Are the statutory authority references correct?	Y				
8.11 Are the General Revenue Service Charge percentage rates used for each revenue source correct? (Refer to Chapter 2009-78, Laws of Florida, for appropriate general revenue service charge percentage rates.)	Y				
8.12 Is this an accurate representation of revenues based on the most recent Consensus Estimating Conference forecasts?	Y				
8.13 If there is no Consensus Estimating Conference forecast available, do the revenue estimates appear to be reasonable?	Y				
8.14 Are the federal funds revenues reported in Section I broken out by individual grant? Are the correct CFDA codes used?	Y				
8.15 Are anticipated grants included and based on the state fiscal year (rather than federal fiscal year)?	Y				
8.16 Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y				
8.17 If applicable, are nonrecurring revenues entered into Column A04?	Y				
8.18 Has the agency certified the revenue estimates in columns A02 and A03 to be the latest and most accurate available? Does the certification include a statement that the agency will notify OPB of any significant changes in revenue estimates that occur prior to the Governor's Budget Recommendations being issued?	Y				
8.19 Is a 5% trust fund reserve reflected in Section II? If not, is sufficient justification provided for exemption? Are the additional narrative requirements provided?	Y				
8.20 Are appropriate service charge nonoperating amounts included in Section II?	Y				
8.21 Are nonoperating expenditures to other budget entities/departments cross-referenced accurately?	Y				
8.22 Do transfers balance between funds (within the agency as well as between agencies)? (See also 8.6 for required transfer confirmation of amounts totaling $100,000 or more.)	Y				

		Program or Service (Budget Entity Codes)				
	Action	68200000				
8.23	Are nonoperating expenditures recorded in Section II and adjustments recorded in Section III?	Y				
8.24	Are prior year September operating reversions appropriately shown in column A01?	Y				
8.25	Are current year September operating reversions appropriately shown in column A02? **DUE TO THE EARLY TRANSMISSION DATE OF THE 2012-13 LBR, CERTIFIED FORWARD REVERSIONS AT 9/30/11 WILL NEED TO BE ADDED BY AGENCIES DURING THE TECHNICAL REVIEW PERIOD.**	N/A				
8.26	Does the Schedule IC properly reflect the unreserved fund balance for each trust fund as defined by the LBR Instructions, and is it reconciled to the agency accounting records?	Y				
8.27	Does Column A01 of the Schedule I accurately represent the actual prior year accounting data as reflected in the agency accounting records, and is it provided in sufficient detail for analysis?	Y				
8.28	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y				
AUDITS:						
8.29	Is Line I a positive number? (If not, the agency must adjust the budget request to eliminate the deficit).	Y				
8.30	Is the June 30 Adjusted Unreserved Fund Balance (Line I) equal to the July 1 Unreserved Fund Balance (Line A) of the following year? If a Schedule IB was prepared, do the totals agree with the Schedule I, Line I? **(SC1R, SC1A - Report should print "No Discrepancies Exist For This Report")**	Y				
8.31	Has a Department Level Reconciliation been provided for each trust fund and does Line A of the Schedule I equal the CFO amount? If not, the agency must correct Line A. **(SC1R, DEPT)**	Y				
TIP	The Schedule I is the most reliable source of data concerning the trust funds. It is very important that this schedule is as accurate as possible!					
TIP	Determine if the agency is scheduled for trust fund review. (See page 125 of the LBR Instructions.)					
TIP	Review the unreserved fund balances and compare revenue totals to expenditure totals to determine and understand the trust fund status.					
TIP	Typically nonoperating expenditures and revenues should not be a negative number. Any negative numbers must be fully justified.					
9. SCHEDULE II (PSCR, SC2)						
AUDIT:						
9.1	Is the pay grade minimum for salary rate utilized for positions in segments 2 and 3? **(BRAR, BRAA - Report should print "No Records Selected For This Request")** Note: Amounts other than the pay grade minimum should be fully justified in the D-3A issue narrative. (See *Base Rate Audit* on page 157 of the LBR Instructions.)	Y				

	Program or Service (Budget Entity Codes)				
Action	68200000				

10. SCHEDULE III (PSCR, SC3)						
10.1	Is the appropriate lapse amount applied in Segment 3? (See page 90 of the LBR Instructions.)	Y				
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See page 97 of the LBR Instructions for appropriate use of the OAD transaction.) Use **OADI** or **OADR** to identify agency other salary amounts requested.	Y				
11. SCHEDULE IV (EADR, SC4)						
11.1	Are the correct Information Technology (IT) issue codes used?	Y				
TIP	If IT issues are not coded correctly (with "C" in 6th position), they will not appear in the Schedule IV.					
12. SCHEDULE VIIIA (EADR, SC8A)						
12.1	Is there only one #1 priority, one #2 priority, one #3 priority, etc. reported on the Schedule VIII-A? Are the priority narrative explanations adequate?	Y				
13. SCHEDULE VIIIB-1 (EADR, S8B1)						
13.1	**NOT REQUIRED FOR THIS YEAR**	N/A				
14. SCHEDULE VIIIB-2 (EADR, S8B2)						
14.1	Do the reductions comply with the instructions provided on pages 102 through 104 of the LBR Instructions regarding a 10% reduction in recurring General Revenue and Trust Funds, including the verification that the 3BXXX0 issue has not been used?	Y				
15. SCHEDULE XI (LAS/PBS Web - see page 108 of the LBR Instructions for detailed instructions)						
15.1	Agencies are required to generate this spreadsheet via the LAS/PBS Web. **The Final Excel version no longer has to be submitted to OPB for inclusion on the Governor's Florida Performs Website.** (Note: Pursuant to *section 216.023(4)(b), Florida Statutes,* the Legislature can reduce the funding level for any agency that does not provide this information.)	N/A				
15.2	Do the PDF files uploaded to the Florida Fiscal Portal for the LRPP and LBR match?	Y				
AUDITS INCLUDED IN THE SCHEDULE XI REPORT:						
15.3	Does the FY 2010-11 Actual (prior year) Expenditures in Column A36 reconcile to Column A01? (**GENR, ACT1)**	Y				
15.4	None of the executive direction, administrative support and information technology statewide activities (ACT0010 thru ACT0490) have output standards (Record Type 5)? **(Audit #1 should print "No Activities Found")**	Y				
15.5	Does the Fixed Capital Outlay (FCO) statewide activity (ACT0210) only contain 08XXXX or 14XXXX appropriation categories? **(Audit #2 should print "No Operating Categories Found")**	N/A				

	Action	Program or Service (Budget Entity Codes)				
		68200000				
15.6	Has the agency provided the necessary demand (Record Type 5) for all activities which should appear in Section II? (Note: Audit #3 will identify those activities that do NOT have a Record Type '5' and have not been identified as a 'Pass Through' activity. These activities will be displayed in Section III with the 'Payment of Pensions, Benefits and Claims' activity and 'Other' activities. Verify if these activities should be displayed in Section III. If not, an output standard would need to be added for that activity and the Schedule XI submitted again.)	Y				
15.7	Does Section I (Final Budget for Agency) and Section III (Total Budget for Agency) equal? **(Audit #4 should print "No Discrepancies Found")**	Y				
TIP	If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.					
16. MANUALLY PREPARED EXHIBITS & SCHEDULES						
16.1	Do exhibits and schedules comply with LBR Instructions (pages 110 through 154 of the LBR Instructions), and are they accurate and complete?	Y				
16.2	Are appropriation category totals comparable to Exhibit B, where applicable?	Y				
16.3	Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y				
AUDITS - GENERAL INFORMATION						
TIP	Review *Section 6: Audits* of the LBR Instructions (pages 156-158) for a list of audits and their descriptions.					
TIP	Reorganizations may cause audit errors. Agencies must indicate that these errors are due to an agency reorganization to justify the audit error.					
17. CAPITAL IMPROVEMENTS PROGRAM (CIP)						
17.1	Are the CIP-2, CIP-3, CIP-A and CIP-B forms included?	Y				
17.2	Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	N/A				
17.3	Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	Y				
17.4	Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	Y				
17.5	Are the appropriate counties identified in the narrative?	Y				
17.6	Has the CIP-2 form (Exibit B) been modified to include the agency priority for each project and the modified form saved as a PDF document?	Y				
TIP	Requests for Fixed Capital Outlay appropriations which are Grants and Aids to Local Governments and Non-Profit Organizations must use the Grants and Aids to Local Governments and Non-Profit Organizations - Fixed Capital Outlay major appropriation category (140XXX) and include the sub-title "Grants and Aids". These appropriations utilize a CIP-B form as justification.					

	Program or Service (Budget Entity Codes)				
Action	68200000				

18. FLORIDA FISCAL PORTAL						
18.1	Have all files been assembled correctly and posted to the Florida Fiscal Portal as outlined in the Florida Fiscal Portal Submittal Process?	Y				
19. CREATION OF DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)						
19.1	If you are an agency that no longer exists or is transferred to DEO after the approval of the reorganization by the Legislative Budget Commission (LBC), have you submitted the following schedules, as applicable: · Schedule I: Trust Funds Available and Schedule IB - DEPARTMENT LEVEL · Schedule IA: Detail of Fees and Related Costs (Part I and Part II) · Schedule IC: Reconciliation of Unreserved Fund Balances · Reconciliation: Beginning Trial Balance to Schedule I and IC · Exhibit D-1: Detail of Expenses · Schedule XI: Agency-Level Unit Cost Summary · Opening Trial Balance as of July 1, 2011 · Schedule I Narratives related to Column A01 · Inter-Agency Transfer Form	N/A				

Fiscal Year 2012-13 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Adminstration / Childrens' Special Health Care

Agency Budget Officer/OPB Analyst Name: Michele Tallent / Kate West

A "Y" indicates "YES" and is acceptable, an "N/J" indicates "NO/Justification Provided" - these require further explanation/justification (additional sheets can be used as necessary), and "TIPS" are other areas to consider.

		Program or Service (Budget Entity Codes)				
	Action	68500100				
1. GENERAL						
1.1	Are Columns A01, A02, A04, A05, A36, A90, A91, A92, A93, A94, A95, IA1, IA4, IA5, IP1,V1, IV3 and NV1 set to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for both the Budget and Trust Fund columns? Are Columns A06, A07, A08 and A09 for Fixed Capital Outlay (FCO) set to TRANSFER CONTROL for DISPLAY status only? **(CSDI)**	Y				
1.2	Is Column A03 set to TRANSFER CONTROL for DISPLAY and UPDATE status for both the Budget and Trust Fund columns? **(CSDI)**	Y				
AUDITS:						
1.3	Has Column A03 been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y				
1.4	Has security been set correctly? **(CSDR, CSA)**	Y				
TIP	The agency should prepare the budget request for submission in this order: 1) Lock columns as described above; 2) copy Column A03 to Column A12; and 3) set Column A12 column security to ALL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status.					
2. EXHIBIT A (EADR, EXA)						
2.1	Is the budget entity authority and description consistent with the agency's LRPP and does it conform to the directives provided on page 56 of the LBR Instructions?	Y				
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y				
2.3	Are the issue codes and titles consistent with *Section 3* of the LBR Instructions (pages 15 through 30)? Do they clearly describe the issue?	Y				
2.4	Have the coding guidelines in *Section 3* of the LBR Instructions (pages 15 through 30) been followed?	Y				
3. EXHIBIT B (EXBR, EXB)						
3.1	Is it apparent that there is a fund shift and were the issues entered into LAS/PBS correctly? Check D-3A funding shift issue 340XXX0 - a unique deduct and unique add back issue should be used to ensure fund shifts display correctly on the LBR exhibits.	N/A				
3.2	Are the 33XXXX0 issues negative amounts only and do not restore nonrecurring cuts from a prior year or fund any issues that net to a positive or zero amount? Check D-3A issues 33XXXX0 - a unique issue should be used for issues that net to zero or a positive amount.	N/A				

	Program or Service (Budget Entity Codes)				
Action	68500100				

AUDITS:						
3.3	Negative Appropriation Category Audit for Agency Request (Columns A03 and A04): Are all appropriation categories positive by budget entity at the FSI level? Are all nonrecurring amounts less than requested amounts? **(NACR, NAC - Report should print "No Negative Appropriation Categories Found")**	Y				
3.4	Current Year Estimated Verification Comparison Report: Is Column A02 equal to Column B07? **(EXBR, EXBC - Report should print "Records Selected Net To Zero")**	Y				
TIP	Generally look for and be able to fully explain significant differences between A02 and A03.					
TIP	Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.					
TIP	Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, the Special Categories appropriation category (10XXXX) should be used.					
4. EXHIBIT D (EADR, EXD)						
4.1	Is the program component objective statement consistent with the agency LRPP, and does it conform to the directives provided on page 62 of the LBR Instructions?	Y				
4.2	Is the program component code and title used correct?	Y				
TIP	Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.					
5. EXHIBIT D-1 (ED1R, EXD1)						
5.1	Are all object of expenditures positive amounts? (This is a manual check.)	Y				
AUDITS:						
5.2	Do the fund totals agree with the object category totals within each appropriation category? **(ED1R, XD1A - Report should print "No Differences Found For This Report")**	Y				
5.3	FLAIR Expenditure/Appropriation Ledger Comparison Report: Is Column A01 less than Column B04? **(EXBR, EXBB - Negative differences need to be corrected in Column A01.)**	Y				
5.4	A01/State Accounts Disbursements and Carry Forward Comparison Report: Does Column A01 equal Column B08? **(EXBR, EXBD - Differences need to be corrected in Column A01.)**	Y				

	Program or Service (Budget Entity Codes)				
Action	68500100				

TIP	If objects are negative amounts, the agency must make adjustments to Column A01 to correct the object amounts. In addition, the fund totals must be adjusted to reflect the adjustment made to the object data.					
TIP	If fund totals and object totals do not agree or negative object amounts exist, the agency must adjust Column A01.					
TIP	Exhibit B - A01 less than B04: This audit is to ensure that the disbursements and carry/certifications forward in A01 are less than FY 2009-10 approved budget. Amounts should be positive.					
TIP	If B08 is not equal to A01, check the following: 1) the initial FLAIR disbursements or carry forward data load was corrected appropriately in A01; 2) the disbursement data from departmental FLAIR was reconciled to State Accounts; and 3) the FLAIR disbursements did not change after Column B08 was created.					
6. EXHIBIT D-3 (ED3R, ED3) (Not required in the LBR - for analytical purposes only.)						
6.1	Are issues appropriately aligned with appropriation categories?	Y				
TIP	Exhibit D-3 is no longer required in the budget submission but may be needed for this particular appropriation category/issue sort. Exhibit D-3 is also a useful report when identifying negative appropriation category problems.					
7. EXHIBIT D-3A (EADR, ED3A)						
7.1	Are the issue titles correct and do they clearly identify the issue? (See pages 15 through 30 of the LBR Instructions.)	N/A				
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See page 65 of the LBR Instructions.)	N/A				
7.3	Does the narrative for Information Technology (IT) issue follow the additional narrative requirements described on pages 66 through 70of the LBR Instructions?	N/A				
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	N/A				
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E-4 and E-5 of the LBR Instructions.)	N/A				
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	N/A				
7.7	Does the issue narrative thoroughly explain/justify all Salaries and Benefits amounts entered into the Other Salary Amounts transactions (OADA/C)? Amounts entered into OAD are reflected in the Position Detail of Salaries and Benefits section of the Exhibit D-3A.	N/A				

		Program or Service (Budget Entity Codes)				
	Action	68500100				
7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A				
7.9	Does the issue narrative reference the specific county(ies) where applicable?	N/A				
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #12-009?	N/A				
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A				
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A				
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A				
7.14	Do the amounts reflect appropriate FSI assignments?	N/A				
7.15	Do the issues relating to *salary and benefits* have an "A" in the fifth position of the issue code (XXXXAXX) and are they self-contained (not combined with other issues)? (See page 29 and 88 of the LBR Instructions.)	N/A				
7.16	Do the issues relating to *Information Technology (IT)* have a "C" in the sixth position of the issue code (36XXXCX) and are the correct issue codes used (361XXC0, 362XXC0, 363XXC0, 17C01C0, 17C02C0, 17C03C0, 24010C0, 33001C0 or 55C01C0)? Have the correct issue codes been used for the Statewide Email Consolidation (17C10C0, 17C11C0, 17C14C0, 33015C0 and 55C04C0)	N/A				
7.17	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A				
AUDIT:						
7.18	Are all FSI's equal to '1', '2', '3', or '9'? There should be no FSI's equal to '0'. **(EADR, FSIA - Report should print "No Records Selected For Reporting")**	N/A				
7.19	Does the General Revenue for 160XXXX (Adjustments to Current Yeer Expenditures) issues net to zero? **(GENR, LBR1)**	N/A				
7.20	Does the General Revenue for 180XXXX (Intra-Agency Reorgaznizations) issues net to zero? **(GENR, LBR2)**	N/A				
7.21	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? **(GENR, LBR3)**	N/A				

		Program or Service (Budget Entity Codes)				
	Action	68500100				
7.22	Have FCO appropriations been entered into the nonrecurring column A04? **(GENR, LBR4 - Report should print "No Records Selected For Reporting" or a listing of D-3A issue(s) assigned to Debt Service (IOE N) or in some cases State Capital Outlay - Public Education Capital Outlay (IOE L))**	N/A				
TIP	Salaries and Benefits amounts entered using the OADA/C transactions must be thoroughly justified in the D-3A issue narrative. Agencies can run **OADA/OADR** from STAM to identify the amounts entered into OAD and ensure these entries have been thoroughly explained in the D-3A issue narrative.					
TIP	The issue narrative must completely and thoroughly explain and justify each D-3A issue. Agencies must ensure it provides the information necessary for the OPB and legislative analysts to have a complete understanding of the issue submitted. Thoroughly review pages 67 through 71 of the LBR Instructions.					
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.					
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).					
TIP	If an appropriation made in the FY 2010-11 General Appropriations Act duplicates an appropriation made in substantive legislation, the agency must create a unique deduct nonrecurring issue to eliminate the duplicated appropriation. Normally this is taken care of through line item veto.					
8. SCHEDULE I & RELATED DOCUMENTS (SC1R, SC1 - Budget Entity Level *or* SC1R, SC1D - Department Level)						
8.1	Has a separate department level Schedule I and supporting documents package been submitted by the agency?	Y				
8.2	Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y				
8.3	Have the appropriate Schedule I supporting documents been included for the trust funds (Schedule IA, Schedule IB, Schedule IC, and Reconciliation to Trial Balance)?	Y				
8.4	Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs?	Y				
8.5	Have the required detailed narratives been provided (5% trust fund reserve narrative; method for computing the distribution of cost for general management and administrative services narrative; adjustments narrative; revenue estimating methodology narrative)?	Y				

	Action	Program or Service (Budget Entity Codes)				
		68500100				
8.6	Has the Inter-Agency Transfers Reported on Schedule I form been included as applicable for transfers totaling $100,000 or more for the fiscal year?	Y				
8.7	If the agency is scheduled for the annual trust fund review this year, have the Schedule ID and applicable draft legislation been included for recreation, modification or termination of existing trust funds?	Y				
8.8	If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to *section 215.32(2)(b), Florida Statutes* - including the Schedule ID and applicable legislation?	Y				
8.9	Are the revenue codes correct? In the case of federal revenues, has the agency appropriately identified direct versus indirect receipts (object codes 000700, 000750, 000799, 001510 and 001599)?	Y				
8.10	Are the statutory authority references correct?	Y				
8.11	Are the General Revenue Service Charge percentage rates used for each revenue source correct? (Refer to Chapter 2009-78, Laws of Florida, for appropriate general revenue service charge percentage rates.)	Y				
8.12	Is this an accurate representation of revenues based on the most recent Consensus Estimating Conference forecasts?	Y				
8.13	If there is no Consensus Estimating Conference forecast available, do the revenue estimates appear to be reasonable?	Y				
8.14	Are the federal funds revenues reported in Section I broken out by individual grant? Are the correct CFDA codes used?	Y				
8.15	Are anticipated grants included and based on the state fiscal year (rather than federal fiscal year)?	Y				
8.16	Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y				
8.17	If applicable, are nonrecurring revenues entered into Column A04?	Y				
8.18	Has the agency certified the revenue estimates in columns A02 and A03 to be the latest and most accurate available? Does the certification include a statement that the agency will notify OPB of any significant changes in revenue estimates that occur prior to the Governor's Budget Recommendations being issued?	Y				
8.19	Is a 5% trust fund reserve reflected in Section II? If not, is sufficient justification provided for exemption? Are the additional narrative requirements provided?	Y				
8.20	Are appropriate service charge nonoperating amounts included in Section II?	Y				
8.21	Are nonoperating expenditures to other budget entities/departments cross-referenced accurately?	Y				
8.22	Do transfers balance between funds (within the agency as well as between agencies)? (See also 8.6 for required transfer confirmation of amounts totaling $100,000 or more.)	Y				

		Program or Service (Budget Entity Codes)				
	Action	68500100				
8.23	Are nonoperating expenditures recorded in Section II and adjustments recorded in Section III?	Y				
8.24	Are prior year September operating reversions appropriately shown in column A01?	Y				
8.25	Are current year September operating reversions appropriately shown in column A02? **DUE TO THE EARLY TRANSMISSION DATE OF THE 2012-13 LBR, CERTIFIED FORWARD REVERSIONS AT 9/30/11 WILL NEED TO BE ADDED BY AGENCIES DURING THE TECHNICAL REVIEW PERIOD.**	N/A				
8.26	Does the Schedule IC properly reflect the unreserved fund balance for each trust fund as defined by the LBR Instructions, and is it reconciled to the agency accounting records?	Y				
8.27	Does Column A01 of the Schedule I accurately represent the actual prior year accounting data as reflected in the agency accounting records, and is it provided in sufficient detail for analysis?	Y				
8.28	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y				
AUDITS:						
8.29	Is Line I a positive number? (If not, the agency must adjust the budget request to eliminate the deficit).	Y				
8.30	Is the June 30 Adjusted Unreserved Fund Balance (Line I) equal to the July 1 Unreserved Fund Balance (Line A) of the following year? If a Schedule IB was prepared, do the totals agree with the Schedule I, Line I? **(SC1R, SC1A - Report should print "No Discrepancies Exist For This Report")**	Y				
8.31	Has a Department Level Reconciliation been provided for each trust fund and does Line A of the Schedule I equal the CFO amount? If not, the agency must correct Line A. **(SC1R, DEPT)**	Y				
TIP	The Schedule I is the most reliable source of data concerning the trust funds. It is very important that this schedule is as accurate as possible!					
TIP	Determine if the agency is scheduled for trust fund review. (See page 125 of the LBR Instructions.)					
TIP	Review the unreserved fund balances and compare revenue totals to expenditure totals to determine and understand the trust fund status.					
TIP	Typically nonoperating expenditures and revenues should not be a negative number. Any negative numbers must be fully justified.					
9. SCHEDULE II (PSCR, SC2)						
AUDIT:						
9.1	Is the pay grade minimum for salary rate utilized for positions in segments 2 and 3? **(BRAR, BRAA - Report should print "No Records Selected For This Request")** Note: Amounts other than the pay grade minimum should be fully justified in the D-3A issue narrative. (See *Base Rate Audit* on page 157 of the LBR Instructions.)	N/A				

	Program or Service (Budget Entity Codes)				
Action	68500100				

10. SCHEDULE III (PSCR, SC3)						
10.1	Is the appropriate lapse amount applied in Segment 3? (See page 90 of the LBR Instructions.)	N/A				
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See page 97 of the LBR Instructions for appropriate use of the OAD transaction.) Use **OADI** or **OADR** to identify agency other salary amounts requested.	N/A				
11. SCHEDULE IV (EADR, SC4)						
11.1	Are the correct Information Technology (IT) issue codes used?	N/A				
TIP	If IT issues are not coded correctly (with "C" in 6th position), they will not appear in the Schedule IV.					
12. SCHEDULE VIIIA (EADR, SC8A)						
12.1	Is there only one #1 priority, one #2 priority, one #3 priority, etc. reported on the Schedule VIII-A? Are the priority narrative explanations adequate?	N/A				
13. SCHEDULE VIIIB-1 (EADR, S8B1)						
13.1	**NOT REQUIRED FOR THIS YEAR**	N/A				
14. SCHEDULE VIIIB-2 (EADR, S8B2)						
14.1	Do the reductions comply with the instructions provided on pages 102 through 104 of the LBR Instructions regarding a 10% reduction in recurring General Revenue and Trust Funds, including the verification that the 3BXXX0 issue has not been used?	N/A				
15. SCHEDULE XI (LAS/PBS Web - see page 108 of the LBR Instructions for detailed instructions)						
15.1	Agencies are required to generate this spreadsheet via the LAS/PBS Web. The Final Excel version no longer has to be submitted to OPB for inclusion on the Governor's Florida Performs Website. (Note: Pursuant to section 216.023(4) (b), Florida Statutes, the Legislature can reduce the funding level for any agency that does not provide this information.)	Y				
15.2	Do the PDF files uploaded to the Florida Fiscal Portal for the LRPP and LBR match?	Y				
AUDITS INCLUDED IN THE SCHEDULE XI REPORT:						
15.3	Does the FY 2010-11 Actual (prior year) Expenditures in Column A36 reconcile to Column A01? (**GENR, ACT1)**	Y				
15.4	None of the executive direction, administrative support and information technology statewide activities (ACT0010 thru ACT0490) have output standards (Record Type 5)? **(Audit #1 should print "No Activities Found")**	Y				
15.5	Does the Fixed Capital Outlay (FCO) statewide activity (ACT0210) only contain 08XXXX or 14XXXX appropriation categories? **(Audit #2 should print "No Operating Categories Found")**	N/A				

	Program or Service (Budget Entity Codes)				
Action	68500100				
15.6 Has the agency provided the necessary demand (Record Type 5) for all activities which should appear in Section II? (Note: Audit #3 will identify those activities that do NOT have a Record Type '5' and have not been identified as a 'Pass Through' activity. These activities will be displayed in Section III with the 'Payment of Pensions, Benefits and Claims' activity and 'Other' activities. Verify if these activities should be displayed in Section III. If not, an output standard would need to be added for that activity and the Schedule XI submitted again.)	Y				
15.7 Does Section I (Final Budget for Agency) and Section III (Total Budget for Agency) equal? **(Audit #4 should print "No Discrepancies Found")**	Y				
TIP If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.					
16. MANUALLY PREPARED EXHIBITS & SCHEDULES					
16.1 Do exhibits and schedules comply with LBR Instructions (pages 110 through 154 of the LBR Instructions), and are they accurate and complete?	Y				
16.2 Are appropriation category totals comparable to Exhibit B, where applicable?	Y				
16.3 Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y				
AUDITS - GENERAL INFORMATION					
TIP Review *Section 6: Audits* of the LBR Instructions (pages 156-158) for a list of audits and their descriptions.					
TIP Reorganizations may cause audit errors. Agencies must indicate that these errors are due to an agency reorganization to justify the audit error.					
17. CAPITAL IMPROVEMENTS PROGRAM (CIP)					
17.1 Are the CIP-2, CIP-3, CIP-A and CIP-B forms included?	N/A				
17.2 Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	N/A				
17.3 Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	N/A				
17.4 Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	N/A				
17.5 Are the appropriate counties identified in the narrative?	N/A				
17.6 Has the CIP-2 form (Exibit B) been modified to include the agency priority for each project and the modified form saved as a PDF document?	N/A				
TIP Requests for Fixed Capital Outlay appropriations which are Grants and Aids to Local Governments and Non-Profit Organizations must use the Grants and Aids to Local Governments and Non-Profit Organizations - Fixed Capital Outlay major appropriation category (140XXX) and include the sub-title "Grants and Aids". These appropriations utilize a CIP-B form as justification.					

	Program or Service (Budget Entity Codes)				
Action	68500100				

18. FLORIDA FISCAL PORTAL						
18.1	Have all files been assembled correctly and posted to the Florida Fiscal Portal as outlined in the Florida Fiscal Portal Submittal Process?	Y				
19. CREATION OF DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)						
19.1	If you are an agency that no longer exists or is transferred to DEO after the approval of the reorganization by the Legislative Budget Commission (LBC), have you submitted the following schedules, as applicable: · Schedule I: Trust Funds Available and Schedule IB - DEPARTMENT LEVEL · Schedule IA: Detail of Fees and Related Costs (Part I and Part II) · Schedule IC: Reconciliation of Unreserved Fund Balances · Reconciliation: Beginning Trial Balance to Schedule I and IC · Exhibit D-1: Detail of Expenses · Schedule XI: Agency-Level Unit Cost Summary · Opening Trial Balance as of July 1, 2011 · Schedule I Narratives related to Column A01 · Inter-Agency Transfer Form	N/A				

Fiscal Year 2012-13 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Adminstration / Executive Direction/Support Services

Agency Budget Officer/OPB Analyst Name: Michele Tallent / Kate West

A "Y" indicates "YES" and is acceptable, an "N/J" indicates "NO/Justification Provided" - these require further explanation/justification (additional sheets can be used as necessary), and "TIPS" are other areas to consider.

		Program or Service (Budget Entity Codes)				
	Action	68500200				
1. GENERAL						
1.1	Are Columns A01, A02, A04, A05, A36, A90, A91, A92, A93, A94, A95, IA1, IA4, IA5, IP1,V1, IV3 and NV1 set to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for both the Budget and Trust Fund columns? Are Columns A06, A07, A08 and A09 for Fixed Capital Outlay (FCO) set to TRANSFER CONTROL for DISPLAY status only? **(CSDI)**	Y				
1.2	Is Column A03 set to TRANSFER CONTROL for DISPLAY and UPDATE status for both the Budget and Trust Fund columns? **(CSDI)**	Y				
AUDITS:						
1.3	Has Column A03 been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y				
1.4	Has security been set correctly? **(CSDR, CSA)**	Y				
TIP	The agency should prepare the budget request for submission in this order: 1) Lock columns as described above; 2) copy Column A03 to Column A12; and 3) set Column A12 column security to ALL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status.					
2. EXHIBIT A (EADR, EXA)						
2.1	Is the budget entity authority and description consistent with the agency's LRPP and does it conform to the directives provided on page 56 of the LBR Instructions?	Y				
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y				
2.3	Are the issue codes and titles consistent with *Section 3* of the LBR Instructions (pages 15 through 30)? Do they clearly describe the issue?	Y				
2.4	Have the coding guidelines in *Section 3* of the LBR Instructions (pages 15 through 30) been followed?	Y				
3. EXHIBIT B (EXBR, EXB)						
3.1	Is it apparent that there is a fund shift and were the issues entered into LAS/PBS correctly? Check D-3A funding shift issue 340XXX0 - a unique deduct and unique add back issue should be used to ensure fund shifts display correctly on the LBR exhibits.	N/A				
3.2	Are the 33XXXX0 issues negative amounts only and do not restore nonrecurring cuts from a prior year or fund any issues that net to a positive or zero amount? Check D-3A issues 33XXXX0 - a unique issue should be used for issues that net to zero or a positive amount.	Y				

	Program or Service (Budget Entity Codes)				
Action	68500200				

AUDITS:						
3.3	Negative Appropriation Category Audit for Agency Request (Columns A03 and A04): Are all appropriation categories positive by budget entity at the FSI level? Are all nonrecurring amounts less than requested amounts? **(NACR, NAC - Report should print "No Negative Appropriation Categories Found")**	Y				
3.4	Current Year Estimated Verification Comparison Report: Is Column A02 equal to Column B07? **(EXBR, EXBC - Report should print "Records Selected Net To Zero")**	Y				
TIP	Generally look for and be able to fully explain significant differences between A02 and A03.					
TIP	Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.					
TIP	Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, the Special Categories appropriation category (10XXXX) should be used.					
4. EXHIBIT D (EADR, EXD)						
4.1	Is the program component objective statement consistent with the agency LRPP, and does it conform to the directives provided on page 62 of the LBR Instructions?	Y				
4.2	Is the program component code and title used correct?	Y				
TIP	Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.					
5. EXHIBIT D-1 (ED1R, EXD1)						
5.1	Are all object of expenditures positive amounts? (This is a manual check.)	Y				
AUDITS:						
5.2	Do the fund totals agree with the object category totals within each appropriation category? **(ED1R, XD1A - Report should print "No Differences Found For This Report")**	Y				
5.3	FLAIR Expenditure/Appropriation Ledger Comparison Report: Is Column A01 less than Column B04? **(EXBR, EXBB - Negative differences need to be corrected in Column A01.)**	Y				
5.4	A01/State Accounts Disbursements and Carry Forward Comparison Report: Does Column A01 equal Column B08? **(EXBR, EXBD - Differences need to be corrected in Column A01.)**	Y				

	Program or Service (Budget Entity Codes)				
Action	68500200				

TIP	If objects are negative amounts, the agency must make adjustments to Column A01 to correct the object amounts. In addition, the fund totals must be adjusted to reflect the adjustment made to the object data.					
TIP	If fund totals and object totals do not agree or negative object amounts exist, the agency must adjust Column A01.					
TIP	Exhibit B - A01 less than B04: This audit is to ensure that the disbursements and carry/certifications forward in A01 are less than FY 2009-10 approved budget. Amounts should be positive.					
TIP	If B08 is not equal to A01, check the following: 1) the initial FLAIR disbursements or carry forward data load was corrected appropriately in A01; 2) the disbursement data from departmental FLAIR was reconciled to State Accounts; and 3) the FLAIR disbursements did not change after Column B08 was created.					
6. EXHIBIT D-3 (ED3R, ED3) (Not required in the LBR - for analytical purposes only.)						
6.1	Are issues appropriately aligned with appropriation categories?	Y				
TIP	Exhibit D-3 is no longer required in the budget submission but may be needed for this particular appropriation category/issue sort. Exhibit D-3 is also a useful report when identifying negative appropriation category problems.					
7. EXHIBIT D-3A (EADR, ED3A)						
7.1	Are the issue titles correct and do they clearly identify the issue? (See pages 15 through 30 of the LBR Instructions.)	Y				
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See page 65 of the LBR Instructions.)	Y				
7.3	Does the narrative for Information Technology (IT) issue follow the additional narrative requirements described on pages 66 through 70of the LBR Instructions?	Y				
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	Y				
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E-4 and E-5 of the LBR Instructions.)	Y				
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	Y				
7.7	Does the issue narrative thoroughly explain/justify all Salaries and Benefits amounts entered into the Other Salary Amounts transactions (OADA/C)? Amounts entered into OAD are reflected in the Position Detail of Salaries and Benefits section of the Exhibit D-3A.	Y				

	Action	Program or Service (Budget Entity Codes)				
		68500200				
7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A				
7.9	Does the issue narrative reference the specific county(ies) where applicable?	Y				
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #12-009?	Y				
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A				
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A				
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A				
7.14	Do the amounts reflect appropriate FSI assignments?	Y				
7.15	Do the issues relating to *salary and benefits* have an "A" in the fifth position of the issue code (XXXXAXX) and are they self-contained (not combined with other issues)? (See page 29 and 88of the LBR Instructions.)	Y				
7.16	Do the issues relating to Information Technology (IT) have a "C" in the sixth position of the issue code (36XXXCX) and are the correct issue codes used (361XXC0, 362XXC0, 363XXC0, 17C01C0, 17C02C0, 17C03C0, 24010C0, 33001C0 or 55C01C0)? Have the correct issue codes been used for the Statewide Email Consolidation (17C10C0, 17C11C0, 17C14C0, 33015C0 and 55C04C0)	Y				
7.17	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A				
AUDIT:						
7.18	Are all FSI's equal to '1', '2', '3', or '9'? There should be no FSI's equal to '0'. **(EADR, FSIA - Report should print "No Records Selected For Reporting")**	Y				
7.19	Does the General Revenue for 160XXXX (Adjustments to Current Yeer Expenditures) issues net to zero? (GENR, LBR1)	N/A				
7.20	Does the General Revenue for 180XXXX (Intra-Agency Reorgaznizations) issues net to zero? (GENR, LBR2)	N/A				
7.21	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? (GENR, LBR3)	N/A				

	Program or Service (Budget Entity Codes)				
Action	68500200				

7.22	Have FCO appropriations been entered into the nonrecurring column A04? **(GENR, LBR4 - Report should print "No Records Selected For Reporting" or a listing of D-3A issue(s) assigned to Debt Service (IOE N) or in some cases State Capital Outlay - Public Education Capital Outlay (IOE L))**	N/A				
TIP	Salaries and Benefits amounts entered using the OADA/C transactions must be thoroughly justified in the D-3A issue narrative. Agencies can run **OADA/OADR** from STAM to identify the amounts entered into OAD and ensure these entries have been thoroughly explained in the D-3A issue narrative.					
TIP	The issue narrative must completely and thoroughly explain and justify each D-3A issue. Agencies must ensure it provides the information necessary for the OPB and legislative analysts to have a complete understanding of the issue submitted. Thoroughly review pages 67 through 71 of the LBR Instructions.					
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.					
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).					
TIP	If an appropriation made in the FY 2011-12 General Appropriations Act duplicates an appropriation made in substantive legislation, the agency must create a unique deduct nonrecurring issue to eliminate the duplicated appropriation. Normally this is taken care of through line item veto.					
8. SCHEDULE I & RELATED DOCUMENTS (SC1R, SC1 - Budget Entity Level *or* SC1R, SC1D - Department Level)						
8.1	Has a separate department level Schedule I and supporting documents package been submitted by the agency?	Y				
8.2	Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y				
8.3	Have the appropriate Schedule I supporting documents been included for the trust funds (Schedule IA, Schedule IB, Schedule IC, and Reconciliation to Trial Balance)?	Y				
8.4	Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs?	Y				
8.5	Have the required detailed narratives been provided (5% trust fund reserve narrative; method for computing the distribution of cost for general management and administrative services narrative; adjustments narrative; revenue estimating methodology narrative)?	Y				

	Action	Program or Service (Budget Entity Codes)				
		68500200				
8.6	Has the Inter-Agency Transfers Reported on Schedule I form been included as applicable for transfers totaling $100,000 or more for the fiscal year?	Y				
8.7	If the agency is scheduled for the annual trust fund review this year, have the Schedule ID and applicable draft legislation been included for recreation, modification or termination of existing trust funds?	Y				
8.8	If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to *section 215.32(2)(b), Florida Statutes* - including the Schedule ID and applicable legislation?	Y				
8.9	Are the revenue codes correct? In the case of federal revenues, has the agency appropriately identified direct versus indirect receipts (object codes 000700, 000750, 000799, 001510 and 001599)?	Y				
8.10	Are the statutory authority references correct?	Y				
8.11	Are the General Revenue Service Charge percentage rates used for each revenue source correct? (Refer to Chapter 2009-78, Laws of Florida, for appropriate general revenue service charge percentage rates.)	Y				
8.12	Is this an accurate representation of revenues based on the most recent Consensus Estimating Conference forecasts?	Y				
8.13	If there is no Consensus Estimating Conference forecast available, do the revenue estimates appear to be reasonable?	Y				
8.14	Are the federal funds revenues reported in Section I broken out by individual grant? Are the correct CFDA codes used?	Y				
8.15	Are anticipated grants included and based on the state fiscal year (rather than federal fiscal year)?	Y				
8.16	Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y				
8.17	If applicable, are nonrecurring revenues entered into Column A04?	Y				
8.18	Has the agency certified the revenue estimates in columns A02 and A03 to be the latest and most accurate available? Does the certification include a statement that the agency will notify OPB of any significant changes in revenue estimates that occur prior to the Governor's Budget Recommendations being issued?	Y				
8.19	Is a 5% trust fund reserve reflected in Section II? If not, is sufficient justification provided for exemption? Are the additional narrative requirements provided?	Y				
8.20	Are appropriate service charge nonoperating amounts included in Section II?	Y				
8.21	Are nonoperating expenditures to other budget entities/departments cross-referenced accurately?	Y				
8.22	Do transfers balance between funds (within the agency as well as between agencies)? (See also 8.6 for required transfer confirmation of amounts totaling $100,000 or more.)	Y				

		Program or Service (Budget Entity Codes)				
	Action	68500200				
8.23	Are nonoperating expenditures recorded in Section II and adjustments recorded in Section III?	Y				
8.24	Are prior year September operating reversions appropriately shown in column A01?	Y				
8.25	Are current year September operating reversions appropriately shown in column A02? **DUE TO THE EARLY TRANSMISSION DATE OF THE 2012-13 LBR, CERTIFIED FORWARD REVERSIONS AT 9/30/11 WILL NEED TO BE ADDED BY AGENCIES DURING THE TECHNICAL REVIEW PERIOD.**	N/A				
8.26	Does the Schedule IC properly reflect the unreserved fund balance for each trust fund as defined by the LBR Instructions, and is it reconciled to the agency accounting records?	Y				
8.27	Does Column A01 of the Schedule I accurately represent the actual prior year accounting data as reflected in the agency accounting records, and is it provided in sufficient detail for analysis?	Y				
8.28	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y				
AUDITS:						
8.29	Is Line I a positive number? (If not, the agency must adjust the budget request to eliminate the deficit).	Y				
8.30	Is the June 30 Adjusted Unreserved Fund Balance (Line I) equal to the July 1 Unreserved Fund Balance (Line A) of the following year? If a Schedule IB was prepared, do the totals agree with the Schedule I, Line I? **(SC1R, SC1A - Report should print "No Discrepancies Exist For This Report")**	Y				
8.31	Has a Department Level Reconciliation been provided for each trust fund and does Line A of the Schedule I equal the CFO amount? If not, the agency must correct Line A. **(SC1R, DEPT)**	Y				
TIP	The Schedule I is the most reliable source of data concerning the trust funds. It is very important that this schedule is as accurate as possible!					
TIP	Determine if the agency is scheduled for trust fund review. (See page 125 of the LBR Instructions.)					
TIP	Review the unreserved fund balances and compare revenue totals to expenditure totals to determine and understand the trust fund status.					
TIP	Typically nonoperating expenditures and revenues should not be a negative number. Any negative numbers must be fully justified.					
9. SCHEDULE II (PSCR, SC2)						
AUDIT:						
9.1	Is the pay grade minimum for salary rate utilized for positions in segments 2 and 3? **(BRAR, BRAA - Report should print "No Records Selected For This Request")** Note: Amounts other than the pay grade minimum should be fully justified in the D-3A issue narrative. (See *Base Rate Audit* on page 157 of the LBR Instructions.)	Y				

	Program or Service (Budget Entity Codes)				
Action	68500200				

10. SCHEDULE III (PSCR, SC3)						
10.1	Is the appropriate lapse amount applied in Segment 3? (See page 90of the LBR Instructions.)	Y				
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See page 97 of the LBR Instructions for appropriate use of the OAD transaction.) Use **OADI** or **OADR** to identify agency other salary amounts requested.	Y				
11. SCHEDULE IV (EADR, SC4)						
11.1	Are the correct Information Technology (IT) issue codes used?	Y				
TIP	If IT issues are not coded correctly (with "C" in 6th position), they will not appear in the Schedule IV.					
12. SCHEDULE VIIIA (EADR, SC8A)						
12.1	Is there only one #1 priority, one #2 priority, one #3 priority, etc. reported on the Schedule VIII-A? Are the priority narrative explanations adequate?	Y				
13. SCHEDULE VIIIB-1 (EADR, S8B1)						
13.1	**NOT REQUIRED FOR THIS YEAR**	N/A				
14. SCHEDULE VIIIB-2 (EADR, S8B2)						
14.1	Do the reductions comply with the instructions provided on pages 102 through 104 of the LBR Instructions regarding a 10% reduction in recurring General Revenue and Trust Funds, including the verification that the 3BXXX0 issue has not been used?	Y				
15. SCHEDULE XI (LAS/PBS Web - see page 108 of the LBR Instructions for detailed instructions)						
15.1	Agencies are required to generate this spreadsheet via the LAS/PBS Web. The Final Excel version no longer has to be submitted to OPB for inclusion on the Governor's Florida Performs Website. (Note: Pursuant to section 216.023(4) (b), Florida Statutes, the Legislature can reduce the funding level for any agency that does not provide this information.)	Y				
15.2	Do the PDF files uploaded to the Florida Fiscal Portal for the LRPP and LBR match?	Y				
AUDITS INCLUDED IN THE SCHEDULE XI REPORT:						
15.3	Does the FY 2010-11 Actual (prior year) Expenditures in Column A36 reconcile to Column A01? (**GENR, ACT1)**	Y				
15.4	None of the executive direction, administrative support and information technology statewide activities (ACT0010 thru ACT0490) have output standards (Record Type 5)? **(Audit #1 should print "No Activities Found")**	Y				
15.5	Does the Fixed Capital Outlay (FCO) statewide activity (ACT0210) only contain 08XXXX or 14XXXX appropriation categories? **(Audit #2 should print "No Operating Categories Found")**	N/A				

	Action	Program or Service (Budget Entity Codes)				
		68500200				
15.6	Has the agency provided the necessary demand (Record Type 5) for all activities which should appear in Section II? (Note: Audit #3 will identify those activities that do NOT have a Record Type '5' and have not been identified as a 'Pass Through' activity. These activities will be displayed in Section III with the 'Payment of Pensions, Benefits and Claims' activity and 'Other' activities. Verify if these activities should be displayed in Section III. If not, an output standard would need to be added for that activity and the Schedule XI submitted again.)	Y				
15.7	Does Section I (Final Budget for Agency) and Section III (Total Budget for Agency) equal? **(Audit #4 should print "No Discrepancies Found")**	Y				
TIP	If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.					
16. MANUALLY PREPARED EXHIBITS & SCHEDULES						
16.1	Do exhibits and schedules comply with LBR Instructions (pages 110 through 154 of the LBR Instructions), and are they accurate and complete?	Y				
16.2	Are appropriation category totals comparable to Exhibit B, where applicable?	Y				
16.3	Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y				
AUDITS - GENERAL INFORMATION						
TIP	Review Section 6: Audits of the LBR Instructions (pages 156-158) for a list of audits and their descriptions.					
TIP	Reorganizations may cause audit errors. Agencies must indicate that these errors are due to an agency reorganization to justify the audit error.					
17. CAPITAL IMPROVEMENTS PROGRAM (CIP)						
17.1	Are the CIP-2, CIP-3, CIP-A and CIP-B forms included?	Y				
17.2	Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	N/A				
17.3	Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	Y				
17.4	Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	Y				
17.5	Are the appropriate counties identified in the narrative?	Y				
17.6	Has the CIP-2 form (Exibit B) been modified to include the agency priority for each project and the modified form saved as a PDF document?	Y				
TIP	Requests for Fixed Capital Outlay appropriations which are Grants and Aids to Local Governments and Non-Profit Organizations must use the Grants and Aids to Local Governments and Non-Profit Organizations - Fixed Capital Outlay major appropriation category (140XXX) and include the sub-title "Grants and Aids". These appropriations utilize a CIP-B form as justification.					

	Program or Service (Budget Entity Codes)				
Action	68500200				

18. FLORIDA FISCAL PORTAL						
18.1	Have all files been assembled correctly and posted to the Florida Fiscal Portal as outlined in the Florida Fiscal Portal Submittal Process?	Y				
19. CREATION OF DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)						
19.1	If you are an agency that no longer exists or is transferred to DEO after the approval of the reorganization by the Legislative Budget Commission (LBC), have you submitted the following schedules, as applicable: · Schedule I: Trust Funds Available and Schedule IB - DEPARTMENT LEVEL · Schedule IA: Detail of Fees and Related Costs (Part I and Part II) · Schedule IC: Reconciliation of Unreserved Fund Balances · Reconciliation: Beginning Trial Balance to Schedule I and IC · Exhibit D-1: Detail of Expenses · Schedule XI: Agency-Level Unit Cost Summary · Opening Trial Balance as of July 1, 2011 · Schedule I Narratives related to Column A01 · Inter-Agency Transfer Form	N/A				

Fiscal Year 2012-13 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Adminstration / Health Services to Indviduals

Agency Budget Officer/OPB Analyst Name: Michele Tallent / Kate West

A "Y" indicates "YES" and is acceptable, an "N/J" indicates "NO/Justification Provided" - these require further explanation/justification (additional sheets can be used as necessary), and "TIPS" are other areas to consider.

		Program or Service (Budget Entity Codes)				
	Action	68501400				
1. GENERAL						
1.1	Are Columns A01, A02, A04, A05, A36, A90, A91, A92, A93, A94, A95, IA1, IA4, IA5, IP1,V1, IV3 and NV1 set to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for both the Budget and Trust Fund columns? Are Columns A06, A07, A08 and A09 for Fixed Capital Outlay (FCO) set to TRANSFER CONTROL for DISPLAY status only? **(CSDI)**	Y				
1.2	Is Column A03 set to TRANSFER CONTROL for DISPLAY and UPDATE status for both the Budget and Trust Fund columns? **(CSDI)**	Y				
AUDITS:						
1.3	Has Column A03 been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y				
1.4	Has security been set correctly? **(CSDR, CSA)**	Y				
TIP	The agency should prepare the budget request for submission in this order: 1) Lock columns as described above; 2) copy Column A03 to Column A12; and 3) set Column A12 column security to ALL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status.					
2. EXHIBIT A (EADR, EXA)						
2.1	Is the budget entity authority and description consistent with the agency's LRPP and does it conform to the directives provided on page 56 of the LBR Instructions?	Y				
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y				
2.3	Are the issue codes and titles consistent with *Section 3* of the LBR Instructions (pages 15 through 30)? Do they clearly describe the issue?	Y				
2.4	Have the coding guidelines in *Section 3* of the LBR Instructions (pages 15 through 30) been followed?	Y				
3. EXHIBIT B (EXBR, EXB)						
3.1	Is it apparent that there is a fund shift and were the issues entered into LAS/PBS correctly? Check D-3A funding shift issue 340XXX0 - a unique deduct and unique add back issue should be used to ensure fund shifts display correctly on the LBR exhibits.	N/A				
3.2	Are the 33XXXX0 issues negative amounts only and do not restore nonrecurring cuts from a prior year or fund any issues that net to a positive or zero amount? Check D-3A issues 33XXXX0 - a unique issue should be used for issues that net to zero or a positive amount.	Y				

	Program or Service (Budget Entity Codes)				
Action	68501400				

AUDITS:						
3.3	Negative Appropriation Category Audit for Agency Request (Columns A03 and A04): Are all appropriation categories positive by budget entity at the FSI level? Are all nonrecurring amounts less than requested amounts? **(NACR, NAC - Report should print "No Negative Appropriation Categories Found")**	Y				
3.4	Current Year Estimated Verification Comparison Report: Is Column A02 equal to Column B07? **(EXBR, EXBC - Report should print "Records Selected Net To Zero")**	Y				
TIP	Generally look for and be able to fully explain significant differences between A02 and A03.					
TIP	Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.					
TIP	Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, the Special Categories appropriation category (10XXXX) should be used.					
4. EXHIBIT D (EADR, EXD)						
4.1	Is the program component objective statement consistent with the agency LRPP, and does it conform to the directives provided on page 62of the LBR Instructions?	Y				
4.2	Is the program component code and title used correct?	Y				
TIP	Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.					
5. EXHIBIT D-1 (ED1R, EXD1)						
5.1	Are all object of expenditures positive amounts? (This is a manual check.)	Y				
AUDITS:						
5.2	Do the fund totals agree with the object category totals within each appropriation category? **(ED1R, XD1A - Report should print "No Differences Found For This Report")**	Y				
5.3	FLAIR Expenditure/Appropriation Ledger Comparison Report: Is Column A01 less than Column B04? **(EXBR, EXBB - Negative differences need to be corrected in Column A01.)**	Y				
5.4	A01/State Accounts Disbursements and Carry Forward Comparison Report: Does Column A01 equal Column B08? **(EXBR, EXBD - Differences need to be corrected in Column A01.)**	Y				

	Program or Service (Budget Entity Codes)				
Action	68501400				

TIP	If objects are negative amounts, the agency must make adjustments to Column A01 to correct the object amounts. In addition, the fund totals must be adjusted to reflect the adjustment made to the object data.					
TIP	If fund totals and object totals do not agree or negative object amounts exist, the agency must adjust Column A01.					
TIP	Exhibit B - A01 less than B04: This audit is to ensure that the disbursements and carry/certifications forward in A01 are less than FY 2009-10 approved budget. Amounts should be positive.					
TIP	If B08 is not equal to A01, check the following: 1) the initial FLAIR disbursements or carry forward data load was corrected appropriately in A01; 2) the disbursement data from departmental FLAIR was reconciled to State Accounts; and 3) the FLAIR disbursements did not change after Column B08 was created.					
6. EXHIBIT D-3 (ED3R, ED3) (Not required in the LBR - for analytical purposes only.)						
6.1	Are issues appropriately aligned with appropriation categories?	Y				
TIP	Exhibit D-3 is no longer required in the budget submission but may be needed for this particular appropriation category/issue sort. Exhibit D-3 is also a useful report when identifying negative appropriation category problems.					
7. EXHIBIT D-3A (EADR, ED3A)						
7.1	Are the issue titles correct and do they clearly identify the issue? (See pages 15 through 30 of the LBR Instructions.)	Y				
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See page 65 of the LBR Instructions.)	Y				
7.3	Does the narrative for Information Technology (IT) issue follow the additional narrative requirements described on pages 66 through 70 of the LBR Instructions?	N/A				
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	N/A				
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E-4 and E-5 of the LBR Instructions.)	N/A				
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	N/A				
7.7	Does the issue narrative thoroughly explain/justify all Salaries and Benefits amounts entered into the Other Salary Amounts transactions (OADA/C)? Amounts entered into OAD are reflected in the Position Detail of Salaries and Benefits section of the Exhibit D-3A.	N/A				

	Program or Service (Budget Entity Codes)				
Action	68501400				

7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A				
7.9	Does the issue narrative reference the specific county(ies) where applicable?	N/A				
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #12-009?	N/A				
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A				
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A				
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A				
7.14	Do the amounts reflect appropriate FSI assignments?	Y				
7.15	Do the issues relating to *salary and benefits* have an "A" in the fifth position of the issue code (XXXXAXX) and are they self-contained (not combined with other issues)? (See page 29 and 88 of the LBR Instructions.)	N/A				
7.16	Do the issues relating to Information Technology (IT) have a "C" in the sixth position of the issue code (36XXXCX) and are the correct issue codes used (361XXC0, 362XXC0, 363XXC0, 17C01C0, 17C02C0, 17C03C0, 24010C0, 33001C0 or 55C01C0)? Have the correct issue codes been used for the Statewide Email Consolidation (17C10C0, 17C11C0, 17C14C0, 33015C0 and 55C04C0)	N/A				
7.17	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A				
AUDIT:						
7.18	Are all FSI's equal to '1', '2', '3', or '9'? There should be no FSI's equal to '0'. **(EADR, FSIA - Report should print "No Records Selected For Reporting")**	Y				
7.19	Does the General Revenue for 160XXXX (Adjustments to Current Yeer Expenditures) issues net to zero? (GENR, LBR1)	N/A				
7.20	Does the General Revenue for 180XXXX (Intra-Agency Reorgaznizations) issues net to zero? (GENR, LBR2)	N/A				
7.21	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? (GENR, LBR3)	N/A				

	Program or Service (Budget Entity Codes)				
Action	68501400				

7.22	Have FCO appropriations been entered into the nonrecurring column A04? **(GENR, LBR4 - Report should print "No Records Selected For Reporting" or a listing of D-3A issue(s) assigned to Debt Service (IOE N) or in some cases State Capital Outlay - Public Education Capital Outlay (IOE L))**	N/A				
TIP	Salaries and Benefits amounts entered using the OADA/C transactions must be thoroughly justified in the D-3A issue narrative. Agencies can run **OADA/OADR** from STAM to identify the amounts entered into OAD and ensure these entries have been thoroughly explained in the D-3A issue narrative.					
TIP	The issue narrative must completely and thoroughly explain and justify each D-3A issue. Agencies must ensure it provides the information necessary for the OPB and legislative analysts to have a complete understanding of the issue submitted. Thoroughly review pages 67 through 71 of the LBR Instructions.					
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.					
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).					
TIP	If an appropriation made in the FY 2010-11 General Appropriations Act duplicates an appropriation made in substantive legislation, the agency must create a unique deduct nonrecurring issue to eliminate the duplicated appropriation. Normally this is taken care of through line item veto.					
8. SCHEDULE I & RELATED DOCUMENTS (SC1R, SC1 - Budget Entity Level *or* SC1R, SC1D - Department Level)						
8.1	Has a separate department level Schedule I and supporting documents package been submitted by the agency?	Y				
8.2	Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y				
8.3	Have the appropriate Schedule I supporting documents been included for the trust funds (Schedule IA, Schedule IB, Schedule IC, and Reconciliation to Trial Balance)?	Y				
8.4	Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs?	Y				
8.5	Have the required detailed narratives been provided (5% trust fund reserve narrative; method for computing the distribution of cost for general management and administrative services narrative; adjustments narrative; revenue estimating methodology narrative)?	Y				

	Action	Program or Service (Budget Entity Codes)				
		68501400				
8.6	Has the Inter-Agency Transfers Reported on Schedule I form been included as applicable for transfers totaling $100,000 or more for the fiscal year?	Y				
8.7	If the agency is scheduled for the annual trust fund review this year, have the Schedule ID and applicable draft legislation been included for recreation, modification or termination of existing trust funds?	Y				
8.8	If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to *section 215.32(2)(b), Florida Statutes* - including the Schedule ID and applicable legislation?	Y				
8.9	Are the revenue codes correct? In the case of federal revenues, has the agency appropriately identified direct versus indirect receipts (object codes 000700, 000750, 000799, 001510 and 001599)?	Y				
8.10	Are the statutory authority references correct?	Y				
8.11	Are the General Revenue Service Charge percentage rates used for each revenue source correct? (Refer to Chapter 2009-78, Laws of Florida, for appropriate general revenue service charge percentage rates.)	Y				
8.12	Is this an accurate representation of revenues based on the most recent Consensus Estimating Conference forecasts?	Y				
8.13	If there is no Consensus Estimating Conference forecast available, do the revenue estimates appear to be reasonable?	Y				
8.14	Are the federal funds revenues reported in Section I broken out by individual grant? Are the correct CFDA codes used?	Y				
8.15	Are anticipated grants included and based on the state fiscal year (rather than federal fiscal year)?	Y				
8.16	Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y				
8.17	If applicable, are nonrecurring revenues entered into Column A04?	Y				
8.18	Has the agency certified the revenue estimates in columns A02 and A03 to be the latest and most accurate available? Does the certification include a statement that the agency will notify OPB of any significant changes in revenue estimates that occur prior to the Governor's Budget Recommendations being issued?	Y				
8.19	Is a 5% trust fund reserve reflected in Section II? If not, is sufficient justification provided for exemption? Are the additional narrative requirements provided?	Y				
8.20	Are appropriate service charge nonoperating amounts included in Section II?	Y				
8.21	Are nonoperating expenditures to other budget entities/departments cross-referenced accurately?	Y				
8.22	Do transfers balance between funds (within the agency as well as between agencies)? (See also 8.6 for required transfer confirmation of amounts totaling $100,000 or more.)	Y				

		Program or Service (Budget Entity Codes)				
	Action	68501400				
8.23	Are nonoperating expenditures recorded in Section II and adjustments recorded in Section III?	Y				
8.24	Are prior year September operating reversions appropriately shown in column A01?	Y				
8.25	Are current year September operating reversions appropriately shown in column A02? **DUE TO THE EARLY TRANSMISSION DATE OF THE 2012-13 LBR, CERTIFIED FORWARD REVERSIONS AT 9/30/11 WILL NEED TO BE ADDED BY AGENCIES DURING THE TECHNICAL REVIEW PERIOD.**	N/A				
8.26	Does the Schedule IC properly reflect the unreserved fund balance for each trust fund as defined by the LBR Instructions, and is it reconciled to the agency accounting records?	Y				
8.27	Does Column A01 of the Schedule I accurately represent the actual prior year accounting data as reflected in the agency accounting records, and is it provided in sufficient detail for analysis?	Y				
8.28	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y				
AUDITS:						
8.29	Is Line I a positive number? (If not, the agency must adjust the budget request to eliminate the deficit).	Y				
8.30	Is the June 30 Adjusted Unreserved Fund Balance (Line I) equal to the July 1 Unreserved Fund Balance (Line A) of the following year? If a Schedule IB was prepared, do the totals agree with the Schedule I, Line I? **(SC1R, SC1A - Report should print "No Discrepancies Exist For This Report")**	Y				
8.31	Has a Department Level Reconciliation been provided for each trust fund and does Line A of the Schedule I equal the CFO amount? If not, the agency must correct Line A. **(SC1R, DEPT)**	Y				
TIP	The Schedule I is the most reliable source of data concerning the trust funds. It is very important that this schedule is as accurate as possible!					
TIP	Determine if the agency is scheduled for trust fund review. (See page 125 of the LBR Instructions.)					
TIP	Review the unreserved fund balances and compare revenue totals to expenditure totals to determine and understand the trust fund status.					
TIP	Typically nonoperating expenditures and revenues should not be a negative number. Any negative numbers must be fully justified.					
9. SCHEDULE II (PSCR, SC2)						
AUDIT:						
9.1	Is the pay grade minimum for salary rate utilized for positions in segments 2 and 3? **(BRAR, BRAA - Report should print "No Records Selected For This Request")** Note: Amounts other than the pay grade minimum should be fully justified in the D-3A issue narrative. (See *Base Rate Audit* on page 157 of the LBR Instructions.)	N/A				

	Program or Service (Budget Entity Codes)				
Action	68501400				

10. SCHEDULE III (PSCR, SC3)						
10.1	Is the appropriate lapse amount applied in Segment 3? (See page 90 of the LBR Instructions.)	N/A				
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See page 97 of the LBR Instructions for appropriate use of the OAD transaction.) Use **OADI** or **OADR** to identify agency other salary amounts requested.	N/A				
11. SCHEDULE IV (EADR, SC4)						
11.1	Are the correct Information Technology (IT) issue codes used?	N/A				
TIP	If IT issues are not coded correctly (with "C" in 6th position), they will not appear in the Schedule IV.					
12. SCHEDULE VIIIA (EADR, SC8A)						
12.1	Is there only one #1 priority, one #2 priority, one #3 priority, etc. reported on the Schedule VIII-A? Are the priority narrative explanations adequate?	Y				
13. SCHEDULE VIIIB-1 (EADR, S8B1)						
13.1	**NOT REQUIRED FOR THIS YEAR**	N/A				
14. SCHEDULE VIIIB-2 (EADR, S8B2)						
14.1	Do the reductions comply with the instructions provided on pages 102 through 104 of the LBR Instructions regarding a 10% reduction in recurring General Revenue and Trust Funds, including the verification that the 3BXXX0 issue has not been used?	Y				
15. SCHEDULE XI (LAS/PBS Web - see page 108 of the LBR Instructions for detailed instructions)						
15.1	Agencies are required to generate this spreadsheet via the LAS/PBS Web. The Final Excel version no longer has to be submitted to OPB for inclusion on the Governor's Florida Performs Website. (Note: Pursuant to section 216.023(4) (b), Florida Statutes, the Legislature can reduce the funding level for any agency that does not provide this information.)	Y				
15.2	Do the PDF files uploaded to the Florida Fiscal Portal for the LRPP and LBR match the Excel file e-mailed to OPB?	Y				
AUDITS INCLUDED IN THE SCHEDULE XI REPORT:						
15.3	Does the FY 2010-11 Actual (prior year) Expenditures in Column A36 reconcile to Column A01? (**GENR, ACT1)**	Y				
15.4	None of the executive direction, administrative support and information technology statewide activities (ACT0010 thru ACT0490) have output standards (Record Type 5)? **(Audit #1 should print "No Activities Found")**	Y				
15.5	Does the Fixed Capital Outlay (FCO) statewide activity (ACT0210) only contain 08XXXX or 14XXXX appropriation categories? **(Audit #2 should print "No Operating Categories Found")**	N/A				

	Action	Program or Service (Budget Entity Codes)				
		68501400				
15.6	Has the agency provided the necessary demand (Record Type 5) for all activities which should appear in Section II? (Note: Audit #3 will identify those activities that do NOT have a Record Type '5' and have not been identified as a 'Pass Through' activity. These activities will be displayed in Section III with the 'Payment of Pensions, Benefits and Claims' activity and 'Other' activities. Verify if these activities should be displayed in Section III. If not, an output standard would need to be added for that activity and the Schedule XI submitted again.)	Y				
15.7	Does Section I (Final Budget for Agency) and Section III (Total Budget for Agency) equal? **(Audit #4 should print "No Discrepancies Found")**	Y				
TIP	If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.					
16. MANUALLY PREPARED EXHIBITS & SCHEDULES						
16.1	Do exhibits and schedules comply with LBR Instructions (pages 110 through 154 of the LBR Instructions), and are they accurate and complete?	Y				
16.2	Are appropriation category totals comparable to Exhibit B, where applicable?	Y				
16.3	Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y				
AUDITS - GENERAL INFORMATION						
TIP	Review Section 6: Audits of the LBR Instructions (pages 156-158) for a list of audits and their descriptions.					
TIP	Reorganizations may cause audit errors. Agencies must indicate that these errors are due to an agency reorganization to justify the audit error.					
17. CAPITAL IMPROVEMENTS PROGRAM (CIP)						
17.1	Are the CIP-2, CIP-3, CIP-A and CIP-B forms included?	N/A				
17.2	Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	N/A				
17.3	Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	N/A				
17.4	Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	N/A				
17.5	Are the appropriate counties identified in the narrative?	N/A				
17.6	Has the CIP-2 form (Exibit B) been modified to include the agency priority for each project and the modified form saved as a PDF document?	N/A				
TIP	Requests for Fixed Capital Outlay appropriations which are Grants and Aids to Local Governments and Non-Profit Organizations must use the Grants and Aids to Local Governments and Non-Profit Organizations - Fixed Capital Outlay major appropriation category (140XXX) and include the sub-title "Grants and Aids". These appropriations utilize a CIP-B form as justification.					

	Program or Service (Budget Entity Codes)				
Action	68501400				

18. FLORIDA FISCAL PORTAL						
18.1	Have all files been assembled correctly and posted to the Florida Fiscal Portal as outlined in the Florida Fiscal Portal Submittal Process?	Y				
19. CREATION OF DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)						
19.1	If you are an agency that no longer exists or is transferred to DEO after the approval of the reorganization by the Legislative Budget Commission (LBC), have you submitted the following schedules, as applicable: · Schedule I: Trust Funds Available and Schedule IB - DEPARTMENT LEVEL · Schedule IA: Detail of Fees and Related Costs (Part I and Part II) · Schedule IC: Reconciliation of Unreserved Fund Balances · Reconciliation: Beginning Trial Balance to Schedule I and IC · Exhibit D-1: Detail of Expenses · Schedule XI: Agency-Level Unit Cost Summary · Opening Trial Balance as of July 1, 2011 · Schedule I Narratives related to Column A01 · Inter-Agency Transfer Form	N/A				

Fiscal Year 2012-13 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Adminstration / Long Term Care

Agency Budget Officer/OPB Analyst Name: Michele Tallent / Kate West

A "Y" indicates "YES" and is acceptable, an "N/J" indicates "NO/Justification Provided" - these require further explanation/justification (additional sheets can be used as necessary), and "TIPS" are other areas to consider.

		Program or Service (Budget Entity Codes)				
	Action	68501500				
1. GENERAL						
1.1	Are Columns A01, A02, A04, A05, A36, A90, A91, A92, A93, A94, A95, IA1, IA4, IA5, IP1,V1, IV3 and NV1 set to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for both the Budget and Trust Fund columns? Are Columns A06, A07, A08 and A09 for Fixed Capital Outlay (FCO) set to TRANSFER CONTROL for DISPLAY status only? **(CSDI)**	Y				
1.2	Is Column A03 set to TRANSFER CONTROL for DISPLAY and UPDATE status for both the Budget and Trust Fund columns? **(CSDI)**	Y				
AUDITS:						
1.3	Has Column A03 been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y				
1.4	Has security been set correctly? **(CSDR, CSA)**	Y				
TIP	The agency should prepare the budget request for submission in this order: 1) Lock columns as described above; 2) copy Column A03 to Column A12; and 3) set Column A12 column security to ALL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status.					
2. EXHIBIT A (EADR, EXA)						
2.1	Is the budget entity authority and description consistent with the agency's LRPP and does it conform to the directives provided on page 56 of the LBR Instructions?	Y				
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y				
2.3	Are the issue codes and titles consistent with *Section 3* of the LBR Instructions (pages 15 through 30)? Do they clearly describe the issue?	Y				
2.4	Have the coding guidelines in *Section 3* of the LBR Instructions (pages 15 through 30) been followed?	Y				
3. EXHIBIT B (EXBR, EXB)						
3.1	Is it apparent that there is a fund shift and were the issues entered into LAS/PBS correctly? Check D-3A funding shift issue 340XXX0 - a unique deduct and unique add back issue should be used to ensure fund shifts display correctly on the LBR exhibits.	N/A				
3.2	Are the 33XXXX0 issues negative amounts only and do not restore nonrecurring cuts from a prior year or fund any issues that net to a positive or zero amount? Check D-3A issues 33XXXX0 - a unique issue should be used for issues that net to zero or a positive amount.	N/A				

	Program or Service (Budget Entity Codes)				
Action	68501500				

AUDITS:						
3.3	Negative Appropriation Category Audit for Agency Request (Columns A03 and A04): Are all appropriation categories positive by budget entity at the FSI level? Are all nonrecurring amounts less than requested amounts? **(NACR, NAC - Report should print "No Negative Appropriation Categories Found")**	Y				
3.4	Current Year Estimated Verification Comparison Report: Is Column A02 equal to Column B07? **(EXBR, EXBC - Report should print "Records Selected Net To Zero")**	Y				
TIP	Generally look for and be able to fully explain significant differences between A02 and A03.					
TIP	Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.					
TIP	Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, the Special Categories appropriation category (10XXXX) should be used.					
4. EXHIBIT D (EADR, EXD)						
4.1	Is the program component objective statement consistent with the agency LRPP, and does it conform to the directives provided on page 62of the LBR Instructions?	Y				
4.2	Is the program component code and title used correct?	Y				
TIP	Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.					
5. EXHIBIT D-1 (ED1R, EXD1)						
5.1	Are all object of expenditures positive amounts? (This is a manual check.)	Y				
AUDITS:						
5.2	Do the fund totals agree with the object category totals within each appropriation category? **(ED1R, XD1A - Report should print "No Differences Found For This Report")**	Y				
5.3	FLAIR Expenditure/Appropriation Ledger Comparison Report: Is Column A01 less than Column B04? **(EXBR, EXBB - Negative differences need to be corrected in Column A01.)**	Y				
5.4	A01/State Accounts Disbursements and Carry Forward Comparison Report: Does Column A01 equal Column B08? **(EXBR, EXBD - Differences need to be corrected in Column A01.)**	Y				

	Program or Service (Budget Entity Codes)				
Action	68501500				

TIP	If objects are negative amounts, the agency must make adjustments to Column A01 to correct the object amounts. In addition, the fund totals must be adjusted to reflect the adjustment made to the object data.					
TIP	If fund totals and object totals do not agree or negative object amounts exist, the agency must adjust Column A01.					
TIP	Exhibit B - A01 less than B04: This audit is to ensure that the disbursements and carry/certifications forward in A01 are less than FY 2009-10 approved budget. Amounts should be positive.					
TIP	If B08 is not equal to A01, check the following: 1) the initial FLAIR disbursements or carry forward data load was corrected appropriately in A01; 2) the disbursement data from departmental FLAIR was reconciled to State Accounts; and 3) the FLAIR disbursements did not change after Column B08 was created.					
6. EXHIBIT D-3 (ED3R, ED3) (Not required in the LBR - for analytical purposes only.)						
6.1	Are issues appropriately aligned with appropriation categories?	Y				
TIP	Exhibit D-3 is no longer required in the budget submission but may be needed for this particular appropriation category/issue sort. Exhibit D-3 is also a useful report when identifying negative appropriation category problems.					
7. EXHIBIT D-3A (EADR, ED3A)						
7.1	Are the issue titles correct and do they clearly identify the issue? (See pages 15 through 30 of the LBR Instructions.)	N/A				
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See page 65 of the LBR Instructions.)	N/A				
7.3	Does the narrative for Information Technology (IT) issue follow the additional narrative requirements described on pages 66 through 70 of the LBR Instructions?	N/A				
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	N/A				
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E-4 and E-5 of the LBR Instructions.)	N/A				
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	N/A				
7.7	Does the issue narrative thoroughly explain/justify all Salaries and Benefits amounts entered into the Other Salary Amounts transactions (OADA/C)? Amounts entered into OAD are reflected in the Position Detail of Salaries and Benefits section of the Exhibit D-3A.	N/A				

	Program or Service (Budget Entity Codes)				
Action	68501500				

7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A				
7.9	Does the issue narrative reference the specific county(ies) where applicable?	N/A				
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #12-009?	N/A				
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A				
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A				
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A				
7.14	Do the amounts reflect appropriate FSI assignments?	N/A				
7.15	Do the issues relating to *salary and benefits* have an "A" in the fifth position of the issue code (XXXXAXX) and are they self-contained (not combined with other issues)? (See page 26 and 86 of the LBR Instructions.)	N/A				
7.16	Do the issues relating to Information Technology (IT) have a "C" in the sixth position of the issue code (36XXXCX) and are the correct issue codes used (361XXC0, 362XXC0, 363XXC0, 17C01C0, 17C02C0, 17C03C0, 24010C0, 33001C0 or 55C01C0)? Have the correct issue codes been used for the Statewide Email Consolidation (17C10C0, 17C11C0, 17C14C0, 33015C0 and 55C04C0)	N/A				
7.17	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A				
AUDIT:						
7.18	Are all FSI's equal to '1', '2', '3', or '9'? There should be no FSI's equal to '0'. **(EADR, FSIA - Report should print "No Records Selected For Reporting")**	N/A				
7.19	Does the General Revenue for 160XXXX (Adjustments to Current Yeer Expenditures) issues net to zero? (GENR, LBR1)	N/A				
7.20	Does the General Revenue for 180XXXX (Intra-Agency Reorgaznizations) issues net to zero? (GENR, LBR2)	N/A				
7.21	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? (GENR, LBR3)	N/A				

		Program or Service (Budget Entity Codes)				
	Action	68501500				
7.22	Have FCO appropriations been entered into the nonrecurring column A04? **(GENR, LBR4 - Report should print "No Records Selected For Reporting" or a listing of D-3A issue(s) assigned to Debt Service (IOE N) or in some cases State Capital Outlay - Public Education Capital Outlay (IOE L))**	N/A				
TIP	Salaries and Benefits amounts entered using the OADA/C transactions must be thoroughly justified in the D-3A issue narrative. Agencies can run **OADA/OADR** from STAM to identify the amounts entered into OAD and ensure these entries have been thoroughly explained in the D-3A issue narrative.					
TIP	The issue narrative must completely and thoroughly explain and justify each D-3A issue. Agencies must ensure it provides the information necessary for the OPB and legislative analysts to have a complete understanding of the issue submitted. Thoroughly review pages 67 through 71 of the LBR Instructions.					
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.					
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).					
TIP	If an appropriation made in the FY 2011-12 General Appropriations Act duplicates an appropriation made in substantive legislation, the agency must create a unique deduct nonrecurring issue to eliminate the duplicated appropriation. Normally this is taken care of through line item veto.					
8. SCHEDULE I & RELATED DOCUMENTS (SC1R, SC1 - Budget Entity Level *or* SC1R, SC1D - Department Level)						
8.1	Has a separate department level Schedule I and supporting documents package been submitted by the agency?	Y				
8.2	Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y				
8.3	Have the appropriate Schedule I supporting documents been included for the trust funds (Schedule IA, Schedule IB, Schedule IC, and Reconciliation to Trial Balance)?	Y				
8.4	Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs?	Y				
8.5	Have the required detailed narratives been provided (5% trust fund reserve narrative; method for computing the distribution of cost for general management and administrative services narrative; adjustments narrative; revenue estimating methodology narrative)?	Y				

	Action	Program or Service (Budget Entity Codes)				
		68501500				
8.6	Has the Inter-Agency Transfers Reported on Schedule I form been included as applicable for transfers totaling $100,000 or more for the fiscal year?	Y				
8.7	If the agency is scheduled for the annual trust fund review this year, have the Schedule ID and applicable draft legislation been included for recreation, modification or termination of existing trust funds?	Y				
8.8	If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to *section 215.32(2)(b), Florida Statutes* - including the Schedule ID and applicable legislation?	Y				
8.9	Are the revenue codes correct? In the case of federal revenues, has the agency appropriately identified direct versus indirect receipts (object codes 000700, 000750, 000799, 001510 and 001599)?	Y				
8.10	Are the statutory authority references correct?	Y				
8.11	Are the General Revenue Service Charge percentage rates used for each revenue source correct? (Refer to Chapter 2009-78, Laws of Florida, for appropriate general revenue service charge percentage rates.)	Y				
8.12	Is this an accurate representation of revenues based on the most recent Consensus Estimating Conference forecasts?	Y				
8.13	If there is no Consensus Estimating Conference forecast available, do the revenue estimates appear to be reasonable?	Y				
8.14	Are the federal funds revenues reported in Section I broken out by individual grant? Are the correct CFDA codes used?	Y				
8.15	Are anticipated grants included and based on the state fiscal year (rather than federal fiscal year)?	Y				
8.16	Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y				
8.17	If applicable, are nonrecurring revenues entered into Column A04?	Y				
8.18	Has the agency certified the revenue estimates in columns A02 and A03 to be the latest and most accurate available? Does the certification include a statement that the agency will notify OPB of any significant changes in revenue estimates that occur prior to the Governor's Budget Recommendations being issued?	Y				
8.19	Is a 5% trust fund reserve reflected in Section II? If not, is sufficient justification provided for exemption? Are the additional narrative requirements provided?	Y				
8.20	Are appropriate service charge nonoperating amounts included in Section II?	Y				
8.21	Are nonoperating expenditures to other budget entities/departments cross-referenced accurately?	Y				
8.22	Do transfers balance between funds (within the agency as well as between agencies)? (See also 8.6 for required transfer confirmation of amounts totaling $100,000 or more.)	Y				

		Program or Service (Budget Entity Codes)				
	Action	68501500				
8.23	Are nonoperating expenditures recorded in Section II and adjustments recorded in Section III?	Y				
8.24	Are prior year September operating reversions appropriately shown in column A01?	Y				
8.25	Are current year September operating reversions appropriately shown in column A02? **DUE TO THE EARLY TRANSMISSION DATE OF THE 2012-13 LBR, CERTIFIED FORWARD REVERSIONS AT 9/30/11 WILL NEED TO**	N/A				
8.26	Does the Schedule IC properly reflect the unreserved fund balance for each trust fund as defined by the LBR Instructions, and is it reconciled to the agency accounting records?	Y				
8.27	Does Column A01 of the Schedule I accurately represent the actual prior year accounting data as reflected in the agency accounting records, and is it provided in sufficient detail for analysis?	Y				
8.28	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y				
AUDITS:						
8.29	Is Line I a positive number? (If not, the agency must adjust the budget request to eliminate the deficit).	Y				
8.30	Is the June 30 Adjusted Unreserved Fund Balance (Line I) equal to the July 1 Unreserved Fund Balance (Line A) of the following year? If a Schedule IB was prepared, do the totals agree with the Schedule I, Line I? **(SC1R, SC1A - Report should print "No Discrepancies Exist For This Report")**	Y				
8.31	Has a Department Level Reconciliation been provided for each trust fund and does Line A of the Schedule I equal the CFO amount? If not, the agency must correct Line A. **(SC1R, DEPT)**	Y				
TIP	The Schedule I is the most reliable source of data concerning the trust funds. It is very important that this schedule is as accurate as possible!					
TIP	Determine if the agency is scheduled for trust fund review. (See page 125 of the LBR Instructions.)					
TIP	Review the unreserved fund balances and compare revenue totals to expenditure totals to determine and understand the trust fund status.					
TIP	Typically nonoperating expenditures and revenues should not be a negative number. Any negative numbers must be fully justified.					
9. SCHEDULE II (PSCR, SC2)						
AUDIT:						
9.1	Is the pay grade minimum for salary rate utilized for positions in segments 2 and 3? **(BRAR, BRAA - Report should print "No Records Selected For This Request")** Note: Amounts other than the pay grade minimum should be fully justified in the D-3A issue narrative. (See *Base Rate Audit* on page 157 of the LBR Instructions.)	N/A				

	Program or Service (Budget Entity Codes)				
Action	68501500				

10. SCHEDULE III (PSCR, SC3)						
10.1	Is the appropriate lapse amount applied in Segment 3? (See page 90 of the LBR Instructions.)	N/A				
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See page 97of the LBR Instructions for appropriate use of the OAD transaction.) Use **OADI** or **OADR** to identify agency other salary amounts requested.	N/A				
11. SCHEDULE IV (EADR, SC4)						
11.1	Are the correct Information Technology (IT) issue codes used?	N/A				
TIP	If IT issues are not coded correctly (with "C" in 6th position), they will not appear in the Schedule IV.					
12. SCHEDULE VIIIA (EADR, SC8A)						
12.1	Is there only one #1 priority, one #2 priority, one #3 priority, etc. reported on the Schedule VIII-A? Are the priority narrative explanations adequate?	Y				
13. SCHEDULE VIIIB-1 (EADR, S8B1)						
13.1	NOT REQUIRED FOR THIS YEAR	N/A				
14. SCHEDULE VIIIB-2 (EADR, S8B2)						
14.1	Do the reductions comply with the instructions provided on pages 102 through 104 of the LBR Instructions regarding a 10% reduction in recurring General Revenue and Trust Funds, including the verification that the 3BXXX0 issue has not been used?	Y				
15. SCHEDULE XI (LAS/PBS Web - see page 108 of the LBR Instructions for detailed instructions)						
15.1	Agencies are required to generate this spreadsheet via the LAS/PBS Web. The Final Excel version no longer has to be submitted to OPB for inclusion on the Governor's Florida Performs Website. (Note: Pursuant to section 216.023(4) (b), Florida Statutes, the Legislature can reduce the funding level for any agency that does not provide this information.)	Y				
15.2	Do the PDF files uploaded to the Florida Fiscal Portal for the LRPP and LBR match?	Y				
AUDITS INCLUDED IN THE SCHEDULE XI REPORT:						
15.3	Does the FY 2010-11 Actual (prior year) Expenditures in Column A36 reconcile to Column A01? (**GENR, ACT1)**	Y				
15.4	None of the executive direction, administrative support and information technology statewide activities (ACT0010 thru ACT0490) have output standards (Record Type 5)? **(Audit #1 should print "No Activities Found")**	Y				
15.5	Does the Fixed Capital Outlay (FCO) statewide activity (ACT0210) only contain 08XXXX or 14XXXX appropriation categories? **(Audit #2 should print "No Operating Categories Found")**	N/A				

	Action	Program or Service (Budget Entity Codes)				
		68501500				
15.6	Has the agency provided the necessary demand (Record Type 5) for all activities which should appear in Section II? (Note: Audit #3 will identify those activities that do NOT have a Record Type '5' and have not been identified as a 'Pass Through' activity. These activities will be displayed in Section III with the 'Payment of Pensions, Benefits and Claims' activity and 'Other' activities. Verify if these activities should be displayed in Section III. If not, an output standard would need to be added for that activity and the Schedule XI submitted again.)	Y				
15.7	Does Section I (Final Budget for Agency) and Section III (Total Budget for Agency) equal? **(Audit #4 should print "No Discrepancies Found")**	Y				
TIP	If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.					
16. MANUALLY PREPARED EXHIBITS & SCHEDULES						
16.1	Do exhibits and schedules comply with LBR Instructions (pages 110 through 154 of the LBR Instructions), and are they accurate and complete?	Y				
16.2	Are appropriation category totals comparable to Exhibit B, where applicable?	Y				
16.3	Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y				
AUDITS - GENERAL INFORMATION						
TIP	Review Section 6: Audits of the LBR Instructions (pages 156-158) for a list of audits and their descriptions.					
TIP	Reorganizations may cause audit errors. Agencies must indicate that these errors are due to an agency reorganization to justify the audit error.					
17. CAPITAL IMPROVEMENTS PROGRAM (CIP)						
17.1	Are the CIP-2, CIP-3, CIP-A and CIP-B forms included?	N/A				
17.2	Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	N/A				
17.3	Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	N/A				
17.4	Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	N/A				
17.5	Are the appropriate counties identified in the narrative?	N/A				
17.6	Has the CIP-2 form (Exibit B) been modified to include the agency priority for each project and the modified form saved as a PDF document?	N/A				
TIP	Requests for Fixed Capital Outlay appropriations which are Grants and Aids to Local Governments and Non-Profit Organizations must use the Grants and Aids to Local Governments and Non-Profit Organizations - Fixed Capital Outlay major appropriation category (140XXX) and include the sub-title "Grants and Aids". These appropriations utilize a CIP-B form as justification.					

	Program or Service (Budget Entity Codes)				
Action	68501500				

18. FLORIDA FISCAL PORTAL						
18.1	Have all files been assembled correctly and posted to the Florida Fiscal Portal as outlined in the Florida Fiscal Portal Submittal Process?	Y				
19. CREATION OF DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)						
19.1	If you are an agency that no longer exists or is transferred to DEO after the approval of the reorganization by the Legislative Budget Commission (LBC), have you submitted the following schedules, as applicable: · Schedule I: Trust Funds Available and Schedule IB - DEPARTMENT LEVEL · Schedule IA: Detail of Fees and Related Costs (Part I and Part II) · Schedule IC: Reconciliation of Unreserved Fund Balances · Reconciliation: Beginning Trial Balance to Schedule I and IC · Exhibit D-1: Detail of Expenses · Schedule XI: Agency-Level Unit Cost Summary · Opening Trial Balance as of July 1, 2011 · Schedule I Narratives related to Column A01 · Inter-Agency Transfer Form	N/A				

Fiscal Year 2012-13 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Adminstration / Health Care Regulation

Agency Budget Officer/OPB Analyst Name: Michele Tallent / Kate West

A "Y" indicates "YES" and is acceptable, an "N/J" indicates "NO/Justification Provided" - these require further explanation/justification (additional sheets can be used as necessary), and "TIPS" are other areas to consider.

		Program or Service (Budget Entity Codes)				
	Action	68700700				
1. GENERAL						
1.1	Are Columns A01, A02, A04, A05, A36, A90, A91, A92, A93, A94, A95, IA1, IA4, IA5, IP1,V1, IV3 and NV1 set to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for both the Budget and Trust Fund columns? Are Columns A06, A07, A08 and A09 for Fixed Capital Outlay (FCO) set to TRANSFER CONTROL for DISPLAY status only? **(CSDI)**	Y				
1.2	Is Column A03 set to TRANSFER CONTROL for DISPLAY and UPDATE status for both the Budget and Trust Fund columns? **(CSDI)**	Y				
AUDITS:						
1.3	Has Column A03 been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y				
1.4	Has security been set correctly? **(CSDR, CSA)**	Y				
TIP	The agency should prepare the budget request for submission in this order: 1) Lock columns as described above; 2) copy Column A03 to Column A12; and 3) set Column A12 column security to ALL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status.					
2. EXHIBIT A (EADR, EXA)						
2.1	Is the budget entity authority and description consistent with the agency's LRPP and does it conform to the directives provided on page 56 of the LBR Instructions?	Y				
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y				
2.3	Are the issue codes and titles consistent with *Section 3* of the LBR Instructions (pages 15 through 30)? Do they clearly describe the issue?	Y				
2.4	Have the coding guidelines in *Section 3* of the LBR Instructions (pages 15 through 30) been followed?	Y				
3. EXHIBIT B (EXBR, EXB)						
3.1	Is it apparent that there is a fund shift and were the issues entered into LAS/PBS correctly? Check D-3A funding shift issue 340XXX0 - a unique deduct and unique add back issue should be used to ensure fund shifts display correctly on the LBR exhibits.	N/A				
3.2	Are the 33XXXX0 issues negative amounts only and do not restore nonrecurring cuts from a prior year or fund any issues that net to a positive or zero amount? Check D-3A issues 33XXXX0 - a unique issue should be used for issues that net to zero or a positive amount.	N/A				

	Program or Service (Budget Entity Codes)				
Action	68700700				

AUDITS:						
3.3	Negative Appropriation Category Audit for Agency Request (Columns A03 and A04): Are all appropriation categories positive by budget entity at the FSI level? Are all nonrecurring amounts less than requested amounts? **(NACR, NAC - Report should print "No Negative Appropriation Categories Found")**	Y				
3.4	Current Year Estimated Verification Comparison Report: Is Column A02 equal to Column B07? **(EXBR, EXBC - Report should print "Records Selected Net To Zero")**	Y				
TIP	Generally look for and be able to fully explain significant differences between A02 and A03.					
TIP	Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.					
TIP	Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, the Special Categories appropriation category (10XXXX) should be used.					
4. EXHIBIT D (EADR, EXD)						
4.1	Is the program component objective statement consistent with the agency LRPP, and does it conform to the directives provided on page 62 of the LBR Instructions?	Y				
4.2	Is the program component code and title used correct?	Y				
TIP	Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.					
5. EXHIBIT D-1 (ED1R, EXD1)						
5.1	Are all object of expenditures positive amounts? (This is a manual check.)	Y				
AUDITS:						
5.2	Do the fund totals agree with the object category totals within each appropriation category? **(ED1R, XD1A - Report should print "No Differences Found For This Report")**	Y				
5.3	FLAIR Expenditure/Appropriation Ledger Comparison Report: Is Column A01 less than Column B04? **(EXBR, EXBB - Negative differences need to be corrected in Column A01.)**	Y				
5.4	A01/State Accounts Disbursements and Carry Forward Comparison Report: Does Column A01 equal Column B08? **(EXBR, EXBD - Differences need to be corrected in Column A01.)**	Y				

	Program or Service (Budget Entity Codes)				
Action	68700700				

TIP	If objects are negative amounts, the agency must make adjustments to Column A01 to correct the object amounts. In addition, the fund totals must be adjusted to reflect the adjustment made to the object data.					
TIP	If fund totals and object totals do not agree or negative object amounts exist, the agency must adjust Column A01.					
TIP	Exhibit B - A01 less than B04: This audit is to ensure that the disbursements and carry/certifications forward in A01 are less than FY 2009-10 approved budget. Amounts should be positive.					
TIP	If B08 is not equal to A01, check the following: 1) the initial FLAIR disbursements or carry forward data load was corrected appropriately in A01; 2) the disbursement data from departmental FLAIR was reconciled to State Accounts; and 3) the FLAIR disbursements did not change after Column B08 was created.					
6. EXHIBIT D-3 (ED3R, ED3) (Not required in the LBR - for analytical purposes only.)						
6.1	Are issues appropriately aligned with appropriation categories?	Y				
TIP	Exhibit D-3 is no longer required in the budget submission but may be needed for this particular appropriation category/issue sort. Exhibit D-3 is also a useful report when identifying negative appropriation category problems.					
7. EXHIBIT D-3A (EADR, ED3A)						
7.1	Are the issue titles correct and do they clearly identify the issue? (See pages 15 through 30 of the LBR Instructions.)	Y				
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See page 65 of the LBR Instructions.)	Y				
7.3	Does the narrative for Information Technology (IT) issue follow the additional narrative requirements described on pages 69 through 70of the LBR Instructions?	Y				
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	Y				
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E-4 and E-5 of the LBR Instructions.)	N/A				
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	N/A				
7.7	Does the issue narrative thoroughly explain/justify all Salaries and Benefits amounts entered into the Other Salary Amounts transactions (OADA/C)? Amounts entered into OAD are reflected in the Position Detail of Salaries and Benefits section of the Exhibit D-3A.	N/A				

	Program or Service (Budget Entity Codes)				
Action	68700700				

7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A				
7.9	Does the issue narrative reference the specific county(ies) where applicable?	N/A				
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #12-009?	N/A				
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A				
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A				
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A				
7.14	Do the amounts reflect appropriate FSI assignments?	Y				
7.15	Do the issues relating to *salary and benefits* have an "A" in the fifth position of the issue code (XXXXAXX) and are they self-contained (not combined with other issues)? (See page 29 and 88of the LBR Instructions.)	N/A				
7.16	Do the issues relating to Information Technology (IT) have a "C" in the sixth position of the issue code (36XXXCX) and are the correct issue codes used (361XXC0, 362XXC0, 363XXC0, 17C01C0, 17C02C0, 17C03C0, 24010C0, 33001C0 or 55C01C0)? Have the correct issue codes been used for the Statewide Email Consolidation (17C10C0, 17C11C0, 17C14C0, 33015C0 and 55C04C0)	Y				
7.17	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A				
AUDIT:						
7.18	Are all FSI's equal to '1', '2', '3', or '9'? There should be no FSI's equal to '0'. **(EADR, FSIA - Report should print "No Records Selected For Reporting")**	Y				
7.19	Does the General Revenue for 160XXXX (Adjustments to Current Yeer Expenditures) issues net to zero? **(GENR, LBR1)**	N/A				
7.20	Does the General Revenue for 180XXXX (Intra-Agency Reorgaznizations) issues net to zero? **(GENR, LBR2)**	N/A				
7.21	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? **(GENR, LBR3)**	N/A				

	Program or Service (Budget Entity Codes)				
Action	68700700				

7.22	Have FCO appropriations been entered into the nonrecurring column A04? **(GENR, LBR4 - Report should print "No Records Selected For Reporting" or a listing of D-3A issue(s) assigned to Debt Service (IOE N) or in some cases State Capital Outlay - Public Education Capital Outlay (IOE L))**	N/A				
TIP	Salaries and Benefits amounts entered using the OADA/C transactions must be thoroughly justified in the D-3A issue narrative. Agencies can run **OADA/OADR** from STAM to identify the amounts entered into OAD and ensure these entries have been thoroughly explained in the D-3A issue narrative.					
TIP	The issue narrative must completely and thoroughly explain and justify each D-3A issue. Agencies must ensure it provides the information necessary for the OPB and legislative analysts to have a complete understanding of the issue submitted. Thoroughly review pages 67 through 71 of the LBR Instructions.					
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.					
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).					
TIP	If an appropriation made in the FY 2011-12 General Appropriations Act duplicates an appropriation made in substantive legislation, the agency must create a unique deduct nonrecurring issue to eliminate the duplicated appropriation. Normally this is taken care of through line item veto.					
8. SCHEDULE I & RELATED DOCUMENTS (SC1R, SC1 - Budget Entity Level *or* SC1R, SC1D - Department Level)						
8.1	Has a separate department level Schedule I and supporting documents package been submitted by the agency?	Y				
8.2	Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y				
8.3	Have the appropriate Schedule I supporting documents been included for the trust funds (Schedule IA, Schedule IB, Schedule IC, and Reconciliation to Trial Balance)?	Y				
8.4	Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs?	Y				
8.5	Have the required detailed narratives been provided (5% trust fund reserve narrative; method for computing the distribution of cost for general management and administrative services narrative; adjustments narrative; revenue estimating methodology narrative)?	Y				

	Program or Service (Budget Entity Codes)				
Action	68700700				
8.6 Has the Inter-Agency Transfers Reported on Schedule I form been included as applicable for transfers totaling $100,000 or more for the fiscal year?	Y				
8.7 If the agency is scheduled for the annual trust fund review this year, have the Schedule ID and applicable draft legislation been included for recreation, modification or termination of existing trust funds?	Y				
8.8 If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to *section 215.32(2)(b), Florida Statutes* - including the Schedule ID and applicable legislation?	Y				
8.9 Are the revenue codes correct? In the case of federal revenues, has the agency appropriately identified direct versus indirect receipts (object codes 000700, 000750, 000799, 001510 and 001599)?	Y				
8.10 Are the statutory authority references correct?	Y				
8.11 Are the General Revenue Service Charge percentage rates used for each revenue source correct? (Refer to Chapter 2009-78, Laws of Florida, for appropriate general revenue service charge percentage rates.)	Y				
8.12 Is this an accurate representation of revenues based on the most recent Consensus Estimating Conference forecasts?	Y				
8.13 If there is no Consensus Estimating Conference forecast available, do the revenue estimates appear to be reasonable?	Y				
8.14 Are the federal funds revenues reported in Section I broken out by individual grant? Are the correct CFDA codes used?	Y				
8.15 Are anticipated grants included and based on the state fiscal year (rather than federal fiscal year)?	Y				
8.16 Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y				
8.17 If applicable, are nonrecurring revenues entered into Column A04?	Y				
8.18 Has the agency certified the revenue estimates in columns A02 and A03 to be the latest and most accurate available? Does the certification include a statement that the agency will notify OPB of any significant changes in revenue estimates that occur prior to the Governor's Budget Recommendations being issued?	Y				
8.19 Is a 5% trust fund reserve reflected in Section II? If not, is sufficient justification provided for exemption? Are the additional narrative requirements provided?	Y				
8.20 Are appropriate service charge nonoperating amounts included in Section II?	Y				
8.21 Are nonoperating expenditures to other budget entities/departments cross-referenced accurately?	Y				
8.22 Do transfers balance between funds (within the agency as well as between agencies)? (See also 8.6 for required transfer confirmation of amounts totaling $100,000 or more.)	Y				

		Program or Service (Budget Entity Codes)				
	Action	68700700				
8.23	Are nonoperating expenditures recorded in Section II and adjustments recorded in Section III?	Y				
8.24	Are prior year September operating reversions appropriately shown in column A01?	Y				
8.25	Are current year September operating reversions appropriately shown in column A02? **DUE TO THE EARLY TRANSMISSION DATE OF THE 2012-13 LBR, CERTIFIED FORWARD REVERSIONS AT 9/30/11 WILL NEED TO BE ADDED BY AGENCIES DURING THE TECHNICAL REVIEW PERIOD.**	N/A				
8.26	Does the Schedule IC properly reflect the unreserved fund balance for each trust fund as defined by the LBR Instructions, and is it reconciled to the agency accounting records?	Y				
8.27	Does Column A01 of the Schedule I accurately represent the actual prior year accounting data as reflected in the agency accounting records, and is it provided in sufficient detail for analysis?	Y				
8.28	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y				
AUDITS:						
8.29	Is Line I a positive number? (If not, the agency must adjust the budget request to eliminate the deficit).	Y				
8.30	Is the June 30 Adjusted Unreserved Fund Balance (Line I) equal to the July 1 Unreserved Fund Balance (Line A) of the following year? If a Schedule IB was prepared, do the totals agree with the Schedule I, Line I? **(SC1R, SC1A - Report should print "No Discrepancies Exist For This Report")**	Y				
8.31	Has a Department Level Reconciliation been provided for each trust fund and does Line A of the Schedule I equal the CFO amount? If not, the agency must correct Line A. **(SC1R, DEPT)**	Y				
TIP	The Schedule I is the most reliable source of data concerning the trust funds. It is very important that this schedule is as accurate as possible!					
TIP	Determine if the agency is scheduled for trust fund review. (See page 125 of the LBR Instructions.)					
TIP	Review the unreserved fund balances and compare revenue totals to expenditure totals to determine and understand the trust fund status.					
TIP	Typically nonoperating expenditures and revenues should not be a negative number. Any negative numbers must be fully justified.					
9. SCHEDULE II (PSCR, SC2)						
AUDIT:						
9.1	Is the pay grade minimum for salary rate utilized for positions in segments 2 and 3? **(BRAR, BRAA - Report should print "No Records Selected For This Request")** Note: Amounts other than the pay grade minimum should be fully justified in the D-3A issue narrative. (See *Base Rate Audit* on page 157 of the LBR Instructions.)	Y				

	Program or Service (Budget Entity Codes)				
Action	68700700				

10. SCHEDULE III (PSCR, SC3)						
10.1	Is the appropriate lapse amount applied in Segment 3? (See page 90of the LBR Instructions.)	Y				
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See page 97 of the LBR Instructions for appropriate use of the OAD transaction.) Use **OADI** or **OADR** to identify agency other salary amounts requested.	Y				
11. SCHEDULE IV (EADR, SC4)						
11.1	Are the correct Information Technology (IT) issue codes used?	Y				
TIP	If IT issues are not coded correctly (with "C" in 6th position), they will not appear in the Schedule IV.					
12. SCHEDULE VIIIA (EADR, SC8A)						
12.1	Is there only one #1 priority, one #2 priority, one #3 priority, etc. reported on the Schedule VIII-A? Are the priority narrative explanations adequate?	Y				
13. SCHEDULE VIIIB-1 (EADR, S8B1)						
13.1	**NOT REQUIRED FOR THIS YEAR**	N/A				
14. SCHEDULE VIIIB-2 (EADR, S8B2)						
14.1	Do the reductions comply with the instructions provided on pages 102 through 104 of the LBR Instructions regarding a 10% reduction in recurring General Revenue and Trust Funds, including the verification that the 3BXXX0 issue has not been used?	Y				
15. SCHEDULE XI (LAS/PBS Web - see page 108 of the LBR Instructions for detailed instructions)						
15.1	Agencies are required to generate this spreadsheet via the LAS/PBS Web. **The Final Excel version no longer has to be submitted to OPB for inclusion on the Governor's Florida Performs Website.** (Note: Pursuant to *section 216.023(4)(b), Florida Statutes,* the Legislature can reduce the funding level for any agency that does not provide this information.)	Y				
15.2	Do the PDF files uploaded to the Florida Fiscal Portal for the LRPP and LBR match?	Y				
AUDITS INCLUDED IN THE SCHEDULE XI REPORT:						
15.3	Does the FY 2010-11 Actual (prior year) Expenditures in Column A36 reconcile to Column A01? (**GENR, ACT1)**	Y				
15.4	None of the executive direction, administrative support and information technology statewide activities (ACT0010 thru ACT0490) have output standards (Record Type 5)? **(Audit #1 should print "No Activities Found")**	Y				
15.5	Does the Fixed Capital Outlay (FCO) statewide activity (ACT0210) only contain 08XXXX or 14XXXX appropriation categories? **(Audit #2 should print "No Operating Categories Found")**	N/A				

	Action	Program or Service (Budget Entity Codes)				
		68700700				
15.6	Has the agency provided the necessary demand (Record Type 5) for all activities which should appear in Section II? (Note: Audit #3 will identify those activities that do NOT have a Record Type '5' and have not been identified as a 'Pass Through' activity. These activities will be displayed in Section III with the 'Payment of Pensions, Benefits and Claims' activity and 'Other' activities. Verify if these activities should be displayed in Section III. If not, an output standard would need to be added for that activity and the Schedule XI submitted again.)	Y				
15.7	Does Section I (Final Budget for Agency) and Section III (Total Budget for Agency) equal? **(Audit #4 should print "No Discrepancies Found")**	Y				
TIP	If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.					
16. MANUALLY PREPARED EXHIBITS & SCHEDULES						
16.1	Do exhibits and schedules comply with LBR Instructions (pages 110 through 154 of the LBR Instructions), and are they accurate and complete?	Y				
16.2	Are appropriation category totals comparable to Exhibit B, where applicable?	Y				
16.3	Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y				
AUDITS - GENERAL INFORMATION						
TIP	Review *Section 6: Audits* of the LBR Instructions (pages 156-158) for a list of audits and their descriptions.					
TIP	Reorganizations may cause audit errors. Agencies must indicate that these errors are due to an agency reorganization to justify the audit error.					
17. CAPITAL IMPROVEMENTS PROGRAM (CIP)						
17.1	Are the CIP-2, CIP-3, CIP-A and CIP-B forms included?	Y				
17.2	Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	N/A				
17.3	Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	Y				
17.4	Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	Y				
17.5	Are the appropriate counties identified in the narrative?	Y				
17.6	Has the CIP-2 form (Exibit B) been modified to include the agency priority for each project and the modified form saved as a PDF document?	Y				
TIP	Requests for Fixed Capital Outlay appropriations which are Grants and Aids to Local Governments and Non-Profit Organizations must use the Grants and Aids to Local Governments and Non-Profit Organizations - Fixed Capital Outlay major appropriation category (140XXX) and include the sub-title "Grants and Aids". These appropriations utilize a CIP-B form as justification.					

	Program or Service (Budget Entity Codes)				
Action	68700700				

18. FLORIDA FISCAL PORTAL						
18.1	Have all files been assembled correctly and posted to the Florida Fiscal Portal as outlined in the Florida Fiscal Portal Submittal Process?	Y				
19. CREATION OF DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)						
19.1	If you are an agency that no longer exists or is transferred to DEO after the approval of the reorganization by the Legislative Budget Commission (LBC), have you submitted the following schedules, as applicable: · Schedule I: Trust Funds Available and Schedule IB - DEPARTMENT LEVEL · Schedule IA: Detail of Fees and Related Costs (Part I and Part II) · Schedule IC: Reconciliation of Unreserved Fund Balances · Reconciliation: Beginning Trial Balance to Schedule I and IC · Exhibit D-1: Detail of Expenses · Schedule XI: Agency-Level Unit Cost Summary · Opening Trial Balance as of July 1, 2011 · Schedule I Narratives related to Column A01 · Inter-Agency Transfer Form	N/A				