AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

Fiscal Year 2013 - 2014

Statewide Medicaid Managed Care (SMMC)
Managed Medical Assistance (MMA)
Long-term Care Services
Access to Quality Health Care Services
Quality of Care
Optimizing Resources
Reduce/Eliminate Fraud and Abuse
Better Health Care for All
Streamlining through Regulatory Reduction
Administrative Infrastructure
Prevention, Detection, and Recovery
Strategic Planning
Cost Containment
Regulatory Reform
Health Information Technology
Independent Actuarial Analyses
Statewide Health Policy Flexibility
Enhancements through Technological Advances

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

October 15, 2012

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

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

Terry Rhodes, 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 2013-14 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

Temporary Special Duty – General Pay Additives Implementation Plan for Fiscal Year 2013-2014

Section 110.2035(7), Florida Statutes, prohibits implementing a Temporary Special Duties – General pay additive unless a written plan has been approved by the Executive Office of the Governor. The Agency for Health Care Administration (ACHA) requests approval of the following written plan and is not requesting any additional rate or appropriations for this additive.

In accordance with rule authority in 60L-32.0012, Florida Administrative Code, AHCA has used existing rate and salary appropriations to grant pay additives when warranted based on the duties and responsibilities of the position.

Pay additives are a valuable management tool which allows agencies to recognize and compensate employees for increased or additional duties without providing a permanent pay increase.

Temporary Special Duties – General Pay Additive

AHCA requests approval to grant a temporary special duties – general pay additive in accordance with the collective bargaining agreement and as follows:

1. Justification and Description:

   a) Out-of-Title - When an employee is temporarily assigned to act in a vacant higher level position and actually performs a major portion of the duties of the higher level position.
   b) Vacant – When an employee is temporarily assigned to act in a position and perform a major portion of the duties of the vacant position.
   c) Extended Leave – When an employee is temporarily assigned to act in a position and perform a major portion of the duties of an employee who is on extended leave other than FMLA or authorized military leave.
   d) Special Project – When an employee is temporarily assigned to perform special duties (assignment/project) not normally assigned to the employee's regular job duties.

2. When each type of additive will be initially in effect for the affected employee: AHCA will need to determine this additive on a case by case basis, assessing the proper alignment of the specifications and the reason for the additive being placed. For employees filling any vacant positions, the additive would be placed upon approval and assignment of the additional duties. However, employees who are identified as working "out-of-title" for a period of time that exceeds 22 workdays within any six consecutive months shall also be eligible to receive a temporary special duty – general pay additive beginning on the 23rd day in accordance with the Personnel Rules as stated in the American Federal State, County and Municipal Employees (AFSCME) Master Contract, Article 21.
3. Length of time additive will be used: A temporary special duties – general pay additive may be granted beginning with the first day of assigned additional duties. The additive may be in effect for up to 90 days at which time the circumstances under which the additive was implemented will be reviewed

to determine if the additive should be continued based on the absence of the position incumbent or continued vacant position.

4. The amount of each type of additive: General Pay Additives will range from 5-10 percent over the employee's current salary and be will applied accordingly after proper evaluation. These additives will be provided to positions that have been deemed "mission critical" and that fall into one of the justifications/descriptions stated above. In order to arrive at the total additive to be applied AHCA will use the below formula:

Based on the allotted 90 days (or a total of 18 cumulative weeks) which will total 720 work hours, we will use the current salary and then calculate the adjusted temporary salary by multiplying by our percentile increase. These two totals will be subtracted to get the difference, that difference will be multiplied by the 720 available hours to get the final additive amount. (See example below)

Current Position - PG 024 = $43, 507.36, hourly rate $20.92
With 10% additive - $43,507.36 X .10 = $4,350.74
Anticipated Salary - $43,507.36 + 4,350.74 = $47,858.10
New Hourly Rate - $23.01, difference in hourly rate - $23.01 - $20.92 = $2.09
Projected Additive Total – 720 hours X $2.09 = $1,504.80 is the 90 day difference

5. Classes and number of position affected: This pay additive could potentially affect any of our current 1,227 Career Service position incumbents statewide.

6. Historical Data: Last fiscal year, a total of two (2) FTE career service positions received general pay additives for performing the duties of a vacant position, both positions were considered "mission critical" and played a key role in carrying out the Agency's day-to-day operations. Both additives were in effect for the allotted 90 days.

7. Estimated annual cost of each type of additive: Employees assigned to Temporary Special Duties will be based on evaluation of duties and responsibilities for "mission critical" positions starting with pay grade 024 and above. Based on the last positions granted this additive and positions that have been identified for consideration, the average cost is:

Pay Grade	Annual Min. Salary	X 10%	Ann. Salary	# of FTE
024	$40,948.18	$4,094.82	1	
025	$43,507.36	$4,350.74	1	
026	$46,381.14	$4,638.11	1	

Based on the average estimated salaries stated above, the estimated calculation is as follows: $2,433.60 X 3 = $7,300.80. The agency is not requesting any additional rate or appropriations for this additive.

8. Additional Information: The classes included in this plan are represented by AFSCME Council 79. The relevant collective bargaining agreement language states as follows: "Increases to base rate of pay and salary additives shall be in accordance with state law and the Fiscal Year 2012-2013 General Appropriations Act." See Article 25, Section 1 (B) of the AFSCME Agreement. We would anticipate similar language in future agreements. AHCA has a past practice of providing these pay additives to bargaining unit employees.

Department Level Exhibits and Schedules

Non-Strategic IT Service:	**Network Service**				
Dept/Agency:	**Agency for Health Care Administration**				
Prepared by:	Scott Ward & Angela Findley				
Phone:	850-412-4812				
	Service Provisioning -- Assets & Resources *(Cost Elements)*	*Footnote Number*	*# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service*	*Number w/ costs in FY 2013-14*	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	**Personnel**		3.00		*$161,339*
A-1.1	State FTE	1	2.75		*$158,226*
A-2.1	OPS FTE	2	0.25		*$3,113*
A-3.1	Contractor Positions *(Staff Augmentation)*		0.00		*$0*
B.	**Hardware**				*$54,750*
B-1	Servers	3	20	0	*$0*
B-2	Server Maintenance & Support		0	0	*$0*
B-3	Network Devices & Hardware *(e.g., routers, switches, hubs, cabling, etc.)*	4	299	121	*$43,500*
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)*	5			*$11,250*
C.	**Software**	6			*$13,055*
D.	**External Service Provider(s)**				*$2,043,266*
D-1	MyFloridaNet	7			*$647,379*
D-2	Other *(Please specify in Footnote Section below)*	8			*$1,395,887*
E.	**Other** ***(Please describe in Footnotes Section below)***				*$0*
F.	**Total for IT Service**				**$2,272,410**
G.	**Please identify the number of users of the Network Service**				**1,853**
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.*
1	*For the total count of FTE there are 16 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 provides some portion of their time to this service while also shared with other IT Strategic and Non Strategic services.*
3	*20 VoIP servers - no cost for FY 13/14 as these servers are under manufacturer warranty*
4	*Total includes 120 Routers/Switches & 179 shared network printers; cost for FY13/14 includes Smartnet Support for Routers/Switches & lease for the Division of IT's one shared network printer*
5	*APC UPS's located at HQ and Area Offices*
6	*Solarwinds, Orion, Globalscape*
7	*DMS network lines*
8	*Wireless Air Cards ($199,139.75); DMS STEP 3 (VoIP) charges ($747,883.44); 800 Service ($89,055.07); Dedicated Long Distance ($51,265.91); Local Suncom Service ($256,769.64) & Reservationless Conferencing ($71,951.29)*
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Non-Strategic IT Service: # E-Mail, Messaging, and Calendaring Service

Agency: **Agency for Health Care Administration**
Prepared by: **Scott Ward & Angela Findley**
Phone: **850-412-4812**

	Service Provisioning -- Assets & Resources *(Cost Elements)*	Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number w/ costs in FY 2013-14	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	**Personnel**		1.00		*$52,184*
A-1	State FTE	1	0.75		*$46,996*
A-2	OPS FTE	2	0.25		*$5,188*
A-3	Contractor Positions *(Staff Augmentation)*		0.00		*$0*
B.	**Hardware**				*$93,891*
B-1	Servers	3	10	0	*$0*
B-2	Server Maintenance & Support		0	0	*$0*
B-3	Wireless Communication Devices *(e.g., Blackberries, iPhones, PDAs, etc.)*	4	156	156	*$93,891*
B-4	Online Storage *(indicate GB of storage)*	5	10000		*$0*
B-5	Archive Storage *(indicate GB of storage)*	6	8000		*$0*
B-6	Other Hardware Assets *(Please specify in Footnote Section below)*				*$0*
C.	**Software**	7			*$49,961*
D.	**External Service Provider(s)**				*$0*
D-1	Southwood Shared Resource Center				$0
D-2	Northwood Shared Resource Center	8			$0
D-3	Northwest Regional Data Center				$0
D-4	Other Data Center External Service Provider *(specify in Footnotes below)*				$0
E.	**Other** *(Please describe in Footnotes Section below)*				*$0*
F.	**Total for IT Service**				**$196,036**
G.	**Please provide the number of user mailboxes.**				**1,853**
H.	**Please provide the number of resource mailboxes.**				**239**

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	Servers include: 6 Exchange Servers (4 Production/2 DR), 3 Enterprise Vault, 1 Blackberry Enterprise Server located at the Northwood Shared Resource Center
4	Sprint mobile devices with data services - AHCA has 156 blackberry's. FY13/14 costs include monthly service plans & cost of replacements/upgrades.
5	Housed at Northwood Shared Resource Center
6	Housed at Northwood Shared Resource Center
7	Includes Exchange Enterprise Server Licenses ($2,334), Outlook (179th Office Pro @ $17,926), Lync Server ($1,698), Blackberry Enterprise Server ($4,003), Enterprise Vault ($24,000)
8	Servers & Ironport for Email reside @ Northwood Shared Resource Center - see DataCtr Tab
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Non-Strategic IT Service:

Desktop Computing Service

Agency: Agency for Health Care Administration
Prepared by: Scott Ward & Angela Findley
Phone: 850-412-4812

Service Provisioning -- Assets & Resources (Cost Elements)		Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service	Number w/ costs in FY 2013-14	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	**Personnel**		6.50		$385,859
A-1	State FTE	1, 2	6.25		$378,077
A-2	OPS FTE	3	0.25		$7,782
A-3	Contractor Positions (Staff Augmentation)		0.00		$0
B.	**Hardware**		2500	348	$281,400
B-1	Servers	6	3	0	$0
B-2	Server Maintenance & Support		0	0	$0
B-3.1	Desktop Computers	4, 9	1713	236	$165,200
B-3.2	Mobile Computers (e.g., Laptop, Notebook, Handheld, Wireless Computer)	5, 9	784	112	$116,200
B-3.3	Other Hardware Assets (Please specify in Footnote Section below)		0	0	$0
C.	**Software**	7			$365,369
D.	**External Service Provider(s)**		0	0	$0
E.	**Other** (Please describe in Footnotes Section below)	8			$120,000
F.	**Total for IT Service**				$1,152,628
G.	**Please identify the number of users of this service.**				1,853
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	For the total count of FTE there are 23 people/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 Agency Desktop PCs = 1713; FY 13/14 costs are for replacement of approximately 236 Agency desktop computers (per OPB direction, the planned replacement cycle for desktop PCs extended by 1 year to 5 year target).
5	784 includes Laptops & Tablets for daily business operations PLUS additional laptops for COOP/DR/Pandemic. FY 13/14 costs are for replacement of approximately 112 Agency mobile computers
6	3 Virtual Servers for LAN Desktop Support (Imaging & desktop security patch deployment)
7	Software includes: Office Pro, Windows OS, eCAL, Windows Remote Desktop, Project Professional, Visio
8	Colocation Costs - Rent, Agency Storage
9	Per OPB direction, the planned replacement cycle for desktop and Laptop PCs is extended by 1 year to 5 year target for Desktops, 4 year target for Laptops, 3 year target for tablets. Actual replacement rates will be dependent upon available funding.
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Non-Strategic IT Service: **Helpdesk Service**

Agency: **Agency for Health Care Administration**
Prepared by: **Scott Ward & Angela Findley**
Phone: **850-412-4812**

Service Provisioning -- Assets & Resources (Cost Elements)		Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number w/ costs in FY 2013-14	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel			3.25		$139,197
A-1	State FTE	1	2.25		$106,772
A-2	OPS FTE	2	1.00		$32,425
A-3	Contractor Positions *(Staff Augmentation)*		0.00		$0
B. Hardware			1	0	$0
B-1	Servers	3	1	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					**$161,197**
G. Please identify the number of users of this service.					**1,853**
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?					**4,080**

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 are9 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	*No server costs associated with this service. Call tracking system is an application in SharePoint*
4	*Colocation Costs - Rent, Agency Storage; Training & Supplies*
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Non-Strategic IT Service:

IT Security/Risk Mitigation Service

Agency: Agency for Health Care Administration

Prepared by: Scott Ward & Angela Findley

Phone: 850-412-4812

Service Provisioning -- Assets & Resources (Cost Elements)		Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number w/ costs in FY 2013-14	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	**Personnel**		3.75		$241,332
A-1	State FTE	1	3.75		$241,332
A-2	OPS FTE		0.00		$0
A-3	Contractor Positions *(Staff Augmentation)*		0.00		$0
B.	**Hardware**		21	1	$10,000
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	1	$10,000
C.	**Software**	4			$42,935
D.	**External Service Provider(s)**	5	7	7	$49,040
E.	**Other** *(Please describe in Footnotes Section below)*	6			$15,000
F.	**Total for IT Service**				$358,307

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; Recurring cost of Vulnerability Management/Scanning solution
4	WebStart web-based training; Forefront for Sharepoint, Forefront Threat Management Gateway, Mobile Device Management
5	Cost for Archives Security, Fedex, Emergency Generator maintenance & fuel, Fire Suppression, Risk Assessment, Shred-it Tape/Hard Drive Destruction; DSM Disaster Recovery Services- included in NSRC Data Center Services Cost
6	Colocation Costs - Rent, Agency Storage; Training & Supplies
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Non-Strategic IT Service:	Agency Financial and Administrative Systems Support Service				
Agency:	Agency for Health Care Administration		# of Assets & Resources Apportioned to this IT Service in FY 2013-14		
Prepared by:	Scott Ward & Angela Findley				
Phone:	850-412-4812				
	Service Provisioning -- Assets & Resources (Cost Elements)	Footnote Number	Number used for this service	Number w/ costs in FY 2013-14	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A.	Personnel		1.00		$66,619
A-1	State FTE	1	1.00		$66,619
A-2	OPS FTE		0.00		$0
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)				$0
F.	Total for IT Service				$66,619
G.	Please identify the number of users of this service.				1,853
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.
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Non-Strategic IT Service: # IT Administration and Management Service

Agency: **Agency for Health Care Administration**
Prepared by: Scott Ward & Angela Findley
Phone: 850-412-4812

Service Provisioning -- Assets & Resources *(Cost Elements)*	Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number w/ costs in FY 2013-14	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel		5.25		$368,865
A-1 State FTE	1	4.75		$353,865
A-2 OPS FTE	2	0.50		$15,000
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				**$408,865**
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 29 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	*Documentation destruction; Consumables/Office Supplies; Training; Colocation Costs*
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Non-Strategic IT Service: **Web/Portal Service**

Dept/Agency: **Agency for Health Care Administration**
Prepared by: Scott Ward & Angela Findley
Phone: 850-412-4812

Service Provisioning -- Assets & Resources *(Cost Elements)*		Footnote Number	# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service	Number w/ costs in FY 2013-14	Estimated FY 2013-14 Allocation of Recurring Base Budget (based on Column G64 minus G65)
A. Personnel			**3.50**		$191,728
A-1.1	**State FTE**	1	3.50		$191,728
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			$187,665
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					**$391,893**
G. Please identify the number of Internet users of this service.					**Unknown**
H. Please identify the number of intranet users of this service.					**1,853**
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	Strategic services.
2	22 total - 9 Production servers of which 7 are virtual and 2 are physical & 13 virtual Development servers - Servers reside at the Northwood Shared Resource Center
3	Microsoft Licenses (Sharepoint Server, Sharepoint Internet, Visual Studio Ultimate, VS Team Suite, Team Foundation Server) and Nintex licensing & support
4	TZO Support - monitors status off external ESS (Emergency Status System)
5	Training & Supplies
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Non-Strategic IT Service:	**Data Center Service**				
Dept/Agency:	**Agency for Health Care Administration**				
Prepared by:	Scott Ward & Angela Findley				
Phone:	850-412-4812				
	Service Provisioning -- Assets & Resources *(Cost Elements)*	*Footnote Number*	*# of Assets & Resources Apportioned to this IT Service in FY 2013-14: Number used for this service*	*Number w/ costs in FY 2013-14*	**Estimated FY 2013-14 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.)*		**0.00**		$0
A-1.1	**State FTE**		0.00		$0
A-2.1	**OPS FTE**		0.00		$0
A-3.1	**Contractor Positions** (Staff Augmentation)		0.00		$0
B.	**Hardware**				$15,500
B-1	**Non-Mainframe Servers** *(including single-function logical servers not assigned to another service)*	1	29	0	$0
B-2	**Servers - Mainframe**		0	0	$0
B-3	**Server Maintenance & Support**		0	0	$0
B-4	**Online or Archival Storage Systems** *(indicate GB of storage)*		0		$0
B-5	**Data Center/ Computing Facility Internal Network**				$0
B-6	**Other Hardware** *(Please specify in Footnotes Section below)*	2			$15,500
C.	**Software**	3			$12,810
D.	**External Service Provider(s)**				$855,402
D-1	**Southwood Shared Resource Center** *(indicate # of Board votes)*	4	0		$13,311
D-2	**Northwood Shared Resource Center** *(indicate # of Board votes)*	5	1		$842,091
D-3	**Northwest Regional Data Center** *(indicate # of Board votes)*		0		$0
D-4	**Other Data Center External Service Provider** *(specify in Footnotes below)*				$0
E.	**Plant & Facility**				$83,000
E-1	**Data Center/Computing Facilities Rent & Insurance**	6			$78,000
E-2	**Utilities (e.g., electricity and water)**	6			$0
E-3	**Environmentals (e.g., HVAC, fire control, and physical security)**	7			$5,000
E-4	**Other** *(please specify in Footnotes Section below)*				$0
F.	**Other** *(Please describe in Footnotes Section below)*				$0
G.	**Total for IT Service**				**$966,712**
H.	**Please provide the number of agency data centers.**				**0**
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 29 servers, 15 are physical, 14 are virtual servers located in each area office throughout the state of Florida to support area office activities.
2	Maintenance renewal for EVA 4400 SAN to support local LAN and Area Office activities.
3	Microsoft Server Licenses and Backup Exec
4	Southwood Shared Resource Center Billings for Emergency Status System (ESS-HA), this service will increase by $2,689 to a total of $16,000 for FY13/14
5	Northwood Shared Resource Center Estimated Cost to AHCA for FY13/14 shows an increase of $80,469.28 from FY12/13 for a total estimate of $922,560
6	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
7	A/C maintenance
8	
9	

Agency: **Agency for Health Care Administration**

	Budget Entity Code	Budget Entity	Program Component Code	Program Component	Appropriation Category Code	Appropriation Category	Fund Code	Fund	FSI	Line Item Total	Funding Identified for IT 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
											Identified Funding as % of Total Cost of Service	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
												$196,036	$2,272,410	$1,152,628	$161,197	$358,307	$66,619	$408,865	$391,893	$966,712
1										$0										
2	68200000	Admin & Support	1603000000	Information Technology	010000	Salaries & Benefits	2021	Admin Trust Fund	1	#REF!		$46,996	$158,226	$378,077	$106,772	$241,332	$66,619	$353,865	$191,728	$0
3										$1,543,615										
4	68200000	Admin & Support	1603000000	Information Technology	030000	Other Personal Services	2021	Admin Trust Fund	1	$222,253		$5,188	$3,113	$7,782	$32,425	$67,935	$0	$15,000	$0	$90,810
5										$0										
6	68200000	Admin & Support	1603000000	Information Technology	040000	Expense	2021	Admin Trust Fund	1	$1,284,804		$67,224	$134,000	$766,769	$22,000	$49,040	$0	$40,000	$185,271	$20,500
7	68700700	Health Care Regulation	1204010000	Facility Regulation	040000	Expense	2003	Health Care Trust Fund	1	$679,966		$19,995	$659,971	$0	$0	$0	$0	$0	$0	$0
8	68501400	Admin & Support	1602000000	Health Services for Individuals	040000	Expense	2474	Medical Care Trust Fund	1	$218,422		$20,732	$197,690	$0	$0	$0	$0	$0	$0	$0
9	68700700	Health Care Regulation	1205020000	Managed Care	040000	Expense	2003	Health Care Trust Fund	1	$440,128		$35,901	$404,227	$0	$0	$0	$0	$0	$0	$0
10										$0										
11	68200000	Admin & Support	1603000000	Information Technology	100777	Contracted Services	2021	Admin Trust Fund	1	$82,699		$0	$67,805	$0	$0	$0	$0	$0	$14,894	$0
12										$0										
13	68200000	Admin & Support	1603000002	Information Technology	210012	Data Processing Services	2021	Admin Trust Fund	1	$647,379		$0	$647,379	$0	$0	$0	$0	$0	$0	$0
14										$0										
15	68200000	Admin & Support	1603000000	Information Technology	210021	Southwood Shared Resource Center	2021	Admin Trust Fund	1	$13,311		$0	$0	$0	$0	$0	$0	$0	$0	$13,311
16										$0										
17	68200000	Admin & Support	1603000000	Information Technology	210022	Northwood Shared Resource Center	2021	Admin Trust Fund	1	$842,091		$0	$0	$0	$0	$0	$0	$0	$0	$842,091
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

		Sum of IT Cost Elements Across IT Services	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
Personnel	State FTE (#)	25.00	0.75	2.75	6.25	2.25	3.75	1.00	4.75	3.50	0.00
	State FTE (Costs)	$1,543,615	$46,996	$158,226	$378,077	$106,772	$241,332	$66,619	$353,865	$191,728	$0
	OPS FTE (#)	2.25	0.25	0.25	0.25	1.00	0.00	0.00	0.50	0.00	0.00
	OPS FTE (Cost)	$63,508	$5,188	$3,113	$7,782	$32,425	$0	$0	$15,000	$0	$0
	Vendor/Staff Augmentation (# Positions)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Vendor/Staff Augmentation (Costs)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Hardware	$455,541	$93,891	$54,750	$281,400	$0	$10,000	$0	$0	$0	$15,500
	Software	$671,795	$49,961	$13,055	$365,369	$0	$42,935	$0	$0	$187,665	$12,810
	External Services	$2,950,208	$0	$2,043,266	$0	$0	$49,040	$0	$0	$2,500	$855,402
	Plant & Facility (Data Center Only)	$83,000									$83,000
	Other	$207,000	$0	$0	$120,000	$22,000	$15,000	$0	$40,000	$10,000	$0
	Budget Total	$5,974,667	$196,036	$2,272,410	$1,152,628	$161,197	$358,307	$66,619	$408,865	$391,893	$966,712
	FTE Total	27.25	1.00	3.00	6.50	3.25	3.75	1.00	5.25	3.50	0.00
	Users		2,092	1,853	1,853	1,853		1,853		#VALUE!	
	Cost Per User		$94	1226.341112	622.0334593	86.99244468		35.95196978		#VALUE!	

(cost/all mailboxes)

Help Desk Tickets: 4,080
Cost/Ticket: 3.292422386

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3673

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 sought attorneys' fees and costs.
Amount of the Claim:	The plaintiffs did not seek monetary damages; however, the monetary impact could have exceeded $500,000 annually in additional Medicaid payments if the plaintiffs had been 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. Trial was held February 7 – 11, 2011. Closing arguments were held on February 16, 2011. The Court issued an order on January 3, 2012, dismissing all claims except for the injunction that was issued on September 30, 2008. The September 30, 2008, injunction became permanent and the court reserved the right to hear requests for attorneys' fees. The parties reached a settlement on attorneys' fees. 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).	**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

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3673

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:	This is a claim for prospective declaratory and injunctive relief. Plaintiffs have provided no precise estimates of the increased reimbursement rates they seek. Reportedly, they seek physician fees that are comparable to Medicare rates, and dental reimbursement rates which are set at the 50th percentile of usual and customary charges for dentists (i.e., a reimbursement rate which is equal to what 50% of the physicians charge at or below for dental services). In 2011, there was a reimbursement rate for dental, but not physician services. There are no precise estimates of what it will cost to increase physician reimbursement rates for services to children to Medicare rates or what it will cost to increase dental reimbursement rates to the 50^{th} percentile charge. The best approximation is that it will cost between $250 and $500 million per year.
Specific Law(s) Challenged:	
Status of the Case:	The case has been pending since November 2005. On September 30, 2009, the Court issued an Order Granting In Part The Plaintiffs' Motion For Class Certification. The certified class consists of "all children under the age of 21 who now, or in the future will, reside in Florida and who are, or will be, eligible under Title XIX of the Social Security Act for Early Periodic Screening, Diagnosis and Treatment Services."

	The Court held a 95-day long trial on liability, which spanned the period of December 7, 2009 to April 20, 2012. The trial was held as the Court had time available on its docket. An order on liability is expected in the month of August 2012. Depending on what happens with the order on liability, the next step is a phase to fashion injunctive relief in the case should it be necessary. The Court has indicated that this phase would provide an opportunity to provide more current evidence about whether a remedy is needed. Because this is to be an evidentiary proceeding, some further discovery may be authorized by the Court. It is only after the entry of an injunction and a Final Judgment that the state could exercise any final appellate rights.	
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

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3673

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 11th Circuit Court of Appeals
Case Number:	Lower Court Case No. 1:11-cv-20684-JAL; 12-13785-DD
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 was held on October 6, 2011, but the parties reached an impasse. Trial was held on March 20, 2012 - March 23, 2012. The Court granted injunctive relief on March 26, 2012 and declaratory relief on June 14, 2012. AHCA is currently appealing the trial court decision. Plaintiffs have moved for attorney's fees; that motion has been stayed, pending appeal, by consent of the parties. In the district court, AHCA moved for a partial stay of the injunction, pending appeal; the motion is pending. Eleventh Circuit Mediation is scheduled for September 13, 2012.	
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).		

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3673

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 was a class action lawsuit where plaintiff sought declaratory and injunctive relief to receive Medicaid services which would allow plaintiff to continue to reside in the community and not require institutionalization.	
Amount of the Claim:	The plaintiffs did not seek monetary damages; however, the monetary impact could have exceeded $25,000,000 annually in additional Medicaid payments if the plaintiffs had been 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 a 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. The court denied class status to the plaintiffs. The parties entered into a settlement agreement on July 3, 2012.	
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).	Certification was denied. Disability Rights Florida	

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	Agency for Health Care Administration

Contact Person:	William H. Roberts	Phone Number:	412-3673

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 was a class action lawsuit where plaintiff sought declaratory and injunctive relief to receive Medicaid services which would allow plaintiff to continue to reside in the community and not require institutionalization.	
Amount of the Claim:	The plaintiffs did not seek monetary damages; however, the monetary impact could have exceeded $25,000,000 annually in additional Medicaid payments if the plaintiffs had been 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. On October 12, 2011, hearing was held on the Agency's Motion to Dismiss. Court issued an Order Denying Motion to Dismiss. The parties entered into a settlement agreement on June 14, 2012.	
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).	Steve Gold Sporher & Dodd	

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	Agency for Health Care Administration

Contact Person:	William H. Roberts	Phone Number:	412-3673

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:	The plaintiff challenged the constitutionality of the Florida Abortion Clinic Statutes and rules which denied 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. Case closed on April 23, 2012 for failure to prosecute.	
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

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	Agency for Health Care Administration

Contact Person:	William H. Roberts	Phone Number:	412-3673

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:	The plaintiff challenged the constitutionality of the Florida Abortion Clinic Statutes and rules which denied 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 did not perfect service on the Agency. Case closed on August 23, 2011, for failure to prosecute.

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

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

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

Names of the Parties:	T.H., by and through her next friend, Paolo Annino; A.C., by and through his next friend Zurale Cali; A.R., by and through her next friend, Susan Root; C.V., by and through his next friends, Michael and Johnette Wahlquist; M.D., by and through her next friend, Pamela DeCambra; C.M., by and through his next friend, Norine Mitchell; B.M., by and through his next friend, Kayla Moore; and T.F., by and through his next friend, Michael and Liz Fauerbach; each individually, and on behalf of all other children similarly situated in the State of Florida, v. Elizabeth Dudek, in her official capacity as Secretary of the Agency for Health Care Administration; Harry Frank Farmer, Jr., in his official capacity as the State Surgeon General and Secretary of the Florida Department of Health; Kristina Wiggins, in her official capacity as Deputy Secretary of the Florida Department of Health and Director of Children's Medical Services; and eQHealth Solutions, Inc., a Louisiana non-profit corporation	
Court with Jurisdiction:	United States District Court in and for the Southern District of Florida	
Case Number:	12-60460-CIV-RSR	
Summary of the Complaint:	This is a putative class action lawsuit where plaintiffs challenge AHCA's medical necessity determinations and policies limiting the number of private duty nursing hours that have been approved.	
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 two complaints on March 13, 2012, and moved to consolidate the matters, which was granted. Plaintiffs filed an Amended Consolidated Class Action Complaint on May 16, 2012. AHCA and DOH moved to dismiss on June 1, 2012. eQHealth filed a separate motion to dismiss. The Court denied the motions on July 17, 2012. Defendants are preparing discovery requests and anticipate receiving same from Plaintiffs at any time. Plaintiffs' motion for class certification is expected in September. Pre-Trial Conference has been set for June 14, 2013, and the Court has ordered the parties to be ready for trial "at any time after the pre-trial conference."	
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
	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).	Class has not been certified. Law Offices of Matthew W. Dietz

Office of Policy and Budget - September 2012

Agency:	Agency for Health Care Administration		
Contact Person:	William H. Roberts	Phone Number:	412-3673

Names of the Parties:	Gabrielle Goodwin by her Agent Under Durable Power of Attorney, Donna Ansley v. Florida Agency for Health Care Administration; Elizabeth Dudek, Secretary, Florida Agency for Health Care Administration; Florida Department of Children and Families; David Wilkins, Secretary, Florida Department of Children and Families	
Court with Jurisdiction:	2nd Judicial Circuit, In and For Leon County	
Case Number:	12 CA 2935	
Summary of the Complaint:	This is a putative class action lawsuit where plaintiffs allege that DCF and AHCA violate federal and state Medicaid law by failing to deduct the proper amount of pre-eligibility medical expenses relating to nursing home care when determining the Medicaid patient responsibility amount. Plaintiffs argue that the full expense of pre-eligibility nursing home care should be deducted from the amount that a Medicaid patient must contribute to the cost of long-term care. Plaintiffs seek declaratory and injunctive relief to stop this practice and to require the State to recalculate those amounts retroactively. Plaintiffs also allege that this practice is in breach of the provider agreements that Medicaid has with nursing homes. The plaintiffs claim status as third-party beneficiaries of the provider agreements and seek contractual damages for the alleged breach.	
Amount of the Claim:	Unknown; the allegations of the complaint do not include a specific damages amount, but they would likely exceed $500,000 if plaintiffs were successful.	
Specific Law(s) Challenged:		
Status of the Case:	Plaintiff served the Agency with the Complaint on September 17, 2012.	
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

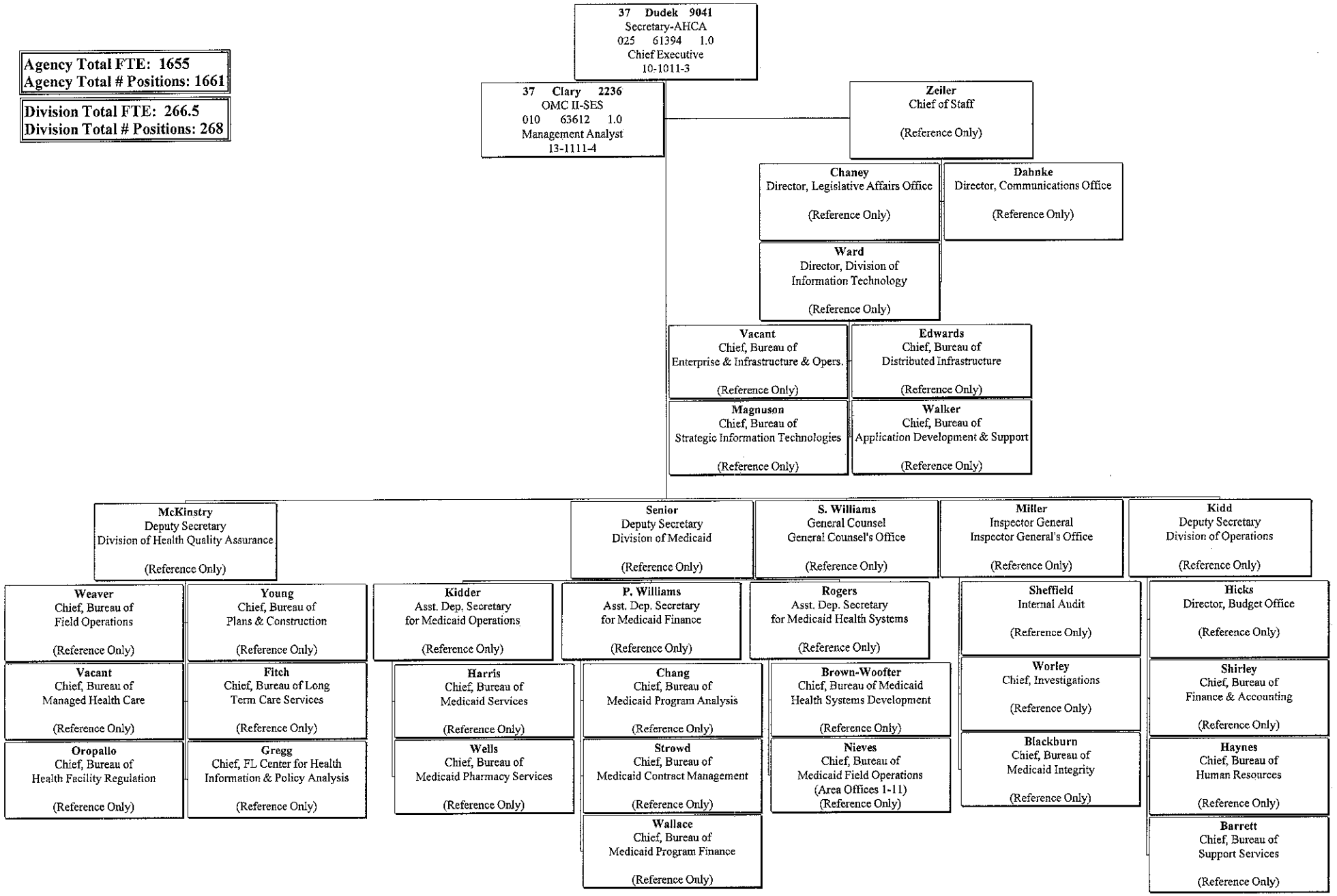
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	Class has not been certified. Carlton Fields, P.A. Zuckerman Spaeder LLP

Effective Date: July 1, 2012
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

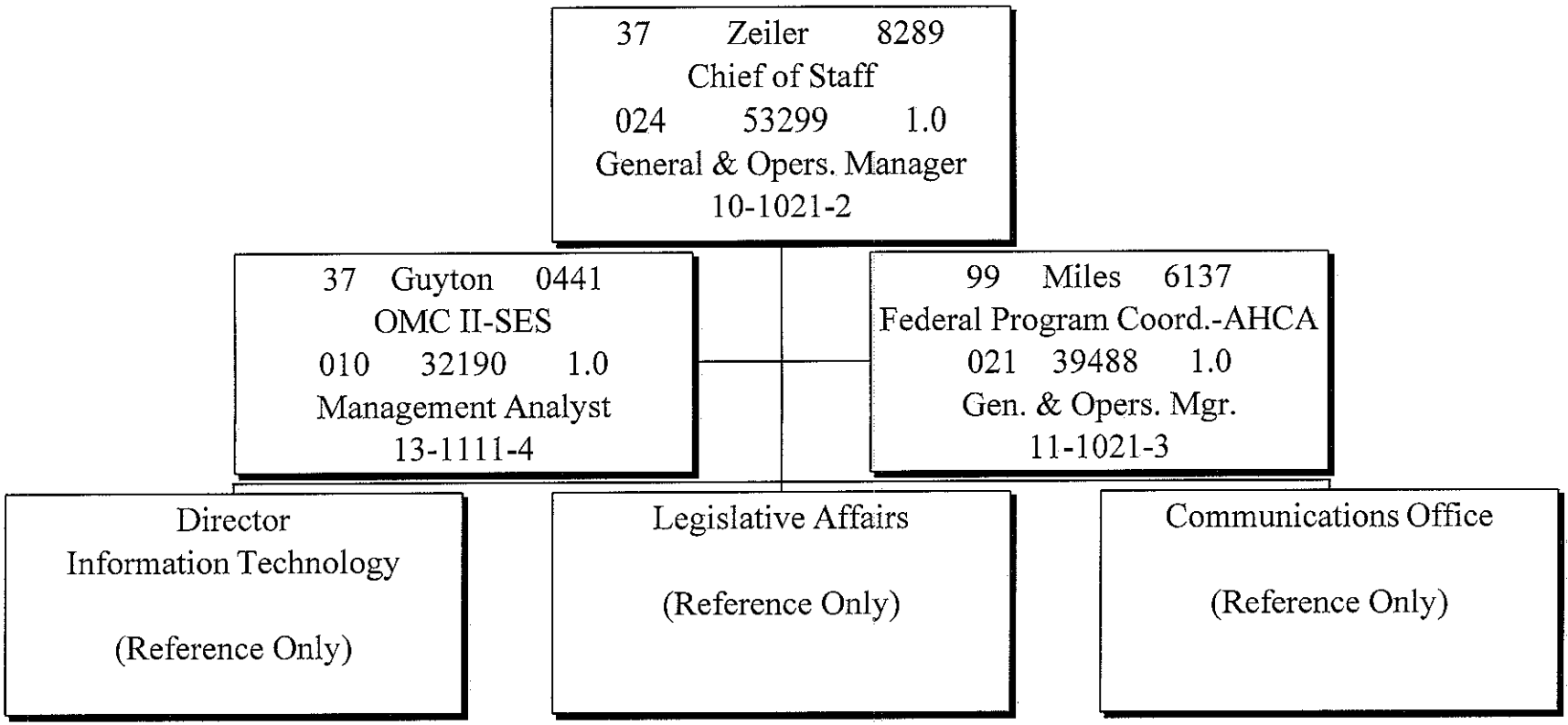
Division Total FTE: 266.5
Division Total # Positions: 268



A-1

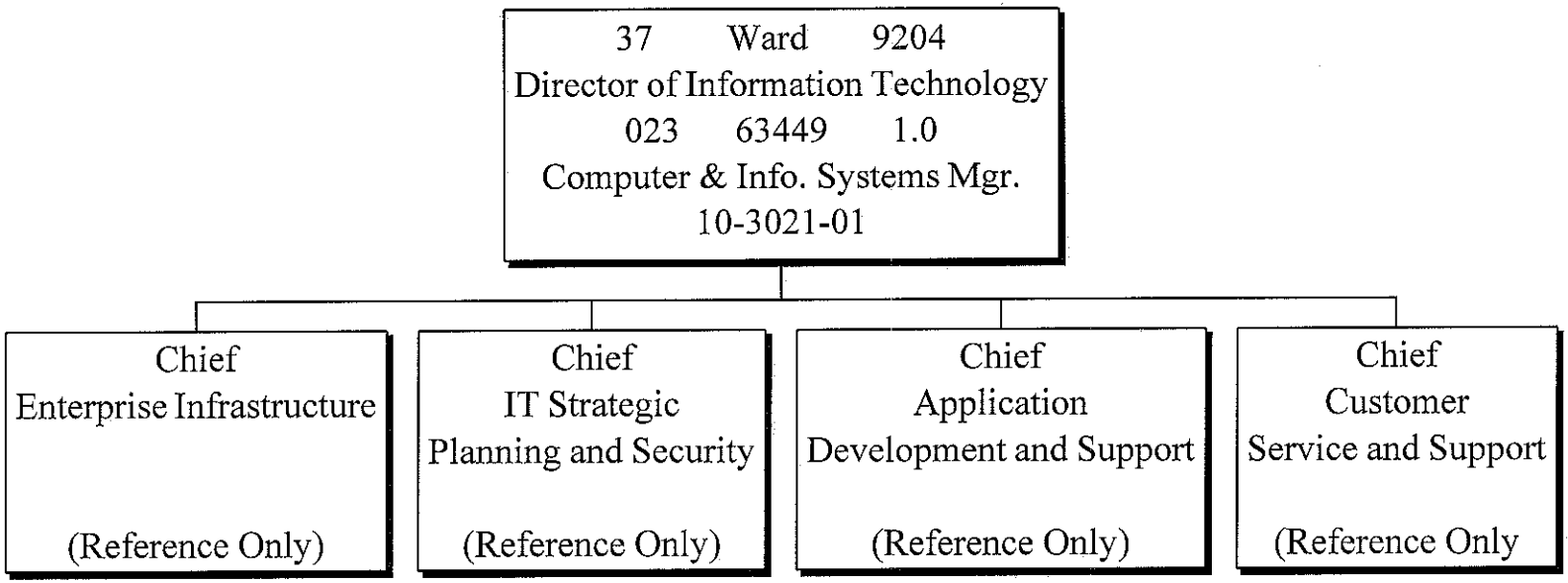
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief of Staff

Effective Date: July 1, 2012
Org. Level: 68-10-10-00-00-000
FTEs: 3 Positions: 3



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

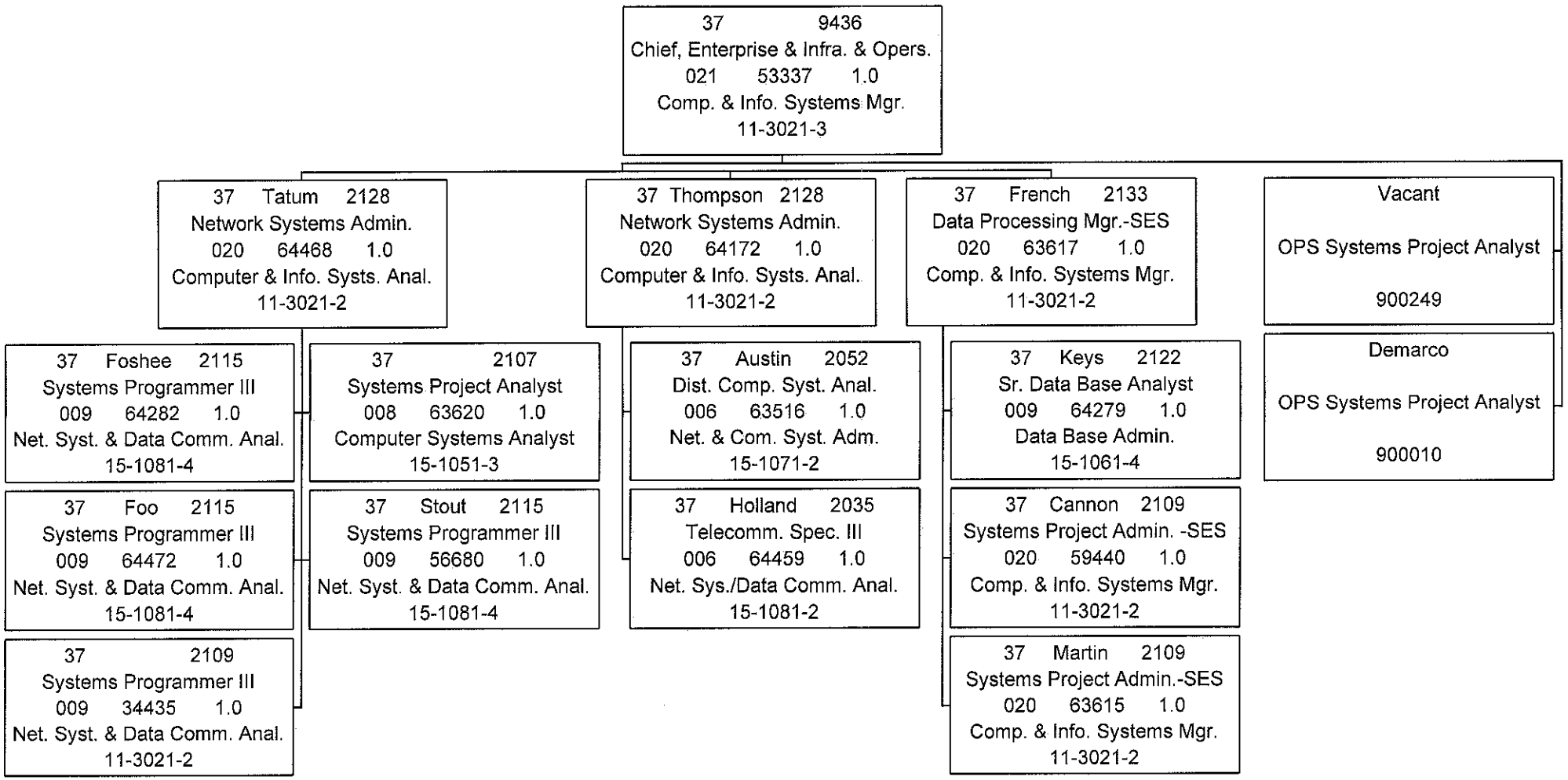
Revised Date: July 1, 2012
Org Level: 68-10-10-40-00-000
FTEs: 1 Positions: 1



A-2-1

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

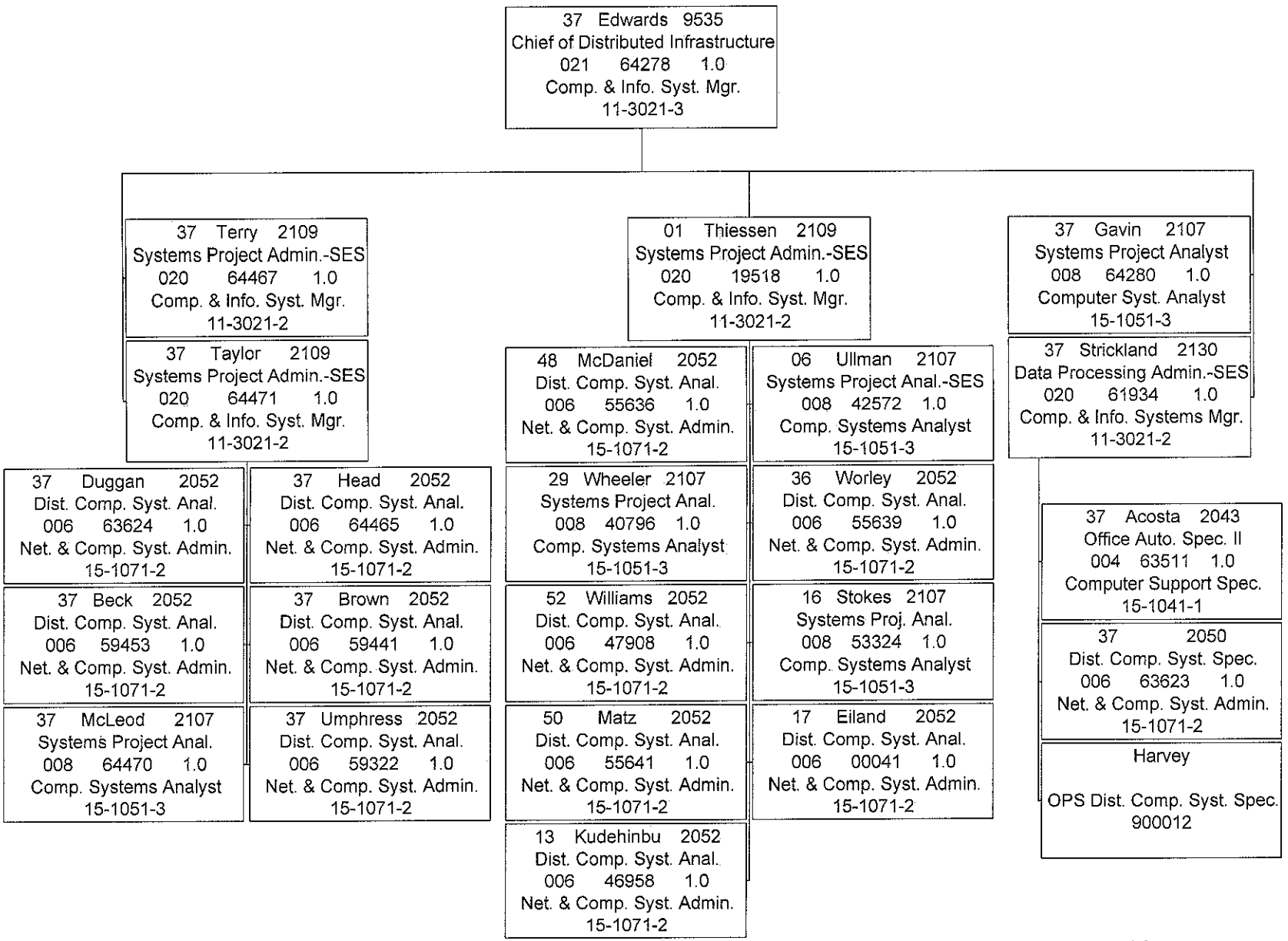
Org. Level: 68-10-10-40-00-100
Revised Date: July 1, 2012
FTEs: 14 Positions: 14



A-2-2

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

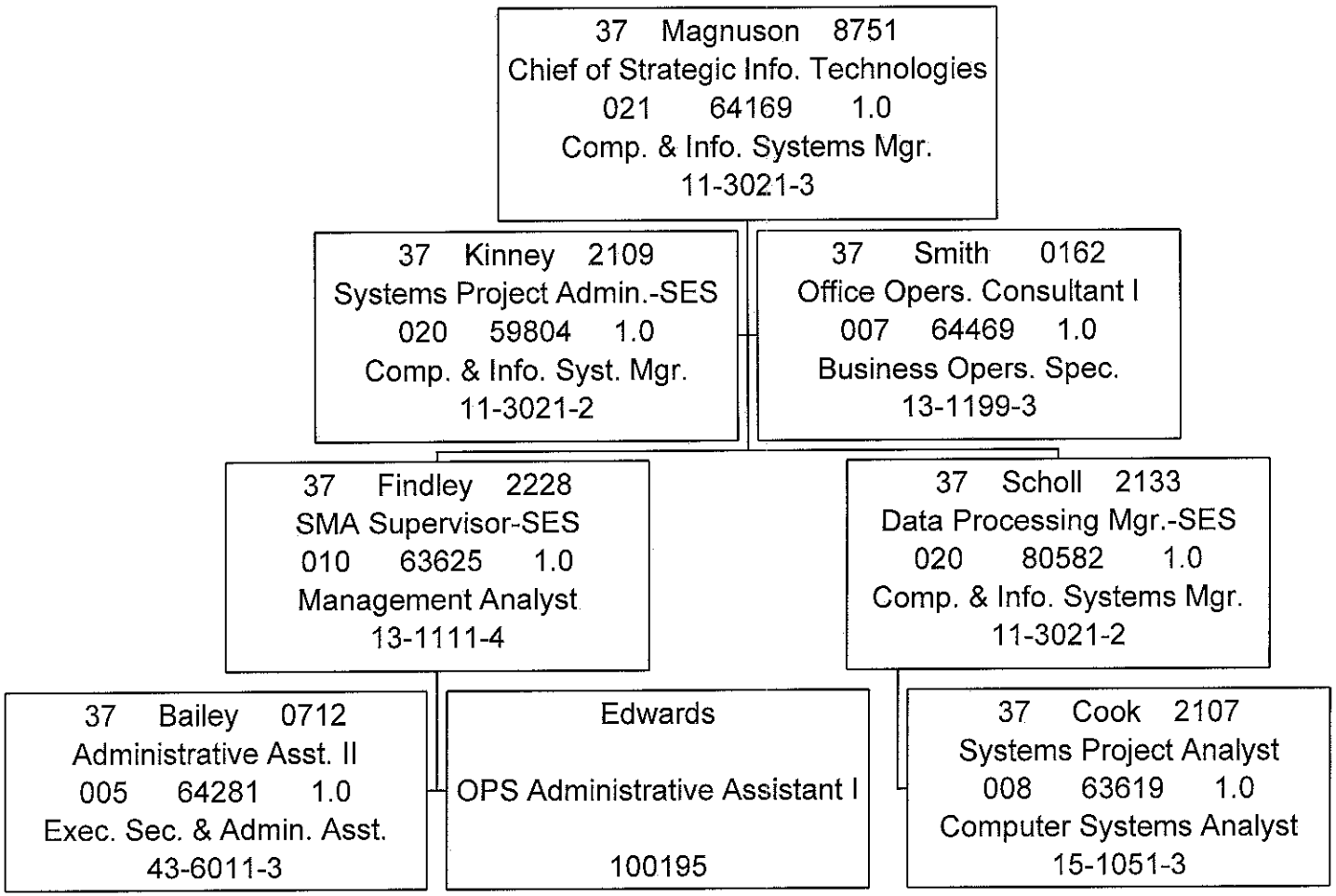
Org. Level: 68-10-10-40-00-200
Revised Date: July 1, 2012
FTEs: 23 Positions: 23



A-2-3

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

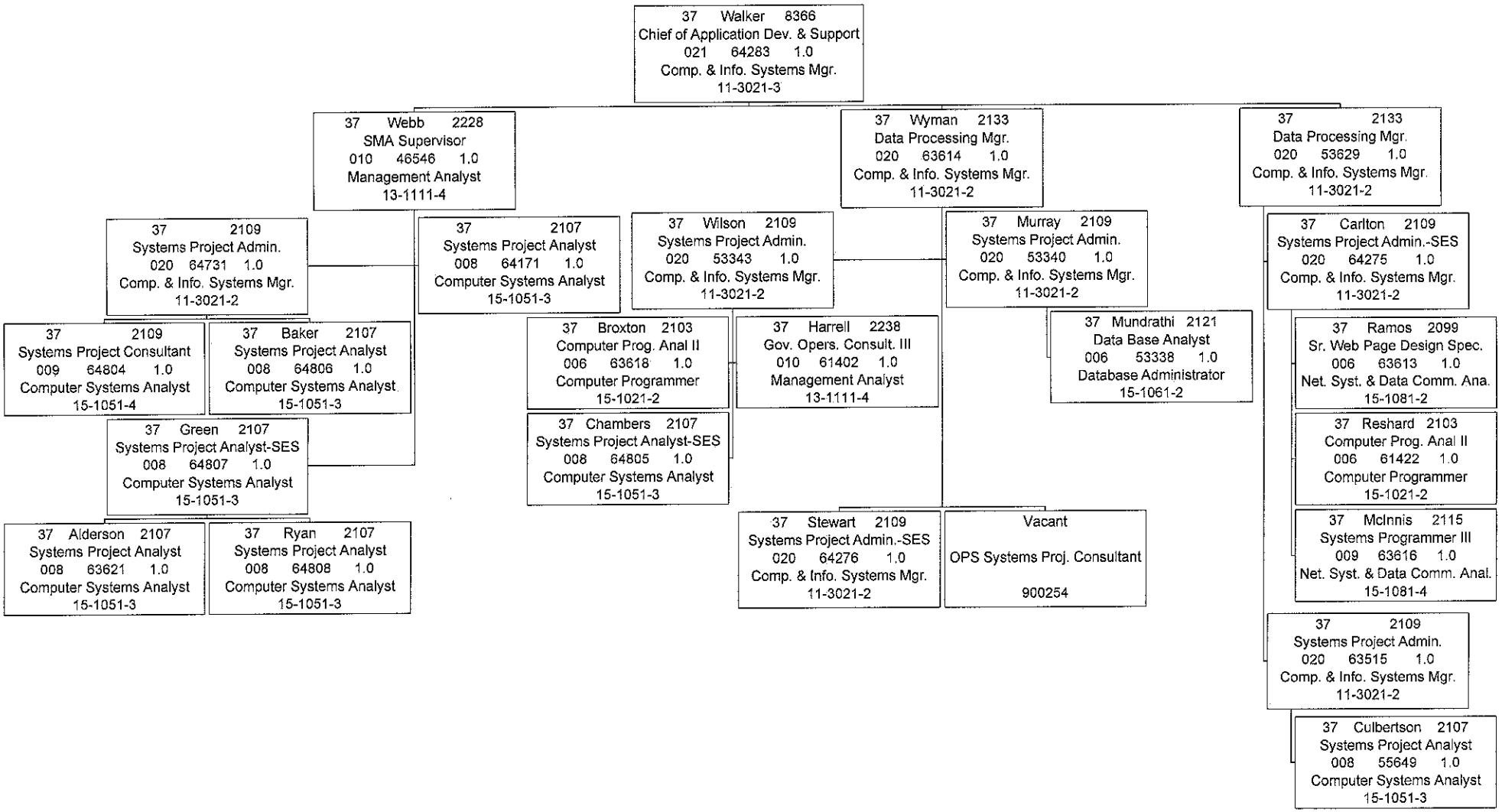
Org. Level: 68-10-10-40-00-300
Revised Date: July 1, 2012
FTEs: 7 Positions: 7



A-2-4

Org. Level: 68-10-10-40-00-400
Revised Date: July 1, 2012
FTEs: 24 Positions: 24

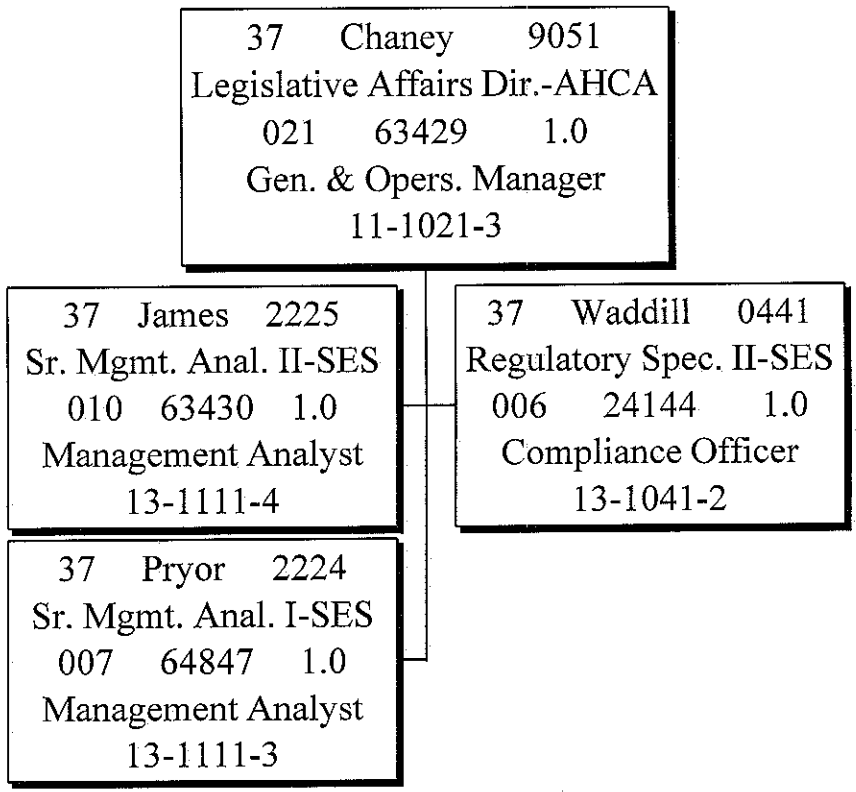
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of Information Technology
Bureau of Application Development and Support



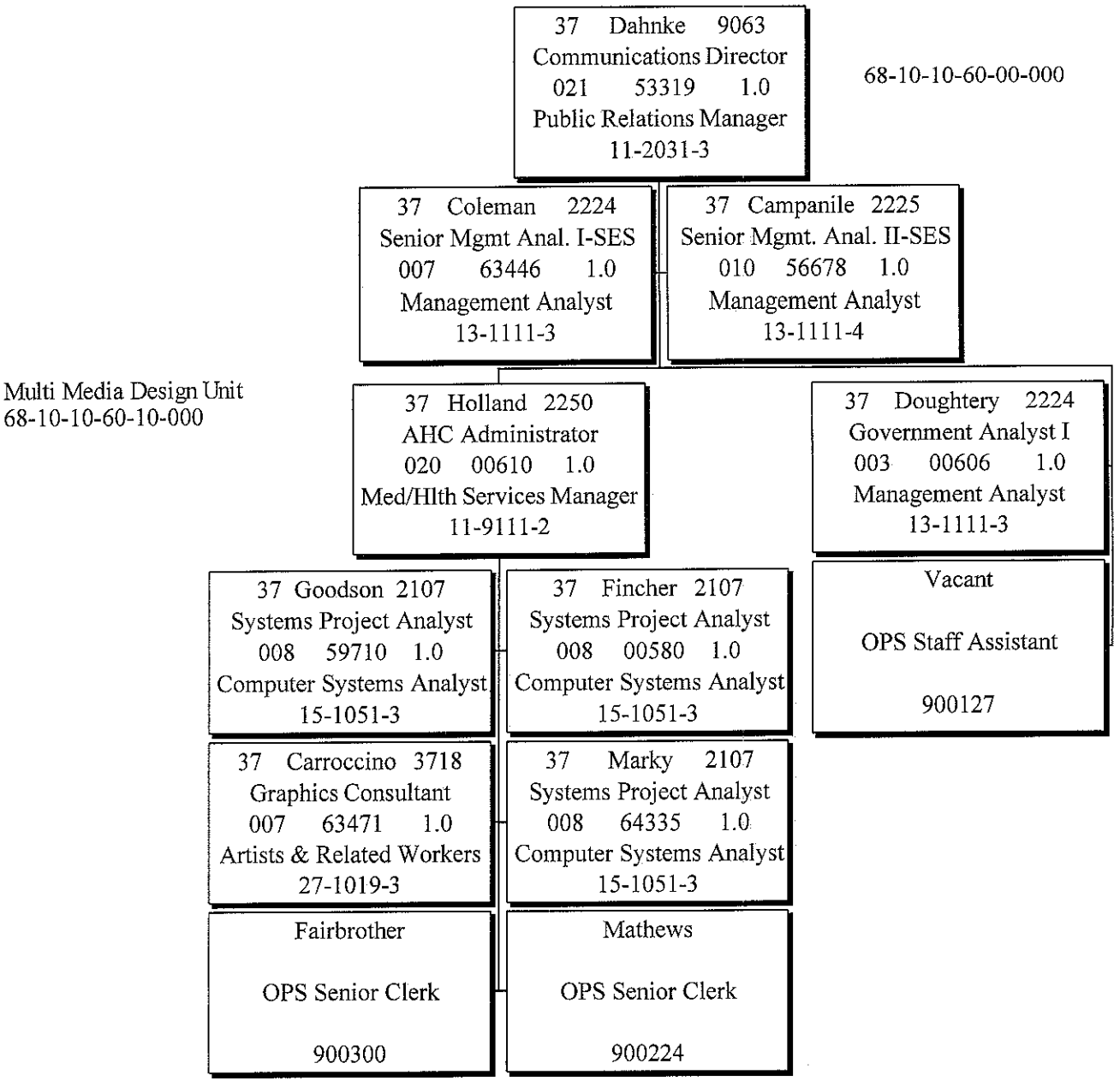
A-2-5

AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Legislative Affairs Office

Effective Date: July 1, 2012
Org Level: 68-10-10-50-00-000
FTEs: 4 Positions: 4

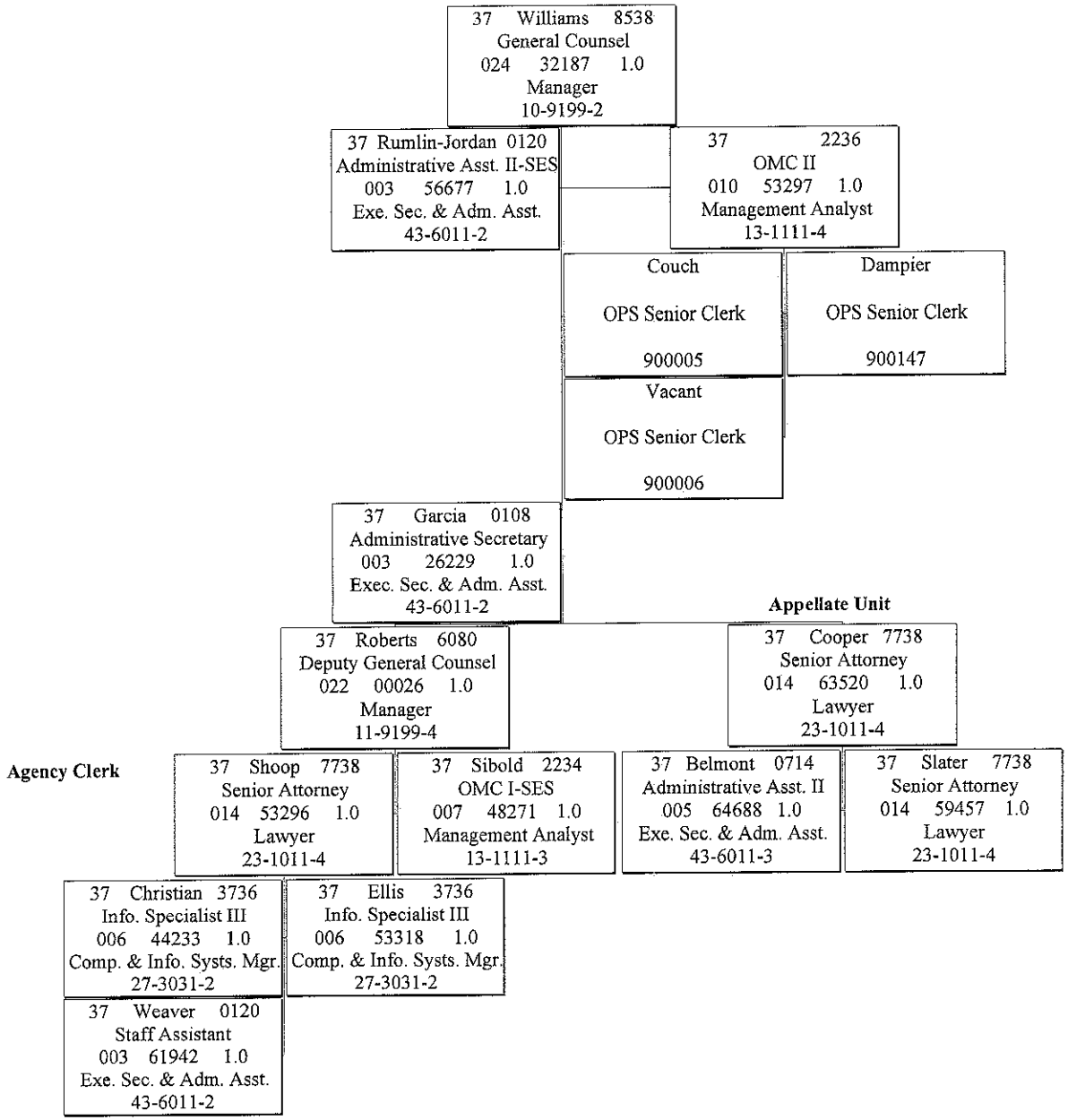


AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Communications Office



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

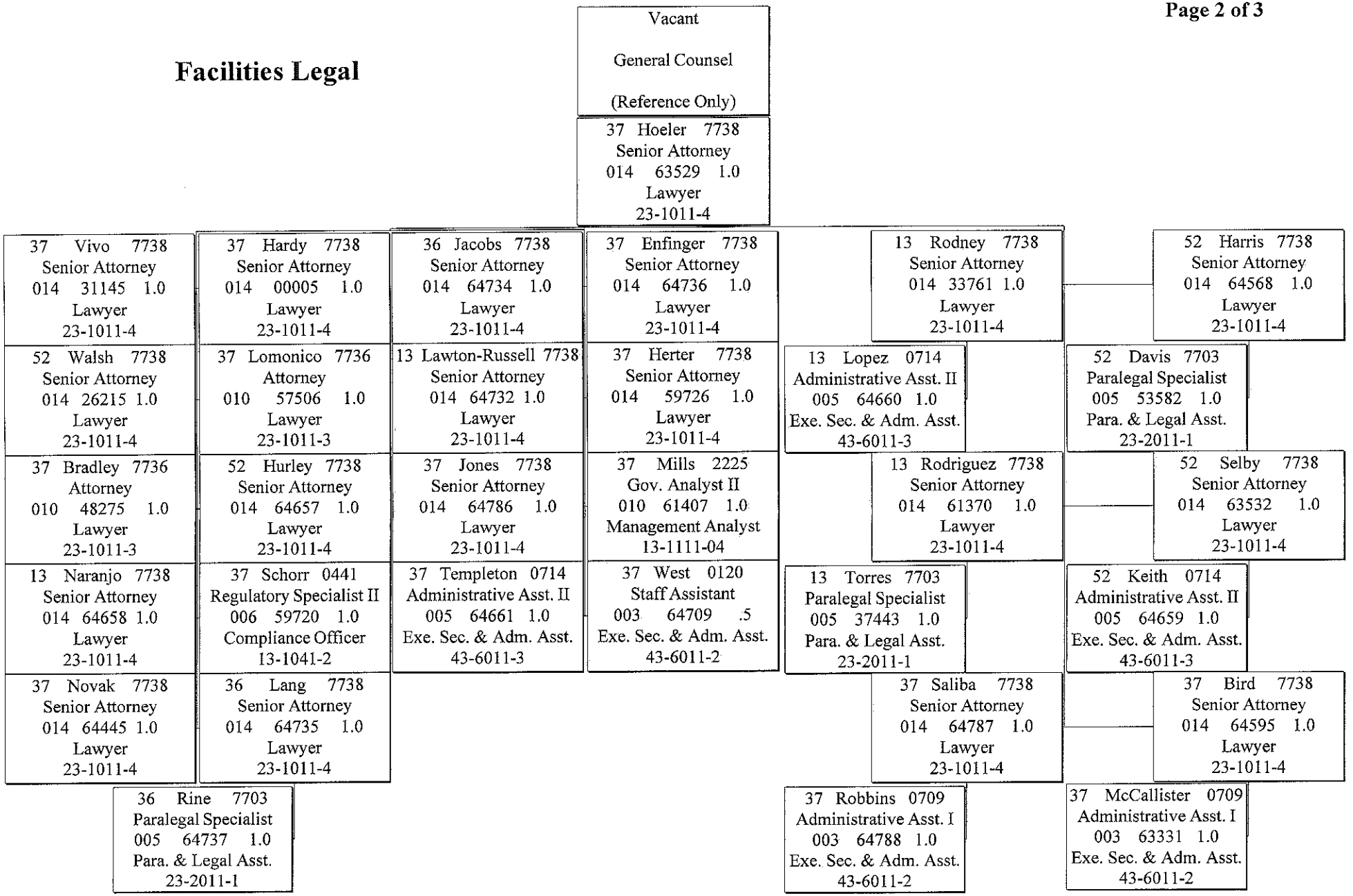
Org. Level: 68 10 20 00 000
Revised Date: July 1, 2012
FTEs: 67.5 Positions: 68



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Org. Level: 68 10 20 00 000
Revised Date: July 1, 2012
FTEs: 67.5 Positions: 68

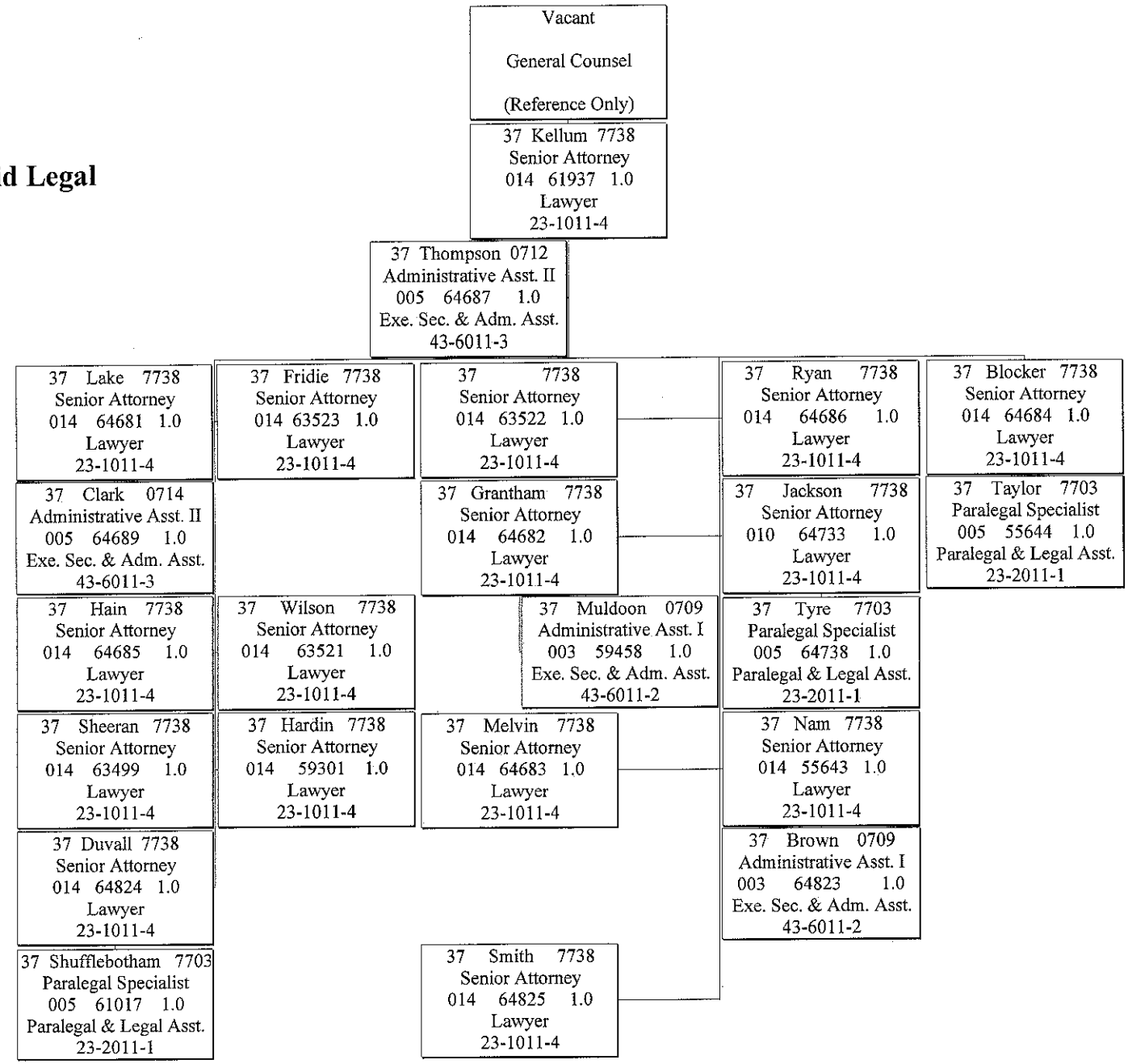
Facilities Legal



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Org. Level: 68 10 20 00 000
Revised Date: July 1, 2012
FTEs: 67.5 Positions: 68

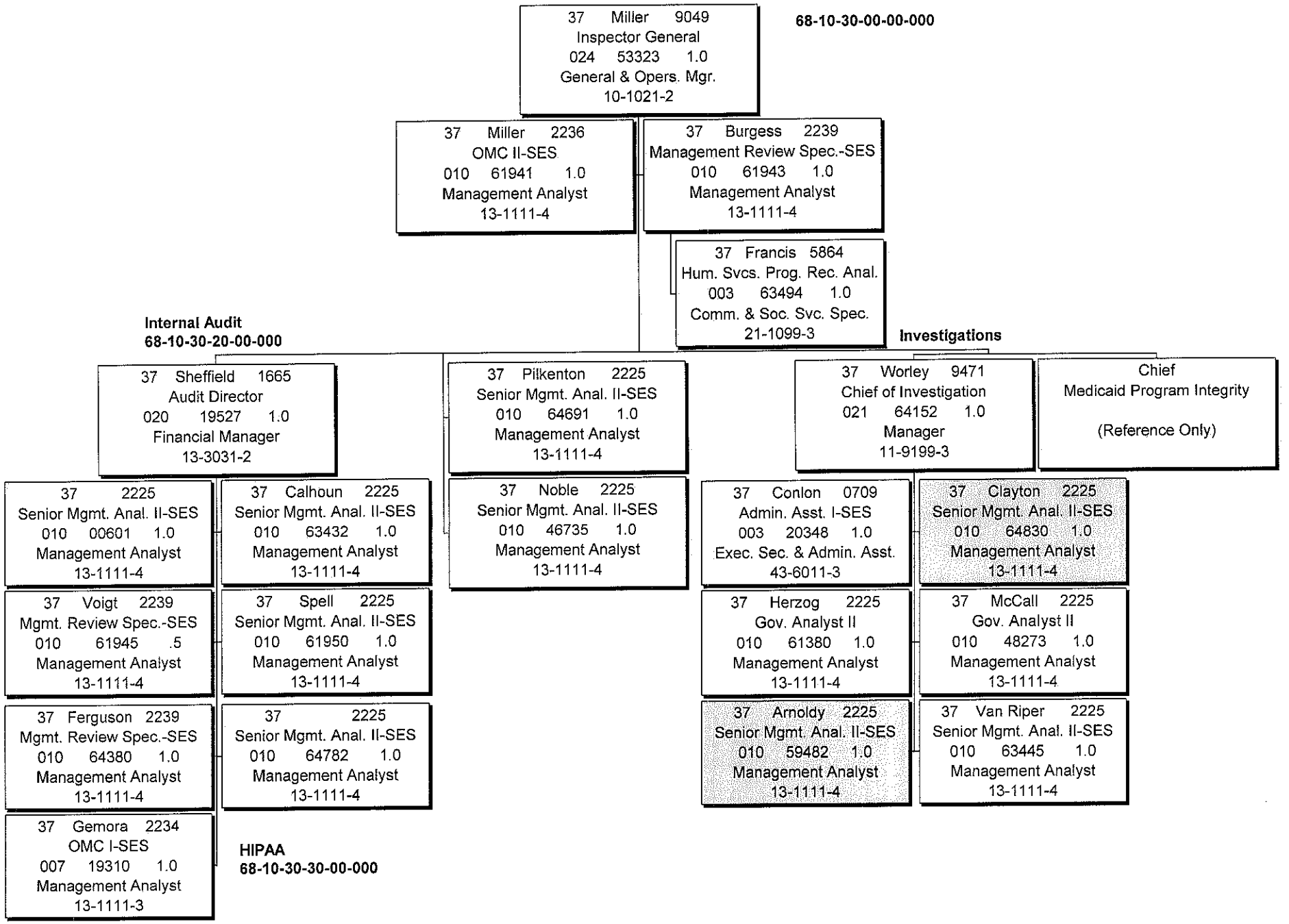
Medicaid Legal



A-4--2

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General

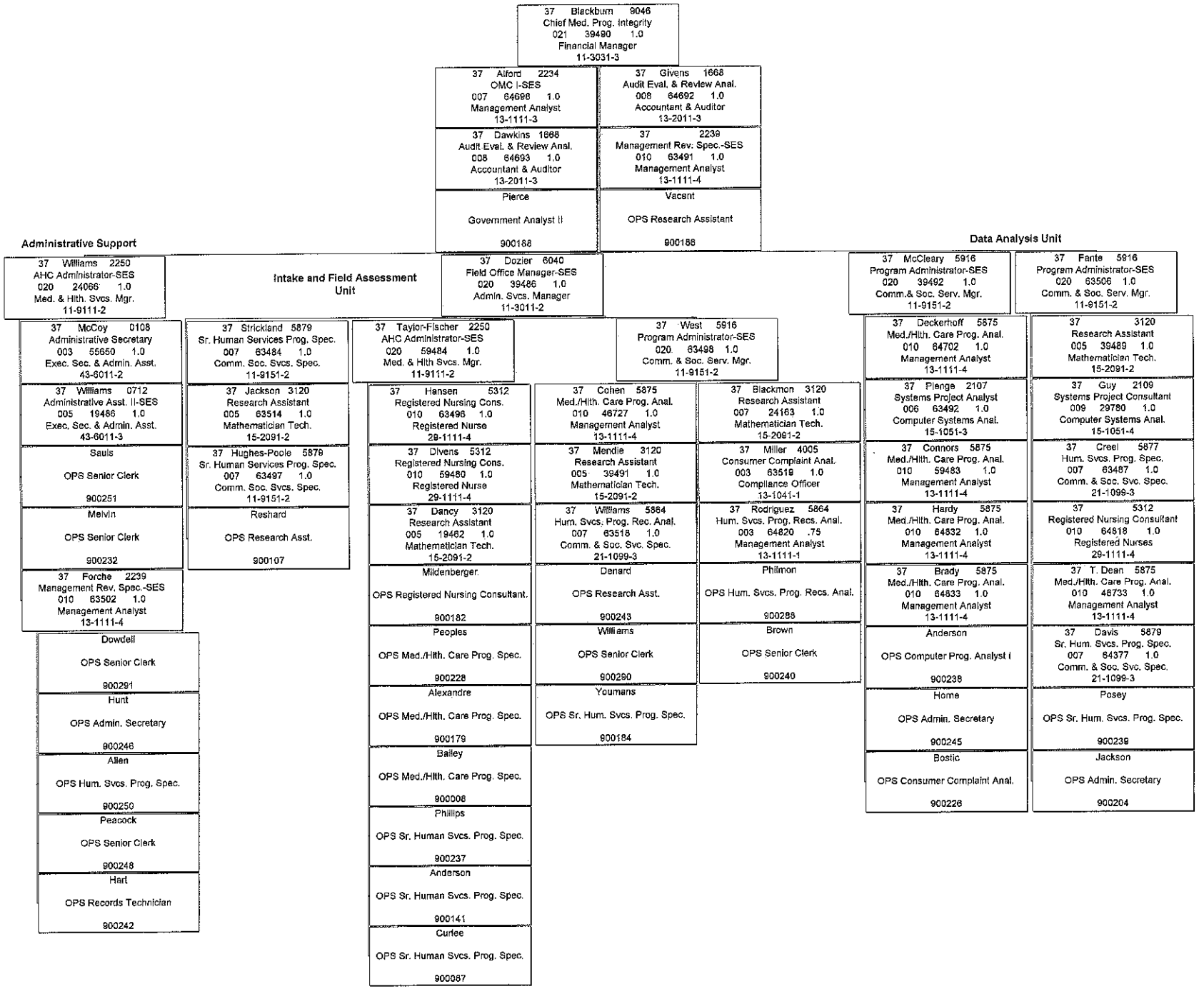
Revised Date: July 1, 2012
FTEs: 18.5 Positions: 19



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

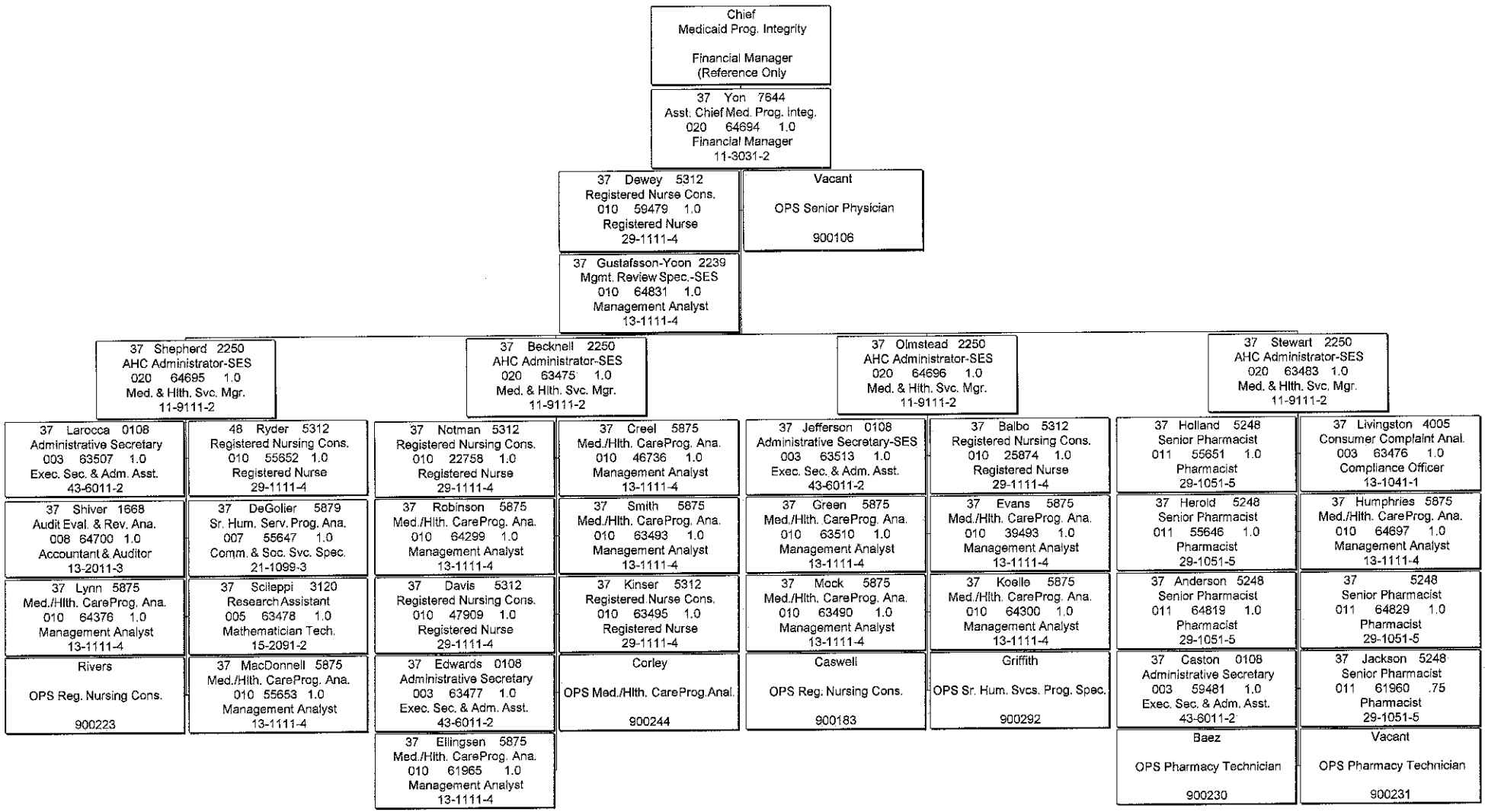
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General
Medicaid Program Integrity

Org. Level: 68-10-30-10-000
Revised Date: July 1, 2012
FTEs: 81.5 Positions: 82



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

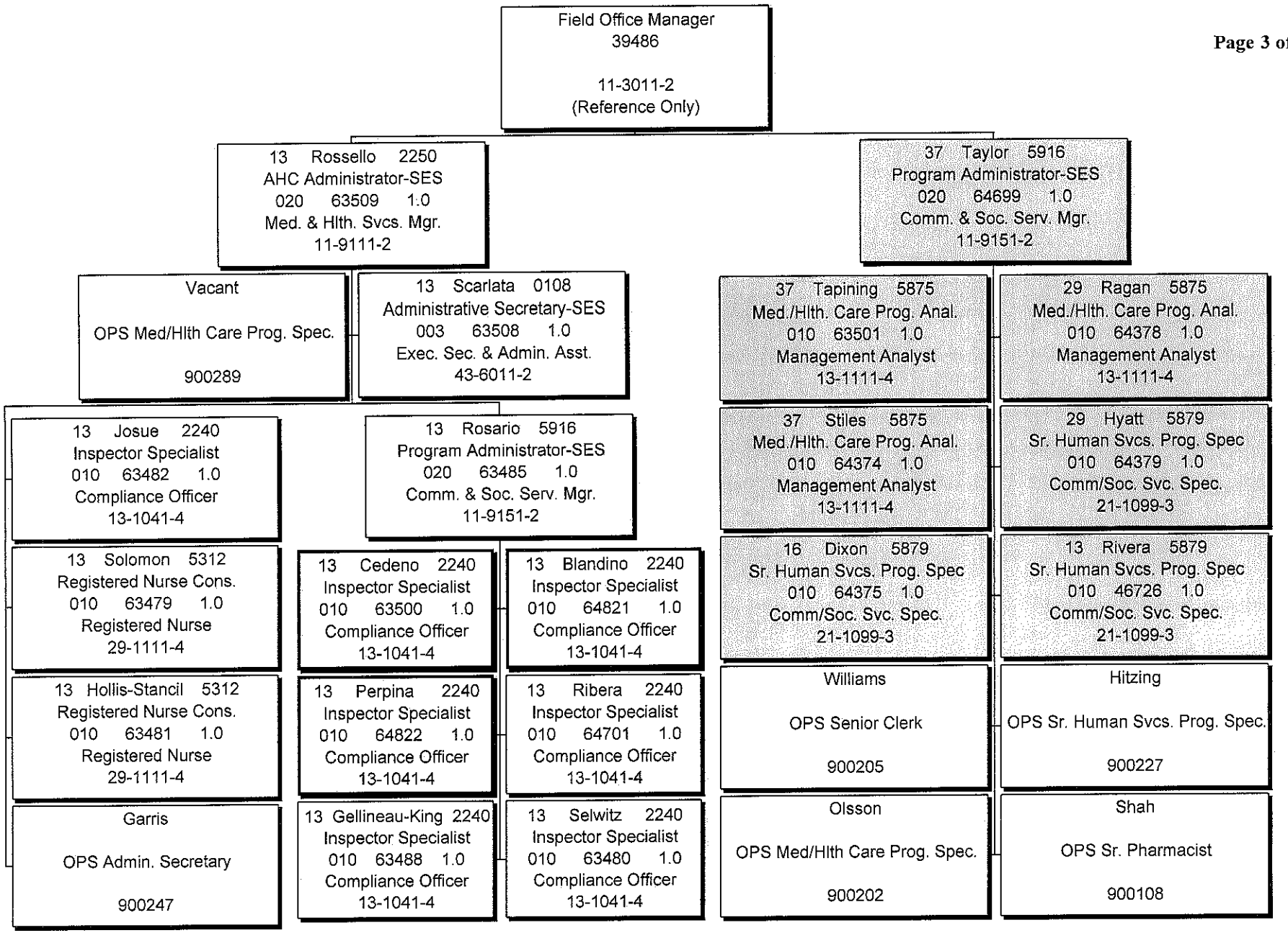
Org. Level: 68-10-30-10-000
Revised Date: July 1, 2012
FTEs: 81.5 Positions: 82



A-6-1

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

Org. Level: 68-10-30-10-01-100
Revised Date: July 1, 2012
FTEs: 12 Positions: 12



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

A-6-2

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

Revised Date: July 1, 2012
Org Level: 68-20-00-00-000
FTEs: 2 Positions: 2

Division of Operations FTE: 85

37 Kidd 9029
Deputy Secretary for Operations
024 61390 1.0
General & Operations Manager
10-3011-02

37 Smith 2236
OMC II-SES
010 53300 1.0
Management Analyst
13-1111-4

Finance & Accounting
(Reference Only)

Human Resources
(Reference Only)

Support Services
(Reference Only)

Budget Office
(Reference Only)

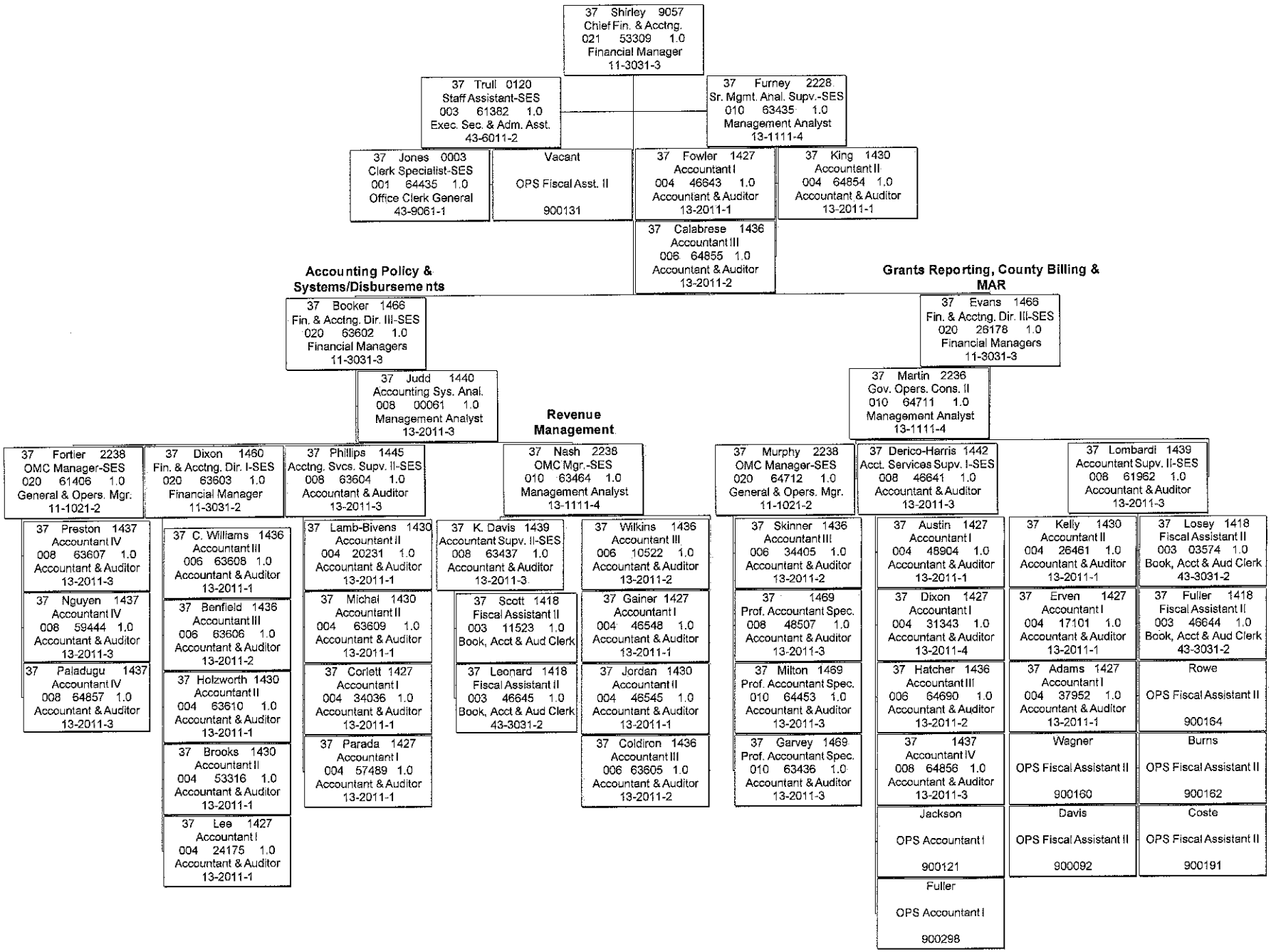
Medicaid Third Party Liability
(Reference Only)

***Shaded box reports to Division of Medicaid**

B-0

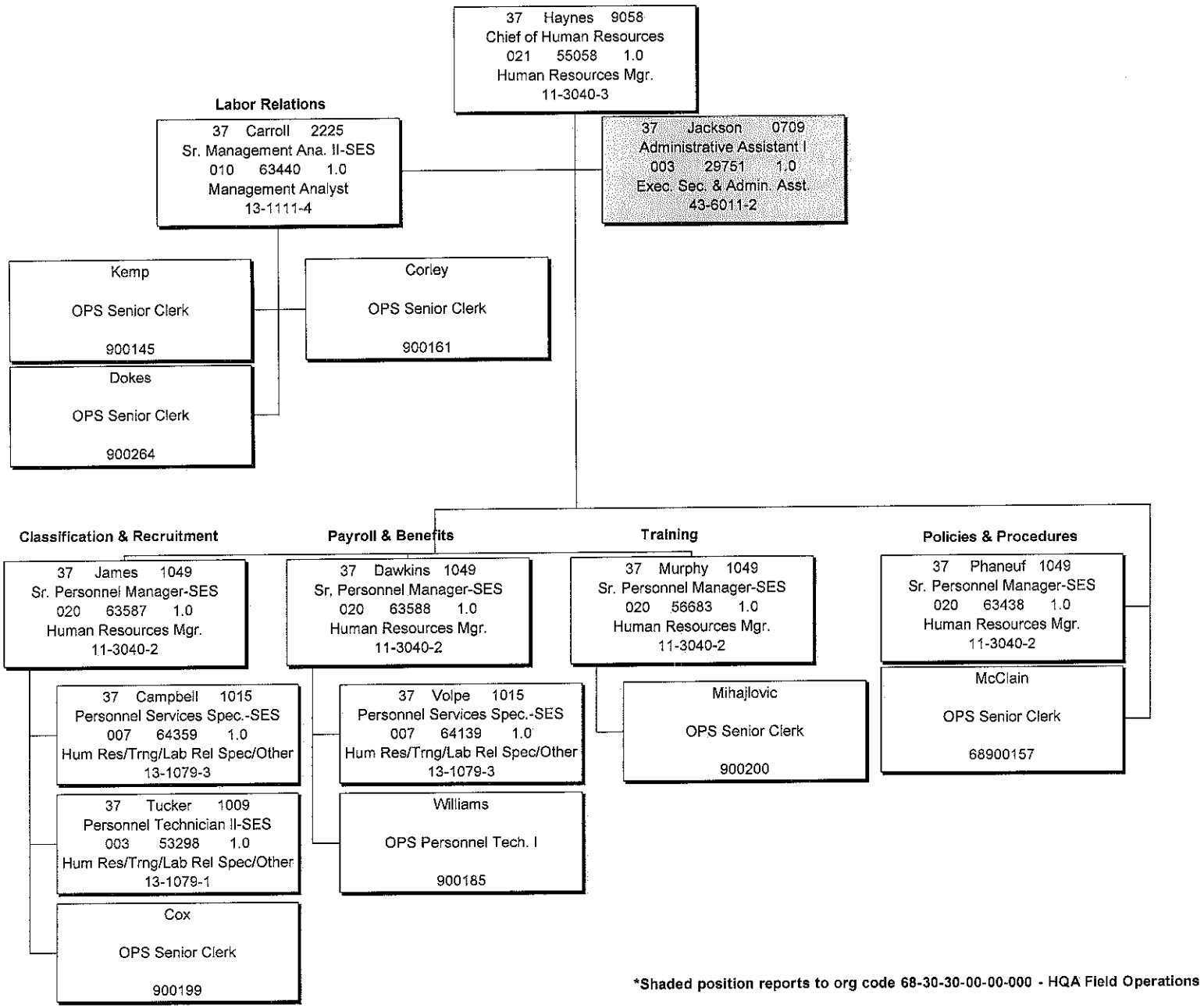
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Finance & Accounting

Org. Level: 68-20-10-00-000
Revised Date: July 1, 2012
FTEs: 50 Positions: 50



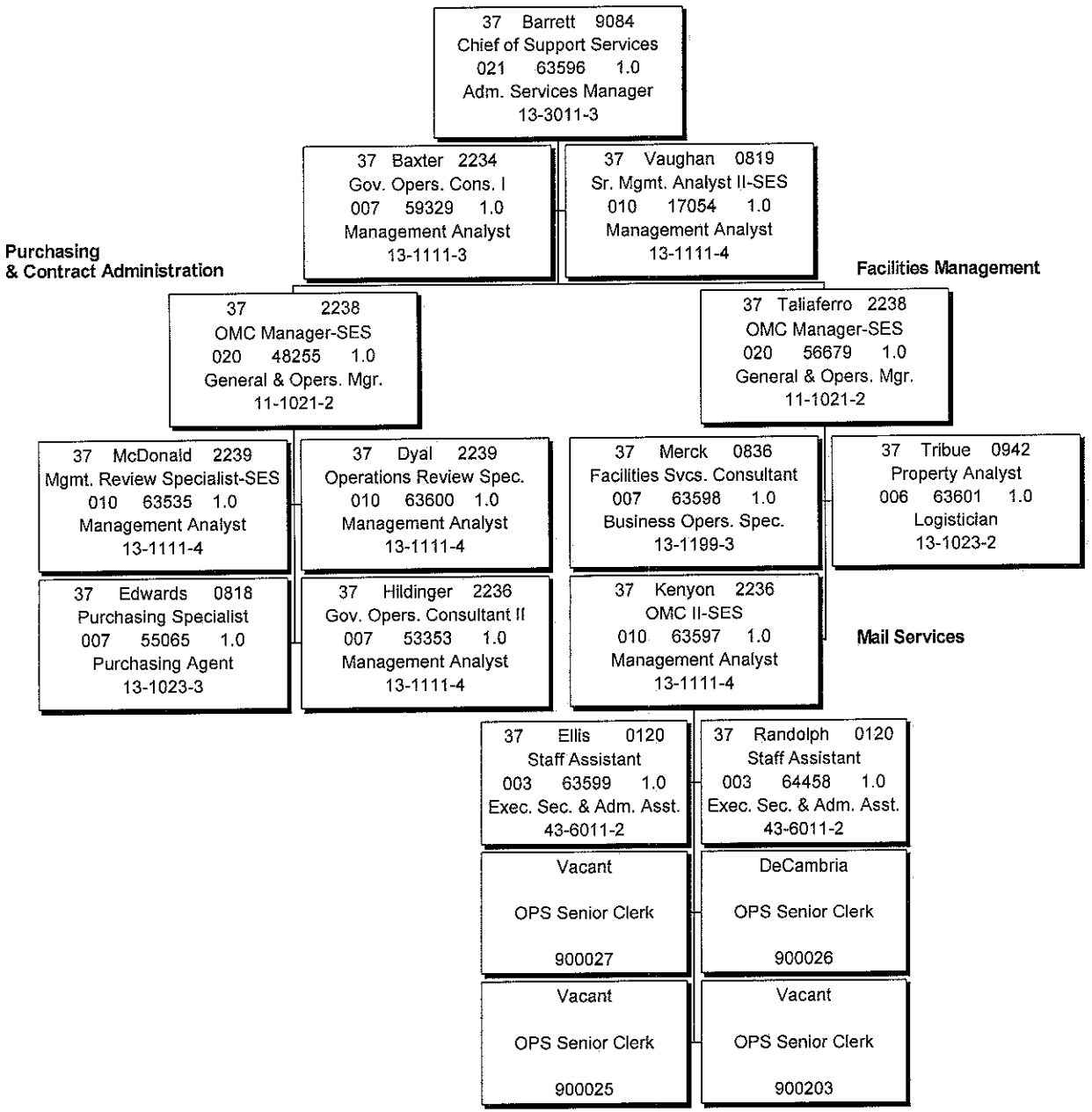
B-1

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



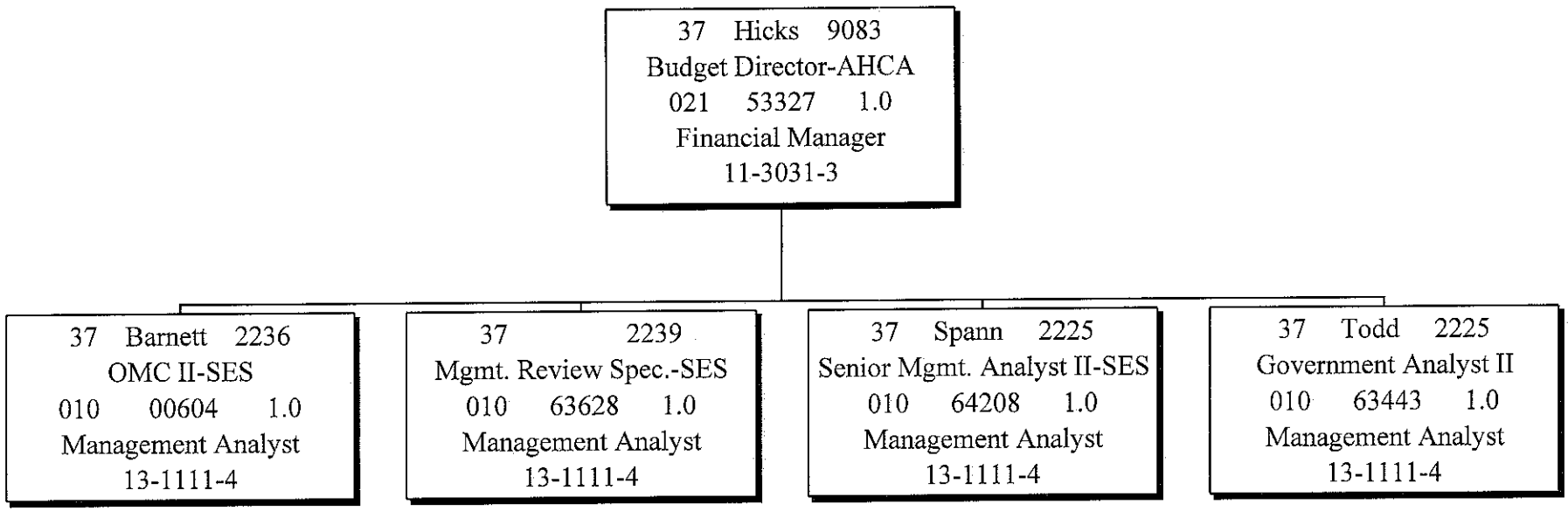
***Shaded position reports to org code 68-30-30-00-00-000 - HQA Field Operations**

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



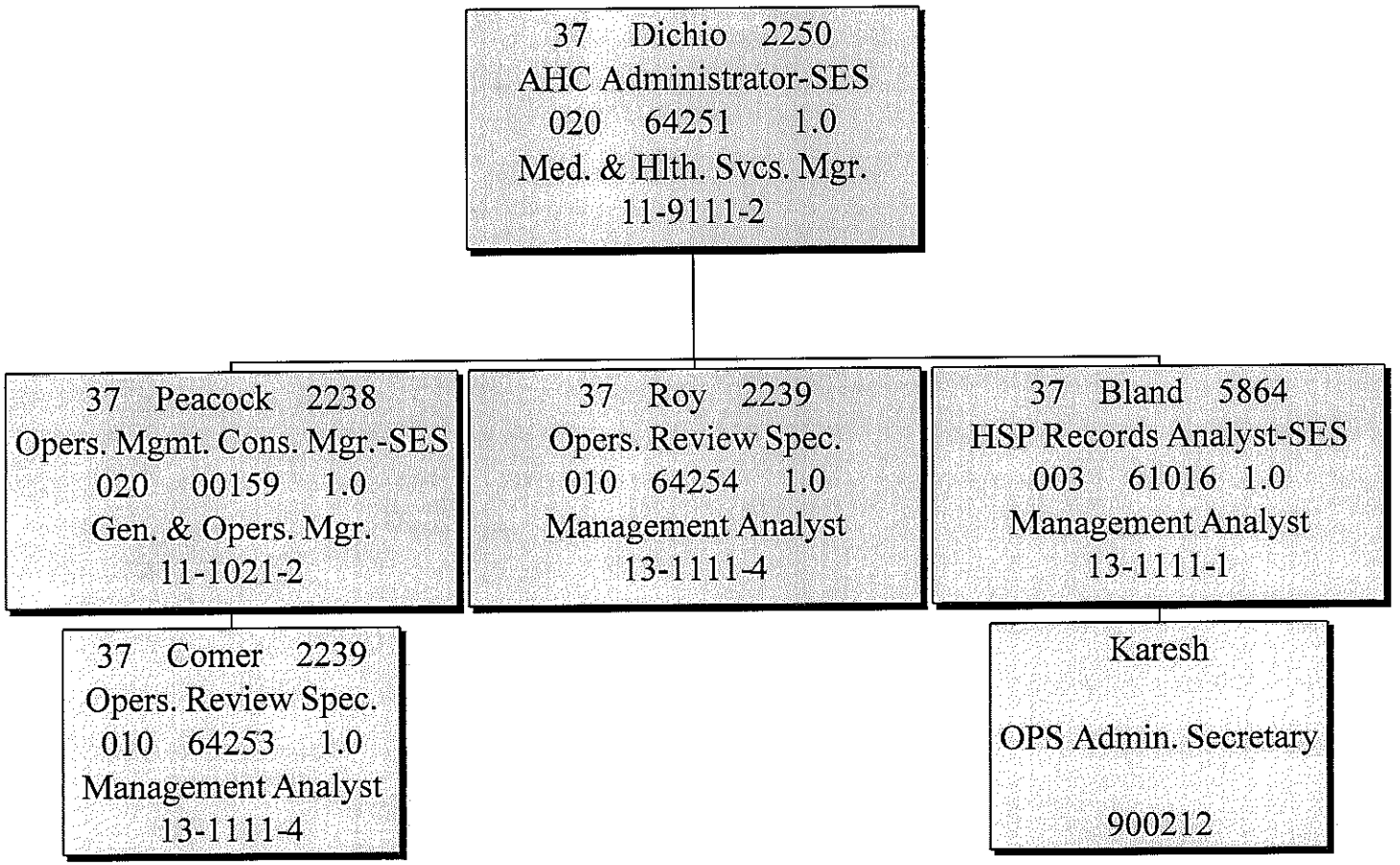
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Budget Office

Org. Level: 68-20-70-00-000
Revised Date: July 1, 2012
FTEs: 5 Positions: 5



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid Third Party Liability

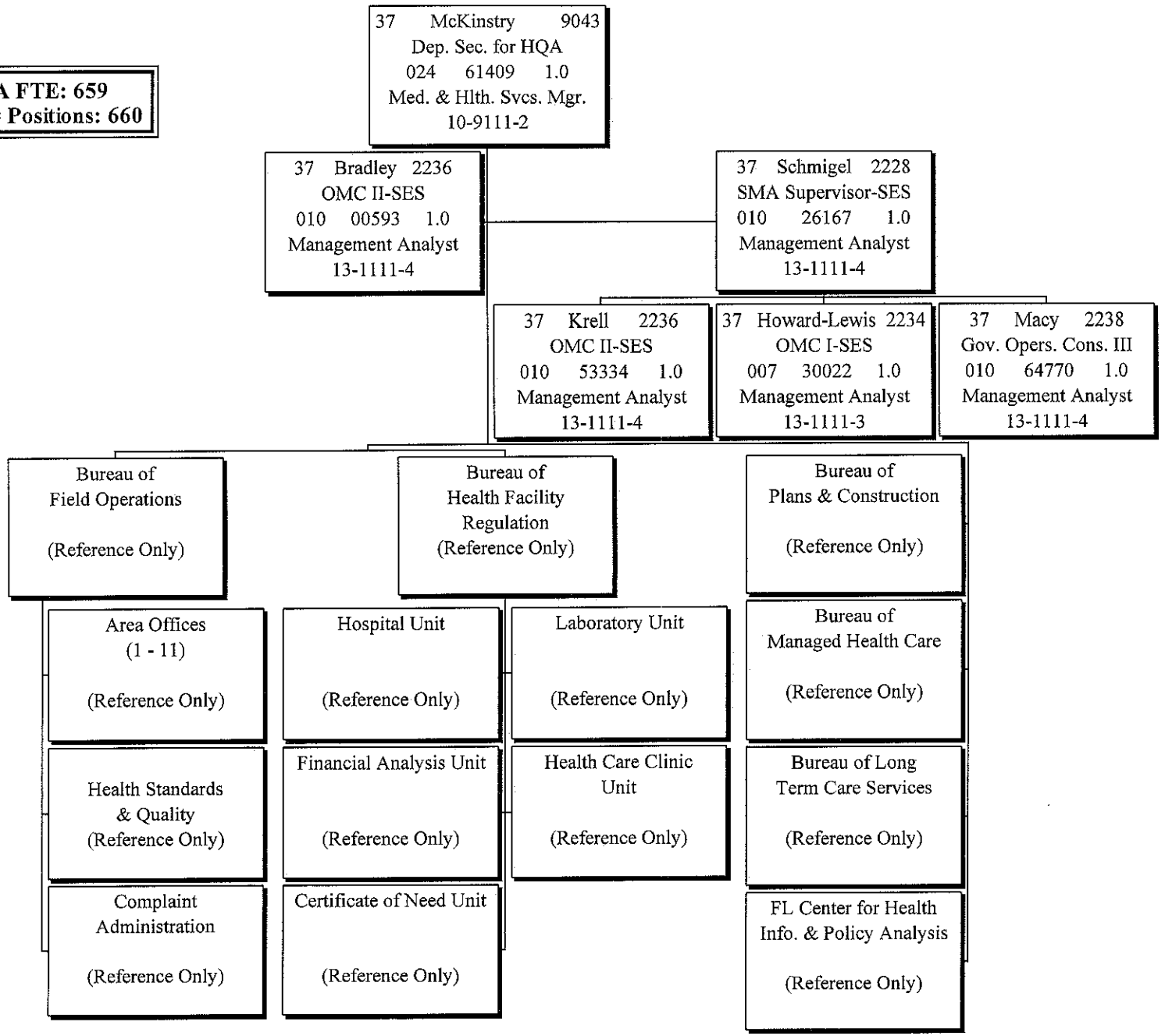
Org. Level: 68-50-70-00-000
Revised Date: July 1, 2012
FTEs: 5 Positions: 5



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

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

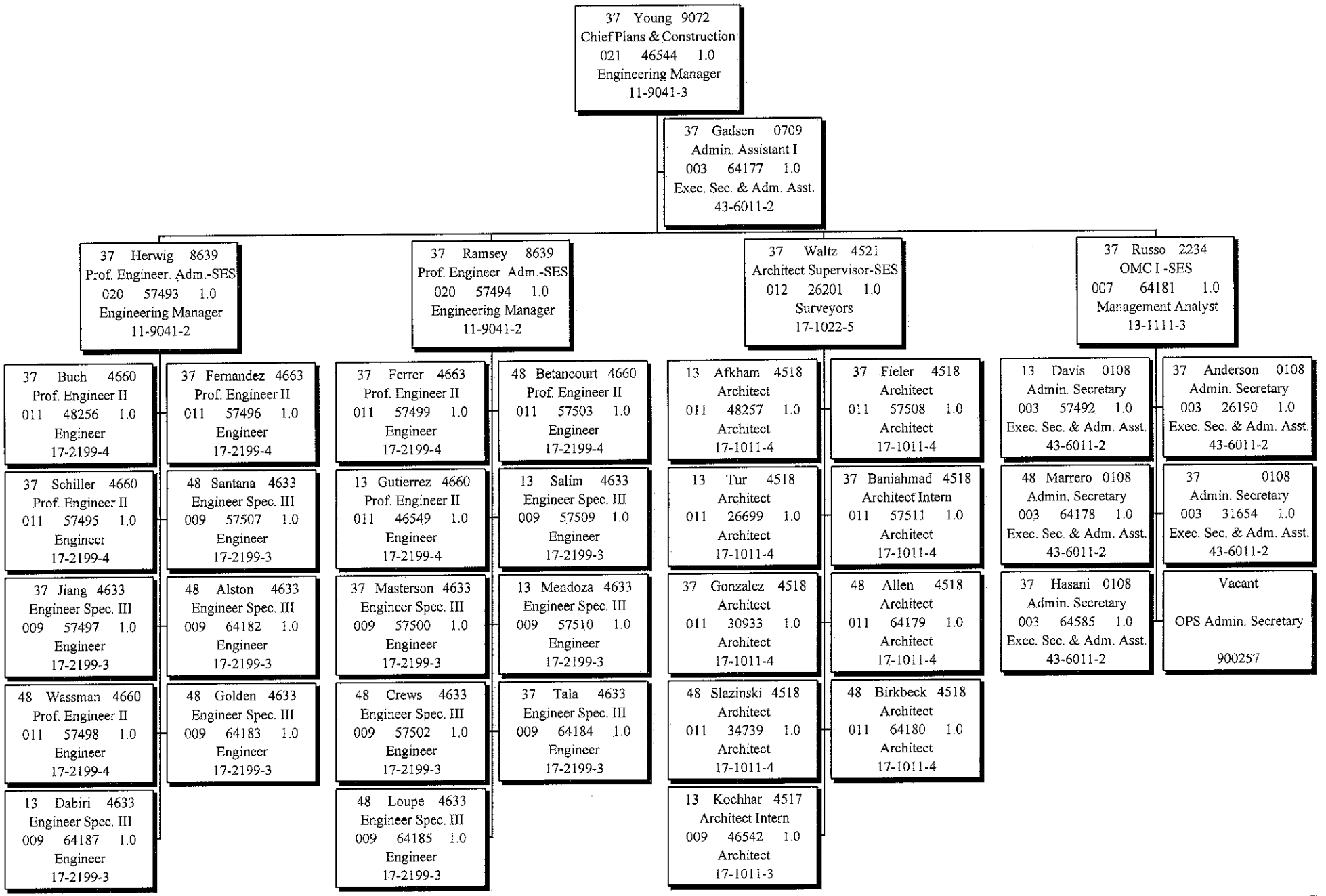
Division of HQA FTE: 659
Division Total # Positions: 660



C-1

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

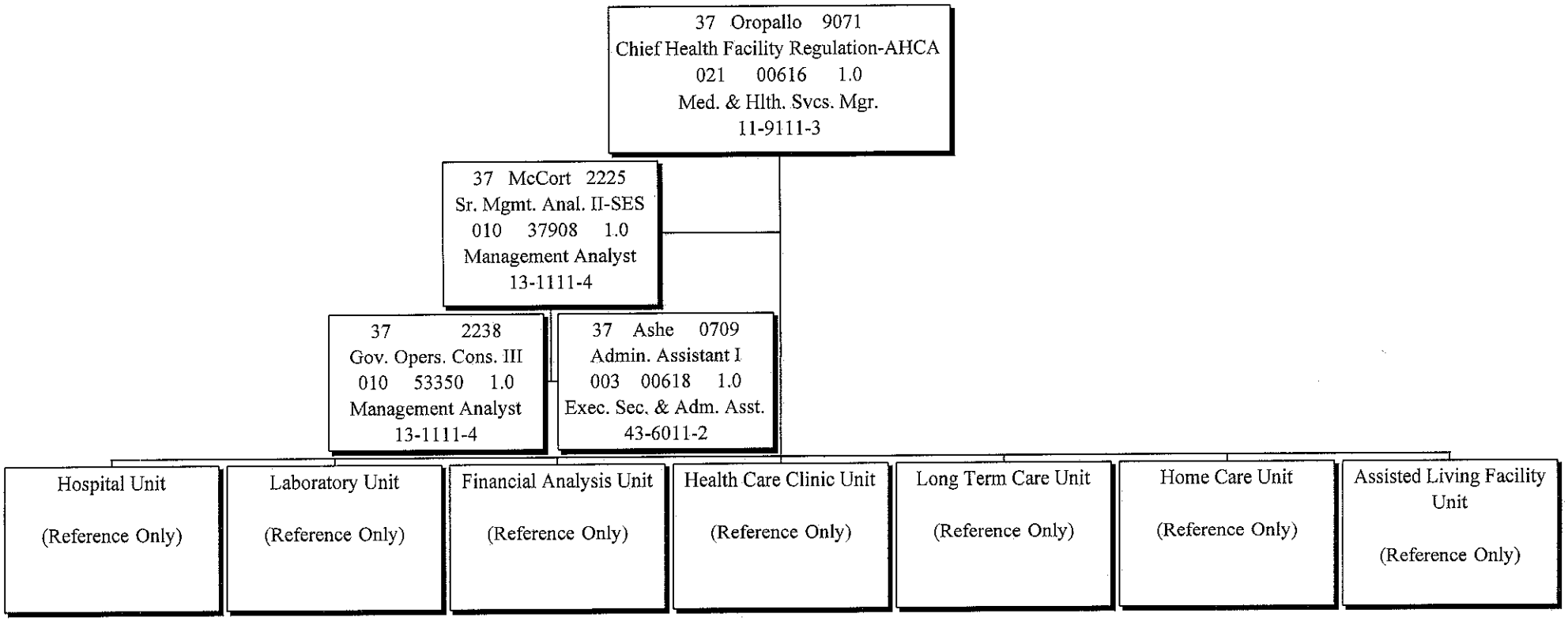
Org. Level: 68 30 10 00 000
Revised Date: July 1, 2012
FTEs: 38 Positions: 38



C-2

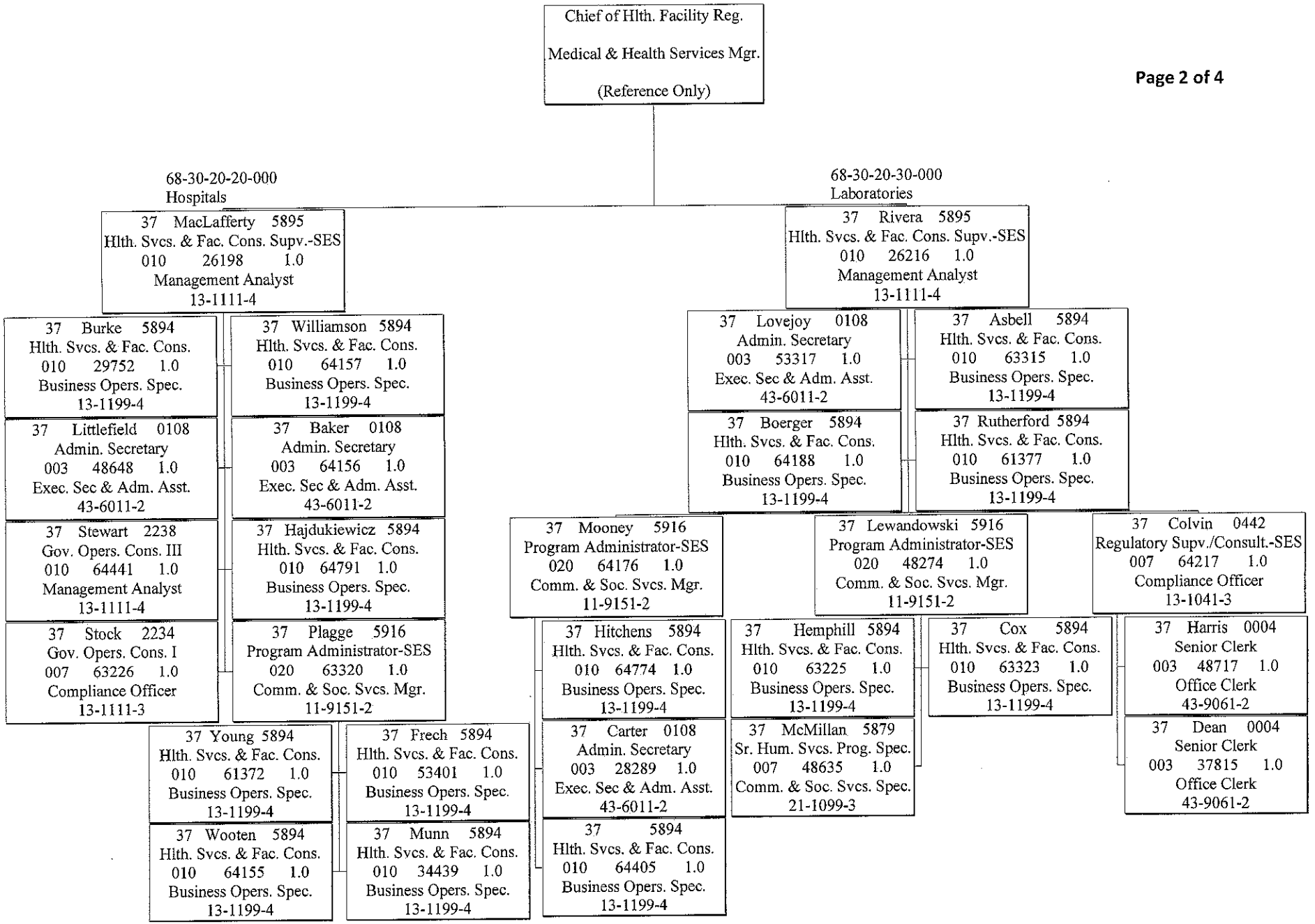
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Org. Level: 68 30 20 00 000
Revised Date: July 1, 2012
FTEs: 93.5 Positions: 94



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

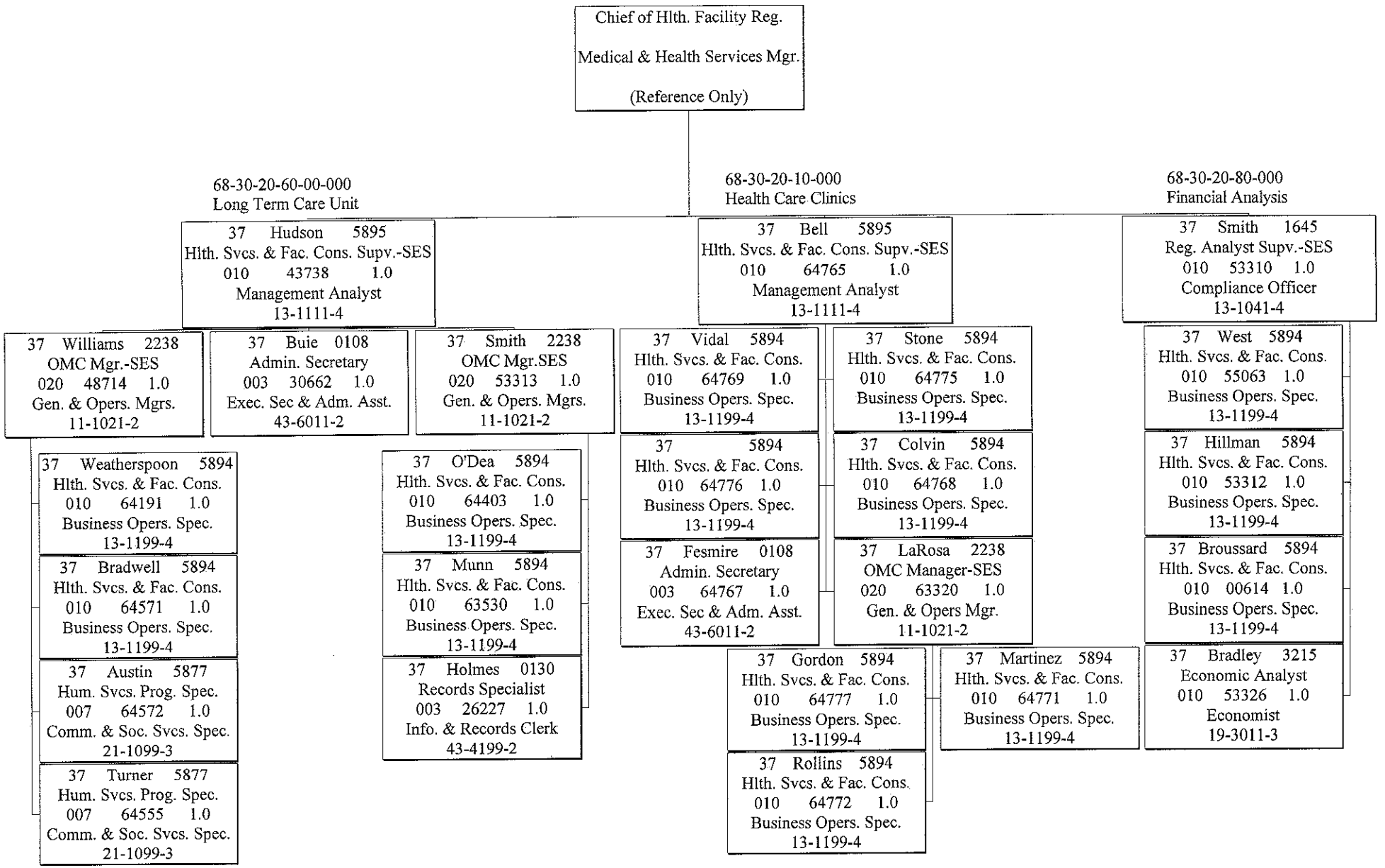
Revised Date: July 1, 2012
FTEs: 93.5 Positions: 94



C-3-1

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

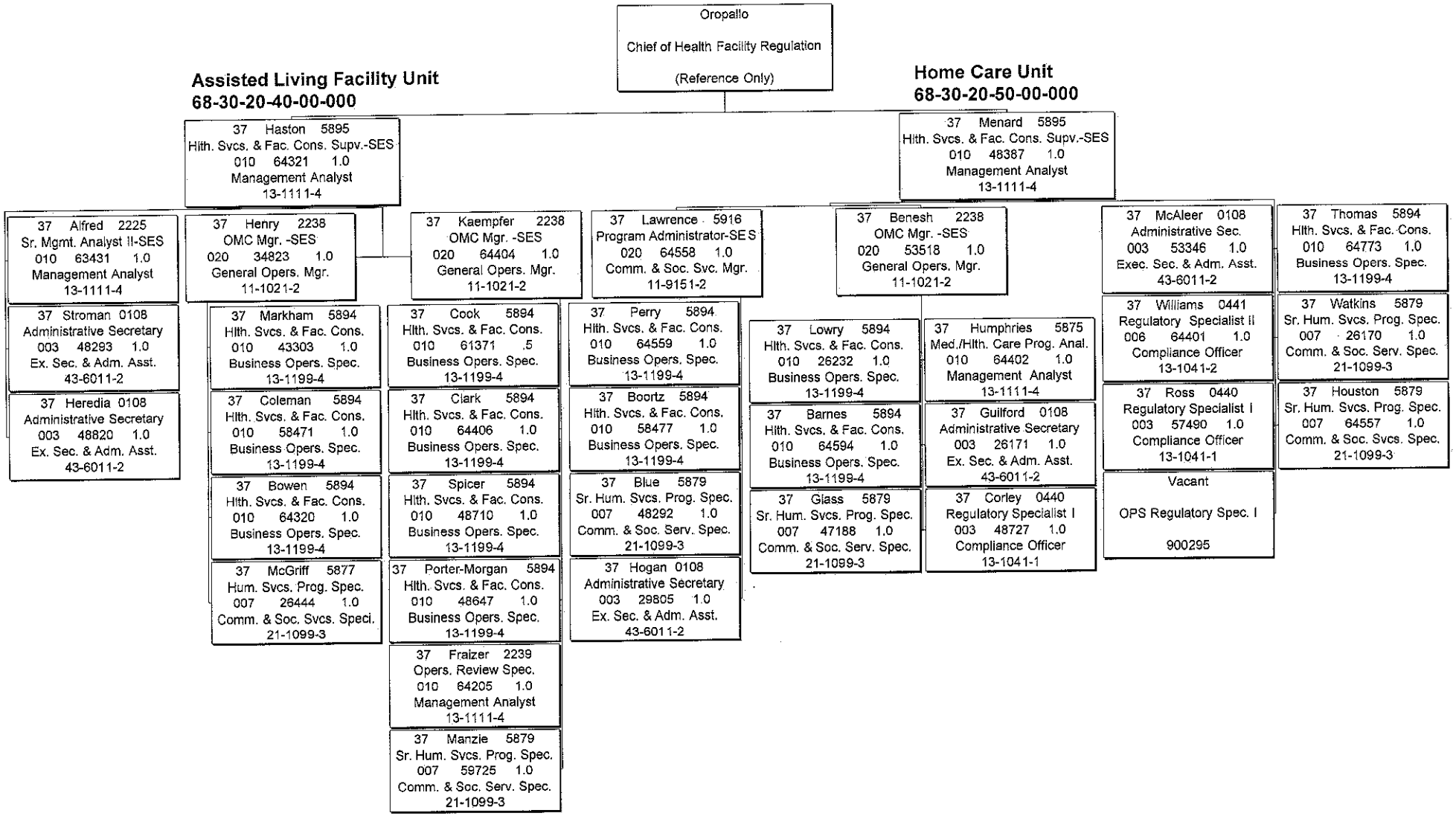
Revised Date: July 1, 2012
FTEs: 93.5 Positions: 94



C-3-2

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

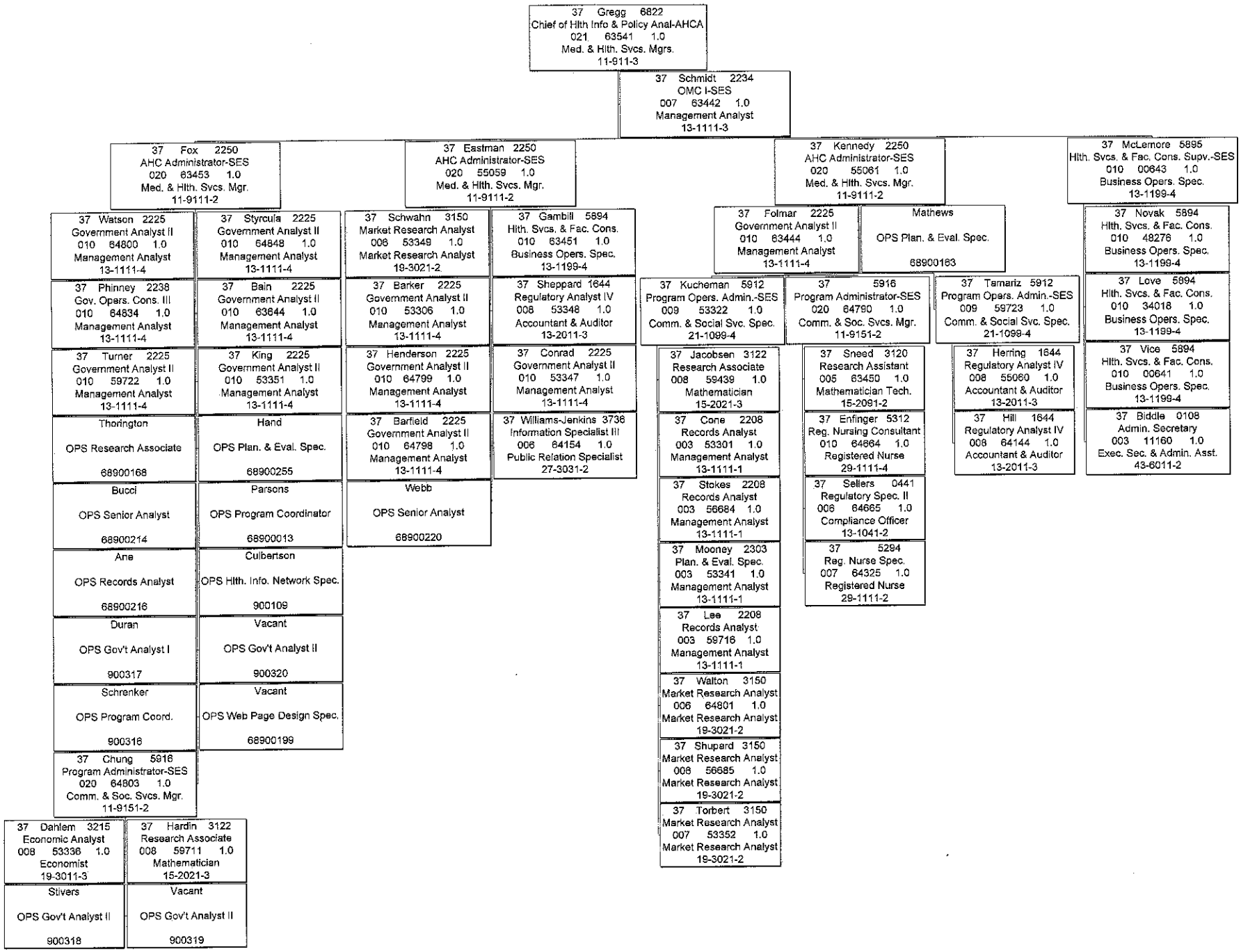
Revised Date: July 1, 2012
FTEs: 93.5 Positions: 94



C-6-2

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

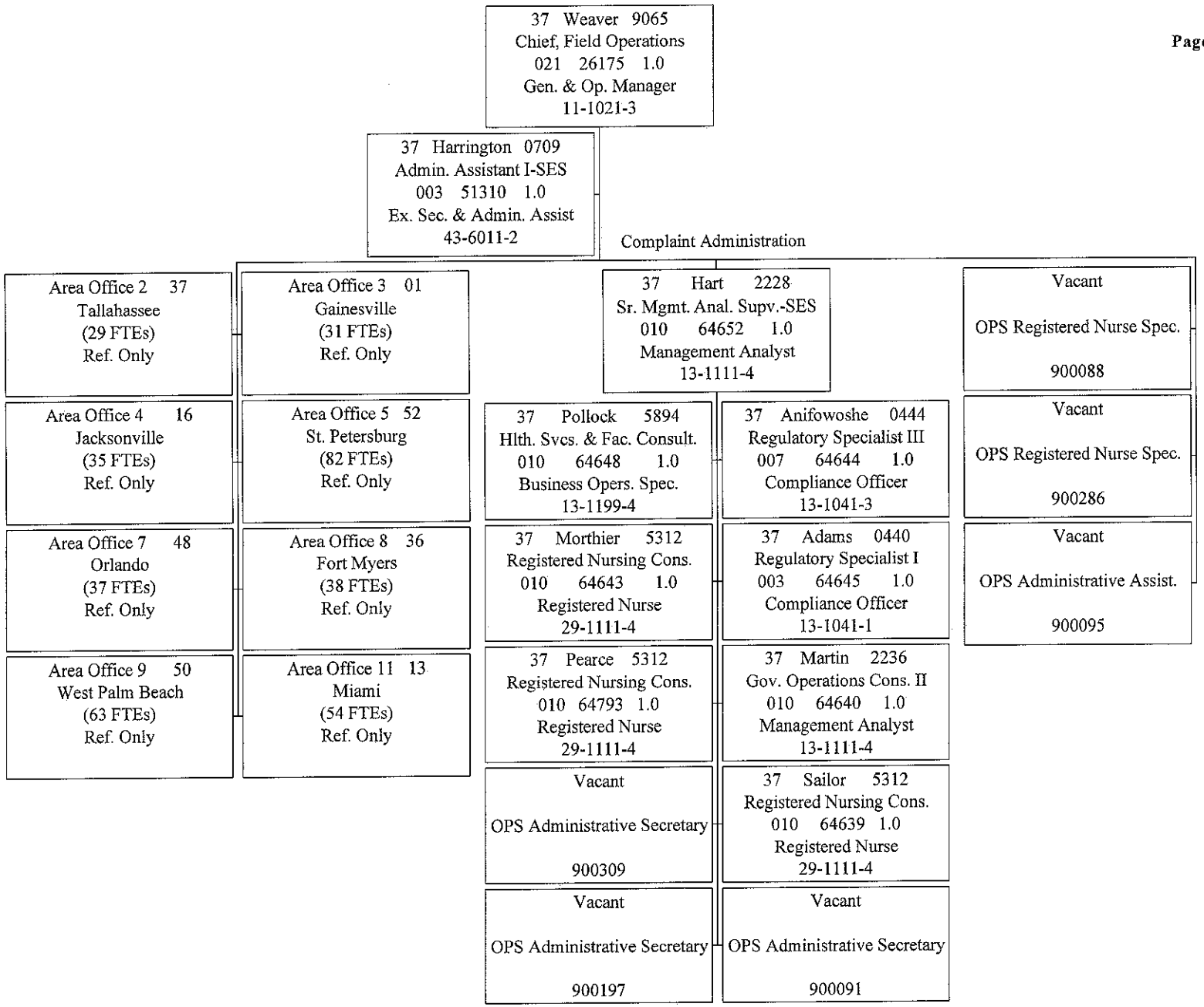
Revised Date: July 1, 2012
Org Level: 68-30-70-00-00-000
FTEs: 45 Positions: 45



C-3-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
(Field Operations)

Org Code: 68-30-30-00-000
Revised Date: July 1, 2012
FTEs: 11 Positions:11

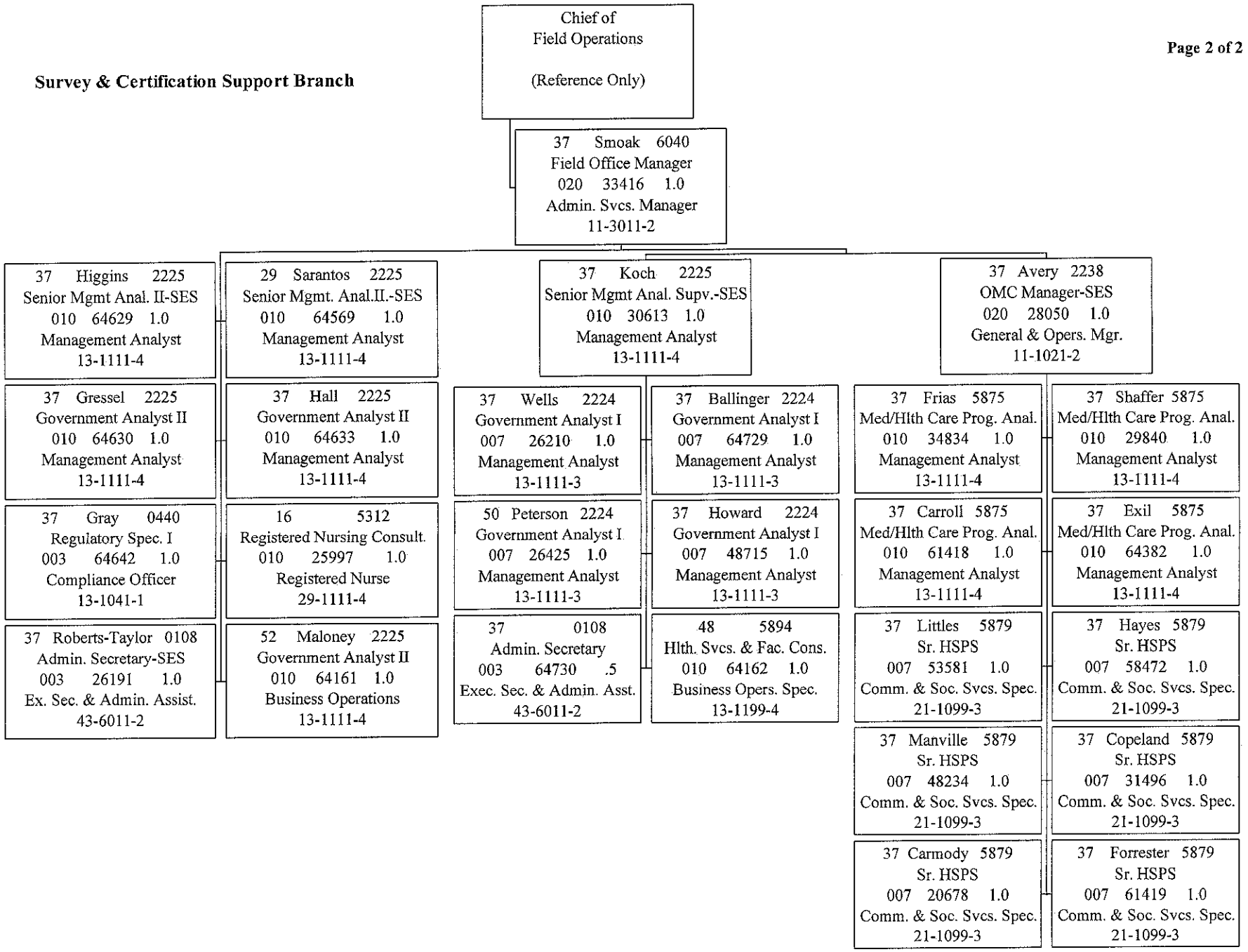


C-4

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

Revised Date: July 1, 2012
Org Level: 68-30-30-30-00-000
FTEs: 26.5 Position: 27

Survey & Certification Support Branch



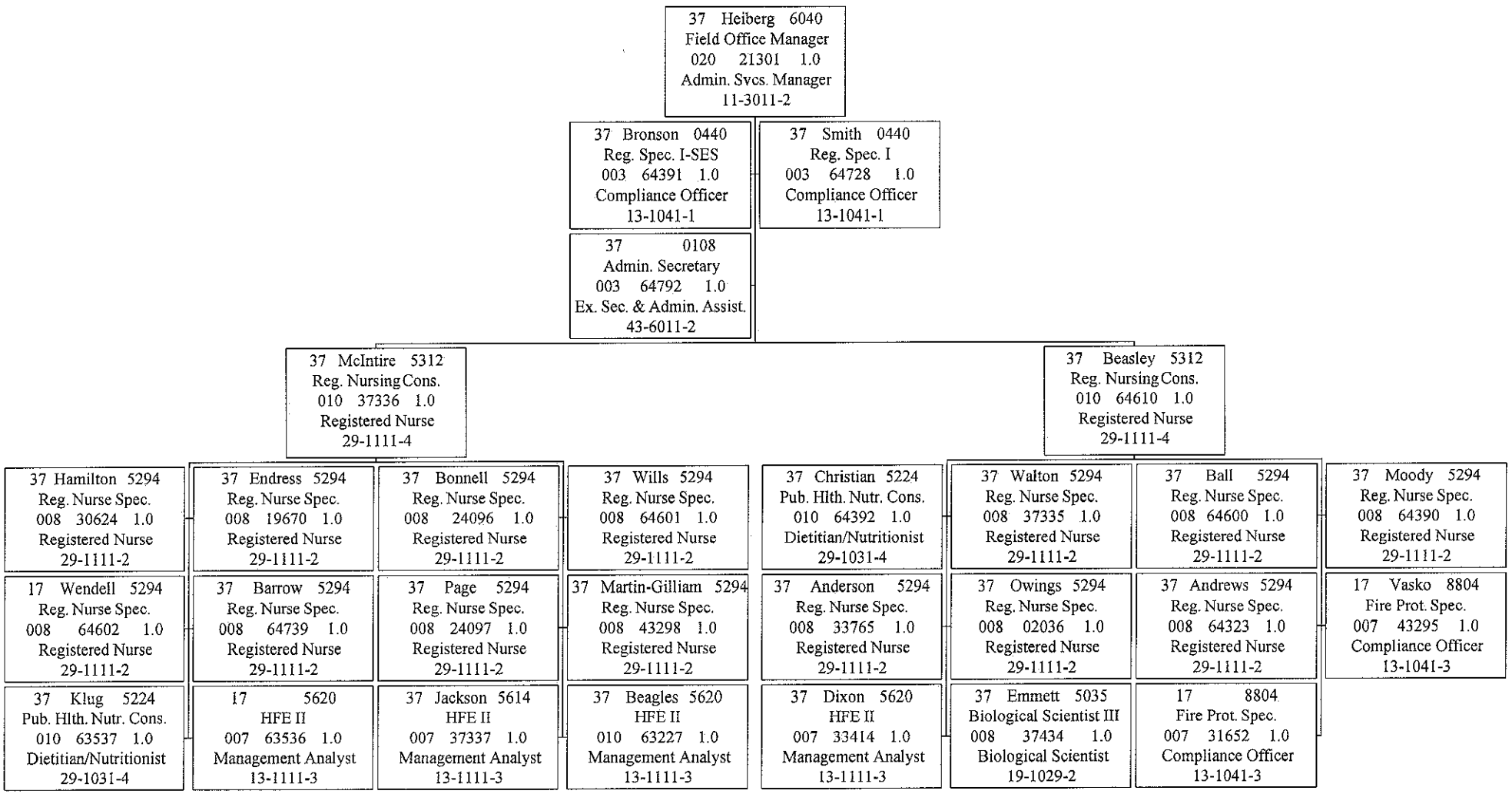
C-4-1

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 2 - Tallahassee

Org. Level: 68 30 30 02 000
Revised Date: July 1, 2012
FTEs: 29 Positions: 29



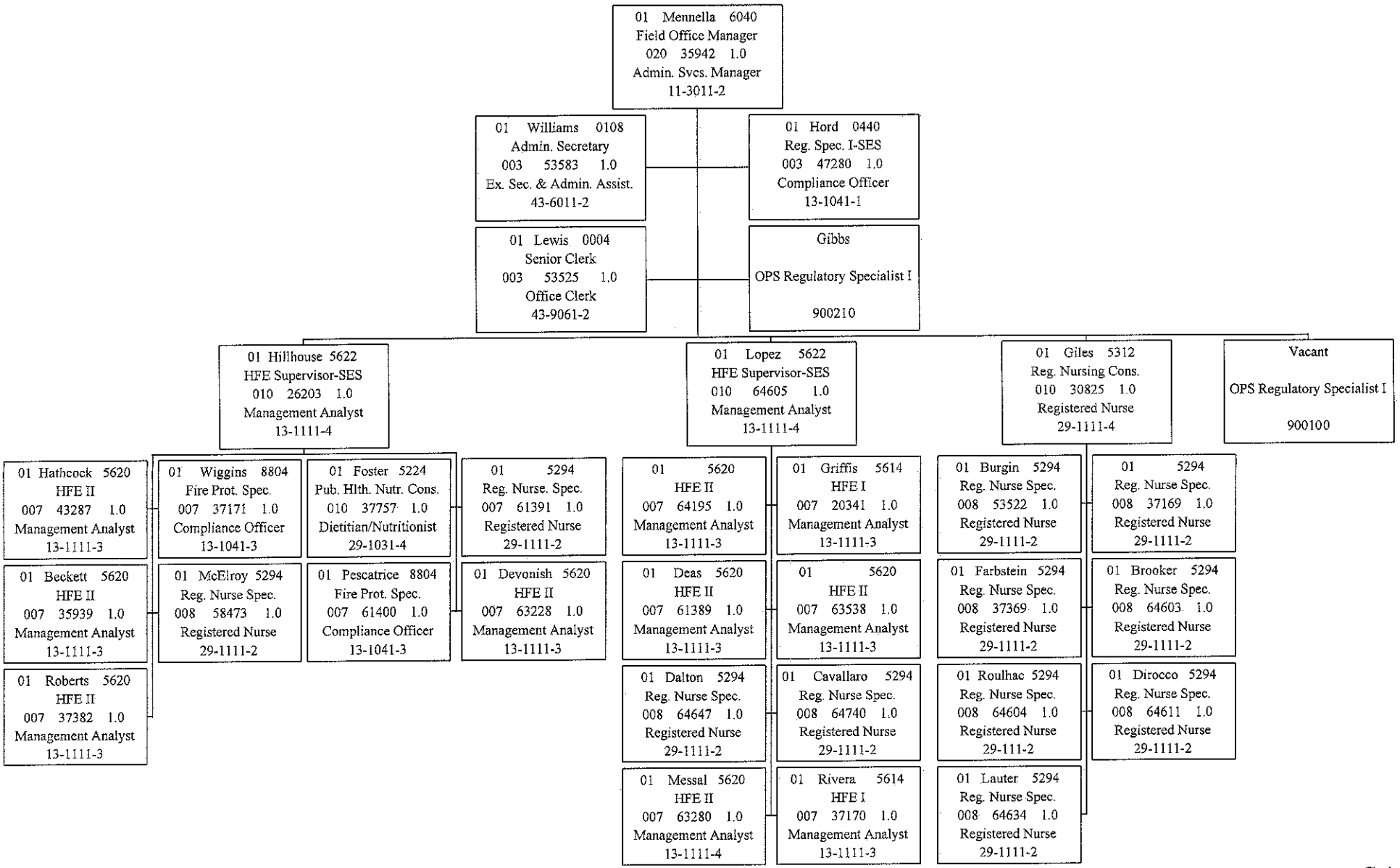
C-4-2

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 3 Alachua

Org. Level: 68 30 30 03 000
Revised Date: July 1, 2012
FTEs: 31 Positions: 31



C-4-3

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 4 - Jacksonville

Org. Level: 68 30 30 04 000
Revised Date: July 1, 2012
FTEs: 35 Positions: 35

16 Dickson 6040
Field Office Manager
020 26197 1.0
Admin. Svcs. Manager
11-3011-2

16 Gill 0441
Reg. Spec. II-SES
006 31144 1.0
Compliance Officer
13-1041-2

16 Edwards 0108
Admin. Secretary
003 43307 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

16 Walker 0440
Reg. Spec. I
003 26211 1.0
Compliance Officer
13-1041-1

16 Morgan 0004
Senior Clerk
003 26187 1.0
Office Clerk
43-9061-2

16 Lynch 5312
Reg. Nursing Cons.
010 26207 1.0
Registered Nurse
29-1111-4

16 Bruer 5620
HFE I
007 26172 1.0
Management Analyst
13-1111-3

16 Distrito 5294
Reg. Nurse Spec.
008 64159 1.0
Registered Nurse
29-1111-2

16 Snyder 5294
Reg. Nurse Spec.
008 64741 1.0
Registered Nurse
29-1111-2

16 5294
Reg. Nurse Spec.
008 48817 1.0
Registered Nurse
29-1111-2

16 Johnson 5294
Reg. Nurse Spec.
008 43291 1.0
Registered Nurse
29-1111-2

16 Estoy 5294
Reg. Nurse Spec.
008 64612 1.0
Registered Nurse
29-1111-2

16 5294
Reg. Nurse Spec.
008 30623 1.0
Registered Nurse
29-1111-2

16 Brennan 8804
Fire Prot. Spec.
007 64635 1.0
Compliance Officer
13-1041-3

16 Foster 5294
Reg. Nurse Spec.
008 34821 1.0
Registered Nurse
29-1111-2

16 Richardson 5294
Reg. Nurse Spec.
008 26223 1.0
Registered Nurse
29-1111-2

16 Woods 5622
HFE Supervisor-SES
010 48821 1.0
Management Analyst
13-1111-4

16 Dorcey 5620
HFE II
007 34825 1.0
Management Analyst
13-1111-3

16 Morin 5620
HFE I
007 39472 1.0
Management Analyst
13-1111-3

16 Hardy 5620
HFE II
007 26224 1.0
Management Analyst
13-1111-3

16 Lyons 5620
HFE II
007 30707 1.0
Management Analyst
13-1111-3

16 Walker 5294
Reg. Nurse Spec.
008 64614 1.0
Registered Nurse
29-1111-2

16 5294
Reg. Nurse Spec.
008 40043 1.0
Registered Nurse
29-1111-2

16 Gustafson 5294
Reg. Nurse Spec.
008 61393 1.0
Registered Nurse
29-1111-2

16 Thompson 5294
Reg. Nurse Spec.
008 30836 1.0
Registered Nurse
29-1111-2

16 Peeples 5622
Registered Nursing Cons.
010 26233 1.0
Management Analyst
13-1111-4

16 Folsom 5035
Bio. Scientist III
008 63328 1.0
Biological Scientist
19-1029-2

16 Linder 5620
HFE II
007 48812 1.0
Management Analyst
13-1111-3

16 Linardi 8804
Fire Prot. Spec.
007 31653 1.0
Compliance Officer
13-1041-3

16 Weerts 5224
Pub. Hlth. Nutr. Cons.
010 37433 1.0
Dietitian/Nutritionist
29-1031-4

16 Branyon 5294
Reg. Nurse Spec.
008 48722 1.0
Registered Nurse
29-1111-2

16 Smith 5294
Reg. Nurse Spec.
008 64606 1.0
Registered Nurse
29-1111-2

16 Vargas-Gonzalez 5294
Reg. Nurse Spec.
008 63229 1.0
Registered Nurse
29-1111-2

16 Floyd-Cox 5294
Reg. Nurse Spec.
008 58474 1.0
Registered Nurse
29-1111-2

16 Nagles 5294
Reg. Nurse Spec.
008 24099 1.0
Registered Nurse
29-1111-2

Vacant
OPS Regulatory Spec. I
900091

Herrin
OPS Reg. Nurse Spec.
900034

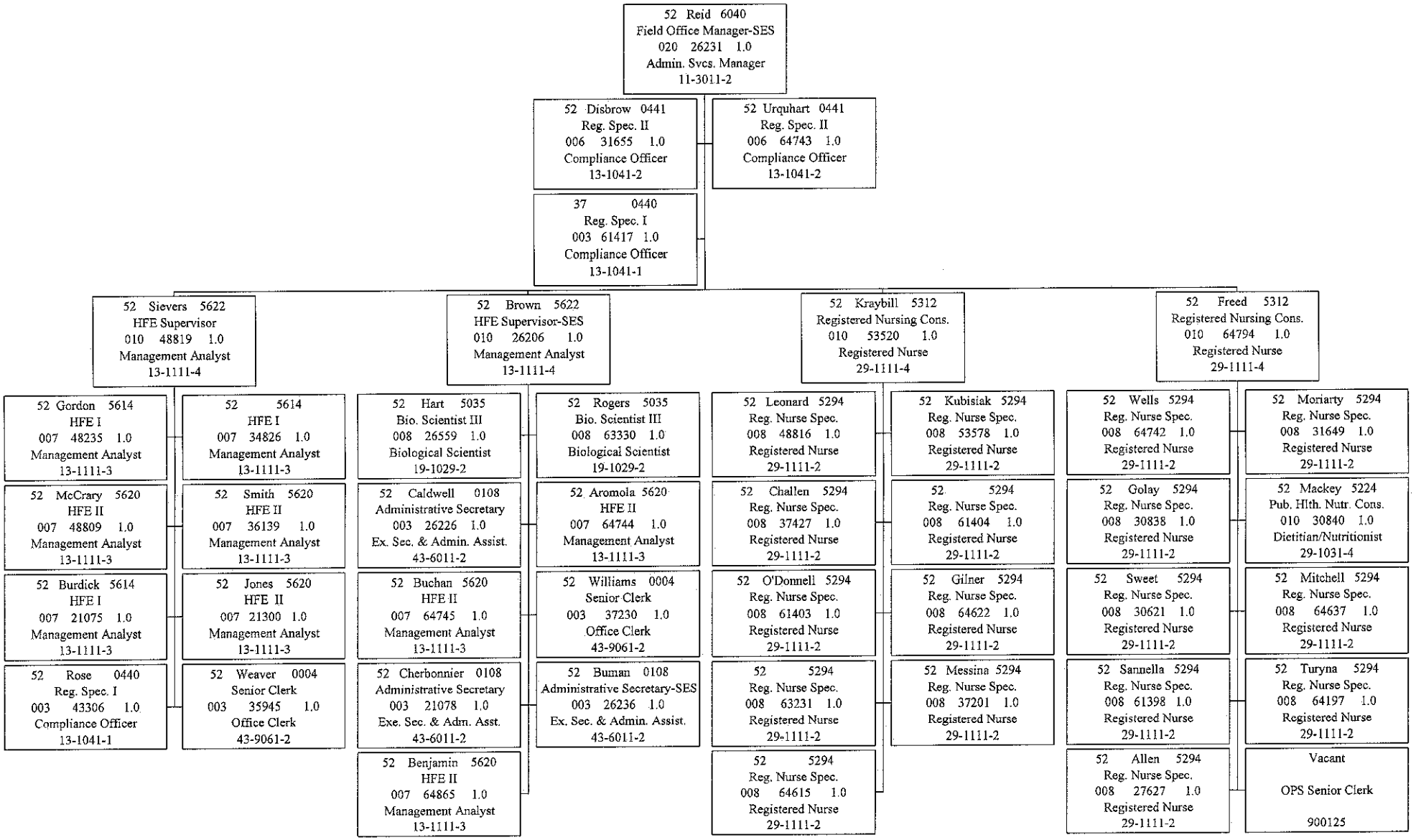
C-4-4

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 5 - St. Petersburg

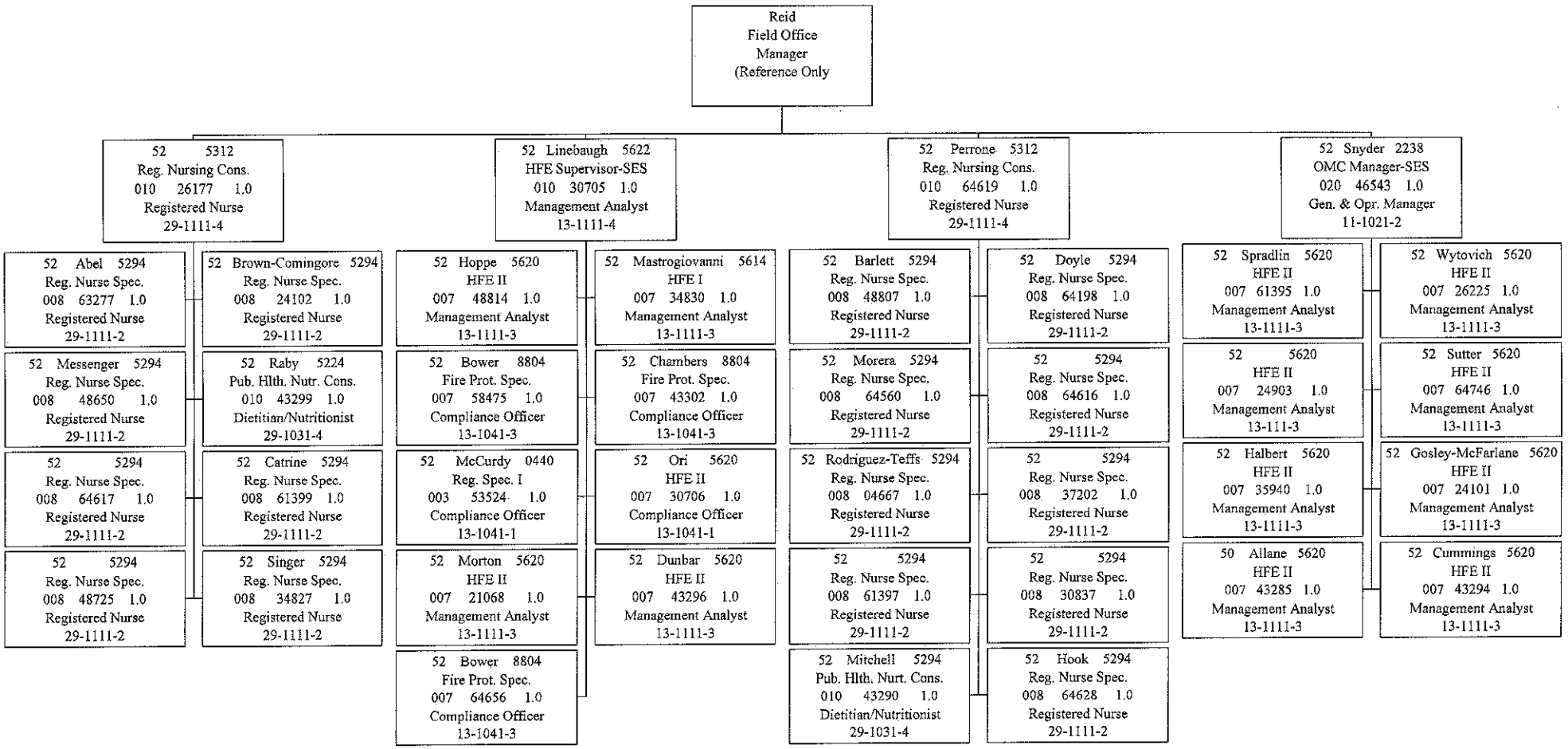
Org Level: 68 30 30 05 00
Revised Date: July 1, 2012
FTEs: 82 Positions: 82



C-4-5

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

Org. Level: 68 30 30 05 000
Revised Date: July 1, 2012
FTEs: 82 Positions: 82

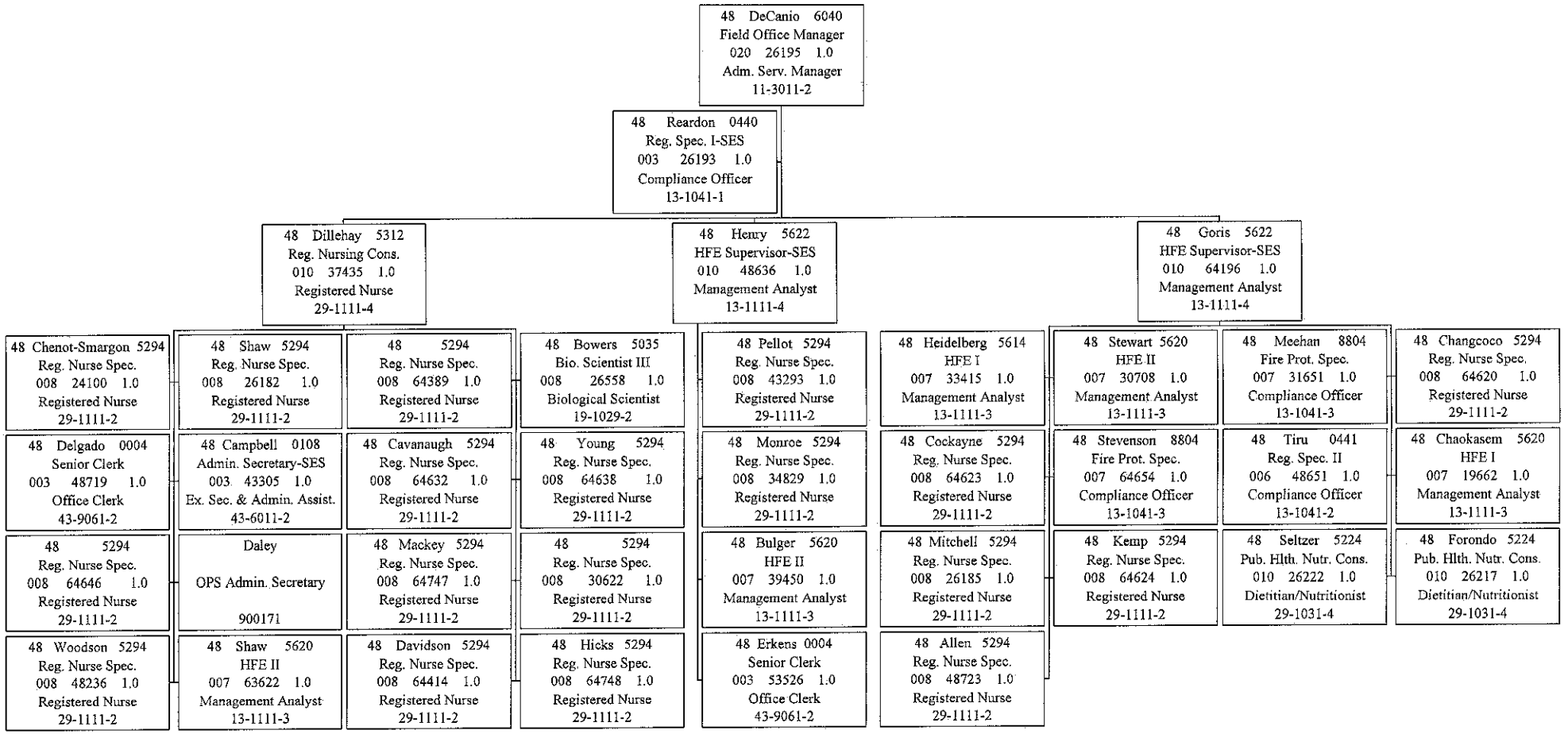


Org. Level: 68 30 30 07 000
Revised Date: July 1, 2012
FTEs: 37 Positions: 37

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 7 - Orlando



C-4-7

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

Org. Level: 68 30 30 08 000
Revised Date: July 1, 2012
FTEs: 38 Positions: 38

36 Williams 6040
Field Office Manager
020 53521 1.0
Adm. Serv. Manager
11-3011-2

36 James 0440
Reg. Spec. I
003 64326 1.0
Compliance Officer
13-1041-1

36 Werts 5622
HFE Supervisor
010 26204 1.0
Management Analyst
13-1111-4

36 S. Smith 0441
Reg. Spec. II
006 64749 1.0
Compliance Officer
13-1041-2

36 Corrales 0004
Senior Clerk
003 25178 1.0
Office Clerk
43-9061-2

36 Bellot 0440
Reg. Spec. I
003 00567 1.0
Compliance Officer
13-1041-1

Quintana
OPS Regulatory Spec. I
900035

36 Tardiff 5294
Reg. Nurse Spec.
008 21982 1.0
Registered Nurse
29-1111-2

36 Alter 5620
HFE II
007 21873 1.0
Management Analyst
13-1111-3

36 Worley 0004
Senior Clerk
003 64388 1.0
Office Clerk
43-9061-2

36 Heckscher 0108
Admin. Secretary
003 25182 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

36 Olivo 5294
Reg. Nurse Spec.
008 61405 1.0
Registered Nurse
29-1111-2

36 Day 5622
HFE Supervisor
010 64200 1.0
Management Analyst
13-1111-4

36 Scavella 5294
Reg. Nurse Spec.
008 63233 1.0
Registered Nurse
29-1111-2

36 Pettigrew 5035
Bio. Scientist III
008 37436 1.0
Biological Scientist
19-1029-2

36 Furdell 8804
Fire Prot. Spec.
007 48808 1.0
Compliance Officer
13-1041-3

36 Stuckey 8804
Fire Prot. Spec.
007 43301 1.0
Compliance Officer
13-1041-3

36 Herbert/O'Connell 5294
Reg. Nurse Spec. (shared)
008 63276 1.0
Registered Nurse
29-1111-2

36 Brandt 5294
Reg. Nurse Spec.
008 30625 1.0
Registered Nurse
29-1111-2

36 Wolfe 5294
Reg. Nurse Spec.
008 63232 1.0
Registered Nurse
29-1111-2

36 Faison 5622
HFE Supervisor
010 48813 1.0
Management Analyst
13-1111-4

36 K. Smith 5620
HFE II
007 64387 1.0
Management Analyst
13-1111-3

36 Elias 5620
HFE II
007 33417 1.0
Management Analyst
13-1111-3

36 McAllister 5620
HFE II
007 64761 1.0
Management Analyst
13-1111-3

36 Seville 5294
Reg. Nurse Spec.
008 31578 1.0
Registered Nurse
29-1111-2

36 Furdell 5620
HFE II
007 19457 1.0
Management Analyst
13-1111-3

36 Steiner 5620
HFE II
007 64194 1.0
Management Analyst
13-1111-3

36 Barrau 5294
Reg. Nurse Spec.
008 61396 1.0
Registered Nurse
29-1111-2

36 Mozen 5294
Reg. Nurse Spec.
008 63230 1.0
Registered Nurse
29-1111-2

36 Fisher 5312
Reg. Nursing Cons.
010 64650 1.0
Registered Nurse
29-1111-4

36 B. Birch 5294
Reg. Nurse Spec.
008 24104 1.0
Registered Nurse
29-1111-2

36 Byrne 5294
Reg. Nurse Spec.
008 64625 1.0
Registered Nurse
29-1111-2

36 Kaczmarek 5294
Reg. Nurse Spec.
008 64626 1.0
Registered Nurse
29-1111-2

36 Seehawer 5294
Reg. Nurse Spec.
008 31574 1.0
Registered Nurse
29-1111-2

36 Taylor 5294
Reg. Nurse Spec.
008 64627 1.0
Registered Nurse
29-1111-2

36 Pinto 5224
Pub. Hlth. Nutr. Cons.
010 64609 1.0
Dietitian/Nutritionist
29-1031-4

36 Leavor 5294
Reg. Nurse Spec.
008 37828 1.0
Registered Nurse
29-1111-2

36 Leinert 5294
Reg. Nurse Spec.
008 43283 1.0
Registered Nurse
29-1111-2

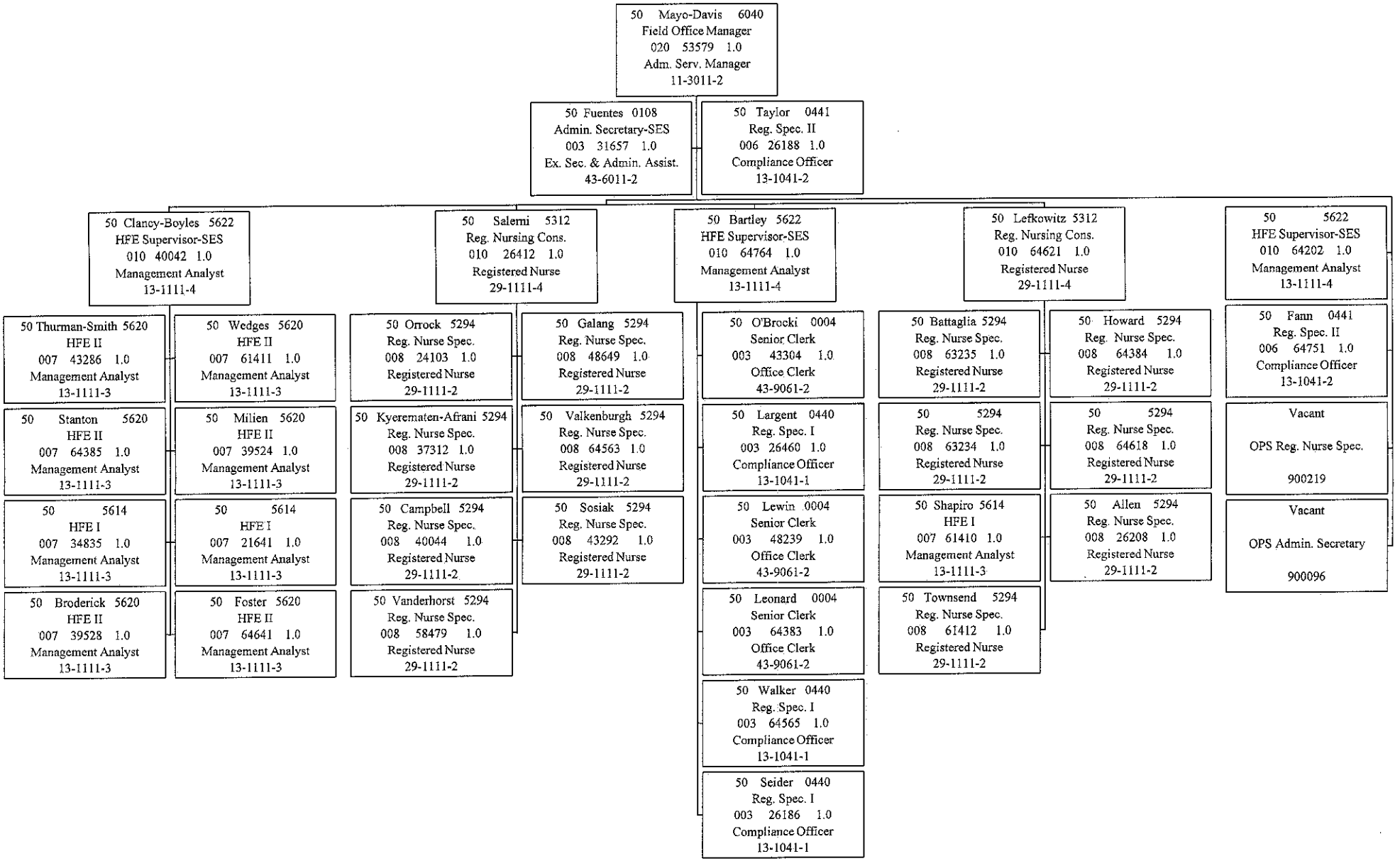
36 Vanderford 5294
Reg. Nurse Spec.
010 34822 1.0
Registered Nurse
29-1111-2

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 9 - West Palm Beach

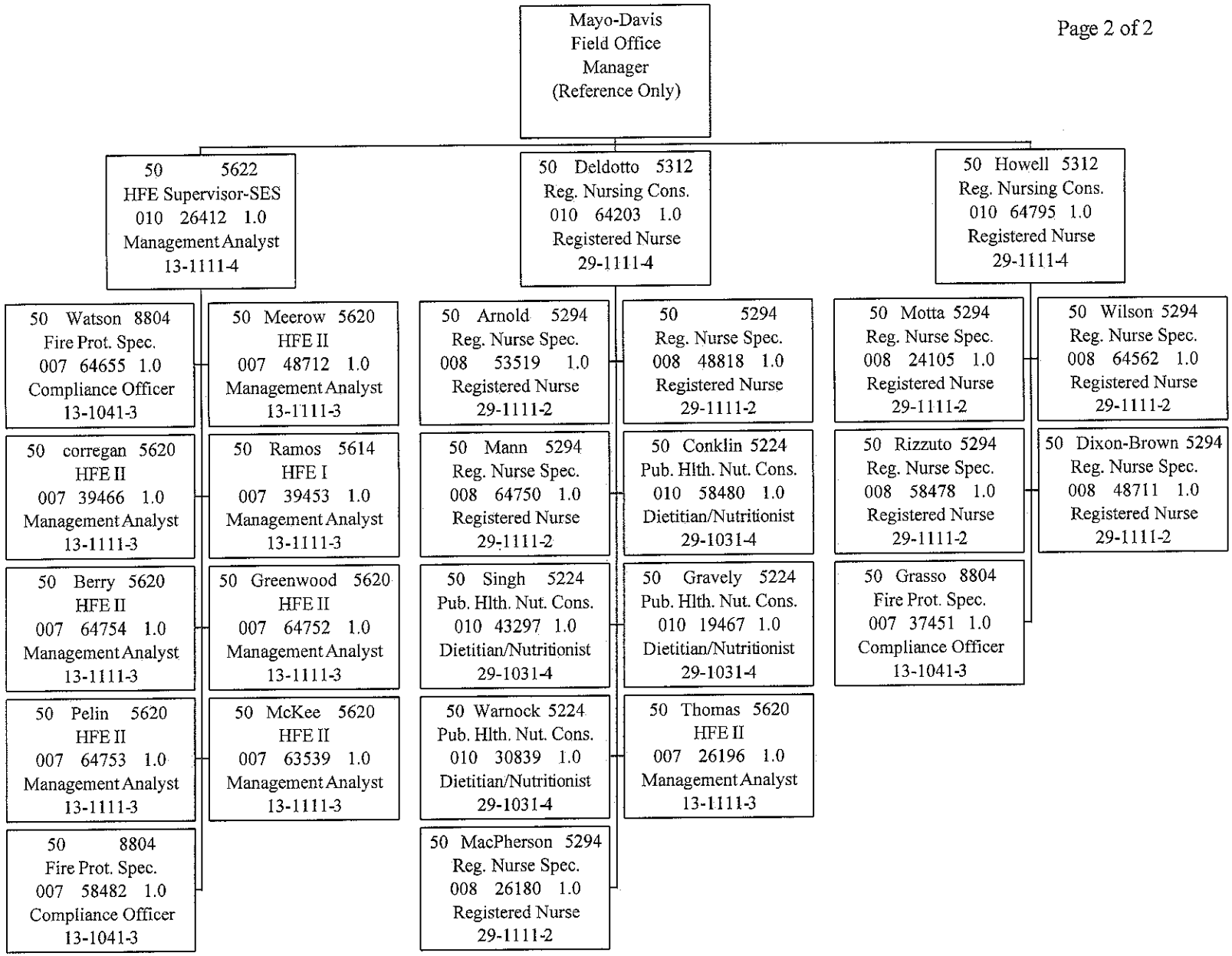
Org. Level: 68 30 30 09 000
Revised Date: July 1, 2012
FTEs: 63 Positions: 63



C-4-9

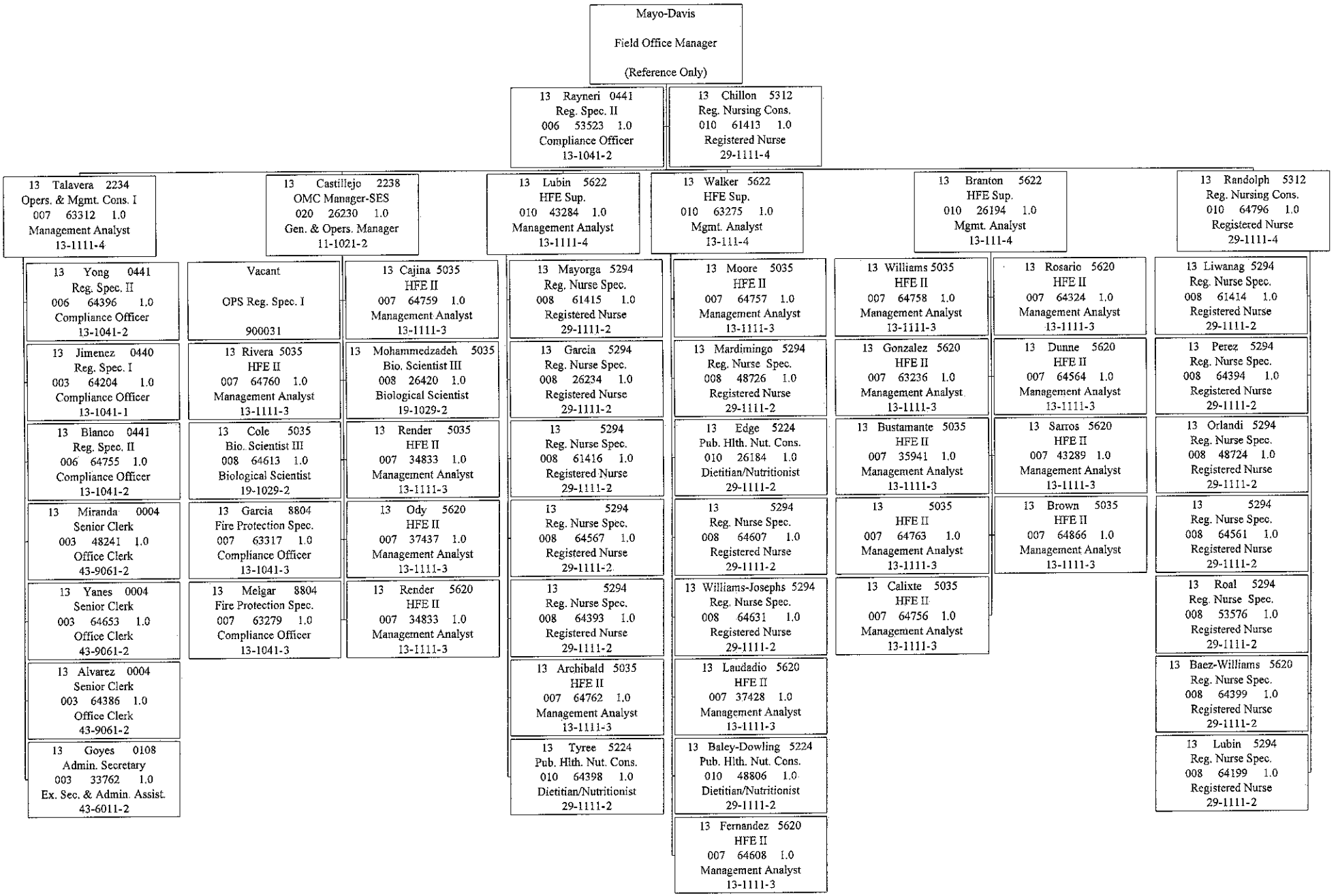
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 9 - West Palm Beach

Org Code: 68 30 30 09 000
Revised Date: July 1, 2012
FTEs: 63 Positions: 63



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

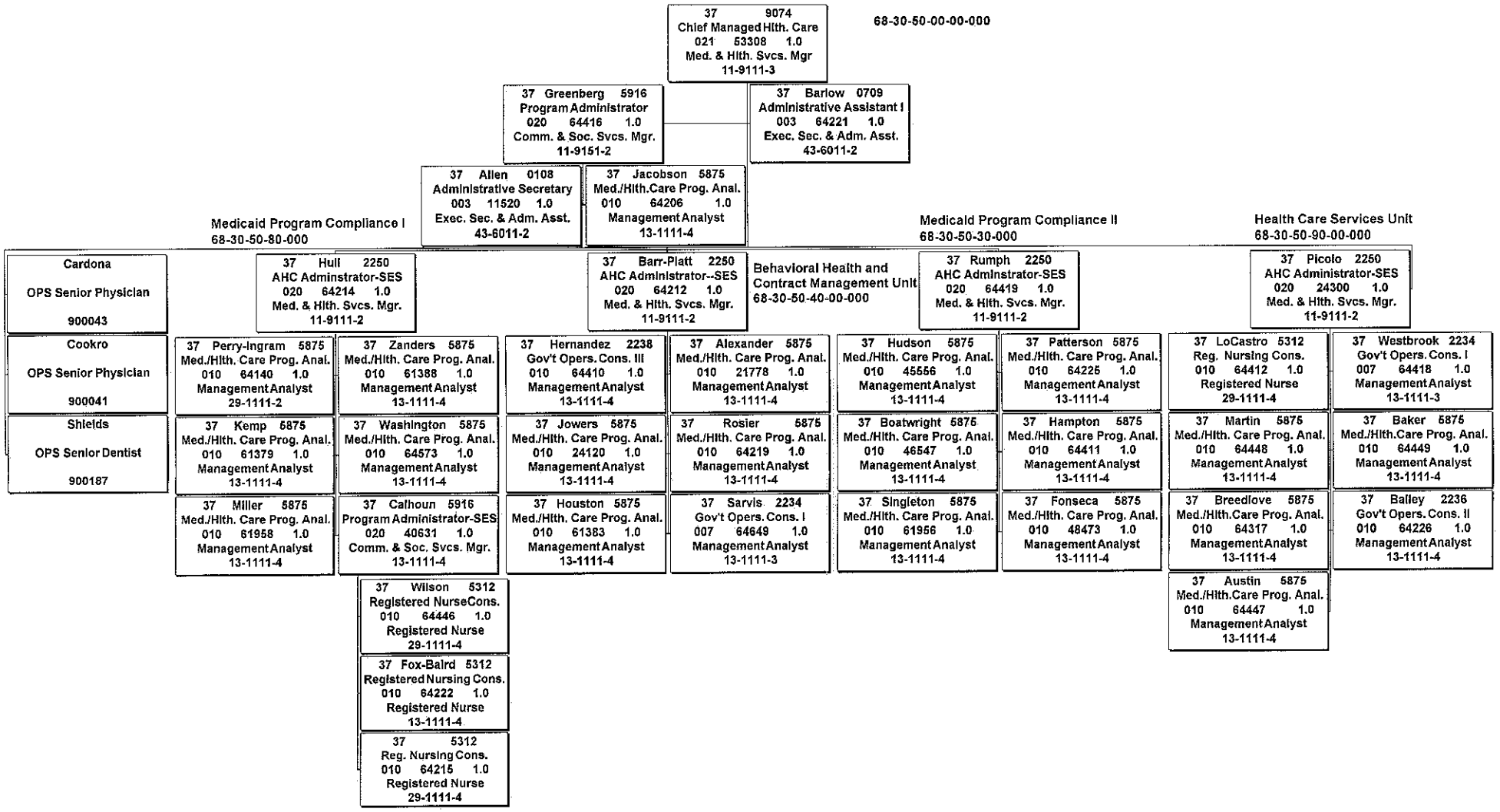
Org. Level: 68 30 30 11 000
Revised Date: July 1, 2012
FTEs: 54 Positions: 54



C-4-11

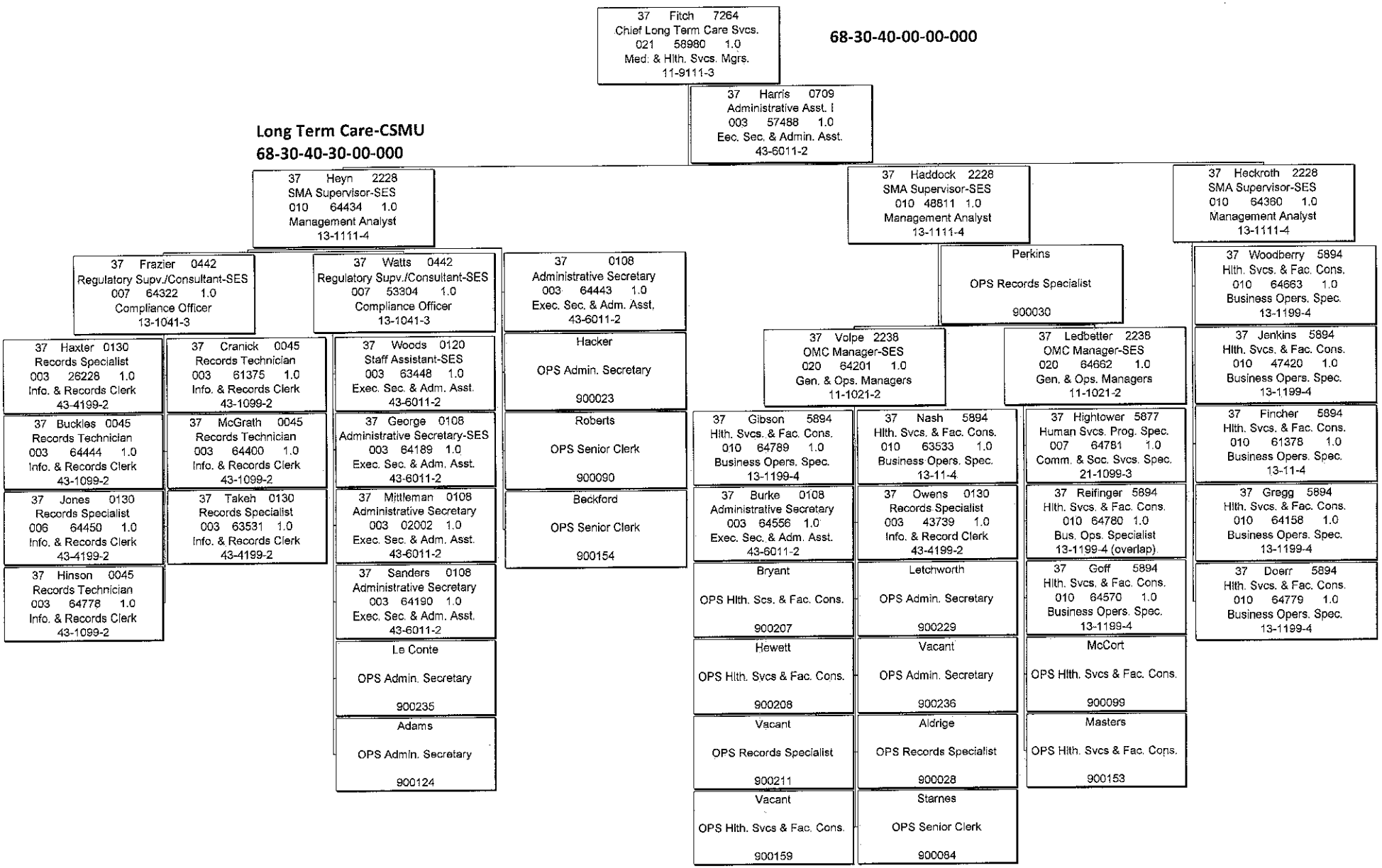
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance - Managed Health Care

Revised Date: July 1, 2012
FTEs: 37 Positions: 37



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

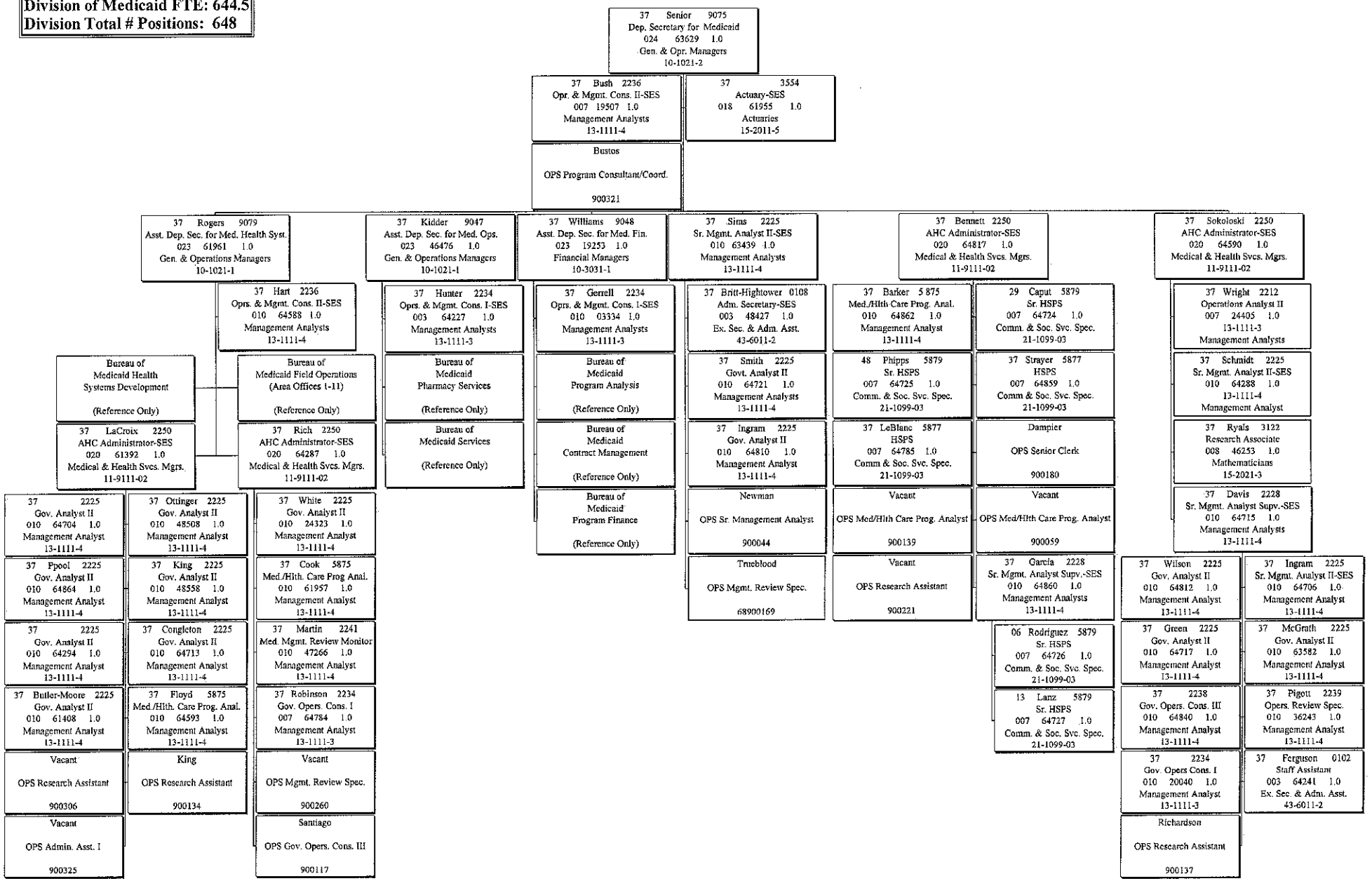
Revised Date: July 1, 2012
FTEs: 33 Positions: 33



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

Org. Level: 68500000000
Revised Date: July 1, 2012
FTEs: 50 Positions: 50

Division of Medicaid FTE: 644.5
Division Total # Positions: 648

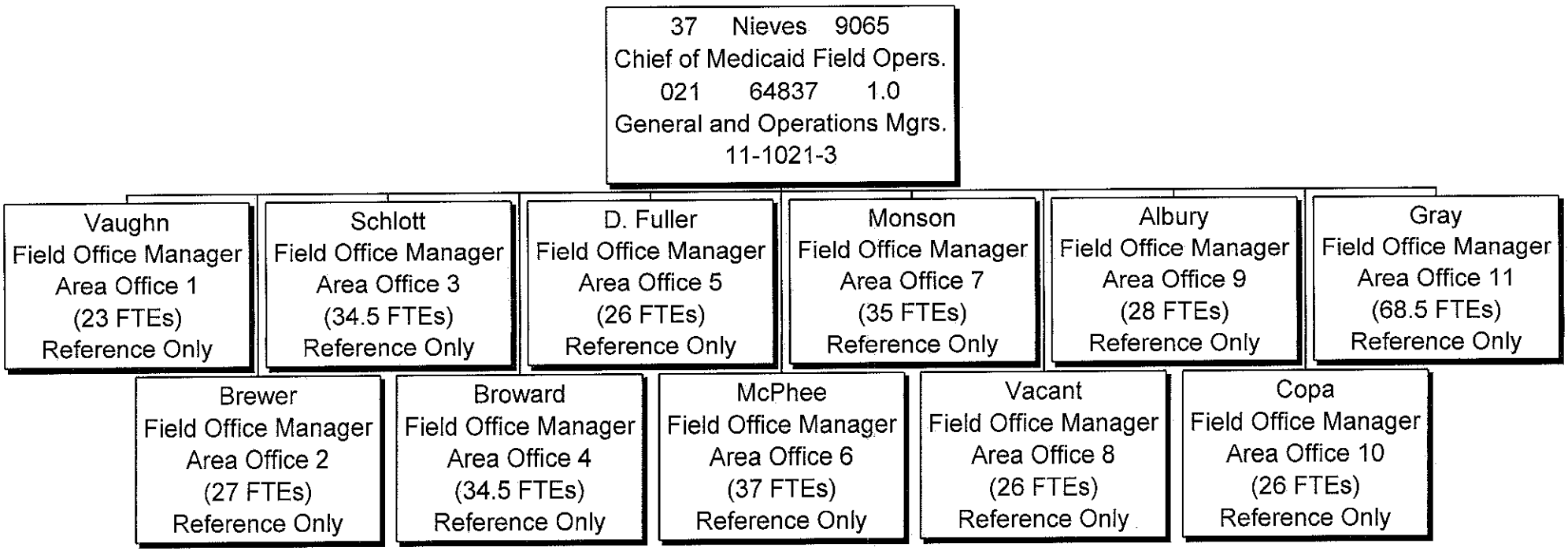


E-1

AGENCY FOR HEALTH CARE ADMINISTRATION

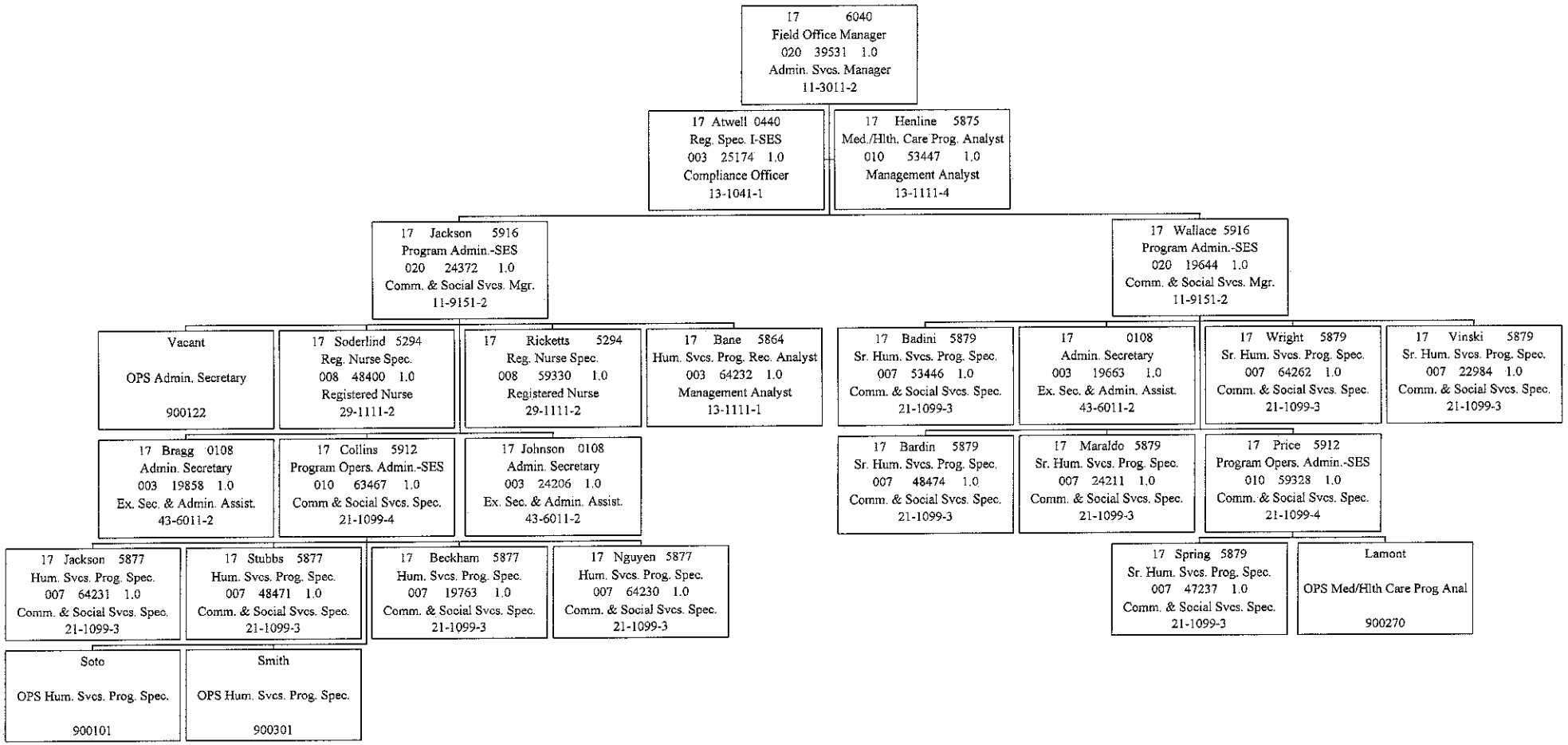
Bureau of Medicaid Field Operations

Org. Level: 68 50 10 00 000
Revised Date: July 1, 2012
FTEs: 365.5 Positions: 369



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 1 - Pensacola

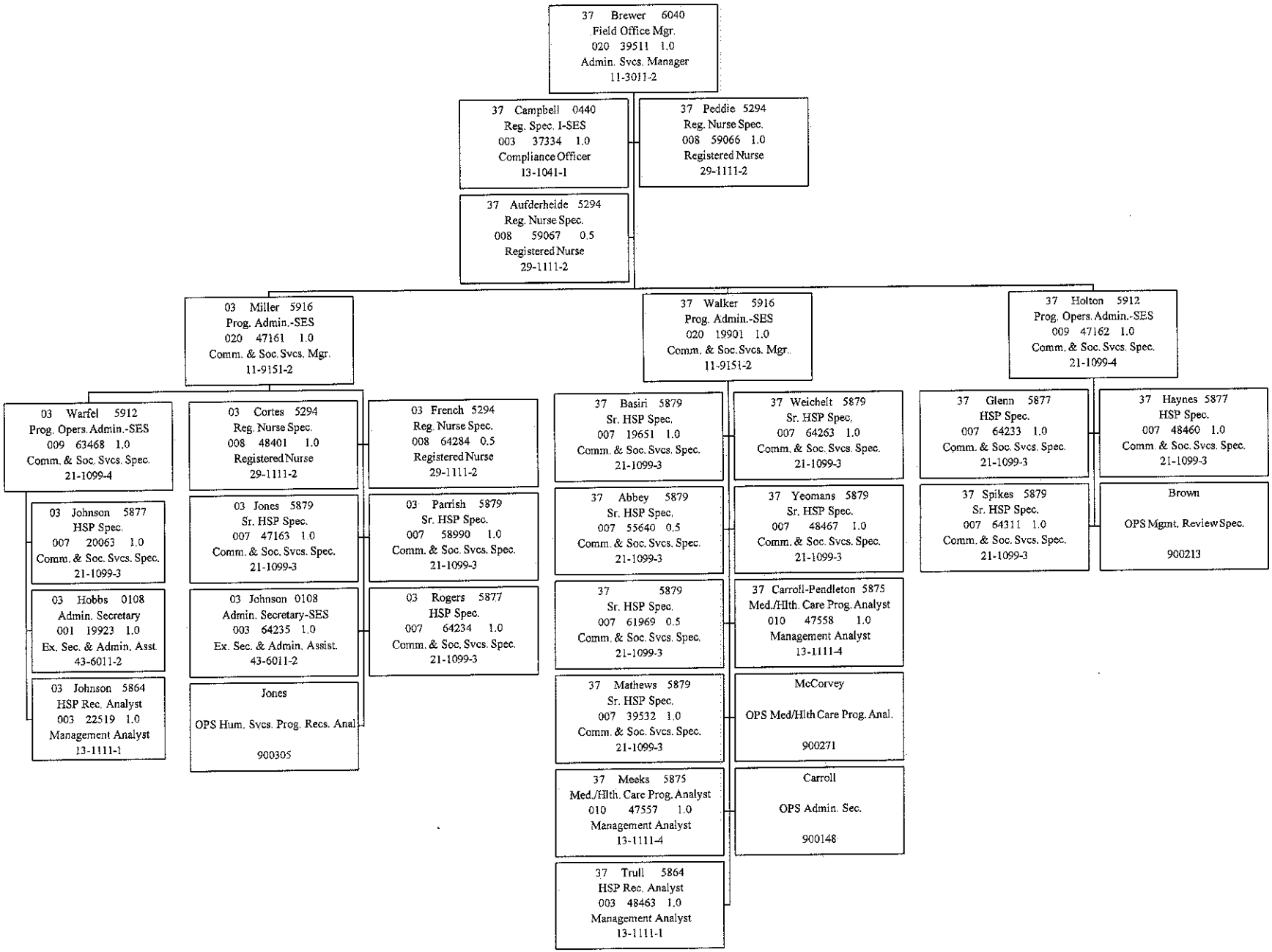
Org. Level: 68 50 10 01 000
Revised Date: July 1, 2012
FTEs: 23 Positions: 23



E-4-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 2 - Tallahassee

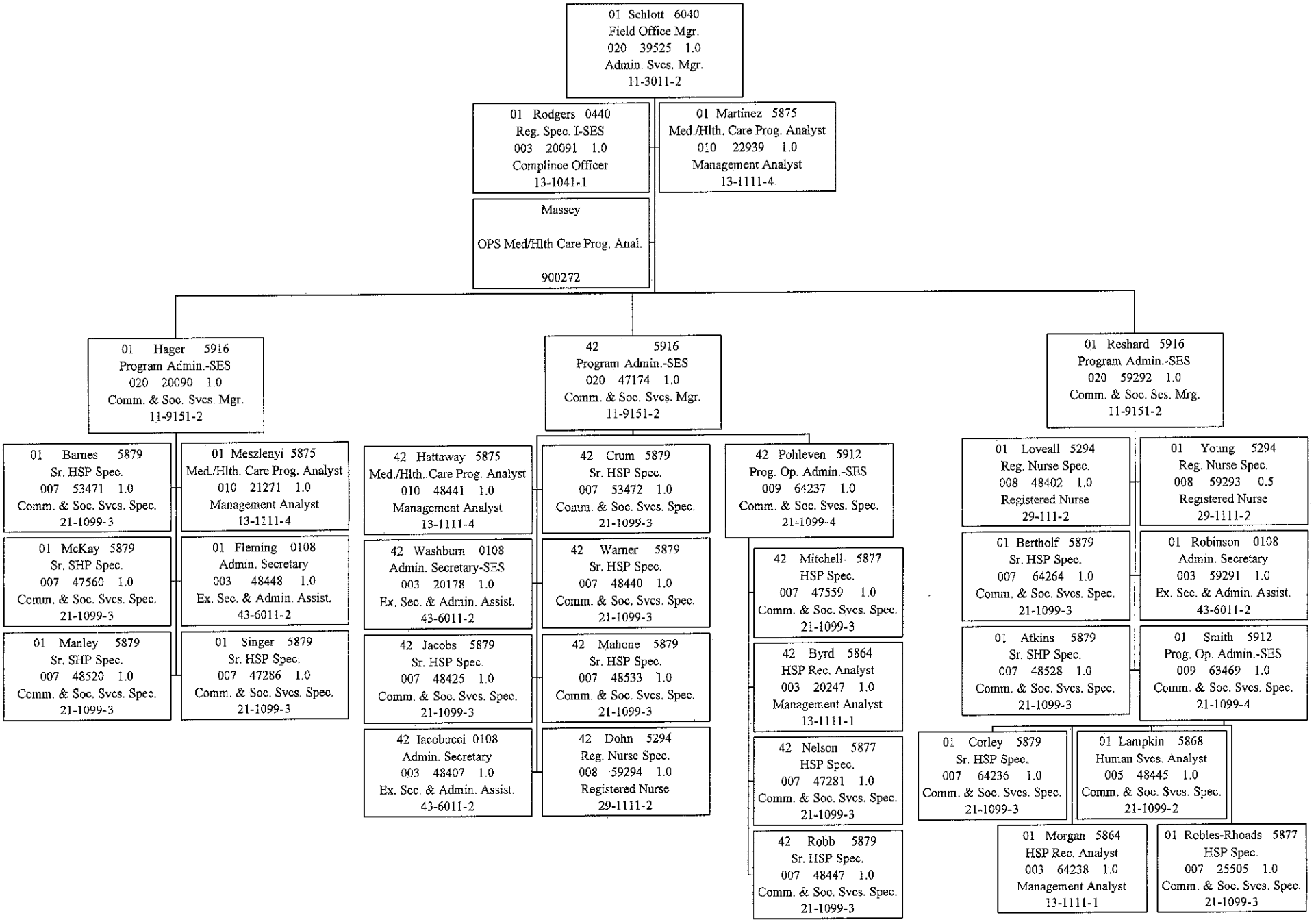
Org. Level: 68 50 10 02 000
Revised Date: July 1, 2012
FTEs: 27 Positions: 29



E-4-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 3 - Gainesville

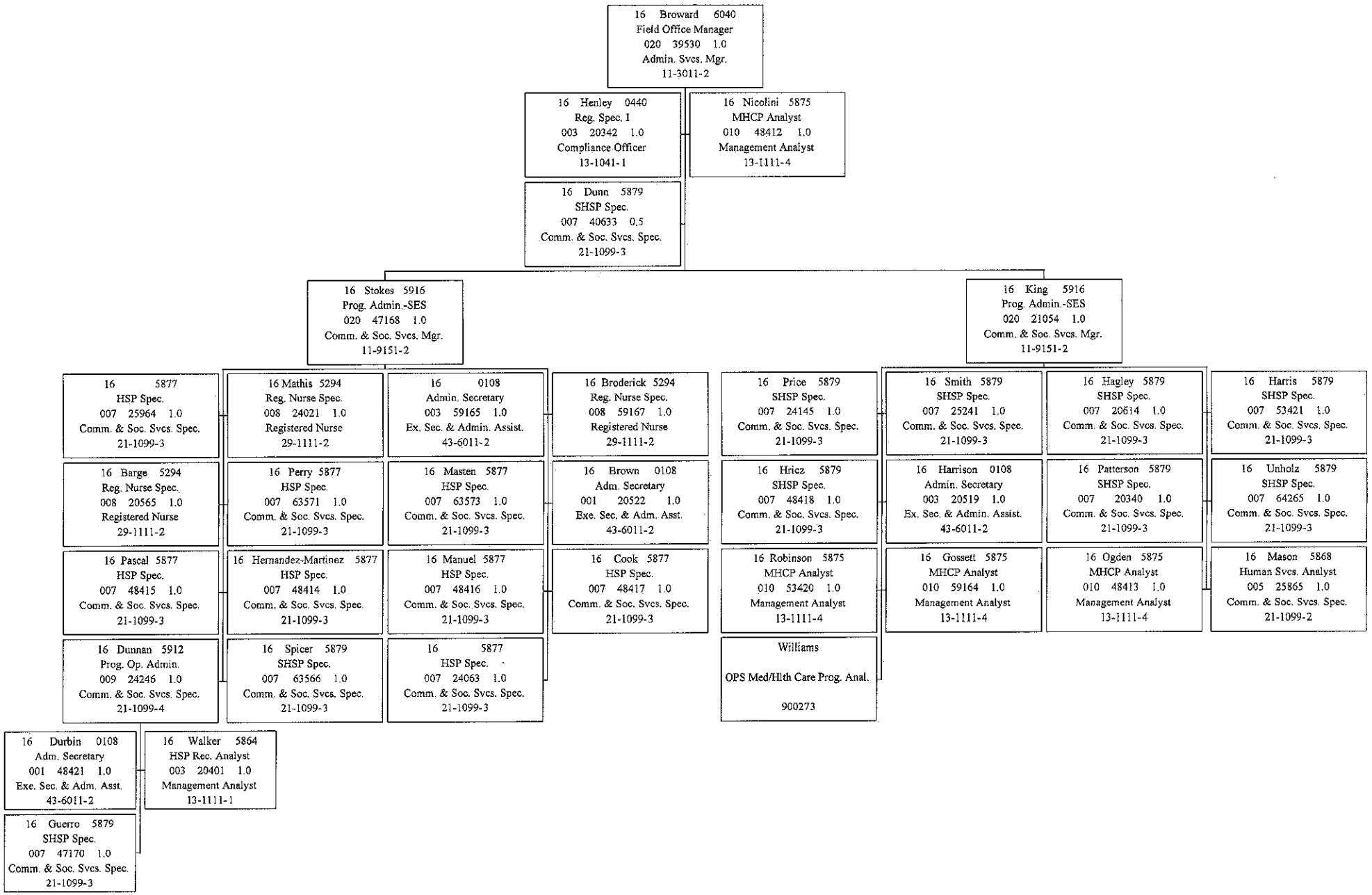
Org. Level: 68 50 10 03 000
Revised Date: July 1, 2012
FTEs: 34.5 Positions: 35



E-4-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 4 - Jacksonville

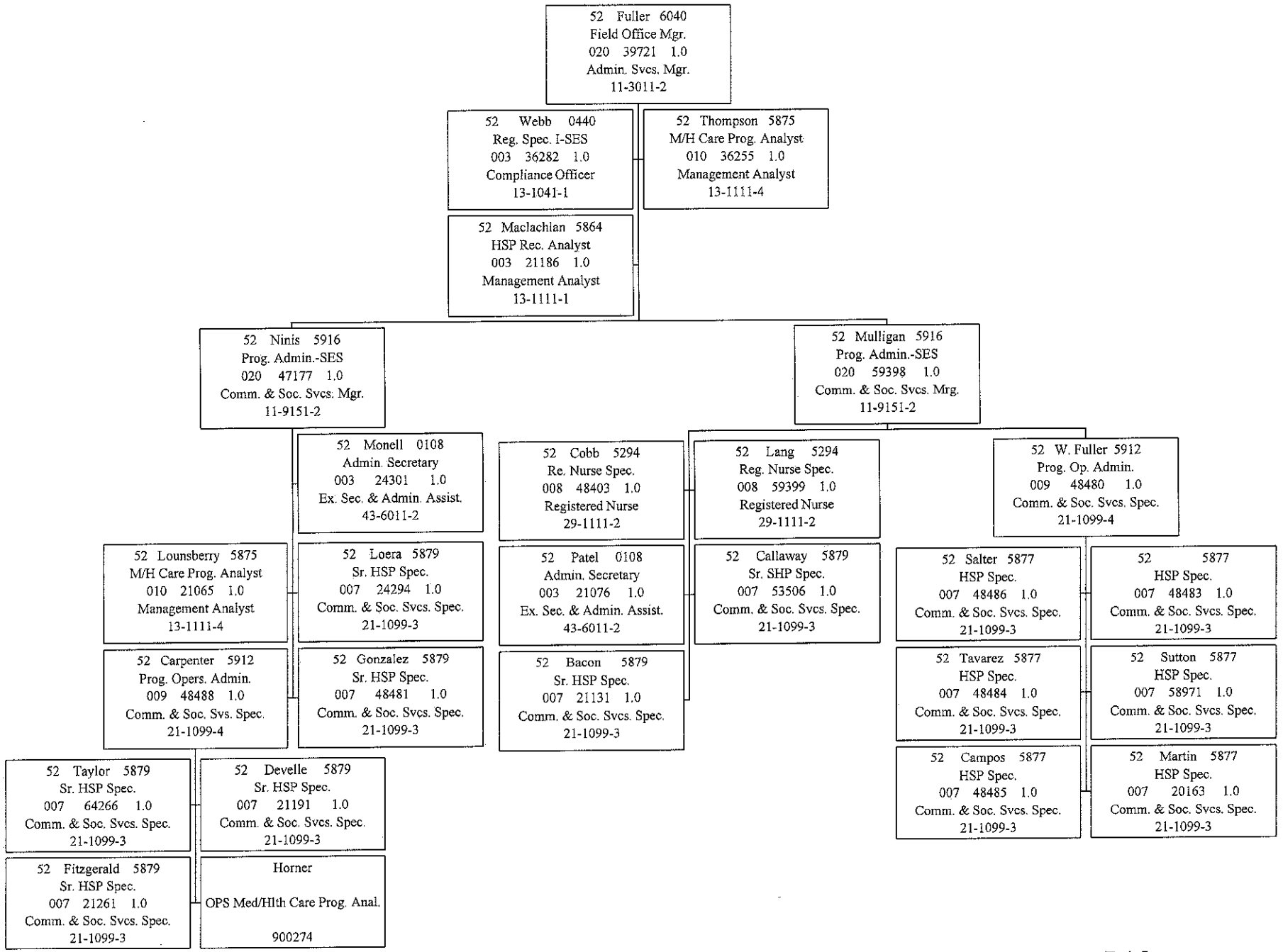
Org. Level: 68 50 10 04 000
Revised Date: July 1, 2012
FTEs: 34.5 Positions: 35



E-4-4

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

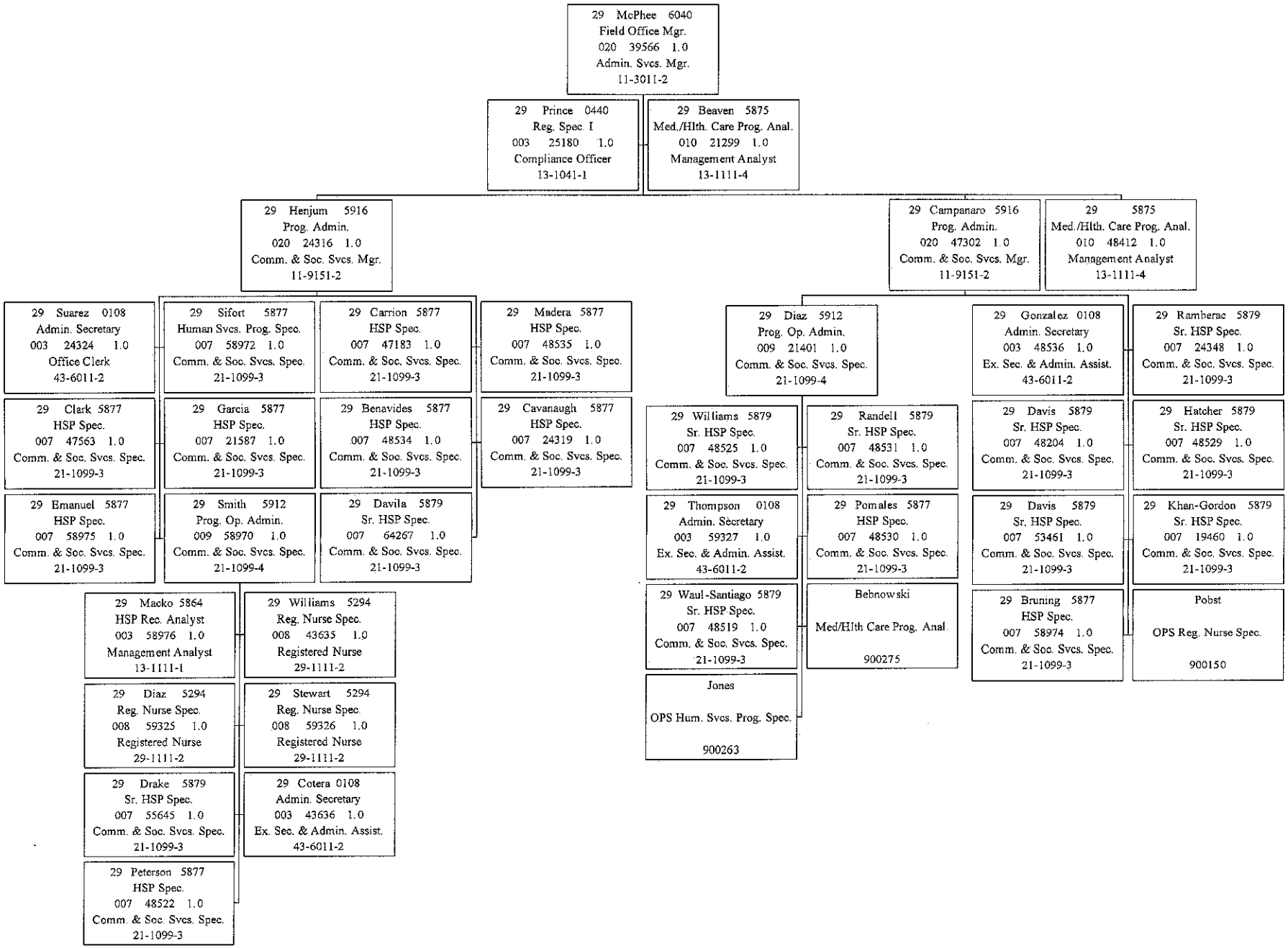
Org. Level: 68 50 10 05 000
Revised Date: July 1, 2012
FTEs: 26 Positions: 26



E-4-5

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 6 - Tampa

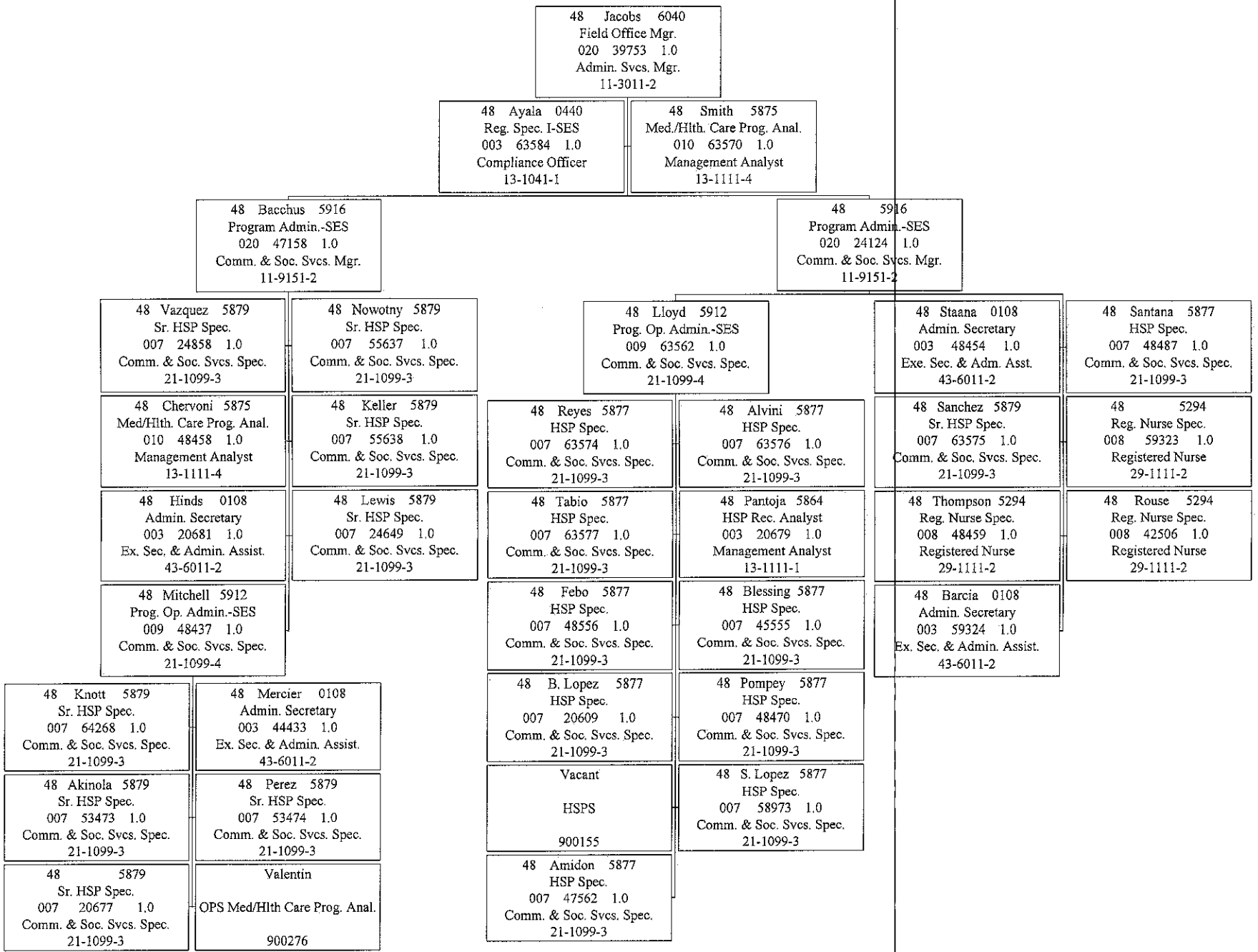
Org. Level: 68 50 10 06 000
Revised Date: July 1, 2012
FTEs: 37 Positions: 37



E-4-6

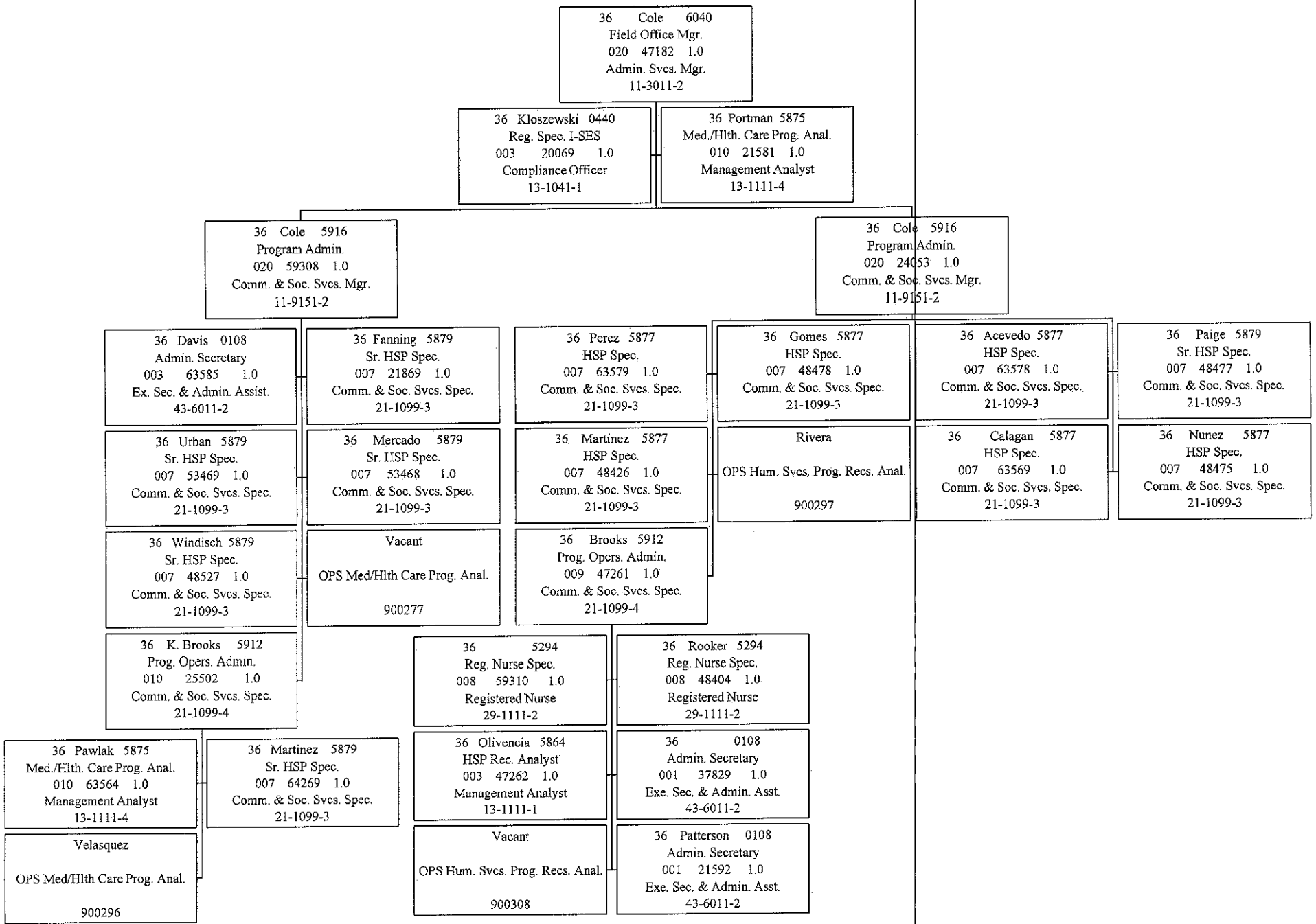
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 7 - Orlando

Org. Level: 68 50 10 07 000
Revised Date: July 1, 2012
FTE: 35 Positions: 35



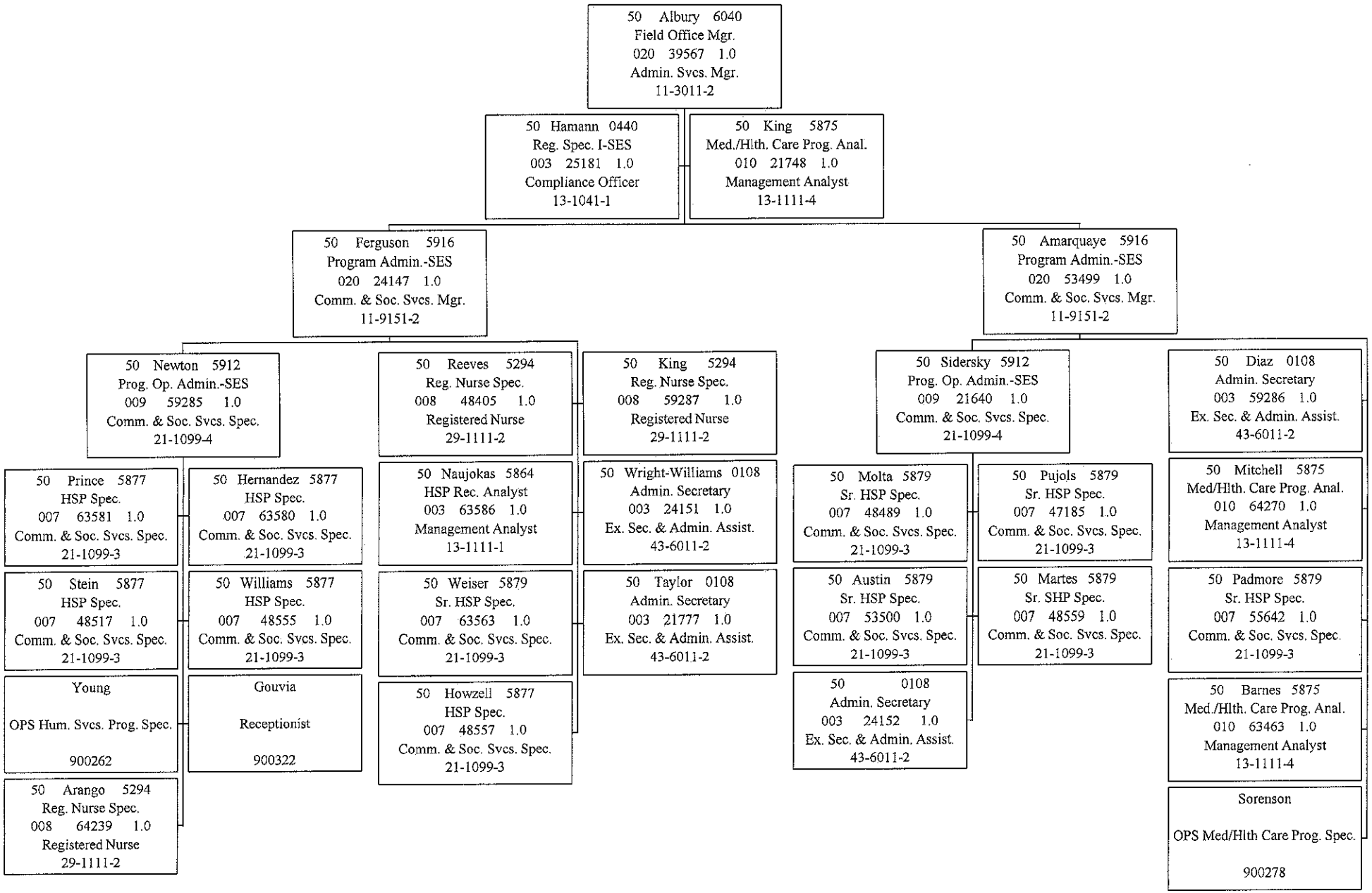
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 8 - Ft. Myers

Org. Level: 68 50 10 08 000
Revised Date: July 1, 2012
FTEs: 26 Positions: 26



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

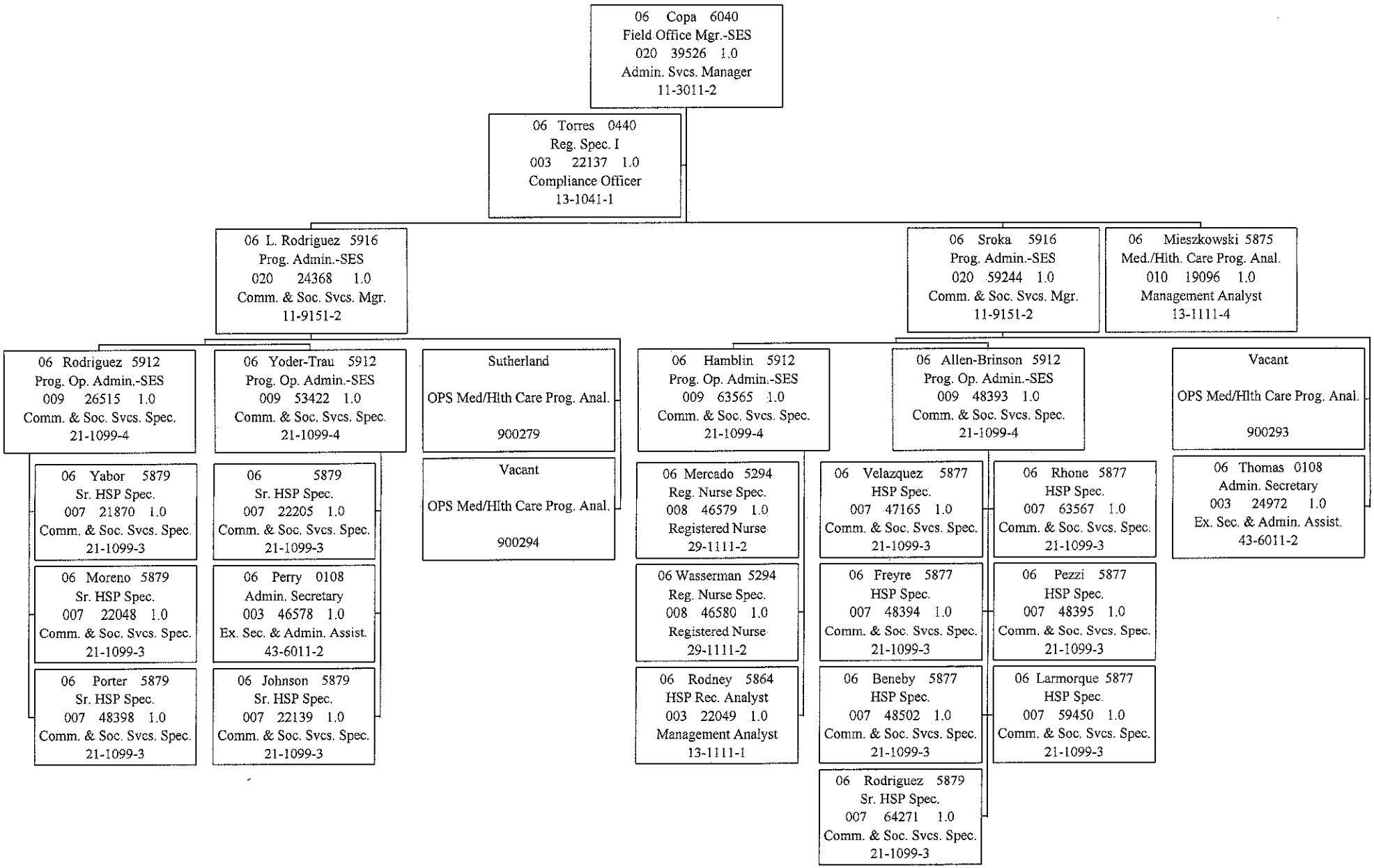
Org. Level: 68 50 10 09 000
Revised Date: July 1, 2012
FTEs: 28 Positions: 28



E-4-9

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

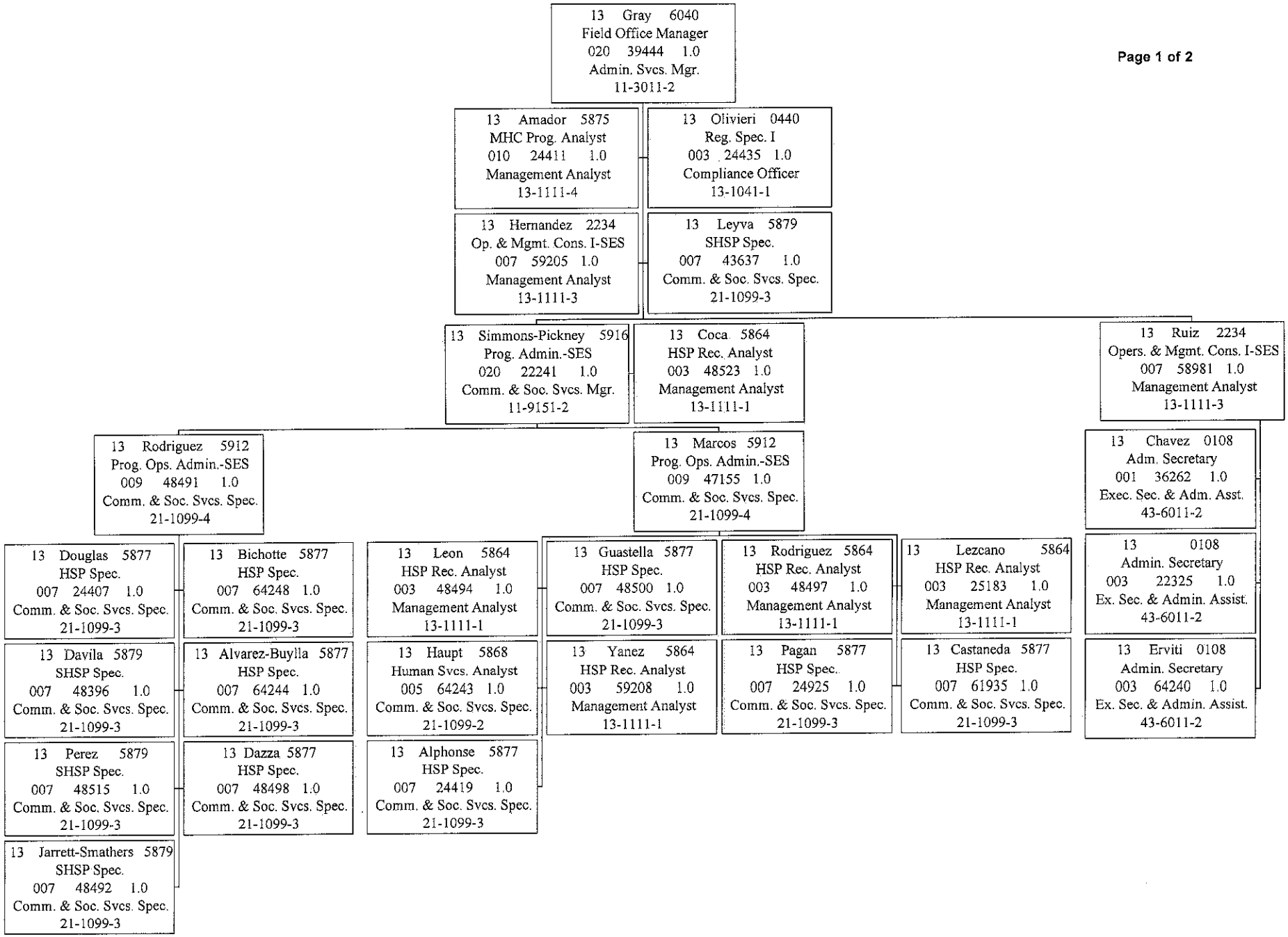
Org. Level: 68 50 10 10 000
Revised Date: July 1, 2012
FTEs: 26 Positions: 26



E-4-10

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
AREA 11 - Miami

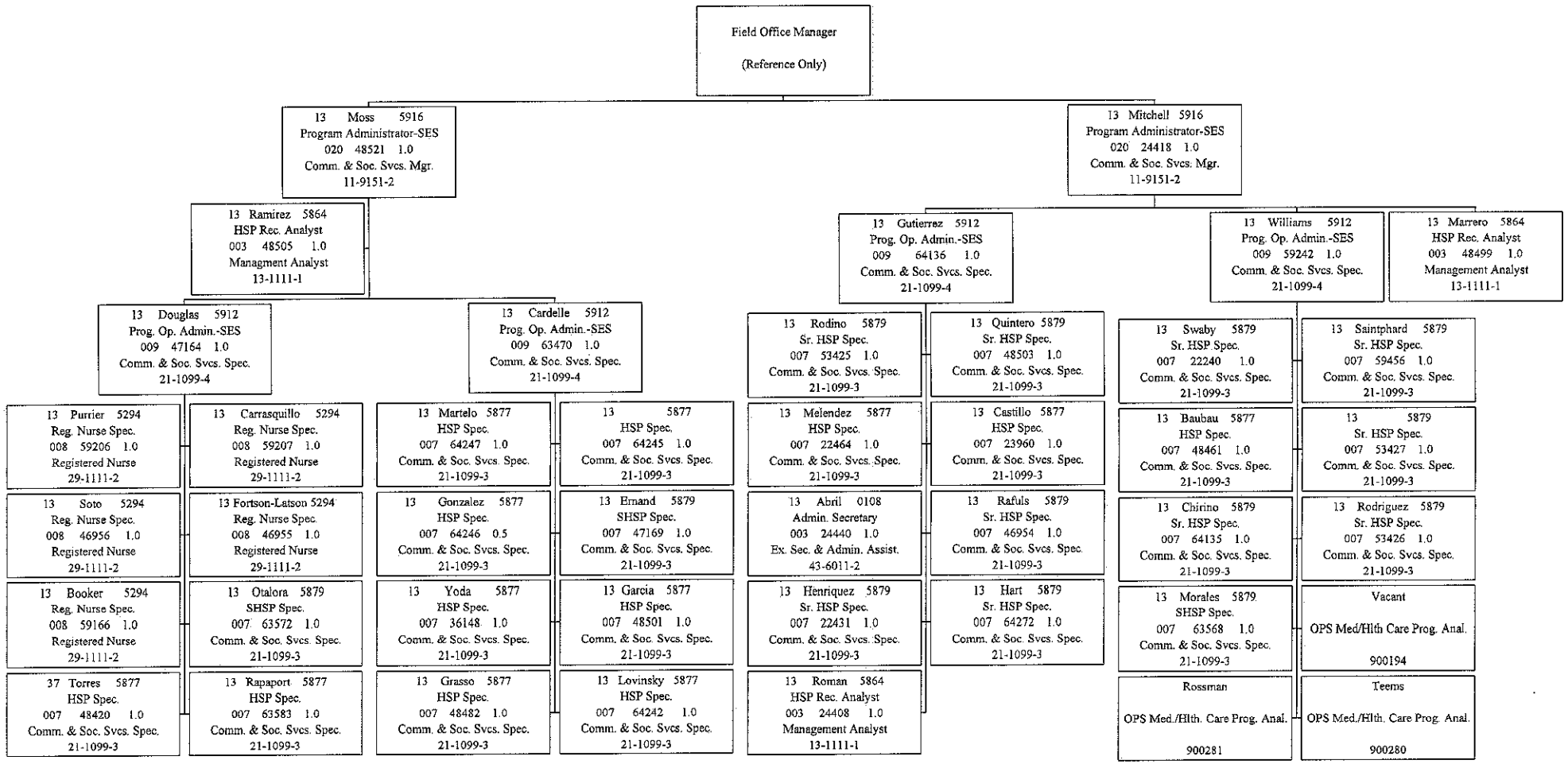
Org. Level: 68 50 10 11 000
Revised Date: July 1, 2012
FTEs: 68.5 Positions: 69



E-4-11-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
AREA 11 - Miami

Org. Level: 68 50 10 11 000
Revised Date: July 1, 2012
FTEs: 68.5 Positions: 69

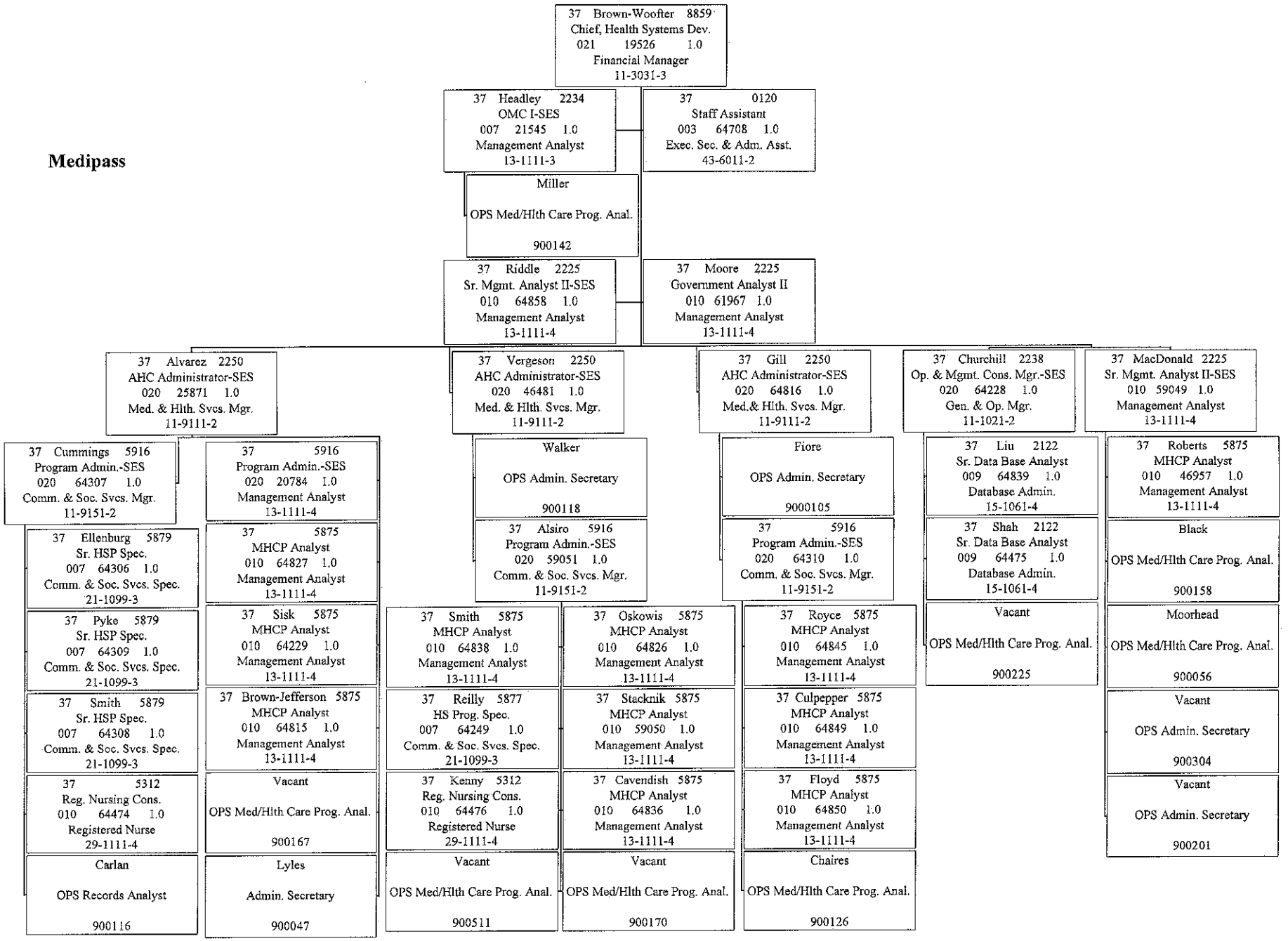


E-4-11-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Health Systems Development

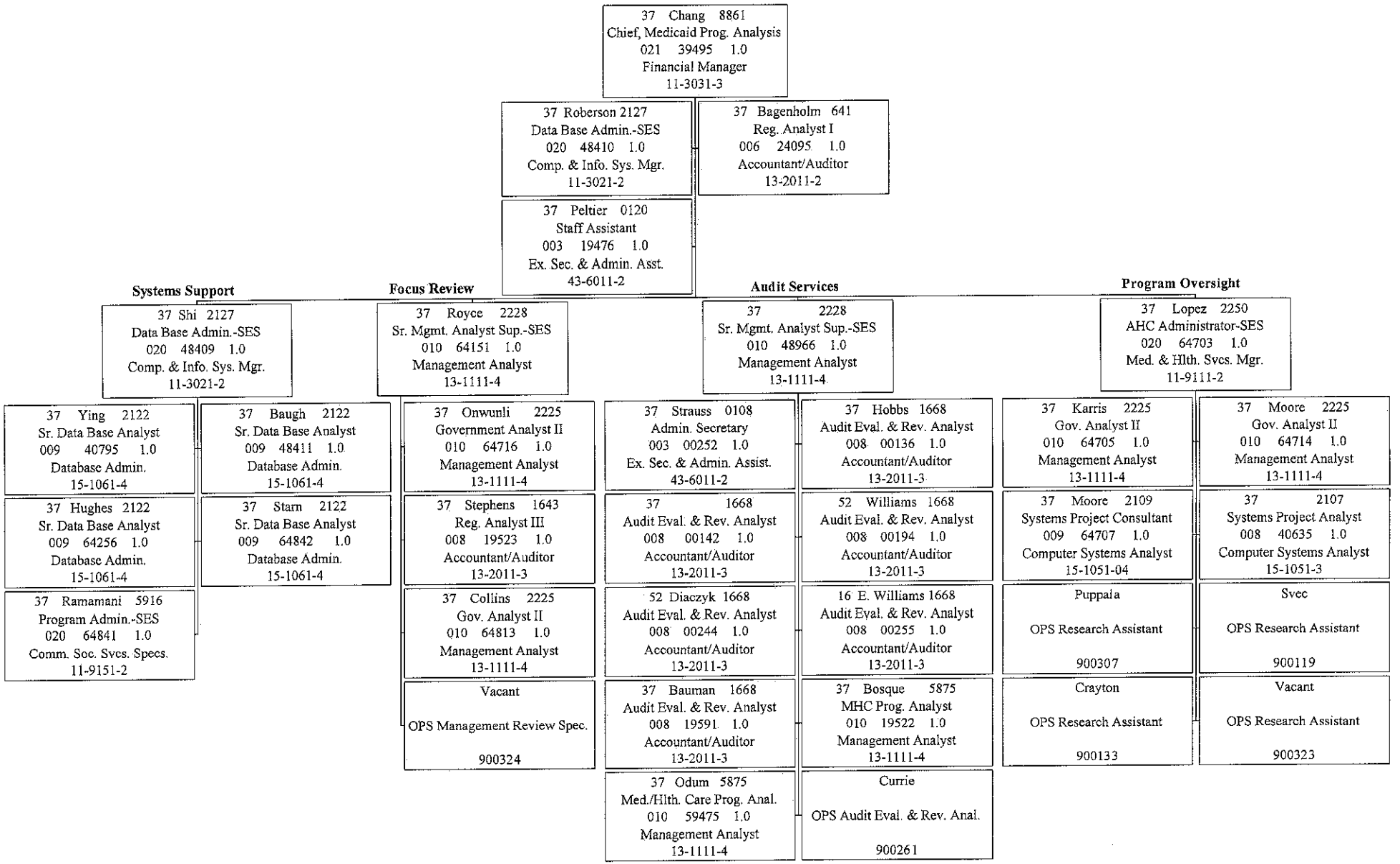
Org. Level: 68 50 40 00 000
Revised Date: July 1, 2012
FTEs: 33 Positions: 33

Medipass



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Medicaid Program Analysis

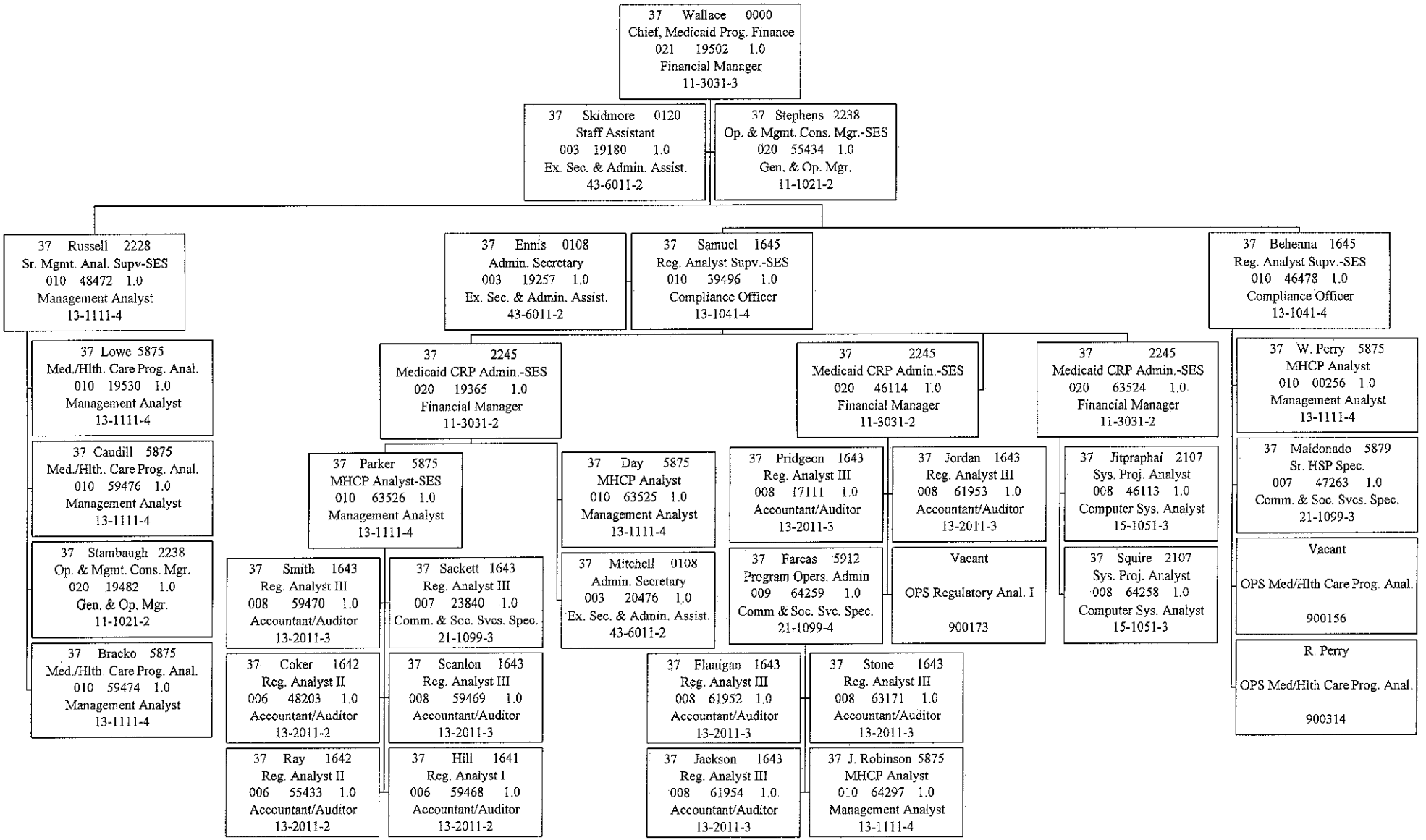
Org Level: 68505000000
Revised Date: July 1, 2012
FTE: 29 Positions: 29



E-7-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Medicaid Program Finance

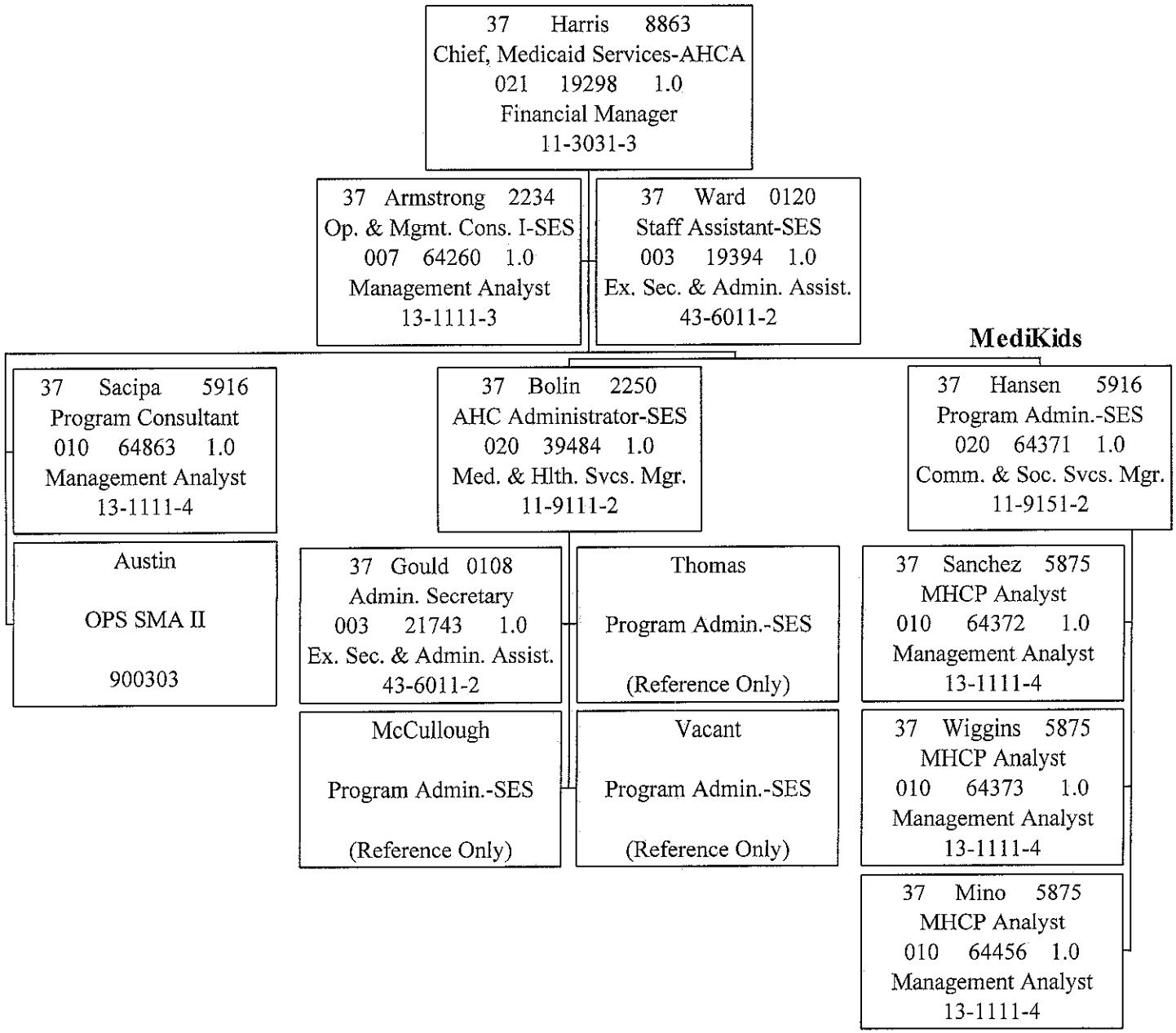
Org. Level: 68 50 55 00 000
Revised Date: July 1, 2012
FTEs: 34 Positions: 34



E-7-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

Org Level: 68 50 60 00 000
Revised Date: July 1, 2012
FTEs: 68 Positions: 68



E-8-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

Chief, Medicaid Services
(Reference Only)

Bolin
AHC Administrator-SES
(Reference Only)

Medicaid State Plan

37 Thomas 5916
Program Admin.-SES
020 46480 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

37 Hall 5875 MHCP Analyst 010 25870 1.0 Management Analyst 13-1111-4	37 Underwood 5875 MHCP Analyst 010 61450 1.0 Management Analyst 13-1111-4	37 Cerasoli 5875 MHCP Analyst 010 39485 1.0 Management Analyst 13-1111-4
37 5875 MHCP Analyst 010 24167 1.0 Management Analyst 13-1111-4	37 Brown 5875 MHCP Analyst 010 59460 1.0 Management Analyst 13-1111-4	37 Anderson 5312 Reg. Nursing Cons. 010 64814 1.0 Registered Nurse 29-1111-4
37 5312 Reg. Nursing Consultant 010 59504 1.0 Registered Nurse 29-1111-4	37 Heiser 0108 Admin. Secretary-SES 003 56425 1.0 Ex. Sec. & Admin. Assist. 43-6011-2	37 Lawrence 5312 Reg. Nursing Cons. 010 64473 1.0 Registered Nurse 29-1111-4
Senesac OPS Physical Therap. Con. 900311	Vacant OPS Occup. Therap. 900312	Hanson OPS Dental Consultant 900252
Vacant OPS Speech Therap. 900313	Vacant OPS Reg. Nursing Consult. 900058	Walby OPS Sr. Physician 900178
Scott OPS Speech Pathologist 900193		

37 McCullough 5916
Program Admin.-SES
020 59463 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

37 Hudson 5312 Reg. Nursing Cons. 010 19528 1.0 Registered Nurse 29-1111-4	37 5875 MHCP Analyst 010 59466 1.0 Management Analyst 13-1111-4
37 Lucas 5312 Reg. Nursing Cons. 010 25875 1.0 Registered Nurse 29-1111-4	37 Kumar 5312 Reg. Nursing Cons. 010 19531 1.0 Registered Nurse 29-1111-4
37 Kimball 0108 Admin. Secretary-SES 003 21558 1.0 Ex. Sec. & Admin. Assist. 43-6011-2	Deeb OPS Sr. Physician 900051
Jones OPS Sr. Physician 900052	Klein OPS Sr. Physician 900063

Acute Care Services

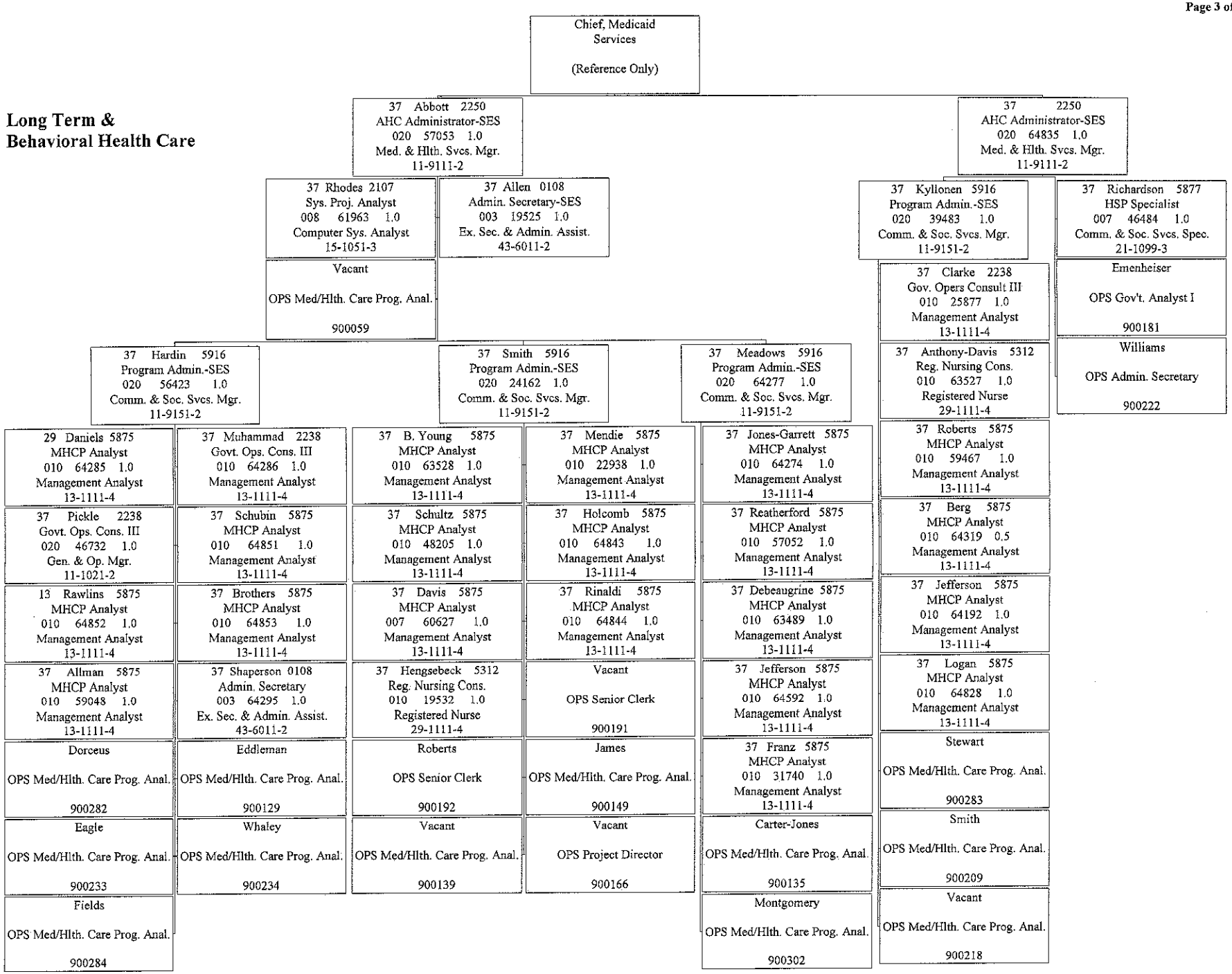
37 5916
Program Admin.-SES
020 59478 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

37 DeMarco 5312 Reg. Nursing Cons. 010 64255 1.0 Registered Nurse 29-1111-4	37 5312 Reg. Nursing Cons. 010 59502 1.0 Registered Nurse 29-1111-4	37 5875 MHCP Analyst 010 19512 1.0 Management Analyst 13-1111-4
37 Core 5312 Reg. Nursing Cons. 010 59462 1.0 Registered Nurse 29-1111-4	37 Hamrick 5875 MHCP Analyst 010 19470 1.0 Management Analyst 13-1111-4	37 Gabric 2238 Gov. Opers. Consul. III 010 59503 1.0 Management Analyst 13-1111-4
Fifer OPS Sr. Physician 900064	Vacant OPS Sr. Hum. Svcs. Prog. Spec. 900256	Gambrell OPS Physical Therapy Consult. 900258
Sheppard OPS Sr. Physician 900054	Hardiman OPS Sr. Physician 900048	Cox OPS Med/Hlth. Care Prog. Anal. 900287
	Huber OPS Sr. Physician 900065	Winter OPS Physical Therapy Consult. 900050
	Koyn OPS Physical Therapy Consult. 900152	Wright OPS Physical Therapy Consult. 900285

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

Org. Level: 68 50 60 00 000
Revised Date: July 1, 2012
FTEs: 68 Positions: 68

Long Term & Behavioral Health Care



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Contract Management

Org. Level: 68 50 80 00 000
Revised Date: June, 2012
FTEs: 50 Positions: 50

37 Strowd 9394
Chief, Medicaid Contract Mgmt.
021 64292 1.0
Financial Manager
11-3031-3

37 Colvin 0120
Staff Assistant-SES
003 64293 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

37 Austin 0108
Admin. Secretary
003 55430 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

37 2225
Gov. Analyst II
010 25857 1.0
Management Analyst
13-1111-4

37 5875
Med./Hlth. Care Prog. Anal.
010 64861 1.0
Management Analyst
13-1111-4

Vacant
OMC Mgr.
900068

Financial/Audit

37 Meyer 2228
SMA Supervisor-SES
010 61959 1.0
Management Analyst
13-1111-4

37 Peters 2236
Gov. Opers. Cons. II
010 47265 1.0
Management Analyst
13-1111-4

37 Vickers 0108
Administrative Secretary-SES
003 55472 1.0
Ex. Sec. & Admin. Asst.
43-6011-2

37 Lewis-Lamb 2234
Gov. Opers. Cons. I
007 00287 1.0
Management Analyst
13-1111-3

37 Lasko 1667
Senior Contract Auditor
008 10652 1.0
Accountant/Auditor
13-2011-3

Monitoring/Compliance

37 Gordon 2228
SMA Supervisor-SES
010 46463 1.0
Management Analyst
13-1111-4

37 Winterbottom2241
Medicaid Mgmt. Rev. Mon.
010 00346 1.0
Management Analyst
13-1111-4

37 Lashus 2241
Medicaid Mgmt. Rev. Mon.
010 24191 1.0
Management Analyst
13-1111-4

37 Eichenlaub 2241
Medicaid Mgmt. Rev. Mon.
010 59454 1.0
Management Analyst
13-1111-4

37 Son 5894
Health Svcs. & Fac. Cons.
010 46483 1.0
Business Opers. Spec.
13-1199-4

Procurement

37 Ramsey 2228
SMA Supervisor-SES
426 47268 1.0
Management Analyst
13-1111-4 PB 10

37 Maloney 2238
Gov. Opers. Cons. III
010 36278 1.0
Management Analyst
13-1111-4

37 Wilkersosn 5875
Med./Hlth. Care Prog. Anal.
010 64719 1.0
Management Analyst
13-1111-4

DSS Freedom

37 Kline 2117
Systems Program Admin.-SES
020 63517 1.0
Comp. & Info. SystemsMgr.
11-3021-2

37 Hebenthal 2107
Systems Project Analyst
008 55648 1.0
Computer Systems Analyst
15-1051-3

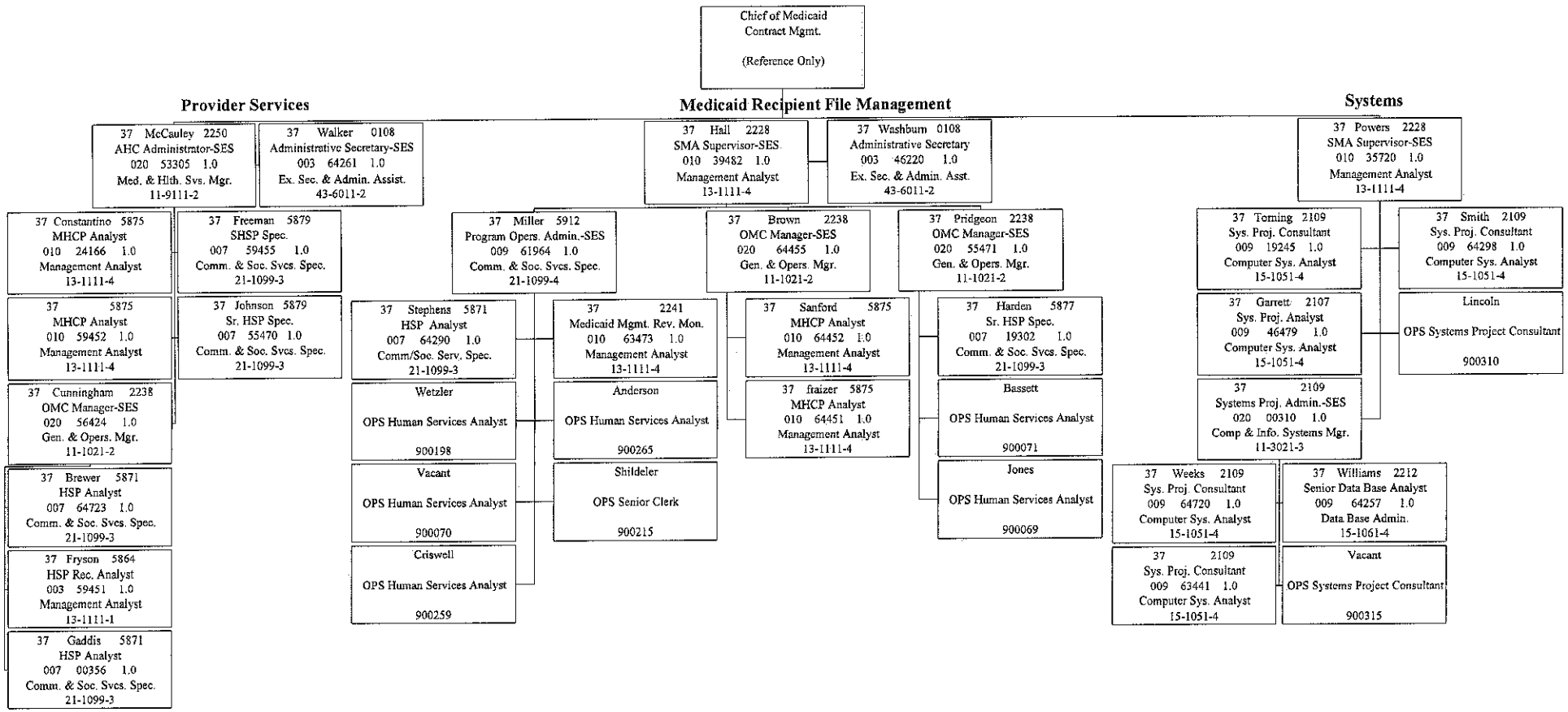
HIPAA

37 Fuller 2228
SMA Supervisor-SES
426 64296 1.0
Management Analyst
13-1111-4 PB 10

37 Lasseter 0108
Administrative Secretary
003 64718 1.0
Exec. Sec. & Admin. Asst.
43-6011-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Contract Management

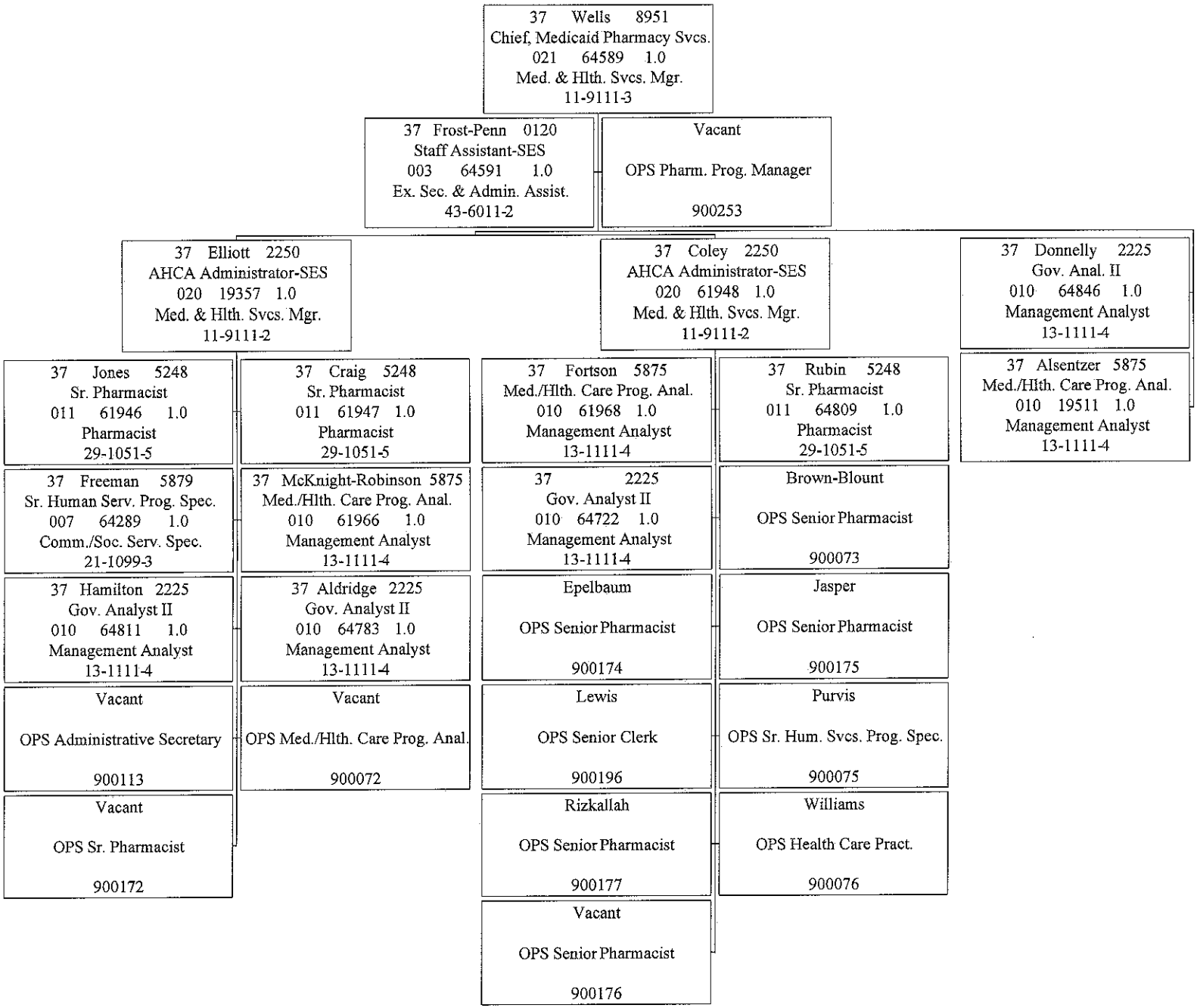
Org. Level: 68 50 80 00 000
Revised Date: July 1, 2012
FTEs: 50 Positions: 50



E-9-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Pharmacy Services

Org Level: 68-50-90-00-000
Revised Date: July 1, 2012
FTE: 15 Positions: 15



AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET	FISCAL YEAR 2011-12 OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	22,319,933,599	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)	32,283,154	0
FINAL BUDGET FOR AGENCY	22,352,216,753	0

SECTION II: ACTIVITIES * MEASURES	Number of Units	*(1) Unit Cost*	Expenditures	*(2) Expenditures (Allocated)*	*(3) FCO*
Executive Direction, Administrative Support and Information Technology (2)			28,242,397		0
Prepaid Health Plans - Elderly And Disabled *	2,055,276	861.93	1,771,511,702	1,771,511,702	
Prepaid Health Plans - Families *	12,678,708	114.90	1,456,728,751	1,456,728,751	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	482,926	4,300.15	2,076,655,079	2,076,655,079	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	482,926	2,166.57	1,046,293,294	1,046,293,294	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased	482,926	1,044.12	504,231,612	504,231,612	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	482,926	916.08	442,397,807	442,397,807	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	286,731	3,813.03	1,093,312,847	1,093,312,847	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	87,590	222.60	19,497,156	19,497,156	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased	482,926	131.47	63,491,358	63,491,358	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased	482,926	181.17	87,492,287	87,492,287	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased	482,926	133.59	64,515,221	64,515,221	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	87,590	203.28	17,805,636	17,805,636	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased	274,017	438.21	120,076,710	120,076,710	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	482,926	366.39	176,939,920	176,939,920	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased	87,590	2,556.49	223,922,684	223,922,684	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	482,926	1,364.02	658,722,197	658,722,197	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	1,013,754	1,797.23	1,821,952,299	1,821,952,299	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	1,013,754	307.60	311,835,642	311,835,642	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased	1,013,754	646.00	654,880,212	654,880,212	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	1,013,754	617.00	625,485,031	625,485,031	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	991	201,603.02	199,788,591	199,788,591	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	803,206	290.94	233,686,249	233,686,249	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased	1,013,754	75.16	76,193,573	76,193,573	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased	1,013,754	10.50	10,648,634	10,648,634	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased	1,013,754	103.38	104,806,910	104,806,910	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	803,206	66.25	53,210,855	53,210,855	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased	1,013,754	126.37	128,113,081	128,113,081	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	1,013,754	444.68	450,800,666	450,800,666	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	40,687	6,635.45	269,976,373	269,976,373	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	40,687	3,353.33	136,436,884	136,436,884	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	40,687	1,575.81	64,114,826	64,114,826	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	40,687	1,963.21	79,877,238	79,877,238	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	4,776	1,415.26	6,759,276	6,759,276	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	6,457	157.47	1,016,800	1,016,800	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	40,687	56.41	2,295,347	2,295,347	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	40,687	38.47	1,565,389	1,565,389	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	40,687	41.85	1,702,925	1,702,925	
Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased	6,457	5.50	35,526	35,526	
Medically Needy - Other * Number of case months Medicaid program services purchased	40,687	25,423.14	1,034,391,414	1,034,391,414	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	4,690	2,190.70	10,274,369	10,274,369	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	4,690	105,932.65	496,824,123	496,824,123	
Refugees - Physician Services * Number of case months Medicaid program services purchased	4,690	770.17	3,612,118	3,612,118	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	4,690	327.59	1,536,420	1,536,420	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	683	322.74	220,430	220,430	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	4,690	17.91	83,976	83,976	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	4,690	51.74	242,662	242,662	
Refugees - Other * Number of case months Medicaid program services purchased	4,690	377.87	1,772,196	1,772,196	
Nursing Home Care * Number of case months Medicaid program services purchased	73,504	37,094.12	2,726,566,334	2,726,566,334	
Home And Community Based Services * Number of case months Medicaid program services purchased	88,907	11,526.43	1,024,780,402	1,024,780,402	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program services purchased	517	213,483.58	110,371,009	110,371,009	
Mental Health Disproportionate Share Program * Number of case months Medicaid program services purchased	720	93,274.38	67,157,553	67,157,553	
Purchase Medikids Program Services * Number of case months	29,156	2,113.98	61,635,249	61,635,249	
Purchase Children's Medical Services Network Services * Number of case months	22,960	6,535.68	150,059,173	150,059,173	
Purchase Florida Healthy Kids Corporation Services * Number of case months	200,664	1,503.85	301,768,180	301,768,180	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	3,546	454.28	1,148,646	1,610,878	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification applications	22,082	611.00	7,968,490	13,492,167	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations	64,929	671.38	26,027,300	43,592,130	
Health Standards And Quality * Number of transactions	2,902,773	1.07	1,873,198	3,098,114	
Plans And Construction * Number of reviews performed	4,869	1,135.18	3,770,693	5,527,176	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys	176	17,758.90	2,108,656	3,125,567	
Background Screening * Number of requests for screenings	189,756	3.13	593,911	593,911	
Subscriber Assistance Panel * Number of cases	406	2,139.53	498,865	868,651	
Health Facilities And Practitioner Regulation - Medicaid Choice Counseling * Number of new enrollees provided choice counseling	372,458	0.87	138	323,700	
TOTAL			21,122,304,490	21,122,304,490	

SECTION III: RECONCILIATION TO BUDGET	
PASS THROUGHS	
TRANSFER - STATE AGENCIES	
AID TO LOCAL GOVERNMENTS	
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS	
OTHER	1,105,751,662
REVERSIONS	124,160,696
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	22,352,216,848

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.

Schedule XIV
Variance from Long Range Financial Outlook

Agency: Agency for Health Care Administration **Contact: Anita Hicks**

Article III, Section 19(a)3, Florida Constitution, requires each agency Legislative Budget Request to be based upon and reflect the long range fina 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 2012 contain revenue or expenditu 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 2013-2014 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 2013-2014 Estimate/Request Amount	
			Long Range Financial Outlook	Legislative Budget Request
a	Medicaid Price Level and Workload	B	$1,165.6 Billion ($301.7 GR)	
b	Federal Health Care Reform - Increased Rates for Primary Care Practitioners - Existing Program	B	$849.7 million (Trust Fund)	
c	Kid Care	B	$9.4 million (-$1.9 GR)	
d	Restore Non-recurring Rate Reductions	B	$100.4 million ($30 million GR)	
e	Restore Non-recurring Funding for Florida Healthy Kids Medical Loss Ratio 85	B	$8.5 million ($2.5 million GR)	

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 Services Conference and is not included in the LBR.

* R/B = Revenue or Budget Driver

Office of Policy and Budget - July 2012

Administration and Support Schedules

Administration and Support

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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

	Balance as of 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**617,992**	(A)		**617,992**	
ADD: Other Cash (See Instructions)	**120**	(B)		**120**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)	**2,563,113**	**2,563,113**	
ADD: _____		(E)	**50**	**50**	
Total Cash plus Accounts Receivable	**618,112**	(F)	**2,563,163**	**3,181,275**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**1,567,793**	(H)	**-456,815**	**1,110,979**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**2,000,000**	(I)		**2,000,000**	
LESS: Payables not Certified Forwards			**43,475**	**43,475**	
LESS: Current Compensated Absences Liability	**26,822**	(J)		**26,822**	
Unreserved Fund Balance, 07/01/12	**-2,976,503**	(K)	**3,019,978**	**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.**

Office of Policy and Budget - July, 2012

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

Department Title: Agency for Health Care Administration
Trust Fund Title: Grants and Donation Trust Fund
Budget Entity: 68200000
LAS/PBS Fund Number: 2339

	Balance as of 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance		(A)		**0**	
ADD: Other Cash (See Instructions)	**104,104**	(B)		**104,104**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable		(D)		**0**	
ADD: _____		(E)		**0**	
Total Cash plus Accounts Receivable	**104,104**	(F)	**0**	**104,104**	
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)	**104,104**	(I)		**104,104**	
LESS: Payables not Certified Forwards				**0**	
LESS: Current Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**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.**

Office of Policy and Budget - July, 2012

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS

Budget Period: 2013-2014

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 2011-12					
AHCA 12-05	Mar-12	Enterprise Wide Audit of Contract Monitoring	**Finding 2012-05-01** The Agency specific Contract Manager Training needs to be expanded to detail all aspects of contract management. **Recommendation** We recommend that Contract Administration continue to develop and present mini-trainings periodically that will further address the basic principles and fundamentals of Agency contract management. Some topics to focus on include the day-to-day management of contracts, contract monitoring, contract requirements, closeout procedures, fiscal monitoring, and invoicing (specifically the review of invoices and supporting documentation prior to payment). We also recommend that Contract Administration consider recording training sessions and posting to SharePoint for future review by contract managers. Recording specific training will help limit the need for face-to-face training.	Contract Administration is currently working on expanding the Contract Manager mini-trainings to include the new DFS requirements regarding the FACTS system and Contract Summary forms (in addition to other items). New set of mini-trainings to begin in early November 2012.	
			Finding 2012-05-02		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Contract closeout procedures are not specifically defined and documented. **Recommendation** We recommend the Contract Administration unit update the contract closeout section of the Contract Manager Desk Reference. This section should include additional guidance to contract managers for ensuring proper closeout of Agency contracts.	The contract closeout section of the Contract Manager Desk Reference has been updated to include additional contract closeout items and instructions. Contract closeout will also be covered in upcoming Contract Manager Training.	
			Finding 2012-05-03 The Agency's Agency Agreements Policy (Policy/Procedure #4028) should be updated to include procedures for the development, use, and monitoring of such agreements. **Recommendation** We recommend that the Procurement Office, in concert with General Counsel (to ensure compliance with Section 112.24, F.S. and Section 215.971, F.S.) develop policies and procedures for Agency agreements to address these issues and to help ensure consistency in the development, execution, and monitoring of Agency agreements.	Contract Administration is currently revising the Agency Agreement procedures to match the Agency's Contract procedures. This process is where Contract Administration will handle the creation, routing, and execution of Agency Agreements, and also conduct annual file reviews to ensure all required information is current and correct in the Agency Agreement files. Anticipated completion date is September 28, 2012.	
			Finding 2012-05-04		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Agency contract policies and procedures lack certain requirements specified by Florida Statutes. These statutes include Section 287.057(14), Section 287.057(16)(a)&(b), and Section 287.133(3)(b) as follows: • Section 287.057 (14), F.S., requires agency contract managers responsible for contracts exceeding the Category Two threshold amount ($35,000) to attend training conducted by the Chief Financial Officer for accountability in contracts and grant management. Agency contract managers must meet this requirement. • Section 287.057(16)(a)&(b), F.S., states the requirements for the appointments of contract evaluators, contract negotiators, and project management professionals for agency contracts exceeding the Category Four threshold amount. • Section 287.133(3)(b), F.S., states that "Any person must notify the department within 30 days after a conviction of a public entity crime applicable to that person or to an affiliate of that person. Any public entity which receives information that a person has been convicted of a public entity crime shall transmit that information to the department in writing within 10 days." These requirements should be documented in the appropriate Agency policy and procedures. **Recommendation**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			We recommend updating the appropriate policies and procedures, specifically the Procurement Policy and the Contract Manager Desk Reference, to include the requirements specified in Section 287.057(14), Section 287.057(16)(a)&(b), and Section 287.133(3)(b), F.S.	The requirements specified in Section 287.057(14), F.S. and Section 287.057(16)(a)&(b), F.S. are now included in both the Procurement Policy (#4006) and the Contract Manager's Desk Reference and will continue to be covered in Contract Manager Training. Contract Administration is currently in the process of revising the Procurement Policy. Section 287.133(3)(b), F.S., which was not included in the last update, will be added to the policy. Estimated completion date is October 15, 2012.	
OAG #2012-021	**9/30/2010**	**FMMIS Controls and the Prevention of Improper Medicaid Payments**	**Finding 2012-021-01** The Agency's ineffective risk assessment processes contributed to the disbursement of improper payments. **Recommendation** We recommend that the Agency review its internal controls, including its risk assessment processes, as related to the prevention of improper payments for Medicaid services, and implement effective controls designed to ensure that improper payments are minimized to the greatest extent possible.	The Bureau of Internal Audit performed a review of Medicaid's risk management processes as they pertain to the prevention of improper payments for Medicaid services. Staff have been interviewing senior management, and other applicable staff to document Medicaid's risk governance process for identifying, assessing and controlling risks associated with improper Medicaid payments. We anticipate issuing the report in August 2012.	
			Finding 2012-021-02		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			To ensure that FMMIS includes the necessary audits, the Agency should have a process in place to periodically review FMMIS to determine that audits are in place and operating as intended and that they are based on current Medicaid limitations. **Recommendation**		
			1. During fieldwork for this audit, the Agency's Bureau of Medicaid Program Integrity began a review of Medicaid services and applicable edits and audits in January 2011. We recommend that the Agency continue its review of Medicaid services and applicable edits and audits to ensure that FMMIS contains all controls necessary to prevent payment of claims for services in excess of policy limitations. This review should extend to all Medicaid services. We also recommend that the Agency give this project a high priority considering the likelihood that overpayments have and will be made until project completion.	1. The Agency concurs with this finding and will continue its review of Medicaid services and applicable edits and audits within the FMMIS system. The Edits and Audits Task Force, created in January 2011 by AHCA, is a multi-bureau task force with members from Medicaid Program Integrity (MPI), Medicaid Services and Medicaid Contract Management. The Edits and Audits Task Force continues to meet on a biweekly basis. The team continues to explore new areas on which to focus, having completed the review of the waiver services.	
			2. After project completion, the Agency should attempt to recover overpayments that were made in excess of program limitations, including the amounts identified by this audit.	2. MPI has received the referrals and will conduct Generalized Analysis projects to attempt to recoup the overpayments identified.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			3. We also recommend that the Agency implement procedures to ensure that whenever an existing policy is modified or a new policy is added, all applicable edits and audits are reviewed to determine whether programming changes are needed. 4. Additionally, procedures should be implemented to provide for the periodic review of edits and audits for each service type to ensure that all cost-effective edits and audits are in place and programmed for the correct policy. **Finding 2012-021-03** FMMIS was not programmed to ensure the proper payment of outpatient Medicare crossover claims. Our review of 286 claims disclosed that 182, or 63.6 percent, had been paid amounts in excess of authorized amounts. When the errors identified by our audit are projected to the total of the amounts paid for outpatient hospital crossover claims during the three fiscal years tested, the total overpayment is estimated to be $117,659,683. **Recommendation**	3. The Bureau of Medicaid Services developed a checklist to be used throughout the Division of Medicaid for employment whenever an existing policy is modified or when policy additions or changes are required by legislation, judicial or executive orders, or other mandates. 4. The Agency has undertaken a systematic review of edits and audits, starting with the most expensive and heavily utilized codes. The review team is carefully documenting its work to determine the most cost-effective way to continue to review and update the system edits and audits.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			1. We recommend that the Agency ensure that FMMIS is programmed with the correct methodology for the payment of outpatient crossover claims. Appropriate priority should be given to these programming changes considering the likelihood that overpayments will continue until the changes have been implemented. 2. We also recommend the Agency review outpatient crossover claims and initiate recovery efforts for any payments made that were not consistent with Florida law. **Finding 2012-021-04**	1. Medicaid Services bureau staff, with MCM bureau staff, reviewed the statute language, State Plan language, and Handbook (Rule/ Administrative Code) language, and FMMIS logic, and identified conflicting perspectives among the three legal readings. The Handbook is the guiding documentation for the provider community, and has not appropriately reflected the intent of the statute. The Agency's guidance and directive is to always hold providers accountable to the Handbook's instructions. At present, because the Handbook is not in line with statute and the State Plan, Medicaid Services is promulgating revised Handbook language to properly align it with statute and the State Plan. 2. Once this revision is made, a reprocessing of past paid claims would be inappropriate because doing so would be contrary to previous Handbook direction and instruction. However, going forward claims should adjudicate appropriately. The rule promulgation should be completed in the next several months.	

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			FMMIS was not programmed to correctly calculate the amounts due for some professional Medicare crossover claims. **Recommendation** 1. We recommend that the Agency correct the payment methodology used by FMMIS to pay professional Part B Medicare crossover claims. Any programming changes should be given an appropriate priority considering the likelihood that overpayments will continue to occur until the changes have been implemented. 2. We also recommend the Agency review professional crossover claims and initiate recovery efforts for any payments made that were not consistent with Medicaid policy or Florida law.	1. Completed -Staff has logged into the System documentation records issues of reports of overpayments (or underpayments) since the System transition in July 2008, and at this time, all known issues have been logged, and those issues that have identified claims as processing incorrectly have already been addressed with associated CSRs and Change Orders (COs). 2. Reprocessing/ recoupment start date for the associated CSR "fixes" (above), began in February/March 2012. The MCM Bureau will present recoupment amounts for this issue to Medicaid Services in April and implement a takeback plan in May 2012.	
			Finding 2012-021-05 Medicare crossover claims were paid on behalf of recipients without consideration of whether the recipient was eligible for the assistance. Related overpayments disclosed by our audit tests totaled $26,071,070. **Recommendation**		

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			1. We recommend that the Agency ensure that Medicare crossover claims are calculated and paid with consideration of the recipient's assistance category. Any programming changes required to FMMIS should be given a high priority due to the likelihood that overpayments will continue until the changes have been implemented. 2. We also recommend the Agency review crossover claims and initiate recovery efforts for any payments made on behalf of recipients who were not eligible for Medicaid payment of coinsurance and deductible amounts. **Finding 2012-021-06** Programming changes to FMMIS electronic edits and audits were not made in a timely manner. Our review of 28 FMMIS change orders to determine whether the changes were implemented by the effective date of the policy change disclosed that for 21 of the 28 change orders reviewed, the program change to FMMIS was not timely implemented. The period of time between the effective date of the policy change and the date the change was implemented in FMMIS ranged from 20 to 2,542 days and averaged 541 days. **Recommendation**	1. & 2. The Agency has acted on and completed the system corrections as recommended. Recoupment is at 91% thru the March 24 financial cycle. The Agency has identified terminated providers to whom demand letters will be sent to attempt to recoup outstanding dollars not collected prior to their termination; all other providers with outstanding balances will have their recoupment plans modified to collect outstanding balances by end of the fiscal year.	

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			We recommend the Agency strengthen procedures to ensure that Medicaid policy changes are identified and any FMMIS programming changes required are timely communicated to Medicaid Contract Management for timely implementation in FMMIS.	The Bureau of Medicaid Services developed and implemented a checklist to be used throughout the Division of Medicaid for employment whenever an existing policy is modified or when policy additions or changes are required by legislation, judicial or executive orders, or other mandates. The Bureaus of Medicaid Contract Management and Medicaid Services have worked together to develop streamlined approaches to communicating policy and system changes.	
			Finding 2012-021-07 The Agency should strengthen the process by which the Bureau of Medicaid Program Integrity's recommendations are reviewed and tracked. **Recommendation** Recommendation: We recommend that the Agency strengthen its procedures for tracking MPI recommendations. These procedures should include: ☐ Submission of recommendations to both the Agency Secretary and Medicaid Services for consideration. ☐ A requirement that edit or policy recommendations submitted include annual projected cost savings, if subject to reasonable estimation. ☐ Provisions for more accurate tracking of recommendations, including dates and final disposition of the recommendation.	MPI amended its existing procedures for issuing and tracking Policy and Edit Recommendations to include the Auditor General's recommendations. The revised procedures were issued and implemented in January 2012. MCM and Medicaid Services have collaborated with MPI on a revised set of procedures for tracking recommendations.	

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			☐ To assist the Agency in consideration of the recommendation, a requirement that Medicaid Services provide a formal response within a specified timeframe concerning its views regarding the recommendation. If the recommendation will not be implemented, the reason(s) for the rejection should be included in the response. **Finding 2012-021-08** The Agency should automate processes for the screening of new and currently enrolled Medicaid providers. Automating these processes would also improve the timeliness with which Medicaid providers are terminated from the Medicaid Program due to adverse actions. **Recommendation** 1. We recommend the Agency implement automated processes by which electronic files of license information and the LEIE can be uploaded into FMMIS and compared against currently enrolled Medicaid providers. 2. We also recommend the Agency modify the provider agreement to inform providers of their obligation to screen their employees against the LEIE and to explicitly require providers to agree to comply with this obligation as a condition of participation.	1. The LEIE match has been fully incorporated into the central background screening system at HQA. The central background screening system receives an upload of all providers from the FMMIS and performs a match against the LEIE. If the provider is excluded on the LEIE, the provider's status in the screening system changes to Not Eligible. MCM receives a data file with all providers with a change of status. The data file is used to update the FMMIS provider records. 2. Provider agreement modified to specifically address the notification requirement.	

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			3. Finally, we recommend the Agency strengthen procedures to ensure that timely notifications to the USDHHS–OIG occur in instances where the Agency chooses to deny or limit participation in the Medicaid Program.	3. Five Agency employees have access to load lists of excluded providers to the LEIE. This was established with federal CMS in compliance with federal law. To date, the staff at MPI have successfully loaded a report. MCM is working with Agency IT staff to gain the reporting access.	
			Finding 2012-021-09 To enhance its effectiveness as a deterrent to unacceptable performance, should such occur, the methodology used to periodically monitor the performance of the Medicaid fiscal agent and assess related penalties should be modified.		
			Recommendation 1. We recommend that the Agency take the steps necessary to revise its scoring methodology to subject each performance measure to a monetary penalty or allow scores of less than 65 should they be warranted. 2. We also recommend that the Agency amend the contract with the fiscal agent to provide for an escalation of monetary penalties for a continued failure to achieve satisfactory levels of performance. The escalation of penalties should increase to an amount that encourages the contractor to timely correct performance deficiencies.	1. & 2. The Agency follows the RFP/contract requirements/references with regard to the grading methodologies associated with the fiscal agent report cards. The contracted fiscal agent receives a monetary penalty when a report card is assessed a score below 77. The performance of the fiscal agent continues to be monitored closely and the Agency has, when necessary, added additional penalties when a scored area has remained static or failed to improve. This escalated penalty application was applied as recently as May 2011, after corrective action plans imposed failed to achieve improvement. AHCA is also considering placement of an associated performance dashboard on the Internet.	

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OAG #2012-035	9/30/2010	**Medicaid Program Fraud Prevention and Detection Policies and Procedures Facility Cost Reports**	**Finding 2012-035-01** Cost Report Audit Coverage. The Agency did not select for audit facility cost reports at a frequency sufficient to reasonably ensure that improper payments were not made to facilities due to overstated or inaccurate cost reports. **Recommendation** The Agency should develop policies specifying the frequency with which each facility's cost report shall be audited. The policy should include provisions requiring the scheduling of follow-up audits for those facilities whose previous cost reports have contained significant error and the imposition of sanctions when errors in the costs reported are knowingly repeated by the provider in subsequent cost reports.	The Agency has added "number of years since last examination" to the risk criteria to the written policy. The Agency has also added Medicaid utilization to the written risk criteria. Both of these have been used in the past when considering cost reports to be added to the examination list, although not specifically stated. The current policy has been updated to include a section related to the potential imposition of sanctions when errors in the costs are knowingly repeated by the provider in subsequent cost reports.	
			Finding 2012-035-02		

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			Cost Report Audit Timeliness. The Agency did not release cost report audits in a timely manner. The failure to timely release audit reports limited the Agency's ability to timely correct errors in per diem rates. **Recommendation** 1. The Agency develop policies and procedures to provide for the timely release of cost report audits. These procedures should provide timeframes within which cost report audits are to be reviewed and released. 2. With respect to delays attributable to facilities failing to submit their cost report in a timely manner, the Agency should finalize a rule that subjects facilities to monetary penalties for failing to submit their cost reports within specified timeframes. **Finding 2012-035-03** Cost Report Audit Appeals Process. The Agency should consider revising the process used by facilities to appeal the results of cost report audits. A reduction in the number of appeals would reduce the time and resources needed by the Agency to process the appeals and may increase the frequency or timeliness with which the Agency can release cost report audits and finalize and apply corrected per diem rates. **Recommendation**	1. The Agency strives to issue reports and conclude legal challenges as soon as processes allow. The Agency will be including a timeline requirement in future nursing home and ICF/DD cost report examination contracts. 2. CMS approved the State Plan change to all sanctions for late cost reports on May 23, 2011.	

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			We recommend that the Agency pursue steps to reduce the number of appeals and the length of time involved in closing appeals. Steps to reduce the number of appeals should include the disallowance of those appeals that seek to extend consideration of audit adjustments made in response to facility documentation deficiencies.	The AHCA General Counsel's Office has been consulted on this issue. The recommendation from the General Counsel's Office is to expedite the timeline for the exchange of documents once an appeal is filed. This suggestion will be taken up with Medicaid management to determine further action to reduce the length of time involved in closing appeals.	
			Finding 2012-035-04 Consideration of Cost Report Fraud. The Agency had not developed written policies and procedures requiring further scrutiny or inquiry into the cost reports of facilities that may contain indications of fraudulent preparation.		
			Recommendation We recommend that the Agency develop and communicate to relevant staff written policies and procedures describing the steps to be followed should the results of cost report audits contain indications of facility fraud.	The Agency has expanded its policy regarding how cost report examinations with fraud indicators are to be handled. This policy is adhered to by all analysts during the cost report review process.	
			Finding 2012-035-05 Hospital Cost Report Oversight. The level of oversight provided by the Agency over the hospital cost report audit process was not sufficient. Increased Agency involvement in the hospital cost report audit process could provide additional assurance that hospital cost reports are accurate, complete, and free of material error.		
			Recommendation		

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			The Agency should increase the level of oversight provided for the hospital cost report audit process. We recommend the Agency define and increase its role by: 1. Documenting an understanding of the relationship between FCSO's work as Medicare intermediary and FCSO's review of hospital Medicaid cost reports, as well as how that relationship impacts the prevention and detection of errors and fraud in the Medicaid cost reports of hospitals. 2. Documenting the extent of the Agency's participation in the hospital cost reports selected for audit. 3. Reviewing cost report audits as they are received to ensure that the Agency is in agreement with the adjustments made by FCSO. 4. Reviewing and approving of all adjustments made through the reopening process.	1. Contract monitoring documents the relationship between FCSO's work as Medicare intermediary and FCSO's review of hospital cost reports. This documentation will become part of the file and will be updated during subsequent contract monitoring. 2. Contract monitoring documents the participation of the Agency in the selection of hospital cost reports to be audited. This documentation will become part of the file and will be updated during subsequent monitoring. 3. Contract monitoring reviews a sample of the audited hospital cost reports along with the supporting documentation of the work performed and adjustments to the cost reports. The Agency reviewed its process for (a) documentation of hospital cost reports received to indicate review for changes, outlier information, and transpositions, and (b) concerns addressed with FCSO. A tracking form has been created to record any outlier and transpositions with FCSO. 4. Contract monitoring includes a review of a reopening. Future monitoring will also include a review of a reopening.	
AG 2012-142	**6/30/2011**	**Compliance and Internal Controls over Financial Reporting and Federal Awards**	**FS 11-001**		

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			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 finding. Staff recorded the liability, but inadvertently overlooked the receivable and deferred revenue entry. A financial statement adjustment entry was submitted. Staff has been reminded that this is a two-part entry, and notes have been added to the checklist to ensure all steps are completed.	
			FS 11-002 The FAHCA Bureau of Finance and Accounting (Bureau) erroneously recorded adjusting entries to payables and expenditures that caused material misstatements in the Health and Family Services Fund. **Recommendation** We recommend that the Bureau revise its procedures for recording Medicaid Claims payable and the related accounts (expenditures) to ensure accurate amounts are recorded at year-end based on historical data and other relevant factors.	We concur with the finding. The financial statement adjustment entries have been submitted. The finance statement checklist has been updated to include the use of the claims payable general ledger code. Staff was instructed to review adjusting entries more closely to reduce the risk of errors.	
			FS 11-003 The FAHCA Bureau of Finance and Accounting (Bureau) recorded a post-closing entry to Net Receivables and Fees and Charges based on budgeted amounts rather than billed transactions. **Recommendation**		

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			We recommend that the Bureau ensure that revenue and receivables for fees collected from county and local government entities be recorded based on billed rather than budgeted amounts.	The financial statement adjusting entry has been submitted. The county agreements and actual deposits in the first quarter following fiscal year end will be used for the calculations.	
			FA 11-039 FAHCA did not always maintain appropriate records to support salary and benefits charged to the Program.		
			Recommendation We recommend that FAHCA ensure that salary charges reflect actual time worked as recorded in time and effort records.	The adjustment to the employee's position description was made on January 12, 2012. The estimated corrective action date, to correct the financial reporting for the applicable grants, is April 30, 2012, when prior period adjustments for the quarter ending 3/31/2012 is submitted.	
			FA 11-041 Inadequate supervisory review and lack of written policies and procedures contributed to FAHCA incorrectly calculating cash draw amounts.		
			Recommendation We recommend that FAHCA develop and implement written policies and procedures to ensure that the correct amounts and FMAP rates are used in the calculation of draw amounts to ensure that cash needs are appropriately met. Additionally, we recommend FAHCA ensure that cash draw calculations are reviewed before a cash draw is made.	FAHCA concurs with this finding. The two deposits that were incorrectly recorded as federal draws, GL code 000700, were subsequently adjusted to the correct GL on June 29, 2011. FAHCA has drafted and implemented procedures for completion of the Federal cash draws. Additionally, the section manager will review and confirm the accuracy of the draws on a weekly basis.	

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			FA 11-042 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 CMIA data to FDFS, including procedures for ensuring that the amounts are accurate and complete. Additionally, we recommend FAHCA continue to perform reconciliations to ensure cash draws are correctly reported.	The reconciliation procedures were used in November 2011 during the preparation of the FY 2010-11 CMIA report. The procedures were incorporated in the formal desk top procedures and were finalized on 2/28/12.	
			FA 11-061 1. Payments were made to providers on behalf of CHIP recipients who were not eligible for the Program. 2. Additionally, CHIP payments were made for a service type for which no fee schedule or policy had been developed.		
			Recommendation 1. We recommend that FAHCA establish a process to timely adjust payments when retroactive Medicaid eligibility determinations are made. 2. We also recommend that FAHCA finalize the changes to the handbook to ensure that a fee schedule or policy has been established for the omitted service.	1. At the time in question, MediKids coverage was correctly provided. Even though there were overlapping coverage months for the nine cases cited, there was no dual payment. A state plan amendment will be submitted to request provisional eligibility which CMS advises will eliminate this problem. 2. The Child Health Services Targeted Case Management Coverage and Limitations Handbook and rule number 59G-8.700, F.A.C., was adopted on July 19, 2012.	

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			FA 11-064 Medical service claim payments made to providers of Medicaid services 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.	The agency has addressed or has a scheduled implementation dates to strengthen the controls in the areas cited in the finding.	
			FA 11-065 Controls were not sufficient to ensure that amounts paid by FAHCA to CTD or amounts paid by CTD to transportation providers under a Medicaid transportation program were reasonable.		
			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 CTD for administrative costs. FAHCA should also conduct appropriate monitoring to evaluate CTD and STP compliance with governing laws, regulations, and contract terms and communicate the results of the monitoring to CTD and STPs.	The Commission for the Transportation Disadvantaged (CTD) submitted a new allocation methodology that took effect January 1, 2012. The allocation is based on a formula that takes into account recent data relating to the Medicaid Non-Emergency Transportation program.	

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				The CTD submitted audit reports for each Fiscal Year (FY) 08/09, 09/10, and 10/11. The Agency issued a corrective action plan to the CTD relating to the untimely submission of these reports, and to address what steps will be taken to prevent the non-compliance in FY 11/12. The independent auditors reported the expenditures conformed to GAAP. Based upon these criteria, the Agency determined the CTD expenditures to be reasonable; however, the audit reports found that the schedule of expenditures provided by the CTD was not reconciled to the financial statement spreadsheet numbers provided by the CTD. CTD remarked the difference was due to administrative charges allowable per the grant, not included on the spreadsheet numbers. The Agency has requested that the CTD submit a corrective action plan to reconcile the schedules to the state's FLAIR system. The corrective action plan is due August 31, 2012.	
			FA 11-066 Synopsis of OAG audits 2012-021 and 2012-035 **Recommendation** See 2012-021 and 2012-035 **FA 11-067** As noted in the prior year audit, FAHCA continued to record expenditures to incorrect appropriation categories in the State's accounting records.	See 2012-021 and 2012-035	

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			Recommendation We recommend that FAHCA ensure that expenditures are accurately recorded in the State's accounting records. We also recommend that FAHCA continue to pursue the necessary changes to the budget amendment process to ensure that funds are available in the appropriate categories.	FAHCA's procedure is to pay the weekly Medicaid claims payment in as few categories as possible that have the largest amount of budget released, and then to do an adjusting journal transfer to move the expenditures to the correct categories. The adjusting journal transfers are generally completed within the same week. There may be occasions at fiscal year-end or at the conclusion of carry forward processing that the FLAIR Medical Services appropriation categories may not agree with the FMMIS appropriation categories due to insufficient FLAIR budget. In the payments made on September 29, 2010 there were some adjustments necessary due to insufficient budget. Additionally, expenditures for Title XXI are included in the FMMIS report under the specific appropriation category. These are identified as category type 8 (Title XXI) expenditures on the weekly report and are moved to the FLAIR appropriation category 102340 (Medici's), which is used for Title XXI. The amounts for Title XXI are $59,499.29 and $2,475,025.24 for Inpatient Services and Prepaid Health Plan, respectively.	

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				The FMMIS expenditures, less Title XXI, were $60,389,925.43 for Inpatient Services and $243,561,314.48 for Prepaid Health Plans. On the FMMIS report, there are three appropriation categories for prepaid health plans: 102671, 102672 and 102674. The sum of these three categories are paid from FLAIR category 102673. FAHCA has made and continues to make efforts to secure the needed legislative authority to move budget between categories to align with expenditures at year end.	
			FA 11-069 (also FS11-004) FAHCA had not documented that the State met the matching requirements of the Medicaid Program for the 2009-10 Federal fiscal year (FFY). Additionally, FAHCA did not have a process in place to monitor compliance with matching requirements.		
			Recommendation We recommend FAHCA implement policies and procedures detailing the method for calculating, documenting, and verifying the Medicaid Program State match. To allow timely identification of deficiencies, those policies and procedures should require periodic verifications of State matching contributions.	FAHCA concurs with the findings. FAHCA has implemented procedures to calculate and document the Medicaid Program State match. FAHCA has modified its methodology to verify the other entities' actual expenditure reports representing the State match contributions.	
			FA 11-070		

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			FAHCA procedures were not sufficient to ensure that Medicaid providers receiving payments had a current Medicaid Provider Agreement in effect. Additionally, FAHCA did not always maintain Medicaid provider files containing applications, agreements, and other required documentation evidencing the provider's eligibility to participate in the Medicaid program. **Recommendation** We recommend that FAHCA ensure that payments are made only to providers with current Medicaid Provider Agreements in effect. FAHCA should continue to work with the fiscal agent to ensure that providers have current Medicaid Provider Agreements in place, or assess appropriate penalties for nonperformance against the fiscal agent. Additionally, FAHCA should work with the fiscal agent to ensure provider files are maintained and accessible. **FA 11-072** FAHCA's established policies and procedures did not provide for the timely review and release of cost report audits of nursing home and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).	The Agency has completed the process of reenrolling providers whose agreements expired prior to the launch of the automated reenrollment process in January 2010. The Agency installed an additional automated job in November 2010 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. The provider had 90-days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who failed to respond within the 90-day window were restricted in the system to prevent claims with dates of services after the deadline from processing.	

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			Recommendation We recommend FAHCA enhance its policies and procedures to specify the frequency with which each facility's cost report should be audited and to provide for the timely release of cost report audits. These procedures should identify time frames within which cost reports audits are to be reviewed and released to ensure the timeliness and usefulness of the information contained within the audits.	The Audit Services policy (updated January 2012) states that cost reports selected for audit are generally assigned within three (3) years of receipt, regardless of the fiscal year end. To address audits beyond the policy timelines, we will evaluate each step of the process to determine if new policies or procedures need to be incorporated in order to streamline the overall timeliness of the entire audit process. Currently all audits performed are reviewed by Agency staff to ensure that we can defend any adjustments in case of legal challenges. As such, we do not recommend limiting the reviews of the audits performed. The Agency may be able to assign fewer audits to be performed by our independent CPA vendors. In addition to evaluating our current audit policy, we will be evaluating the need for additional qualified staff to review the audits in a timely and efficient manner.	
DFS 10-11	**7/1/10-5/31/11**	**Contract and Grant Agreements**	**Finding 10-11-01**		

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			1. One contract did not contain a clear scope of work with minimum performance standards. 2. Two contracts did not contain adequate deliverables. Payments for the first contract were based on quarterly provider reports and did not establish a minimum level of acceptable performance. The second contract did not contain any deliverables for year two of the contract. 3. AHCA contracted through a state term contract for remote, disaster recovery IT services. However, AHCA agreed to pay the vendor rates that exceeded the maximum allowed under the state term contract. 4. Payments related to two services contracts were missing the required written certification statement by the contract manager. 5. No documentation was provided for six services contracts to evidence that the number of hours billed by vendors had been verified by the AHCA prior to approving invoices for payment. 6. Our review disclosed that the contract management activity for six contracts was not sufficient, as the contract manager did not document verification that services were delivered satisfactorily prior to approving invoices for payment. 7. The documentation related to services performed for one service contract was not always consistent with the services included in the contract, the vendor's invoices, or the related STC. **Recommendation**		

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			1-3. Each contract must include a clear scope of work; deliverables that are directly related to the scope of work; minimum required levels of service(s); criteria to successfully evaluate satisfactory performance; and compensation aligned with each deliverable.	1. The Agency has entered into a new contract with the University of South Florida which addresses performance standards, as well as related financial consequences. 2. AHCA Contract No. MED077 expired June 30, 2011. The Agency has entered into a new contract with the University of South Florida, which includes a "Deliverable" table outlining, in detail, each deliverable, its due date and amount. AHCA Contract No. MED111 was previously set to expire 12/31/12. The Agency has amended the contract to include deliverables for year two (2) and is ending it early with an expiration date of 01/31/12. A new contract will be written and will contain clear deliverables, performance standards, and financial consequences. 3. DFS requested that the Agency Direct Order (DO) Manager match up the line items on the DO price schedule with the line items on the State Term Contract (STC) price list. In doing so, it was discovered that the Vendor charged "Cloud" pricing on a couple of line items instead of their "Warm" price. The Agency has since received a credit back in the amount of $2,041.20 for January 2011-June 2011 overages. The Department of Management Services' (DMS) State Term Contract Manager has also approved the vendor's request to have the "Warm" price increased to match the "Cloud" price. The Agency will also be more diligent in reviewing pricing to ensure rates do not exceed those allowable under state term contract.	

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			4. Contract managers must enforce performance of the contract terms and conditions; review and document all deliverables for which payment is requested by vendors; provide written certification of the receipt of goods and services, and ensure all payment requests are certified.	4. The Agency is currently in the process of reviewing its contract manager training program. Beginning in 2012, in addition to certification training, continuing education training will be mandatory for every active contract manager. Additionally, effective July 1, 2012, all DOs for services in excess of Category II will be managed by an Agency certified contract manager. The Agency will be more diligent in making sure each Contract Summary Form is completed and signed by the Contract Manager upon receipt of goods and services and prior to submission to DFS. The Agency's Bureau of Finance and Accounting will continue to provide invoice processing and approval training to all Agency contract and DO managers. Additionally, effective July 1, 2011, the Agency implemented the use of a Staff Augmentation Template. The template requires detailed timesheets be submitted and signed by the Agency prior to invoice approval.	
			5. The verification process should include reconciling vendor-generated data, such as timesheets and activity reports, to data controlled and maintained by AHCA or an independent third party. 6. The validation process should include reconciling vendor-generated data, such as timesheets and activity reports, to data controlled and maintained by AHCA or an independent third party. The contract files should contain documentation of the steps taken to verify service delivery.	5-6. Effective July 1, 2011, the Agency implemented the use of a Staff Augmentation Template, which includes, but is not limited to, timesheets, reports, deliverables, and financial consequences.	

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			7. If AHCA intended to purchase hosting services, an appropriate procurement method should have been used. Additionally, AHCA's contract and the vendor's invoices should identify the services purchased.	7. The Agency does entirely concur with this finding. However, the Agency intends to cancel DO2035512 and has issued a new RFQ which provides a clearer scope of services within the appropriate Project Area(s). The Agency sought clarification from the DMS' State Term Contract Manager, who did not think the Agency was out of compliance with the STC, but simply contracted under the wrong Project Area.	
HHS A-04-11-07020	**1/1/09- 12/31/09**	**Review of Medicaid Payments to Excluded or Terminated Durable Medicaid Equipment Suppliers (DME) in Florida**	**Finding 04-11-07020-01** The State agency did not make improper payments to DME suppliers that had been excluded from the Medicare or Medicaid programs. However, it made improper payments totaling $230,992 ($127,407 Federal share) to 31 DME suppliers that the Clearinghouse had terminated from the Medicare program during 2009. The State agency made improper payments to these 31 suppliers because it did not have procedures to validate DME suppliers' billing privileges through the Clearinghouse to ensure that they were not terminated from the Medicare program.		
			Recommendation 1. We recommend that the State agency refund $127,407 to the Federal Government for the improper Medicaid payments made to terminated DME suppliers.	1. We concur with this finding. The Agency will initiate recoupment activities on the 31 providers identified during the audit.	

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			2. Improve controls to ensure that the State agency validates DME suppliers' billing privileges before paying them.	2. The Agency will also implement processes to identify DME providers terminated by CMS and take appropriate action. Over the past year, our MPI field offices have reviewed the weekly terminations list to try and identify terminated DME providers in their area. However, with only a business name and city/state data to go on, locating the providers has proven difficult. If staff is able to confirm that the business identified on the termination list is an active Medicaid provider, then payment review actions would be initiated. The state is currently working with CMS to identify a database that contains sufficient identifying information to enable the application of administrative action.	
HHS OEI-07-10-00370	**6/30/2009**	**Medicaid Payments for Therapy Services in Excess of State Limits**	**Finding 07-10-00370-01** Despite reported program safeguards, six States improperly paid claims for therapy services totaling $744,000. Florida paid $621,364. States lacked system edits to prevent payments in excess of limits, but described actions taken to prevent future improper payments. **Recommendation**		

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			Implement system edits and seek policy clarification.	In Florida, the largest portion of claims paid improperly (10,936 claims totaling $491,604) was paid for more than 4 units per day or 14 units per week for services within each therapy discipline. Following our review, Florida Medicaid officials stated that they had implemented a system edit to deny claims for more than 4 units per day and were implementing an edit to deny claims in excess of 14 units per calendar week. The next-largest portion of improperly paid claims was paid for therapy evaluations for recipients under age 21 (2,162 claims totaling $103,990). Florida officials stated that these payments were caused by conflicting policy. Following our review, officials stated that they distributed policy clarification to providers via a provider forum, email, and the therapy services section of the Florida Medicaid Web site. Additionally, Florida officials stated that they implemented an edit in the claims system to prevent payments for evaluations that exceed the limits.	
AUDITS FOR FISCAL YEAR 2010-2011					
AHCA 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**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	1. An Aging Out program Monitoring Tool and Compliance Checklist and a Client Satisfaction Survey have been developed. The analyst continues to require case managers and other A/DA Waiver service providers to submit necessary documentation per Aging Out program requirements. 2. On-site monitoring visits are scheduled quarterly.	
			Finding 10-09-02 Providers were reimbursed for more than what was authorized by the Program Analyst via the authorization letters.		
			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.	1. Based on the OIG's 2008-09 audit report referrals have been made to MPI for recoupment of inappropriately paid claims. 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.	
			Finding 10-09-03 Recipients received Waiver services not authorized by the Program Analyst.		
			Recommendation		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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. **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**	1. The Program has made 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 Monitoring Tool and Compliance Checklist and the Client Satisfaction Survey are complete and are in use. 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.	

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			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. **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.	1. The Consumer Directed Care Plus (CDC+) Consultant (with the assistance of an Area Office RN) completed a new plan of care and purchasing plan that has been approved. The Consultant is in the process of enrolling client in the CDC+ program. 2. The $1200 was recouped. 1. This issue was referred to MPI for recoupment. The provider has been disenrolled as a Medicaid provider. The DOEA was contacted and instructed to remind Medicaid Waiver Specialists to research FMMIS prior to enrolling new providers.	

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			2. Ensure that only enrolled Medicaid DME providers be authorized to provide specialized medical equipment and supplies to Program recipients.	2. Case managers are given a list of enrolled Medicaid providers. In addition, 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. This provider was terminated from the A/DA waiver.	
			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.	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. Reword authorization letters reissued to providers to specifically include the new effective start date for the revised authorization of waiver services.	2. Authorization letters were revised to include new effective dates for authorized services.	
			Finding 10-09-08		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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**	The Aging Out analyst is working on an Excel spreadsheet to track effective and expiration dates on plans of care, levels of care and effective dates for service authorizations. The analyst will continue to provide information, technical assistance and reminders to case managers to ensure all documentation is submitted to the analyst, so that she can provide timely authorizations for services. The analyst will continue to talk with home health service providers to ensure submission of current documentation. Documentation for case manager qualifications were obtained.	

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			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 Referral Agreement template has been developed, approved and is in use.	
AHCA 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. Public records, open meetings, equal opportunity and the proper personnel procedures were incorporated into the Agency's required New Employee Orientation and Keep Informed training classes in June 2011. The subject of records retention is currently being reviewed for updates to the Agency Policy and Procedures. There is no anticipated completion date at this time. 2. The Bureau of Human Resources continues to track and send email reminders to all employees who have not completed their annual training requirements. We also continue to notify the supervisor, via email, if an employee is non-compliant for inclusion on their evaluation. The Division of Information Technology is still developing the database to make tracking more efficient and effective.	
OAG #2011-002	**07/2010**	**Operational Audit - Prior Audit Follow-up**	**Finding 2011-002-01**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			The Agency needs to enhance its contract management policies and procedures regarding attestations of independence with respect to contracted entities. **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		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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. **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. **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**	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.	

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			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. **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. **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	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. 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.	

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				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.		
			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.	

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				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.	
			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		

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			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.	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.	
			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.	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.	
			Finding 2011-002-10 The Agency needs to improve procedures to ensure TPP is timely and accurately recorded.		
			Recommendation		

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			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.		
			Recommendation		

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			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		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	
			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.	The security form and associated procedures define guidelines for terminations and transferred employees within the organization, as well as within departments.	
			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.	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.	
			Finding 2011-057-05		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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. **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**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	
			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		

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			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. **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 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.	

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			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.	
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		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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. **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.	We concur with the findings and recommendation. The position's responsibilities have been revised to be related only to Title XXI. Activity reports were initiated in January 2011. Completed. 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.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				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. 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. 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. This item has been fully corrected.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				DENTAL File maintenance is complete. Claims submitted with certain procedure codes will deny if: • A quadrant indicator is not on the line item; • The line item has a quadrant indicator other than 10, 20, 30, or 40; or • If a duplicate quadrant indicator is present. CHIROPRACTIC Re: Chiropractic visits paid in excess of 24 per calendar year: 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	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				Re: Reimbursements for chiropractic services provided in exceptional places of service: 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 procedure will recoup chiropractic visits that were provided in an exceptional place of service, without the appropriate referral required by policy.	

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 recoup 12 days reimbursement paid in error	
			Finding FA 10-059		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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. **Recommendation**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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 has followed up with the CTD on numerous occasions regarding completion of policies and procedure that would help the CTD meet its contractual obligation to the Agency. Agency staff chose this course with the belief that appropriate operating policies and procedures needed to be in place to ensure the CTD understands what the Agency would be looking for on monitoring visits. During this time the Agency issued two corrective action plans in response to repeated failure on the part of the CTD to complete the operating policies and procedures. In part due to the lack of completed operating policies and procedures the CTD has also not produced the annual audited financial reports required to answer this audit finding. The CTD does not dispute that it is required to produce the required reports, but it maintains that it hasn't had the manpower or leadership, until recently, to begin development of the report. The Agency has amended the contract twice since the previous response. The first was to decrease the dollar amount of the contract and the second was to extend the contract and make major revisions that would hold the CTD more accountable. The Agency is taking additional steps to work with the CTD to ensure that it meets all contractual obligations and audit requirements.	
			Finding FA 10-060		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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. **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.	Procedures have been established to ensure carry forward budget is not used to pay for current year expenditures. The status of expenditures to correct appropriations is still in process. The agency has no control over what claims are submitted against which appropriation code. The agency is in the process of seeking Legislative authority to align appropriations to expenditures at year end to help resolve the finding.	
			Finding FA 10-061 FAHCA could not always properly support salaries and wages charged to the Medicaid Program. **Recommendation**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	
			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.	
			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		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	Written procedures have been put in place to reconcile the draw worksheet to the Payment Management System and to identify refunds to be reported in the CMIA annual report.	
			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.		
			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. Written procedures have been put in place to ensure that all expenditures are supported by provider claims.	
			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		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.		
			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.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				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. 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		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	
			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**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	
			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.	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.	
			Finding FS 10-004		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	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.	

Health Care Services Schedules

Children Special Health Care

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**311,657**	(A)		**311,657**	
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	**311,657**	(F)	**0**	**311,657**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**311,657**	(H)	**-267,415**	**44,242**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards			**267,415**	**267,415**	
LESS: Current Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**0**	(K)	**267,415**	**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, 2012

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**5,617,607.79**	(A)		**5,617,607.79**	
ADD: Other Cash (See Instructions)		(B)		**0.00**	
ADD: Investments		(C)		**0.00**	
ADD: Outstanding Accounts Receivable		(D)		**0.00**	
ADD: _____		(E)		**0.00**	
Total Cash plus Accounts Receivable	**5,617,607.79**	(F)	**0.00**	**5,617,607.79**	
LESS: Allowances for Uncollectibles		(G)		**0.00**	
LESS: Approved "A" Certified Forwards	**4,242,331.50**	(H)	**-4,212,837.10**	**29,494.40**	
Approved "B" Certified Forwards		(H)		**0.00**	
Approved "FCO" Certified Forwards		(H)		**0.00**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0.00**	
LESS: Payables not Certified Forwards				**0.00**	
LESS: Current Compensated Absences Liability		(J)		**0.00**	
Unreserved Fund Balance, 07/01/12	**1,375,276.29**	(K)	**4,212,837.10**	**5,588,113.39**	**

Notes:

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**** 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, 2012

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**10,037,378**	(A)		**10,037,378**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**78,071,950**	(D)	**(37,325,418)**	**40,746,532**	
ADD: Other Loans and Notes Receivable		(E)		**0**	
Total Cash plus Accounts Receivable	**88,109,328**	(F)	**(37,325,418)**	**50,783,910**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**23,342,781**	(H)	**(22,202,008)**	**1,140,773**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**1,450,114**	(I)		**1,450,114**	
LESS: Payables not Certified Forwards				**0**	
LESS: Deferred Revenues		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**63,316,433**	(K)	**(15,123,410)**	**48,193,023**	**

Notes:

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Office of Policy and Budget - July, 2012

Executive Direction and Support Services

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**267,848**	(A)		**267,848**	
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	**267,848**	(F)		**267,848**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**60,821**	(H)		**60,821**	
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, 07/01/12	**207,027**	(K)	**0**	**207,027**	**

Notes:

***SWFS = Statewide Financial Statement**

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Office of Policy and Budget - July, 2011

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**19,323,634**	(A)		**19,323,634**	
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	**19,323,634**	(F)	**0**	**19,323,634**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**28,254,715**	(H)	**(15,326,091)**	**12,928,624**	
Approved "B" Certified Forwards	**88,405**	(H)		**88,405**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**6,306,606**	(I)		**6,306,606**	
LESS: Payables not Certified Forwards				**0**	
LESS: Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**(15,326,091)**	(K)	**15,326,091**	**(0)**	**

Notes:

***SWFS = Statewide Financial Statement**

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Office of Policy and Budget - July, 2012

AGENCY FOR HEALTH CARE ADMINISTRATION
SCHEDULE IV-B
FOR
PROVIDER NETWORK VERIFICATION SYSTEM ENHANCEMENTS

FOR

FISCAL YEAR 2013-14

State of Florida

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

October 12, 2012

Table of Contents

I. Schedule IV-B Cover Sheet

Schedule IV-B Cover Sheet and Agency Project Approval	
Agency: The Agency for Health Care Administration	Schedule IV-B Submission Date: October 15, 2012
Project Name: Provider Network Verification System Enhancement	Is this project included in the Agency's LRPP? _X_ Yes ____ No
FY 2013-14 LBR Issue Code:	FY 2012-13 LBR Issue Title: Provider Network Verification System Enhancement
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Molly Mckinstry, 850-412-4334	

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: 10/12/12
Agency Chief Information Officer: Printed Name: Scott Ward	Date: 10/12/12
Budget Officer: Printed Name: Anita Hicks	Date: 10/13/12
Planning Officer: Printed Name:	Date:
Project Sponsor: Printed Name: Molly McKinstry	Date: 10/12/12

Schedule IV-B Preparers (Name, Phone #, and E-mail address):

Business Need:	Damon T. Rich, (850) 412-3448, Damon.Rich@ahca.myflorida.com
Cost Benefit Analysis:	
Risk Analysis:	Damon T. Rich, (850) 412-3448, Damon.Rich@ahca.myflorida.com

Technology Planning:	Damon T. Rich, (850) 412-3448, Damon.Rich@ahca.myflorida.com
Project Planning:	Damon T. Rich, (850) 412-3448, Damon.Rich@ahca.myflorida.com

II. Schedule IV-B Business Case

Business Case Section	$1-1.99M	$2 – 10 M		> $10 M
		Routine upgrades & infrastructure	Business or organizational change	
Background and Strategic Needs Assessment			X	X
Baseline Analysis			X	X
Proposed Business Process Requirements			X	X
Cost Benefit Analysis		X	X	X

A. Background and Strategic Needs Assessment

1. Agency Program(s)/Service(s) Environment
   The Agency for Health Care Administration's (Agency) broad health care oversight responsibility involves receiving and processing significant amounts of data that directly and indirectly impact the administration and operation of the Medicaid program, including maintaining program integrity through fraud and abuse monitoring. The Provider Network Verification (PNV) links managed care plan provider network submissions with the Agency's Medicaid fiscal agent and facility licensing systems, the Department of Health licensing database, and the Office of the Inspector General's excluded provider lists. The Provider Network Verification process replaces manual processes with automation. Managed care plans submit weekly provider network files to through Agency's choice counseling system. The PNV process connects address basic licensure status, but enhancements are necessary to provide detailed licensing information such as sanctions and violations. Professional staff who spend a significant amount of time making manual comparisons across various data sources are only able to review a sample of networks; automation will enable through monitoring.

   The Agency is in the process of expanding Medicaid managed care statewide, first with long term care managed care in 2013, followed by medical assistance managed care in 2014. The additional volume of plans and provider networks necessitate automation to provide sufficient validation and management of provider networks.

2. Business Objectives

   The Provider Network Verification system enables automation of managed care plan provider network reviews, including eligibility based on criminal background, health care exclusions, and other eligibility criteria. This project will enhance the automated Provider Network Verification system further improving managed care network reviews and providing a rapid response to stakeholders. As a benefit, the Agency will be able to perform ongoing and

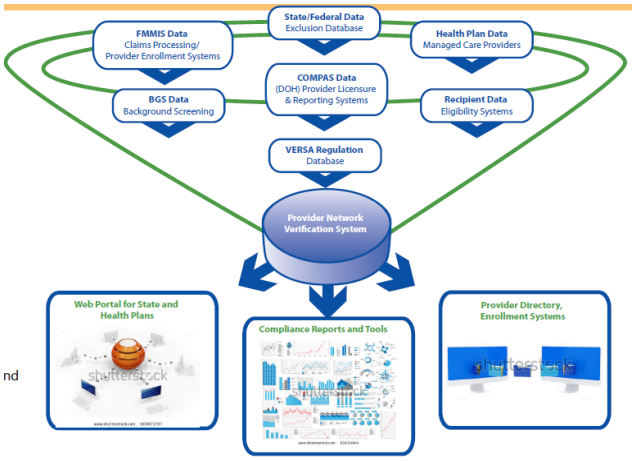
targeted managed care network provider verification and oversight thus ensuring the adequacy, accuracy and quality of health care in Florida. Enhancements will enable managed care plans to monitor and manage the quality of their networks, providing faster, more detailed information regarding network providers. The initial system meets basic automation needs for Medicaid Managed Long Term Care implementation, however, enhancements are necessary to expand use for the Medicaid Medical Assistance Managed Care and increase overall functionality.

Automation of additional and more detailed interfaces will further relieve manual and labor intensive processes. Enhancements will expand data connectivity to include Medicaid Program Integrity status, other state and federal health care provider exclusions systems, and additional licensing information. Other enhancements will expand qualitative information from existing system connections. For example, the current connections address basic licensure status, but enhancements will provide detailed licensing information such as sanctions and violations.

B. Baseline Analysis

1. Current Business Process Requirements
   a. Inputs: Health Care Practitioner Licensure Information (COMPAS), Health Care Facility/Provider Licensure Information (VERSA Regulation), Medicaid Provider Information (FMMIS), Federal Contractor Exclusion Information (OIG Exclusion List), Health Plan Network Information (Managed Care Organizations), criminal background eligibility information (BGS).
   b. Processing: Manual review and comparison of a sample of each health plan network submission against most of the inputs.
   c. Outputs: Compliance reports for use by plan analysts, citizens and program integrity for the identification of possible contract violations.
   d. Business Process Interfaces: To validate a network, some data from health plan network submissions are compared against the following external sources: COMPAS and the Federal Exclusion List.
   e. Business Process Participants: AHCA Division of Health Quality Assurance-Responsible for certifying managed care organizations (MCO's) to operate in Florida by conducting plan readiness reviews and validating network adequacy; also responsible for the licensure and regulation of health care facilities/provider organizations. AHCA Division of Medicaid-Responsible for processing capitation payments to MCO's and Provider Enrollment. Medicaid Program Integrity-Responsible for monitoring Medicaid provider fraudulent and/or abusive behavior. Managed Care Plans-Contract with the State of Florida to provide managed, health care services to Florida Medicaid Recipients; Florida Department of Health-Responsible for licensure of health care practitioners.

Process Map



2. Assumptions and Constraints: While the current inputs are primarily related to analysis of data systems, the evaluation and output process is manual and labor intensive, involving manual comparison across various data sources. This increases the chance for errors and only allows a sample of each network to be reviewed, thus depending heavily on the attestation of the plan regarding network adequacy.

C. Proposed Business Process Requirements

1. Proposed Business Process
   The proposed solution will accept provider network file submissions from managed care plans and provide the plans with a response file indicating any deficiencies. The solution will provide detailed reporting for the Agency, including trending and submission comparison reports. Additionally, the solution will produce Ad-Hoc reports and interface with multiple data systems, and assist with the provider reconciliation process.

   The proposed solution will improve the safety and reliability of managed care provider networks, improving the ability to identify network concerns, improve plan knowledge of qualitative licensure issues, and improve consumer access to adequate network providers. Efficient reporting and processing improve plan compliance and monitoring, enabling a comprehensive review of the network rather than a sample. Ineligible providers will be proactively identified by managed care plans and prevented from participating in the Medicaid program. Additionally, the Agency will gain the ability to assure that only providers approved by the Agency are displayed to the consumer for their health care choices.

2. Business Solution Alternatives:
   A. No action – would retain manual processes for provider eligibility and limit managed care plan ability to readily know adverse status of network providers.

B. Create a free-standing Provider Network Verification System – would require more funding and complete rebuild of current network submission process.

C. Expand the current Medicaid Choice Counseling project to improve the data connectivity for additional systems and enhance system interfaces.

3. Rationale for Selection: "C" Leverage the enhancements in process to fully automate eligibility system interfaces. Provides the most cost effective solution.

4. Recommended Business Solution: Enhance the Choice Counseling Vendor's system to interface with eligibility systems and provide immediate feedback of ineligible providers. Support ongoing interface with the Florida Medicaid fraud and abuse information.

III. Major Project Risk Assessment Component

The inability to implement this project would result in the loss of an opportunity to improve service delivery and communication with consumers and health care community with regards to adequate care networks. The risk allowing of ineligible providers to compromise the network of managed care plans will be minimized if this project proceeds. The project also increases the administrative effectiveness of health plan monitoring and compliance enforcement in an increased managed care environment.

A. Risk Assessment Tool

Please See Attachment III

A. Current Information Technology Environment

Managed care plans are required to submit network files to the Agency for Health Care Administration for approval of a Health Care Provider Certificate for Health Maintenance Organization licensure, and as required in the Medicaid managed care contract. In addition to reviewing a sufficient number of providers based on enrollee volume, the files are submitted showing geographic locations of providers to allow the Agency to evaluate the proximity to beneficiaries in the plan. Although the initial system will allow a simple check for valid licensure, there is a need for enhanced qualitative review of licensure information and other data.

B. Proposed Solution Description

The automated Provider Network Verification (PNV) system provides the Agency with the tools to ensure that managed care network reviews are complete and thorough. Enhancements will further eliminate manual reviews of qualitative information and the need to sample the current file and networks, as this solution would enable evaluation of all network and network provider requirements through automation. Agency staff will be able to perform more regular and specific monitoring and oversight of the adequacy, accuracy and quality of provider networks. The enhancements to system will enable matching files with other state licensing, excluded provider lists for state Medicaid programs, and Medicaid prescription database. Enhancements will also improve and expand connects to criminal databases, Agency licensure data, Medicaid enrollment, and other available sources to confirm accuracy and eligibility. Managed care plans will get immediate feedback and alerts regarding their network adequacy. Additional functionality will include attachment of documents that would be housed in the Agency's document management system. State, and Federal security requirements are followed in compliance with the Agency's ISDM.. The system has both internal and external interfaces with different functionality for business purposes.

C. Capacity Planning

The system will be utilized by between 14 and 28 managed care organizations in Florida.

D. Analysis of Alternatives

Business Solution Alternatives:

A. No action – would retain manual processes for provider eligibility and limit managed care plan ability and the Agency's ability to readily know adverse status of network providers.
B. Create a free-standing Provider Network Verification System – would require more funding and complete rebuild of current network submission process.
C. Expand the current Medicaid Choice Counseling project to improve the data connectivity for additional systems and enhance system interfaces.

Option A is not practical. Given the expansion of Medicaid managed care, the business unit would have to increase its staff size significantly just to maintain the current minimal ability to evaluate network adequacy. This would have a negative impact on meeting the Agency's mission and vision. Option B and C are similar with the difference being the cost and time associated with a complete rebuild.

Recommended Business Solution: Enhance the Choice Counseling Vendor's system to interface with eligibility systems and provide immediate feedback of ineligible providers. Support ongoing interface with the Florida Medicaid fraud and abuse information.

E. Risk Assessment Summary

The Agency believes the risk of implementing a Provider Network Validation system to assist with the facilitation of data integration will be low. However, the overall risk assessment is medium due mainly to the changes in internal and external business processes.

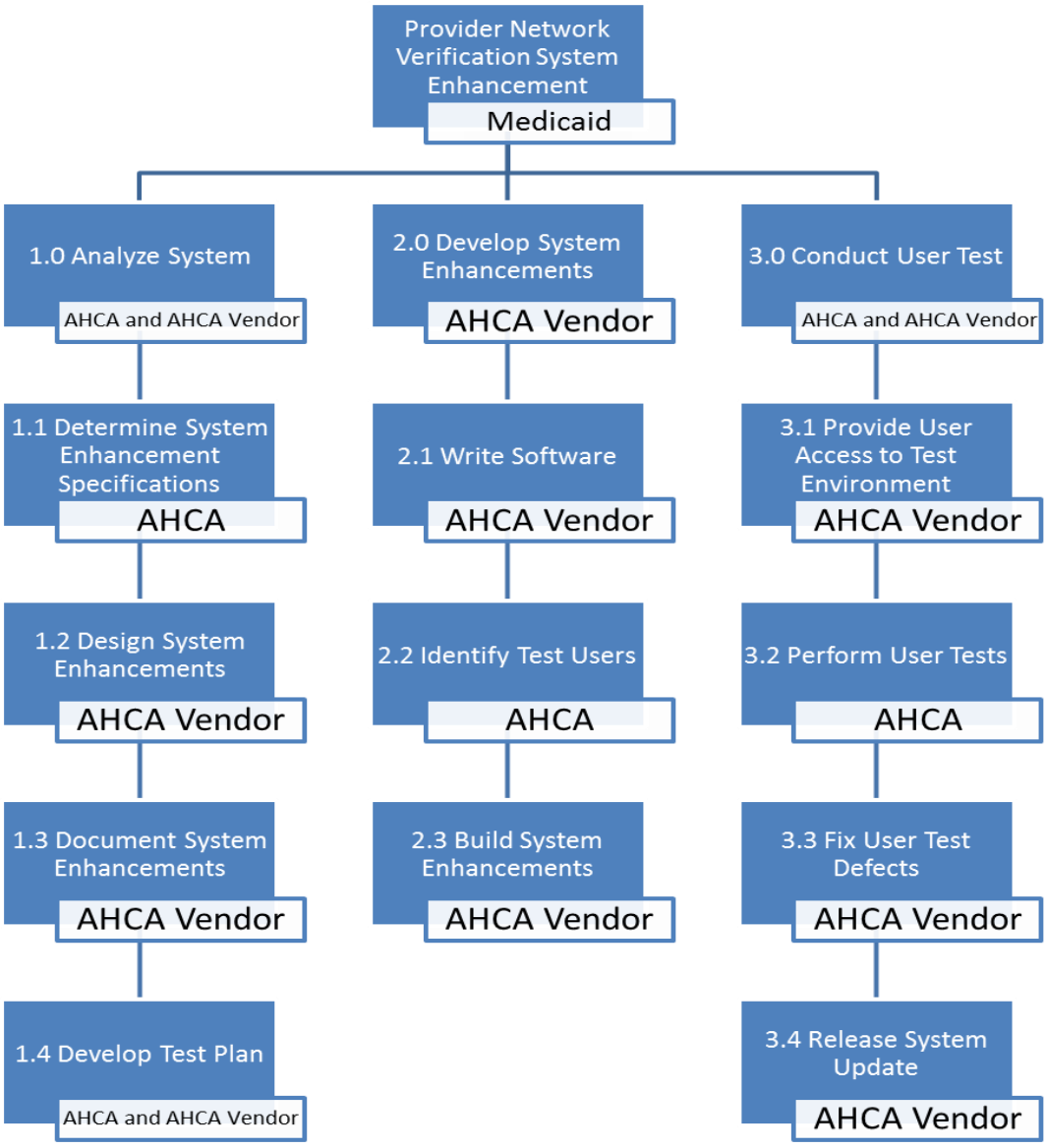
IV. Project Management Planning Component

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

See Attachment I

B. Work Breakdown Structure



C. Resource Loaded Project Schedule

See Attachment I

D. Project Budget

See Appendix K

E. Risk Management

See Attachment II

V. Appendices

- Appendix K

Provider Network Validation Project Charter

1. Project Charter Document

1.1 Purpose

The Purpose of the Project Charter is to document "what" the Project is, as approved by Governance. The charter includes: Approved Project Scope and Project Constraints. Project Constraints include: Project Priority and Resource allocations.

1.2 Author(s)

(1) Molly McKinstry – Project Sponsor

(2) Damon Rich – Project Lead

(3) Eric Lingswiler – Project Lead

(4) David Oropallo – Project Lead

(5) Ryan Fitch –Project Leasd

1.3 Document Revision History

This table contains the complete version history of this document. The 'description of Revision' is intended to record the essential purpose of each revision; it is **not** intended to be a complete list of changes from one version to another.

Date	Author	Versi	Description of Revision
NA			

2. Approved Project Scope

This section defines the scope of the project as approved by AHCA Project Governance or the Project Steering Committee.

2.1 In Scope

This project will provide enhancement to the current enrollment system to include functionalities to support health plan provider network monitoring (Provider Network Verification System, or PNV) by both the Agency, the Agency's vendors and Managed Care Organizations (MCOs) via a secure WebPortal.

The implementation will require the system to process data from the following data points:

VERSA Regulation-AHCA HQA
COMPAS-DOH MQA
FMMIS-AHCA Vendor
BGS-AHCA
MCOs-AHCA Vendor
State/Federal Exclusion Lists
DBPR
Other State Databases as needed

Included in the full implementation will be a secure web portal for AHCA, AHCA vendor staff, and MCOs. The web portal will allow MCOs to submit provider network data, research potiental providers, research specialist providers, access and review file history, participate in online discussions, request assistance from AHCA and AHCA vendor staff, access announcements, and access extensive reports. The web portal will allow AHCA to post relevant announcements, identify the provider capacity for targeted areas, identify providers with uncommon specialites serving as primary care providers (PCPs), review and approve providers based on relevant conditions, and access the tools available for MCOs.

The results of this project will provide AHCA with:

- Increased data accuracy and consistency of provider network files from MCOs,
- Timely tracking and resolution of issues including provider ineligibility,
- More accurate provider data resulting in better enrollments and assignments decisions for plan recipients,
- Unprecented system connectivity and data transparency across systems,
- Enhanced monitoring of network adequacy and errors,
- Centralized communicaton platform and data repository, along with powerful research tools,
- Enhanced ability to identify and detect fraud.

In addition, the full implementation of the PNV system will provide MCOs with:

- Timely tracking and resolution of issues,
- Enhanced ability to preemptively identify and correct issues, and
- Enhanced ability to meet and improve provider network standards.

The aforementioned benefits for AHCA and the MCOs will be achieved throughseveral tools that include but are not limited to:

- **Provider Flagging and Review**: This tool allows AHCA to flag a provider for a stated reason requiring additional research or review (e.g., incorrect Provider Medicaid Number). The file process will automatically flag providers based on certain conditions. AHCA can use this tool to review the flagged providers and approve, deny, or cancel each record. AHCA users can also submit a request for more information to the MCO that submitted the record.
- **Practitioner Tracking Number Research**: This tool allows the user to enter a unique provider or site tracking number and retrieve all the system history of that record, including all the provider file submissions that contained that record, as well as any events in the past related to the record. This tool answers one of the most common questions related to managing a provider network – why is my provider not showing up or showing up incorrectly.
- **Practitioner Report Research Tool**: This tool allows the MCO to find out whether a certain provider counted on a required State Practitioner report (specialty-based), and if not, why. This tool allows the MCOs' analysts to quickly determine why they may have failed to meet particular reporting requirements.
- **File History**: Each MCO can log-in and download their data file submissions and response files from the Vendor. This provides the MCOs with an additional method of retrieving files for the MCOs' convenience.

The vendor will collaborate with AHCA on additional tools as needed.

The following items are in scope:

1. External User Management
   A. The vendor will provide use of a single portal (Single Sign-On) for signing into Provider Network Verification sytem.
   B. AHCA will provide external administration of approved users and assignment of rights to their approved users.
2. External Vendor User
   A. Support will be provided to the external customers. Support will include:
      1) raining and User Documentation
      2) Training
      3) Threaded Discussions
      4) Issue List
      5) Help
      6) Contact Us

7) Frequently Asked Questions

3. AHCA User
   A. Support will be provided to the internal customers. Support will include:
      1) Training and User Documentation
      2) Training
      3) Threaded Discussions
      4) Issue List
      5) Help
      6) Contact Us
      7) Frequently Asked Questions
   B. The provider network monitoring systems will provide administrative functionality.
      1) Roles and permissions based on user roles
      2) AHCA-approved announcements and alerts
      3) Practitioner Report Research Tool
      4) MCO-specific reports
      5) AHCA reports detailing provider network activity on a statewide or regional basis as well as delineated according to specific MCOs
      6) Ad hoc reporting
   C. Changes to existing processes
      1) Several relational files and record types to ensure consistency of data
      2) Unique tracking numbers to allow update capability to specific records instead of requiring full refresh each time
      3) Multiple restrictions per record
      4) Business rules can be encorced more strictly, with granular error codes per record type
      5) Monthly (or weekly) provider reconciliation file process
      6) Enhanced reporting
      7) Centralized communications with MCOs with automatic logging of all communications
      8) Electronic discussion boards to allow MCO analysts to submit requests and issues
      9) MCO can research provider network status in real-time
4. Internal, Inside AHCA, Systems Integration/Interfaces
   A. The provider network verification system will integrate several types of data.
      1) FMMIS Data (claims processing, provider enrollment)
      2) BGS (background screening)
      3) State/federal data (exclusion database)
      4) COMPAS Data (DOH Provider licensure & Reporting)
      5) VERSA Regulation
      6) Health Plan Data
      7) Recipient Data
   B. The provider network verification system will allow for several types of communication.
      1) Issue Tracking
      2) Secure email to the Vendor or AHCA

3) Contact the Vendor via Secure Email
4) Request Assistance from the Vendor (automatically time stamped and searchable)
5) Logging and search history capabilities for all AHCA and vendor announcements.

2.2 Out of Scope

The following items are out of scope:

1. The operations and processes that are not specifically mentioned in 2.1.
2. The use of the Single Sign-on system for the purposes of this project is limited to the provider network verification system customers.

3. Project Assumptions, Constraints and Risks

This section documents the Project Assumptions and Constraints set by AHCA Project Governance or the Project Steering Committee. Assumptions are those conditions that are considered true, certain, or real for planning purposes. Constraints are items that limit a project team's options. Constraints typically relate to schedule, resources, budget, technology, or contractual provisions.

3.1 Assumptions

1. All external web interfaces will be available to users 24 hours a day, 7 days a week.
2. Versa Regulation will remain the primary source of data storage for licensing data. Data not currently collected or stored in Versa Regulation but will not be be collected in the Provider Network Verification System will and require Versa Regulation to be modified/updated for it to reflect in the Provider Network Verification System.
3. FMMIS will remain the primary source of data storage for Provider MCO data. Data not currently collected or stored in FMMIS but will be requested by the plans to update and add to the FMMIS system.
4. The project will receive continued support from AHCA management.
5. There are sufficient resources (staff, software, hardware) to complete the project and the resources will be available when needed.
6. There will be sufficient budget to fund the project.
7. The business units' System Matter Experts (SME) will be knowledgeable and experienced in their current business process and available to meet with the Business Analyst to convey their process.
8. Business units' staff will be available and involved in executing test scenarios.
9. The individual functional teams will have the expertise to determine an all inclusive set of requirements, which can be prioritized into three categories of need (high, medium and low).
10. The project organization structure as defined in section 3.8 of this document will be followed.
11. IT staff and augmented IT staff have the skills necessary to develop the application.
12. IT staff and augmented IT staff will receive project specific training if needed.
13. Technical standards will be uniform.
14. AHCA IT will have oversight over the project developers.
15. Deliverables will be subject to no more than two review cycles.

3.2 Constraints

1. Success of the project will depend on the ability to provide an online service to the AHCA and MCO by the enrollment vendor.
2. Deliverables submitted for approval will require the AHCA stakeholders' approval.

3.3 Risks

Risk	Mitigation
1. Part of the project depends on other entities' cooperation in transfer of data. Other Entities may not cooperate because of technical restrictions, resource restrictions, or reluctance to share data.	a. To mitigate this risk the current manual process will continue or an alternative automated process will be explored.
2. Strategic Assessment	a. This project is strong strategically and focuses on enhancing our process for evaluating provider networks and given feedback and resources to managed care organizations to help them ensure adequate quality and available coverage of health care resources. The project is will be actively managed by the project manager and sponsor and will be enhancements to a platform currently being completed. Risk related to external use are low given the data required to be submitted by the plans will not materially change from the preceding phase of this project.
3. Organizational Change Management Assessment - We do not believe there will be an organizational change with this project; however, business processes will change.	a. Business processes are constantly evaluated as a matter of course in the Agency and staffing and roles are adjusted accordingly on a regular basis. Benchmarks are in place and being developed to evaluate the business process and plan for any changes if necessary.
4. Fiscal Assessment	a The complexity of the project is primarily in the area of data connection and coordination. Agency plans to use an experienced project manager with knowledge of the PNV system and existing data elements. The experience in

	leveraging phase one of this project will also help mitigate risk related to the complexity of the project.
5. Project Complexity Assessment	a. The complexity of the project is primarily in the area of data connecti on and coordination. Agency plans to use an experienced project manager with knowledge of the PNV system and existing data elements. The experience in leveraging phase one of this project will also help mitigate risk related to the complexity of the project.

3.4 Project Priority as of August 29, 2011

Priority # Given Steering Committee	Priority # By Division	Project Name	Status	ProjectScale	Division or Office	Description	IT & Vendor Resources Actively Working
1	1	Provider Network Verification	In Progress	XL	HQA / Medicaid	To create a centralized provider verification tool for use by multiple AHCA divisions and DOEA that will accomplish the below: • Centralized PNV data provides efficiencies for end users through PNV systematic review and reporting. • Improved data mining opportunitites for end users. • Improved communication with plans regarding their Provider Network Files (PNF). • Improvided control over plans displayed PNF for recipient use.	Y

3.5 Project Schedule

Project Milestone	Date Estimate
Project Start Date	April 2012
Determine Path for Completion	April 2012
Identify Project Initial Needs	May 2012
Determine Connectivity Requirements	May 2012

DDI	September 2012
Connectivity and Interface Testing	November 2012
Functionality Testing	December 2012
Training Project Staff	December 2012
Training End Users	January 2012

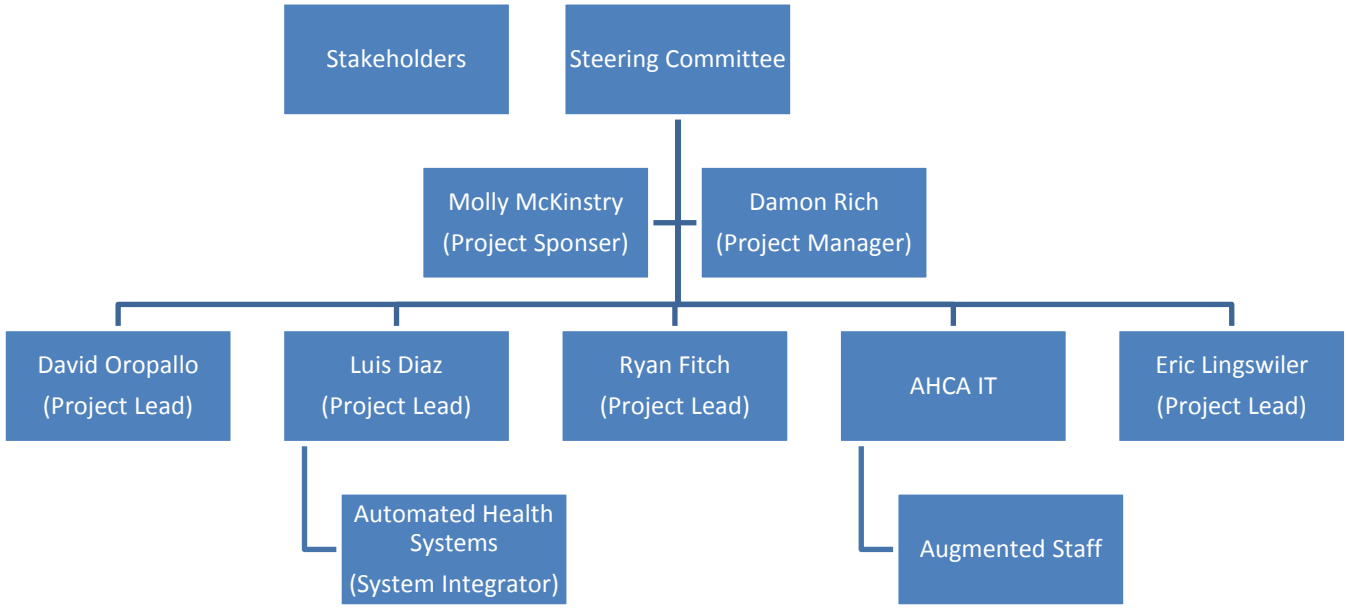
3.6 Project Resource Allocation

Staff	Organization	Role	Type	Start Date	End Date	Utilization	Total Hours	Supervisor
Molly McKinstry	AHCA - HQA	Project Sponsor	FTE	04/01/2012		As Needed	N/A	Liz Dudek
Damon Rich	AHCA – CCU	Project Lead	FTE	04/01/2012		As Needed	N/A	David Rogers
Eric Lingswiler	AHCA – HQA	Project Lead	FTE	04/01/2012		As Needed	N/A	Molly McKinstry
David Oropallo	AHCA – HQA	Project Lead	FTE	04/01/2012		As Needed	N/A	Molly McKinstry
Ryan Fitch	AHCA – HQA	Project Lead	FTE	04/01/2012		As Needed	N/A	Molly McKinstry
Luis Diaz	AHCA – CCU	PNV TEAM (SME)	FTE	04/01/2012		As Needed	N/A	Damon Rich
Melissa Vergeson	AHCA – HSD	PNV TEAM (SME)	FTE	04/01/2012		As Needed	N/A	Melanie Brown-Woofter
Lisa Gill	AHCA – HSD	PNV TEAM (SME)	FTE	04/01/2012		As Needed	N/A	Melanie Brown-Woofter
Suzanne Stacknik	AHCA – HSD	PNV TEAM (SME)	FTE	04/01/2012		As Needed	N/A	Melissa Vergeson
Beratriz Hernandez	AHCA – HQA	PNV TEAM (SME)	FTE	04/01/2012		As Needed	N/A	Eric Lingswiler
Nicole Trainor	DOEA	PNV TEAM (SME)	FTE	04/01/2012		As Needed	N/A	Cheryl Young

3.7 Project Governance

Voting Steering Member	Role	Position
Secretary Dudek	Agency for Health Care Administration	Secretary
Karen Zeiler	Agency for Health Care Administration	Chief of Staff
Molly McKinstry	Division of Health Quality Assurance	Deputy Secretary
Tonya Kidd	Division of Operations	Deputy Secretary
Scott Ward	Division of Information Technology	Chief Information Officer
Justin Senior	Division of Medicaid	Medicaid Director
Eric Miller	Inspector General's Office	Inspector General
David Roger	Agency for Health Care Administration	Deputy Secretary

3.8 Project Organizational Chart



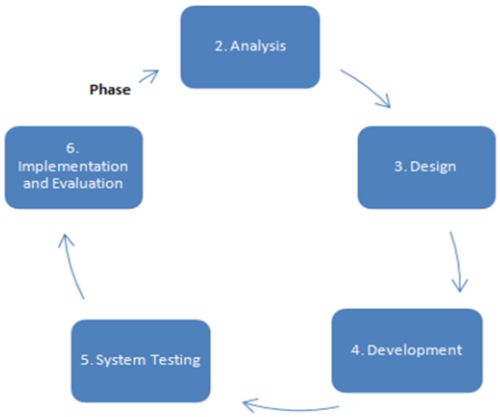
4. Project Milestones

This section documents the Project Milestones. These milestones will become core tasks that generate a more complete set of tasks or Work Breakdown Structure for the project schedule.

Project Milestones

1. Initiation Phases
    a. Charter
    b. Project Plan
    c. Schedule
2. System Analysis
    a. Requirements gathering
    b. Requirements documentation
    c. Processes documentation
3. Design Specifications
    a. Program Specifications
    b. logical screen design
    c. Process documentation
4. System Development
    a. Program coding
    b. Technical documentation
5. System Testing
    a. Unit testing
    b. System testing
    c. UAT Testing
    d. Make necessary system modifications discovered in testing
    e. Training Materials
    f. Train internal users
    g. User documentation
6. Implementation and Evaluation
    a. Install the program into Production
    b. Train external users
    c. Evaluate system's functionality
    d. Make necessary system modifications discovered by users
7. Project Closure
    a. AHCA acceptance testing
    b. Organizational Impact to AHCA
    c. User and manager attitude assessment
8. Follow-up
    a. Review the functionality of the implemented system
    b. Assess the project's development strategy

Provider Network Verification Milestones



5. Communications Plan

This section documents the Communications Plan for the Project, describing how to assure visibility and co-operation by communicating status and news about the project to all appropriate stakeholders. The communications plan encompasses meetings as well as documents. A separate matrix is provided for meetings and for documentation.

MEETINGS			
Description	**Target Audience**	**Frequency**	**Owner(s)**
PNV Team Meeting	PNV team (including, business users, and business analysts)	Weekly	Business Analysts, Project Leads and Manager.
Project Steering Committee Meeting	Project Team, Project Sponsor, IT Bureau Chiefs	Monthly (scheduled as schedules permit)	Project Sponsor, Project Leads, Project Director
Vendor Meetings	AHCA and Vendor staff (including IT staff, business analysts, Vendor enrollment broker project staff, vendor corporate staff)	Monthly	
External Stakeholder Meetings	AHCA, Vendor staff and other parties as needed (e.g., MCOs)	As needed	

DOCUMENTATION

Description	Target Audience	Delivery Format	Frequency	Owner
Project SharePoint Site	Project Team Members / Sponsor(s)	Internal SharePoint page at http://ahcaportal/IT/OLR/SitePages/Home.aspx	Update as needed	Project Managers
Team Meeting Agenda	Team Members	Available on SharePoint, emailed link	1 Day Before Team Meeting	Team Business Analyst Project Managers (for Technical team)
Team Meeting Summary	Team Members	Available on SharePoint, emailed link	Within 3 Days Following Team Meeting	Team Business Analyst Project Managers (for Technical team)
Steering Meeting Agenda	Steering Committee and Stakeholders	Available on SharePoint, emailed link, printed for meeting	No later than 5 business days prior to meeting, drafted with sponsor, deliver via email to participants with materials within 3 days of meeting	Project Managers/ Project Director
Action Items (AI)	Project Team	Internal SharePoint page at http://ahcaportal/IT/OLR/SitePages/Home.aspx	As AIs are identified. The AIs will be monitored through completion/resolution.	Project Team Project Managers Project Director

DOCUMENTATION

Description	Target Audience	Delivery Format	Frequency	Owner
Risk Tracker	Project Team	Internal SharePoint page at http://ahcaportal/IT/OLR/SitePages/Home.aspx	As risks are identified and each will be monitored throughout the project or risk resolution.	Project Team Project Managers Project Director
Decision Log (As decision points are identified, they will be entered on Internal SharePoint page at http://ahcaportal/IT/OLR/SitePages/Home.aspxand will be presented to the Steering Committee for decision. There will also be a standing item on the Steering Committee meeting agenda to review decisions made outside the Steering Committee meeting. Decisions will be communicated back to the with a description of the decision made.)	Project Team	Internal SharePoint page at http://ahcaportal/IT/OLR/SitePages/Home.aspx	Due in the Decision Point Template format by the day before the Team Lead meeting or three days before the Steering meeting	Project Team Steering Committee

DOCUMENTATION

Description	Target Audience	Delivery Format	Frequency	Owner
Idea Brief	Governance	Available on SharePoint	Idea Phase (completed prior to project charter)	Business Lead
Conceptual Analysis	Governance	Available on SharePoint	Conceptual Analysis Phase (completed prior to project charter)	Business owner IT ISDM Compliance Unit
Project Plan (using Microsoft Project)	Project Team / ISDM Compliance Unit and Stakeholders	Available on SharePoint	Updated weekly	Project Managers/ Project Director
Requirements / Design Documents	Project Team/Stakeholders	Available on SharePoint	Active Phase	Team Leads/ Business Analysts
Project Budget	Project Team/Stakeholders	Available on SharePoint and provided in Steering Agenda	Project Initiation / Update for Steering Meetings	Project Managers/ Project Director
Testing Plan	Project Team/Sponsor	Available on SharePoint	Active Phase	Project Manager / Business Lead
Training Plan	Project Team/Sponsor	Available on SharePoint	Active Phase	Project Managers / Business Lead
Deployment Plan	Project Team/IT Component Areas	Available on SharePoint	Active Phase	Project Managers / Technical Lead
Troubleshooting Guide	Project Team/IT Component Areas	Available on SharePoint	Active	Project Managers / Technical Lead
Project Closeout Report	Project Team/Sponsor/ Stakeholders	Available on SharePoint	Conclusion of the Project	Project Managers
Project Calendar – Recurring Project Meetings	Project Team	SharePoint	On-going	All Team members

DOCUMENTATION

Description	Target Audience	Delivery Format	Frequency	Owner
Project Calendar – All Project Meetings	Project Team	Outlook	On-going	All Team members
Weekly Project Status Report	All project members and stakeholders	SharePoint link in email and email attachment upon request	Weekly	Project Managers/ Project Director
Ad Hoc Comunication to External Users	Project Team	Outlook	As needed	Project Manager

6. Project Responsibilities/Decision Management

This section documents Agency best practices for managing changes to project scope and other decisions. For each item, verify the roles and responsibilities; and document the change request.

6.1 Slipping tasks

- Team Leads and Project Managers shall identify, document and discuss in each of the weekly team meetings all slipping tasks.
- Project Managers should analyze, document and communicate to the Team the impact of the Slipping task(s).
- Team Leads and Project Managers shall identify and document possible options to get the slipping tasks back on schedule.
- Slipping tasks shall be reported by the Team Lead, co-lead and/or Project Managers in the weekly Team Lead Meeting.
- Project Director shall communicate the slipping task(s) and the impact of the slipping task(s) to the Sponsor.

6.2 Contract Administration (If Applicable)

- The Contract Manager will conduct procurement(s) in order to select the most suitable staff augmentation vendor(s) to complete the project activities.
- The Contract Manager will administer the Vendor Contract(s) for the approved terms and conditions as established in the Vendor Contract(s).

6.3 Resource Management

- The Team Lead is responsible for making work assignments to team members and working with project management staff to track completion of those assignments.
- Project Managers are responsible for managing the project schedule to show the completion of work assignments by the team members and/or resources assigned to the tasks.
- Project Director is responsible for managing the Project Managers and the project coordination.
- Project Director is responsible for communicating the status of the project to the Sponsor and Steering Committee.

6.4 Project Documentation

- Project Managers are responsible for documenting the work breakdown structure in the project schedule, working with team leads to define detailed tasks for the Project Milestones and estimating task duration.
- Project Managers are responsible for documenting and escalating project issues, risks and mitigation options. Project management documentation shall be maintained in the SharePoint project site under the designated ISDM folder.
- The Project Managers are responsible for maintaining all project documents related to the team in the designated folders in the project SharePoint site.
- Action items will be tracked by the Project Managers and documented on the Meeting Summary and placed on the next meeting Agenda with a date assigned and responsible

person. Any items remaining open after two consecutive weeks will be transferred to the project schedule as a task.

- All final project deliverables and acceptance documents shall be maintained in the assigned project folder.
- Decision Points are drafted and saved in the assigned project folder. Each time a document is presented, it is updated in this folder. Once approved, the decision document is updated. The title of the file should be brief and concise.

6.5 Change Management

- All requests for changes in scope shall be communicated to the project sponsor and project leads.
- Changes in Scope or Issues requiring Project Governance Committee resolution will be brought before the Team Leads during the weekly Team Lead meetings prior to the Project Governance Committee meetings.
- Project Schedule updates resulting in project delay will be brought to the attention of the Team Lead and project sponsor.

6.6 Risk and Issue Management

- Risks are defined on the project as uncertain future events having an impact on the project, while issues are known events. Risks and Issues will be identified by the team and addressed regularly through team meetings.
- A Project Risk Matrix will be updated weekly by the Project Managers. Risks will be addressed during the weekly Team meeting and if needed escalated to the Team Lead meeting and Project Steering Committee.
- Project issues will be tracked in the Action Item Tracker; entered by all team members and updated weekly by the Project Managers. Issues will be addressed during the weekly Team meeting and if needed escalated to the Team Lead meeting and Project Steering Committee.
- Risks and Issues will escalate through the three-tiered resolution process when necessary.

6.7 Decision Making Process

- Tier One - Project Teams attempt to resolve problem at the team level. Decisions affecting only the team and the teams/ objectives not influencing other areas of the project and not requiring Senior Management approval should be resolved at the team level and documented using the appropriate project management documents. At times two or more teams will need to work together before escalating an item to the next level.
- Tier Two - Team Leads – Items crossing over to more than two teams requiring input or resolution by the Project Steering Committee will be brought in the form of a Decision Point to the weekly Team Lead meeting.
- Tier Three - Project Steering Committee – Once a set of recommended options has been determined through the Team Leads, the initiating team will present the Decision Document for final resolution to the Steering Committee, if a resolution has not yet been found or the Team Leads lack the authority to make such a decision. All decisions

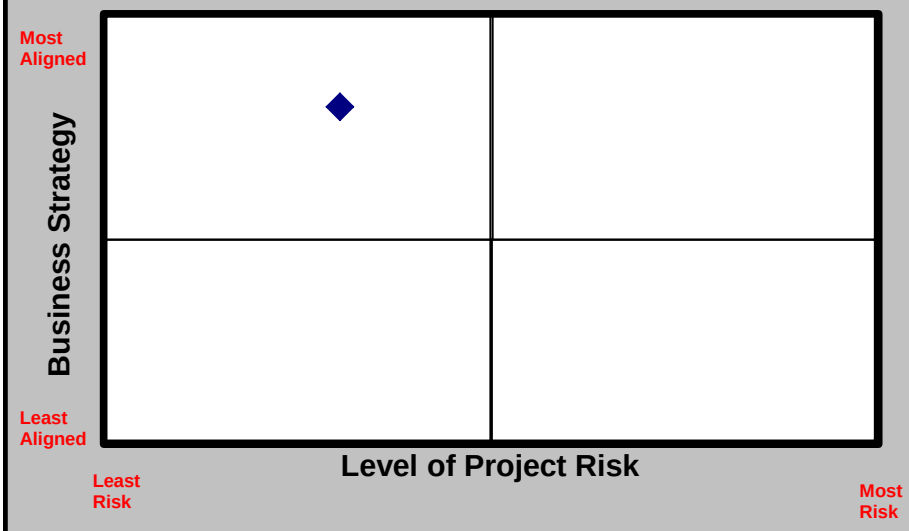
and resolutions will be updated on the appropriate document and communicated back to the team level.

7. Project Charter

Project Member	Signature	Date
Molly McKinstry, Project Sponsor		10/12/12
Scott Ward, AHCA CIO		10/12/12

Project	*Provider Network Verification and Data Integration*	
Agency	*Agency for Health Care Administration*	
FY 2013-14 LBR Issue Code:	**FY 2013-14 LBR Issue Title:**	
Issue Code	*Issue Title*	
Risk Assessment Contact Info (Name, Phone #, and E-mail Address):		
Damon T. Rich, (850) 412-3448, Damon.Rich@ahca.myflorida.com		
Executive Sponsor	*Molly McKinstry*	
Project Manager	*Damon T. Rich*	
Prepared By	*David Oropollo*	*10/11/2012*

Risk Assessment Summary



Project Risk Area Breakdown

Risk Assessment Areas	*Risk Exposure*
Strategic Assessment	MEDIUM
Technology Exposure Assessment	LOW
Organizational Change Management Assessment	MEDIUM
Communication Assessment	LOW
Fiscal Assessment	MEDIUM
Project Organization Assessment	LOW
Project Management Assessment	LOW
Project Complexity Assessment	MEDIUM
Overall Project Risk	MEDIUM

Agency: Agency for Health Care Administration Project: Provider Network Verification and Data Integration

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	Extensive 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	Between 1 and 3 years
		Between 3 and 5 years	
		Between 1 and 3 years	
		1 year or less	

Agency: Agency for Health Care Administration Project: Provider Network Verification and Data Integration

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	Internal resources have sufficient knowledge for implementation and operations
		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	All or nearly all 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 based on historical data and new system design specifications and performance requirements
		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: Provider Network Verification and Data Integration

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	Moderate changes to organization structure, staff or business processes
		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	Yes
		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	41% to 80% -- Some process changes defined 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	No
		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)	Moderate 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	Proactive use of 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	Success measures have been developed for some messages
		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: Provider Network Verification and Data Integration

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)	Combination FFP and T&E
		Firm Fixed Price (FFP)	
		Combination FFP and T&E	
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	Just-in-time purchasing of hardware and software is documented in the project schedule
		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	Contract manager is the project manager
		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	All or nearly all selection criteria and expected outcomes have been defined and documented
		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	

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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	System Integrator (contractor)
		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	Some or most staff roles and responsibilities and needed skills have been identified
		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	Yes, experienced project manager dedicated full-time, 100% to project
		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	Yes, business, functional or technical experts dedicated full-time, 100% to project
		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	Mostly staffed 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	Yes, all stakeholders are represented by functional manager
		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: Provider Network Verification and Data Integration

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	Yes
		Project Management team will use the methodology selected by the systems integrator	
		Yes	
7.02	For how many projects has the agency successfully used the selected project management methodology?	None	More than 3
		1-3	
		More than 3	
7.03	How many members of the project team are proficient in the use of the selected project management methodology?	None	All or nearly all
		Some	
		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	81% to 100% -- All or nearly all 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	
7.05	Have all design specifications been unambiguously defined and documented?	0% to 40% -- None or few 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	
		81% to 100% -- All or nearly all 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	81% to 100% -- All or nearly all requirements and specifications are traceable
		41 to 80% -- Some 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	All or nearly all deliverables and acceptance criteria 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	
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	Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables
		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	
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
		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	
7.10	Has a documented project schedule been approved for the entire project lifecycle?	Yes	Yes
		No	
7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints), critical milestones, and resources?	Yes	Yes
		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 uses formal processes	
		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?	No templates are available	All planning and reporting templates are available
		Some templates are available	
		All planning and reporting templates are available	
7.14	Has a documented Risk Management Plan been approved for this project?	Yes	Yes
		No	
7.15	Have all known project risks and corresponding mitigation strategies been identified?	None or few have been defined and documented	All known risks and mitigation strategies have been defined
		Some have been defined and documented	
		All known risks and mitigation strategies have been defined	
7.16	Are standard change request, review and approval processes documented and in place for this project?	Yes	Yes
		No	
7.17	Are issue reporting and management processes documented and in place for this project?	Yes	Yes
		No	

Agency: Agency for Health Care Administration Project: Provider Network Verification and Data Integration

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	3 sites or fewer
		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	Agency-wide 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	Greater size and complexity
		Lesser size and complexity	
		Similar size and complexity	
		Greater size and complexity	

Project Costs for Provider Network Verification System Enhancements

Produced R 41,194.00 For **Agency for Health Care Admi** By **Damon Rich** **FY 2013-14**

PROJECT BUDGET WORKSHEET 1 (Captures All Major Direct & Indirect Costs associated with Development, Implementation, and Transition)

Quarter / Project Cost	Jul-Sep Planned	Jul-Sep Actual	Oct-Dec Planned	Oct-Dec Actual	Jan-March Planned	Jan-March Actual	April-June Planned	April-June Actual	Budget to Date	Actual to Date	Variance to Date
State Staff											
# FTEs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Subcontractors											
# FTEs	$122,200.00	$0.00	$122,200.00	$0.00	$122,200.00	$0.00	$122,200.00	$0.00	$488,800	$0	$488,800
Hardware											
Item 1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Item 2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Software											
Item 1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Item 2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Misc Equipment											
Item 1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Item 2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Other Costs											
Item 1	$250,000.00	$0.00	$250,000.00	$0.00	$250,000.00	$0.00	$250,000.00	$0.00	$1,000,000	$0	$1,000,000
Item 2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0	$0	$0
Total Costs	$372,200	$0	$372,200	$0	$372,200	$0	$372,200	$0	$1,488,800	$0	$1,488,800
Progress Payments									$0	$0	$0

Project Costs for **Provider Network Verification System Enhancements**

Produced **R 41,194.00** For **Agency for Health Care Admi** By **Damon Rich** **FY 2013-14**

PROJECT BUDGET WORKSHEET 2 - OPERATIONAL COST IMPACT *(INCURRED AFTER PROJECT IMPLEMENTATION and / or PRO-RATED IF PHASED ROLLOUT)*

	FY 2013-14			FY 2014-15			FY 2015-16			FY 2016-17		
OPERATIONAL COSTS	(a) Current	(b) Project	(c) = (b)-(a) Incremental Effect of Project	(a) Current	(b) Project	(c) = (b)-(a) Incremental Effect of Project	(a) Current	(b) Project	(c) = (b)-(a) Incremental Effect of Project	(a) Current	(b) Project	(c) = (b)-(a) Incremental Effect of Project
Salaries and Wages	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Pensions and Benefits	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Personal Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Consulting	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hardware	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Software	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Data Processing	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Data Processing Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Data Processing Comunications	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Training	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Travel	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL OPERATIONAL COSTS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTE	0	0	0	0	0	0	0	0	0	0	0	0

Medicaid Services to Individuals

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**3,740,789.22**	(A)		**3,740,789.22**	
ADD: Other Cash (See Instructions)		(B)		**0.00**	
ADD: Investments		(C)		**0.00**	
ADD: Outstanding Accounts Receivable		(D)	**56,850,129.70**	**56,850,129.70**	
ADD: Outstanding Accounts Receivable		(E)		**0.00**	
Total Cash plus Accounts Receivable	**3,740,789.22**	(F)	**56,850,129.70**	**60,590,918.92**	
LESS: Allowances for Uncollectibles		(G)		**0.00**	
LESS: Approved "A" Certified Forwards	**51,265,293.78**	(H)	**(51,265,293.78)**	**0.00**	
Approved "B" Certified Forwards		(H)		**0.00**	
Approved "FCO" Certified Forwards		(H)		**0.00**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0.00**	
LESS: Payables not Certified Forwards				**0.00**	
LESS: Deferred Revenue		(J)		**0.00**	
Unreserved Fund Balance, 07/01/12	**(47,524,504.56)**	(K)	**108,115,423.48**	**60,590,918.92**	**

Notes:

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Office of Policy and Budget - July, 2011

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		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)	**267,415**	**267,415**	
ADD: _____		(E)		**0**	
Total Cash plus Accounts Receivable	**0**	(F)	**267,415**	**267,415**	
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)	**311,657**	(I)	**-44,242**	**267,415**	
LESS: Payables not Certified Forwards				**0**	
LESS: Current Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**-311,657**	(K)	**311,656**	**0**	**

Notes:

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Office of Policy and Budget - July, 2011

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**227,676,322.06**	(A)		**227,676,322.06**	
ADD: Other Cash (See Instructions)	**20,154,175.27**	(B)		**20,154,175.27**	
ADD: Investments		(C)		**0.00**	
ADD: Outstanding Accounts Receivable	**204,163,747.88**	(D)		**204,163,747.88**	
ADD: Outstanding Accounts Receivable	**45,764.20**	(D)		**45,764.20**	
ADD: Outstanding Accounts Receivable	**852.06**	(D)		**852.06**	
ADD: Other Loans and Notes Receivable		(E)		**0.00**	
Total Cash plus Accounts Receivable	**452,040,861.47**	(F)	**0.00**	**452,040,861.47**	
LESS: Allowances for Uncollectibles	**1,270,479.11**	(G)		**1,270,479.11**	
LESS: Approved "A" Certified Forwards	**679,719,683.71**	(H)	**(477,513,277.09)**	**202,206,406.62**	
Approved "B" Certified Forwards		(H)		**0.00**	
Approved "FCO" Certified Forwards		(H)		**0.00**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0.00**	
LESS: Payables not Certified Forwards				**0.00**	
LESS: Deferred Revenues	**72,385,809.26**	(J)		**72,385,809.26**	
Unreserved Fund Balance, 07/01/12	**(301,335,110.61)**	(K)	**477,513,277.09**	**176,178,166.48**	**

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Office of Policy and Budget - July, 2012

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**923,571,657**	(A)		**923,571,657**	
ADD: Other Cash (See Instructions)	**1,420,722**	(B)		**1,420,722**	
ADD: Investments	**10,541,552**	(C)		**10,541,552**	
ADD: Outstanding Accounts Receivable	**1,668,106,341**	(D)	**-25,983,894**	**1,642,122,448**	
ADD: Other Loans and Notes Receivable				**0**	
Total Cash plus Accounts Receivable	**2,603,640,272**	(F)	**-25,983,894**	**2,577,656,379**	
LESS: Allowances for Uncollectibles	**10,927,968**	(G)		**10,927,968**	
LESS: Approved "A" Certified Forwards	**1,564,710,547**	(H)		**1,564,710,547**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)	**27,174,364**	(I)	**384,858**	**27,559,222**	
LESS: Payables not Certified Forwards			**(926,409,471)**	**(926,409,471)**	
LESS: Deferred Revenue		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**1,000,827,393**	(K)	**900,040,719**	**1,900,868,113**	**

Notes:

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Office of Policy and Budget - July, 2012

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**32,981,375**	(A)		**32,981,375**	
ADD: Other Cash (See Instructions)		(B)		**0**	
ADD: Investments		(C)		**0**	
ADD: Outstanding Accounts Receivable	**43,949,294**	(D)	**5,609,451**	**49,558,745**	
ADD: Advance		(E)		**0**	
Total Cash plus Accounts Receivable	**76,930,669**	(F)	**5,609,451**	**82,540,120**	
LESS: Allowances for Uncollectibles	**525**	(G)		**525**	
LESS: Approved "A" Certified Forwards	**17,181,060**	(H)		**17,181,060**	
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	**17,273,637**	(J)		**17,273,637**	
Unreserved Fund Balance, 07/01/12	**42,475,446**	(K)	**5,609,451**	**48,084,898**	**

Notes:

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Office of Policy and Budget - July, 2011

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**286,607.72**	(A)		**286,607.72**	
ADD: Other Cash (See Instructions)		(B)		**0.00**	
ADD: Investments		(C)		**0.00**	
ADD: Outstanding Accounts Receivable	**4,700,428.57**	(D)		**4,700,428.57**	
ADD: Advance		(E)		**0.00**	
Total Cash plus Accounts Receivable	**4,987,036.29**	(F)	**0.00**	**4,987,036.29**	
LESS: Allowances for Uncollectibles		(G)		**0.00**	
LESS: Approved "A" Certified Forwards	**12,290,489.93**	(H)	**-9,203,225.23**	**3,087,264.70**	
Approved "B" Certified Forwards		(H)		**0.00**	
Approved "FCO" Certified Forwards		(H)		**0.00**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0.00**	
LESS: Payables not Certified Forwards				**0.00**	
LESS: Deferred Revenue		(J)		**0.00**	
Unreserved Fund Balance, 07/01/12	**-7,303,453.64**	(K)	**9,203,225.23**	**1,899,771.59**	**

Notes:

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Office of Policy and Budget - July, 2011

Medicaid Long Term Care

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**0.00**	(A)		**0.00**	
ADD: Other Cash (See Instructions)		(B)		**0.00**	
ADD: Investments		(C)		**0.00**	
ADD: Outstanding Accounts Receivable		(D)		**0.00**	
ADD: Advance		(E)		**0.00**	
Total Cash plus Accounts Receivable	**0.00**	(F)	**0.00**	**0.00**	
LESS: Allowances for Uncollectibles		(G)		**0.00**	
LESS: Approved "A" Certified Forwards	**25,648,790.72**	(H)	**(25,648,790.72)**	**0.00**	
Approved "B" Certified Forwards		(H)		**0.00**	
Approved "FCO" Certified Forwards		(H)		**0.00**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0.00**	
LESS: Payables not Certified Forwards				**0.00**	
LESS: Deferred Revenue		(J)		**0.00**	
Unreserved Fund Balance, 07/01/12	**(25,648,790.72)**	(K)	**25,648,790.72**	**0.00**	**

Notes:

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Office of Policy and Budget - July, 2011

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**50,182,034.07**	(A)		**50,182,034.07**	
ADD: Other Cash (See Instructions)	**27,281.60**	(B)		**27,281.60**	
ADD: Investments		(C)		**0.00**	
ADD: Outstanding Accounts Receivable	**2,480,910.43**	(D)		**2,480,910.43**	
ADD: Other Loans and Notes Receivable		(E)		**0.00**	
Total Cash plus Accounts Receivable	**52,690,226.10**	(F)	**0.00**	**52,690,226.10**	
LESS: Allowances for Uncollectibles	**542,371.82**	(G)		**542,371.82**	
LESS: Approved "A" Certified Forwards	**53,484,954.76**	(H)	**(49,258,321.67)**	**4,226,633.09**	
Approved "B" Certified Forwards		(H)		**0.00**	
Approved "FCO" Certified Forwards		(H)		**0.00**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0.00**	
LESS: Payables not Certified Forwards				**0.00**	
LESS: Deferred Revenues	**230,767.66**	(J)		**230,767.66**	
Unreserved Fund Balance, 07/01/12	**(1,567,868.14)**	(K)	**49,258,321.67**	**47,690,453.53**	**

Notes:

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Office of Policy and Budget - July, 2012

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		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	**931,588,782**	(D)	**(725,241,610)**	**206,347,172**	
ADD: Advance		(E)		**0**	
Total Cash plus Accounts Receivable	**931,588,782**	(F)	**(725,241,610)**	**206,347,172**	
LESS: Allowances for Uncollectibles		(G)		**0**	
LESS: Approved "A" Certified Forwards	**324,877,210**	(H)		**324,877,210**	
Approved "B" Certified Forwards		(H)		**0**	
Approved "FCO" Certified Forwards		(H)		**0**	
LESS: Other Accounts Payable (Nonoperating)		(I)		**0**	
LESS: Payables not Certified Forwards			**(118,530,038)**	**-118,530,038**	
LESS: Deferred Revenue		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**606,711,572**	(K)	**(606,711,572)**	**(0)**	**

Notes:

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Office of Policy and Budget - July, 2012

Health Care Regulation Schedules

Health Care Regulation

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2013-2014

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 6/30/2012		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	**4,991,812**	(A)		**4,991,812**	
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	**4,991,812**	(F)	**0**	**4,991,812**	
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)	**13,337**	(I)		**13,337**	
LESS: Payables not Certified Forwards				**0**	
LESS: Current Compensated Absences Liability		(J)		**0**	
Unreserved Fund Balance, 07/01/12	**4,978,475**	(K)	**0**	**4,978,475**	**

Notes:

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Office of Policy and Budget - July, 2011

AGENCY FOR HEALTH CARE ADMINISTRATION
SCHEDULE IV-B
FOR
ONLINE LICENSING AND RECONCILIATION SYSTEM
FOR
FISCAL YEAR 2013-14

State of Florida

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

July 1, 2013

I. Schedule IV-B Cover Sheet

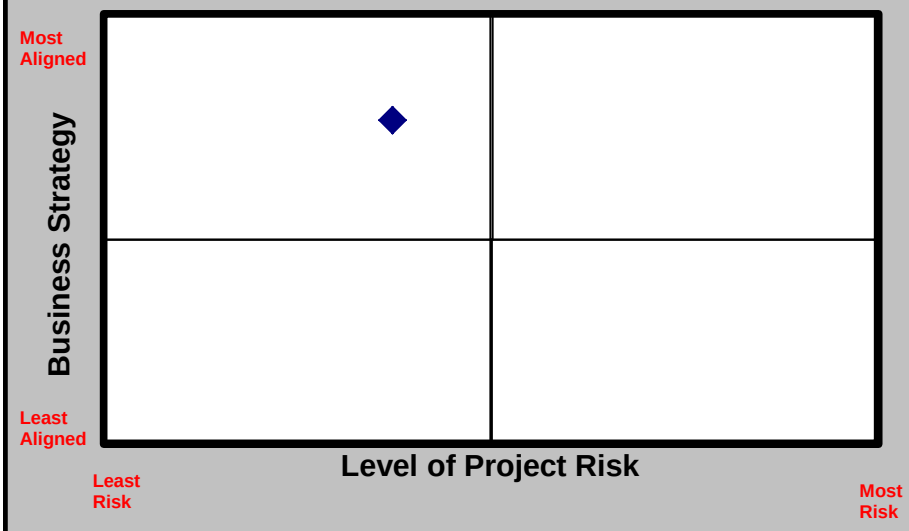
Schedule IV-B Cover Sheet and Agency Project Approval	
Agency: The Agency for Health Care Administration	Schedule IV-B Submission Date: October 15, 2012
Project Name: Provider Network Verification System Enhancement	Is this project included in the Agency's LRPP? _X_ Yes ____ No
FY 2013-14 LBR Issue Code:	FY 2012-13 LBR Issue Title: Provider Network Verification System Enhancement
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Molly Mckinstry, 850-412-4334	

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: Donya Kudd Printed Name: Elizabeth Dudek	Date: 10/12/12
Agency Chief Information Officer: Printed Name: Scott Ward	Date: 10/12/12
Budget Officer: Printed Name: Anita Hicks	Date:
Planning Officer: Printed Name:	Date:
Project Sponsor: Printed Name: Molly McKinstry	Date: 10/12/12

Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Damon T. Rich, (850) 412-3448, Damon.Rich@ahca.myflorida.com
Cost Benefit Analysis:	
Risk Analysis:	Damon T. Rich, (850) 412-3448, Damon.Rich@ahca.myflorida.com

Project	*Licensing System Upgrade*	
Agency	*Agency for Health Care Administration*	
FY 2013-14 LBR Issue Code:	**FY 2013-14 LBR Issue Title:**	
36375C0	*Online Licensing and Reconciliation*	
Risk Assessment Contact Info (Name, Phone #, and E-mail Address):		
Ryan Fitch, 850-412-3797, ryan.fitch@ahca.myflorida.com		
Executive Sponsor	*Molly Mckinstry*	
Project Manager	*Yvonne Gulley*	
Prepared By	*Ryan Fitch & Yvonne Gulley*	*10/10/2012*

Risk Assessment Summary



Project Risk Area Breakdown

Risk Assessment Areas	*Risk Exposure*
Strategic Assessment	MEDIUM
Technology Exposure Assessment	LOW
Organizational Change Management Assessment	MEDIUM
Communication Assessment	LOW
Fiscal Assessment	MEDIUM
Project Organization Assessment	MEDIUM
Project Management Assessment	LOW
Project Complexity Assessment	MEDIUM
Overall Project Risk	MEDIUM

Agency: Agency for Health Care Administration Project: Licensing System Upgrade

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	Project charter signed by executive sponsor and executive team actively engaged in 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	All or nearly all
		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	Extensive 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	Between 1 and 3 years
		Between 3 and 5 years	
		Between 1 and 3 years	
		1 year or less	

Agency: Agency for Health Care Administration Project: Licensing System Upgrade

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	Internal resources have sufficient knowledge for implementation and operations
		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	All or nearly all 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	Moderate 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 based on historical data and new system design specifications and performance requirements
		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: Licensing System Upgrade

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	Moderate changes to organization structure, staff or business processes
		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	Yes
		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	1% to 10% 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)	Extensive change or new way of providing/receiving services or information)
		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	Proactive use of 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	Success measures have been developed for some messages
		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: Licensing System Upgrade

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 $2 M and $10 M
		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	Neither requested nor 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 3 years
		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)	Combination FFP and T&E
		Firm Fixed Price (FFP)	
		Combination FFP and T&E	
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	Purchase all hardware and software at start of project to take advantage of one-time discounts
		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	Contract manager is the procurement manager
		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	Yes
		No	
5.16	Have all procurement selection criteria and outcomes been clearly identified?	No selection criteria or outcomes have been identified	All or nearly all selection criteria and expected outcomes have been defined and documented
		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 not planned/used for procurement
		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	

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	1
		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	Yes, experienced project manager dedicated full-time, 100% to project
		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	No, business, functional or technical experts dedicated more than half-time but less than full-time to project
		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	Mostly staffed 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	Moderate 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	Yes, all stakeholders are represented by functional manager
		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	

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	81% to 100% -- All or nearly all 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	81% to 100% -- All or nearly all 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	All or nearly all 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?	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	81% to 100% -- All or nearly all have been defined to the work package level
7.10	Has a documented project schedule been approved for the entire project lifecycle?	Yes No	Yes
7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints), critical milestones, and resources?	Yes No	Yes
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 processes
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	All planning and reporting templates are available
7.14	Has a documented Risk Management Plan been approved for this project?	Yes No	Yes
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	All known risks and mitigation strategies have been defined
7.16	Are standard change request, review and approval processes documented and in place for this project?	Yes No	Yes
7.17	Are issue reporting and management processes documented and in place for this project?	Yes No	Yes

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	More complex
		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	Single location
		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	Agency-wide 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	Implementation requiring software development or purchasing commercial off the shelf (COTS) software
		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	

Project Risk & Mitigation Table					
#	Risk Description/Impact	Probability of Occurrence (high, medium, low)	Tolerance Level (high, medium, low)	Mitigation Strategy	Assigned Owner
1	Strategic Assessment – We believe the strategic vision and plan for this project is strong and supported both by the Agency and	Low	High	This project is strong strategically and focuses on streamlining our application process for our licensees. The project is actively managed by the project manager and sponsor. Risk related to external use are low given we will still have a paper process available if this project is delayed for any reason. In addition, rollout is being conducted in phases to minimize any potential negative impacts that might arise. The rulemaking has been identified as minor changes primarily around form adoption.	Molly McKinstry, Yvonne Gulley
2	Organizational Change Management Assessment - We do not believe there will be an organizational change with this project; however, business processes will change and how we handle those changes going forward has been discussed with project sponsor and business units and a draft plan has been outlined. We do not view this as a project risk but rather an opportunity.	Low	High	Business processes are constantly evaluated as a matter of course in the Agency and staffing and roles are adjusted accordingly on a regular basis. Sufficient benchmarks are in place to evaluate the business process and plan for any changes if necessary. The existing draft plan directs steps to evaluate and implement change using these metrics.	Ryan Fitch, Molly McKinstry

3	Fiscal Assessment	Low	Medium	The project sponsor is updated on the budget weekly by the project manager. The project manager and AHCA IT budget staff actively monitor the budget. All changes to the budget are described in detail to the project sponsor.	Molly McKinstry, Yvonne Gulley
4	Project Origination Assessment - Developer Staffing turn-over	Medium	Medium	Project Manager actively evaluates this risk and reports weekly to project sponsor. Contingencies including relying on existing IT staff and shifting resources as needed have been utilized to minimize this risk. Despite key turn-over, the project plan and budget has not materially been impacted by this issue due to the active project management and mitigation strategies.	Yvonne Gulley

5	Project Complexity Assessment	Low	Low	Although this is a complex project, the underlying functions and rational is a mirror of existing agency processes. The project team has taken on similar enterprises. This project is being rolled out in phases and the first phase includes a team of AHCA staff that has a high level of experience in the process and with implementing new technology into their work. The entire process and business requirements have been exhaustively researched. The strategy of using highly experienced staff in phase one of this project mitigates the complexity risk of the project.	Molly McKinstry, Yvonne Gulley, Ryan Fitch
6					
7					
8					

Fiscal Year 2013-14 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Adminstration

Agency Budget Officer/OPB Analyst Name: Anita Hicks / 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.

	Action	Program or Service (Budget Entity Codes)					
		68200000	685001	685002	685014	685015	687007
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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
AUDITS:							
1.3	Has Column A03 been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y	Y	Y	Y	Y	Y
1.4	Has security been set correctly? **(CSDR, CSA)**	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
2.4	Have the coding guidelines in *Section 3* of the LBR Instructions (pages 15 through 30) been followed?	Y	Y	Y	Y	Y	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	N/A	N/A	N/A	N/A	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	Y	Y	Y	Y	Y

	Action	Program or Service (Budget Entity Codes)					
		68200000	685001	685002	685014	685015	687007
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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
4.2	Is the program component code and title used correct?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
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.						

Action	Program or Service (Budget Entity Codes)					
	68200000	685001	685002	685014	685015	687007
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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
7.8 Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A	N/A	N/A	N/A	N/A	N/A
7.9 Does the issue narrative reference the specific county(ies) where applicable?	N/A	N/A	N/A	N/A	N/A	N/A

	Action	Program or Service (Budget Entity Codes)					
		68200000	685001	685002	685014	685015	687007
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	Y	Y	Y	Y	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	N/A	N/A	N/A	N/A	N/A
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A	N/A	N/A	N/A	N/A	N/A
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A	N/A	N/A	N/A	N/A	N/A
7.14	Do the amounts reflect appropriate FSI assignments?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
7.17	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A	N/A	N/A	N/A	N/A	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	Y	Y	Y	Y	Y
7.19	Does the General Revenue for 160XXXX (Adjustments to Current Yeer Expenditures) issues net to zero? **(GENR, LBR1)**	N/A	N/A	N/A	N/A	N/A	N/A
7.20	Does the General Revenue for 180XXXX (Intra-Agency Reorgaznizations) issues net to zero? **(GENR, LBR2)**	N/A	N/A	N/A	N/A	N/A	N/A
7.21	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? **(GENR, LBR3)**	N/A	N/A	N/A	N/A	N/A	N/A
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	N/A	N/A	N/A	N/A	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.						

Action	Program or Service (Budget Entity Codes)					
	68200000	685001	685002	685014	685015	687007
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	Y	Y	Y	Y	Y
8.2 Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
8.4 Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y

	Action	Program or Service (Budget Entity Codes)					
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8.10	Are the statutory authority references correct?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
8.12	Is this an accurate representation of revenues based on the most recent Consensus Estimating Conference forecasts?	Y	Y	Y	Y	Y	Y
8.13	If there is no Consensus Estimating Conference forecast available, do the revenue estimates appear to be reasonable?	Y	Y	Y	Y	Y	Y
8.14	Are the federal funds revenues reported in Section I broken out by individual grant? Are the correct CFDA codes used?	Y	Y	Y	Y	Y	Y
8.15	Are anticipated grants included and based on the state fiscal year (rather than federal fiscal year)?	Y	Y	Y	Y	Y	Y
8.16	Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y	Y	Y	Y	Y	Y
8.17	If applicable, are nonrecurring revenues entered into Column A04?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
8.20	Are appropriate service charge nonoperating amounts included in Section II?	Y	Y	Y	Y	Y	Y
8.21	Are nonoperating expenditures to other budget entities/departments cross-referenced accurately?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
8.23	Are nonoperating expenditures recorded in Section II and adjustments recorded in Section III?	Y	Y	Y	Y	Y	Y
8.24	Are prior year September operating reversions appropriately shown in column A01?	Y	Y	Y	Y	Y	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	N/A	N/A	N/A	N/A	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y

Action		Program or Service (Budget Entity Codes)					
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8.28	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y	Y	Y	Y	Y	Y
AUDITS:							
8.29	Is Line I a positive number? (If not, the agency must adjust the budget request to eliminate the deficit).	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y

Action	Program or Service (Budget Entity Codes)					
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10. SCHEDULE III (PSCR, SC3)						
10.1 Is the appropriate lapse amount applied in Segment 3? (See page 90 of the LBR Instructions.)	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
11. SCHEDULE IV (EADR, SC4)						
11.1 Are the correct Information Technology (IT) issue codes used?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
13. SCHEDULE VIIIB-1 (EADR, S8B1)						
13.1 **NOT REQUIRED FOR THIS YEAR**	N/A	N/A	N/A	N/A	N/A	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	Y	Y	Y	Y	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	N/A	N/A	N/A	N/A	N/A
15.2 Do the PDF files uploaded to the Florida Fiscal Portal for the LRPP and LBR match?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	N/A	N/A	N/A	N/A	N/A

	Action	Program or Service (Budget Entity Codes)					
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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	Y	Y	Y	Y	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	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
16.2	Are appropriation category totals comparable to Exhibit B, where applicable?	Y	Y	Y	Y	Y	Y
16.3	Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	Y
17.2	Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	N/A	N/A	N/A	N/A	N/A	N/A
17.3	Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	Y	Y	Y	Y	Y	Y
17.4	Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	Y	Y	Y	Y	Y	Y
17.5	Are the appropriate counties identified in the narrative?	Y	Y	Y	Y	Y	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	Y	Y	Y	Y	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.						

Action	Program or Service (Budget Entity Codes)					
	68200000	685001	685002	685014	685015	687007
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	Y	Y	Y	Y	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	N/A	N/A	N/A	N/A	N/A