AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

October 15, 2014

Ms. Cynthia Kelly, Director
Office of Policy and Budget
Executive Office of the Governor
1701 The Capitol
400 South Monroe Street
Tallahassee, Florida 32399-0001

Dear Ms. Kelly:

Following the instructions dated July 15, 2014, the Agency Capital Improvements Program for FY 2015-16 through FY 2019-20 for the Agency for Health Care Administration is submitted and has been posted to the Florida Fiscal Portal. The Agency is not requesting any fixed capital outlay projects in our Capital Improvements Program for the 2015-16 fiscal year.

Included in the Capital Improvements Program are the Agency's CIP 3: Short-Term Project Explanation forms, CIP-A: Leased Space: Current Usage and Short-Term Projections for FY 2015-16 through FY 2019-20, and the CIP-B: Infrastructure Support Grants and Aids to Local Governments forms. This submission has been approved by Elizabeth Dudek, Secretary.

Sincerely,

Tonya Kidd

Tonya Kidd
Deputy Secretary, Operations

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Temporary Special Duty – General Pay Additives Implementation Plan for Fiscal Year 2015-2016

Section 110.2035(7)(b), 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 (AHCA) 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 120 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 commonly be between 3 to 10 percent but may range up to 20 percent over the employee's current salary and will be applied accordingly after proper evaluation. Any pay additive over 10 percent is subject to the review and approval of the Agency Head or their delegate. 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 an average 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 positions affected: This pay additive could potentially affect any of our 1186 Career Service positions.

6. Historical Data: Last fiscal year, a total of six (6) FTE Career Service positions received general pay additives for performing the duties of a vacant position, all positions were considered "mission critical" and played a key role in carrying out the Agency's day-to-day operations. All additives were in effect for an average of 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. Based on the last positions granted this additive and positions that have been identified for consideration, the average cost is as follows:

Average Annual Salary	X 10% of Annual Salary	# of FTE
$37,319.35	3,731.90	6

Based on the average estimated salaries stated above, the estimated calculation is as follows: 1,296 X 6 = $7,776**. 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 2015-2016 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.

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

DEPARTMENT LEVEL EXHIBITS AND SCHEDULES

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Stephanie Daniel	Phone Number:	414-3666

Names of the Parties:	FLORIDA PEDIATRIC SOCIETY/THE FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS; FLORIDA ACADEMY OF PEDIATRIC DENTISTRY, INC.; A.D., as the next friend of K.K., a minor child; RITA GORENFLO and LES GORENFLO, as the next friends of Thomas and Nathaniel Gorenflo, minor children, J.W., a minor child, by and through his next friend, E.W.; N.A., now known as N.R., a minor child, by and through his next friend, C.R., K.S., as the next friend of J.S., S.B., as the next friend of S.M., S.C., as the next friend of L.C., and K.V., as the next friend of N.V.[1] v. ELIZABETH DUDEK, in her official capacity as interim Secretary of the Florida Agency for Health Care Administration; DAVID WILKINS, in his official capacity as acting Secretary of the Florida Department of Children and Family Services; and JOHN H. ARMSTRONG, M.D., in his official capacity as the Surgeon General of the Florida Department of Health
Court with Jurisdiction:	United States District Court, Southern District of Florida
Case Number:	05-23037-CIV-JORDAN/O'Sullivan
Summary of the Complaint:	This is a class action for declaratory and injunctive relief challenging the administration of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The action is brought pursuant to 42 U.S.C. §1983, and various provisions of the Social Security Act, 42 U.S.C. §1396 et seq. Plaintiffs primarily challenge the adequacy of Medicaid reimbursement rates for pediatric physician and dental services. Plaintiffs assert that Medicaid enrolled beneficiaries under the age of 21 are being denied timely access to necessary physician care as well as dental care. Plaintiffs also allege that outreach to the uninsured about Medicaid is inadequate, and that, as a result, children who would otherwise be eligible for Medicaid are not enrolled in Medicaid (and don't get the EPSDT services to which they are entitled). Plaintiffs also allege that the outreach conducted to Medicaid enrolled children is not adequate, and that, as a result, parents and children do not know the Medicaid services available for Medicaid enrolled children. The Plaintiffs include both pediatric and dental associations, as well as individual plaintiffs. The named official capacity Defendants are the agency heads of the Department of Health, Agency for Health Care Administration, and the Department of Children and Families. If Plaintiffs succeed, they seek, among other things, increased reimbursement rates to physician and dentist providers, which they allege will ensure access to services for children.

[1] This lawsuit involves minor children. With the exception of the Gorenflo children, all children are referred to by initials only. Regarding the Gorenflo children, their mother, Rita Gorenflo waived confidentiality in the lawsuit for all matters pertaining to Thomas and Nathaniel.

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 dentists charge at or below for dental services). In 2011, there was a statutory reimbursement rate increase for Medicaid dental services which required an increase in dental rates by 50%. Plaintiffs contend that the dental rates are still too low, because they are not set at the median rate for non-Medicaid dental services. Effective January 1, 2013, the Medicaid reimbursement rates for certain primary care services provided by eligible providers were increased to the 2009 Medicare level (which is higher than the present Medicare). This increase was required by the Affordable Care Act and will remain a federal statutory mandate until December 31, 2014. Florida would have to obtain federal approval by CMS to discontinue that increase through a proposed state plan amendment even if it is not reauthorized as a statutory mandate pursuant to the Affordable Care Act. Plaintiffs seek increased reimbursement rates for all physician services provided to all Medicaid eligible children. The primary care rate increases implemented will not necessarily provide increased Medicaid reimbursement rates to all physician providers for all services provided to children. Therefore, should Plaintiffs prevail as to the reimbursement rates for all physician services to Medicaid children, it will be necessary to obtain additional appropriations to pay the increased reimbursement rate for all services provided to Medicaid children. Also, should the federal and Florida legislatures choose not to continue the increased primary care rates beyond December 31, 2014, Plaintiffs may seek a court order obligating the State to continue those rate increases. Plaintiffs have also complained and seek relief to address alleged problems with continuous eligibility. At trial, they referenced the need for computer system changes. Should the Court award injunctive relief that will cause programming changes in DCF's ACCESS systems, there will be costs associated with any programming changes, and those costs may be significant.
Specific Law(s) Challenged:	42 U.S.C. §§1396a(a)(8), (10), (30)(A) & (43). (Plaintiffs do not challenge these statutory provisions; rather, Plaintiffs base their claims primarily upon these statutory provisions.)
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. The Court held a hearing on July 8, 2014, on whether

<table>
<tr><td></td><td colspan="2">certain of Plaintiffs' claims were mooted because of the enhanced primary care rates and the implementation of statewide Medicaid Managed Care. Judge Jordan stated at a hearing that he intends to issue a ruling as to whether Defendants are currently violating the law before October 31, 2014.

Depending on the Court’s ruling on liability in October 2014, the Court has indicated it will conduct a second trial as to the appropriate remedy needed to remedy the Defendants violations of law (e.g., injunctive relief). It is expected that the Court will authorize further discovery prior to conducting this second “remedy phase” trial.

It is only after the entry of an injunction and a Final Judgment that the state could exercise any final appellate rights to the U.S. Court of Appeals for the Eleventh Circuit.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td></td><td>Agency Counsel</td></tr>
<tr><td>X</td><td>Office of the Attorney General or Division of Risk Management</td></tr>
<tr><td>X</td><td>Outside Contract Counsel</td></tr>
<tr><td>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).</td><td colspan="2">Stuart H. Singer, Esq.
Carl E. Goldfarb, Esq.
Damien J. Marshall, Esq.
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401 East Las Olas Blvd.
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Philadelphia, PA 19103

Louis W. Bullock, Esq.,
Bullock, Bullock, & Blakemore
110 W. 7th Street
Tulsa, Oklahoma 74112</td></tr>
</table>

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Andrew Sheeran	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 (AHCA)
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 did not seek monetary damages. Plaintiffs prevailed in obtaining an order requiring AHCA to provide applied behavior analysis services to the named Plaintiffs. The "amount of the claim" could be construed as the cost to AHCA to provide these services to the named Plaintiffs. Since the Court's grant of injunctive relief, however, AHCA has amended its policy regarding applied behavior analysis and now provides these services to all Medicaid recipients under the age of 21 for whom it is medically necessary.
Specific Law(s) Challenged:	N/A
Status of the Case:	The trial court granted injunctive relief on March 26, 2012 and declaratory relief on June 14, 2012, purported on behalf of the three named plaintiffs but also on behalf of all similarly situated Medicaid recipients. AHCA appealed the trial court's decision to the U.S. Court of Appeals for the Eleventh Circuit on the sole basis that the underlying case was not a putative or certified class action suit, but rather a suit brought solely on behalf of the three named plaintiffs; consequently, that the trial court exceeded its jurisdiction by purporting to grant what effectively constituted class relief. The U.S. Court of Appeals granted the relief requested by AHCA on appeal and reversed the district court as to those issues raised on appeal by AHCA, with instructions to the trial court upon remand to amend its injunction accordingly. The only matter that remains pending in regard to this litigation is the issue of whether Plaintiffs are entitled to appellate attorneys fees. Plaintiffs contend that they prevailed on appeal notwithstanding the fact that AHCA obtained all of the relief they sought on appeal. A magistrate judge assigned to the appellate attorney's fees issue on remand issued a recommended order on September 17, 2014 recommending that the District Court grant Plaintiffs' motion for appellate attorney's fees in the amount of $209,999. AHCA objections to the recommended order are due to be filed on or before October 1, 2014.

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).		

Office of Policy and Budget – July 2014

Schedule VII: Agency Litigation Inventory				
Agency:	Agency for Health Care Administration			
Contact Person:	Stuart F. Williams		Phone Number:	412-3669

Names of the Parties:	Petitioners: Agency for Health Care Administration (AHCA) Respondent: Centers for Medicaid & Medicare Services (CMS)	
Court with Jurisdiction:	Department of Health and Human Services (DHHS)	
Case Number:	A-12-49	
Summary of the Complaint:	CMS found that the State Agency claimed Federal Financial Participation (FFP) for CHIP enrollees who were also enrolled in Medicaid.	
Amount of the Claim:	$7,592,568 (FFP $5,348,853).	
Specific Law(s) Challenged:	This is an overpayment determination, and so the validity of state law is not at issue.	
Status of the Case:	As of September 23, 2014, this case has been resolved. CMS reconsidered its overpayment determination, dropping the amount due to $843,614 and issued a positive adjustment of $5,348,853 to our payment management system account. The case is 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
	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).		

Office of Policy and Budget – July 2014

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Stuart F. Williams	Phone Number:	412-3669

Names of the Parties:	Petitioners: Agency for Health Care Administration (AHCA) and Agency for Persons with Disabilities (APD) Respondent: Centers for Medicaid & Medicare Services (CMS)	
Court with Jurisdiction:	None, but this will be an administrative appeal through the Department of Health and Human Services (DHHS).	
Case Number:	None at this time. For identifying purposes, this will be an appeal of (OIG) Audit A-04-10-00076.	
Summary of the Complaint:	In March 2013, CMS issued a demand letter memorializing the findings of CMS Audit A-04-10-00076 which requests a refund of $4,386,952 ($2, 193,476 federal share). This amount represents payments in excess of the allowable amount identified in the Department of Health & Human Services, Office of Inspector General's report on Florida Claimed Some Medicaid Administrative Costs That Did Not Comply With Program Requirements for federal fiscal year 2007 through 2009 (Report number A-04-1 0-00076), issued March 1, 2013. The review found that the Medicaid Agency claimed Medicaid administrative costs that did not comply with federal requirements. The report identified costs that did not comply because certain employees in sampled positions did not complete the RMS observation forms as specified in the cost allocation plan, and the RMS coordinator's review did not detect noncompliance. As a result, the Agency for Persons With Disabilities' Medicaid reimbursable observation percentages used to calculate its Medicaid administrative costs were overstated.	
Amount of the Claim:	$4,386,952 ($2,193,476 federal share).	
Specific Law(s) Challenged:	This is an overpayment determination, and so the validity of state law is not at issue.	
Status of the Case:	The Agency responded to the Demand Letter on June 3, 2014. The Agency for Persons with Disabilities sent a second response on June 13, 2014. The APD response is still under review at CMS.	
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).	

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Stuart F. Williams	Phone Number:	412-3669

Names of the Parties:	Petitioners: Agency for Health Care Administration (AHCA) and Department of Children and Families (DCF) Respondent: Centers for Medicaid & Medicare Services (CMS)
Court with Jurisdiction:	None, but this will be an administrative appeal through the Department of Health and Human Services (DHHS).
Case Number:	None at this time. For identifying purposes, this will be an appeal of OIG Audit A-04-11-08007.
Summary of the Complaint:	On August 20, 2013, CMS issued a demand letter memorializing the findings of CMS Audit A-04-11-08007, that requests a refund of $19,783,761 ($10,850,377 federal share) based upon a finding alleging that AHCA "did not refund the federal share for state identified uncollected Medicaid overpayments for ineligible individuals" based upon the following. AHCA entered into a cooperative agreement with the DCF to conduct Medicaid eligibility determinations in accordance with the approved State plan. DCF's Benefit Recovery (Recovery Unit) identifies and documents the existence, circumstances, and amount of public assistance overpayments. In addition, it pursues recovery of overpayments from the party receiving the overpayment or from the party responsible for causing the overpayment. The Recovery Unit defines a reportable overpayment as existing when funds may have been expended on behalf of beneficiaries who were not eligible for Medicaid coverage or who were eligible only after meeting a share of costs. The Recovery Unit is responsible for identifying all overpayment claims and recouping overpayments within DCF. As stated in CMS's Audit Report dated March 2013, at no point in the process described above did DCF notify AHCA of the Medicaid overpayments or collections. Therefore, AHCA did not return to CMS the Federal share of overpayments that it identified or collected. AHCA did not receive reports from, or have access to, DCF's Recovery unit accounting system. Furthermore, instead of returning Medicaid overpayment recoveries to AHCA, DCF retained all recoveries from Medicaid overpayments that it identified to partially fund the operation of its Recovery Unit. Thus, the State agency had no knowledge of Medicaid overpayments identified or collected by DCF and could not ensure that it appropriately adjusted its Federal funds to comply with applicable Federal requirements.

	During the relevant audit period (July 1, 2007 through June 30, 2010), DCF's Recovery Unit identified $22,383,131 in Medicaid overpayments and reported recovery of $2,499,370 in overpayments. In CMS's Audit report, CMS found that AHCA did not return the federal share for the Medicaid overpayments identified or collected by DCF. CMS adopted DCF's finding of $22,283,131 ($12,251,265 federal share) in Medicaid overpayments. Of this amount, DCF collected $2,499,370 ($1,400,888 federal share) but had not collected the remaining $19,783,761 ($10,850,377 federal share). On August 20, 2013, CMS issued a demand letter memorializing the findings of CMS Audit A-04-11-08007 that requests a refund of $19,783,761 ($10,850,377 federal share) based upon a finding alleging that AHCA "did not refund the federal share for state identified uncollected Medicaid overpayments for ineligible individuals."	
Amount of the Claim:	$19,783,761 ($10,850,377 federal share).	
Specific Law(s) Challenged:	This is an overpayment determination, so the validity of state law is not an issue.	
Status of the Case:	CMS granted two extensions to formally appeal this determination and the response to the demand letter was filed October 4, 2013. However, CMS closed this audit on August 4, 2014. This case is 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
	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).		

Office of Policy and Budget – July 2014

Schedule VII: Agency Litigation Inventory				
Agency:	Agency for Health Care Administration			
Contact Person:	Stuart F. Williams		Phone Number:	412-3669

Names of the Parties:	Petitioners: Agency for Health Care Administration (AHCA) Respondent: Centers for Medicaid & Medicare Services (CMS)	
Court with Jurisdiction:	Department of Health and Human Services (DHHS)	
Case Number:	2013-01	
Summary of the Complaint:	Pursuant to 42 U.S.C. § 1316(a) and 42 U.S.C. § 1396, et. seq., the Florida Agency for Health Care Administration (Florida or State) sought administrative reconsideration of the denial of the Florida Medicaid State Plan Amendment 2012-015 (SPA 12-015), received by the Centers for Medicare & Medicaid Services (CMS) on September 14, 2012.	
Amount of the Claim:	None, as this is a State Plan Amendment (SPA) denial. However, should the SPA not be approved, the Agency will necessarily need to alter its stance on limiting outpatient hospital visitations to six per fiscal year.	
Specific Law(s) Challenged:	SPA 12-015	
Status of the Case:	Discovery was completed and the case is in the briefing stage. On February 20, 2014, CMS initiated a compliance action against the Agency because the Agency had implemented the contested SPA. The Agency appealed the compliance action and it has been consolidated with the SPA denial action. The Agency and CMS have both filed their initial briefs. The Agency's response brief will be filed on September 29, 2014. A hearing on the consolidated matters is set for December 4, 2014.	
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).		

Office of Policy and Budget – July 2014

Schedule VII: Agency Litigation Inventory				
Agency:	Agency for Health Care Administration			
Contact Person:	Andrew Sheeran		Phone Number:	412-3670
Names of the Parties:	Smiley & Smiley, P.A. v. State of Florida, Agency for Health Care Administration (AHCA)			
Court with Jurisdiction:	Circuit Court for the Second Judicial Circuit in and for Leon County			
Case Number:	2010-CA-3706			
Summary of the Complaint:	The Complaint alleges that AHCA has breached its contracts with the plaintiff, an auditor of nursing facility and intermediate care facility cost reports. The plaintiff alleges that AHCA has failed to pay for work done pursuant to the "canceled audit" provisions of the contracts.			
Amount of the Claim:	Per the Complaint, "over $15,000"; per correspondence from Plaintiff's counsel, approximately $691,000.00.			
Specific Law(s) Challenged:	N/A			
Status of the Case:	The parties settled the case after mediation. 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).	Not a class action. Law Offices of Matthew W. Dietz			

Office of Policy and Budget - July 2014

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Leslei Street	Phone Number:	412-3686

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:	Alleges patient responsibility amount for those in nursing homes is not calculated correctly. Putative class composed of all Florida residents who have been recipients of Medicaid long-term care benefits in the last four years, or all those who will receive such benefits, where at the time of eligibility those persons had/will have outstanding incurred medical benefits/nursing home charges during a time when they were not eligible for such benefits.
Amount of the Claim:	Amount > $500,000 cost in implementing injunctive and equitable relief; possible breach of contract damages; attorney's fees if Plaintiffs prevail
Specific Law(s) Challenged:	1. Section 1983 alleged violation of Medicaid Act, 42 U.S.C. §1396a(r)(1)(A)(ii); 2. Violation of Medicaid Act, again § 1396a(r)(1)(A)(ii); and state law, Fla. Stat. 409.902; 3. Declaratory judgment and Supplemental Relief, pursuant to Florida Statues 86.021, 061, is actually a challenge to Florida Administrative Code § 65A-1.7141, based on alleged violations of § 1396a(r)(1)(A)(ii) and § 409.903; and 4. Breach of contract as third party beneficiary of AHCA's institutional Medicaid provider agreement.
Status of the Case:	AHCA and DCF filed a joint motion to dismiss, which was heard on September 23, 2013. The Court denied the majority of the MTD and lifted the stay on prospective injunctive relief issues. The Defendants can renew their defense that Goodwin must exhaust her administrative remedies before seeking relief in the circuit court and, pursuant to court order, filed a supplemental brief on September 20, 2013, arguing that sovereign immunity has not been waived for breach of contract claims by third parties. The Court has not ruled on that issue. Discovery is ongoing.

	AHCA and DCF prepared an amendment to the Florida Medicaid State Plan that provides for nursing home charges incurred during the three months preceeding the month of application for Medicaid benefits to be deducted from the individual's income. For those individuals who have nursing home charges and enough income to matter, this will reduce their patient responsibility amount until the nursing home bill is paid off. DCF implemented this proposed amendment in February 2013, retroactive to December 19, 2012. They changed the calculation methodology for every applicant as of December 19, 2012 and later. DCF is promulgating a rule change to conform the rule to the SPA. Goodwin has commented on the proposed rule. CMS approved the State Plan Amendment as of May 9, 2013, effective retroactively to December 13, 2012. (The day the proposed amendment was published in the Florida Administrative Register.)	
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
		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).	Robert Pass, Martha Chumbler, Donald Schmidt, Carlton Fields P.A. Zuckerman Spaeder LLP Lauchlin Waldoch, Jana McConnaughhay, Waldoch & McConnaughhay, P.A. Ron M. Landsman, P.A. Woods Oviatt Gilman LLP	

Schedule VII: Agency Litigation Inventory				
Agency:	Agency for Health Care Administration			
Contact Person:	Stuart F. Williams		Phone Number:	412-3630
Names of the Parties:	TW, PM and Disability Rights Florida v. DCF & AHCA			
Court with Jurisdiction:	United States District Court for the Northern District of Florida			
Case Number:	4-13-cv-457			
Summary of the Complaint:	Putative class action on behalf of over 300 individuals with psychiatric disabilities allegedly unnecessarily segregated in Florida state psychiatric hospitals.			
Amount of the Claim:	Amount unknown; declaratory and injunctive relief, potential attorney's fees			
Specific Law(s) Challenged:	Alleged violation of Title II of the Americans With Disabilities Act			
Status of the Case:	AHCA filed a Motion to Dismiss on September 13, 2013. On January 13, 2014, the Court granted AHCA's Motion to Dismiss in an order dismissing all claims against AHCA. As to AHCA, this case is closed. It remains pending against DCF.			
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).	Disability Rights Florida			

Office of Policy and Budget - July 2014

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Stuart F. Williams	Phone Number:	412-3654

Names of the Parties:	ANN STORK CENTER, INC., a Florida Not-For-Profit Corporation; ST. AUGUSTINE CENTER FOR LIVING, a Florida Corporation; RES CARE, INC., a Corporation; RESIDENTIAL CRF INC., a Corporation; MIAMI CEREBRAL PALSY RESIDENTIAL SERVICES, INC., a Florida Not-For-Profit Corporation; SUNRISE COMMUNITY, INC., a Florida Not-For-Profit Corporation; MACTOWN, INC., a Florida Not-For-Profit Corporation; BARC HOUSING, INC., a Florida Not-For-Profit Corporation; CENTRAL FLORIDA COMMUNITIES, INC., a Florida Not-For-Profit Corporation; PENSACOLA CARE,INC., a Florida Not-For-Profit Corporation; CARE CENTERS OF NASSAU, LLC, a Florida Limited Liability Corporation; EIDETIK, INC., a Florida Corporation; NATIONAL MENTOR HEALTHCARE, LLC D/B/A FLORIDA MENTOR, a Delaware Limited Corporation; LIFE CONCEPTS, INC. D/B/A QUEST INC., a Florida Not-For-Profit Corporation; NEW VUE, LLC, a Florida Limited Liability Corporation; FLORIDA PREFERRED CARE DEVELOPMENTAL CENTERS I, INC., a Florida Corporation; DDMS, INC., a Florida Corporation and FERN PARK, INC., a Florida Corporation; Petitioner, vs. STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	13-2402	
Summary of the Complaint:	Petitioners, a large group of independent facilities for the disabled are challenging the reimbursement rates and the methodology of setting reimbursement rates from Medicaid for facilities.	
Amount of the Claim:	Valued in excess of $500,000	
Specific Law(s) Challenged:	GAA line 223 FY 2012-2013; ICF/DD Rate Reimbursement Plan; 42 USCA 1396a; 59G-6.045; 409.908; and 409.9083.	
Status of the Case:	Final order entered. 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).	Steven M. Weinger, Esquire Kurzban, Kurzban, Weinger, Tetzeli and Pratt, P.A. 2650 S.W. 27th Avenue, Second Floor Miami, Florida 33133

Office of Policy and Budget - July 2014

Schedule VII: Agency Litigation Inventory				
Agency:	Agency for Health Care Administration			
Contact Person:	Stuart F. Williams		Phone Number:	412-3654
Names of the Parties:	Alachua County, Florida; et al., Plaintiffs vs. Elizabeth Dudek, in her official capacity as Secretary of the State of Florida, Agency for Health Care Administration; and Lisa Vickers, in her official capacity as Executive Director of the State of Florida, Department of Revenue, Defendants,			
Court with Jurisdiction:	In the Circuit Court of the Second Judicial Circuit In and For Leon County, Florida			
Case Number:	2012-CA-1328			
Summary of the Complaint:	There are 68 counties in Florida. This case was brought by 55 counties plus the Florida Association of Counties, challenging a new law regarding county contributions to Medicaid. The Amended Complaint includes three (3) counts. The first and second counts assert challenges pursuant to Article VII, section 18(a) and (c), Florida Constitution, for violation of the unfunded mandate provisions. The third count asserts that unpaid claims extending from 2001 - 2008 are time barred pursuant to the Florida statute of limitations.			
Amount of the Claim:	Valued in excess of $500,000			
Specific Law(s) Challenged:	"Unfunded Mandates Provision" of article VII, section 18 of the Florida Constitution; 409.915.			
Status of the Case:	In September 2014, the Court entered an Order to Show Cause as to why the matter should not be dismissed for failure to prosecute.			
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).	Susan H. Churuti Bryant Miller Olive, P.A. One Tampa City Center, Suite 2700 Tampa, Florida 33602 Virginia Saunders Delegal General Counsel Florida Association of Counties 111 S. Monroe Street Tallahassee, Florida 32301			

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Leslei Street	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, among other claims.		
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:	N/A		
Status of the Case:	The operative complaint is Plaintiffs' Second Amended Consolidated Complaint, filed August 23, 2013, alleging violations of the Medicaid Act, Title II of the Americans With Disabilities Act, § 1983, and § 504 of the Rehabilitation Act. The Court denied Plaintiffs' first Motion for Class Certification but provided the Plaintiffs with additional time for further discovery. Plaintiffs filed their renewed Motion for Class Certification on December 19, 2013, and Defendants filed their response in opposition on March 3, 2014. Plaintiffs filed their reply on April 1, 2014. On September 9, 2014, Judge Zloch (who was assigned the case after Judge Rosenbaum was appointed to the federal appellate court) dismissed the renewed motion for class certification without prejudice, pending the Court's ruling on Defendants' Renewed Motion to Dismiss based on lack of subject matter jurisdiction On December 6, 2013, this case was consolidated with the civil action *United States v. State of Florida*, also filed in the Southern District of Florida.		

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 - July 2014

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Leslei Street	Phone Number:	850-412-3686

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	United States v. State of Florida; now consolidated with AR, above	
Court with Jurisdiction:	Southern District of Florida	
Case Number:	3-61576 (Previous Case No.- 13-61576-CIV-Dimitrouleas)	
Summary of the Complaint:	Alleged violations of the Americans With Disabilities Act, as amended; persons under the age of 21 are unnecessarily in nursing facilities (NF) and at risk of being placed in NF; state has not funded necessary services.	
Amount of the Claim:	The United States seeks compensatory damages for pain and suffering of Medicaid recipients under the age of 21, plus injunctive relief. The amount of compensatory damages is unknown but could be large. In addition, the monetary impact of injunctive relief could exceed $25,000,000 annually in additional Medicaid payments if the United States were to be successful.	
Specific Statutes or Laws (including GAA) Challenged:	Americans With Disabilities Act, as amended	
Status of the Case:	The State filed a Motion to Dismiss, asserting that the U.S. Department of Justice (DOJ) does not have lawful authority to bring the suit. The Court denied the motion. Disability Rights Florida filed a motion to intervene in this litigation on September 5, 2013. The Court denied that motion. Discovery is under way.	
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).	Quasi class action brought by the U.S. Department of Justice.	

Schedule VII: Agency Litigation Inventory			
Agency:	Agency for Health Care Administration		
Contact Person:	Shena Grantham William Roberts	Phone Number:	850-412-3691

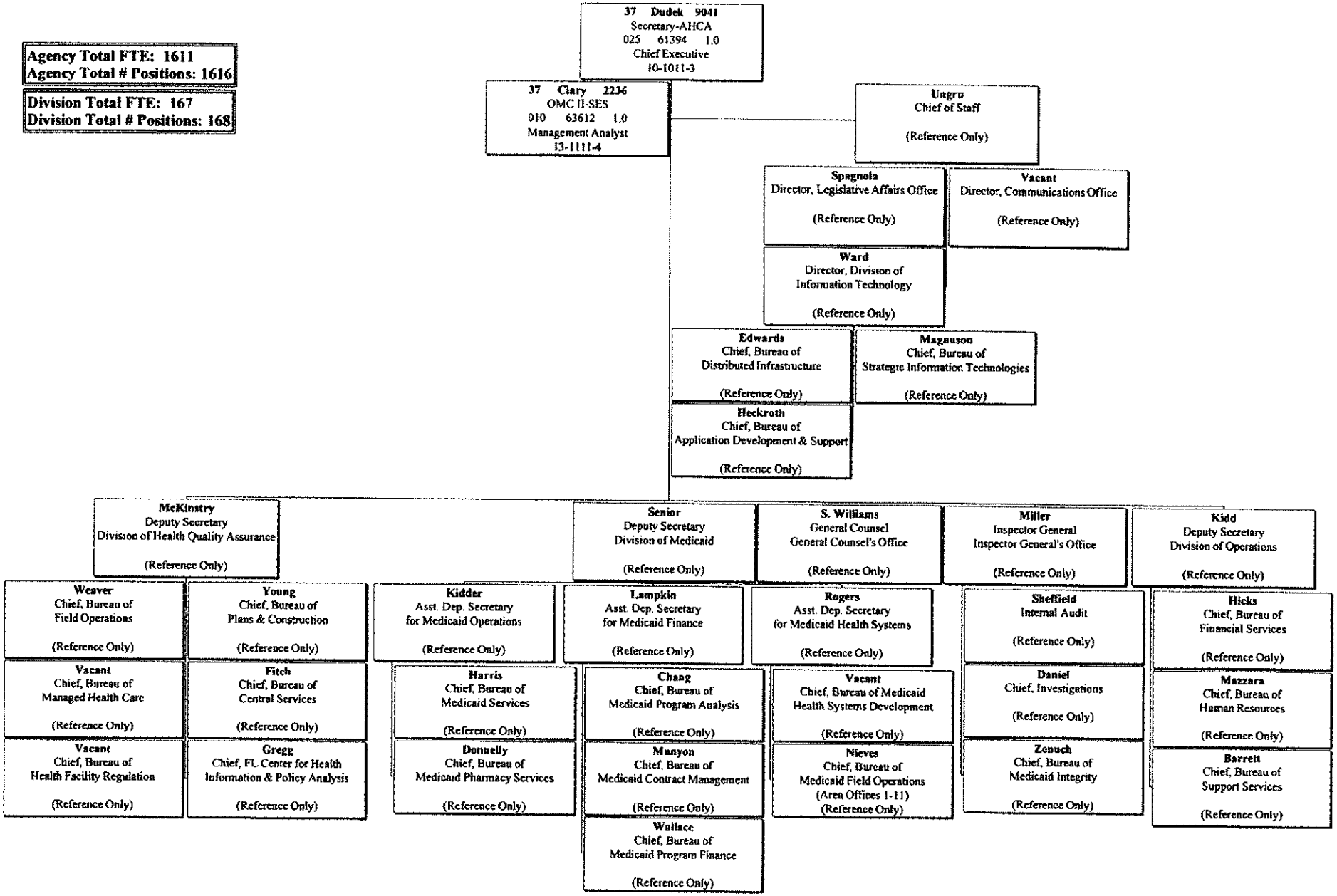
Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Federal Demand Letter A	
Court with Jurisdiction:	United States Department of Health and Human Services	
Case Number:	04-12-18633	
Summary of the Complaint:	On August 28, 2013, CMS issued a demand letter memorializing the findings of Audit 1-04-12-18633, which requests a refund of $117,274,230 ($74,545,746 federal share). The review found that FMMIS was not programmed to ensure the proper payment of outpatient Medicare crossover claims. The audit identified errors within a sample and projected the sample error rate to the total amounts paid for outpatient hospital claims during state fiscal years 2007/08, 2008/09, 2009/10.	
Amount of the Claim:	$117,274,230 ($74,545,746 federal share).	
Specific Statutes or Laws (including GAA) Challenged:	This is an overpayment determination, and so the validity of state law is not at issue.	
Status of the Case:	We have been granted several extensions from CMS to formally appeal this determination. The Agency has been working with CMS and notified CMS on September 24, 2014 that the Agency would seek recoupment against providers for the 2008/09 and 2009/10 fiscal years.	
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).		

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Secretary's Office

Effective Date: July 1, 2014
Org. Level: 68-10-00-00-000
FTEs: 2 Positions: 2

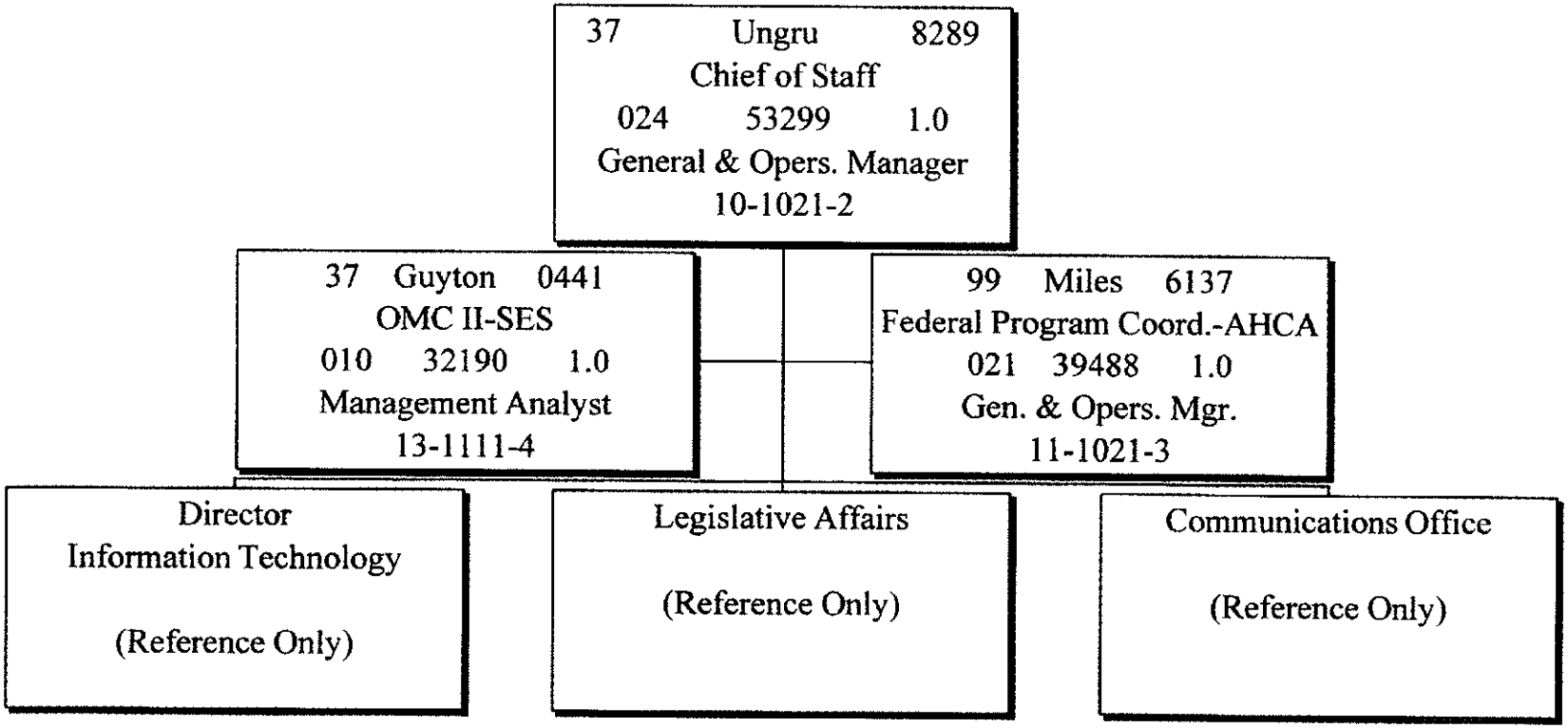
Agency Total FTE: 1611
Agency Total # Positions: 1616

Division Total FTE: 167
Division Total # Positions: 168



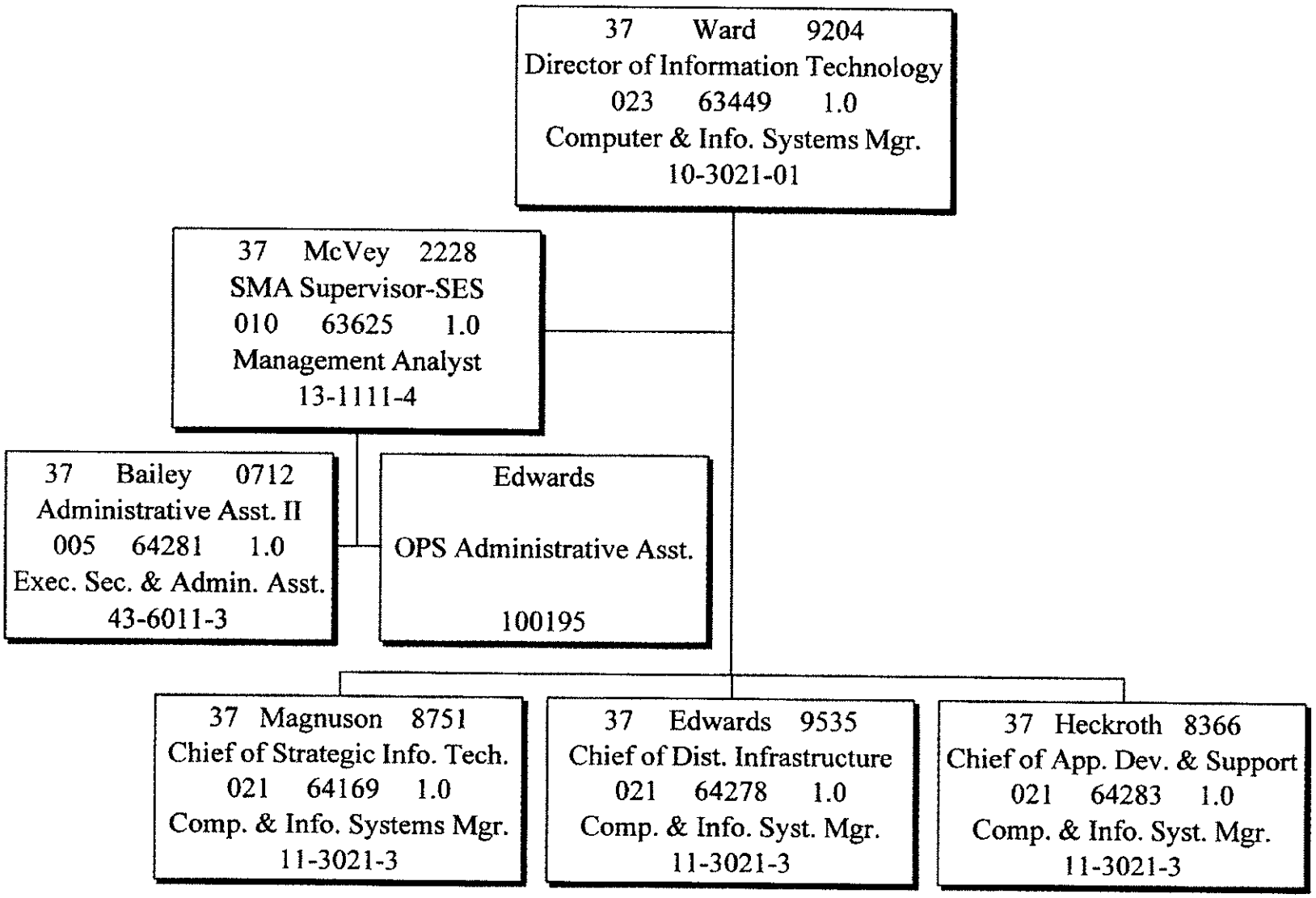
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief of Staff

Effective Date: July 1, 2014
Org. Level: 68-10-10-00-000
FTEs: 3 Positions: 3



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

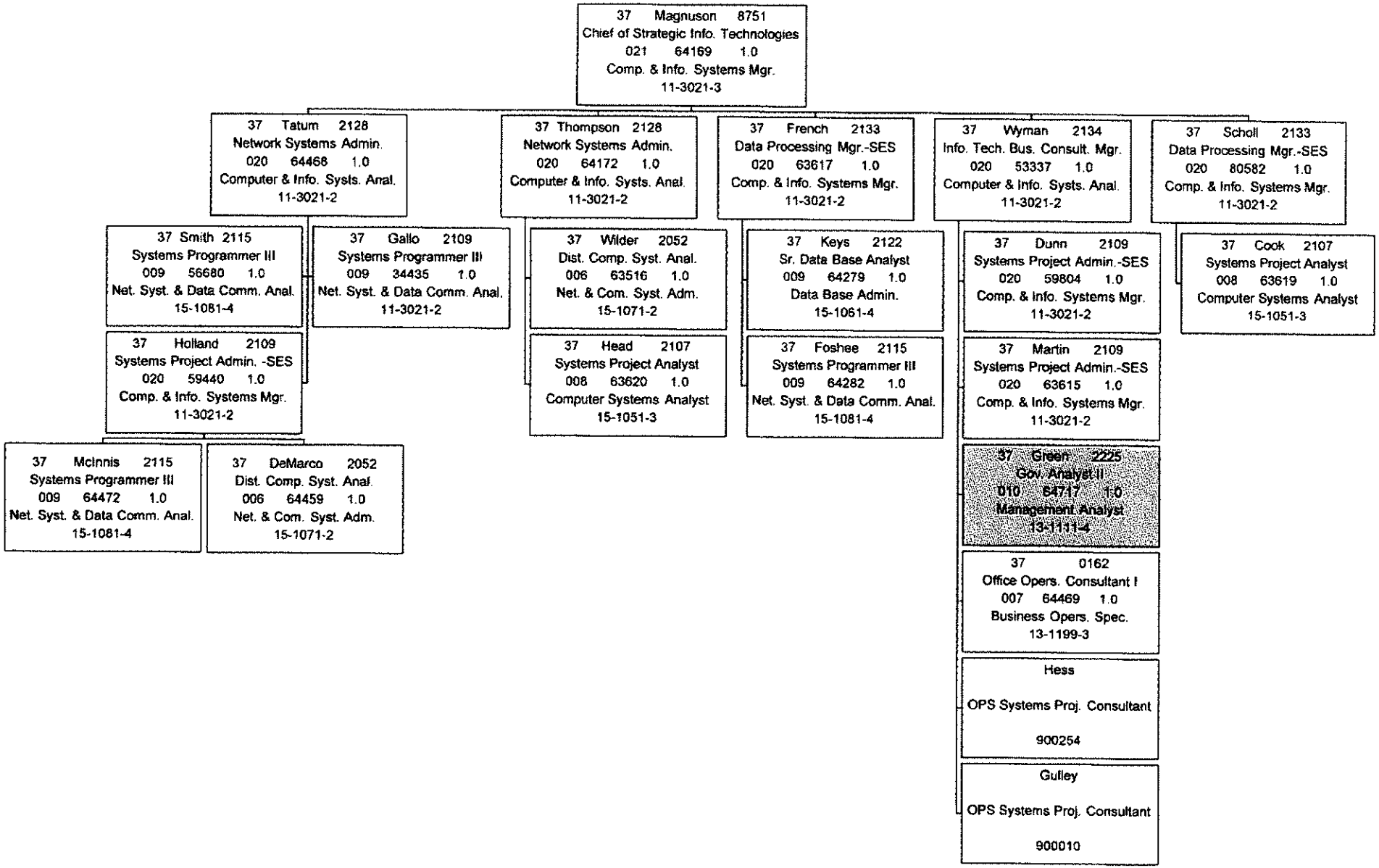
Effective Date: July 1, 2014
Org Level: 68-10-10-40-000
FTEs: 3 Positions: 3



A-2-1

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

Effective Date: July 1, 2014
Org. Level: 68-10-10-40-000
FTEs: 19 Positions: 19

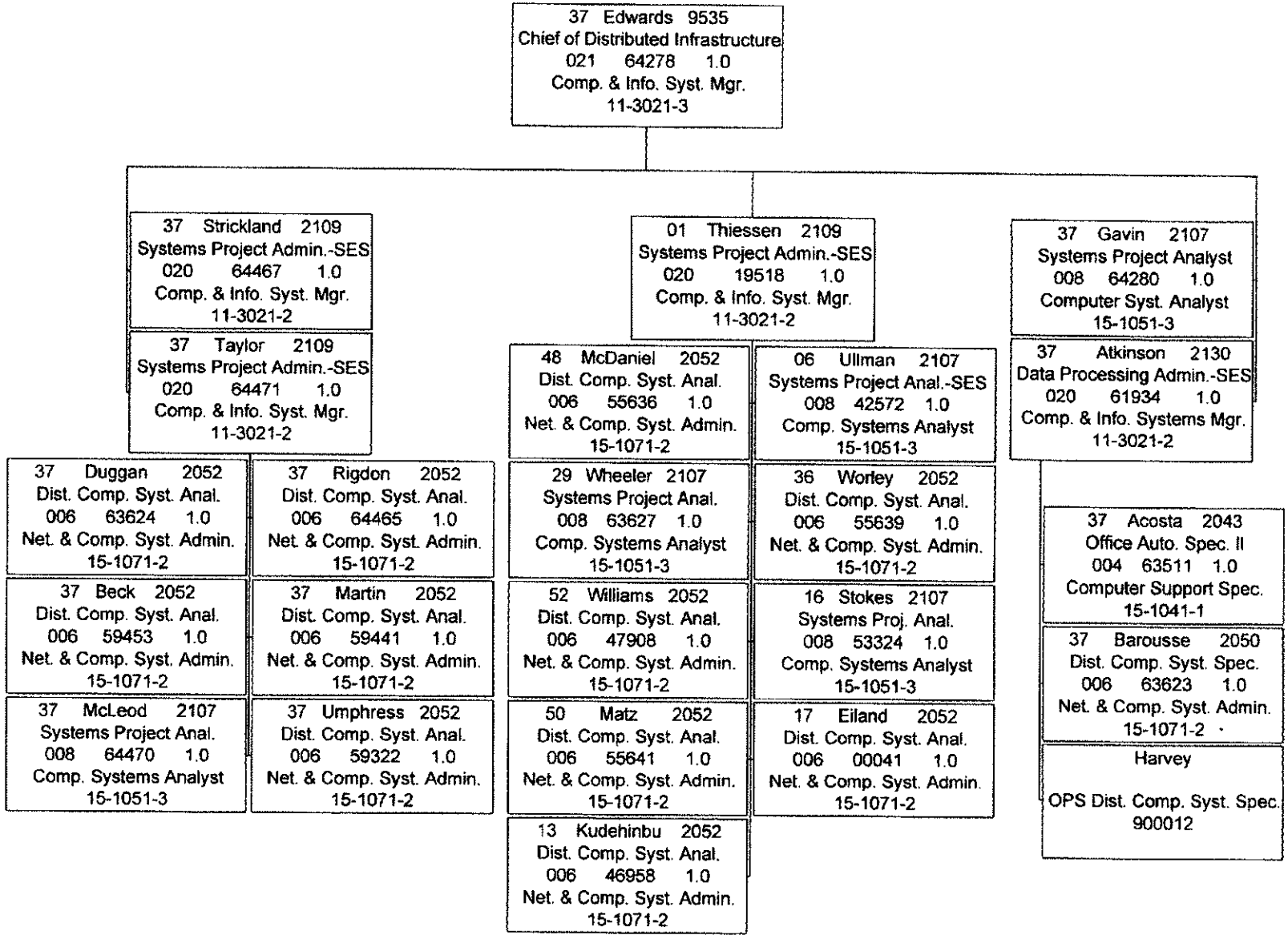


*Shaded position reports to org code 68-50-00-00-00-000 - Division of Medicaid, Deputy Secretary's Office

A-2-2

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

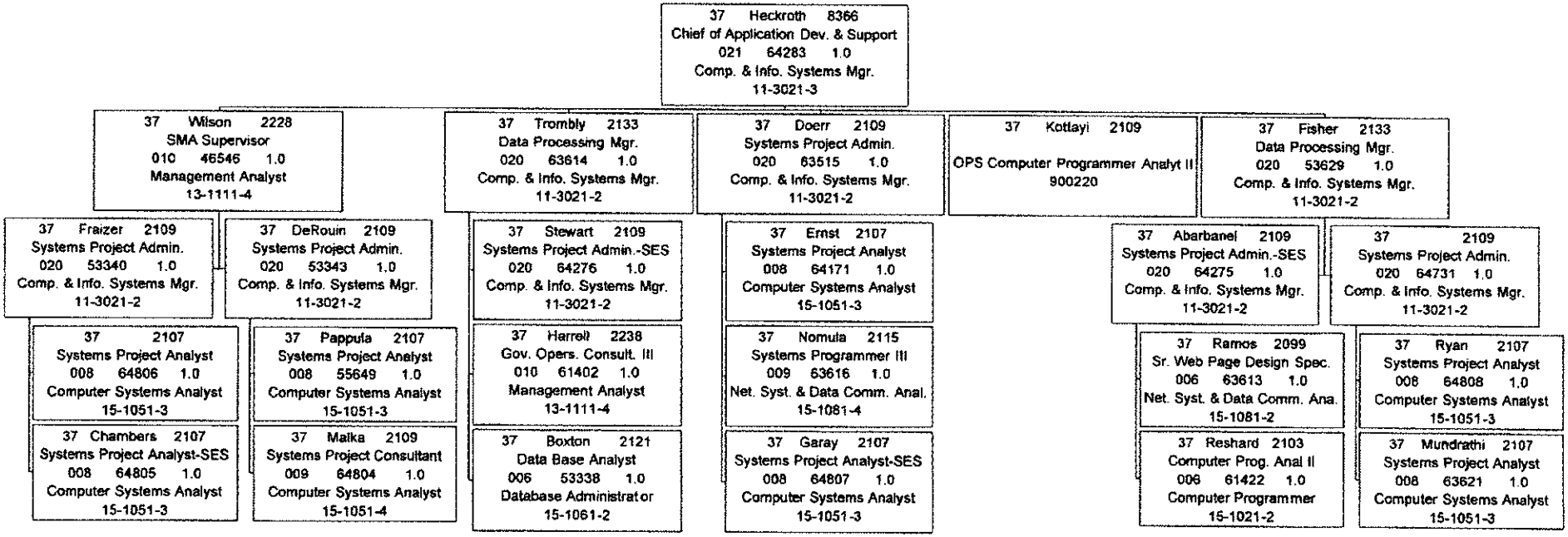
Effective Date: July 1, 2014
Org. Level: 68-10-10-40-000
FTEs: 23 Positions: 23



A-2-3

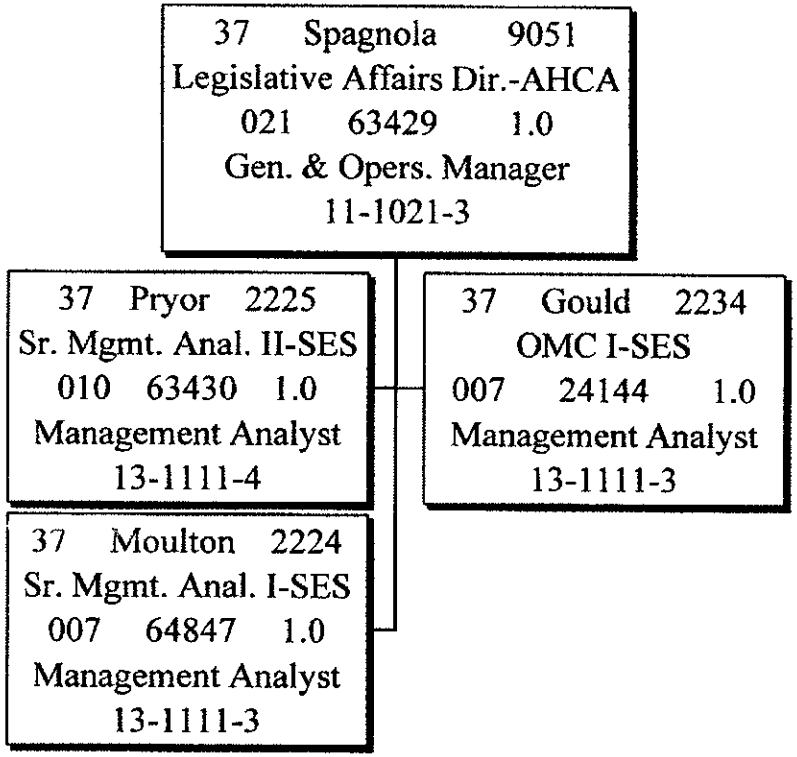
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of Information Technology
Bureau of Application Development and Support

Effective Date: July 1, 2014
Org. Level: 68-10-10-40-000
FTEs: 23 Positions: 23



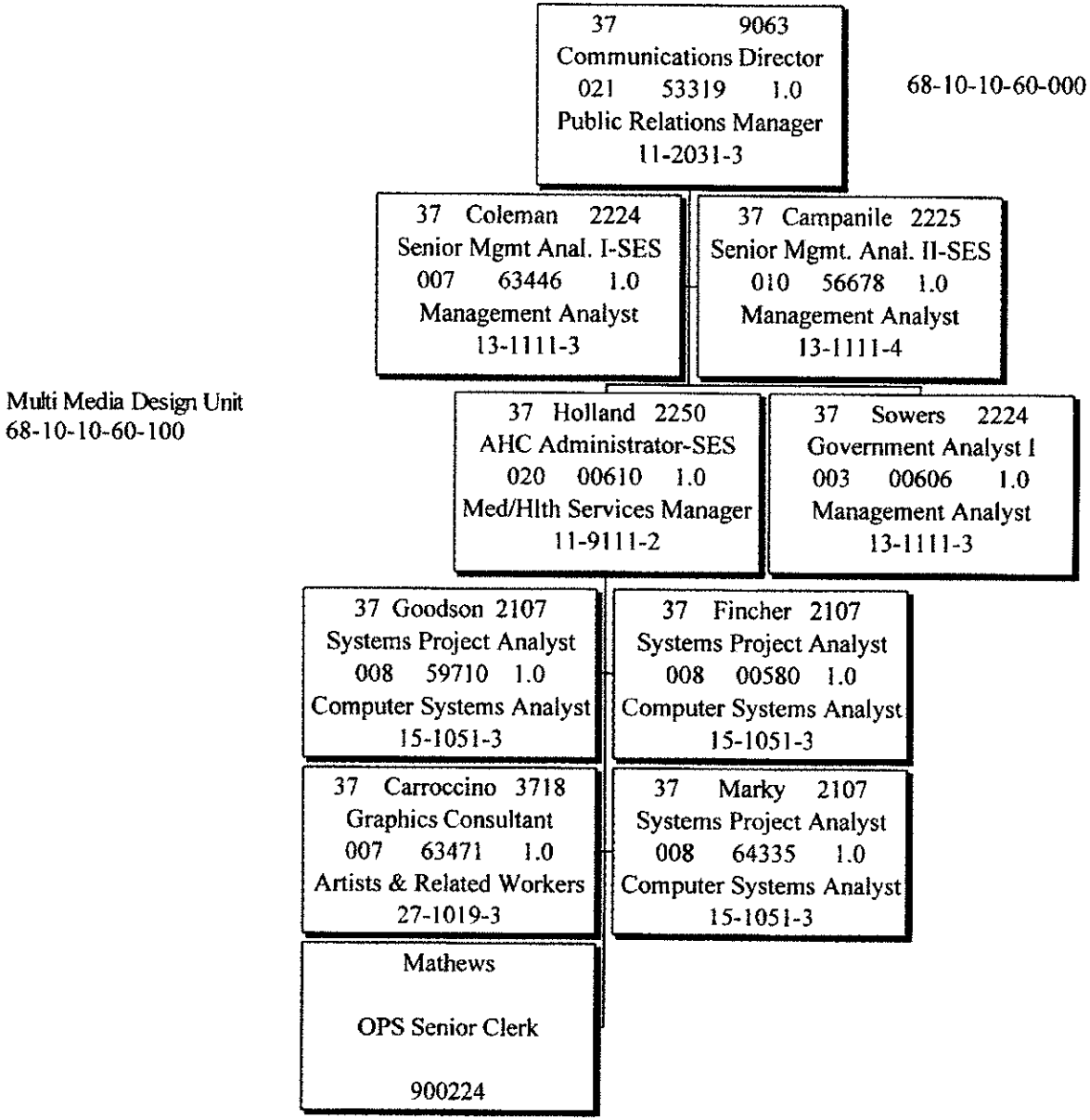
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Legislative Affairs Office

Effective Date: July 1, 2014
Org Level: 68-10-10-50-000
FTEs: 4 Positions: 4



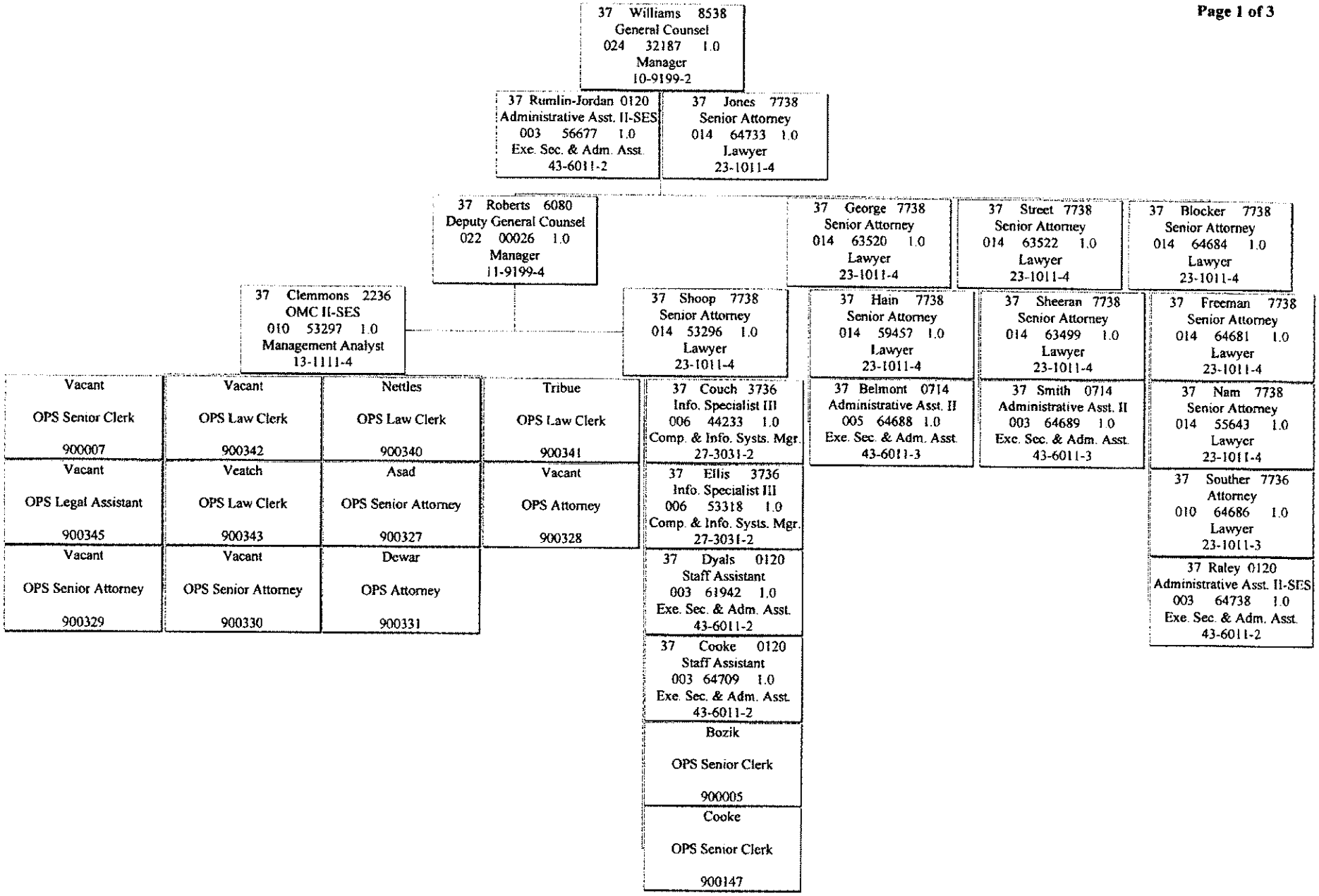
Effective Date: July 1, 2014
FTEs: 9 Positions: 9

AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Communications Office



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

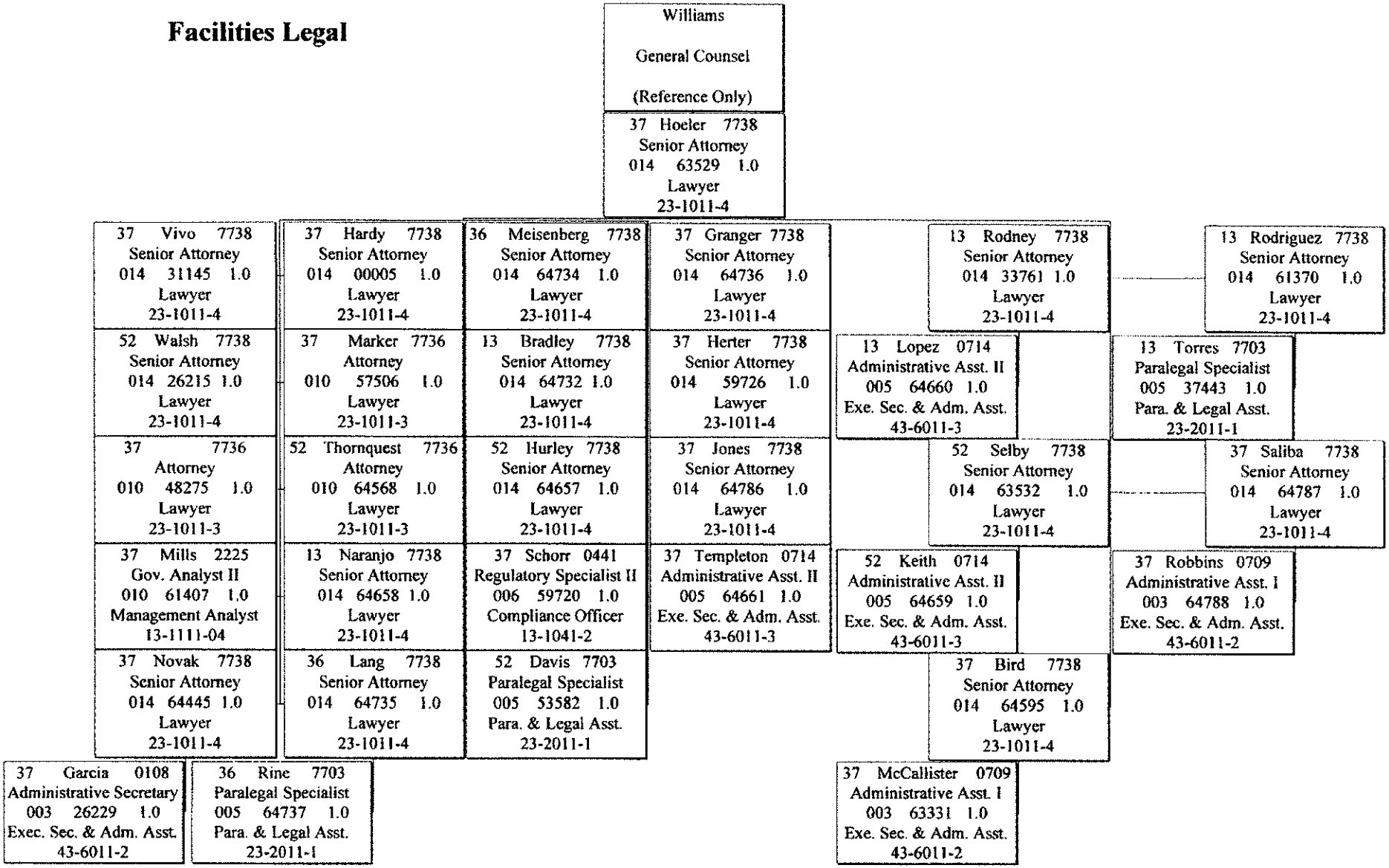
Effective: July 1, 2014
Org. Level: 68-10-20-00-000
FTEs: 65.5 Positions: 66



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Effective Date: July 1, 2014
Org. Level: 68-10-20-00-000
FTEs: 65.5 Positions: 66

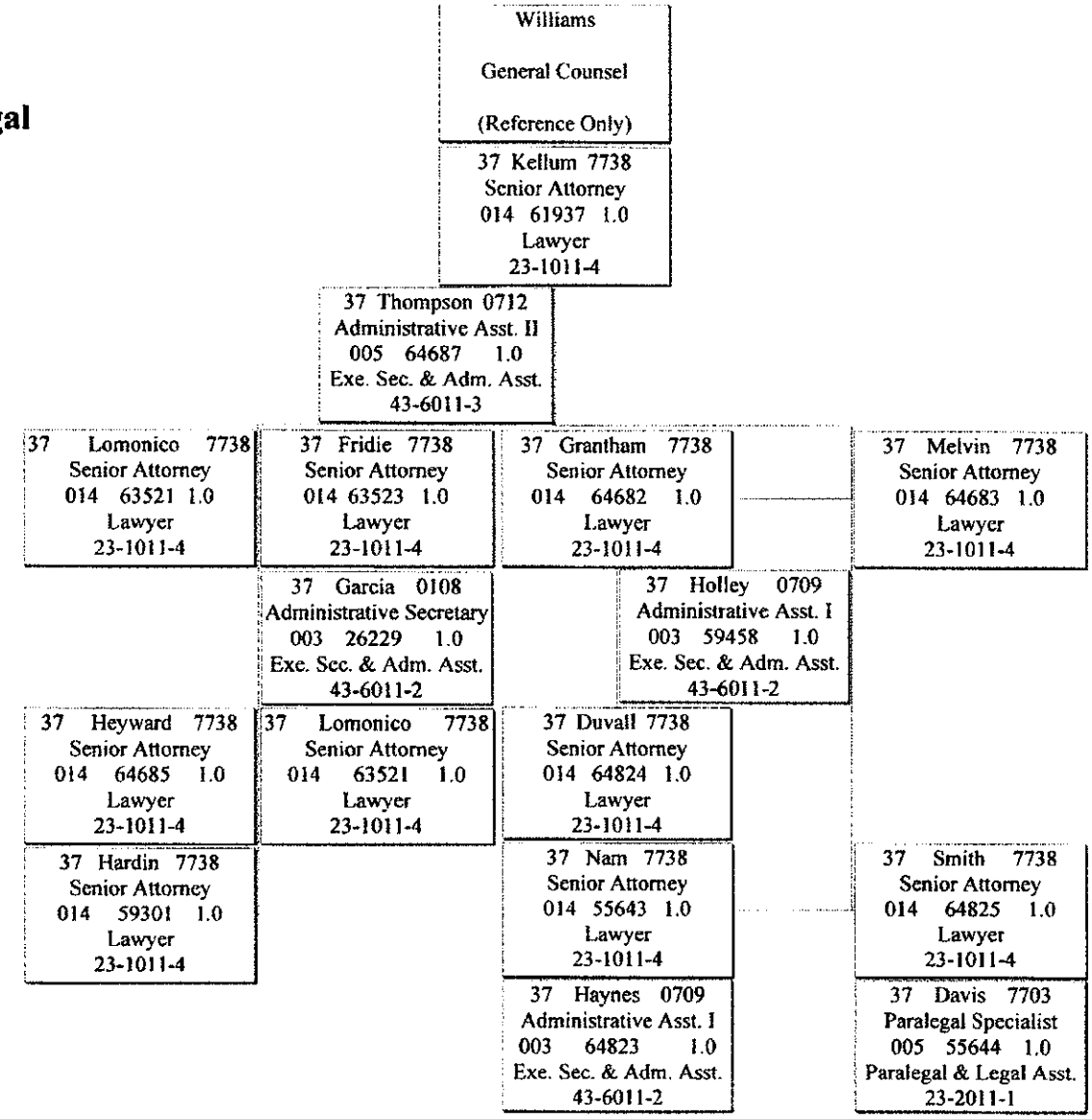
Facilities Legal



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

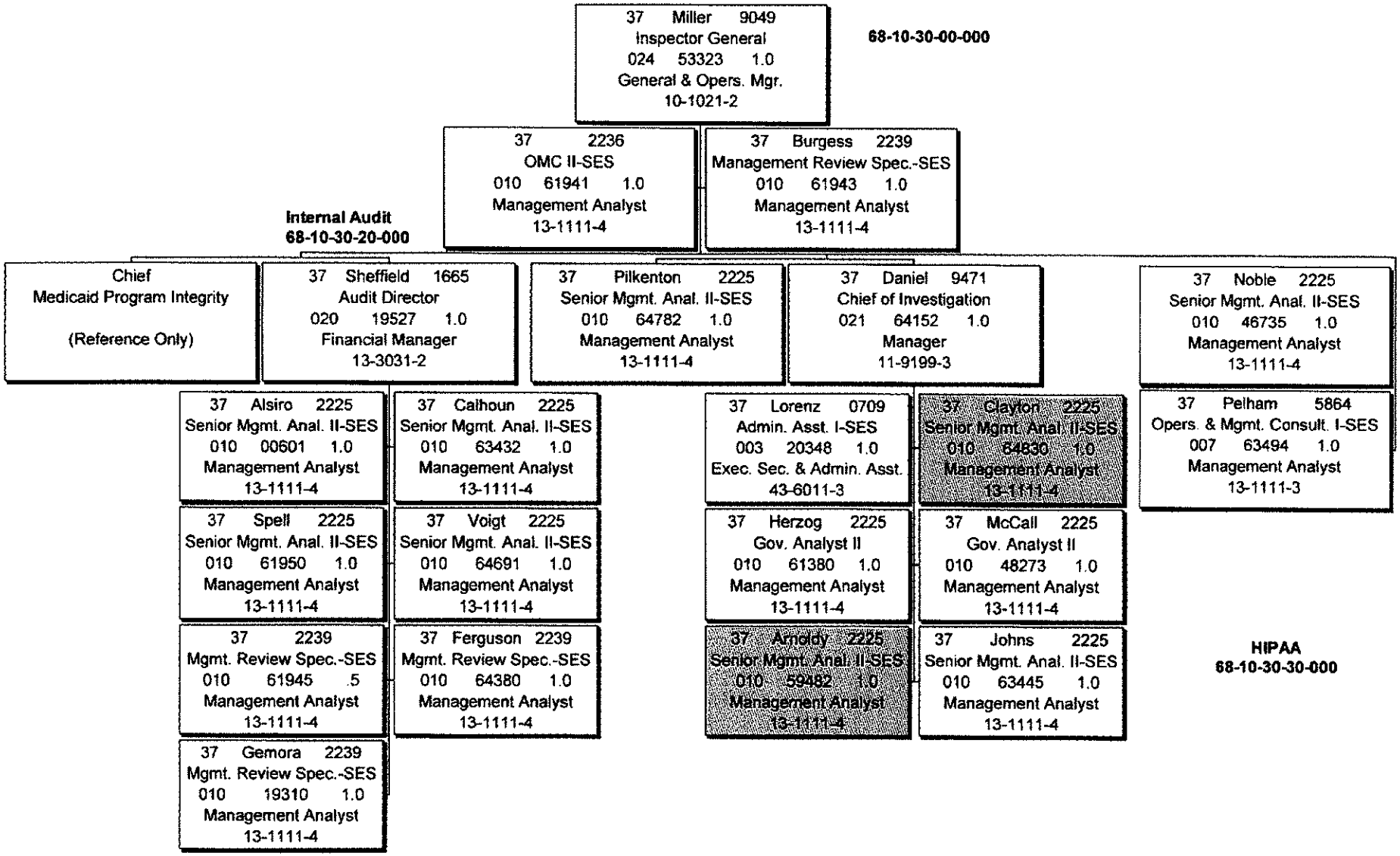
Effective Date: July 1, 2014
Org. Level: 68-10-20-00-000
FTEs: 65.5 Positions: 66

Medicaid Legal



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General

Effective Date: July 1, 2014
FTEs: 18.5 Positions: 19



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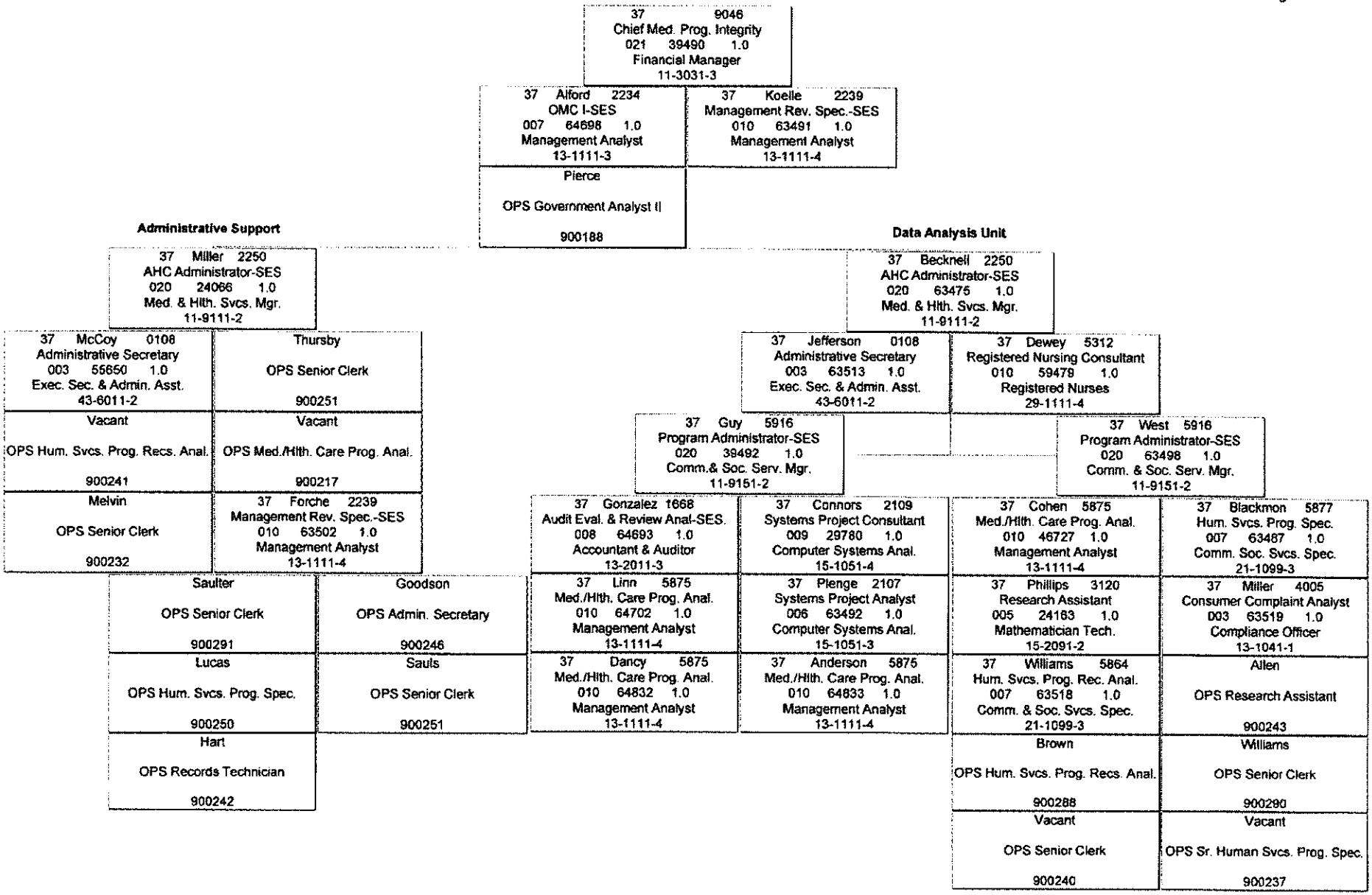
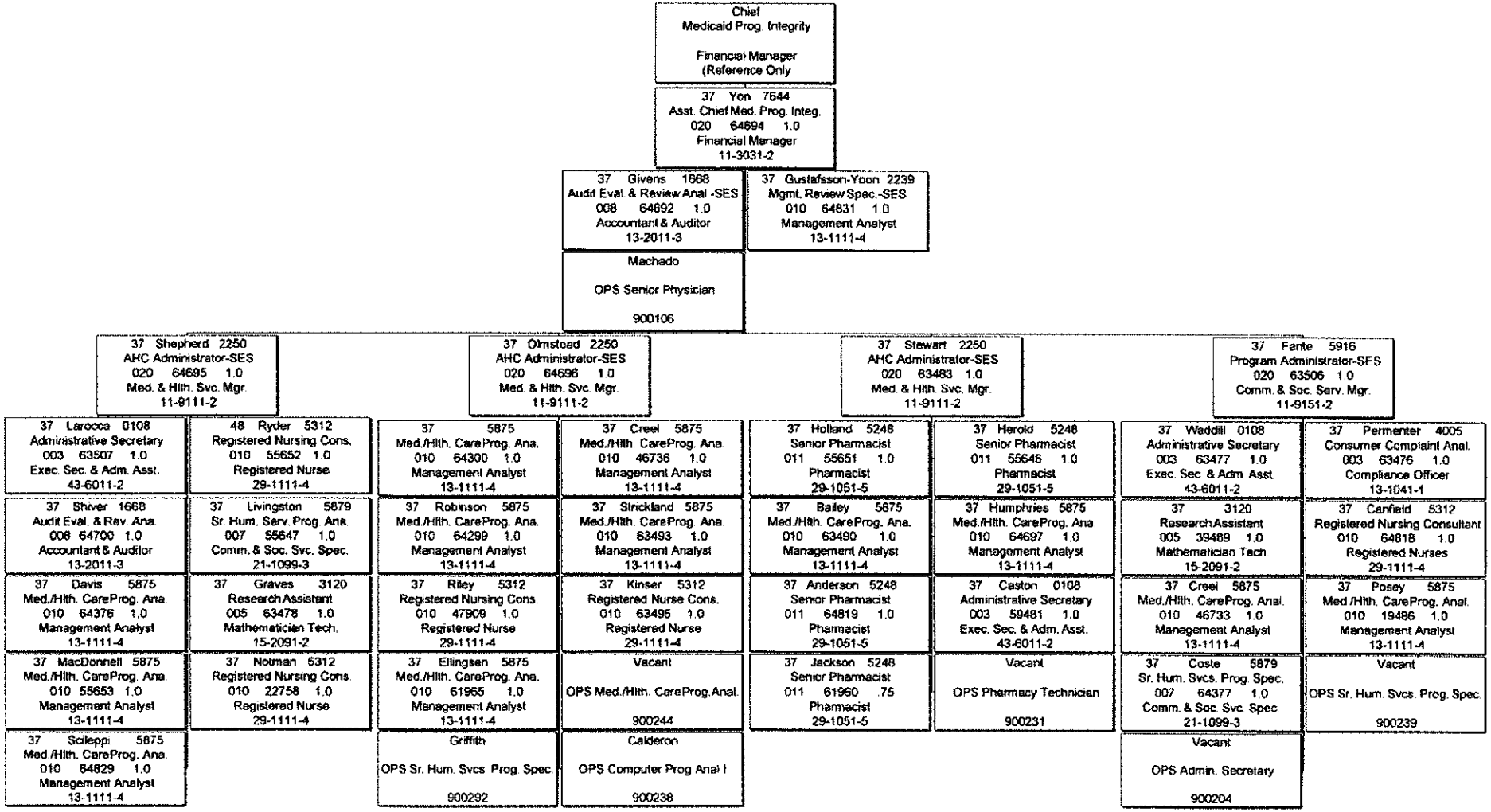
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General
Medicaid Program Integrity

Effective Date: July 1, 2014
Org. Level: 68-10-30-10-000
FTEs: 93.5 Positions: 94



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

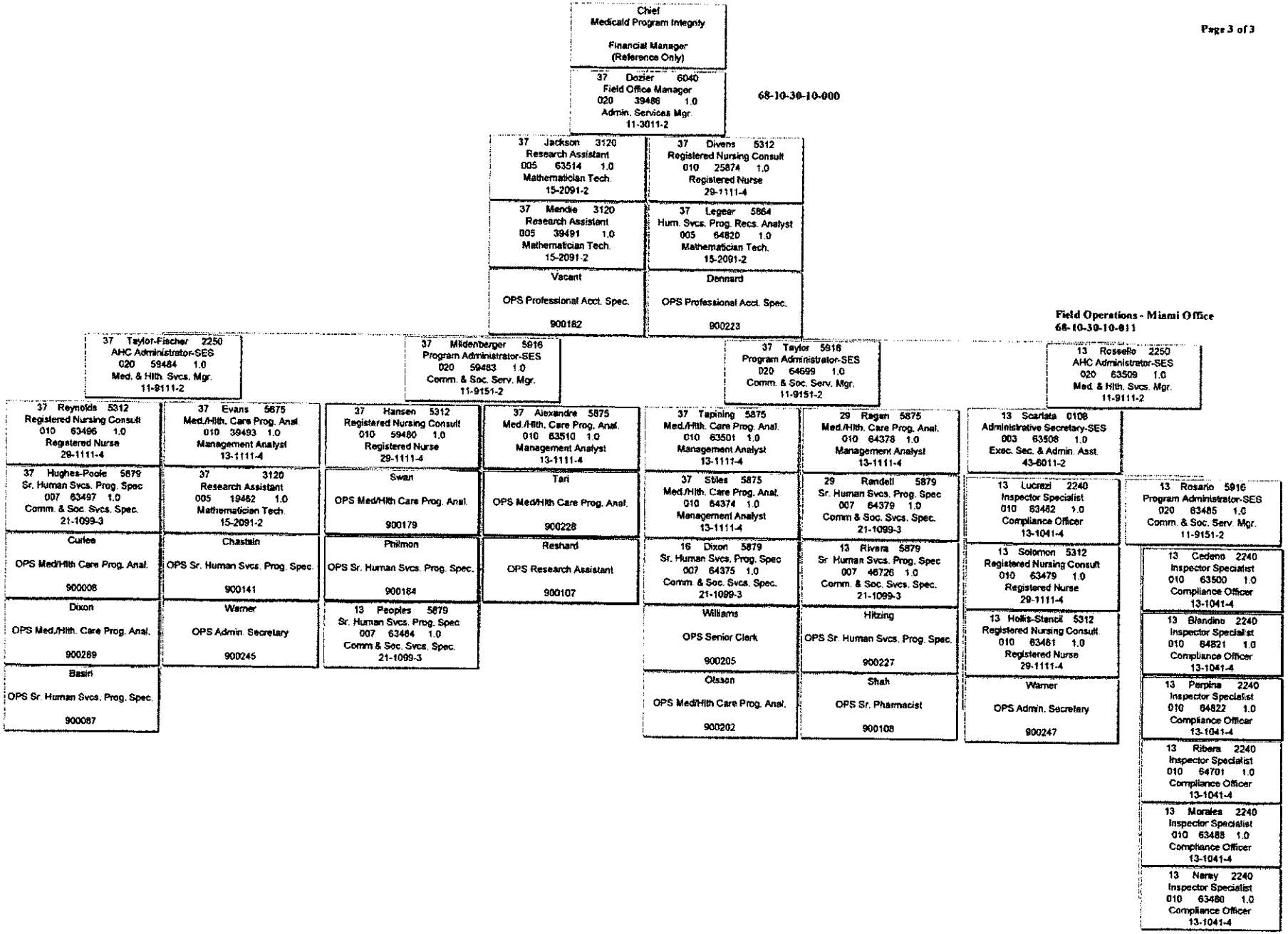
Effective Date: July 1, 2014
Org. Level: 68-10-30-10-000
FTEs: 93.5 Positions: 94



A-6-1

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

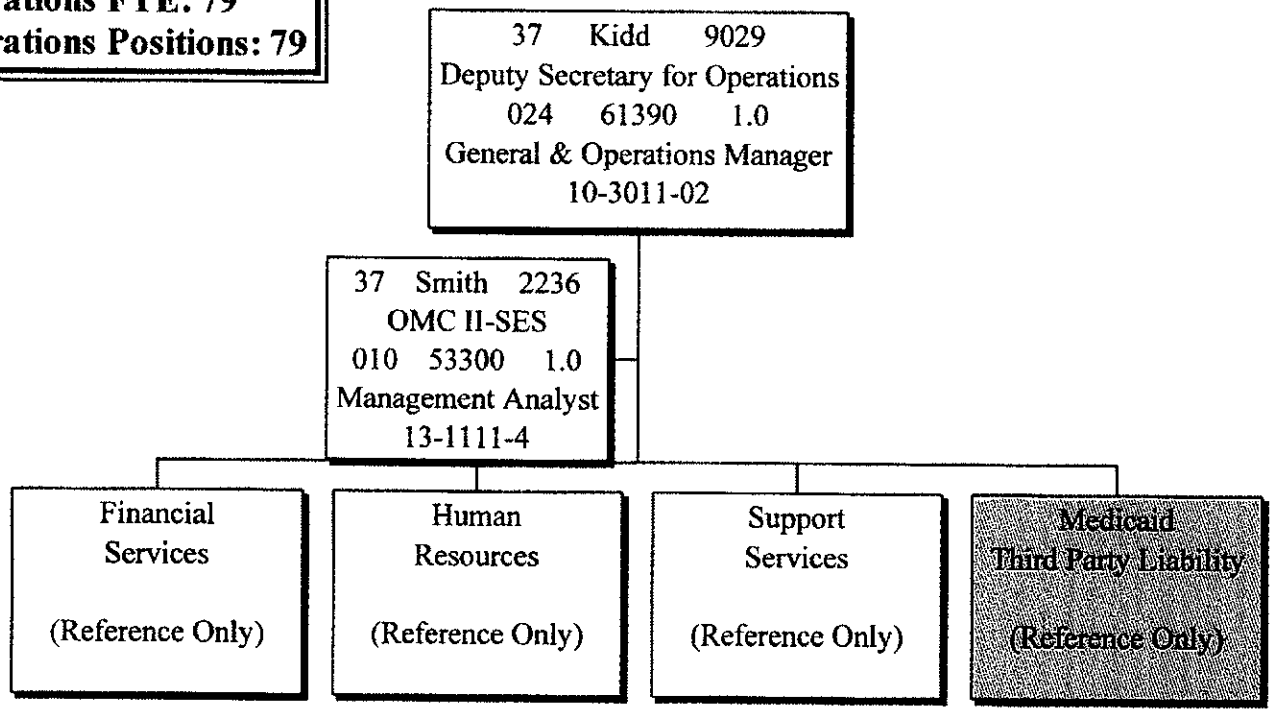
Effective Date: July 1, 2014
FTEs: 12 Positions: 12



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

Effective Date: July 1, 2014
Org Level: 68-20-00-00-000
FTEs: 2 Positions: 2

Division of Operations FTE: 79
Division of Operations Positions: 79

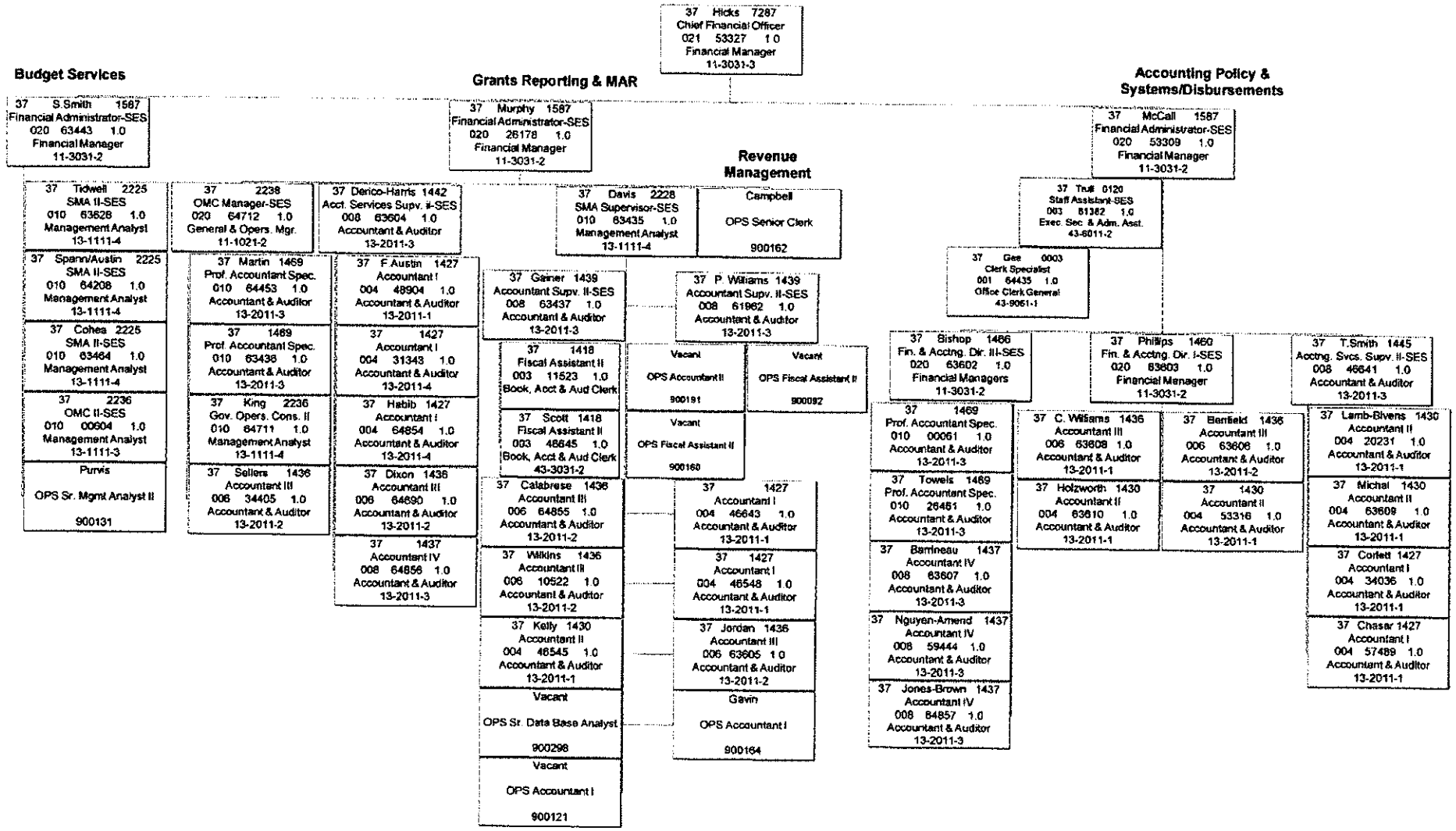


***Shaded box reports to Division of Medicaid**

B-0

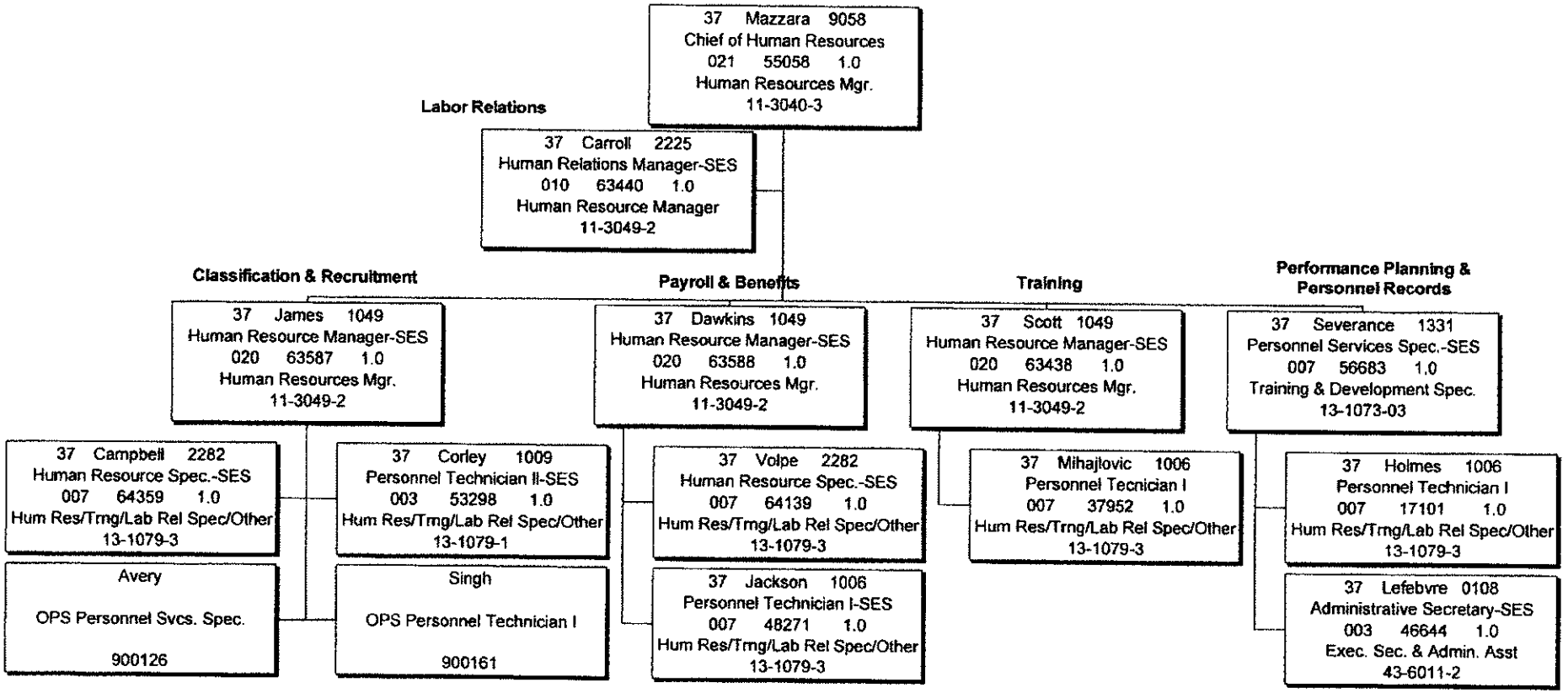
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Financial Services

Effective Date: July 1, 2014
Org. Level: 68-20-15-00-000
FTEs: 48 Positions: 48



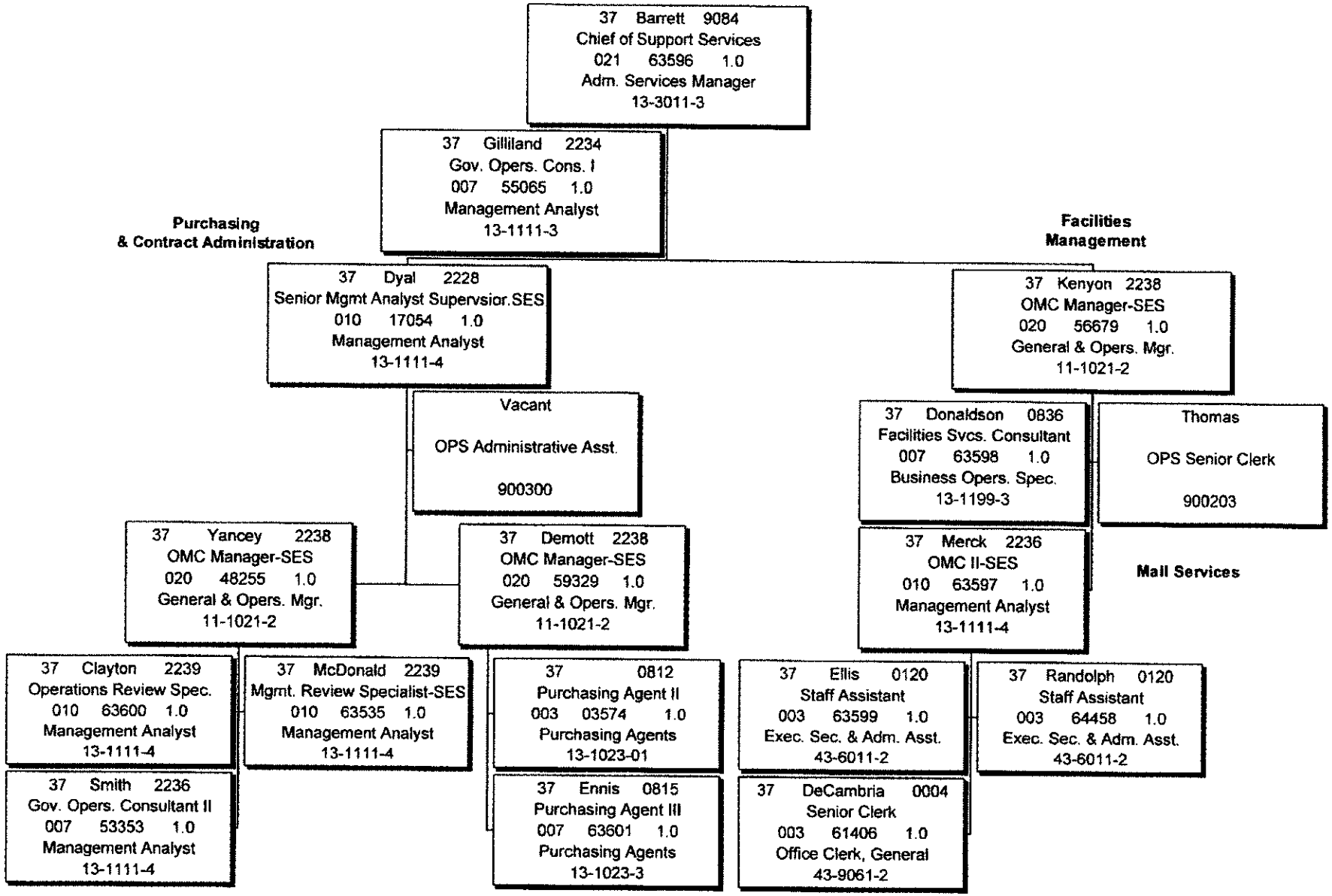
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Human Resources

Effective Date: July 1, 2014
Org. Level: 68-20-20-00-000
FTEs: 13 Positions: 13



Effective Date: July 1, 2014
Org. Level: 68-20-40-00-000
FTEs: 16 Positions: 16

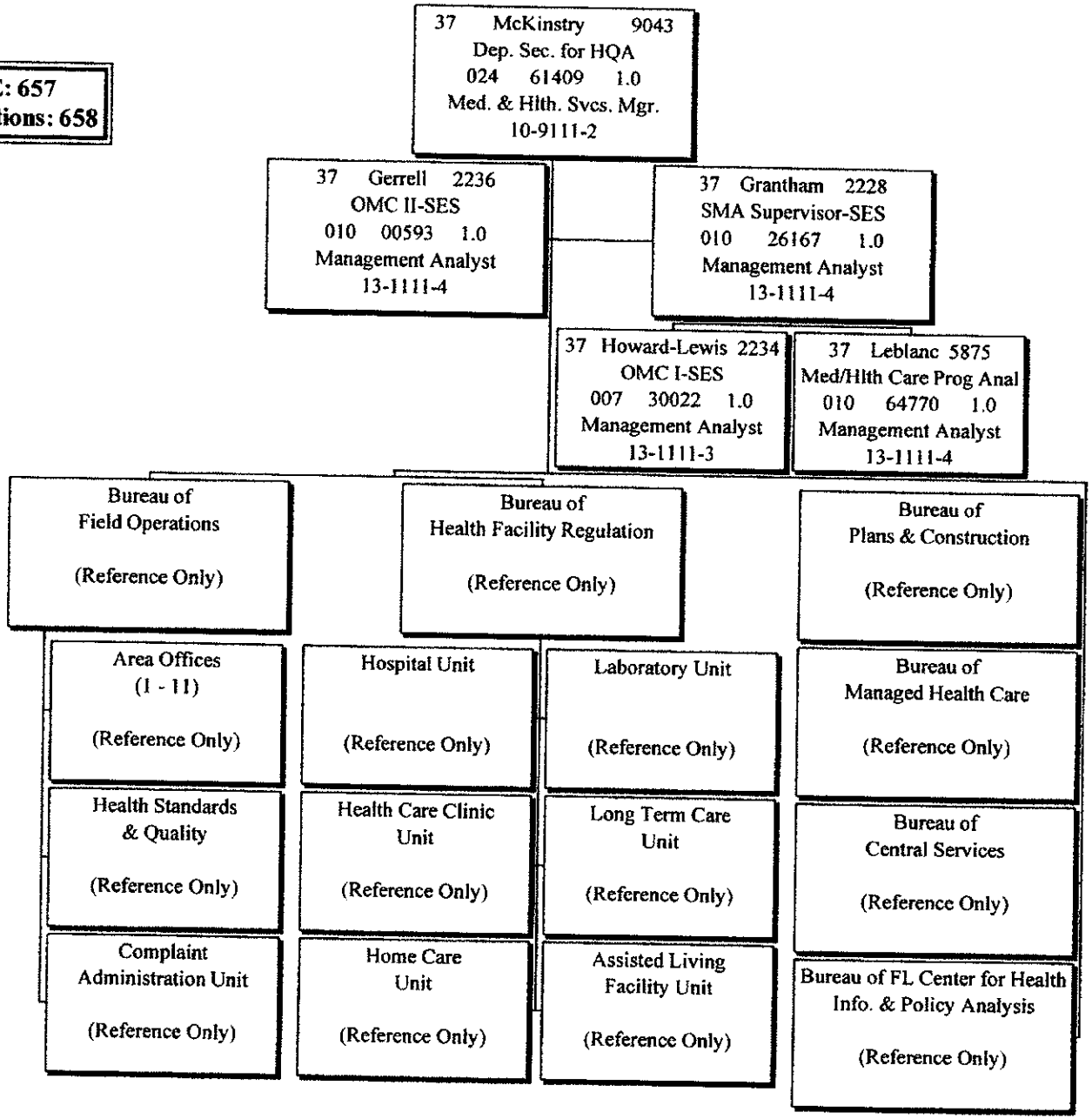
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Support Services



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

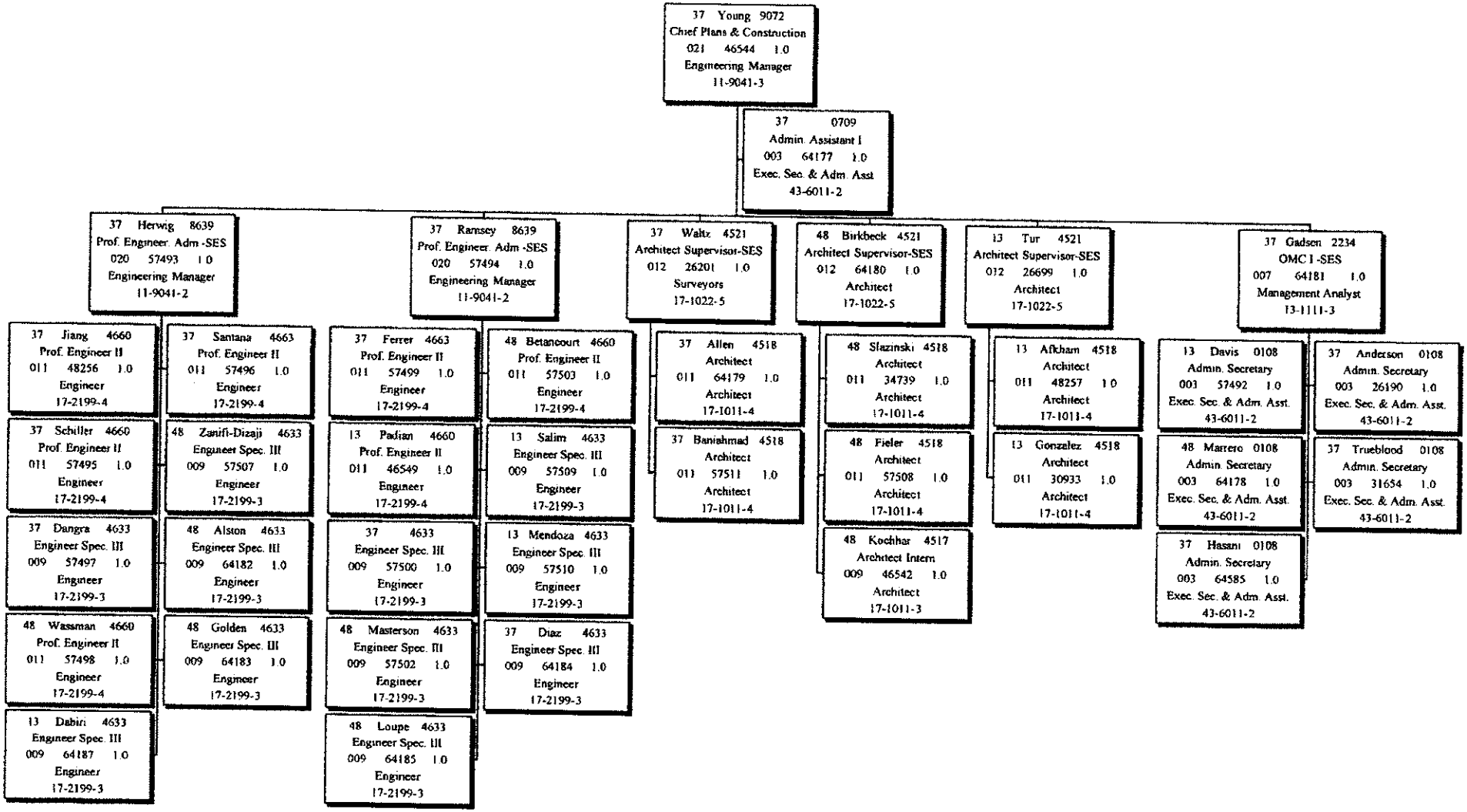
Effective Date: July 1, 2014
Org. Level: 68-30-00-00-000
FTEs: 6 Positions: 6

Division of HQA FTE: 657
Division Total # Positions: 658



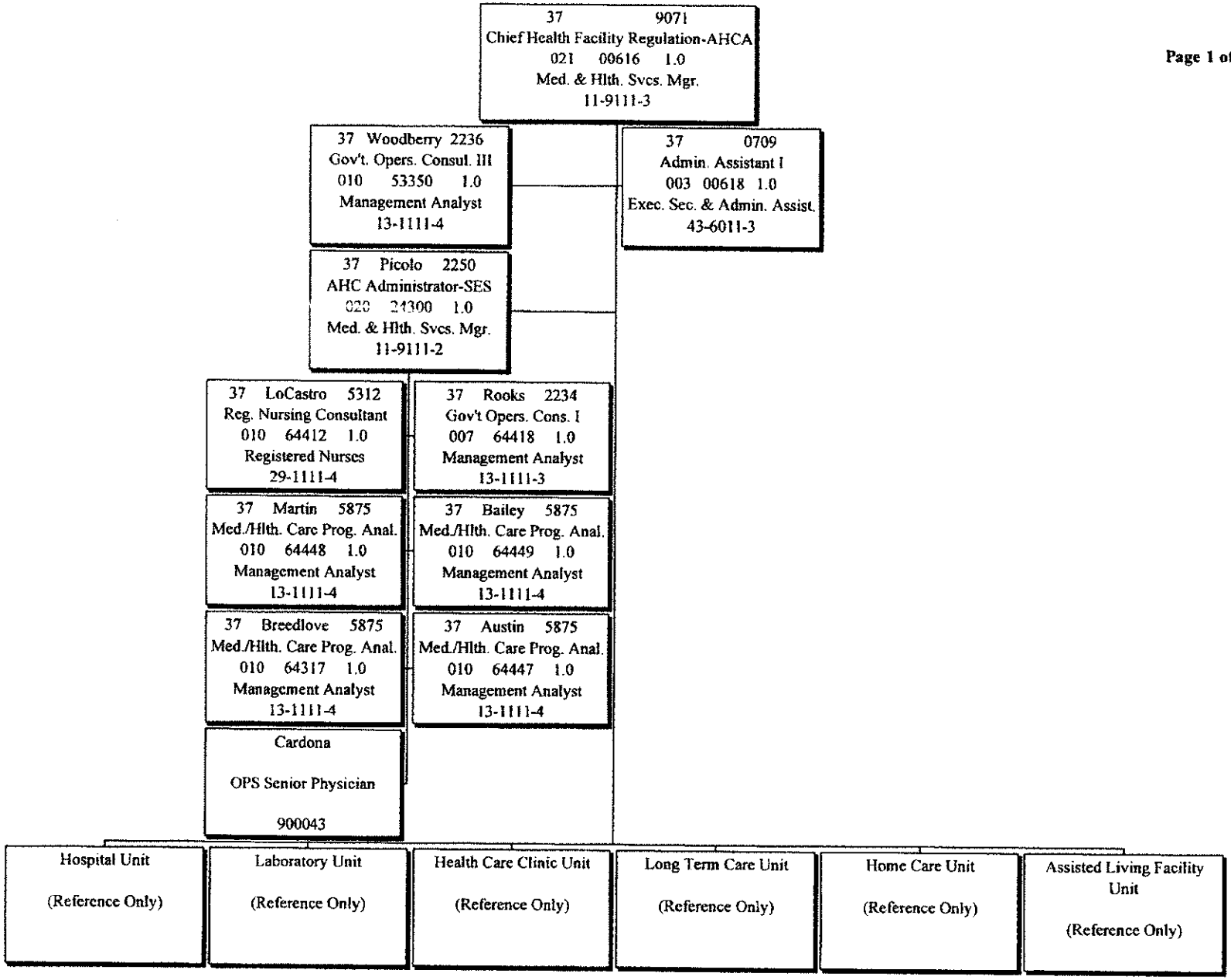
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance - Plans and Construction

Effective Date: July 1, 2014
Org. Level: 68 30 10 00 000
FTEs: 38 Positions: 38



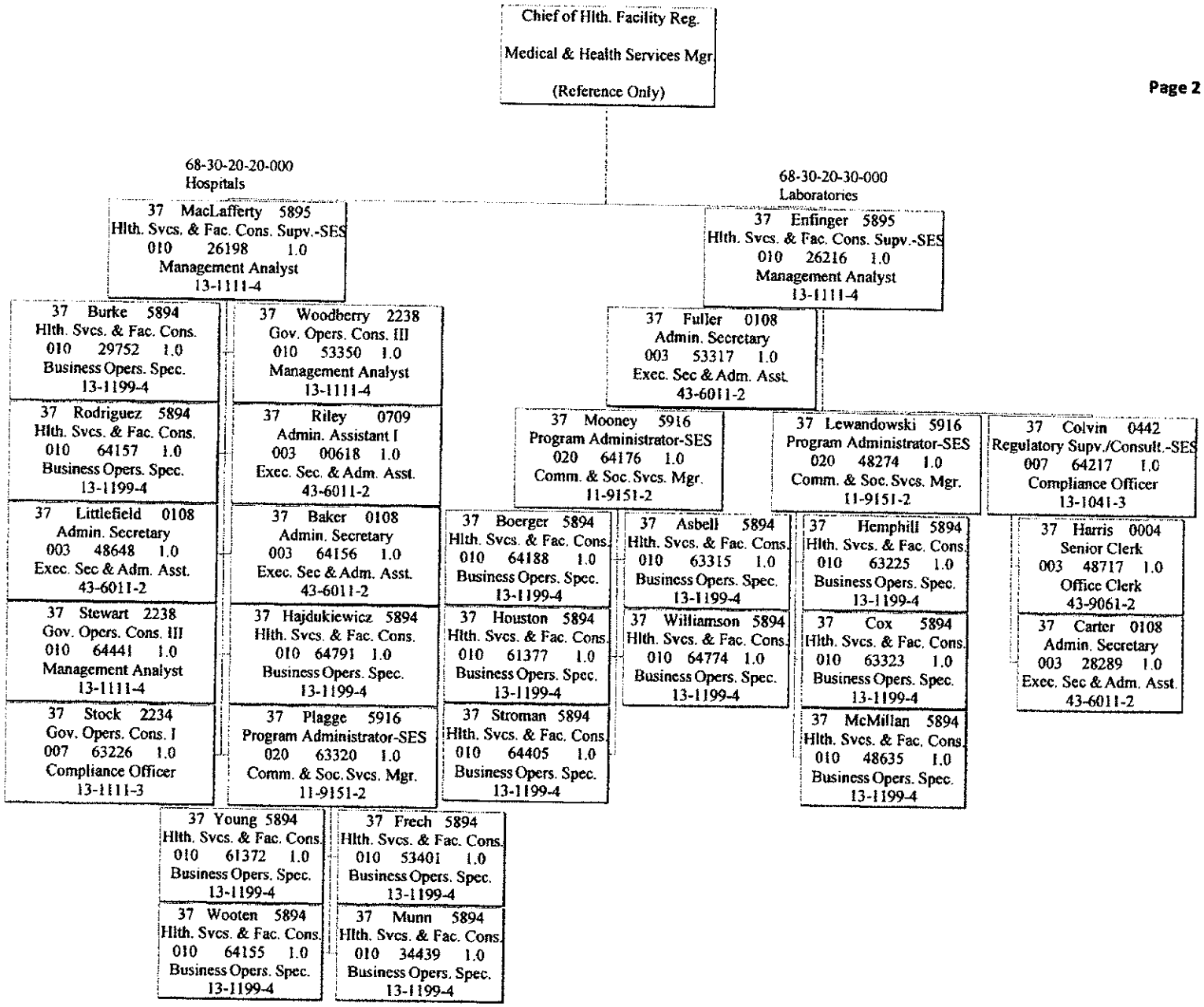
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Effective Date: July 1, 2014
Org. Level: 68-30-20-00-000
FTEs: 92.5 Positions: 93



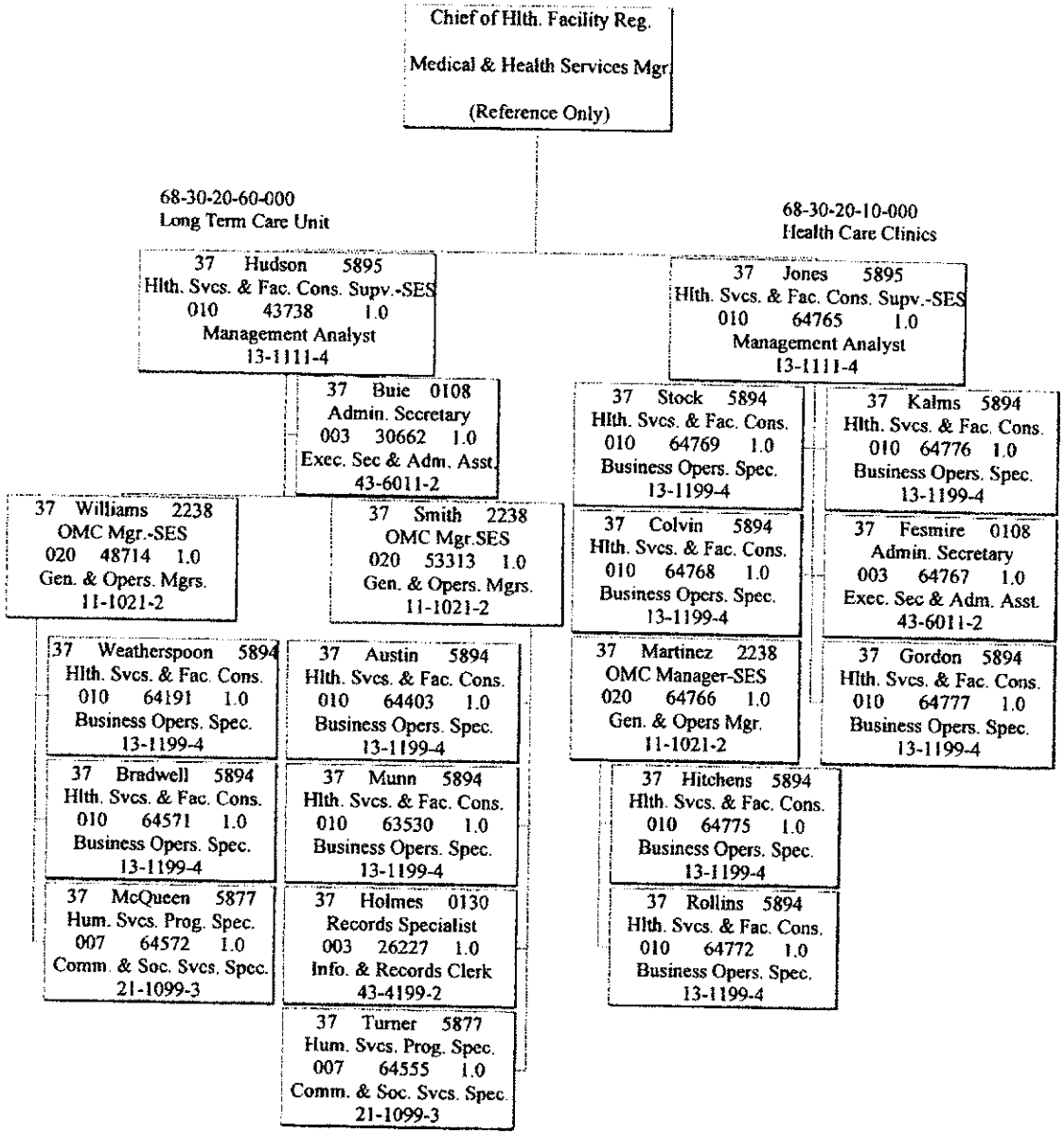
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Effective Date: July 1, 2014
FTEs: 92.5 Positions: 93



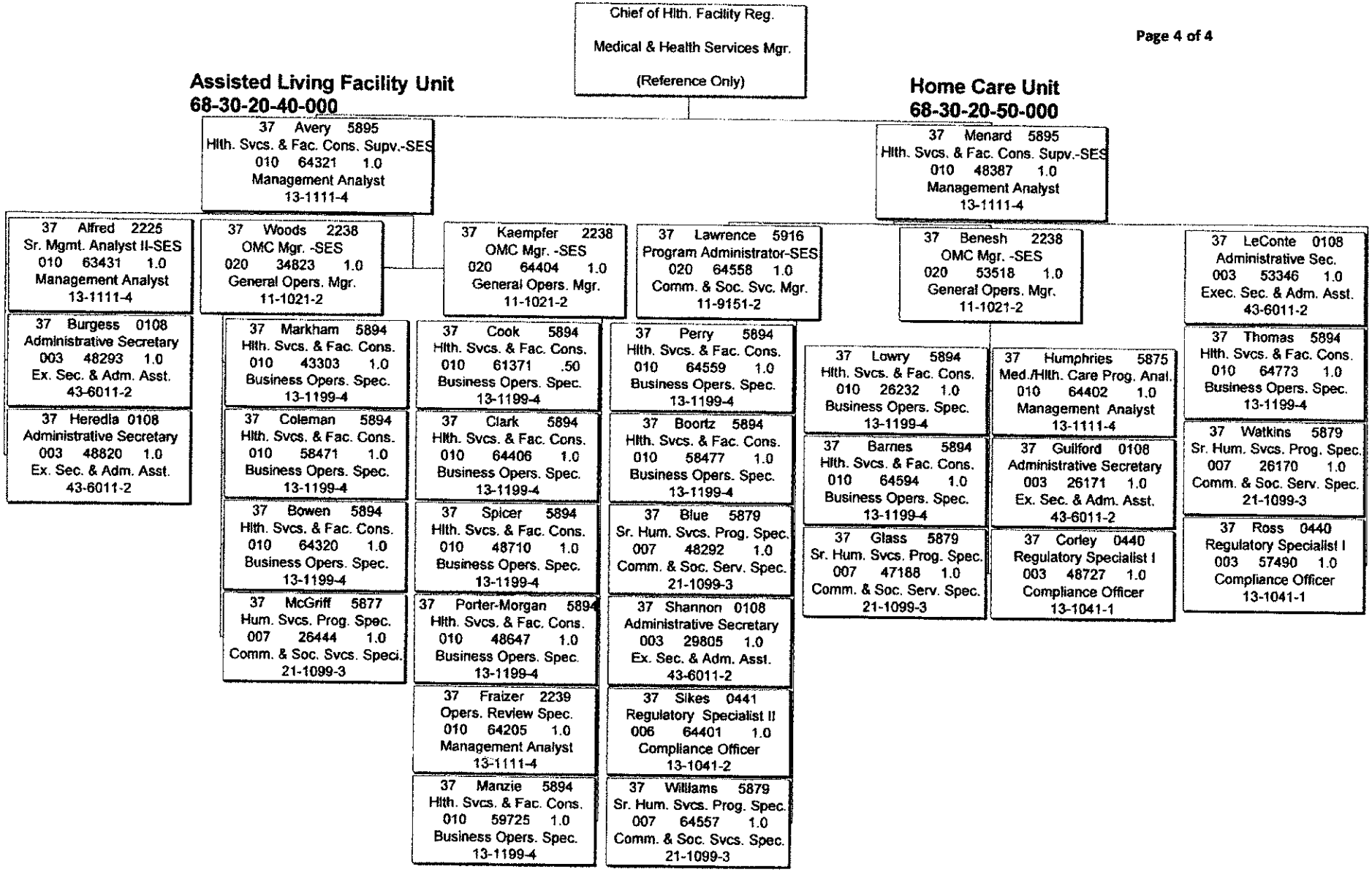
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Effective Date: July 1, 2014
FTEs: 92.5 Positions: 93



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

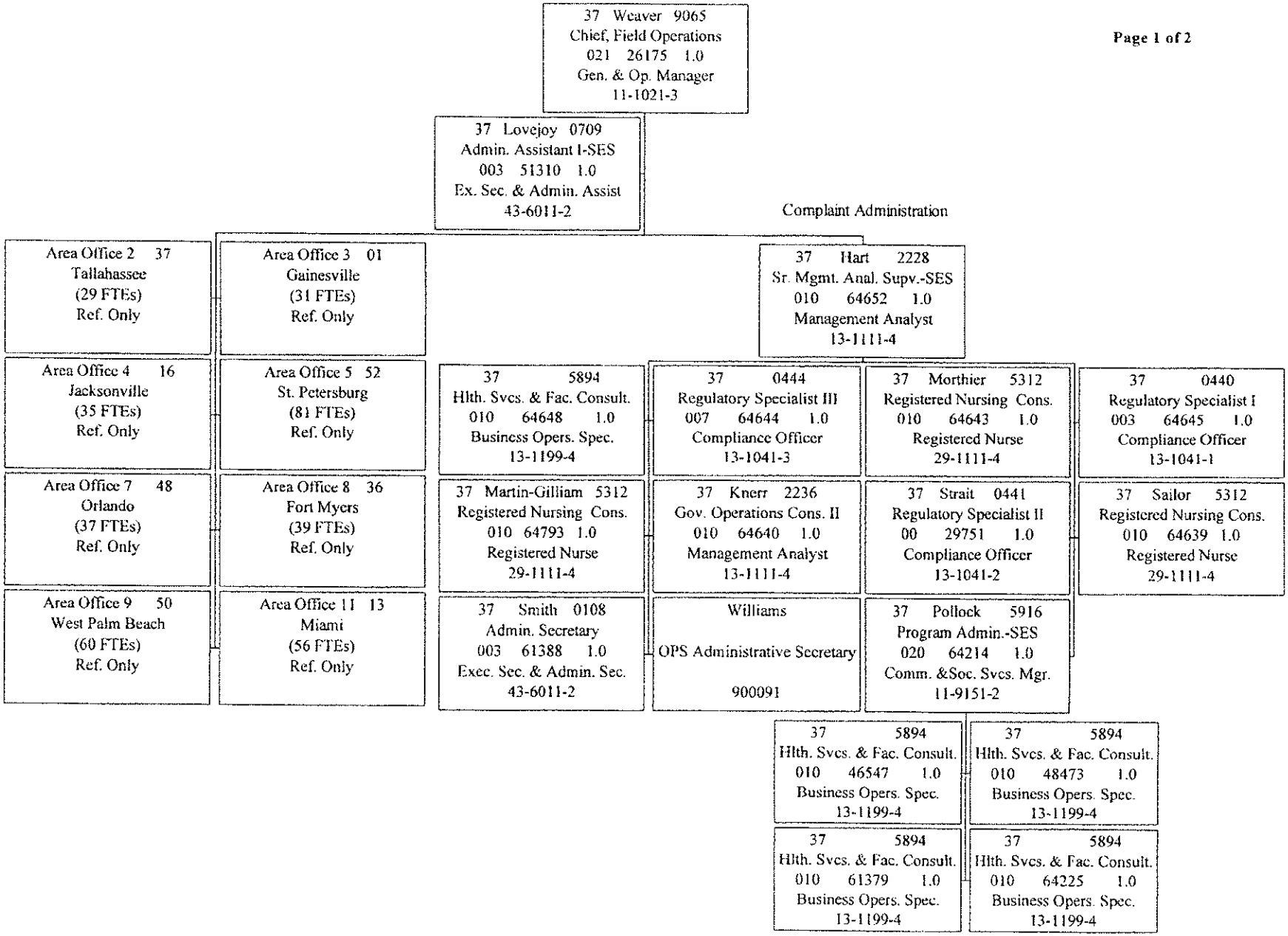
Effective Date: July 1, 2014
FTEs: 92.5 Positions: 93



C-3-3

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

Org Code: 68-30-30-00-000
Revised Date: July 1, 2014
FTEs: 17 Positions: 17



C-4

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

Revised Date: July 1, 2014
Org Level 68-30-30-30-00-000
FTEs: 30.5 Position: 31

Chief of
Field Operations

(Reference Only)

37 Smoak 6040
Field Office Manager
020 33416 1.0
Admin. Svcs. Manager
11-3011-2

Survey & Certification Support Branch

37 Higgins 2225
Senior Mgmt Anal. II-SES
010 64629 1.0
Management Analyst
13-1111-4

37 Gressel 2225
Government Analyst II
010 64630 1.0
Management Analyst
13-1111-4

37 0440
Regulatory Spec. I
003 64642 1.0
Compliance Officer
13-1041-1

37 Roberts-Taylor 0108
Admin. Secretary-SES
003 26191 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

16 Caswell 5312
Registered Nursing Consult.
010 53519 1.0
Registered Nurse
29-1111-4

37 Kaczmarek 5312
Registered Nursing Consult.
010 64569 1.0
Registered Nurse
29-1111-4

37 Alday 2225
Government Analyst II
010 64633 1.0
Management Analyst
13-1111-4

16 5312
Registered Nursing Consult.
010 25997 1.0
Registered Nurse
29-1111-4

52 Maloney 2225
Government Analyst II
010 64161 1.0
Business Operations
13-1111-4

37 Koch 2225
Senior Mgmt Anal. Supv.-SES
010 30613 1.0
Management Analyst
13-1111-4

37 2224
Government Analyst I
007 26210 1.0
Management Analyst
13-1111-3

37 Everett 2224
Government Analyst I
007 64729 1.0
Management Analyst
13-1111-3

37 Gray 2236
Government Opers. Cons. II
010 26425 1.0
Management Analyst
13-1111-4

37 Howard 2236
Government Opers. Cons. II
010 48715 1.0
Management Analyst
13-1111-4

48 Wells 5894
Hlth. Svcs. & Fac. Cons.
010 64162 1.0
Business Opers. Spec.
13-1199-4

50 Frias 5875
Med/Hlth Care Prog. Anal.
010 34834 1.0
Management Analyst
13-1111-4

16 Standifer 5879
Sr. HSPS
007 53581 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

01 5879
Sr. HSPS
007 20678 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

01 5294
Registered Nurse Spec.
008 11520 1.0
Registered Nurse
29-1111-2

37 Avery 2238
OMC Manager-SES
020 28050 1.0
General & Opers. Mgr.
11-1021-2

29 Manville 5875
Med/Hlth Care Prog. Anal.
010 29840 1.0
Management Analyst
13-1111-4

48 Kruppenbacher 5879
Sr. HSPS
007 58472 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

13 5879
Sr. HSPS
007 61419 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

50 5294
Registered Nurse Spec.
008 64771 1.0
Registered Nurse
29-1111-2

13 Forrester 5875
Med/Hlth Care Prog. Anal.
010 61418 1.0
Management Analyst
13-1111-4

29 Evans 5879
Sr. HSPS
007 48234 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

37 0108
Admin. Secretary
003 64730 .5
Exec. Sec. & Admin. Asst.
43-6011-2

13 Exil 5875
Med/Hlth Care Prog. Anal.
010 64382 1.0
Management Analyst
13-1111-4

37 Byrd 5879
Sr. HSPS
007 31496 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

13 Davis 5294
Registered Nurse Spec.
008 63234 1.0
Registered Nurse
29-1111-2

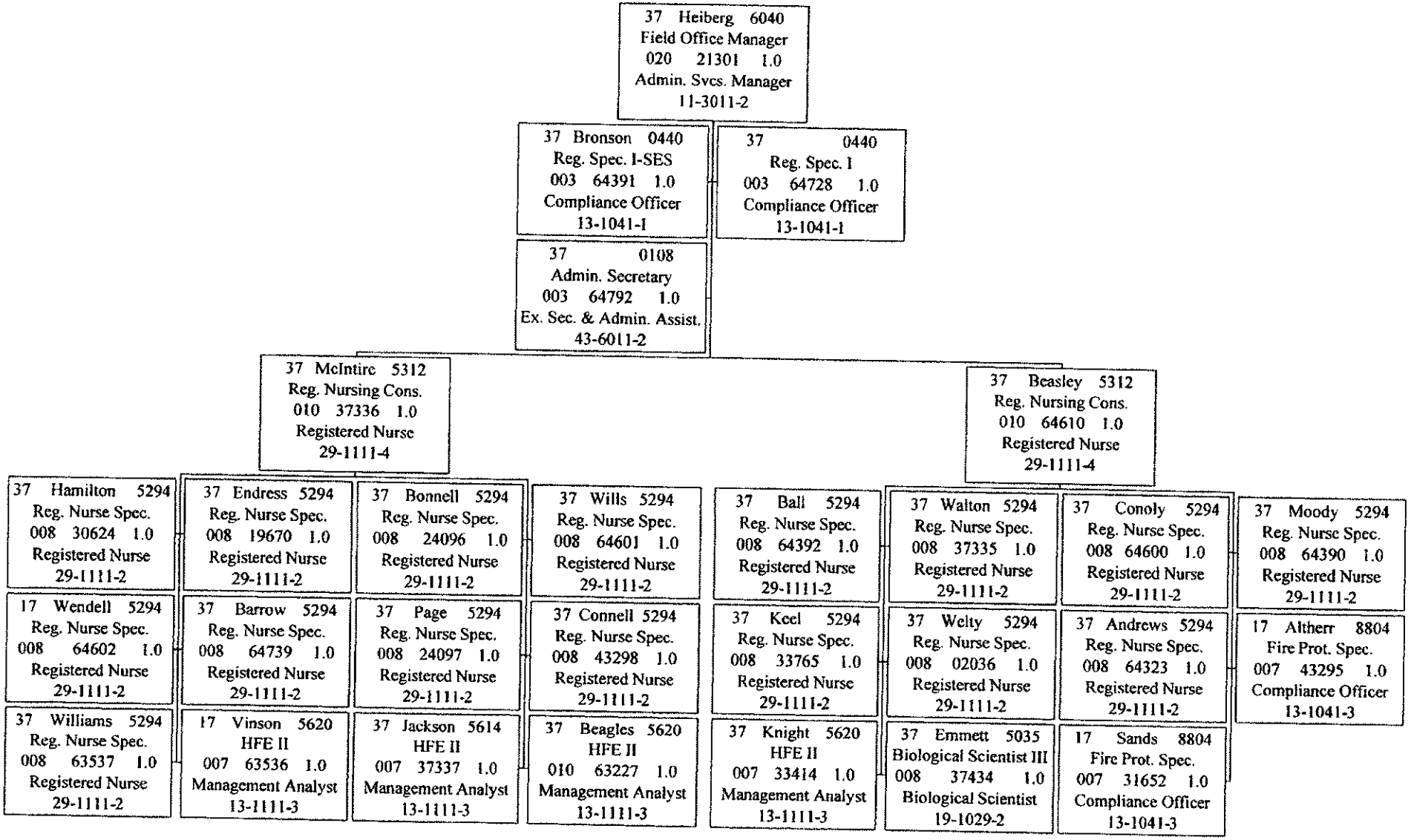
C-4-1

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 2 - Tallahassee

Effective Date: July 1, 2014
Org. Level: 68-30-30-02-000
FTEs: 29 Positions: 29



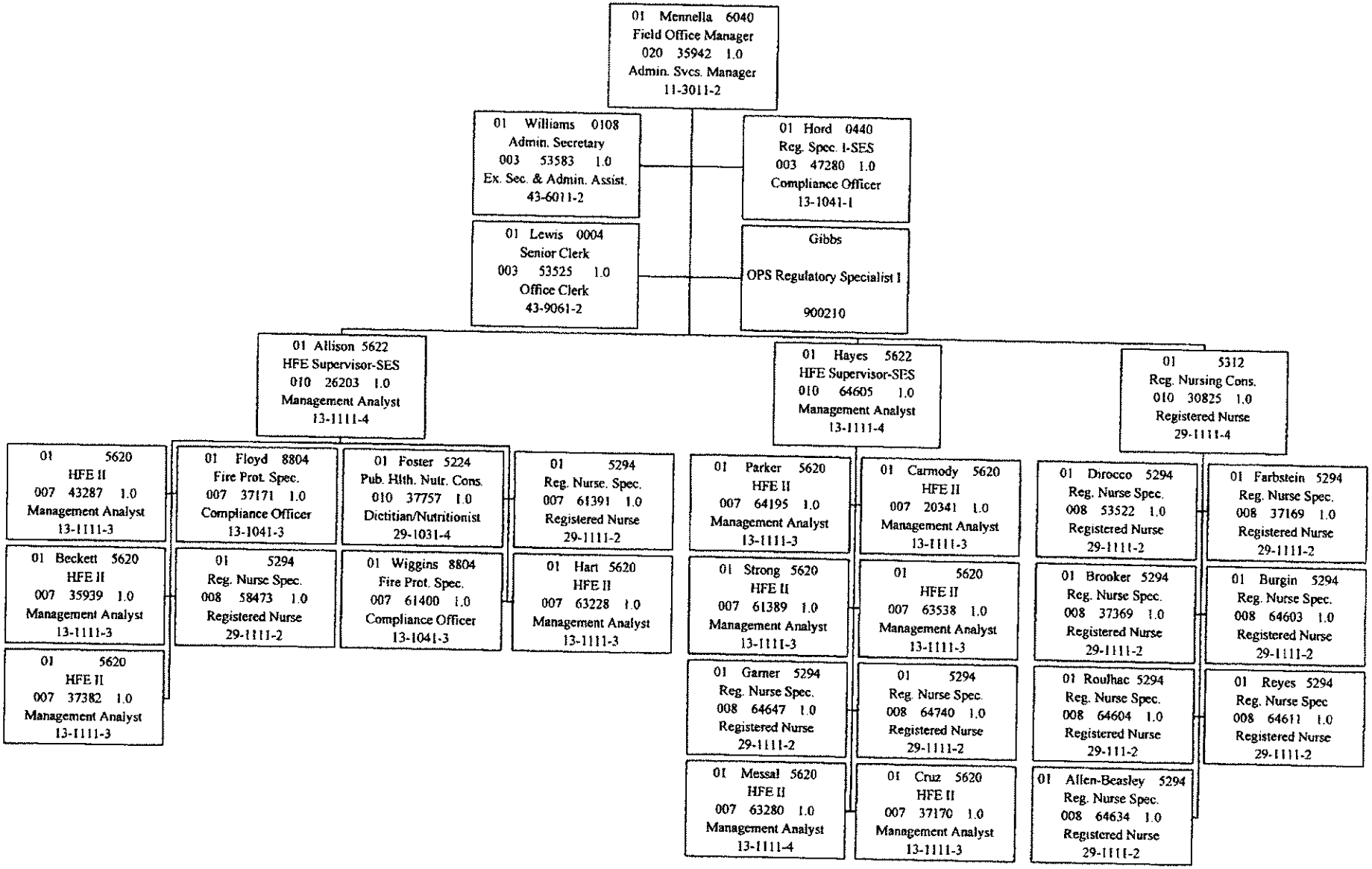
C-4-2

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 3 Alachua

Effective Date: July 1, 2014
Org. Level: 68-30-30-03-000
FTEs: 31 Positions: 31



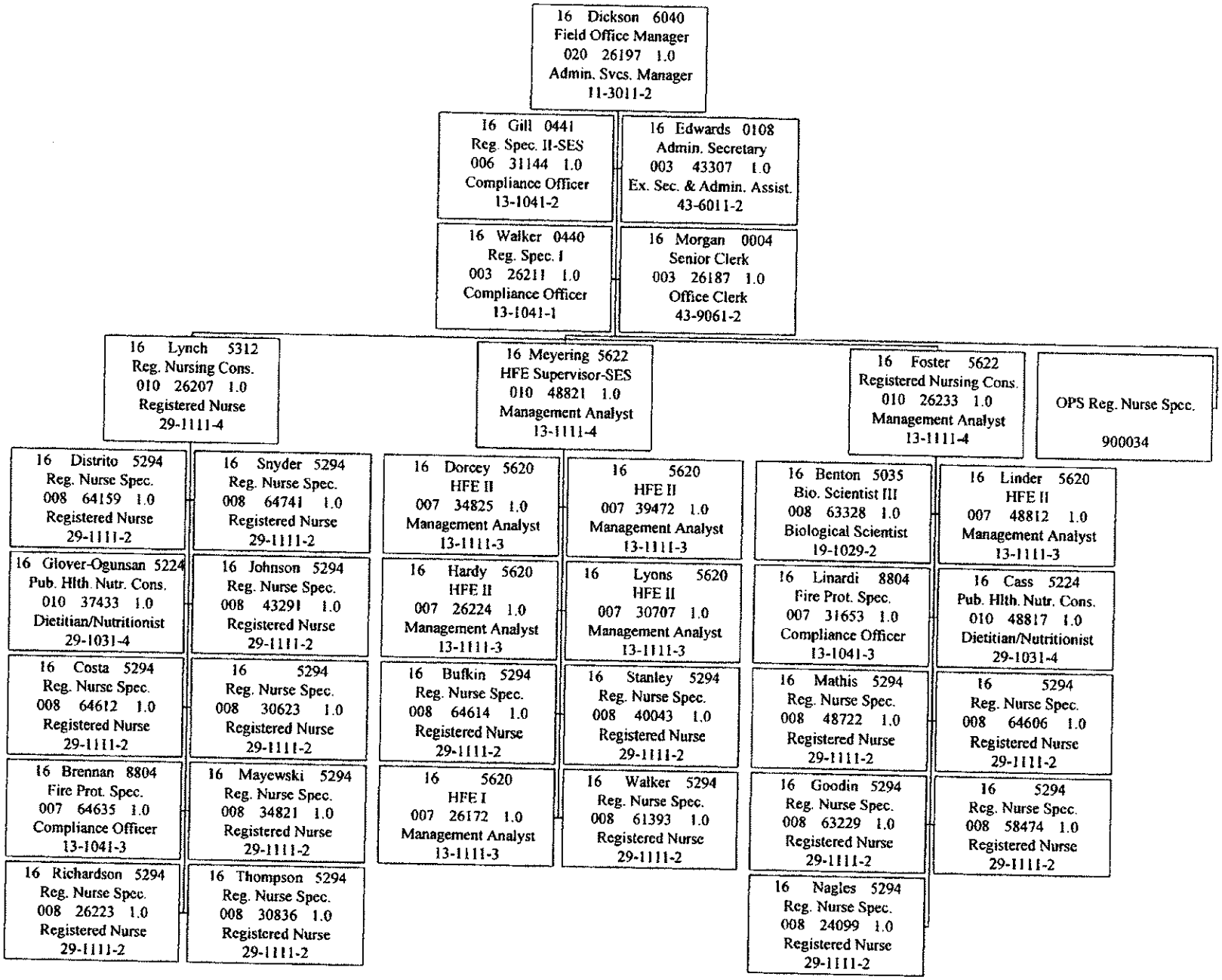
C-4-3

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 4 - Jacksonville

Effective Date: July 1, 2014
Org. Level: 68-30-30-04-000
FTEs: 35 Positions: 35

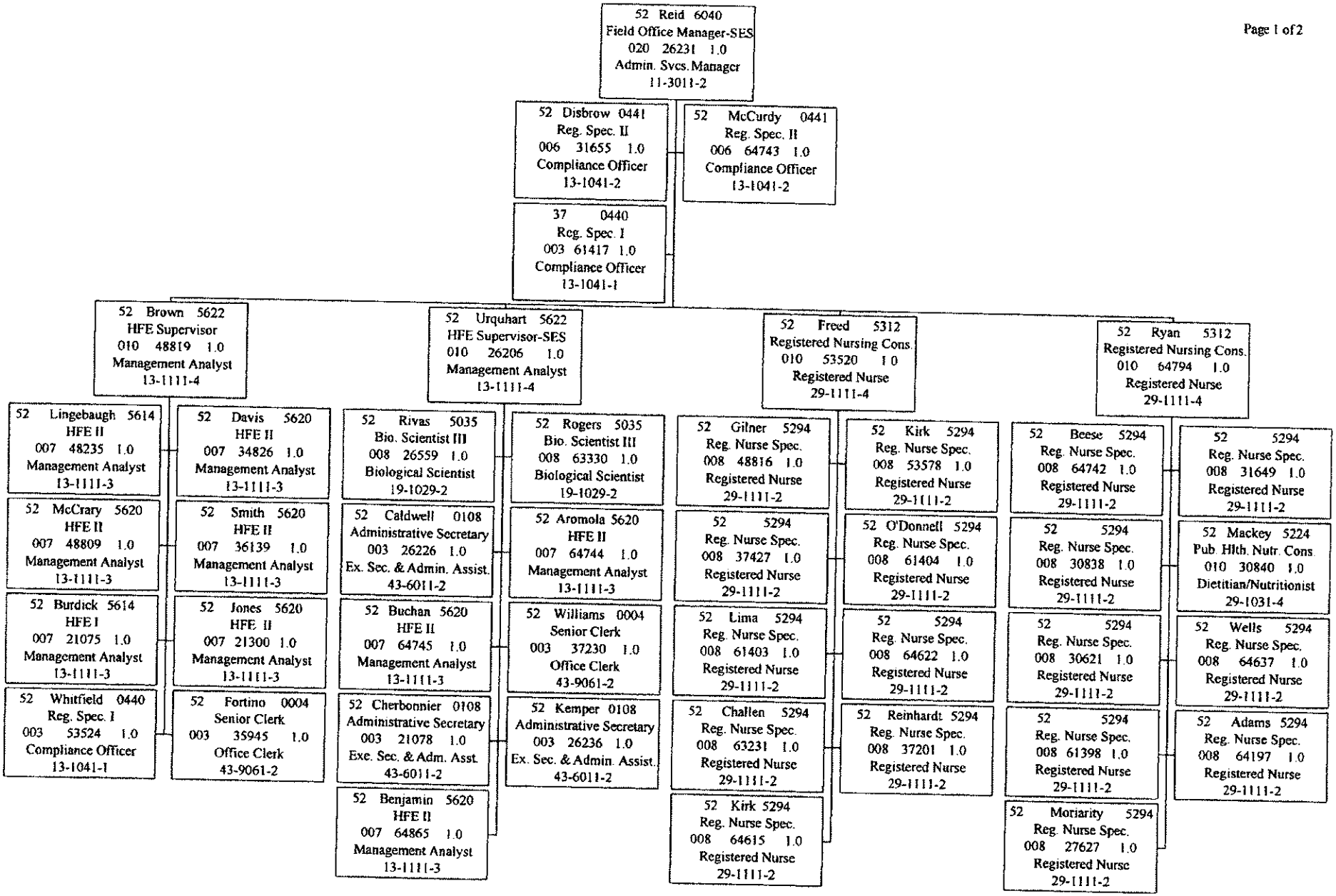


AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

Area 5 - St. Petersburg

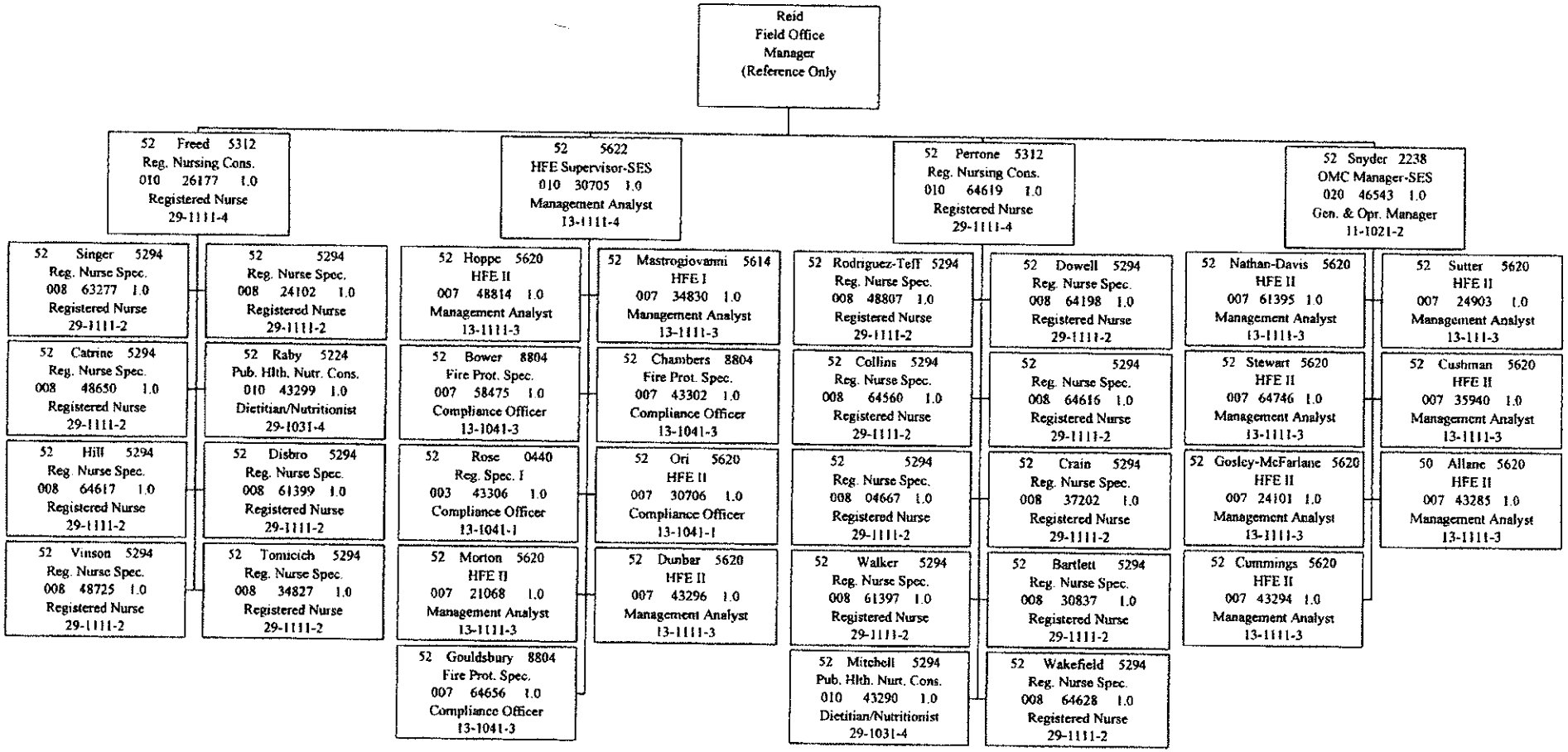
Revised Date: July 1, 2014
Org Level: 68-30-30-05-000
FTEs: 81 Positions: 81



C-4-5

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

Effective Date: July 1, 2014
Org. Level: 68-30-30-05-000
FTEs: 81 Positions: 81

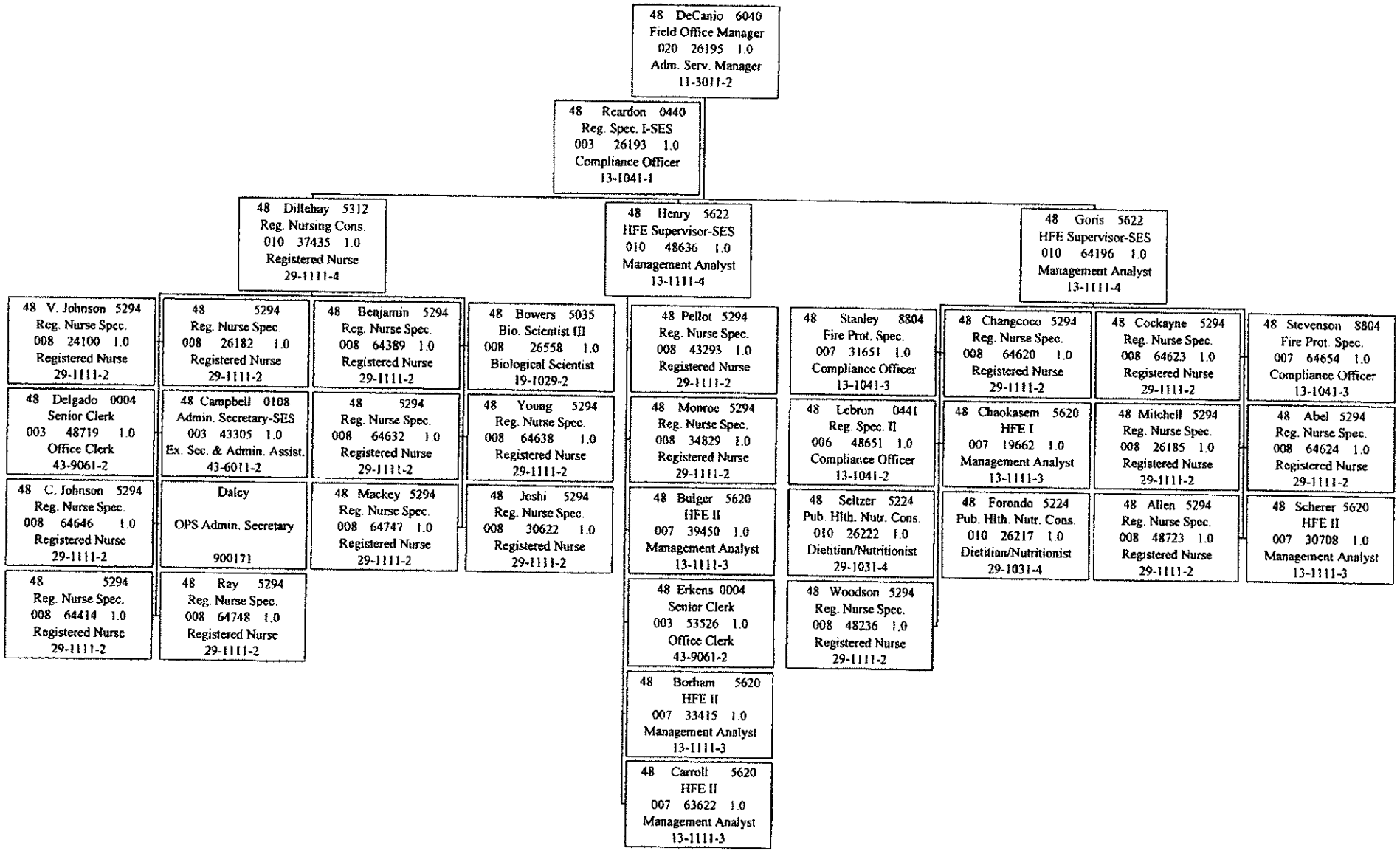


AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

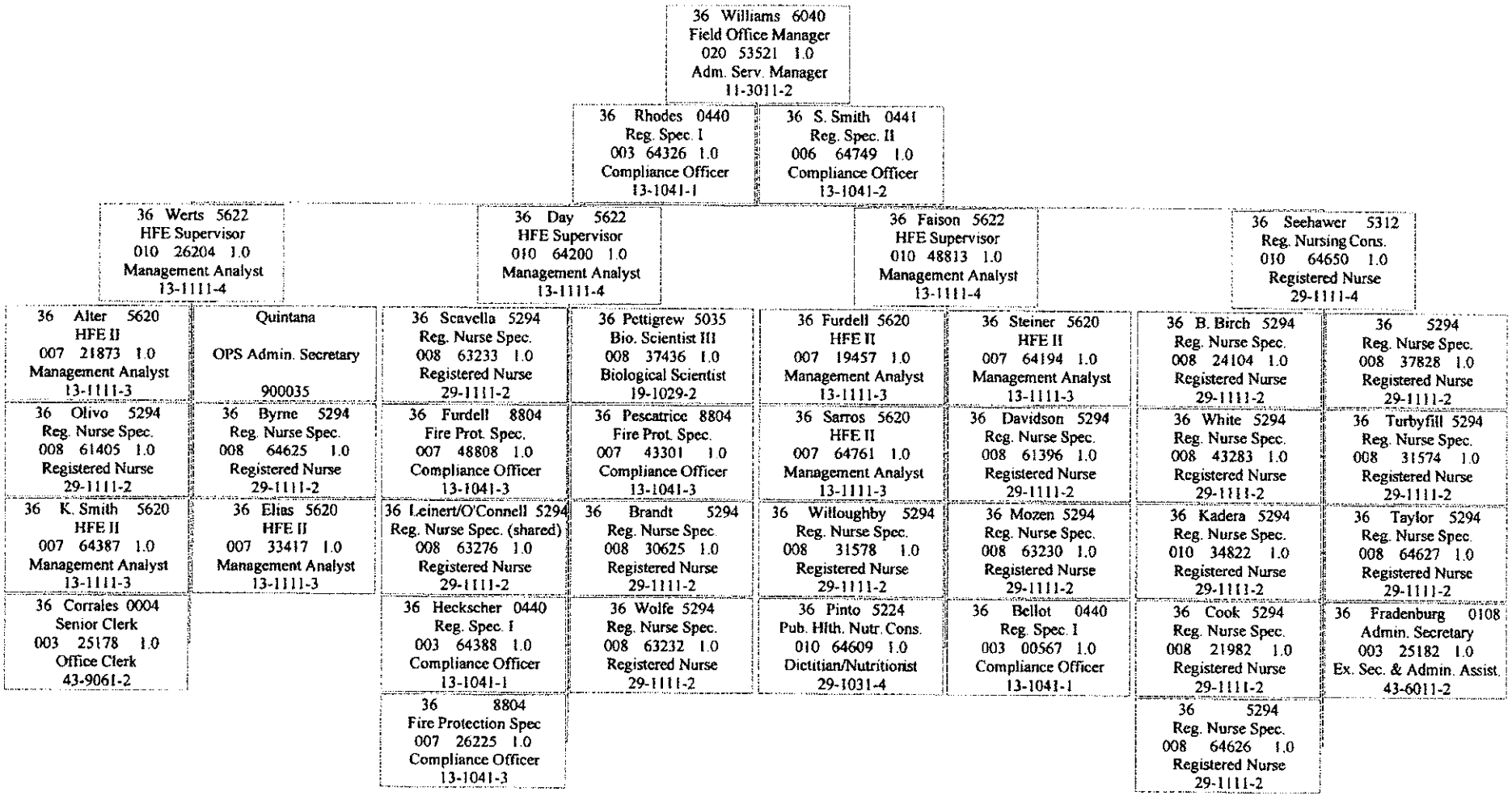
Area 7 - Orlando

Effective Date: July 1, 2014
Org. Level: 68-30-30-07-000
FTEs: 37 Positions: 37



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

Effective Date: July 1, 2014
Org. Level: 68-30-30-08-000
FTEs: 39 Positions: 39

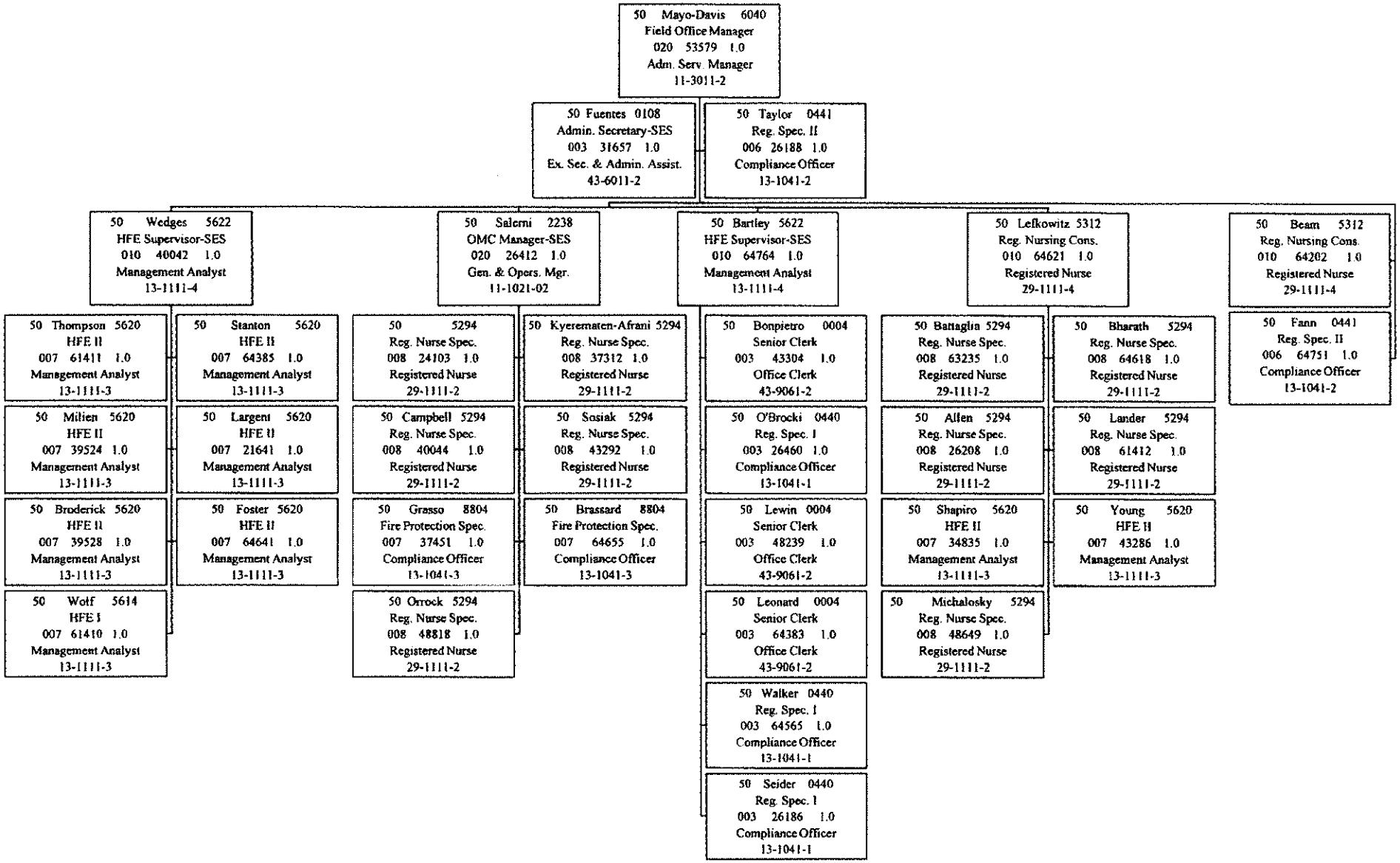


AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

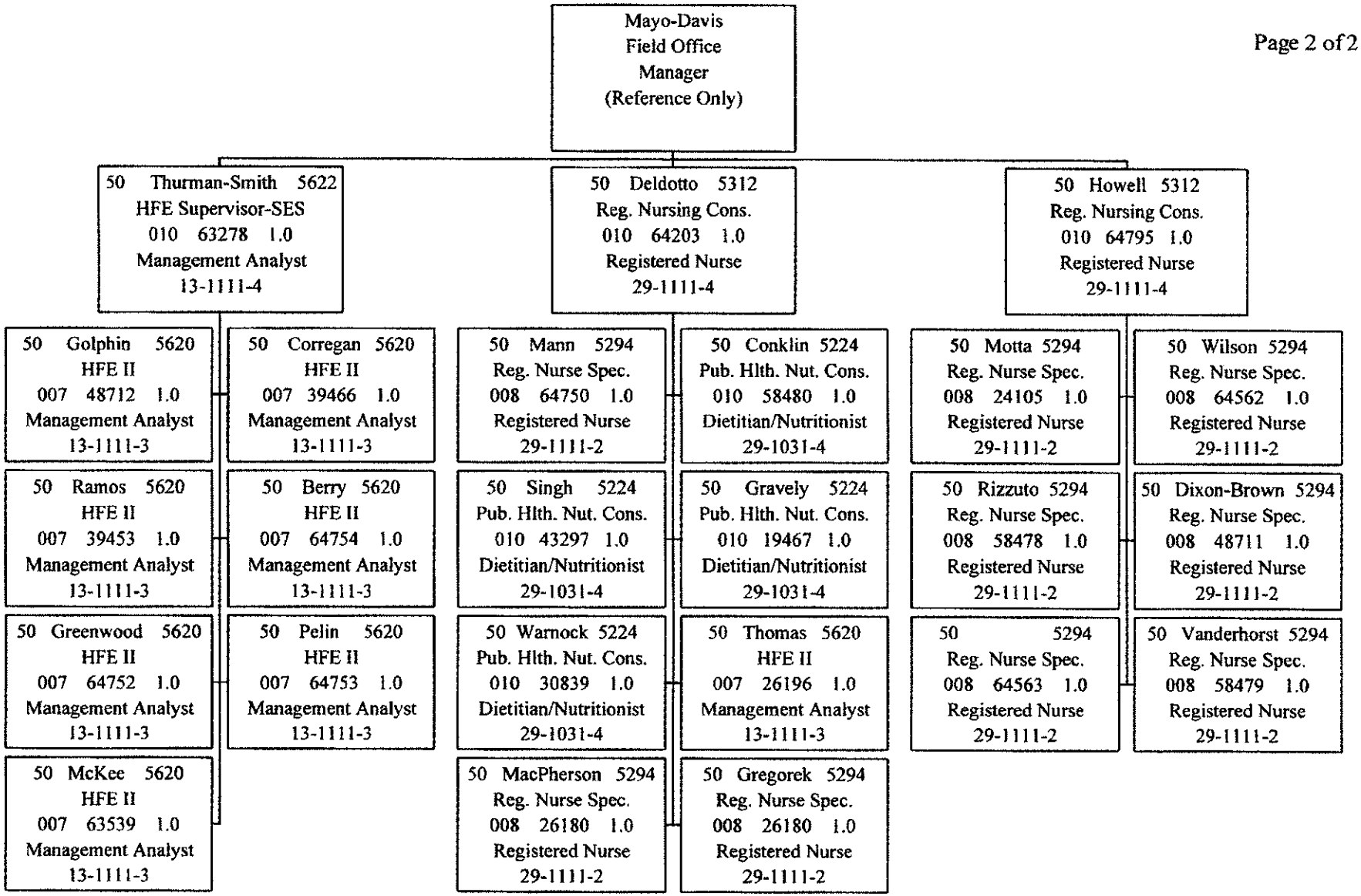
Area 9 - Delray Beach

Effective Date: July 1, 2014
Org. Level: 68-30-30-09-000
FTEs: 60 Positions: 60



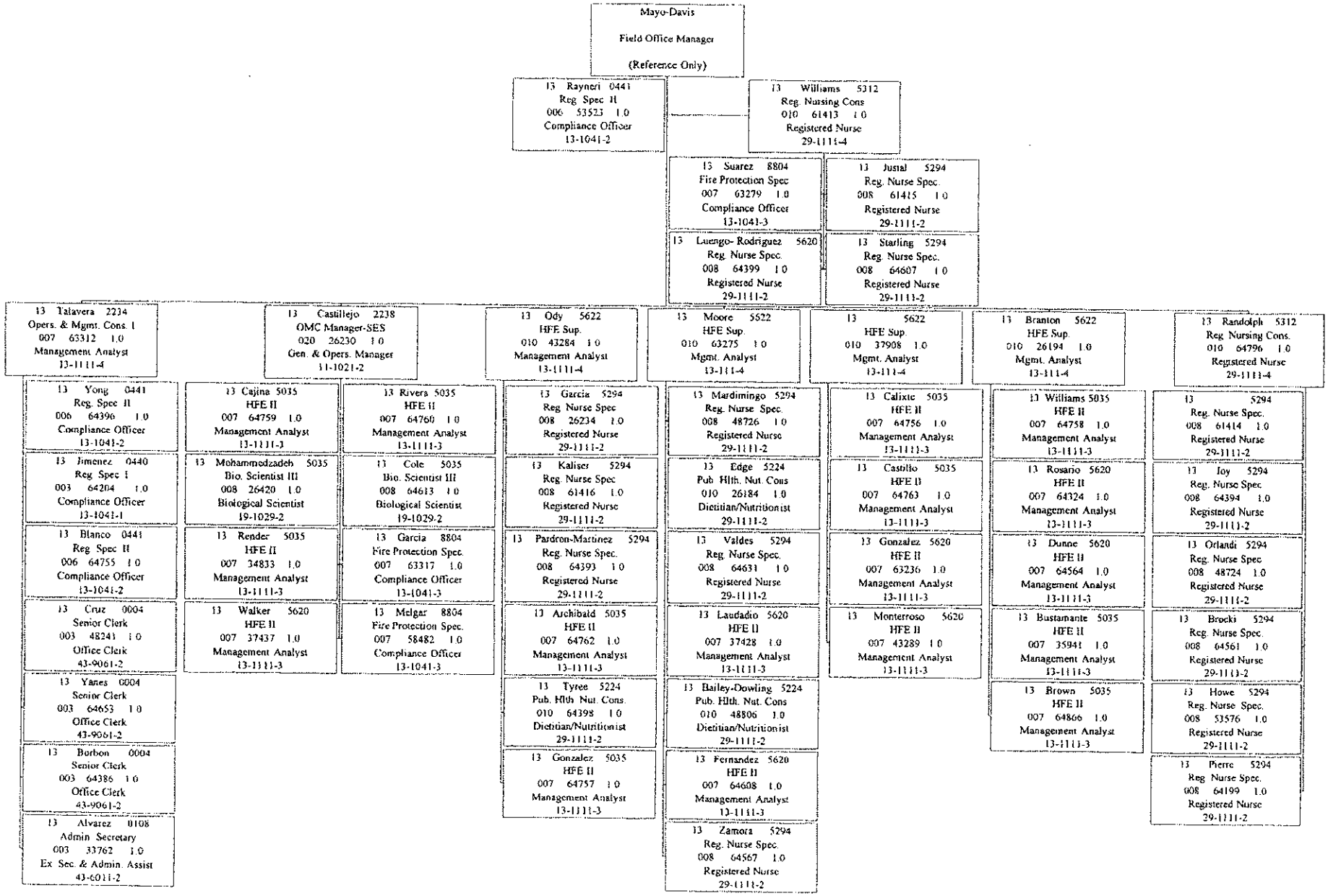
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 9 - Delray Beach

Effective Date: July 1, 2014
Org Code: 68-30-30-09-000
FTEs: 60 Positions: 60



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

Org. Level: 68 30 30 11 000
Revised Date: July 1, 2014
FTEs: 56 Positions: 56

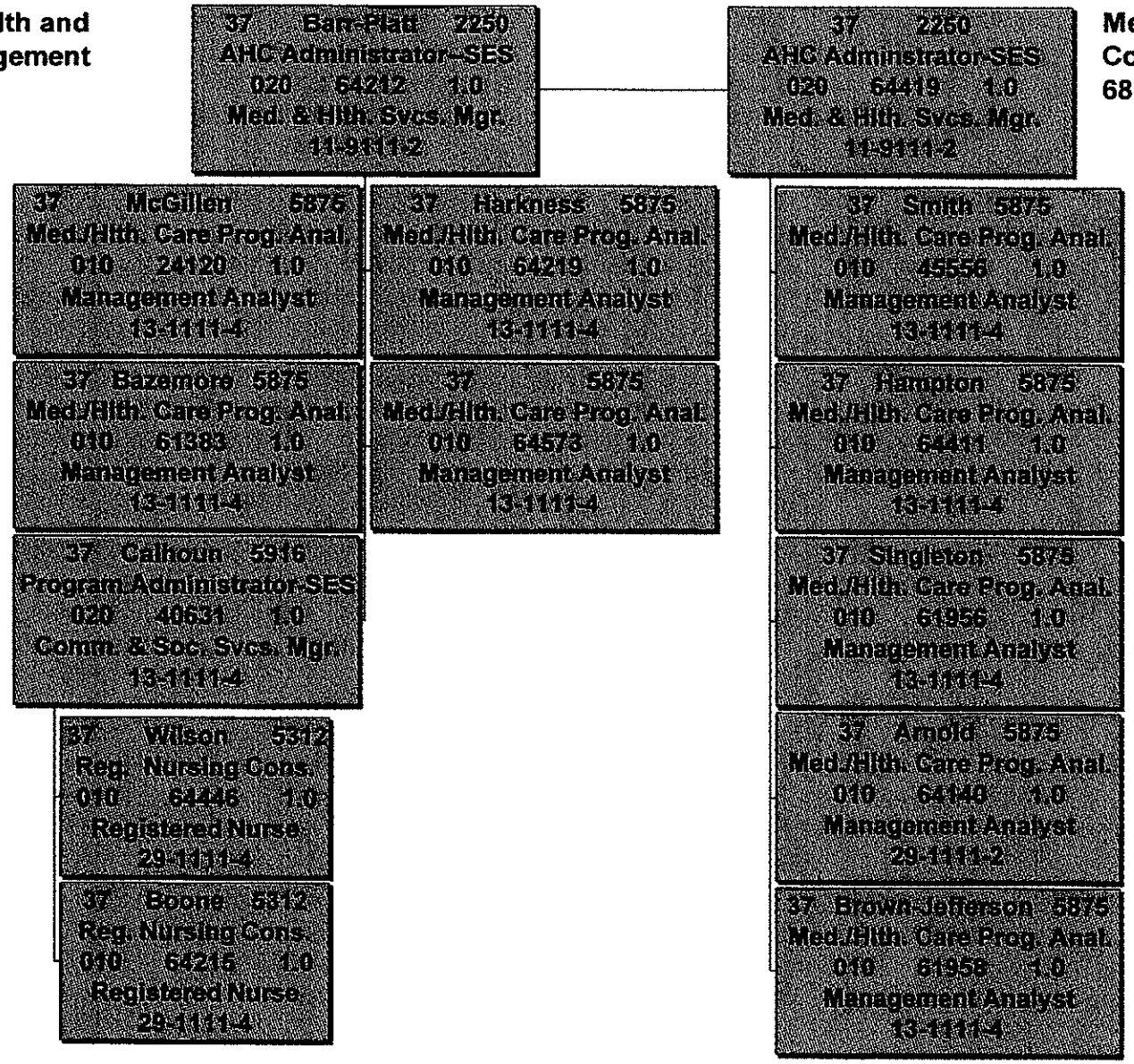


C-4-11

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

Effective Date: July 1, 2014
FTEs: 15 Positions: 15

Behavioral Health and Contract Management Unit
68-30-50-40-000



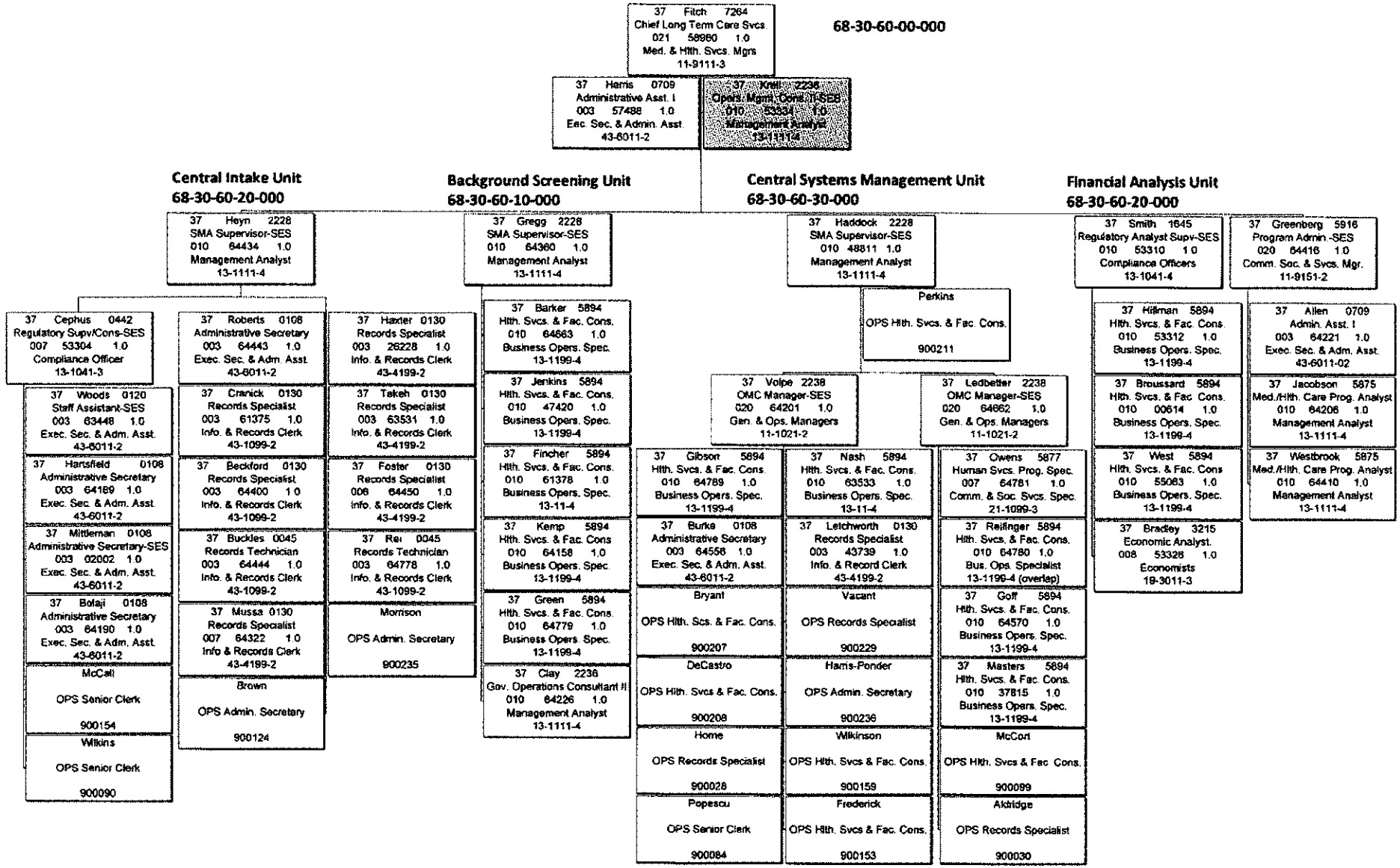
Medicaid Program Compliance II
68-30-50-30-000

Shaded positions supervised by Chief of Medicaid Services, Division of Medicaid

Shaded positions supervised by Field Office Manager, Division of Medicaid

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Bureau of Central Services

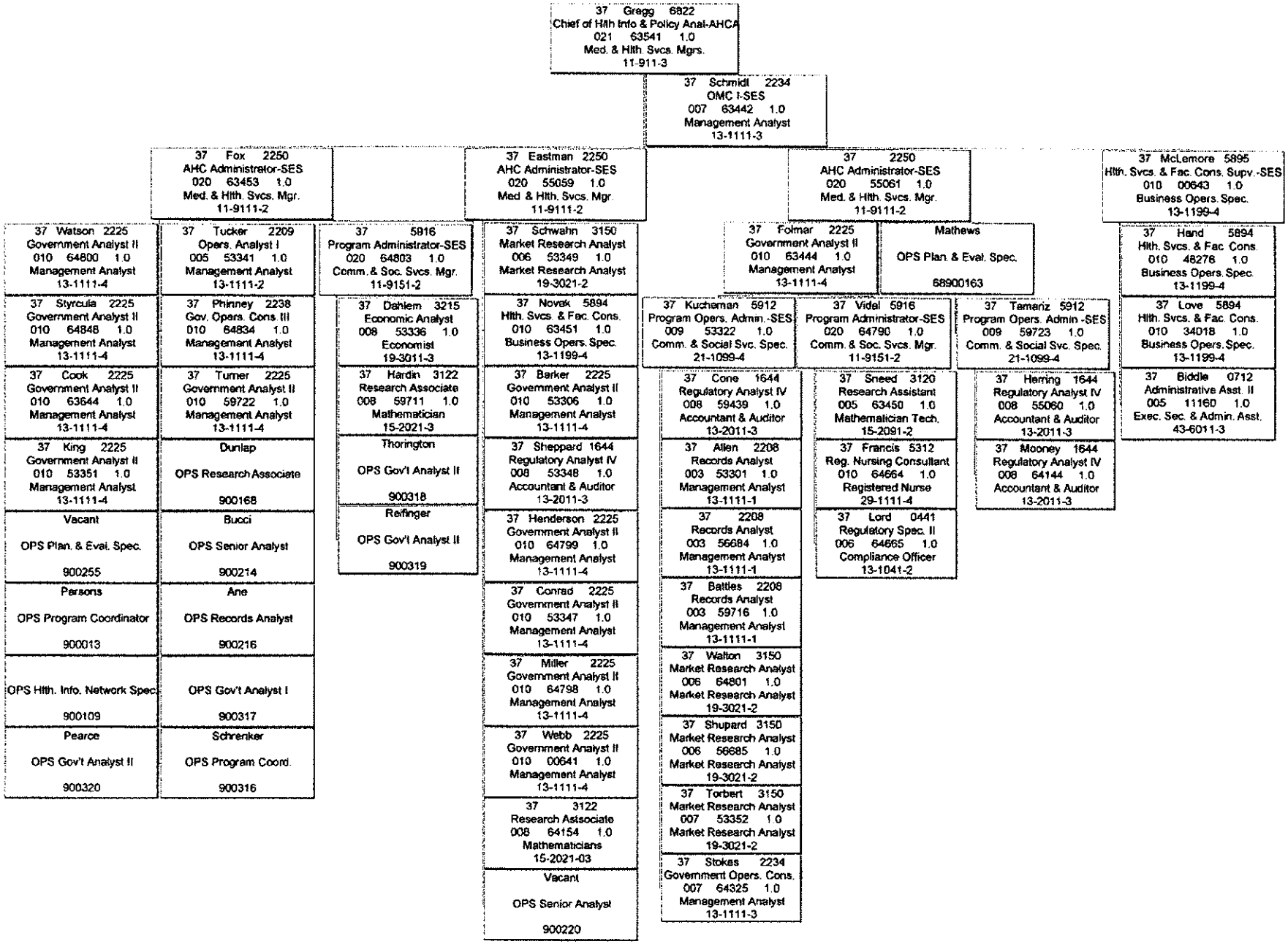
Effective Date: July 1, 2014
FTEs: 44 Positions: 44



Shaded position reports to 6830000000 - HQA Director's Office

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

Effective Date: July 1, 2014
Org Level: 68-30-70-00-000
FTEs: 45 Positions: 45

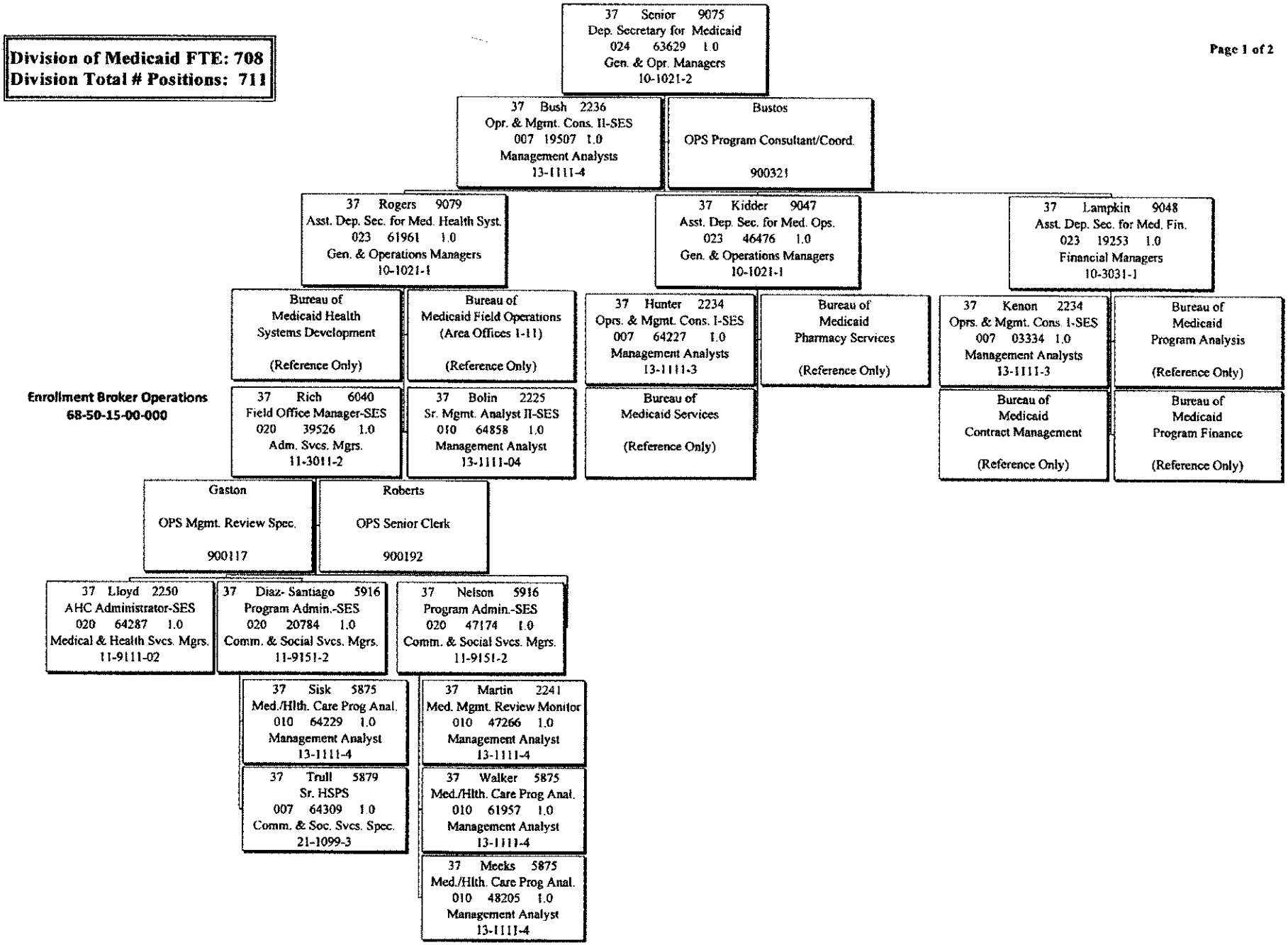


C-3-4

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

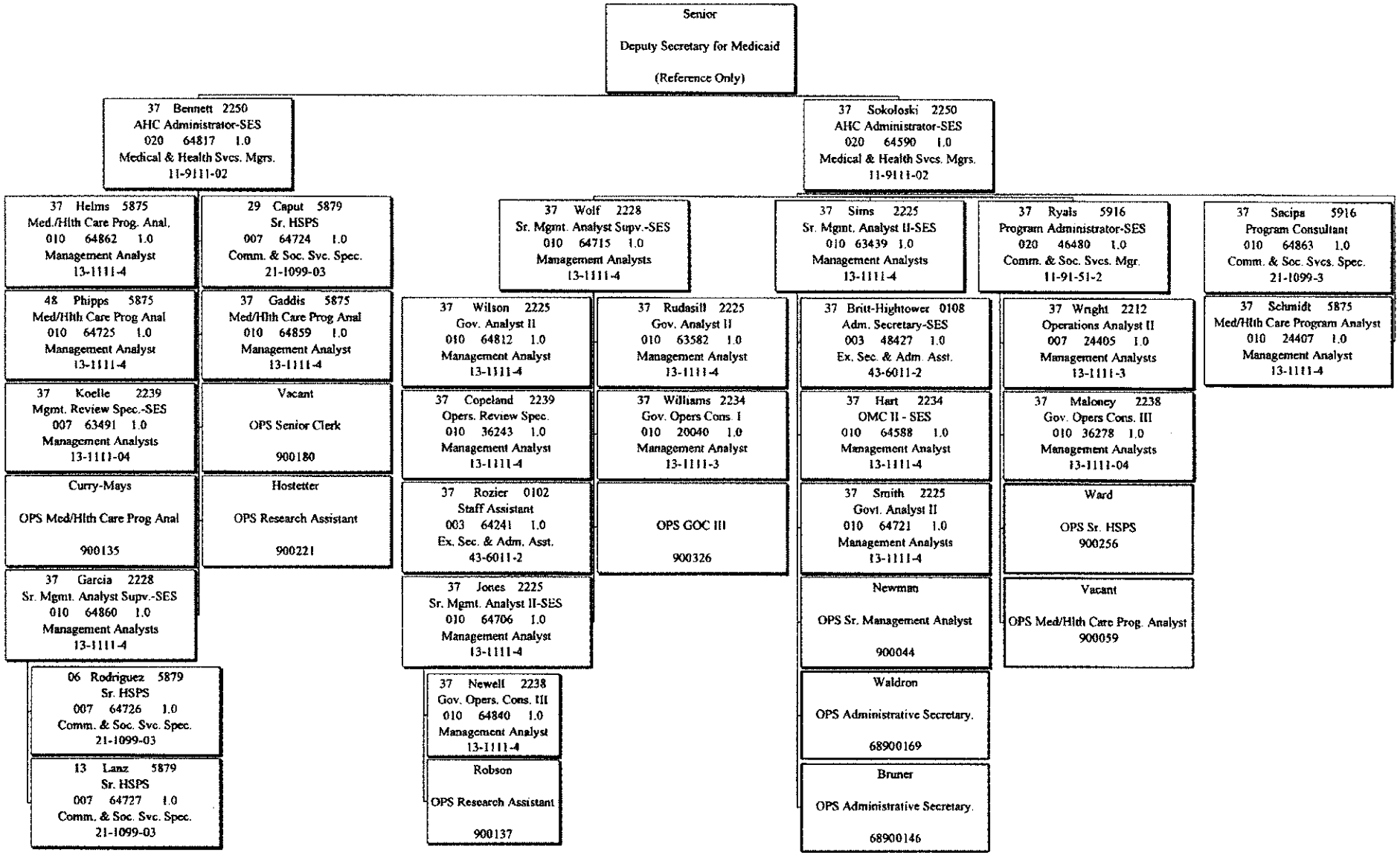
Org. Level: 68-50-00-00-000
Effective Date: July 1, 2014
FTEs: 47 Positions: 47

Division of Medicaid FTE: 708
Division Total # Positions: 711



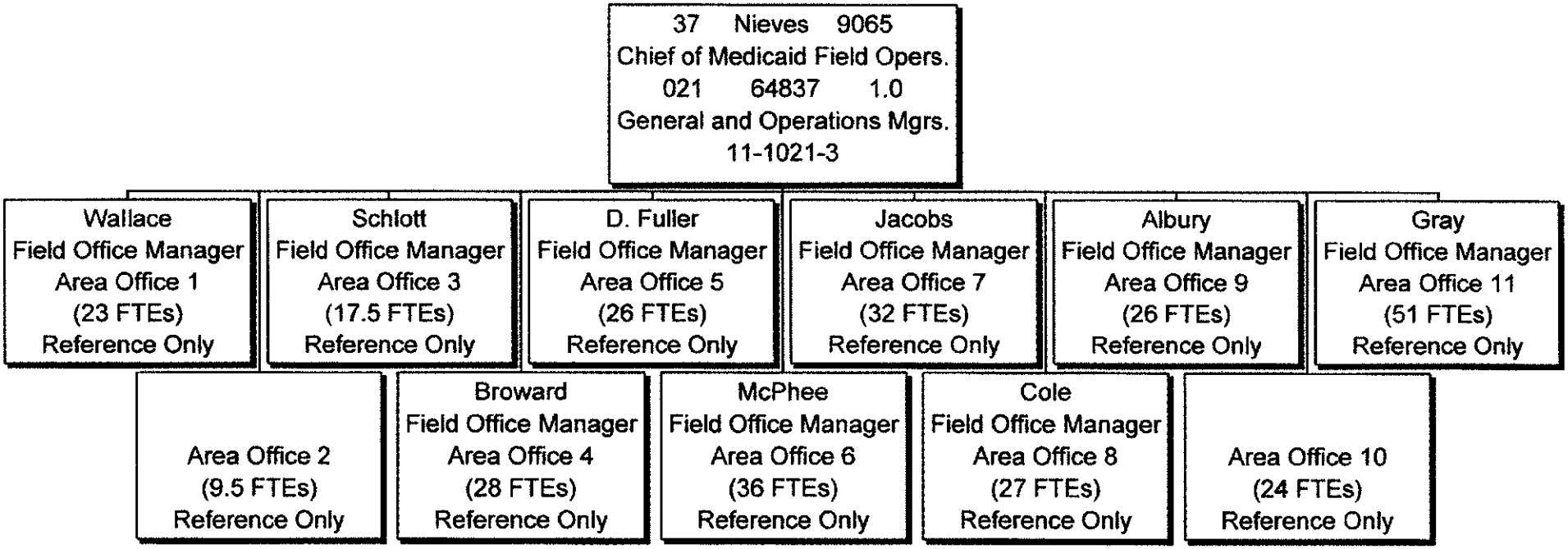
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid - Deputy Secretary's Office

Effective Date: July 1, 2014
Org. Level: 68-50-00-00-000
FTEs: 47 Positions: 47



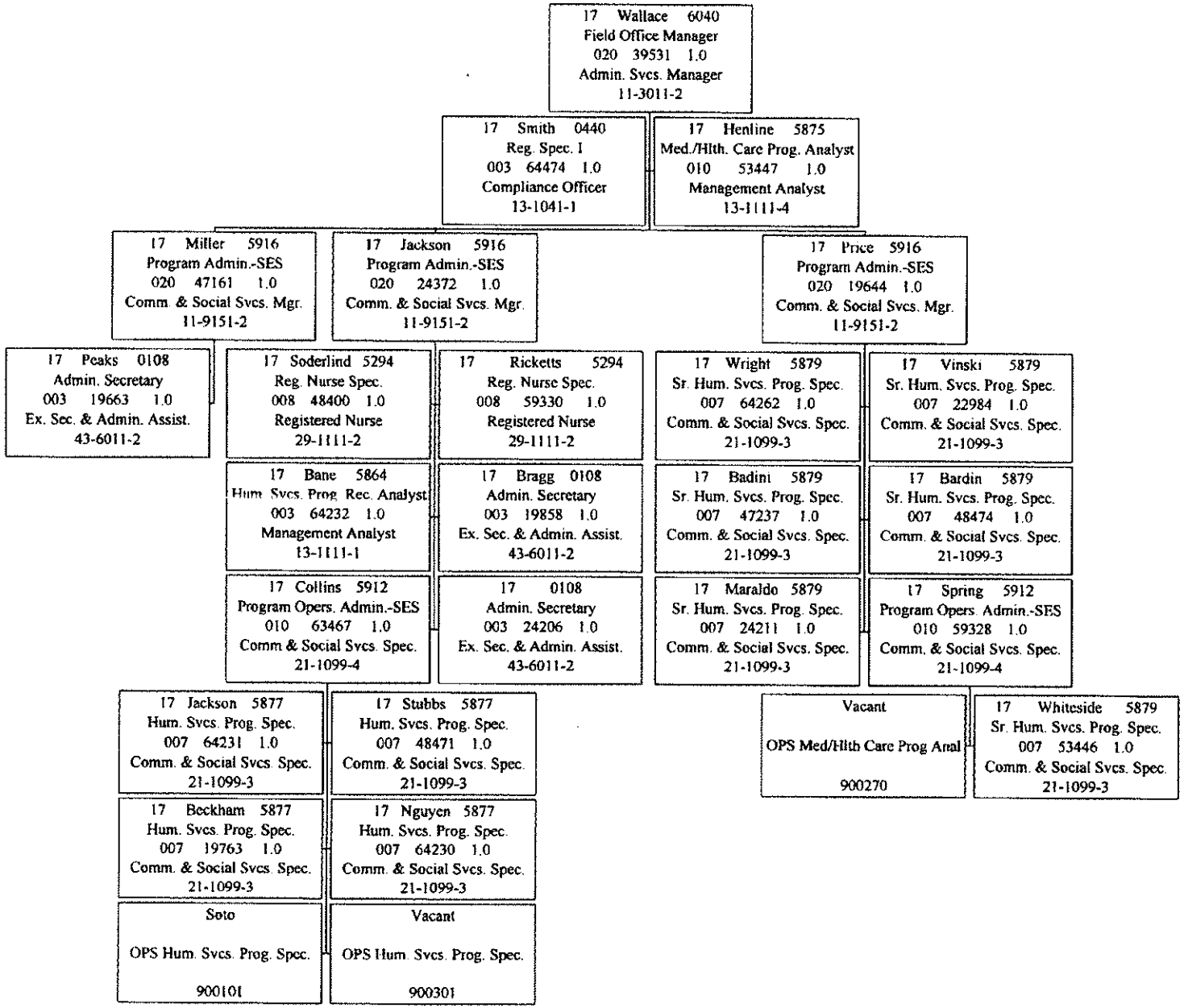
AGENCY FOR HEALTH CARE ADMINISTRATION
Bureau of Medicaid Field Operations

Effective Date: July 1, 2014
Org. Level: 68-50-10-00-000
FTEs: 300 Positions: 302



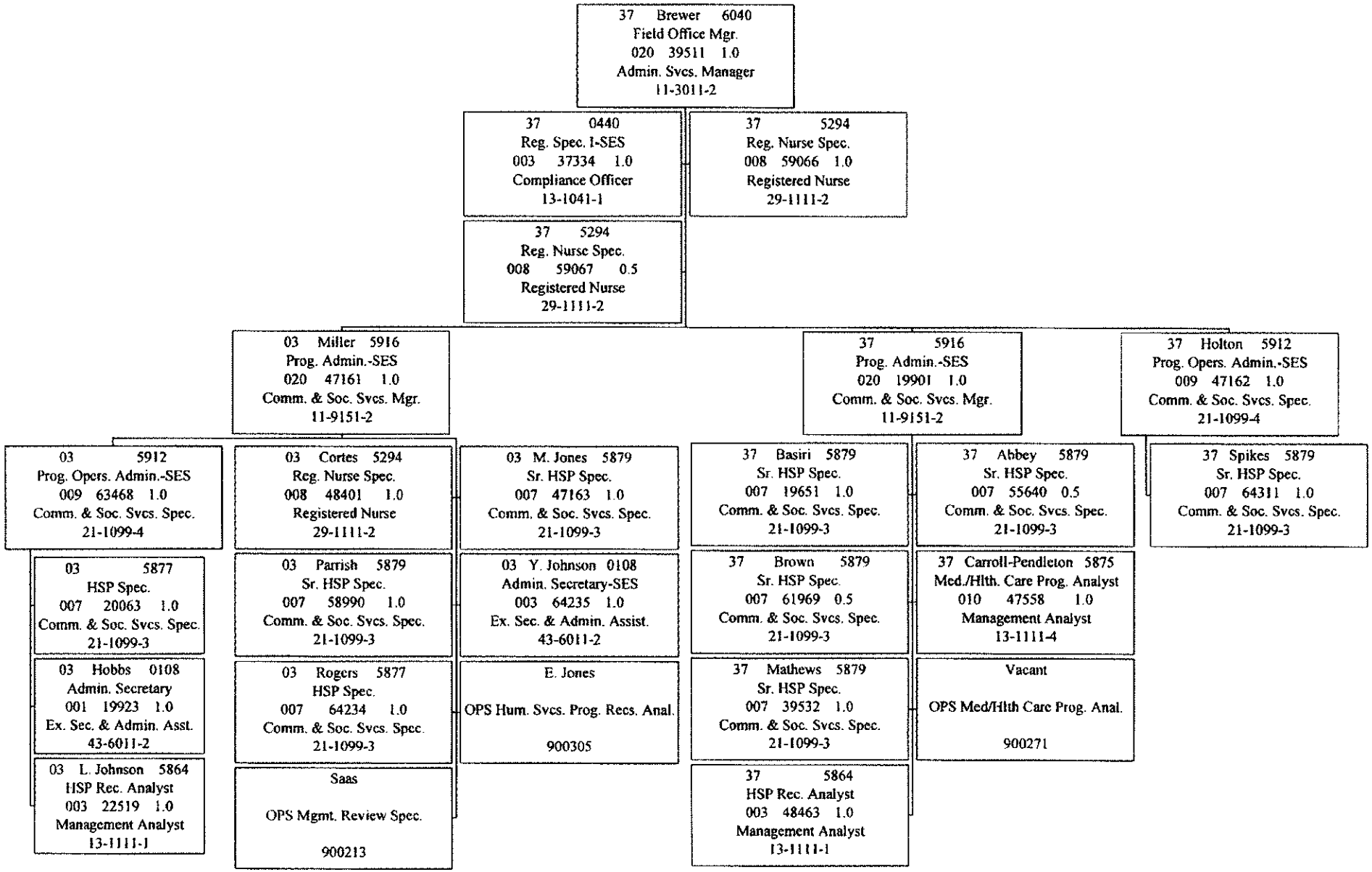
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 1 - Pensacola

Effective Date: July 1, 2014
Org. Level: 68-50-10-01-000
FTEs: 23 Positions: 23



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 2 - Tallahassee

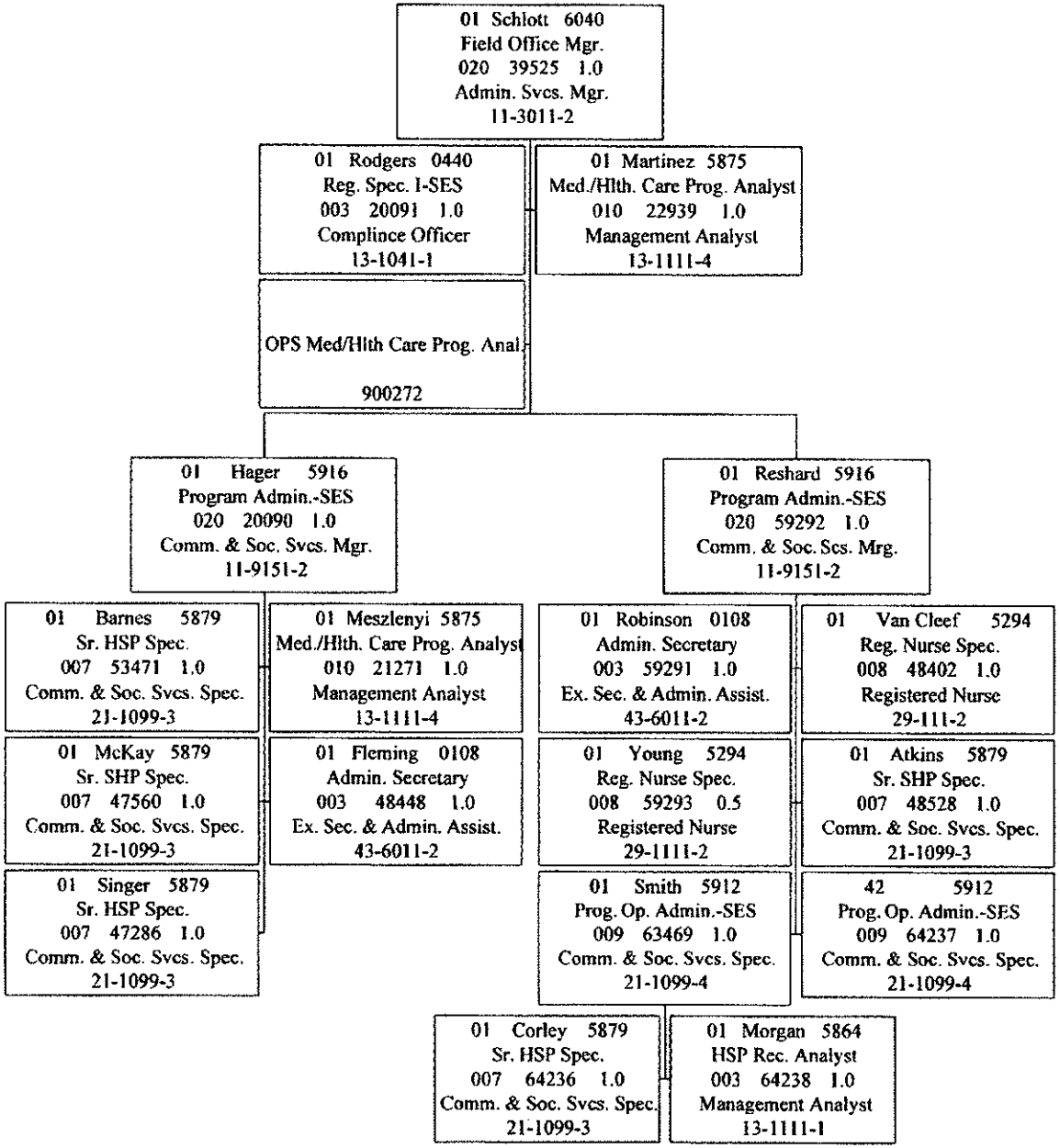
Effective Date: July 1, 2014
Org. Level: 68-50-10-02-000
FTEs: 9.5 Positions: 10



E-4-2

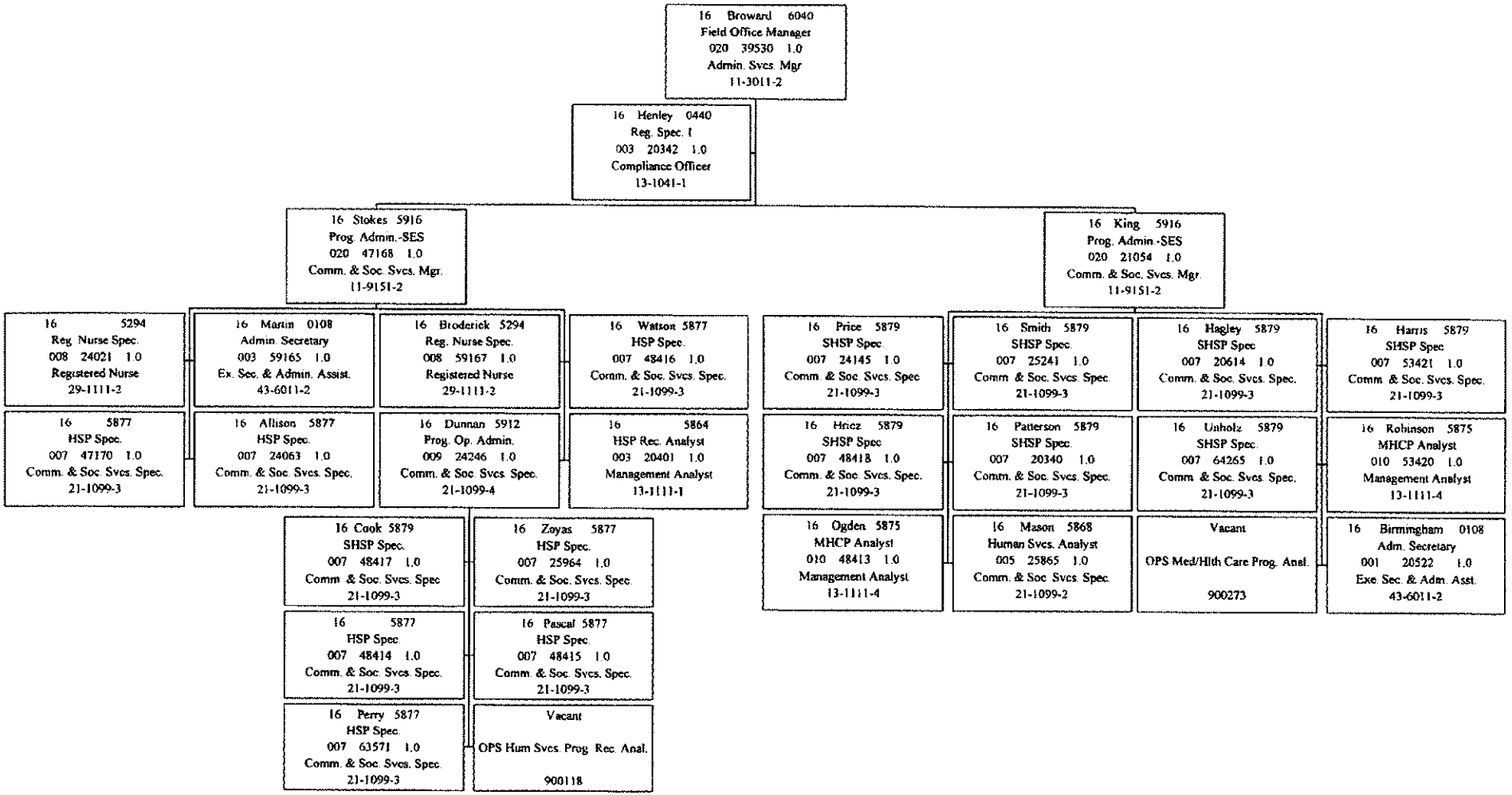
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 3 - Gainesville

Effective Date: July 1, 2014
Org. Level: 68-50-10-03 000
FTEs: 17.5 Positions: 18



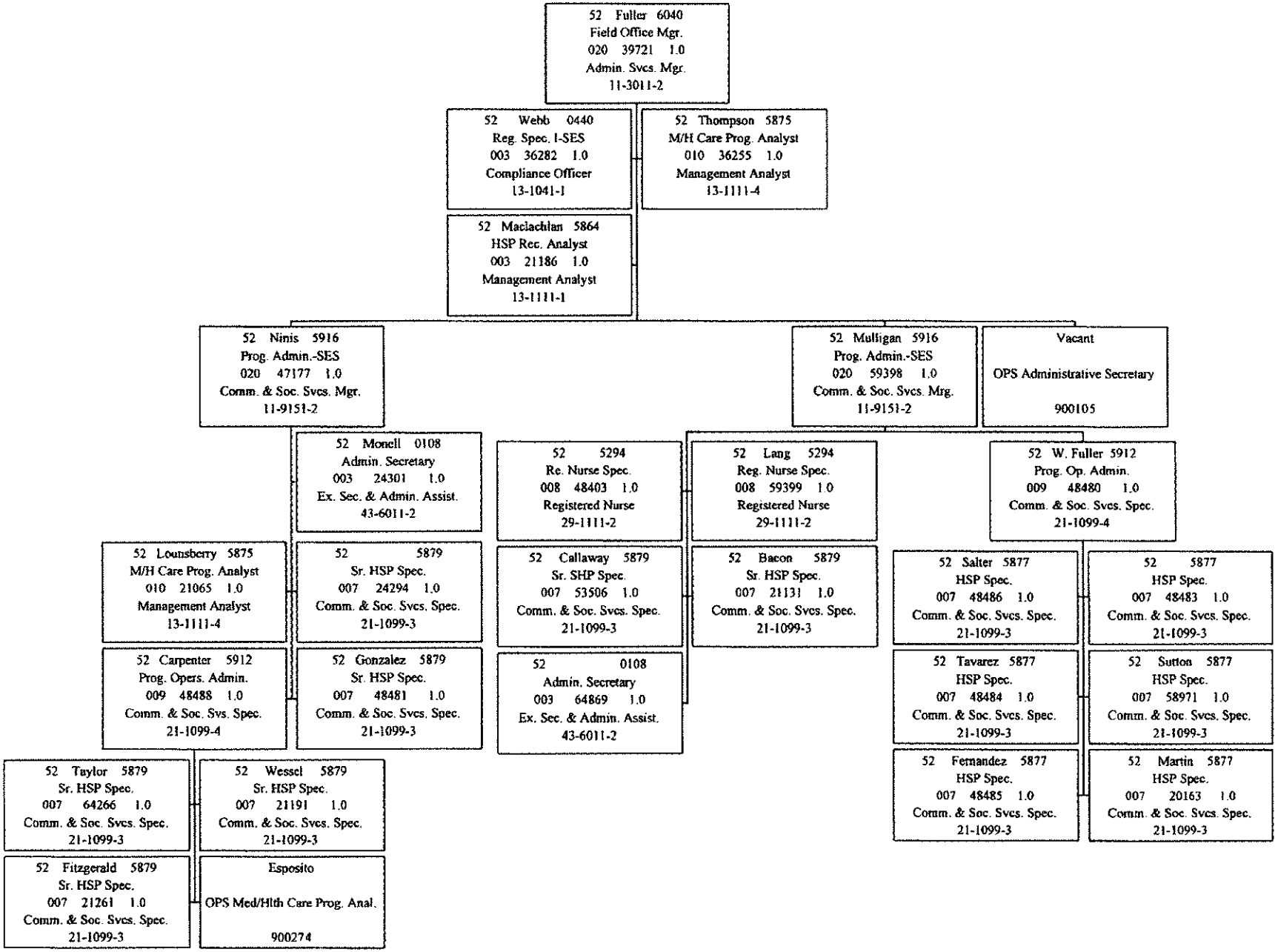
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 4 - Jacksonville

Effective Date: July 1, 2014
Org. Level: 68-50-10-04-000
FTEs: 28 Positions: 28



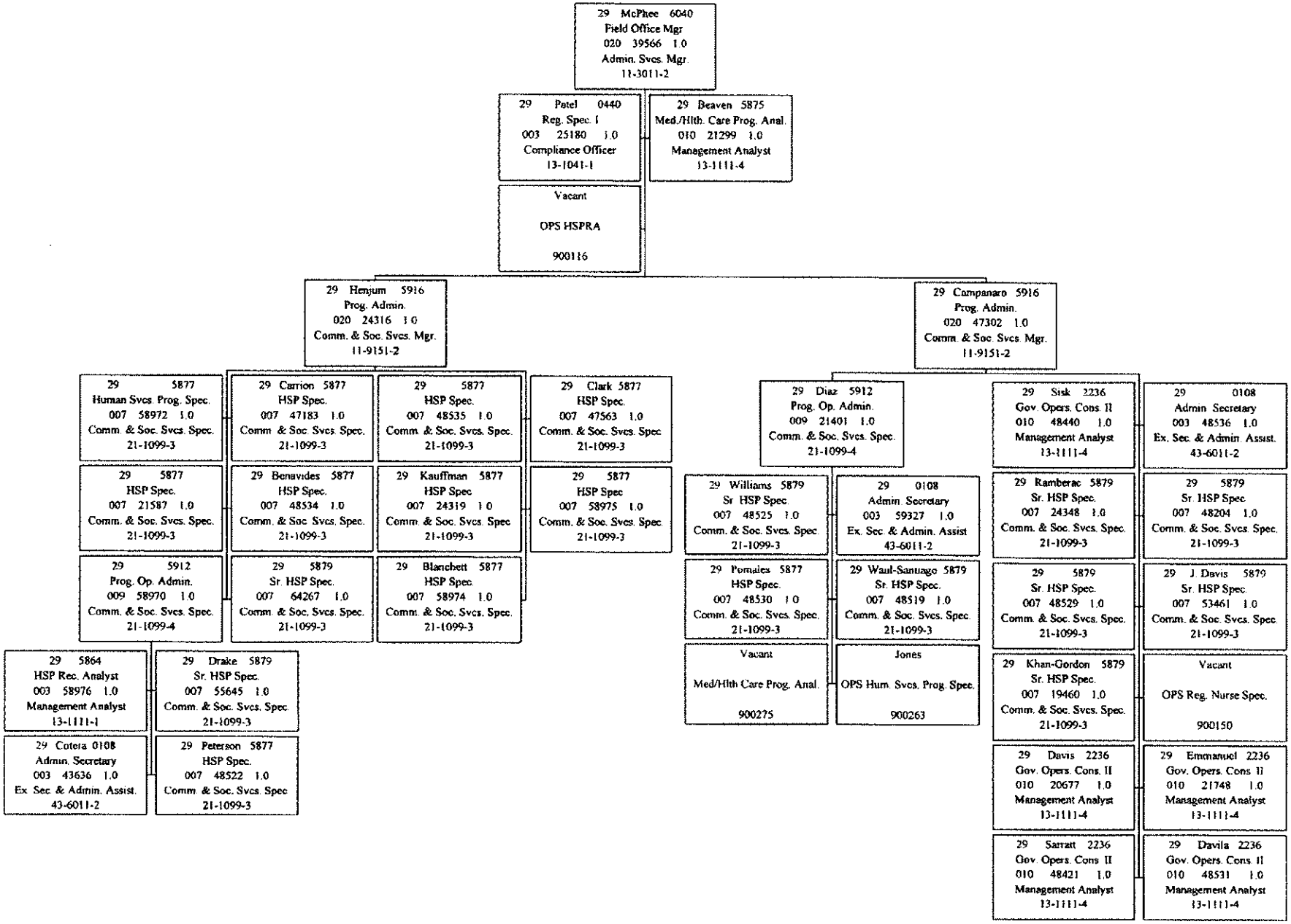
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 5 - St. Petersburg

Effective Date: July 1, 2014
Org. Level: 68-50-10-05-000
FTEs: 26 Positions: 26



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 6 - Tampa

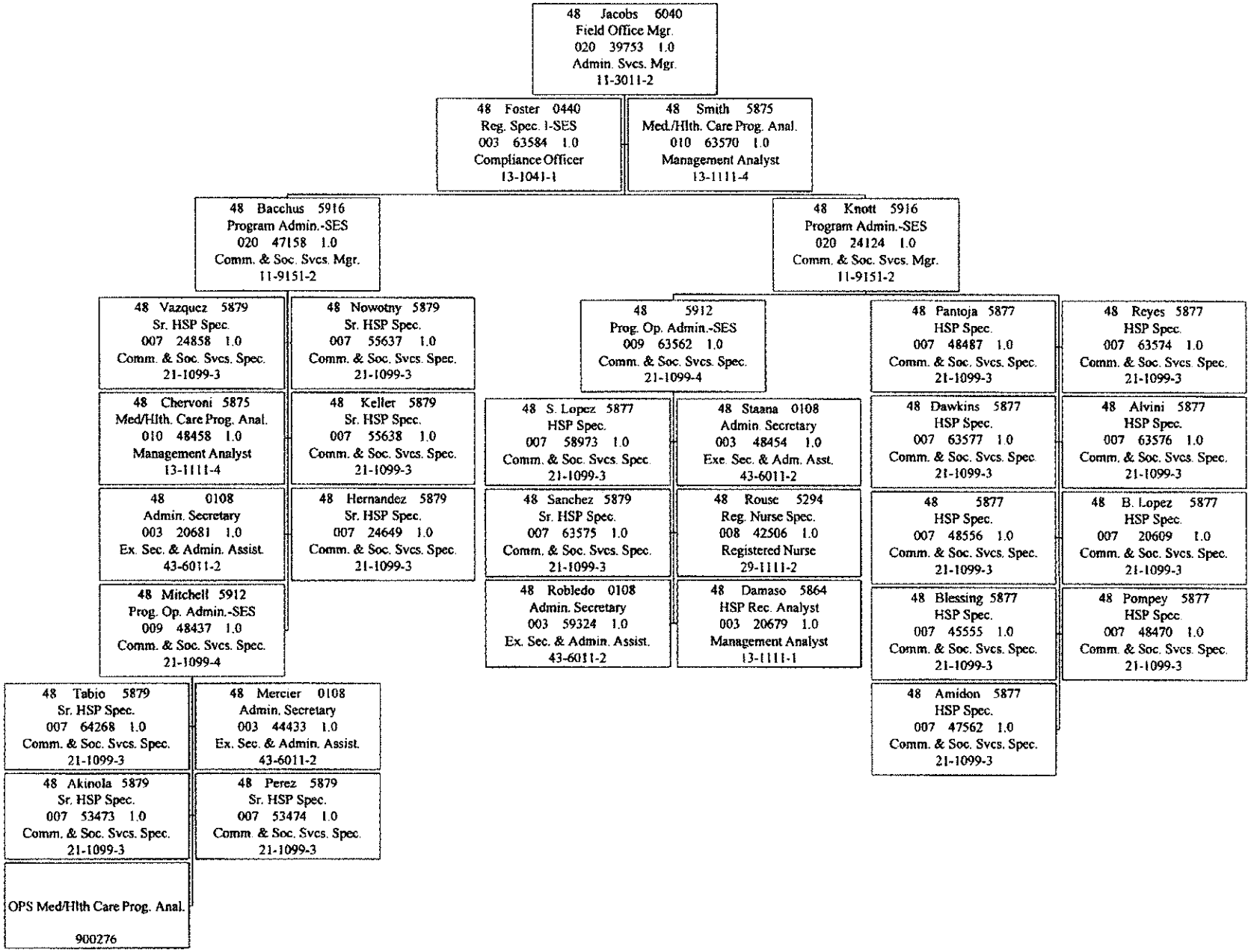
Effective Date: July 1, 2014
Org. Level: 68-50-10-06-000
FTEs: 36 Positions: 36



E-4-6

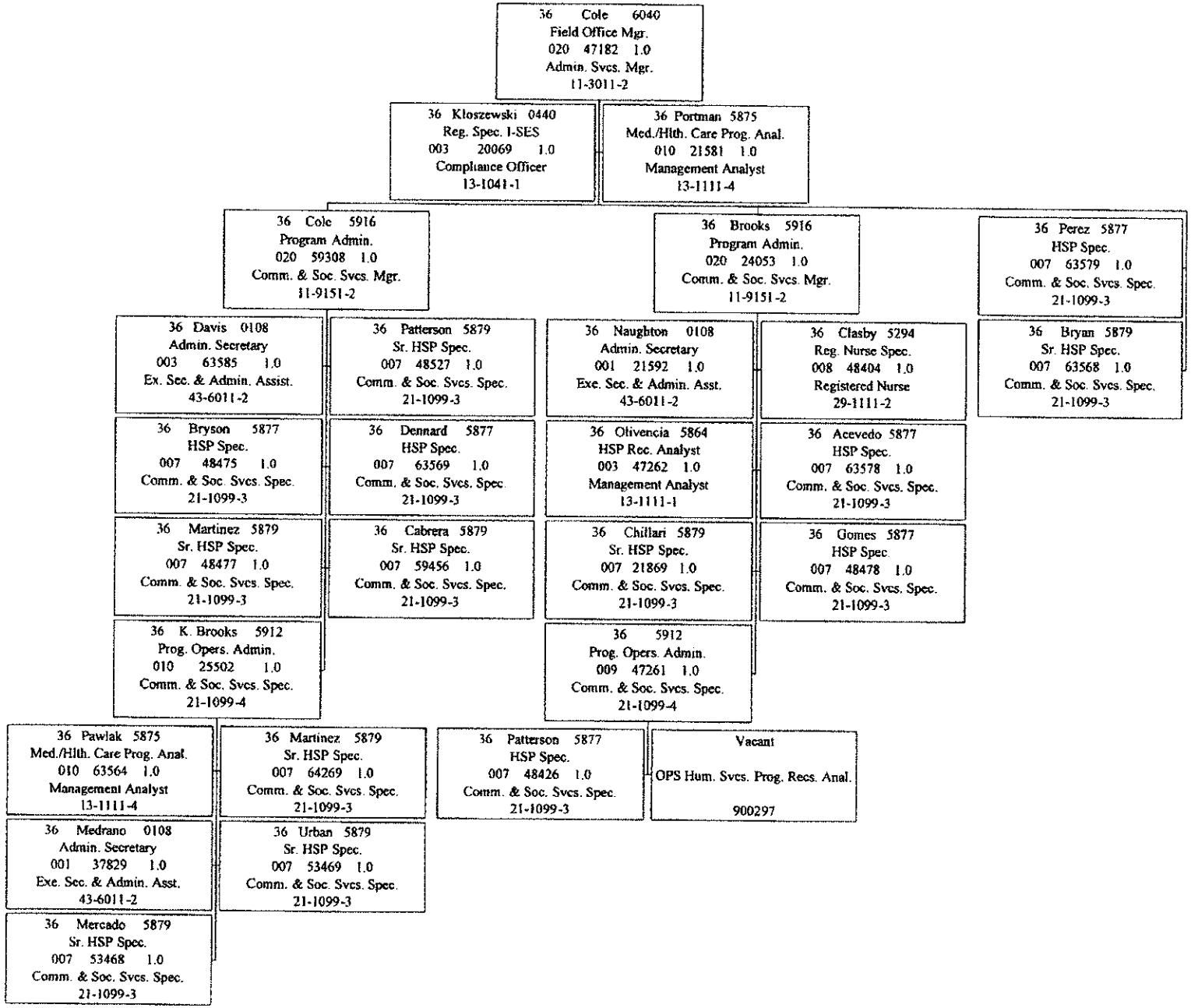
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 7 - Orlando

Effective Date: July 1, 2014
Org. Level: 68-50-10-07-000
FTE: 32 Positions: 32



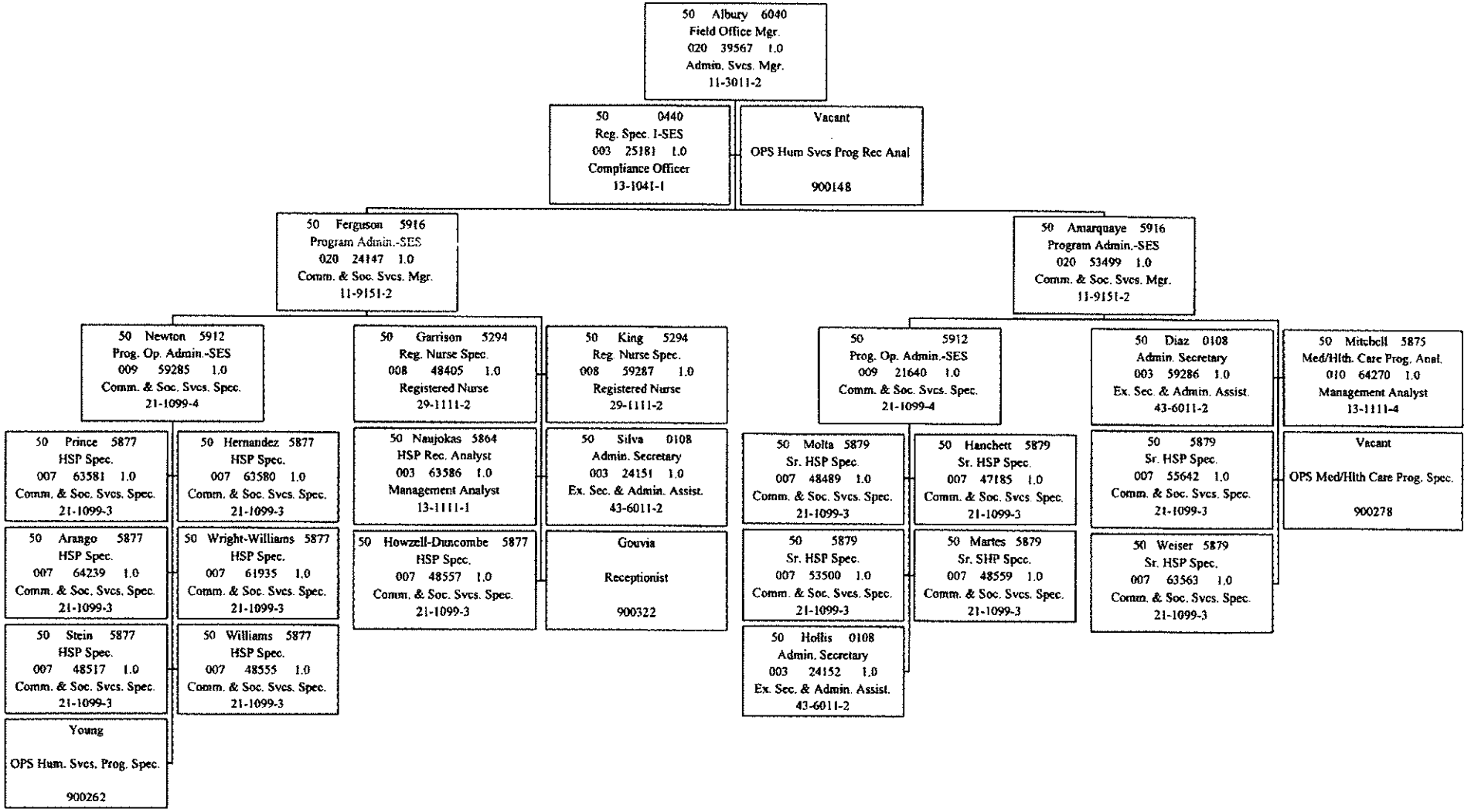
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 8 - Ft. Myers

Effective Date: July 1, 2014
Org. Level: 68-50-10-08-000
FTEs: 27 Positions: 27



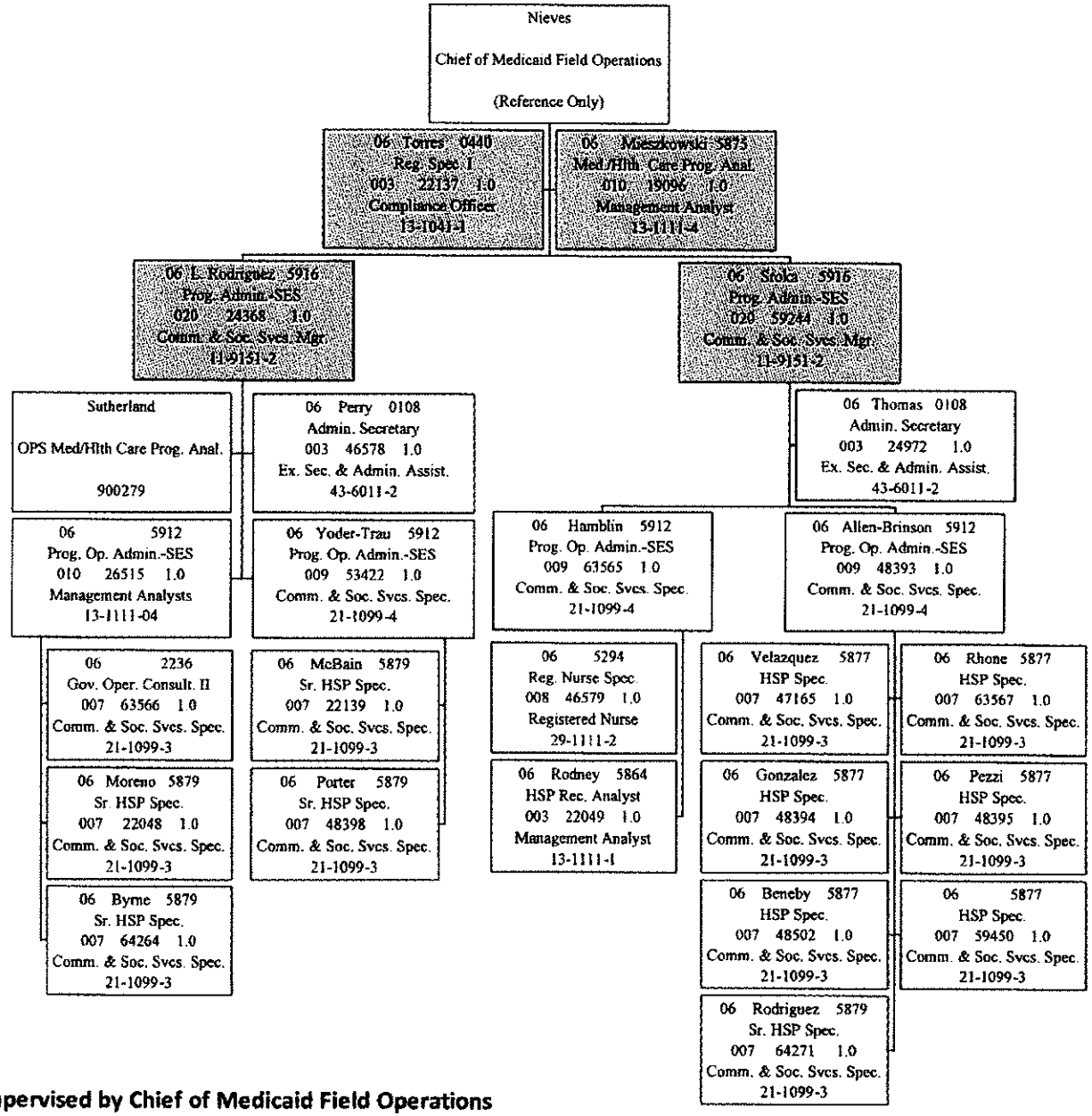
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Area 9 - West Palm Beach

Effective Date: July 1, 2014
Org. Level: 68-50-10-09-000
FTEs: 26 Positions: 26



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

Effective Date: July 1, 2014
Org. Level: 68-50-10-10-000
FTEs: 24 Positions: 24

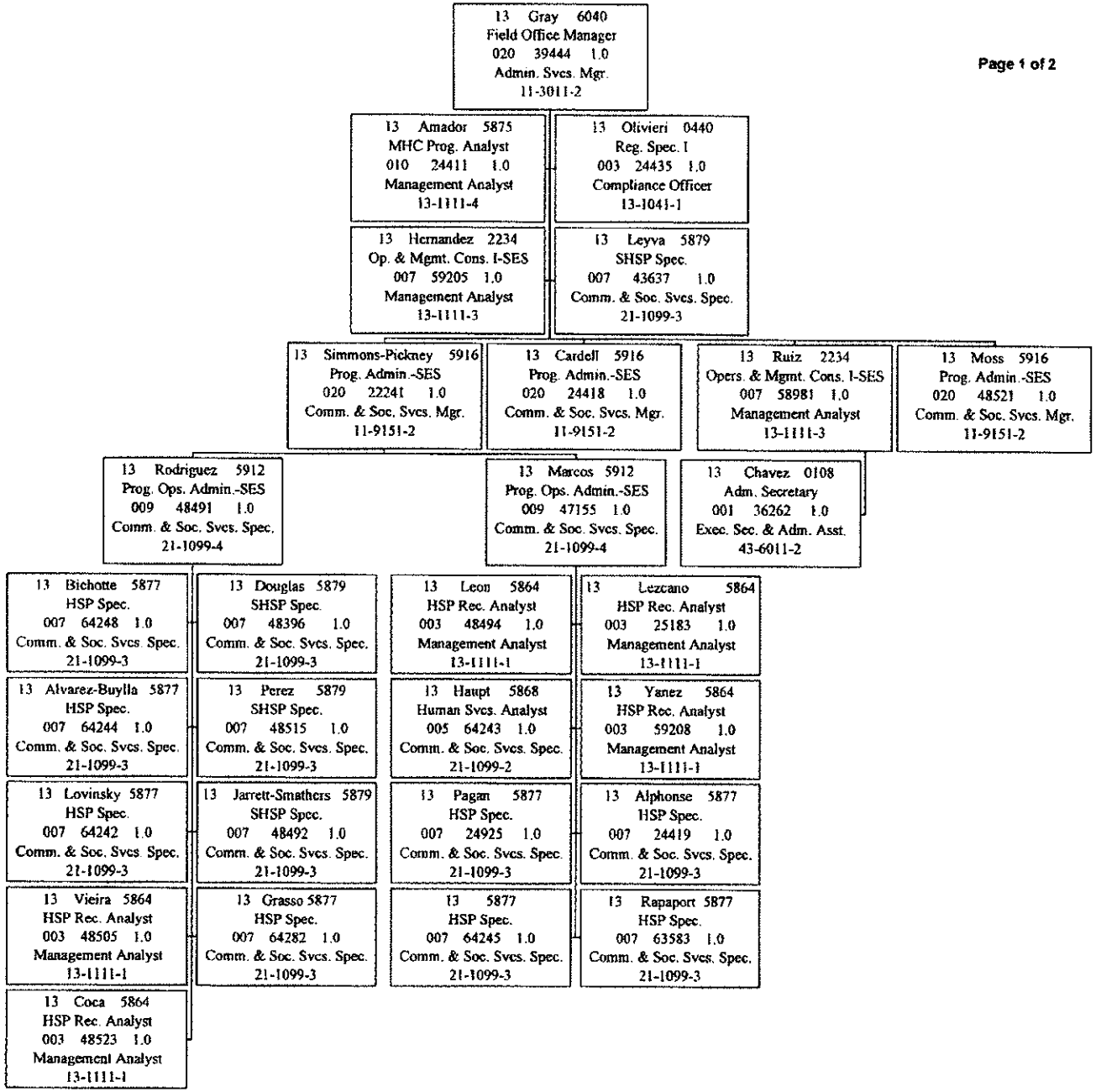


Shaded Positions Supervised by Chief of Medicaid Field Operations

E-4-10

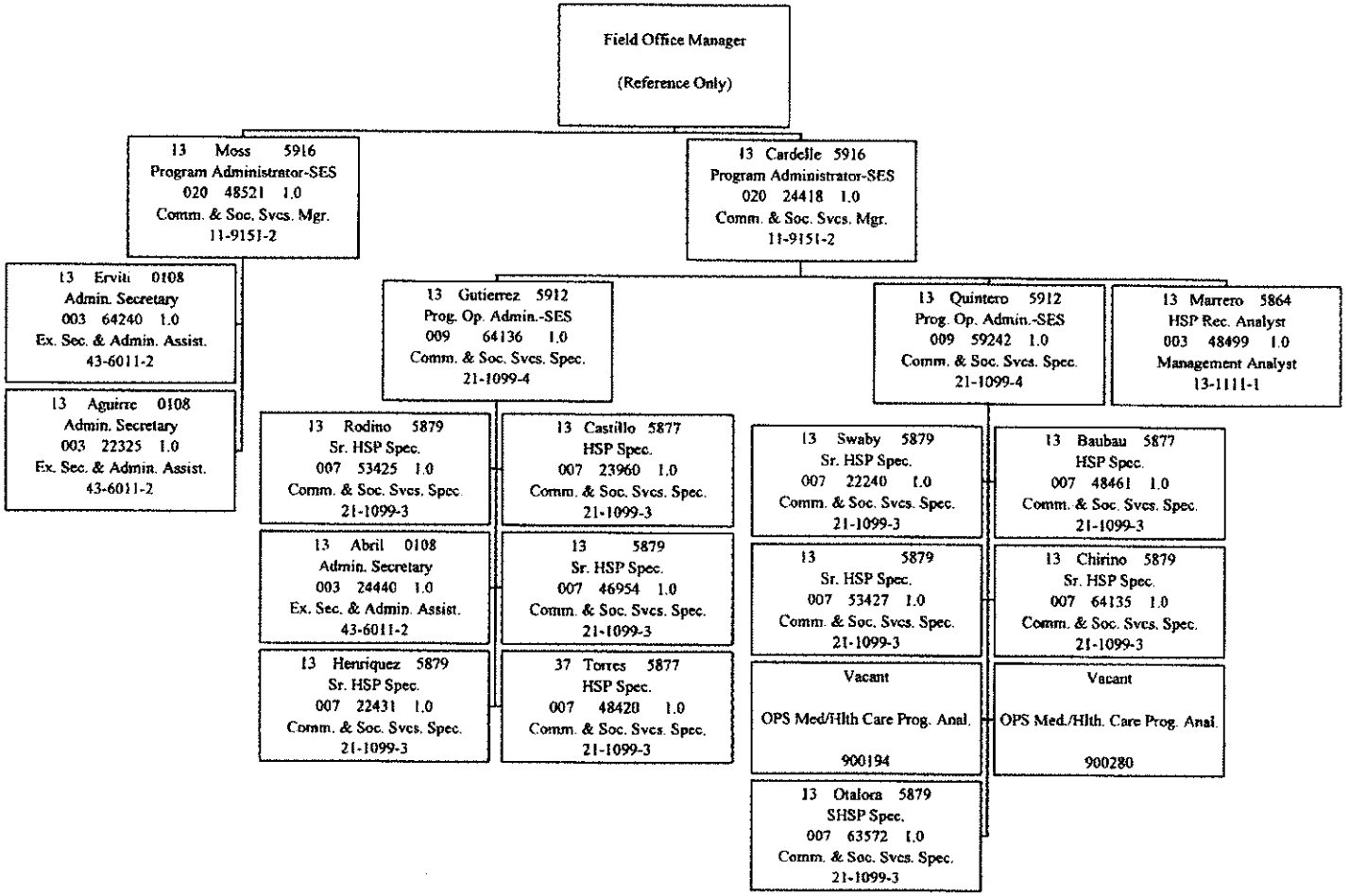
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
AREA 11 - Miami

Effective Date: July 1, 2014
Org. Level: 68-50-10-11-000
FTEs: 51 Positions: 51



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
AREA 11 - Miami

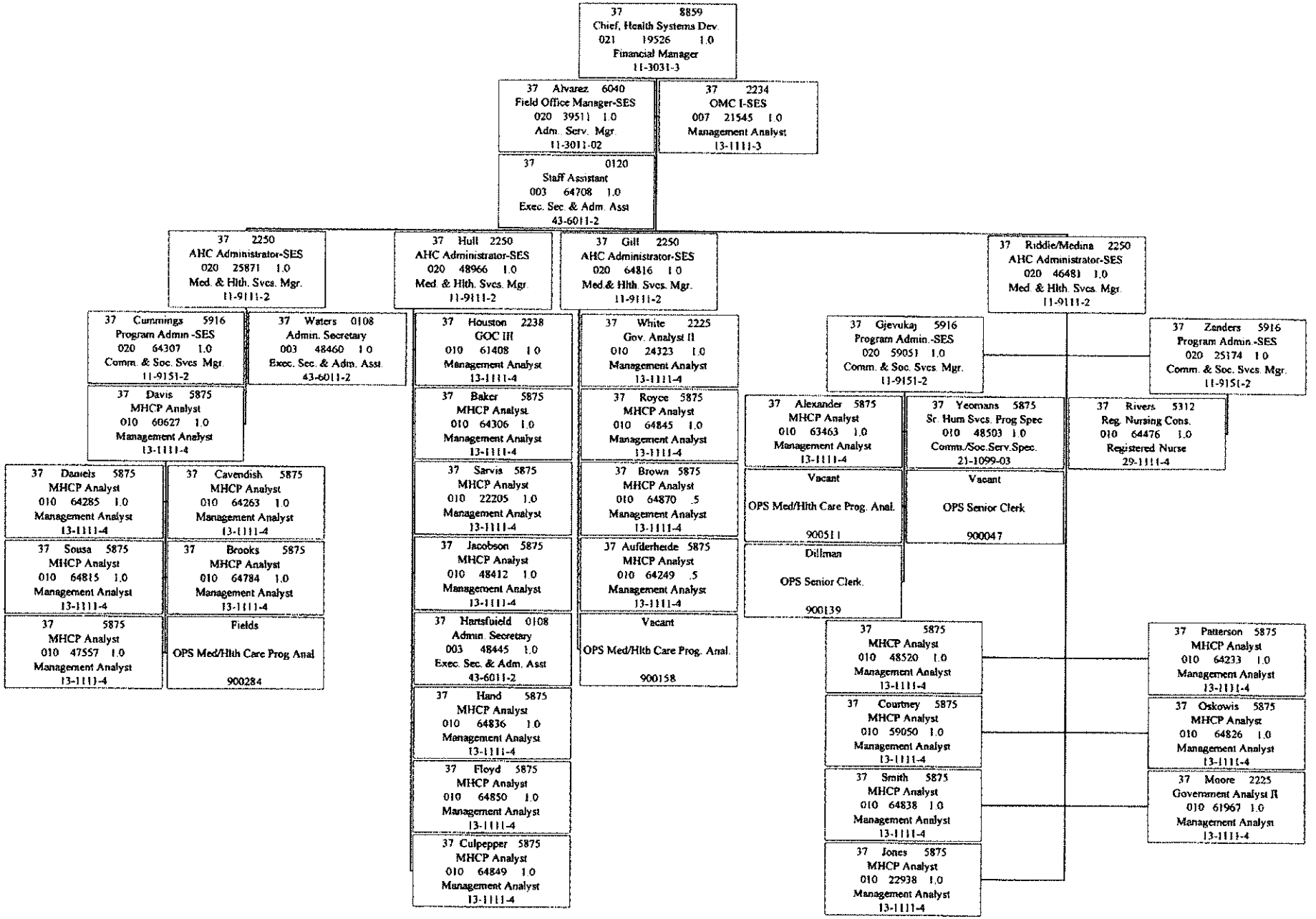
Effective Date: July 1, 2014
Org. Level: 68-50-10-11-000
FTEs: 51 Positions: 51



E-4-11-2

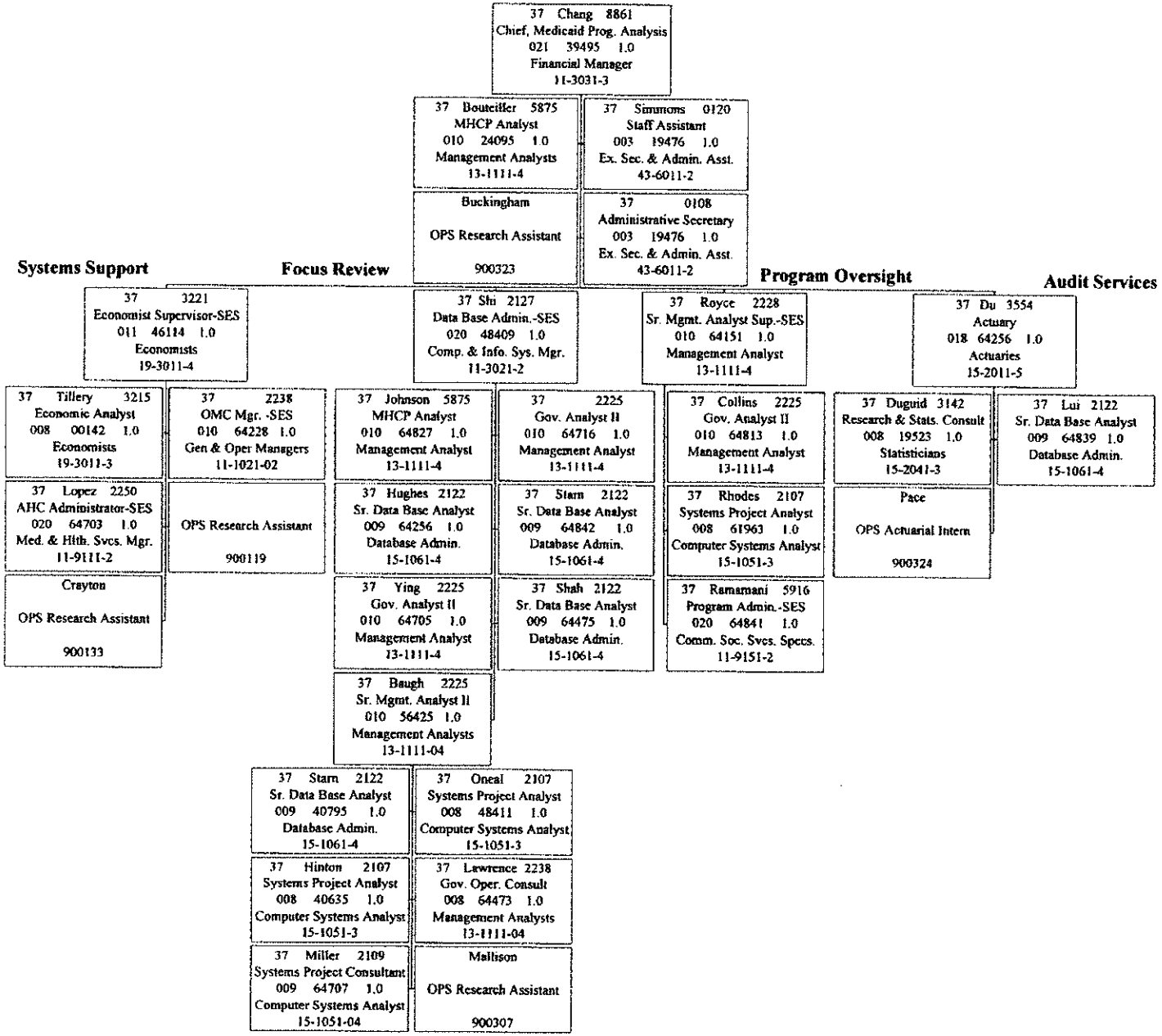
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Health Systems Development

Effective Date: July 1, 2014
Org. Level: 68-50-40-00-000
FTEs: 39 Positions: 40



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Medicaid Program Analysis

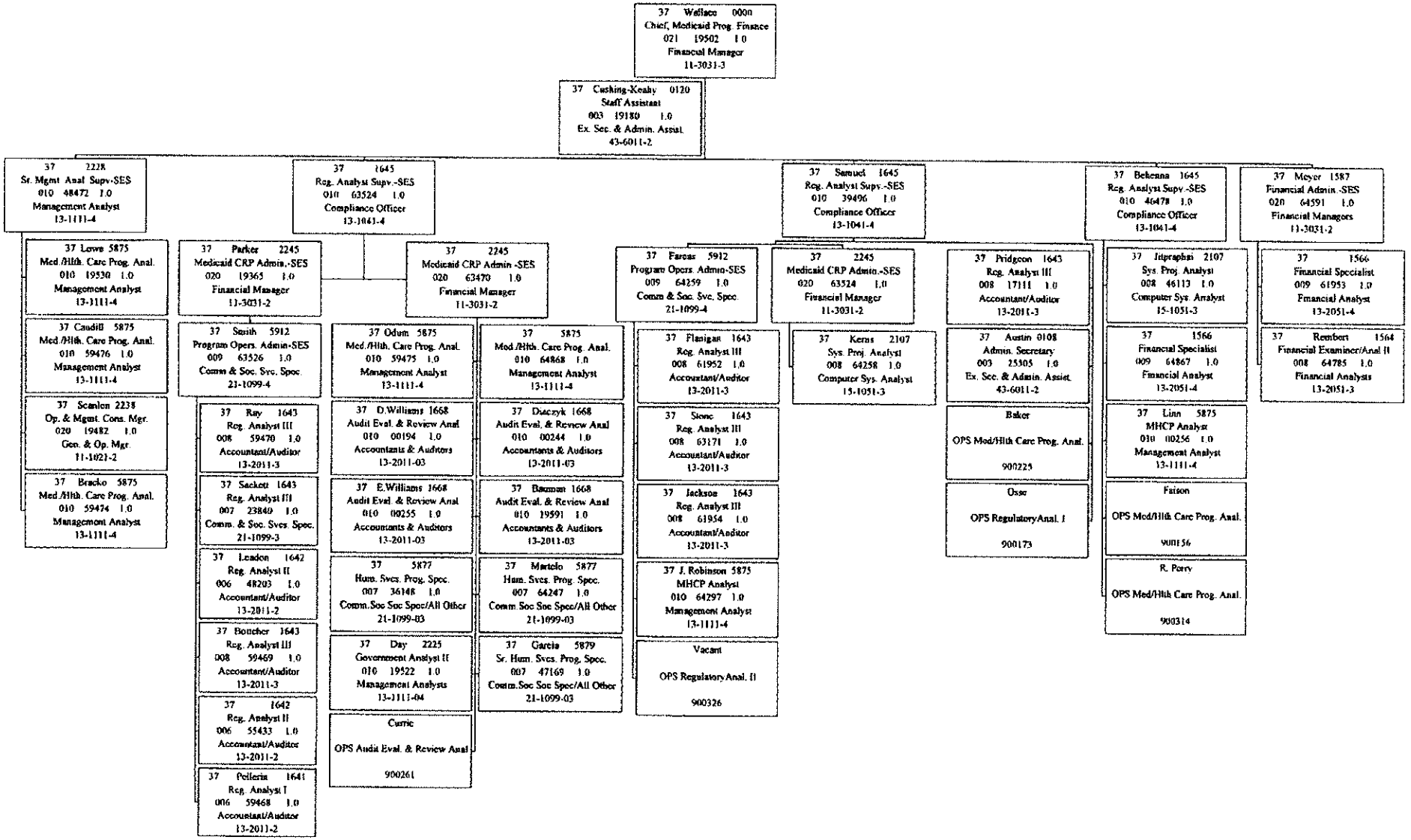
Effective Date: July 1, 2014
Org Level: 68-50-50-00-000
FTE: 28 Positions: 28



E-7-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Medicaid Program Finance

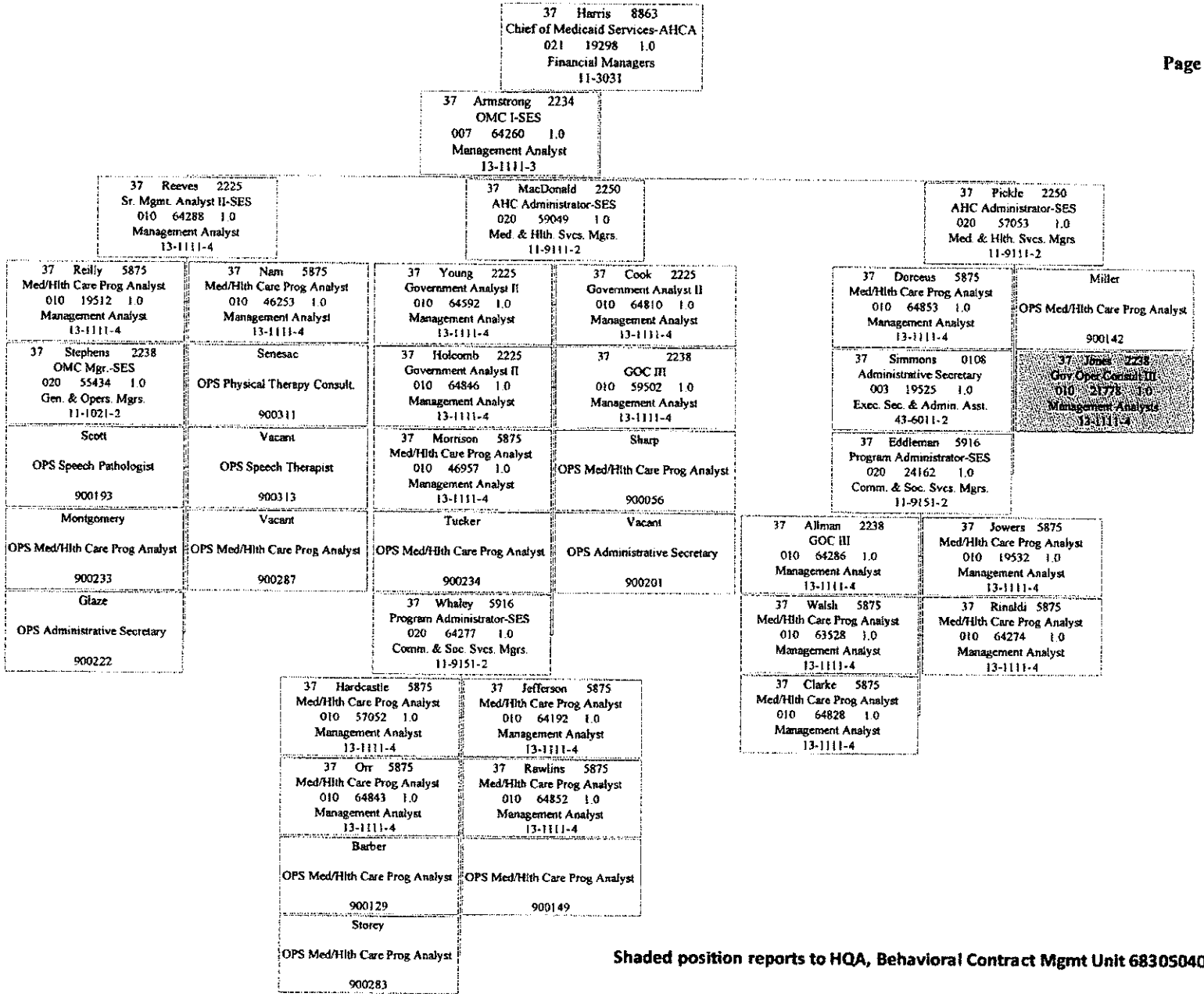
Effective Date: July 1, 2014
Org. Level: 68-50-55-00-000
FTEs: 42 Positions: 42



E-7-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

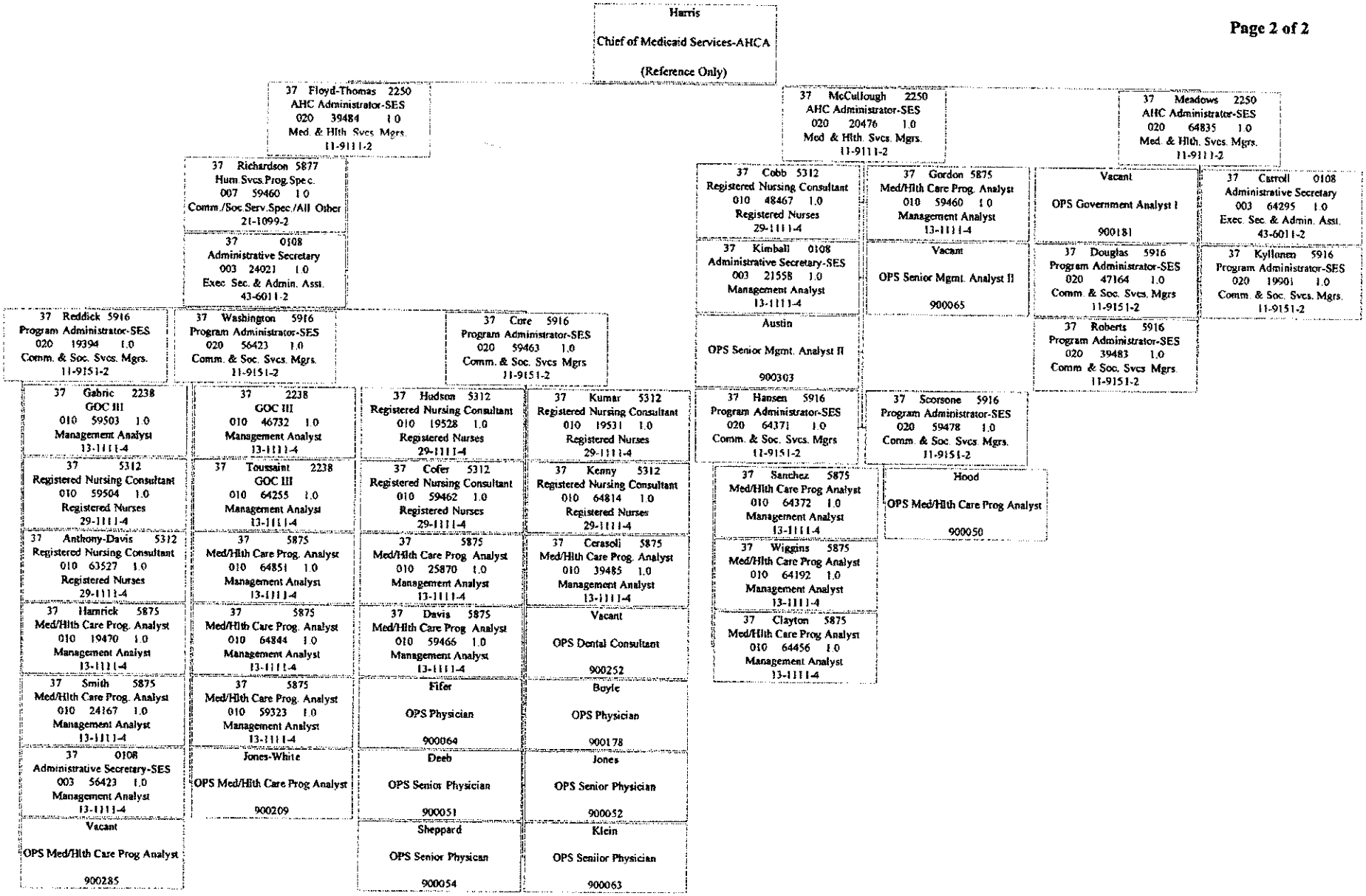
Effective Date: July 1, 2014
Org. Level: 68-50-60-00-000
FTEs: 58 Positions: 58



Shaded position reports to HQA, Behavioral Contract Mgmt Unit 68305040000

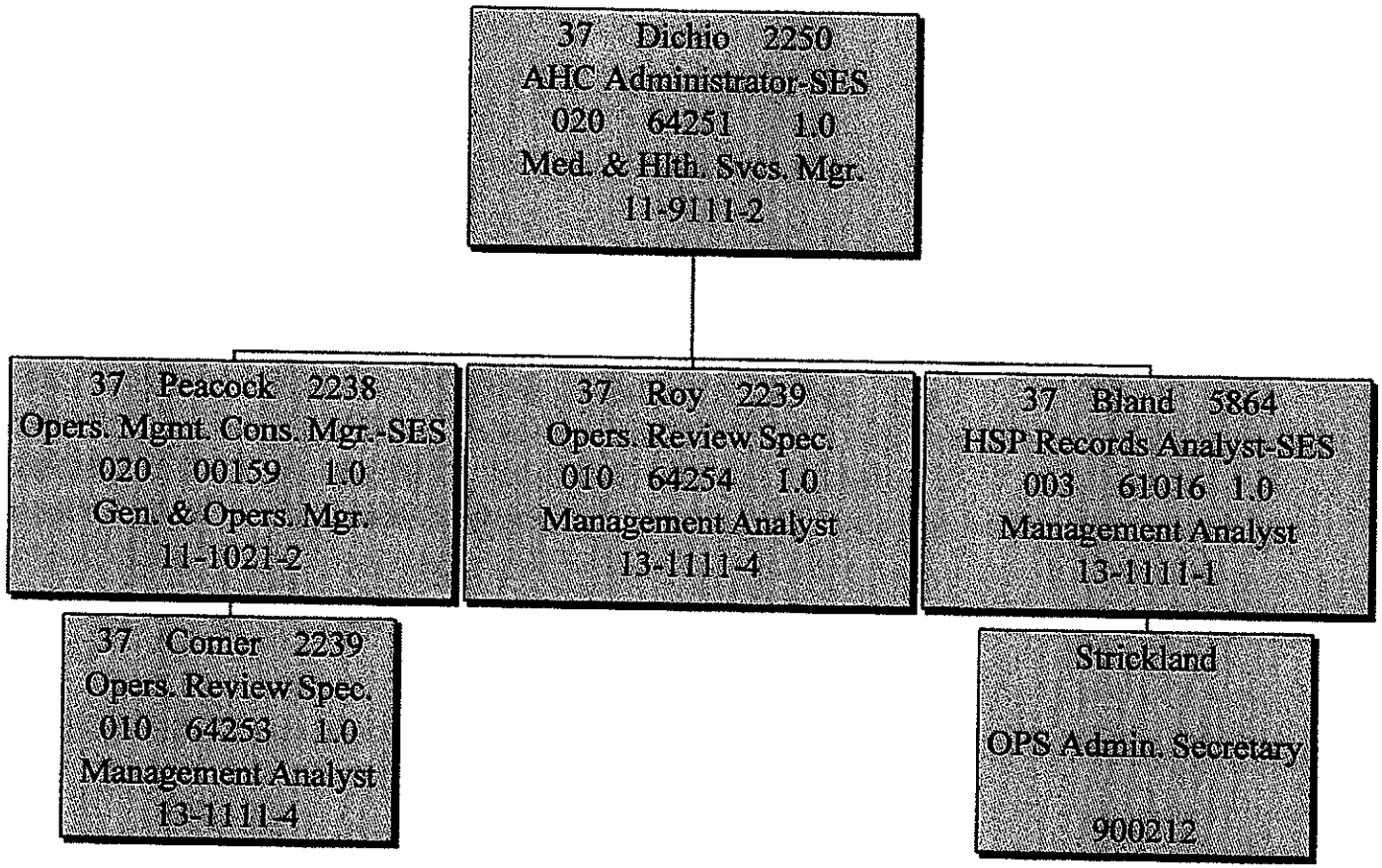
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Medicaid Services

Effective Date: July 1, 2014
Org. Level: 68-50-60-00-000
FTEs: 58 Positions: 58



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid Third Party Liability

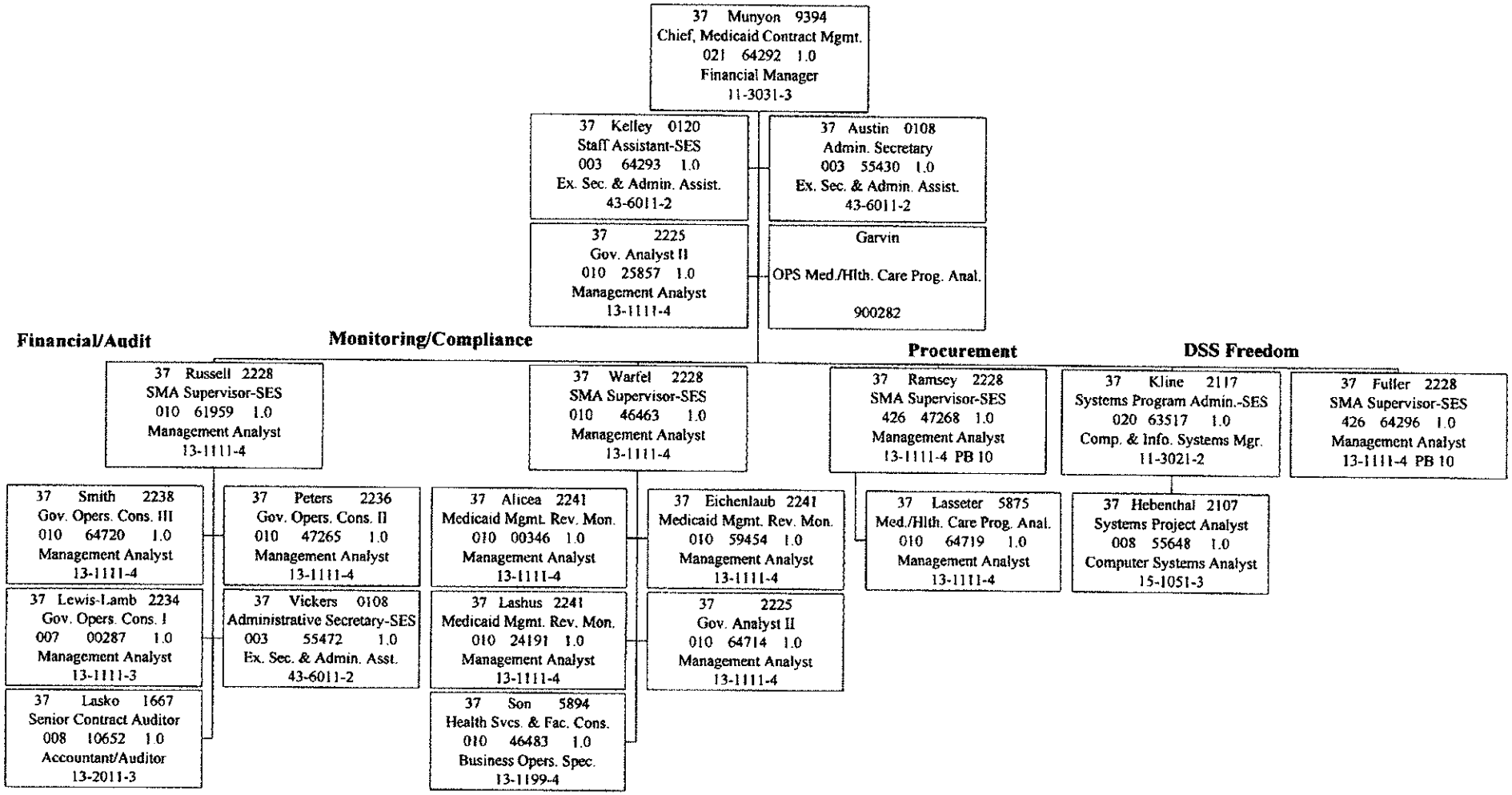
Effective Date: July 1, 2014
Org. Level: 68-50-70-00-000
FTEs: 5 Positions: 5



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

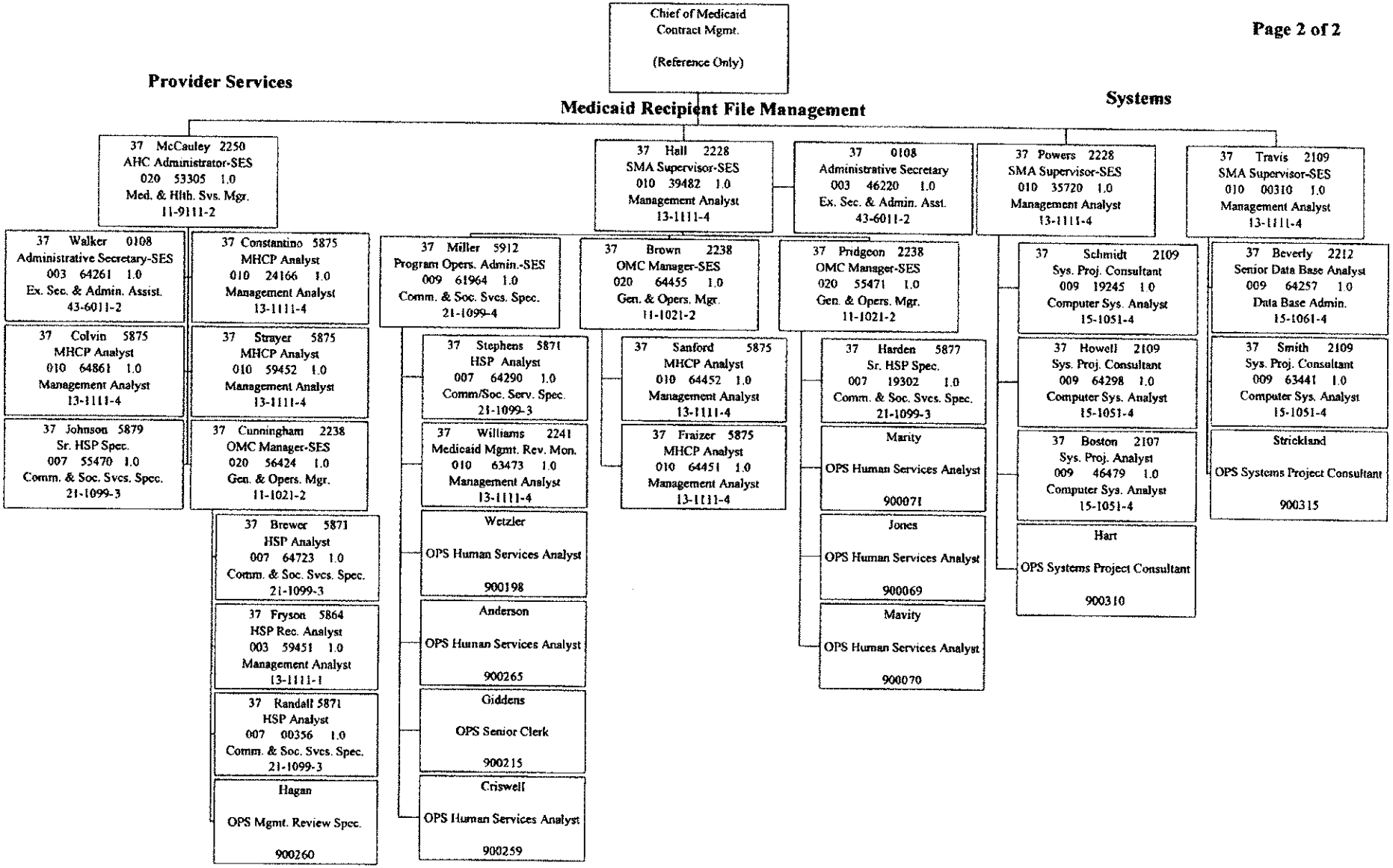
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Contract Management

Effective Date: July 1, 2014
Org. Level: 68-50-80-00-000
FTEs: 48 Positions: 48



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Contract Management

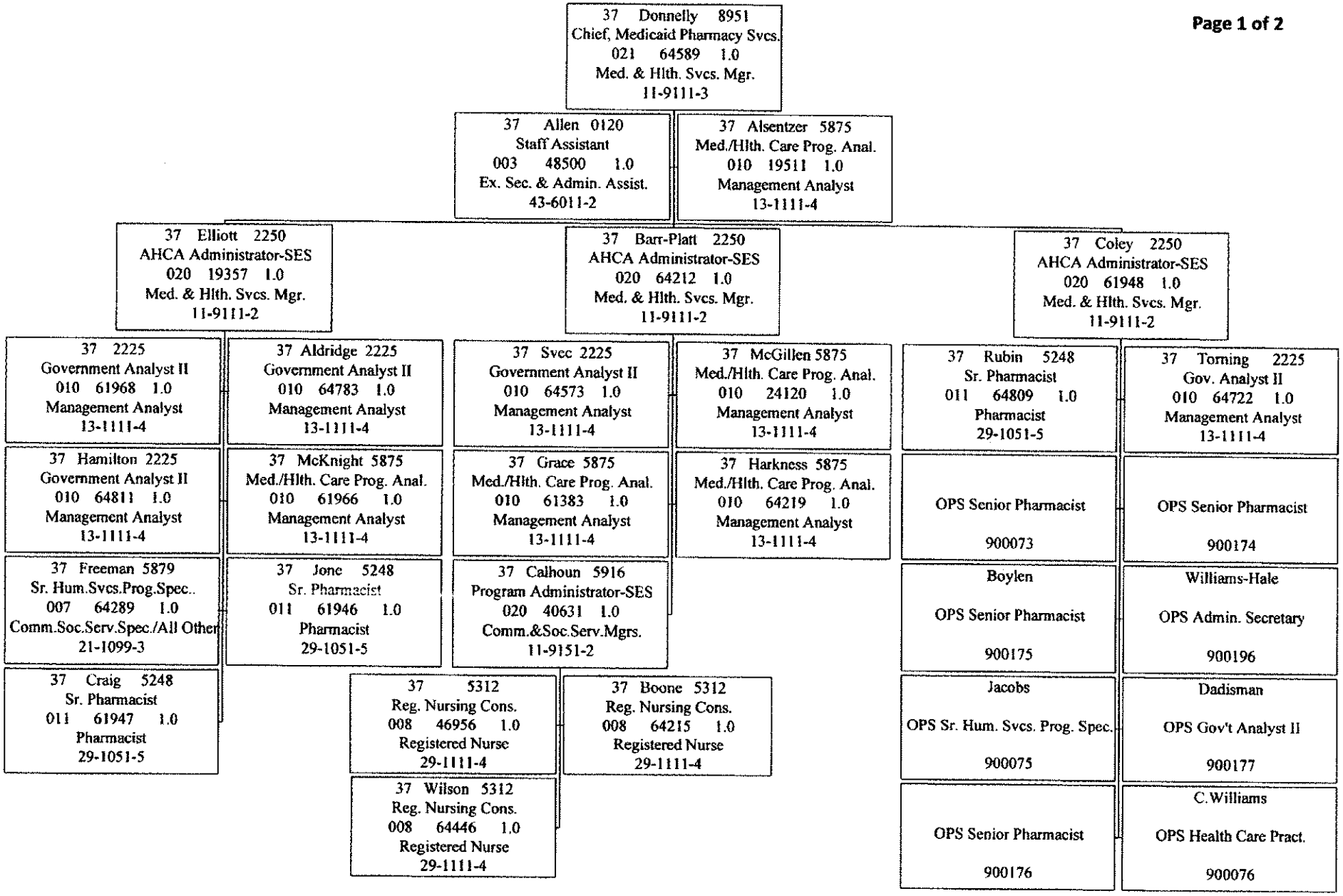
Revised Date: July 1, 2014
Org. Level: 68-50-80-00-000
FTEs: 48 Positions: 48



E-9-2

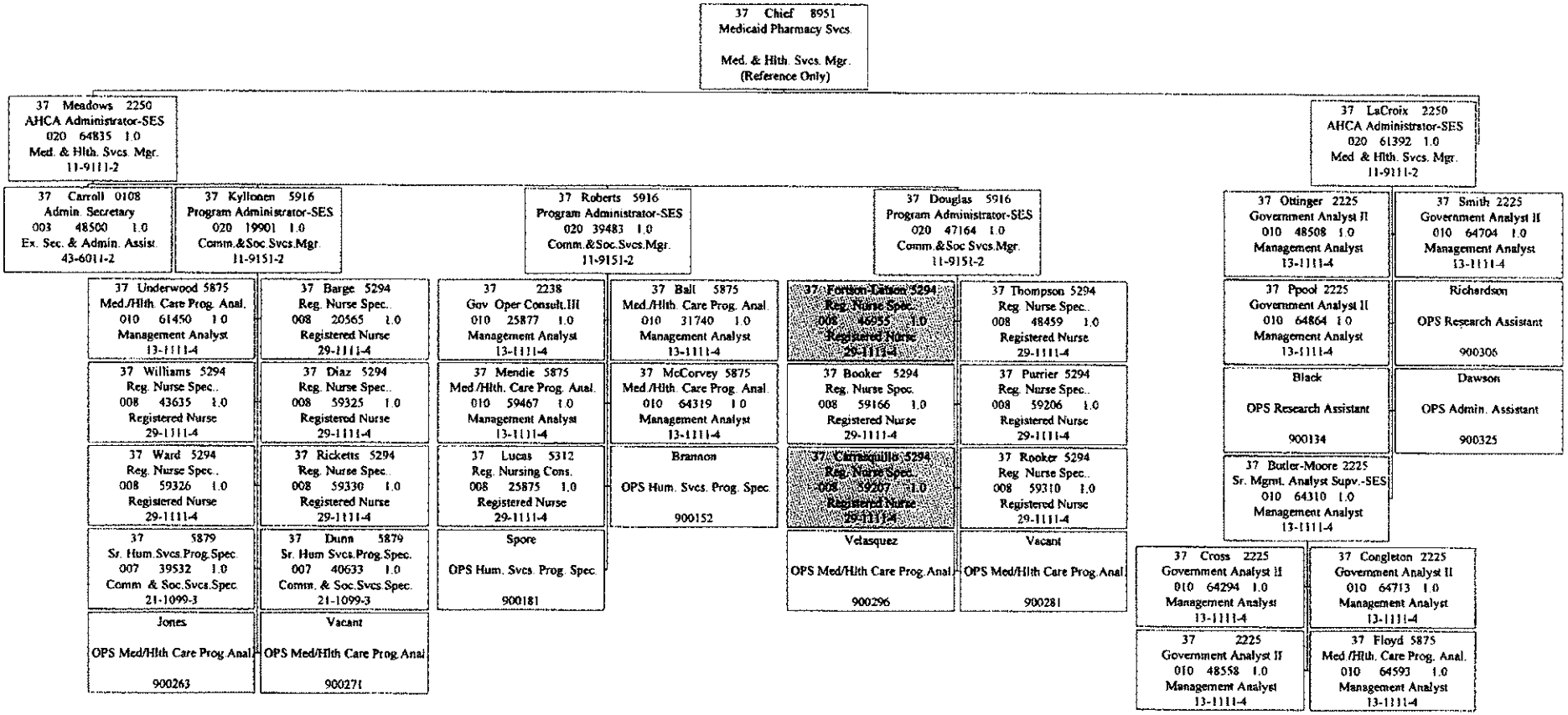
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Pharmacy Services

Effective Date: July 1, 2014
Org Level: 68-50-90-00-000
FTE: 44.5 Positions: 45



AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Pharmacy Services

Effective Date: July 1, 2014
Org Level: 68-50-90-00-000
FTE: 44.5 Positions: 45



Shaded positions report to Org Code 68501011000 -Medicaid Area 11

AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET	FISCAL YEAR 2013-14 OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	24,053,514,688	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)	-821,157,207	0
FINAL BUDGET FOR AGENCY	23,232,357,481	0

SECTION II: ACTIVITIES * MEASURES	Number of Units	(1) Unit Cost	(2) Expenditures (Allocated)	(3) FCO
Executive Direction, Administrative Support and Information Technology (2)				0
Prepaid Health Plans - Elderly And Disabled *	2,257,404	1,000.58	2,258,703,765	
Prepaid Health Plans - Families *	14,217,804	143.04	2,033,774,110	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	499,767	3,378.32	1,688,371,501	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	499,767	2,033.85	1,016,451,915	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased	499,767	1,338.30	668,836,217	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	499,767	934.89	467,228,027	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	324,225	3,323.54	1,077,573,501	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	93,952	285.16	26,791,402	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased	499,767	135.14	67,536,127	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased	499,767	268.62	134,249,828	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased	499,767	126.12	63,030,517	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	93,952	394.45	37,059,080	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased	295,541	364.25	107,650,973	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	499,767	208.93	104,417,009	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased	93,952	1,738.99	163,381,604	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	499,767	1,407.72	703,529,891	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	833,655	1,651.73	1,376,976,424	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	833,655	384.11	320,217,685	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased	833,655	969.84	808,515,342	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	833,655	758.12	632,008,504	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	1,188	165,751.21	196,912,432	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	840,489	382.05	321,112,586	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased	833,655	88.79	74,020,122	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased	833,655	19.60	16,339,466	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased	833,655	136.08	113,442,758	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	722,174	153.35	110,748,384	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased	833,655	58.05	48,393,307	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	833,655	583.49	486,429,250	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	45,119	4,875.87	219,994,585	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	45,119	3,105.22	140,104,265	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	45,119	1,855.06	83,698,258	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	45,119	1,985.03	89,562,589	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	5,163	1,290.33	6,661,969	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	7,030	198.75	1,397,205	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	45,119	54.11	2,441,574	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	45,119	53.24	2,401,963	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	45,119	36.87	1,663,735	
Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased	7,030	10.52	73,941	
Medically Needy - Other * Number of case months Medicaid program services purchased	45,119	23,491.12	1,059,895,890	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	5,476	577.46	3,162,168	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	5,476	86,028.24	471,090,631	
Refugees - Physician Services * Number of case months Medicaid program services purchased	5,476	571.12	3,127,447	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	5,476	390.60	2,138,913	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	797	296.98	236,692	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	5,476	7.49	41,027	
Refugees - Case Management * Number of case months Medicaid program services purchased	5,476	10.46	57,297	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	5,476	23.54	128,927	
Refugees - Therapeutic Services For Children * Number of case months Medicaid program services purchased	797	4.22	3,364	
Refugees - Other * Number of case months Medicaid program services purchased	5,476	301.71	1,652,140	
Nursing Home Care * Number of case months Medicaid program services purchased	45,729	63,597.63	2,908,256,053	
Home And Community Based Services * Number of case months Medicaid program services purchased	68,914	17,025.96	1,173,326,842	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program services purchased	642	524,951.49	337,018,855	
Mental Health Disproportionate Share Program * Number of case months Medicaid program services purchased	720	100,706.52	72,508,697	
Capitated Nursing Home Diversion Waiver * Number of case months Medicaid program services purchased	19,623	19,504.34	382,733,619	
Purchase Medikids Program Services * Number of case months Medicaid Program services purchased	32,070	1,902.90	61,025,932	
Purchase Children's Medical Services Network Services * Number of case months	19,268	7,152.85	137,821,038	
Purchase Florida Healthy Kids Corporation Services * Number of case months	220,260	1,471.15	324,034,791	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	2,928	615.62	1,802,541	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification applications	45,496	329.90	15,009,277	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations	44,204	1,095.41	48,421,694	
Health Standards And Quality * Number of transactions	2,941,083	1.21	3,569,125	
Plans And Construction * Number of reviews performed	5,007	1,237.79	6,197,625	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys	136	22,047.28	2,998,430	
Background Screening * Number of requests for screenings	204,597	3.95	807,516	
Subscriber Assistance Panel * Number of cases	160	5,074.71	811,953	
TOTAL			22,689,580,295	

SECTION III: RECONCILIATION TO BUDGET			
PASS THROUGHS			
TRANSFER - STATE AGENCIES			
AID TO LOCAL GOVERNMENTS			
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS			
OTHER			503,423,074
REVERSIONS			39,354,208
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			23,232,357,577

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 B. Hicks**

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

1) Does the long range financial outlook adopted by the Joint Legislative Budget Commission in September 2014 contain revenue or expenditure estimates related to your agency?

Yes [X] No [ ]

2) If yes, please list the estimates for revenues and budget drivers that reflect an estimate for your agency for Fiscal Year 2015-2016 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 2015-2016 Estimate/Request Amount	
			Long Range Financial Outlook	Legislative Budget Request
a	Medicaid Price Level and Workload	B	$-1,872b ($181.4m GR)	$0
b	Kid Care	B	$82.8m (-$3.3 m GR)	$0
c	Medicaid Waivers	B	$15.81m ($6.4m GR)	$0
d				
e				
f				

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

The Medicaid budget is based upon the Social Services Estimating Conference and is not included in the Agency's LBR.

* R/B = Revenue or Budget Driver

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

ADMINISTRATION AND SUPPORT SCHEDULES

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

ADMINISTRATION AND SUPPORT

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

	Budget Period: 2015 - 2016
Department Title:	Agency for Health Care Administration
Trust Fund Title:	Administrative Trust Fund
Budget Entity:	Department Level
LAS/PBS Fund Number:	2021

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	1,590,862	(A)		1,590,862	
ADD: Other Cash (See Instructions)	1,920	(B)		1,920	
ADD: Investments	-	(C)		-	
ADD: Outstanding Accounts Receivable	54	(D)	415	469	
ADD: _____		(E)		-	
Total Cash plus Accounts Receivable	**1,592,836**	(F)	**415**	**1,593,252**	
LESS: Allowances for Uncollectible	-	(G)		-	
LESS: Approved "A" Certified Forwards	1,161,503	(H)		1,161,503	
Approved "B" Certified Forwards	339,811	(H)		339,811	
Approved "FCO" Certified Forwards	-	(H)		-	
LESS: Other Accounts Payable (Nonoperating)	-	(I)		-	
LESS:		(J)		-	
Unreserved Fund Balance, 07/01/2014	**91,522**	(K)	**415**	**91,937**	**

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 2014

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015 -2016

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/2014		
Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	$ 345,415	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	$ -	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment for net of receivables from other depts. for refund	$ 415	(C)
SWFS Adjustment #		(C)
SWFS Adjustment #		(C)
SWFS Adjustment #		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	$ (339,811)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	$ -	(D)
A/P not C/F-Operating Categories	$ 6,588	(D)
Current Compensated Absences Liability	$ 79,331	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	$ 91,937	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	$ 91,937	(F)
DIFFERENCE:	$ 0	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS

Budget Period: 2015 - 2016

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 2013-14					
13-10	**Report date 11/2013**	**Provider Payment Suspension and Termination Process Reviews**	**Finding 1** Overlap of Job Functions. **Recommendation** 1. We recommend that Agency staff and external parties be instructed to refer any questionable or suspicious provider activity related to fraud or abuse to Office of Medicaid Program Integrity (MPI) and the Agency continue to designate MPI as the Office tasked with detecting and investigating fraud and abuse pursuant to Section 409.913, F.S. 2. As the Agency continues to review the organizational structure and duties related to implementing Statewide Medicaid Managed Care (SMMC), we recommend Agency management review perceived areas of overlap, taking into account MPI's statutory duties, to identify opportunities to realign unit functions and increase coordination between FPCU and MPI.	1. Completed and on-going. This is done on a routine basis through many methods and needn't be further tracked as it is ongoing. Furthermore, where it is not clear whether a matter is related to fraud and abuse (vs. non-compliance), Medicaid staff are encouraged to discuss the matter with the Fraud Prevention and Compliance Unit (FPCU) to assist. 2. Completed and on-going. Reorganization efforts are now focusing on FPCU with changes to the structure beginning in June 2014 and continuing into Fall 2014.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 2 Procedures for Contractual Terminations and Payment Suspensions. **Recommendation** We recommend the FPCU establish written policies and procedures for processing contractual terminations and assigning Medicaid providers for pre-payment review (PPR) when contractually terminating them. These policies and procedures should address when to assign providers to PPR, require review and approval by the Fraud Liaison's immediate supervisor for all PPR requests, and require documentation of reasons why a provider is not assigned to PPR. **Finding 3** Policies on Approving Contractual Termination, Deactivation, and Stacking Requests.	The Agency will transition the Medicaid program from a variety of delivery systems (including fee-for-service and managed care) to a primary delivery system known as the Statewide Medicaid Managed Care (SMMC) program. The Agency expects to roll out the SMMC program by late summer. Under the new SMMC program, the overwhelming majority of Medicaid recipients will receive health services via capitated health plans. This transition requires significant reorganization of Medicaid operations as various programs sunset and phase out, while the Agency stands up new organizational units and functions to run the new managed care system. As part of this process, a critical unit studied in this audit, the Fraud Prevention and Control Unit (FPCU), will no longer exist. Its functions will be going to other organizational units within the Agency, including Medicaid Program Integrity, Medicaid Policy and Quality, and Medicaid Contract Management. Details of the reorganization, however, have not been finalized. This renders responding to the audit findings here extremely difficult, as many of these issues will be addressed as the Agency reorganizes. The Agency will complete SMMC rollout this summer, and will supply more specific responses to audit findings 3-9 on or before September 30, 2014.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			We recommend Medicaid develop a written policy for approving contractual termination, deactivation, and stacking requests. **Finding 4** Review and Communication of Proposed Contractual Terminations. **Recommendation** 1. We recommend that the FPCU develop written policies and procedures for communicating with applicable Agency staff regarding proposed contractual termination requests. 2. We recommend that FPCU document the decision making process for contractual terminations. **Finding 5** Communication with Third Parties. **Recommendation** 1. We recommend that Medicaid (with input from MPI and in consultation with the Communications Director) adopt a communications policy to assist in the prevention of premature information disclosure to third parties regarding with cause and without cause terminations. This policy should be approved by senior management and the Communications Director. 2. We recommend that Medicaid educate all employees on inappropriate information disclosure to third parties.	See Finding 2 Summary of Corrective Action Taken See Finding 2 Summary of Corrective Action Taken See Finding 2 Summary of Corrective Action Taken	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 6 Enrollment Process for Providers with Previous Contractual Terminations.		
			Recommendation We recommend the Prevention and Provider Focus Sub-Committee of the Fraud Steering Committee develop written procedures to guide Medicaid in evaluating the enrollment of providers with previous contractual terminations.	See Finding 2 Summary of Corrective Action Taken	
13-15	**9/1/11 - 8/31/12**	**Review of the Agency's Data Exchange MOU with DHSMV**	**Finding 1** Investigations had no written policies or procedures on the use of Driver and Vehicle Express (DAVE).		
			Recommendation The Investigations Unit should be responsible for development of policies and procedures to address the use of DAVE and Memorandum of Understanding (MOU) compliance requirements.	Investigations will develop a draft of recommended policies and procedures for inclusion in the Investigations Unit Data Aggregator Use Policy. Support Services will assist in drafting procedures as needed.	
			Finding 2 The MOU did not cover the purpose of monitoring Agency parking for improper use of handicapped and visitor spaces.		
			Recommendation Investigations should amend the Agency's MOU with DHSMV to include the purpose for Support Services' access.	A revised MOU has been requested for review and approval by the Agency head.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Finding 3 None of the users had any documentation to support why they accessed license or tag information. **Recommendation** 1. Investigations should formally document its log process in written procedures.	Investigations will develop a draft of recommended written procedures documenting the log process for inclusion with the Data Aggregator Policy.	
			2. Support Services should create a log to document its access to DAVE. The log process should also be formally documented by Investigations in written procedures.	Complete. Support Services has created a log to document its access to DAVE. The log is password protected. Facilities staff and the bureau chief have access to the password. Support Services will assist in drafting the portion of the procedures that pertain to the log as needed.	
			Finding 4 Neither Investigation nor Support Services have any documented procedures on the use of DAVE. **Recommendation** Investigations should document and implement procedures to ensure DAVE users and any associated personnel understand the confidentiality/security of data obtained from DAVE.	Investigations will develop a draft of recommended procedures for DAVE users within the Investigations Unit to ensure the confidentiality/security of data obtained from DAVE for inclusion in the Data Aggregator Policy.	
			Recommendation All Investigations and Support Services (who handle DAVE information) staff should be trained in the handling of DAVE information.	Complete. Investigations staff have received training. Investigations will continue to participate in training required for DAVE use. Users in Support Services have received training. Support Services will continue to participate in training required for DAVE use.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation Any DAVE-related information in Investigations should be contained where it is not accessible to any person coming into the common areas.	Complete. Investigations has implemented storage of all DAVE-related information in closed and locked offices. The data is not accessible to any person coming into the common areas.	
			Recommendation Support Services should ensure any DAVE-related information stored on a shared drive is accessible only to DAVE-authorized staff.	Complete. Support Services has created a log to document its access to DAVE. The log is password protected. Facilities staff and the bureau chief have access to the password.	
			Finding 5 The Agency does not have a process or maintain documentation to ensure compliance with MOU requirements for timely terminations and quarterly reviews of users' access permissions. Although Support Services and Investigations use the Agency's employee separation checklist, this checklist does not address application or system access permission termination.		
			Recommendation Investigations should document and ensure user access permissions are terminated in compliance with the MOU requirements. The DAVE Administrator should be responsible for maintaining all documentation for user access permissions.	Complete. Investigations will ensure user access permissions for DAVE Users in Investigations and will be terminated in compliance with the MOU requirements for staff who leave the office or if access is no longer required. The DAVE administrator will maintain all documentation for user access permissions and terminations. Support Services will ensure it requests termination of DAVE access for staff who leave the bureau or if access is no longer required.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Inspector General should appoint a staff person (Staff Person) independent of the DAVE process to conduct the quarterly reviews. Instructions and the quarterly quality control review form are located at: https://idave.flhsmv.gov/message_center.html	Complete. The Inspector General has appointed a direct reporting person independent of the DAVE process to conduct the quarterly reviews.	
			Recommendation The Staff Person should formally document and conduct quarterly reviews of users' authorizations. This person should develop desk procedures to address responsibilities addressed in this report.	Complete. The appointed staff person within the Office of Inspector General who is independent of the DAVE process will work with the Inspector General to develop desk procedures for quarterly usage reviews.	
			Recommendation The Bureau of Human Resources should modify the "Employee Separation Checklist" to include termination of the employee's access permissions to all systems or applications, whether internal or external. The Checklist should address any type of separation for the employee (e.g. transfer, promotion, demotion, termination, etc.).	Complete. The Bureau of Human Resources made changes to the Employee Separation Checklist to include a space for the supervisor to check that internal and external systems access has been terminated.	
			Finding 6 Investigations does not have any written procedures addressing public records requests or the confidentiality of DAVE information.		
			Recommendation Investigations should document and implement procedures addressing public records requests. The procedures should include specific instructions on how to document confidential information, including DAVE information in investigative files.	Investigations will draft recommended procedures for addressing public record requests received by the Investigations Unit for inclusion in the Data Aggregator Policy.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation All Investigations' staff should be trained about public records and understand the confidentiality of DAVE information, whether they access DAVE or not.	Investigations staff will be trained about public records and understand the confidentiality of DAVE information.	
			Finding 7 The Agency did not have a process or maintain documentation to ensure compliance with the MOU requirement about confidentiality acknowledgements.		
			Recommendation All current DAVE users and any staff with access to DAVE information should sign DHSMV's Confidentiality Acknowledgement forms. These forms should be maintained in a central file maintained by the DAVE Administrator for documentation purposes.	Complete. Investigations staff with access to DAVE will sign DHSMV's Confidentiality Acknowledgement Forms and provide them to the DAVE Administrator. The DAVE administrator will maintain all DHSMV's Confidentiality Acknowledgement Forms for Support Services and Investigations. Support Services staff with access to DAVE will sign DHSMV's Confidentiality Acknowledgement Forms and provide them to the DAVE Administrator.	
			Finding 8 The Agency did not have a process or maintain documentation to ensure compliance with the MOU requirement about criminal sanctions acknowledgements.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation All current DAVE users and any staff with access to DAVE information should sign DHSMV's Criminal Sanctions Acknowledgement forms. These forms should be maintained in a central file maintained by the DAVE Administrator for documentation purposes.	Complete. Investigations staff with access to DAVE will sign DHSMV's Criminal Sanctions Acknowledgement Forms and provide them to the DAVE Administrator. Completed. Support Services staff with access to DAVE will sign DHSMV's Criminal Sanctions Acknowledgement Forms and provide them to the DAVE Administrator.	
			Finding 9 The Agency does not monitor usage on an ongoing basis. There is no documentation to support that the Agency has performed any type of monitoring of user accesses to DAVE. The Agency does not consistently submit annual affirmations.		
			Recommendation To meet the on-going monitoring requirement, the Staff Person should review and document users' accesses to DAVE on a quarterly basis.	An initial quarterly review has already been completed and the Annual Affirmation Statement was submitted to DHSMV on 3/12/14.	
			Recommendation The Staff Person should timely complete and document an annual audit and submit an Annual Affirmation Statement to DHSMV. The audit guide and Annual Affirmation Statements are located at: https://idave.flhsmv.gov/message_center.html The Staff Person should incorporate all responsibilities addressed in this report, including performing the annual audit and quarterly monitoring, in written desk procedures.	Written desk procedures have been created and are currently being followed.	

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			Finding 10 For both the 2008 and 2011 MOUs, the Chief of Investigations, who was also the DAVE Administrator, signed the agreement for the Agency. **Recommendation** The Secretary should sign the DHSMV MOU.	The Chief of Investigations appointed in 2013 is aware that the Agency head is required to execute such inter-agency agreements. All future memoranda of understanding (MOUs) will be reviewed and signed by the Agency head. A revised MOU has been requested for review and approval by the Agency head.	
			Finding 11 One of Support Services' users does not always use DHSMV's DAVE system to perform his responsibility related to parking issues. He uses an older system (KDC) that is still being maintained by DHSMV. **Recommendation** Investigations should request that DHSMV remove the Support Services user's access to KDC.	Complete. Investigations has received confirmation from DHSMV/Support Services that KDC access has been cancelled. The DAVE Administrator will keep the documentation supporting the cancellation on file.	

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13-06 □	CYE 12/31/12	Adverse Incident Report Process	**Recommendation** Any Agency user of DHSMV driver license data should be required to access only DAVE. **Finding 1** Florida Center's Risk Management and Patient Safety office (RMPS) did not monitor for timeliness of report submission nor did they fine facilities for non-compliance with statutory deadlines. **Recommendation** We recommend that RMPS: 1. Develop policies and procedures to monitor the timely submission of reports; and 2. Consult with the Office of the General Counsel (OGC) to determine if the Agency has statutory authority to fine facilities for submitting their adverse incident reports after the statutory deadlines, and if it does have such authority, fine facilities for late report submission. **Finding 2** Finding #2 has been classified as exempt from public records release and/or confidential in accordance with Section 282.318(4)(f), Florida Statutes and thus is not available for public distribution.	Complete. Support Services has contacted DHSMV's Technical Assistance Center to request the KDC access be cancelled. Support Services staff is only accessing DAVE. 1. RMPS has drafted two policies to address monitoring of report timeliness. 2. Completed. Facilities may be fined by surveyors for being out of compliance with reporting requirements. In such cases the RMPS unit will issue a Request for Sanction (RFS) if they fail to receive a report in a timely manner. The surveyors will cite the facility for failing to file a report for a substantiated incident that should have been reported but was not.	

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			Finding 3 RMPS does not adequately document and track report referrals to Complaint Administration Unit (CAU). **Recommendation** We recommend RMPS and CAU jointly: 1. Periodically reconcile report referrals to ensure that all incidents referred by RMPS are actually received. We recommend RMPS: 2. Document the date reviewed on the hospital form. 3. Request that the Assisted Living Facilities (ALF) form be modified to include a date of review.	1. The CAU will coordinate monthly meetings with RMPS for the purpose of reconciling referrals from RMPS. 2. Staff have been instructed to note the date of review in the comment section. The review date field is not accessible to RMPS staff at this time. RMPS plans to submit or modify an existing PSR to correct this issue. 3. A PSR has been submitted and is being managed by HQA IT team. The final project completion date is to be determined based on Agency-wide IT programming priorities and was addressed at the APG meeting on February 13, 2014.	

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			We recommend RMPS: 4. Request that the Nursing Homes (NH) form include a date of receipt and date of review. 5. For all three forms, request a field for date of referral to CAU rather than rely on staff to post this information in the comments' section. 6. Update the policy outlining the criteria for referring reports to CAU.	4. A PSR has been submitted and is being managed by HQA IT team. The final project completion date is to be determined based on Agency-wide IT programming priorities and was addressed at the APG meeting on February 13, 2014. 5. A PSR has been submitted and is being managed by HQA IT team. The final project completion date is to be determined based on Agency-wide IT programming priorities and was addressed at the APG meeting on February 13, 2014. 6. Completed as per policy 11-18. This policy has been adopted by RMPS and shared with CAU staff.	
			We recommend RMPS: 7. Consider an automated method to notify CAU that there is a report for review.	7. Consideration is being given to the feasibility of including this requirement in existing PSRs. Anticipated date of completion.	
			We recommend CAU: 8. Add fields to their complaint tracking database to include the date the report was received by CAU, the date the report was reviewed by CAU, and date the report became a complaint, if applicable.	8. Completed. CAU has considered the recommendations of the auditor and added the appropriate fields in the adverse incident database.	
			Finding 4 Adverse incident reports were not referred to DOH timely or securely.		

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			Recommendation We recommend: 1. The Agency work with DOH to update the MOU to address the security, method and frequency of report transfer to DOH. 2. The Agency work with DOH technical staff to address the Versa System issues that impede DOH staff from reviewing hospital, ASC and HMO reports as well as examine the feasibility of access to the Nursing Homes Reporting System. **Finding 5** The referral of litigation notices to RMPS does not appear to serve a useful purpose. **Recommendation** We recommend: 1. The Florida Center consult with OGC, CAU, and HQA Field Office management to determine the purpose and intended results of reviewing these documents. 2. If it is determined that RMPS should continue to receive and review the documents, the Florida Center should finalize a policy that includes how staff should record, at a minimum, from whom they received the document, the date received by RMPS, the date of review by RMPS, and the action taken by RMPS such as a referral. **Finding 6** The receipt and review of annual reports from facilities does not appear to be a cost effective use of Agency resources.	1. Staff have already discussed this with Agency Privacy Office. We will be moving forward using new “model” MOU language. This will ensure that MOU language best meets unit and Agency needs. 2. A PSR has been submitted and is being managed by HQA IT team. The final project completion date is to be determined based on Agency-wide IT programming priorities and was addressed at the APG meeting on February 13, 2014. 1. The review is mandated by statute. The Agency will include removal of review requirement in the 2015 Agency legislative proposal. Anticipated date of completion: September 30, 2014 2. The review is mandated by statute. The Agency will include removal of review requirement in the 2015 Agency legislative proposal. Anticipated date of completion: September 30, 2014	

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			Recommendation We recommend: 1. Management determine the benefit of requiring facilities to submit annual reports. If Agency management determines that the annual report requirement is not useful or cost beneficial to either the Agency or facilities, we recommend that the law be revisited. 2. RMPS publish the required malpractice claims statistics for hospitals and ASCs as required by law. **Finding 7** Some Agency rules, policies and forms regarding adverse incidents are outdated. **Recommendation** We recommend the Florida Center continue to update and align the rules, policies and forms with current statutory provisions regarding adverse incidents and ensure congruence among these documents.	1. The Agency has determined that the annual reports serve little useful purpose. However, annual reports are required by statute. The Agency unsuccessfully pursued removal of the requirement in 2009 and 2010 legislative sessions. The Agency will include removal of review requirement in 2015 Agency legislative proposal. Anticipated date of completion: September 30, 2014. 2. The 2012 reports have recently been added; the 2013 reports will not arrive until April and will be posted by the end of May. Anticipated date of completion: September 30, 2014. This activity is ongoing but requires coordination with IT and OGC because the forms are or will be automated and must go through the rulemaking process to be activated once they have been developed. However, RMPS has submitted PSRs to modify existing forms for HMOs, ALFs, ASCs, and hospitals.	
13-12	**7/1/12 - 12/31/12**	**MCM Provider Enrollment Process**	**Finding 1** Delay in background screening review. **Finding 2** Non-institutional sub-unit review or File Maintenance (FM) delay.		

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			Finding 3 Fiscal agent referral delay/ "orphan" tasks. **Finding 4** File Mix-ups. **Recommendation 1 (for Findings 1-4)** Require a monthly report or establish performance measures to track the MCM review processing times.	Designing, building, testing, implementing, and supporting new reports in production is more costly than the risk. MCM will table new reporting until procurement of new FMMIS. Preliminary work toward that goal began in 2013 with final product in place July 1, 2018. Ultimately, there are several factors, outside of the control of MCM analysts, which may cause an application to take longer than the average time to process. Activities that can increase MCM processing times include: site surveys, pre-certification reviews, changes of ownership for facility licensure, and rate setting. Anticipated date of completion: Accept risk.	

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				MCM will pursue the feasibility of adding new application status tracking codes, which will be used to show in the FMMIS whenever an application has been forwarded for an action outside of MCM. The status tracking codes will not shorten the time these outside actions take for completion. It will however aid applicants in understanding the exact whereabouts of their application and avoid the impression the application has stalled. As part of the implementation of the new status tracking codes, MCM will also revise the Enrollment Status page on the Medicaid public portal to better display expected processing times and to supply contact points for questions regarding an application at any given stage of processing.	
			Recommendation 2 (for Findings 1-4) Establish a written policy for MCM review processing times.	MCM has begun design sessions for documenting desk level procedures. Completion of the documentation will be impacted by several high priority projects, including the Statewide Medicaid Manage Care rollout, the Affordable Care Act provider screening implementation, and the 2014 Legislative Session. While MCM agrees with the need for desk level procedures, those procedures can only impact the processes directly under the control of MCM analysts. They cannot mitigate the risk of longer review times as the result of waiting for results of site surveys, pre-certification reviews, changes of ownership for facility licensure, and rate setting.	

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			Recommendation 3 (for Findings 1-4) Continue to require all MCM analysts to utilize the reporting functions in iTRACE to regularly track applications assigned to them. This will help ensure that applications do not "fall through the cracks" and do not exceed processing times unnecessarily.	Completed. MCM analysts currently utilize the reporting functions in iTRACE.	
			Recommendation 4 (for Findings 1-4) Continue to require the fiscal agent to conduct periodic monitoring to detect "orphan" tasks that are showing up under "MCM Review" status.	Completed. The Medicaid fiscal agent runs weekly reports and verifies all open Change Orders and there are specific monitoring roles assigned to both state and fiscal agent analysts.	
			Recommendation 5 (for Findings 1-4) Require the fiscal agent to conduct periodic monitoring to detect applications in Return To Provider (RTP) status or have been sent to the wrong analyst for review, and are showing up under "MCM Review" status.	Design session held with Medicaid fiscal agent for creation of a new report which will identify all applications in any status other than RTP which have an RTP letter generated for a later date. Fiscal agent staff will work the report weekly and will correct any application status that is in error. The issue of tasks being assigned to the wrong analyst was corrected under response 6 below.	
			Recommendation 6 (for Findings 1-4) Run a weekly report to identify tasks due within the week to alert both analysts and supervisors and require monitoring of analysts at regular intervals to help ensure applications are handled appropriately and in accordance with processing time frames.	Completed. MCM analysts run daily reports to capture their current workload. Supervisors run weekly reports to identify outliers and work with the analysts to resolve. The daily reports also correct the issue of tasks being assigned to the wrong analyst. These are able to be reassigned in a timely manner.	

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13-02	**7/2012-1/2014**	**Review of Accurint**	**Finding 1** Out-of-date Agreements. Investigations and MPI have not updated their Accurint applications/agreements with LexisNexis since 2005. **Recommendation** 1. Investigations and MPI should review and update their current applications/agreements with LexisNexis. 2. Every three years, both Investigations and MPI should renew their applications/agreements with LexisNexis to ensure the information contained is up-to-date. **Finding 2** Compliance with Fair Credit Reporting Act. MPI has not complied with the Fair Credit Reporting Act (FCRA) terms of the Accurint application/agreement because MPI used Accurint for reviewing employee applicant information. **Recommendation** 1. The Accurint Administrator should document and implement procedures, with the Inspector General's approval, to ensure all Accurint users and any associated personnel understand the consequences if users do not comply with requirements of the Accurint agreement for any misuse, including the Fair Credit Reporting Act.	1. The Investigations Unit and MPI will review and update, as necessary, their agreements with LexisNexis. 2. The OIG will adopt a policy requiring at least a triennial review of the LexisNexis/State of Florida agreement. 1. MPI has already discontinued use of Accurint Services for pre-employment checks and for pre-employment background purposes, effective December 9, 2013. The OIG will adopt a written policy and procedures regulating Accurint and other restricted databases usage, with appropriate guidance provided in the policy statements.	

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			2. The Accurint Administrator should develop and implement a Civil/Criminal Sanctions Acknowledgement form, with the Inspector General's approval, for all Accurint users to sign when given access. The form should address the consequences of any misuse, including the Fair Credit Reporting Act. Signed forms should be in a central file maintained by the Accurint Administrator for documentation purposes.	2. Such an acknowledgement form will be included in the adopted policy regulating Accurint and other restricted databases usage. The retention of acknowledgment forms will be maintained by the Accurint Administrator within the OIG.	
			3. The Accurint Administrator should train all Investigations and MPI staff who have access to Accurint information regarding the requirements of the Accurint agreement, including the Fair Credit Reporting Act.	3. Training of all Accurint users will be required by the adopted policy regulating Accurint and other restricted databases usage. Such training will address the Accurint agreement's allowances and disallowances, including the proscriptions related to the FCRA.	
			Finding 3 Maintaining Documentation Support and Conducting Reviews. The OIG does not have adequate internal controls to ensure Accurint is used for identified purposes and that there is no misuse of information.		
			Recommendation 1. The Accurint Administrator should develop procedures, with the Inspector General's approval, to address Accurint use. The procedures should also require Accurint users to document the reason(s) for each search; for example, case number, reason for audit/investigation, and the name of requestor.	1. The OIG will develop a written policy and procedures for Accurint and other restricted databases usage requiring the documentation of purpose for every Accurint query, documentation of the related case or project number, and requiring the identification of the querying investigator, analyst or auditor.	
			2. The Accurint Administrator should train all staff in the proper use of Accurint and documentation for searches.	2. All staff members within OIG associated with Accurint queries for case support will receive training on Accurint allowances, documentation, and restrictions.	

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			3. The Inspector General should appoint a person independent of both Investigations and MPI to perform reviews of Accurint searches on a quarterly basis. All reviews should be documented and maintained for no less than five years.	3. Completed. On April 11, 2014, personnel action was effected to incorporate Accurint compliance and review duties into the position description of an Inspector General direct report independent of both Investigations and MPI.	
			4. The appointed staff person should also work with the Inspector General to develop desk procedures for quarterly usage reviews.	4. The appointed compliance person, a direct report to the Inspector General, will work with the Inspector General in developing the procedures for quarterly usage reviews and summarizing these procedures for inclusion in the policy related to Accurint and other restricted databases policy.	
			Finding 4 User Access. The OIG does not have a consistent, documented process for adding and deleting Accurint users.		
			Recommendation 1. The OIG should designate specific individuals responsible for approving Accurint access and termination.	1. The Accurint Administrator and the compliance officer, a direct report to the Inspector General, will sequentially approve or disapprove Accurint users based on policy parameters, employment status, and satisfaction of training and acknowledgment requirements.	
			2. The Accurint Administrator should develop written procedures, with the Inspector General's approval, to address user access and termination requests, and distribute them to identified parties. All requests should be documented in writing.	2. The Accurint administrator and the compliance officer will both work with the Inspector General in including access and termination request processes and procedures in the upcoming policy and procedures being developed to address Accurint and other restricted database usage.	
			3. The Accurint Administrator should maintain written documentation for no less than five years for each Accurint addition or termination.	3. A 5-year retention period for records associated with Accurint user additions and user deletions will be included in policy.	

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			Finding 5 Confidentiality and Security. MPI may not be complying with the Drivers' Privacy Protection Act (DPPA) and related state laws.		
			Recommendation		
			1. The Accurint Administrator should develop written procedures, with the Inspector General's approval, to ensure Accurint users and any associated personnel understand the confidentiality/security of data obtained from Accurint.	1. The policy under development by the IG, the Accurint Administrator, and the Accurint Compliance Officer will address the requirement for security and confidentiality of information derived from Accurint.	
			2. The Accurint Administrator should develop and implement a Confidentiality Acknowledgement form, with the Inspector General's approval, for all Accurint users to sign when given access. These forms should be in a central file maintained by the Accurint Administrator for documentation purposes.	2. Such an acknowledgement form will be included in the adopted policy regulating Accurint and other restricted databases usage. The retention of acknowledgment forms will be maintained by the Accurint Administrator within the OIG.	
			3. The Accurint Administrator should train all Investigations and MPI staff who have access to Accurint information regarding the confidentiality/security of the data.	3. The policy under development by the IG, the Accurint Administrator, and the Accurint Compliance Officer will address training and re-training of all Accurint users on the security and confidentiality of information derived from Accurint.	
			4. MPI staff should ensure any Accurint-related information is secured where it is not accessible to any person coming into MPI's offices.	4. MPI will modify its internal security condition to ensure Accurint-based print outs and information are secured and inaccessible to unauthorized parties.	
			Finding 6 Use of Accurint software. Users do not fully utilize Accurint's potential. Some users do not use Accurint on a routine basis.		

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			Recommendation 1. The Accurint Administrator should terminate the Bureau of Financial Services staff's access and discontinue payment for that user's access.	1. Bureau of Financial Services' Accurint access will be terminated no later than May 30, 2014.	
			2. The OIG should re-evaluate its need for Accurint and determine whether it is the appropriate tool for MPI.	2. Completed. Such an evaluation was conducted by the Inspector General and the Chief of MPI prior to offering this audit response. Accurint is an appropriate tool for MPI; however, the assignment of Accurint user rights requires modification by MPI.	
			3. MPI should determine how many licenses are necessary to perform the intended function and consider limiting the licenses to one or two staff whose job responsibilities would include accessing Accurint for all MPI requests.	3. The Chief of MPI has informed the Inspector General of his intention to limit Accurint access to selected employees within the Data Detection Unit, who may process queries for all MPI needs, and to specific designees identified by the Chief of MPI who require access for unique program integrity needs.	
			4. All Accurint users should be trained in the use of all applicable Accurint services, including the Healthcare option.	4. Training of all Accurint users will be required by the adopted policy regulating Accurint and other restricted databases usage. Such training will address the Accurint agreement's allowances and disallowances, Accurint program features enabled, including the Healthcare features for the Accurint product.	

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AG 2014-001	7/2010 - 2/2012	**Operational Audit of AHCA, Prior Audit Follow-up**	**Finding 1** Reimbursement Rate Calculations. The Agency's instructions for the calculation of Medicaid reimbursement rates for hospitals were not up-to-date. Additionally, the Agency did not always document a second-person review of the manual profile sheets used in the calculation of Medicaid reimbursement rates for intermediate care facilities for the developmentally disabled (ICF-DD). **Recommendation** We recommend the Agency ensure that manual profile sheets show evidence of review by a second person. In addition, the Agency should ensure that the instructions to be used in the calculation of reimbursement per diem rates are reliable and up-to date. **Finding 2** Rates Not Timely Entered Into FMMIS. The Agency did not always enter reimbursement rates into the Florida Medicaid Management Information System (FMMIS) prior to the effective date of the rates and, as a result, did not always reimburse claims at the correct rates.	Fully corrected. The Agency is continuing to ensure that the manual profile sheets are signed by the second reviewer. The internal training document has been updated.	

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			Recommendation We again recommend that the Agency enhance controls to ensure that new and adjusted reimbursement rates are entered into FMMIS prior to the rates' effective dates.	Fully corrected. The Agency has always and continues to ensure new rates are submitted in a timely fashion prior to the effective date, subject to deferrals caused by legal action. Any rates submitted after the effective date will be automatically adjusted by our Fiscal Agent for the retroactive payments to the effective date.	
			Finding 3 Cost Report Audit Adjustments. The Agency did not always calculate and timely process facility reimbursement rate changes resulting from cost report audit adjustments.		
			Recommendation To ensure that improper reimbursement rates are timely identified and corrected, we again recommend that the Agency calculate reimbursement rates when cost report audits are reviewed and released. Additionally, we recommend that the Agency strengthen policies and procedures to ensure that rate adjustments are timely calculated, entered into FMMIS, and retroactively applied.	Fully corrected. The Agency continues to complete cost report audit adjustments after all administrative action is legally concluded. The Agency has been able to speed up the time frame in which audit adjustments are completed and any retroactive adjustments are calculated and recouped. Furthermore, Nursing Home staff reviews monthly all rates previously sent to the Fiscal Agent to ensure that they have been entered correctly. Rates not updated or updated incorrectly are addressed with Medicaid Contract Management and the Fiscal Agent immediately in order to resolve any issues.	
			Finding 4 Procedures to Detect a Conflict of Interest. The Agency should continue efforts to enhance policies and procedures to ensure that there are no conflicts of interest (COI) for employees involved in the contract procurement and management processes.		

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			Recommendation The Agency should continue efforts to enhance policies and procedures by requiring that all employees involved in the procurement and contract management processes prepare COI questionnaires.	Fully corrected. The COI form was updated January 2013, and the COI questions were added to the contract initiation form in 2011.	
			Finding 5 Contract Monitoring Plans. Contract Monitoring Plans did not always include all the information required by the Agency's Contract Monitoring Plan Form Instructions. In addition, Contract Monitoring Plan Forms were not always appropriately signed and dated when prepared and approved.		
			Recommendation The Agency should continue efforts to ensure that all Contract Monitoring Plans specify the items or deliverables to be monitored and include a summary plan of action should deficiencies be noted during monitoring. The Agency should also ensure that all Contract Monitoring Plan Forms are signed and dated when prepared and approved.	Fully corrected. The Contract Monitoring Plan Form was updated in December 2013 to allow for documentation of monitoring information on a more regular basis to comport with the monitoring schedule.	
			Finding 6 NET Program Contract Cost Management. The Agency should ensure that sufficient information is obtained and maintained to document that administrative fees paid related to Non-Emergency Transportation (NET) Program services were reasonable and did not result in a profit between State agencies.		

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			Recommendation We recommend that the Agency monitor the Commission for the Transportation Disadvantaged (CTD) administrative costs and maintain documentation to demonstrate that the NET Program contract rates are reasonable and do not result in a profit between State agencies.	Fully corrected. Agency staff met with the auditor and determined the actual issue in the finding entailed the CTD not having a detailed record of the transfer of funds from the CTD to the community transportation coordinators (CTD's subcontractors). This was confirmed with the auditor who then met with CTD staff to review and accept monthly journal transfers that record these transactions. The Agency Contract Manager has included review of these records as an item for annual monitoring visits. The records were in order at the May 2013 on-site contract monitoring. (Spacing)	
			Finding 7 Tangible Personal Property Inventory Procedures. The Agency needs to update its Property Manual and continue efforts to improve the timeliness of the tangible personal property (TPP) physical inventory and related reconciliation process.		
			Recommendation We recommend that the Agency update its Property Manual to comply with the Department of Financial Services (DFS) Rules and continue efforts to improve the timeliness of the TPP physical inventory and related reconciliation process.	Fully corrected. The Agency has updated the Property Manual to comply with DFS Rules effective May 2013. The Agency will also continue to work with staff in order to improve the timeliness of the TPP physical inventory and related reconciliation process.	
			Finding 8 Property Recording and Inventory. The Agency did not always timely and accurately update tangible personal property records for property acquisitions and transfers.		

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AG 2014-057	7/2010 - 2/2012	Operational Audit of AHCA, Health Care Facility Licensing Function and IT Controls	**Recommendation** We recommend that the Agency continue efforts to ensure that property records are timely and accurately updated for property acquisitions and transfers. **Finding 1** Health Care Facility Licensing Requirements. The Agency's health care facilities licensing processes did not always ensure that required background screenings were timely performed for health care facility employees or document Agency efforts to verify that nursing home applicants reported civil verdicts or judgments.	Fully corrected. The Agency will continue its efforts to ensure that property records are timely and accurately updated for property acquisitions and transfers by continuous follow-up with staff until property records are accurate and complete.	

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			Recommendation We recommend that Agency management enhance the licensing procedures to require that Division staff track and verify the timely performance of required background screenings by health care facilities. In addition, Agency management should revise the nursing home licensing procedures and associated checklists to better ensure that nursing homes timely notify the Agency of any civil verdicts or judgments related to medical negligence, violation of residents' rights, or wrongful death. **Finding 2** Timely Receipt and Review of Licensing Applications. The Agency did not always verify that required health care facility licensure due dates were met or ensure that all applicable fees were assessed. **Recommendation** We recommend that Agency management ensure that applicable fees are assessed for late applications. In addition, the Agency should ensure that applications are subject to timely review and, as applicable, appropriate follow-up procedures that include the timely mailing of omission letters.	Fully Corrected. Background Screening The retention of fingerprints provides up-to-date arrest information for individuals that have been screened through the Clearinghouse. The provider and licensure unit are both notified when a new arrest occurs. Additionally, providers are notified of those employees whose fingerprints have been retained and are about to expire, beginning six months prior to expiration. Civil Verdicts This was completed as indicated in October 2013. Analysts review this as part of the application process. The application is posted on the Agency's website at: http://ahca.myflorida.com/mchq/HQALicensureForms/index.shtml Fully Corrected. Reports are now in place for management to track application timeframes and monitor for assessment of applicable fees. These reports represent completion of immediate tasks to ensure that applicable fees are assessed for late applications. In addition to these reports, plans are in place to have IT program VERSA so that the late fee assessments are added automatically to late applications.	

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			Finding 3 Reconciliation of License Fees Received. The Agency could not always demonstrate that health care facility license fee deposits recorded in the Agency's licensing system were timely and appropriately reconciled to those deposits in the State's accounting records.		
			Recommendation We recommend that Agency management enhance the health care facility license fee deposits procedures to ensure that appropriate reconciliations of fee collections are timely and properly completed, documented, and reviewed by appropriate supervisory staff.	Partially Corrected. This measure is an ongoing process. We continue to work with the appropriation staff in the Division of Health Quality Assurance to improve processes and communication. We have re-established our reconciliation process, but it requires some process improvements prior to being fully implemented. We anticipate completion and full implementation by October 2014.	
			Finding 4 Security Controls - Network Authentication. Agency network authentication controls need improvement.		
			Recommendation The Agency should strengthen network authentication controls to ensure the confidentiality, integrity, and availability of Agency data and IT resources.	Not Corrected. As of May 21, 2014, the FL Department of Law Enforcement has not issued a ruling on Criminal Justice Information Services (CJIS) standards for cloud computing which will allow for our Agency to determine if password standards are needed beyond what is recommended by this audit. The FDLE ruling is expected within this fiscal year but could be later.	

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			Finding 5 Change Management Controls. The Agency could not always demonstrate that system and application changes were properly authorized, tested, and approved. **Recommendation** We recommend that Agency management enhance the change management procedures to require that sufficient documentation of any changes to Agency systems and applications be maintained to demonstrate that only those changes that are properly authorized, tested, and approved are made.	Fully Corrected. Change Control/Management Process. By June 2013 we made the following changes due to the audit consultations and findings: • The Request for Change (RFC) number was added, as well as the Central Systems Management Unit (CSMU) number which ties the change control issue to a project or specific application. • Since the person listed cannot be the implementer, the sponsor's name from the business unit or the user-acceptance name are now listed as well. • We have added an actual "Start" and "Complete" date for completion of any changes to a system which requires verification of a test from the requesting business unit before "Actual Complete" date is finalized and submitted. • Further documentation indicating any logistics and actual scripts etc. is now attached as well. IT Policy and Procedure Enhancements. The following AHCA IT policy and procedure were updated as well: • Information Technology Change Management Policy (Policy 09-IT-03) • Change Management Procedure (Policy Reference 09-IT-03)	

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AG 2014-173	FYE 6/30/13	**Compliance and Internal Controls Over Financial Reporting and Federal Awards**	**2013-001** The FAHCA Bureau of Finance and Accounting (Bureau) did not appropriately record in the correct funds the receivables resulting from Medicaid overpayments. **Recommendation** We recommend that the Bureau establish written fiscal year-end reporting procedures to better ensure that receivables resulting from Medicaid overpayments are appropriately recorded in the correct funds. **2013-002** The FAHCA Bureau of Finance and Accounting (Bureau) did not correctly identify, calculate, and record all Disproportionate Share Program receivables, revenues, and deferred revenues. **Recommendation** We recommend that the Bureau strengthen fiscal year-end reporting procedures to ensure that, among other things, the applicable spreadsheet includes correct calculations for receivables and appropriate consideration is given to the 60-day collection period when recognizing deferred revenues and revenues.	The Agency staff reviewing year-end requirements was new last year. However, current staff, even though new to the Agency, is very familiar with financial statement requirements and will ensure future compliance. The Bureau is working to properly document this process to ensure that appropriate consideration is given to the unique financial statement requirements of each fund. Fully Corrected. Developed better communication between the staff of the Bureaus of Financial Services and Medicaid Program Finance. Financial Services provides more detailed fiscal information (check number and individual transactions) to Medicaid Program Finance for tracking and reconciliation purposes. Refined year-end process to include the two bureaus working together to ensure cash receipts are reconciled and to ensure receivables, revenues, and deferred revenues are properly identified and recorded.	

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			2013-008 The FAHCA Bureau of Finance and Accounting (Bureau) did not record all year-end accounts payable (liabilities) and expenditures in the period the transactions occurred. **Recommendation** We recommend that the Bureau establish written fiscal year-end reporting procedures to better ensure that all year-end liabilities and related expenditures are recorded in the period in which the transactions occurred.	Certified accounts payables were established by the Bureau of Financial Services; however, payables were inadvertently deleted once it was determined that sufficient certified forward budget was not available to pay the invoices presented. The appropriate way to handle this situation would have been to remove the certified indicator from the payables that exceeded the available balance. This issue will be addressed with staff during accounts payable training. Also, current supervisory staff is very knowledgeable of the certified forward process and will implement a review process that will ensure this will not happen in the future.	
			2013-045 Refugee Medical Assistance (RMA) claim payments made to providers were not always paid in accordance with established Medicaid policy. **Recommendation** We recommend that the FAHCA ensure that appropriate controls are in place and operating effectively to ensure that RMA claims are accurately and properly processed and paid.	The FAHCA continues to review procedures pertaining to the identification and subsequent recovery of claims paid to retro-terminated providers. Upon completion of this review, procedures will be implemented that will allow for the identification and notification of amounts due from retro-terminated providers.	

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				The audit report listed two claims where the FAHCA did not charge a co-pay for MediPass recipients. In researching the proposed system fix it was determined that the recipients in both claims were also in a Prepaid Mental Health Plan which excludes them from the co-pay rules. There was no error in the transaction.	
			2013-050 Medical service claim payments made to providers of Medicaid services were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, some payments were for improper amounts or for unallowable services.		
			Recommendation We recommend that the FAHCA ensure that appropriate electronic and manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed.	Medicaid/Medicare Crossover Claims: CSR 2642 (Outpatient Crossover Claims - Lessor of Pricing) was implemented April 2014 to make FL MMIS correction. Reprocessing of the claims from FY 2007/2008, 2008/2009 and 2009/2010 is currently in process and the payment recoupment process is expected to be completed by the end of this calendar year. Copayment issue: CSR 2250 was implemented April 17, 2014 to make this correction.	

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				Pharmacy Claim with Underpayment: Drug manufacturers provide drug pricing data to First Data Bank (FDB), a third-party entity acting as a clearinghouse for pharmaceutical companies. FDB supplies the pricing data to the Agency's pharmacy system. The Agency does not determine or control when the manufacturers release drug pricing changes or when FDB delivers them. The Agency does have policy and protocols in place to ensure pricing changes are uploaded in a timely manner once received from FDB. Pharmacy rates are loaded weekly on Saturdays to minimize the impact to point of sale for the partner pharmacies. Pharmacies are aware of this schedule and know to reprocess claims when rate changes occur. The Agency does not reprocess pharmacy claims when pricing changes are completed subsequent to payment. This is due to the nature of the point-of-sale submission methodology and claims tracking and reporting mechanisms unique to pharmacy transactions. The pricing change related to the claim noted in the finding was received by the pharmacy system on January 4, 2014. It was uploaded in a timely manner to the pharmacy system on January 5, 2013, only one day after receipt. The effective date of the new rate was December 28, 2012. The claim in the finding was submitted and paid on December 30, 2012. The claim paid correctly at the rate on file at the time of adjudication. It was the responsibility of the pharmacy to void and reprocess the claim once the new rate was loaded. This issue is closed.	

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			2013-051 The FAHCA continued to record medical assistance related payments to incorrect appropriation categories in the State's accounting records. **Recommendation** We recommend that the FAHCA strengthen procedures for the accurate recording of medical assistance related payments in the State's accounting records. We also recommend that the FAHCA consider revising the methodology used for recording payments to the correct medical services appropriation categories to reduce the need for subsequent journal transfers. **2013-052** The FAHCA did not ensure that refunds, including those for drug rebates, were accurately reported on the Cash Management Improvement Act (CMIA) Annual Report to the Florida Department of Financial Services (FDFS). In addition, the FAHCA did not always reduce Federal cash draws by the Federal share of drug rebates received.	Fully Corrected. The original July 1 budget authority for the medical assistance related payments is based upon the results of the Medicaid Expenditures Social Services Estimating Conference (SSEC), which is normally held in December or January. The Bureau of Financial Services has taken steps to modify internal processes to allocate all expenditures to the correct category when paying them originally. Budget amendments are now submitted after each subsequent SSEC to realign the Medicaid Services categories to reflect the results of the latest conference. As the FAHCA transitions to statewide managed care, we will review the possibility of collapsing categories, which allows for an opportunity to align FMMIS categories and FLAIR categories and reduce the need to pay some expenditures out of alternate categories because there is not a one-for-one correlation of categories.	

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			Recommendation We recommend that the FAHCA ensure that CMIA report data submitted to the FDFS is accurate and complete and that cash draws are appropriately reduced for drug rebates received. **2013-054** The FAHCA made payments to an ineligible provider.	Fully Corrected. We have refined our process to ensure the accurate reporting of data on the CMIA annual report. This includes the compilation and reconciliation of data on a monthly and quarterly basis to ensure the identification of any errors earlier in the process. The Bureau of Financial Services has developed and implemented a monthly reconciliation of Drug Rebate revenues between the rebates collected by Molina, FAHCA's vendor, and the revenues recorded in FLAIR. All unreconciled items are researched and addressed so that an accurate record of revenues is captured each month. Federal draws are reduced on a weekly basis, as needed, corresponding to Drug Rebate revenues and expenditures. Federal draws are also reduced in the first week following the submission of the CMS 64, when needed, to true-up the reduction for Drug Rebates.	

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			Recommendation We recommend that the FAHCA ensure that payments are made only to providers with Medicaid Provider Agreements in effect.	The FAHCA and the Medicaid Fiscal Agent have identified the providers who missed the renewal process and are actively working with the providers to complete their applications. System logic will be implemented in the FMMIS to prevent any further issues once all outstanding renewals are complete. Until then, a monthly report will identify any providers who missed renewal and the FAHCA will manually suspend the provider and direct the fiscal agent to trigger the renewal process. The provider cited in the audit completed renewal and a copy of the agreement covering the audit period was forwarded to HHS. No Federal match money should be owed from the State.	
			2013-055 The FAHCA did not always ensure that facilities receiving Medicaid payments met required health and safety standards.		
			Recommendation We recommend that the FAHCA increase its efforts to ensure that Life Safety Surveys and follow-up surveys are conducted within the established time frames.	As of June 24, 2014 AHCA's Division of Health Quality Assurance (HQA) Field Operations has completed its hiring of the nineteen allocated Fire Protection Specialist and all positions are filled. All surveyors are state certified and nationally recognized by the National Board on Fire Service Professional Qualifications (Pro Board) with the exception of three of the nineteen. One is working to obtain their Pro Board which will be completed by the end of 2014, one has completed the training and is waiting on their certificate and the last one has been on extensive FMLA and was not able to finish the course at this time.	

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				Four of the nineteen surveyors required to complete the CMS Basic Life Safety Course (in order to administer federal surveys) should complete the course by the end of October 2014. This training is required for surveyors to independently survey for compliance with life code requirements. Over the past year the Bureau has deployed Life Safety Code (LSC) surveyors from other field offices to Delray Beach and Miami to ensure nursing homes, ICF's and hospital state/federal LSC surveys are up to date and another position was reclassified to a Fire Protection Specialist (LSC Surveyor Position) to help maintain timely and accurate completion of this survey work. We will continue to monitor to ensure the surveys are within the required timeframe. In October 2013 the Bureau of Field Operations updated their policy for conducting LSC inspections. Inspections are conducted annually, but no later than 15.9 months from the previous annual licensure and/or recertification survey. The Bureau's policy for conducting revisits has also been updated. Each field office is responsible to ensure that the surveys are conducted in accordance with state and federal timeframes. If a revisit is needed based on the initial visit, the field office manager would determine, based on the survey findings, if an onsite revisit will be conducted. If it is determined an onsite revisit is necessary, the onsite visit would be conducted a minimum of 45 days, but no later than 90 days, following the survey for which noncompliance was determined. Exceptions to the scheduling timeframes may be approved by the Chief of Field Operations and documentation of the approval is maintained by the field office and Quality Assurance lead.	

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				The above process will be incorporated into the Licensure & Certification Standard Operating Procedures. This Standard Operating Procedures Manual is currently in the process of being updated and revised to reflect current processes for all provider types regulated by the Division of Health Quality Assurance. The manual is 70% updated as of July 17, 2014 with the expectation that the complete revisions, approval and implementation of all changes will be no later than September 30, 2014.	
			2013-056 The FAHCA's established policies and procedures did not provide for the timely issuance of cost report audits of nursing homes and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). Additionally, the FAHCA had not performed monitoring of the vendor contracted to perform hospital cost report audits.		
			Recommendation We recommend that the FAHCA enhance policies and procedures to provide for the timely issuance of cost report audits. We also recommend that the FAHCA ensure that the performance of the hospital cost report auditor (Medicare intermediary) be timely monitored.	In regards to cost report audits and audits on appeal, an interagency contract has been obtained with the Office of the Attorney General to assist with the backlog of audits on appeal. Settlement of more audits in a timelier manner should be forthcoming. Cost reports are also being addressed and selected for audit as timely as possible. In May 2014, an additional 113 audits have been assigned to various CPA firms. In regards to the monitoring of the vendor contract to perform hospital cost report audits, the FAHCA has a five year contract with Myers and Stauffer, LLC (MCSL). Under this contract with MCSL, an on-line website is available which allows the FAHCA to review the on-going status of audit work for each hospital's cost report. This report is a real time report that allows a review at any given time.	

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AG 2014-193	**Report date 5/2014**	**Statewide Medicaid Managed Care Program Implementation**	**Finding** SMMCP Post-Implementation Staffing Plan. The Agency had not developed a detailed staffing plan designed to promote the efficient and effective performance of the Agency's responsibilities after the Statewide Medicaid Managed Care Program (SMMCP) is fully implemented. **Recommendation** To advance the workforce transition and promote the efficient and effective performance of the Agency's responsibilities after the SMMCP is fully implemented, we recommend that Agency management establish, prior to the full implementation of the SMMCP on October 1, 2014, detailed staffing plans with organizational charts for all Medicaid-related functional areas.	Medicaid and other Agency leadership have worked intensively over the past twelve months to develop a revised organizational model. Major pieces of this model have been detailed and many are already in place. This model will be fully implemented by July 2015, after the SMMC program is operating statewide and after phase down or close out of many major legacy fee-for-service functions. Final determinations regarding the staffing model and staffing level to support the Medicaid program post implementation of SMMC are still underway, as there are uncertainties regarding the workload remaining after full SMMC Program implementation.	

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AUDITS FOR FISCAL YEAR 2012-13					
AG 2013-133	**7/1/10 - 12/31/11**	**Public Assistance Eligibility Determination Processes**	**Finding 8** State agencies did not compare public assistance records and juvenile detention records. Our comparisons identified instances in which improper payments were made by State agencies on behalf of youths who, at the time of payment, were committed to a Department of Juvenile Justice facility. **Recommendation** We recommend that the DCF match public assistance records with DJJ records monthly to timely identify any modifications needed in the program status of applicable youths and the youths' families. In addition, the DJJ should ensure that appropriate forms are completed and sent to the DCF and AHCA for youths in DJJ commitment. **Finding 9** The Agency for Health Care Administration did not conduct matches between Medicaid records and workers' compensation records until March 2012. Our tests disclosed Medicaid claims that, according to State records, were paid to providers who were also paid through workers' compensation insurance.	The Agency worked with Department of Children and Families (DCF) to ensure that Medicaid eligibility is suspended for children entering Department of Juvenile Justice (DJJ) residential commitment programs. DJJ now provides a monthly data file to DCF, and DCF closes the eligibility of youth in a DJJ residential program with a current Child in Care eligibility and closes the eligibility for Medicaid youth upon admission to a DJJ residential program. In addition, the Agency is developing a customer service request to change FMMIS in order to prevent payment of Federal Financial Participation for youth entering a DJJ residential program.	

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			Recommendation We recommend that AHCA ensure the conduct of the workers' compensation data matches and the collection of amounts due from third parties.	The Agency's Third Party Liability contractor, Xerox State Healthcare, LLC (Xerox) has been conducting workers' compensation data matches with the Department of Financial Services, Division of Workers' Compensation (DFS-DWC), since March 2012. Data files are received from DFS-DWC on a monthly basis and Xerox typically conducts the data match every 3-4 months, based upon the size of the files received. Potential tort/casualty recovery cases are initiated and pursued for those Medicaid recipients identified as having Medicaid paid claims that may be associated with a workers' compensation injury and/or settlement. The Agency's Medicaid State Plan requires that the workers' compensation data matches identify Medicaid recipients who are injured in work related accidents, in compliance with Title 42, CFR, Section 3.138(d)(4)(I). As indicated previously, the data file received from DFS-DWC does not contain paid claims data and the Agency does not perform matches of Medicaid paid claims to workers' compensation paid claims. (A chart depicting the worker's compensation data matches have been conducted since March 2012 was provided)	
AG 2013-161	**FYE 6/30/2012**	**Compliance and Internal Control Over Financial Reporting and Federal Awards**	**FS 12-001** The FAHCA Bureau of Finance and Accounting (Bureau) did not follow established fiscal year-end procedures to record adjustments to Claims payable and Expenditures causing a material overstatement of these accounts in the General Fund.		

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			Recommendation We recommend that the Bureau enhance controls to provide additional assurance that fiscal year-end procedures for recording Medicaid claims payable and the related expenditures are followed. **FS 12-002** The FAHCA Bureau of Finance and Accounting (Bureau) incorrectly recorded deferred revenues for financial resources related to incurred-but-not-reported (IBNR) Medicaid claims liabilities as noncurrent deferred revenue rather than current deferred revenue. The Bureau also calculated the Federal share using an incorrect Federal Medical Assistance Percentage (FMAP). **Recommendation** We recommend that the Bureau establish a more thorough supervisory review of the work done in connection with the fiscal year-end close-out procedures related to the State's IBNR Medicaid claims. **FS 12-009** When determining the amount due from the Federal government at year-end, FAHCA did not take into consideration all post-closing adjustments. Also, FAHCA did not retain documentation supporting certain amounts recorded in accounts receivable and applied an incorrect Federal Medical Assistance Percentage (FMAP) to receivables, the allowance for doubtful accounts, and expenditures.	Fully Corrected. The year-end checklist was modified to identify the adjusting entries for each agency trust fund. The checklist was updated prior to May 1, 2013. Fully Corrected. The financial statement checklist was modified to ensure IBNR claims are reported correctly. The checklist was modified to include that the FFP should be the upcoming federal fiscal years' FFP. The checklist was updated prior to May 1, 2013.	

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			Recommendation We recommend that FAHCA establish a more thorough supervisory review to ensure that all post-closing adjustments are considered when establishing net receivables, supporting documentation is retained for all refunds and changes in allowance for doubtful accounts, and the correct FMAP is applied. **FS 12-013** The FAHCA prepared the Schedule of Expenditures of Federal Awards (SEFA) data file using the cash basis of accounting, contrary to instructions from the Florida Department of Financial Services (FDFS). Additionally, the SEFA data file submitted to the FDFS did not include all American Recovery and Reinvestment Act (ARRA) expenditures or amounts sub-granted to other entities. **Recommendation** To ensure that information reported on the SEFA is accurate and complete, the FAHCA should develop and implement policies and procedures specific to their records and processes and update those procedures annually to reflect the FDFS' SEFA instructions. **FA 12-035** The 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).	Fully Corrected. The financial statement checklist was updated to ensure these activities are handled correctly. The checklist was updated prior to May 1, 2013. Fully Corrected. A revised report was submitted on December 12, 2012. Staff has attended a training session and desk procedures have been developed.	

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			Recommendation We recommend that the FAHCA enhance its policies and procedures to ensure that cash draws are accurately recorded, and reported on the CMIA report. In addition, the FAHCA should use the Federally approved FMAP rates when determining the Federal portion of the balances in the MAP and SPIA bank accounts. We also recommend that more care be taken during the supervisory review of the CMIA report prior to its submission to the FDFS. **FA 12-045** Refugee Medical Assistance (RMA) claim payments made to providers were not always paid in accordance with established Medicaid policy. **Recommendation** We recommend that the FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure RMA claims are accurately and properly processed. **FA 12-053** The FAHCA made payments to providers on behalf of ineligible CHIP recipients.	Fully Corrected. Procedures were improved and put in place to ensure amounts, rates, methodologies and calculations will be accurate in futures reports, along with additional managerial reviews. Completed October 31, 2012. Fully Corrected. One cent over max: Claim paid amount calculated by FMMIS is correct. Fee schedules are corrected and procedures are in place to prevent future occurrences. Copayment: Programming request (CSR 2250) submitted 7/9/2012, has not been implemented. Once the correction to FMMIS has been implemented, claims will be reprocessed.	

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			Recommendation We recommend that the FAHCA continue its efforts to amend the State Plan and, once amended, invoke the provisional CHIP eligibility as proposed.	Fully Corrected. CHIP State Plan Amendment (SPA) #23 was approved by CMS on 4/1/2013 with an effective date of 10/1/2013. Through this SPA, the state adopted the policy of provisional CHIP eligibility for up to 60 days for children identified as potentially Medicaid eligible during the eligibility redetermination process. The audit finding involved three CHIP recipients who were referred to Medicaid due to a decrease in income. At the time the MediKids CHIP payments were made for the three recipient payments cited, each child only had MediKids coverage and the payment was made appropriately. When the Medicaid eligibility determination was made, Medicaid coverage was made retroactive to the month previously covered by MediKids. The children were dually enrolled in both programs, but payment was only made by CHIP. SPA #23 allows the child to be provisionally CHIP eligible from the time a referral is made to Medicaid until the Medicaid eligibility determination is made, up to 60 days. This makes the CHIP payments allowable that were made during this period.	
			FA 12-056 The FAHCA and the FDOH did not report applicable CHIP sub-award data in the Federal Funding Accountability and Transparency Act (FFATA) Sub award Reporting System (FSRS) pursuant to Federal regulations.		

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			Recommendation We recommend that the FAHCA and the FDOH ensure that all key data elements are timely reported in the FSRS.	Fully Corrected. Grant reporting procedures were amended to include the requirement to report data identified in FFATA regulations. The data that should have been reported will be entered on the FFATA on-line reporting site. Any new data, covered in FFATA regulations, will also be updated. Data required for reporting by FFATA regulations will be monitored on an on-going basis and updated as required. Corrective action was taken and completed by March 30, 2013. The Florida Department of Health also now has a process to access the FSRS system to ensure compliance with FFATA.	
			FA 12-057 Medical service claim payments made to providers of Medicaid services were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, some payments were for improper amounts or for unallowable services. **Recommendation** We recommend that the FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed.	Fully Corrected. Crossover. The Provider General Handbook has been promulgated by rule, and the Agency continues to identify crossover claims which may have been paid inappropriately. Copayment. Programming request (CSR 2250) submitted July 9, 2012, has not been implemented. Once the correction to FMMIS has been implemented, claims will be reprocessed.	

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				Fully Corrected. Fee schedules - one cent over max. Claim paid amount calculated by FMMIS is correct. Fee schedules are corrected and procedures are in place to prevent future occurrences. Fully Corrected. Capitation Payments. In regard to FMMIS processing one capitation payment for one cent over and three payments for one cent less than the approved Medicaid capitation rate, these differences were caused by a rounding error that has been addressed in the system to prevent future occurrences. Fully Corrected. Home Health Services. Our findings indicated that the claims were paid appropriately. Although the prior authorization (PA) number was not on the claim for some of these services, the paper claims included the PA numbers for the following: 1. The one hour issue (11pm – midnight) which was force paid by AHCA's area offices through paper claims. 2. Provider Service Network claims which were authorized by the PSN. 3. Children's Medical Services (CMS)-PSN claims which were authorized and processed through the CMS-PSN. 4. PSN-Reform health plan claims manually processed through the Agency's fiscal agent.	

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				The Home Health Services Coverage and Limitations Handbook has been updated to remove the 2 hour minimum for personal care and private duty nursing services (to allow the one hour billing) and was effective on June 25, 2013. Fully Corrected. Hospital Services. A programming request (CSR 2052) was submitted on March 21, 2011, to remedy the issue of inpatient claims being paid in excess of 45 days. As a result of this CSR, 15 CO's were created, with the last CO installed on July 12, 2013. System programming has been completed, and the issue has been fully corrected.	
			FA 12-058 Controls were not sufficient to ensure that amounts paid by the FAHCA to the Commission for the Transportation Disadvantaged (CTD), or amounts paid by the CTD to transportation providers under a Medicaid transportation program, were reasonable.		

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			Recommendation We again recommend that current transportation costs be summarized and used to evaluate the reasonableness of the total NET Program contract amount, as well as the amounts to be allocated to the to the CTD and STPs for administrative costs. We also recommend that the FAHCA establish adequate monitoring procedures that include the performance of periodic monitoring of the CTD, timely provision of the results of the monitoring activities, and follow-up on any deficiencies noted during monitoring. In addition, the CTD should establish monitoring procedures to require the periodic review of STP operations, provision of the monitoring results to the STPs, and follow-up on any deficiencies noted during monitoring. **FA 12-059** The FAHCA could not provide documentation to support all Disproportionate Share Hospital (DSH) payments. **Recommendation** We recommend that the FAHCA maintain supporting documentation for all DSH payments. **FA 12-060** The FAHCA did not have effective procedures in place to prevent duplicate processing of Low Income Pool (LIP) payments.	Fully Corrected. The CTD provided financial statements which indicate the amounts paid by the CTD to transportation providers were reasonable. The Agency has updated the contract monitoring tool as a control to ensure the amount paid to the CTD was appropriate. Fully Corrected. This issue has been fully corrected. We keep copies of all payments.	

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			Recommendation We recommend that the FAHCA continue to ensure that the correct amounts are paid to the LIP providers and take actions to recoup the outstanding overpayments.	Fully Corrected. The unrecouped payments identified in the finding have been fully recouped in accordance with the agreement between the Agency and the Florida Department of Health. The Agency requested a Corrective Action Plan from the contractor in which procedures were revised to eliminate e-mail requests.	
			FA 12-061 The FAHCA did not always maintain appropriate records to support the salary and benefits costs charged to the Medicaid Program.		
			Recommendation We recommend that the FAHCA strengthen its procedures to ensure that salary and benefits costs charged to Federal programs are supported by periodic certifications.	Fully Corrected. Procedures were modified to include escalation steps when certifications are not received timely from office managers. This procedure became effective April 2013.	
			FA 12-062 The FAHCA continued to record expenditures to incorrect appropriation categories in the State's accounting records.		
			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 actions to ensure that funds are available in the appropriate categories.	Our procedures have been modified to ensure there is a review and reconciliation of these transactions each week to ensure transactions are processed appropriately. The Agency will have to pursue the necessary permission from the Florida Legislature to move appropriations around to where the expenditures occurred.	

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			FA 12-063 The FAHCA did not maintain documentation evidencing that contract monitoring activities were performed for the contractor responsible for administering the State's Medicaid Drug Rebate Program. **Recommendation** We recommend that the FAHCA perform and document contract monitoring activities in accordance with the contract monitoring plan. **FA 12-064** The FAHCA had not resolved issues related to the determination and return of overpayments for Medicare outpatient hospital crossover claims as identified in the AG report on Florida Medicaid Management Information System (FMMIS) Controls and the Prevention of Improper Medicaid Payments (report No. 2012-021). In our report No. 2012-021, finding No. 3, we identified improper payments for Medicare outpatient hospital crossover claims. The projected overpayments totaled $117,659,683 for the 2007-08, 2008-09, and 2009-10 State fiscal years. The United States Department of Health and Human Services (USDHHS) issued a resolution letter (CIN Number: A-04-12-18633, dated May 4, 2012) that identified $117,659,683 in questioned costs and recommended that the FAHCA determine the amount of overpayments and return those amounts to USDHHS. As of January 23, 2013, the FAHCA had not determined the amounts or returned the overpayments.	Fully Corrected. The Monitoring Plan has been modified to show that monitoring activities are continuous throughout the term of the contract. All correspondence pertaining to monitoring is placed, as documentation, in a separate monitoring file.	

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			Recommendation We recommend that the FAHCA determine and return unallowable costs, as appropriate.	The Provider General Handbook has been promulgated in rule. The Agency will begin identifying overpayments and recouping reimbursement for those claims. Claims will be reprocessed by December 31, 2013, with full recoupment by December 31, 2014.	
			FA 12-066 The FAHCA had not documented that the State met the matching requirements of the Medicaid Program for the 2010-11 Federal fiscal year (FFY). Additionally, the FAHCA's matching requirement calculations were not adequately supported, accurately prepared, or properly reviewed and approved.		
			Recommendation We recommend that the FAHCA implement policies and procedures detailing the method for calculating, documenting, and verifying the Medicaid Program State match. We also recommend that the FAHCA document the review and approval of the Medicaid State match calculations.	Fully Corrected. Procedures were completed in March 2013. Supporting documentation will be filed and available for review when the match calculations are prepared.	
			FA 12-067 The FAHCA made payments to an ineligible provider.		

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			Recommendation We recommend that the FAHCA ensure that payments are made only to providers with Medicaid Provider Agreements in effect. **FA 12-069** The FAHCA did not always ensure that facilities receiving Medicaid payments met required health and safety standards.	Fully Corrected. Significant FMMIS modification was completed in 2011 to automate the renewal process for Medicaid providers. Any provider who fails to complete a timely renewal is automatically restricted and all claims suspended pending completion of the renewal. This ensures no payments are issued to a provider without a valid agreement. After the coding was installed, the FAHCA completed a renewal for each active provider with an expired agreement. The example in this finding pre-dates completion of that renewal period. No further action is required of the FAHCA.	

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			Recommendation We recommend that the FAHCA increase its efforts to ensure that Life Safety Surveys and follow-up surveys be conducted within the established time frames.	The annual state hospital life safety code surveys are required in Rule 59A-3.253(5), F.A.C. Since March 1, 2011 the Bureau of Field Operations reassessed their workload and developed overall priority levels to assist Field Office Management in scheduling their workload. Level 1 includes the Centers for Medicare & Medicaid Services (CMS) Tier 1 and Tier 2, Priority 1 State complaints, state statutory required inspections and initial licensure surveys. Level 2 includes CMS Tier 3 work, Priority 2 State Complaints, state health follow-up inspections and Rule required inspections. As previously stated the Life Safety Code annual inspections referenced in this report are required under the hospital rule, therefore would thus fall under the Level 2 priority levels within the Field Operations Bureau of priority of onsite inspections. These Priority Levels will be included in the HQA Procedures Manual to respond fully to the current and future audits. The HQA Standard Operating Procedures Manual is still being updated. This manual is an overall procedural manual for HQA process, therefore it represents more than Life Safety Code Surveys.	
			FA 12-070 The FAHCA's established policies and procedures did not provide for the timely review and issuance of cost report audits and desk reviews of nursing homes and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).		

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			Recommendation We recommend that the FAHCA enhance its policies and procedures to provide for an adequate number of cost reports to be audited annually, as well as the timely review and issuance of cost report audits and desk audits. To ensure the timeliness and usefulness of the information contained within the cost report audits and desk audits, these procedures should identify the time frames within which the audits and desk audits are to be reviewed and issued.	Fully Corrected. Effective April 2013, the Agency for Health Care Administration initiated a three year contract with a certified public accounting (CPA) firm to perform examination review of ICF-DD cost reports. There will be an average of 50 cost reports to be examined during this contract, an average of 17 cost reports a year. To ensure timeliness and usefulness of the information contained within the cost report, the CPA firm will be submitting monthly reports displaying anticipated dates of the examination review process.	
AHCA 12-04	**FYE 6/30/12**	**Agency Accounts Receivable Process**	**Finding 12-04-01** MAR collection efforts are impeded by manual monitoring of receivables for payment activity. **Recommendation** 1. In order to send notification letters timely, we recommend the MAR unit clarify circumstances that are acceptable exceptions to their policy of sending late payment notification every 30 days. 2. We also recommend the new accounts receivable system include a means of identifying late payment dates and automatically generating notices if a payment has not been received by set deadlines.	1. Completed. The Medicaid Accounts Receivable (MAR) procedure manual has been updated with guidelines for sending notices to providers. Additionally, this has been discussed with MAR unit staff. 2. The Bureau of Financial Services plans to have a draft RFQ by late September or early October 2014	

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			3. We further recommend that the new accounts receivable system include the ability to generate reports that allow monitoring for payment timeliness. Such reports should include information that shows the chronology of Agency action taken (i.e. Final Order, FAR, notification letter), the date of that action, the date(s) the provider is overdue, the number of days an amount is overdue, and if an amount paid is in compliance with the amount owed.	3. The Bureau of Financial Services plans to have a draft RFQ by late September or early October 2014.	
			Finding 12-04-02 MAR case set-up could be more efficient by importing provider information from FMMIS.		
			Recommendation To improve efficiency and expedite data entry, the new accounts receivable system should consider an interface that would automatically populate these fields from FMMIS.	The Bureau of Financial Services plans to have a draft RFQ by late September or early October 2014.	
			Finding 12-04-03 Cases designated for referral to a collection agency may be delayed.		
			Recommendation In order to enhance prompt collection, we recommend F&A develop a written policy or guidelines that meet the approval of the Office of General Counsel specifying how frequently the list of referrals should be sent to the collection agency.	Completed. The MAR unit has written procedures for cases to be referred to a collection agency. The procedures have been updated to better define the timeframes and frequency.	
			Finding 12-04-04 Collection agency report balances did not agree with the account balances in the MAR system.		

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			Recommendation To ensure that cases referred to collection agencies are correctly recorded and their balances are accurate, we recommend MAR staff periodically reconcile the information on the collection agencies' reports with the receivables identified in MAR.	The MAR Unit received MSB's Collection Inventory Report on December 19, 2013 for the period of August 11, 2011 through December 19, 2013 and NCO's Collection Inventory Report on December 10, 2013 for the period of August 16, 2011 through December 10, 2013. The report from NCO included cases rolled over from the GRC collection agency. The reconciliation of both reports was completed on December 19, 2013.	
			Finding 12-04-05 Payment plan finalization may be delayed.		
			Recommendation We recommend that F&A consider adopting a policy limiting the number of negotiations allowed or setting a deadline so that payment plans can be finalized more timely.	Completed. MAR has implemented processing limits at three attempts to secure a payment plan, before placing a lien or referring the case to collections.	
			Finding 12-04-06 The coordination of restitution cases could be improved between MFCU and F&A.		
			Recommendation To clarify the roles and responsibilities between MFCU and F&A, we recommend that the current Memorandum of Understanding be revised and signed specifying: 1. How often periodic reconciliations of open case balances should be performed and documented; and 2. A clarification of responsibilities for monitoring delinquent cases, contacting probation officers in cases of delinquent payment by probationers and referral to a collections agency for non-payment.	During a meeting with the Office of Inspector General and MFCU, the Bureau of Financial Services submitted the below recommendations: 1. Defendant's probationary terms –Restitution is included in the terms of probation and probation officers work with the Agency to establish a repayment schedule/plan. 2. Case information – A case information sheet was submitted for new case referrals to make it easier to identify the amounts owed to the Agency and to clarify if funds are all state monies. 3. Collections – Provide defendant's telephone number, last known address, and probation officer.	

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				In the course of follow-up telephone conversations, it was determined that reconciliations would be completed each month on all payments received from MFCU. The Agency is currently receiving a spreadsheet of all cases processed each month by MFCU and this spreadsheet is used for reconciliations. A meeting has been set with MFCU to discuss the following expectations: 1. Confirm the frequency of reconciliations for collections and how often case reconciliation will be performed. 2. Discuss procedural processes of collections and clarify the responsibilities for monitoring the delinquent cases. Upon completion of the meeting, the Memorandum of Understanding will be drafted and approved to implement the collection procedural change at the beginning of the fiscal year.	
			Finding 12-04-07 Queries used to run reports in OPC Track Billing are ineffective.		

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			Recommendation We recommend: 1. The new accounts receivable system include accurate and relevant queries needed to produce reliable reports for OPC Track Billing.	1. Completed. F&A: The new AR system uses modern technology to create, store and track data for accounts receivables and the capacity to write queries to produce accurate and relevant results, including reports, is an inherent feature of this technology. Completed. HQA: As of March 1, 2013, OPC Track Billing was replaced by the new AR system. The new AR system has access to the data in OPC Track and can produce accurate and relevant queries as well as reports from OPC Track; OPC staff has access to the queries and reports.	
			2. We also recommend the new accounts receivable system includes a way to ensure that appropriate and relevant data from previous billings be accessible for collections.	2. Completed. F&A: The logic within the new AR system generates accounts receivables in a manner that ensures these items can be tracked throughout their lifecycle. Completed. HQA: The new AR system has access to the data in OPC Track and includes a way for the data from previous billings to be retrieved for collections.	
			Finding 12-04-08 Manual processes.		

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			Recommendation To improve efficiency and information security, we recommend the new accounts receivable system accommodate all accounts receivable types so that the areas can discontinue the use of maintaining accounts receivable in MS Excel.	Bureau of Financial Services response: The Bureau of Financial Services plans to have a draft RFQ by late September or early October 2014. HQA response: Prior to Financial Services staff turnover, HQA worked closely with Financial Services on system requirements related to HQA receivables (specifically PMATF assessments and Plans and Construction Site Visit Billing – OPC Track). HQA currently works closely with Financial Services on online payment issues for the Online Licensing and Background Screening Clearinghouse and has a bi-weekly stakeholder meeting on Online Payment and Single Sign-On issues. The Agency also has monthly strategic planning meetings that discuss, among other things, automation and both HQA and Financial Services are represented at these meetings.	
			Finding 12-04-09 Use of Versa as an accounts receivable system. **Recommendation** We recommend: 1. The identified accounts be maintained in the new accounts receivable system instead of Versa. 2. As an alternative, F&A consider implementing an interface between Versa and the new accounts receivable system that would create an accounts receivable and record payments.	Bureau of Financial Services response: The Bureau of Financial Services plans to have a draft RFQ by late September or early October 2014. HQA response: Prior to Financial Services staff turnover, HQA worked closely with Financial Services on system requirements related to HQA receivables (specifically PMATF assessments and Plans and Construction Site Visit Billing – OPC Track). HQA currently works closely with Financial Services on online payment issues for the Online Licensing and Background Screening Clearinghouse and has a bi-weekly stakeholder meeting on Online Payment and Single Sign-On issues. The Agency also has monthly strategic planning meetings that discuss, among other things, automation and both HQA and Financial Services are represented at these meetings.	

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AHCA 12-10	Report date 2/2013	Medicaid Risk Management Processes Review Division of Medicaid	**Finding 12-04-10** Revenue management's documentation processes are inconsistent. **Recommendation** We recommend F&A management and staff evaluate current processes and written procedures to identify process improvements such as updating and/or removing unnecessary forms. **Finding 12-10-01** Internal Environment. Medicaid has no formal enterprise risk management policy. **Recommendation** We recommend: 1. Medicaid formally establish an ERM Steering Committee to oversee efforts to identify, assess, measure, respond to, monitor, and report risks. The Committee should include an executive sponsor and articulate the benefits of ERM.	Financial Services had its kickoff meeting on Friday, January 17, 2014 to discuss the functional assessment of the bureau. Meetings are held on Fridays from 2:30 p.m. – 4:30 p.m. We have completed Phase I and Phase II, which includes listing all tasks and determining the unit the task should be assigned to. A risk management steering committee has been established.	

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			2. Medicaid establish a core team consisting of individuals from the various bureaus. The team should: • Become familiar with the framework's components, concepts, and principles to obtain a common understanding, language, and foundation base needed to design and implement an ERM process; • Assess how ERM components, concepts, and principles are currently being applied across Medicaid; • Develop a ERM Vision that explains how ERM will integrate within Medicaid to achieve its objectives and goals including how to align risk appetite and strategy; and • Develop an implementation plan to adopt ERM.	A risk management steering committee has been established and consists of the Deputy Secretary for Medicaid, the Assistant Deputy Secretary's for Medicaid and the Administrator of the Divisions External Affairs and Project Management Unit.	
			3. Medicaid develop a comprehensive ERM policy. An ERM policy should also clearly communicate Medicaid's risk management philosophy. Components of an ERM policy should include: • Purpose of the policy; • Owner of the policy and stakeholders; • Background information (definition of ERM, its components, and other related terms); • Responsible parties and duties including the roles of the business units as a part of an active ERM process; and • Identification of person(s) who can test compliance with the policy.	The issue of an agency wide enterprise risk management approach has been raised with the Agency Management Team.	
			4. Medicaid appoint an ERM Officer and a business unit responsible for promoting and teaching risk assessment methods to business owners throughout Medicaid.	The issue of an agency wide enterprise risk management approach has been raised with the Agency Management Team.	

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			Finding 12-10-02 Objective setting. Most of Medicaid bureaus do not have a formal process where objectives are created, documented, and communicated upward to senior management.		
			Recommendation We recommend: 1. The Bureaus formalize and document their process of setting objectives.	At this time, formal structures and/or processes outside of the risk management steering committee have not been established.	
			2. Medicaid management periodically reviews objectives to determine if they continue to be consistent with the Agency's and Medicaid's goals and objectives. The review should also be documented.		
			Finding 12-10-03 Event identification. Medicaid has no formal process for identifying risks. In addition, Medicaid has no overall risk inventory where identified risks are stored and categorized.		
			Recommendation We recommend: 1. Medicaid develop and document the process of identifying events that could impact the Agency. 2. Medicaid identify risks related to each objective (i.e. Strategic, Operations, Reporting, and Compliance). 3. Medicaid house the risk inventory within a business unit.	At this time, formal structures and/or processes outside of the risk management steering committee have not been established.	
			4. Medicaid management periodically review risks with senior management.	This is occurring through the structure of the risk management steering committee.	

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			Finding 12-10-04 Risk assessment. Medicaid does not perform a formal risk assessment. **Recommendation** We recommend: 1. Bureaus periodically conduct and document a formal risk assessment. 2. Medicaid assign the duty of compiling all assessments into a comprehensive risk assessment to the ERM Officer and a business unit. **Finding 12-10-05** Risk response. Issues and risk responses are not formally tracked. **Recommendation** We recommend: 1. Bureaus formalize and document risk response as a part of the risk assessment. 2. Bureaus create an implementation plan to outline how responses are executed. **Finding 12-10-06** Control Activities. Because Medicaid does not formally conduct a risk assessment, control activities cannot be identified that would help mitigate associated risks. **Recommendation** We recommend: 1. Bureaus identify control activities that help mitigate identified risks as a part of their risk assessment. 2. Medicaid management periodically review control activities to identify potential gaps and vulnerabilities and to ensure that the controls are current.	At this time, formal structures and/or processes outside of the risk management steering committee have not been established. At this time, formal structures and/or processes outside of the risk management steering committee have not been established. At this time, formal structures and/or processes outside of the risk management steering committee have not been established.	

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			Finding 12-10-07 Information and Communication. Medicaid has no formal documentation method such as meeting minutes which can be disseminated to Medicaid staff. Based on our discussions with management, it appears that management discusses ongoing issues but not necessarily or specifically new emerging risks. **Recommendation** We recommend: 1. Medicaid review its information and communication systems and corresponding outputs to determine if they are sufficient to implement the ERM process. 2. Medicaid management should establish formal communication protocols and procedures, such as meeting minutes. to share risk information. **Finding 12-10-08** Monitoring. There are no monitoring activities to determine if ERM is effective because a formal ERM process has not been established. **Recommendation** We recommend: 1. Medicaid management create and document processes to assess and monitor the effectiveness of the ERM framework. 2. Medicaid management create and document processes and procedures for reporting and tracking deficiencies discovered during its monitoring activities.	At this time, formal structures and/or processes outside of the risk management steering committee have not been established. At this time, formal structures and/or processes outside of the risk management steering committee have not been established.	

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AHCA 13-08	Report date 2/2013	Review of FMMIS and DSS Assessment Project Procurement Divisions of Operations and Medicaid	**Compliance Finding 1** Contract Manager Certification. The person serving as Contract Manager for AHCA RFP 008-11/12 was not an Agency Certified Contract Manager, as required by Agency policy. Although this person received contract manager training conducted by the Department of Financial Services as required by statute, his training occurred approximately two months after his appointment as Contract Manager for RFP 008-11/12. **Recommendation** The Agency should ensure only an Agency Certified Contract Manager is assigned to manage a contractual project.	Complete. The Agency utilizes only Certified Contract Managers to manage active contracts. A Certified Contract Manager is not required during the solicitation process since there is not yet a contract. If an employee who is not certified as an Agency Contract Manager is assigned to a solicitation and will manage the resulting Contract, the Procurement Office will ensure they receive Agency Contract Manager Certification and Department of Financial Services Training as soon as possible.	

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			Compliance Finding 2a Mandatory Criteria. The Mandatory Criteria evaluation sheet, which was completed for the vendor on the day the bids were opened, had a check by "NO" for Criteria F. This criterion is for "Financial Information." The vendor failed to submit the Statement of Cash Flows and Notes to the Financial Statements. In addition, the vendor failed to submit an Income Statement that met the 12-month requirement. On June 12, 2012, the day the proposal was opened and evaluated for mandatory criteria, the proposal should have been rejected and posted to VBS as stipulated in the RFP.		
			Recommendation The Agency should comply with its procurement language, "Failure to submit" any mandatory requirement "will result in the rejection of a prospective vendor's response," or not include those requirements in the procurement package.	Complete. The Agency complies with Florida Statutes, Florida Administrative Code and Department of Management Services' directives in relation to mandatory criteria requirements. The Agency moved forward with evaluation for the one respondent as a result of Section 287.057(5), Florida Statutes. The respondent was provided the opportunity to submit the necessary documents in order to meet mandatory requirements. The respondent was then evaluated.	
			Compliance Finding 2b Mandatory Criteria. The Mandatory Criteria sheet did not contain the vendor's name. Each document in a vendor's file should clearly identify that vendor in case any document is separated from the file.		
			Recommendation The Mandatory Criteria sheet should have a place to identify the vendor whose information is recorded on the Mandatory Criteria sheet.	Complete. The Procurement Office will ensure the vendor name is identified on all mandatory criteria forms.	

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			Compliance Finding 3 Posting of Awards. According to the RFP schedule, the "Anticipated Posting of Notice of Intent to Award" was June 25, 2012. The Agency posted the "Agency's notification of delay in the intended award" on June 26, 2012. For this posting, there were no addenda added to the advertisement or to the original solicitation document as required in the RFP. This may have led to some confusion when, on June 26, two (potential) vendors emailed the Agency and requested a copy of the RFP. The Agency's award decision was not advertised until July 23, 2012.		
			Recommendation The Agency should post timely advertisements on VBS. All advertisements should have an adequate description of the purpose of the advertisement. Addendums should be attached with additional information.	Complete. The Procurement Office will ensure notices are posted timely and accurately to the Vendor Bid System.	
			Documentation Finding 1 Decision Points. The Agency documented some decision points in the procurement process such as the review of the draft RFP, vendor questions and answers, and correspondence with the potential vendor. However, there was no supporting documentation in the bid file explaining the reasons behind the Agency's decision to post a delay of the award; to use Section 287.057(5), F.S.4 and proceed with the only vendor, SES, who responded to the RFP; or to allow SES to amend its proposal even though the vendor had not submitted all the required financial documentation and had an employee who was ineligible to participate on the project.		

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			Recommendation The Agency should document in writing all major decision points in the procurement process. Any communication with the Office of General Counsel should also be documented with specific detail.	Complete. The Procurement Office will ensure sufficient documentation is maintained in procurement files.	
			Documentation Finding 2 Evaluator Score Sheets. The Evaluators' score sheets had numerous changes including strike-throughs, changes noted in red, point changes, and total points changes. These changes were not always initialed, dated and/or explained. In addition, there was no designated place for Evaluators to sign and date their evaluations.		
			Recommendation All changes should be explained in writing, initialed and dated. Evaluators should sign and date their score sheets. In the future, the Agency may want to consider asking the Evaluators to provide a brief narrative to sum up their evaluation and identify any issues/problems that requires a discussion.	Complete. The Procurement Office has implemented new evaluator score sheets that require signatures and dates for each evaluator.	
			Documentation Finding 3a Past Performance Questionnaires (Client Reference Forms). Procurement staff verifying vendor past performance did not sign or date the Past Performance Questionnaire or the attached Reference Check Call Logs.		
			Recommendation Procurement staff should sign and date questionnaires, as required.	Complete. The Procurement Office will continue to ensure that staff sign and date the past	

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			Documentation Finding 3b Past Performance Questionnaires (Client Reference Forms). The Past Performance Questionnaire does not include the verification of the potential vendor's project dates and project description. When employers perform reference checks, they normally ask the reference to verify this information. **Recommendation** The Agency should consider requiring the addition of the project dates and a detailed description of provided services on the questionnaires. **Scoring and Weights Finding 1** Evaluation Criteria and Scoring. The Agency awards three percent (20/656) of the total points for "Financial Information." Three percent would not make a significant difference in any vendor's total score. In addition, the Agency does not currently require audited financial statements. Unaudited statements could contain inaccurate, incomplete and/or unsubstantiated information.	Completed. The Procurement Office has revised the Past Performance Questionnaire to include verification of dates and a project description from the Client Reference.	

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			Recommendation 1. The Agency should consider how scores and weights reflect what is important to the accomplishment of the project. If a category is important for the project, that category should reflect a higher weight and require detailed verification and/or evaluation of criteria. 2. The Agency should consider requiring audited financial statements for projects over a certain dollar threshold (example: $1 million). **Scoring and Weights Finding 2** Minimum Scoring. According to the Evaluator Score Sheets, there are no minimum scores required for the total overall score or individual criteria component scores. For example, if the total points scored in the financial information section is less than the minimum points required for that section, the vendor would be disqualified, even if the proposal otherwise met the minimum overall score. Minimum scoring would ensure the Agency contracts with a vendor who has the best quality, price, design and workmanship. Based on our interviews and reviews of the project's documentation, it appears Agency personnel managing this procurement were more concerned with timeliness of the procurement than what was in the best interest of the Agency.	Complete - Risk Accepted by Management 1. The Procurement Office continues to work with each program office during solicitation development to ensure scoring weights are distributed appropriately per project. 2. The Procurement Office continues to use the revised financial language during solicitation development, if applicable. The Procurement Office has worked with each Program office to determine the language to be used with each solicitation. 3. The Procurement Office met with Agency Management and created revised financial language to use depending on the specific procurement project being developed. Auditor Note: Management is accepting that allowing non-audited financial statement may be a risk.	

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			Recommendation To ensure contracts are awarded in the best interest of the state, the Agency should identify required minimum total scores. Minimum scores can be separated into different categories; for example, financial and technical. If multiple categories are defined, the proposals must meet each category's minimum score. Proposals that fail to attain minimum scores in any category should not be considered.	Complete - Risk accepted by Management. The Agency will consider using minimum scores in making vendor selections if it is feasible to do so depending upon the specifications and requirements of the particular procurement.	
			Scoring and Weights Finding 3 Weighted Options. For this project, there were two questions under "Staffing" that referred to subcontractors. According to the vendor's proposal, SES did not intend to "utilize Subcontractors." However, one of the Evaluators still scored the questions. Procurement staff subsequently marked through the questions on each Evaluator's score sheets and reduced the "Staffing" total score by ten points.		
			Recommendation Evaluation score sheets should not contain questions for non-required options, without a weighted score for those vendors that did not choose that option. This could appear to unfairly reward vendors. The Agency should not delete criteria on any vendor's evaluation when the criteria do not apply to that specific vendor.	Complete. This issue resulted from an error in the evaluation criteria of the audited procurement. The Procurement Office will ensure accurate & appropriate information is included in its Procurements and the score sheets reflect the same information.	

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			Training Finding 1 Evaluations. In interviews, one of the Evaluators could not explain how he/she scored some of the questions. On the score sheets, one of the Evaluators scored two questions that did not apply to the vendor. In addition, two of the Evaluators did not take a copy of the RFP to refer to during the evaluations even though the RFP contained more details than the Evaluator Score Sheets. We also noted, while two Evaluators' total scores were comparable, one Evaluator's total score was 98 points higher than the lowest total score.		
			Recommendation To ensure consistency in how Agency competitive procurements are evaluated, the Agency should develop and implement Evaluator training. Each Evaluator should be required to attend the training before participating in any procurement process.	Complete. The Procurement Office now requires all evaluators to attend a Mandatory Evaluator Instructional Session with each solicitation. The session will be held before evaluations begin on a solicitation.	
			In Evaluator training, the Procurement Office should stress the importance of reviewing and bringing a copy of the RFP to the evaluation. This would ensure consistency in what the Evaluators use in their assessment.	The Procurement Office is continuing to develop/update the Evaluator Training Criteria for future use, on an as needed basis	
			Training Finding 2 Procedures. In our research to determine how the Agency performed procurements, we reviewed the Agency's Procurement of Goods and Services (Policy 4006) and the Contract Manager Desk Reference. These documents did not always address what occurred during this RFP. Examples include documenting decision points, establishing minimum scoring and assessing weights/scores.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation The Procurement Office should update their procedures to address any gaps in the procurement process.	Complete - Risk Accepted by Management. The Procurement Office has updated the Procurement Policy (AHCA Policy 4006 – Procurement of Goods/Services) and it has been posted to the Procurement Office's SharePoint site. The solicitation audited was created from a legislative appropriation from which only one vendor responded. Procurement and Program Staff in consultation with the General Counsel's Office determined the basis for proceeding in award with this RFP. In these instances decisions are made verbally as attorney work product. The Procurement Office works closely with the Program Office to ensure procedures are followed during a solicitation. See below for award process: RFPs are evaluated and the final ranking provided to the Program Office to determine award. The Award is provided to the Procurement Office from the Program Office on an official award decision memo. ITNs are evaluated and the final ranking determines the vendors to invite to negotiations. Negotiations are held and the negotiation team recommends an award to the Program office. The award is provided to the Procurement Office from the Program Office on an official award decision memo.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
				Establishing minimum scoring and assessing weights/scores: The Agency has determined that minimum scoring would not be beneficial to use as the Agency procures multiple different types of services. However, during the evaluation phase, a vendor must meet internal standards of the Procurement Office to be considered for award. A Vendor scoring less than 50% will not be recommended for award. The Procurement Office has internal guidelines in reference to scoring/weights. The Procurement Office strives to meet at least 20% overall score with Past Performance, at least 10% on cost proposal and 10% on financials. These can fluctuate depending on the project and Program Office specific needs. The Procurement Office works with the Program Office during development of a solicitation document to ensure the best scoring criteria is set. Auditor Note: Management is accepting that not requiring minimum scoring or documenting decision points may be a risk in awarding future procurements.	

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

HEALTH CARE SERVICES SCHEDULES

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2015 - 2016

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

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	$ -	(A)		$ -	
ADD: Other Cash (See Instructions)		(B)		$ -	
ADD: Investments		(C)		$ -	
ADD: Outstanding Accounts Receivable		(D)		$ -	
ADD: _____		(E)		$ -	
Total Cash plus Accounts Receivable	**$ -**	(F)	**$ -**	**$ -**	
LESS Allowances for Uncollectibles		(G)		$ -	
LESS Approved "A" Certified Forwards		(H)		$ -	
Approved "B" Certified Forwards		(H)		$ -	
Approved "FCO" Certified Forwards		(H)		$ -	
LESS: Other Accounts Payable (Nonoperating)		(I)		$ -	
LESS: _____		(J)		$ -	
Unreserved Fund Balance, 07/01/2014	**$ -**	(K)	**$ -**	**$ -**	**

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 2014

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015 - 2016

Department Title: Agency for Health Care Administration

Trust Fund Title: Tobacco Settlement Trust Fund

LAS/PBS Fund Number: 2122

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/2014 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**0**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**0**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**0**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

CHILDREN'S SPECIAL HEALTH CARE

Schedule I Series

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015 - 2016

Department Title:	Agency for Health Care Administration
Trust Fund Title:	Grants and Donations Trust Fund
LAS/PBS Fund Number:	2339

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/2014		
Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**$ 297,359,989.00**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	$ -	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	$ 295,944,643.00	(C)
SWFS Adjustment # and Description	$ (171,884,649.00)	(C)
SWFS Long Term Accounts Receivable GL 25XXX	$ (1,561,408.00)	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	$ -	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	$ -	(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**$ 419,858,575.00**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**$ 419,858,575.00**	(F)
DIFFERENCE:	**$ -**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period : 2015-2016

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

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	$ 408,109,777	(A)		$ 408,109,777	
ADD: Other Cash (See Instructions)	$ 44,859,417	(B)		$ 44,859,417	
ADD: Investments	$ -	(C)		$ -	
ADD: Outstanding Accounts Receivable	$ 257,401,997	(D)	$ 295,944,643	$ 553,346,640	
ADD:		(E)		$ -	
Total Cash plus Accounts Receivable	**$ 710,371,191**	(F)	**$ 295,944,643**	**$ 1,006,315,834**	
LESS Allowances for Uncollectibles	$ 975,585	(G)		$ 975,585	
LESS Approved "A" Certified Forwards	$ 261,720,437	(H)		$ 261,720,437	
Approved "B" Certified Forwards	$ -	(H)		$ -	
Approved "FCO" Certified Forwards	$ -	(H)		$ -	
LESS: Other Accounts Payable (Nonoperating)	$ 143,868,519	(I)	$ 171,884,649	$ 315,753,168	
LESS: Defererred Inflows - Unavailable Revenue	$ 8,008,069	(J)		$ 8,008,069	
Unreserved Fund Balance, 07/01/2014	**$ 295,798,581**	(K)	**$ 124,059,994**	**$ 419,858,575**	**

Notes:

***SWFS = Statewide Financial Statement**

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

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2015 - 2016

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

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	548,636,796	(A)		548,636,796	
ADD: Other Cash (See Instructions)	777,776	(B)		777,776	
ADD: Investments	8,750,170	(C)		8,750,170	
ADD: Outstanding Accounts Receivable	1,176,637,937	(D)	2,375,580	1,179,013,517	
ADD: Other Loans and Notes Receivable		(E)		0	
Total Cash plus Accounts Receivable	**1,734,802,679**	(F)	**2,375,580**	**1,737,178,259**	
LESS Allowances for Uncollectibles	3,148,286	(G)	2,374,741	5,523,027	
LESS Approved "A" Certified Forwards	1,316,859,035	(H)		1,316,859,035	
Approved "B" Certified Forwards	7,226,123	(H)		7,226,123	
Approved "FCO" Certified Forwards		(H)		0	
LESS: Other Accounts Payable (Nonoperatir	17,396,397	(I)	(1,073,193)	16,323,204	
LESS: Deferred Inflows - Unavailable Rever	60,360,552	(J)		60,360,552	
Unreserved Fund Balance, 07/01/2014	**329,812,286**	(K)	**1,074,032**	**330,886,318**	**

Notes:

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Office of Policy and Budget - July 2014

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015-2016

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/14		
Total all GLC's 5XXXX for governmental funds;	**332,784,349**	(A)
GLC 539XX for proprietary and fiduciary funds		
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment #B6800007 AR minus Allowance for Uncollecti	45,120,080	(C)
SWFS Adjustment #B6800007 Due from Federal Government	(45,120,080)	(C)
SWFS Adjustment #B6800012 Due to Other Departments	1,073,193	(C)
SWFS Adjustment #B6800014 Due to Other Departments	837	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	(7,226,122)	(D)
Approved "C" Carry Forward Total per LAS/PBS		(D)
A/P not C/F-Operating Categories	9,338,230	(D)
Compensated Absences Liability	55,057	(D)
Long Term Accounts Receiveables	(5,139,227)	(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**330,886,318**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**330,886,318**	(F)
DIFFERENCE:	**(0)**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 201 4

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

EXECUTIVE DIRECTION AND SUPPORT SERVICES

Schedule I Series

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2015 - 2016

Department Title: Agency for Health Care Administration
Trust Fund Title: Quality of Long Term Care Facility Improvement Trust Fund
Budget Entity: Department Level
LAS/PBS Fund Number: 2126

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	$ 10,018,451	(A)		$ 10,018,451	
ADD: Other Cash (See Instructions)		(B)		$ -	
ADD: Investments		(C)		$ -	
ADD: Outstanding Accounts Receivable		(D)		$ -	
ADD: _____		(E)		$ -	
Total Cash plus Accounts Receivable	**$ 10,018,451**	(F	**$ -**	**$ 10,018,451**	
LESS Allowances for Uncollectibles	$ -	(G)		$ -	
LESS Approved "A" Certified Forwards	$ -	(H)		$ -	
Approved "B" Certified Forwards	$ -	(H)		$ -	
Approved "FCO" Certified Forwards	$ -	(H)		$ -	
LESS: Other Accounts Payable (Nonoperating)		(I)		$ -	
LESS: _____		(J)		$ -	
Unreserved Fund Balance, 07/01/0214	**$ 10,018,451**	(K	**$ -**	**$ 10,018,451**	**

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 2014

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015 - 2016

Department Title:	Agency for Health Care Administration
Trust Fund Title:	Quality of Long Term Care Facility Improvement Trust Fund
LAS/PBS Fund Number:	2126

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/2014 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**10,018,451**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories		(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**10,018,451**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**10,018,451**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2015 -2016

Department Title: Agency for Health Care Administration
Trust Fund Title: Public Medical Assistance Trust Fund
Budget Entity: Department Level
LAS/PBS Fund Number: 2565

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	71,465,044	(A)		71,465,044	
ADD: Other Cash (See Instructions)	35,069,831	(B)		35,069,831	
ADD: Investments		(C)		0	
ADD: Outstanding Accounts Receivable	6,645,932	(D)		6,645,932	
ADD: Other Loans and Notes Receivable		(E)		0	
Total Cash plus Accounts Receivable	**113,180,807**	(F)		**113,180,807**	
LESS Allowances for Uncollectibles	165,944	(G)		165,944	
LESS Approved "A" Certified Forwards	57,182,551	(H)		57,182,551	
Approved "B" Certified Forwards		(H)		0	
Approved "FCO" Certified Forwards		(H)		0	
LESS: Other Accounts Payable (Nonoperating)		(I)		0	
LESS: Deferred Inflows - Unavailable Rev. Taxes	2,945,714	(J)	1,089,515	4,035,229	
Unreserved Fund Balance, 07/01/2014	**52,886,597**	(K)	**(1,089,515)**	**51,797,082**	**

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 2014

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015 - 2016

Department Title:	Agency for Health Care Administration
Trust Fund Title:	Public Medical Assistance Trust Fund
LAS/PBS Fund Number:	2565

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/14		
Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**55,998,256**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment #B6800008 - Other Loans and Notes Receivable Less Allowance for Uncollectibles	(1,089,515)	(C)
SWFS Adjustment #		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	0	(D)
A/P not C/F-Operating Categories	0	(D)
Other Loans and Notes Receiveable Less Allowance for Uncollectibles	(3,111,659)	(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**51,797,082**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**51,797,082**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2015 - 2016

Department Title: Agency for Health Care Administration
Trust Fund Title: Refugee Assistance Trust Fund
Budget Entity: Department Level
LAS/PBS Fund Number: 2579

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	4,383,878	(A)		4,383,878	
ADD: Other Cash (See Instructions)		(B)		0	
ADD: Investments		(C)		0	
ADD: Outstanding Accounts Receivable	4,824,467	(D)		4,824,467	
ADD: _____		(E)		0	
Total Cash plus Accounts Receivable	**9,208,345**	(F)	**0**	**9,208,345**	
LESS Allowances for Uncollectibles		(G)		0	
LESS Approved "A" Certified Forwards	6,155,388	(H)		6,155,388	
Approved "B" Certified Forwards		(H)		0	
Approved "FCO" Certified Forwards		(H)		0	
LESS: Other Accounts Payable (Nonoperating)		(I)		0	
LESS: _____		(J)		0	
Unreserved Fund Balance, 07/01/2014	**3,052,957**	(K)	**0**	**3,052,957**	**

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 2014

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015 - 2016

Department Title:	Agency for Health Care Administration
Trust Fund Title:	Refugee Assistance Trust Fund
LAS/PBS Fund Number:	2579

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/14 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**0**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # Balance Sheet Adjustment		(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	3,052,957	(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**3,052,957**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**3,052,957**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

HEALTH FACILITY REGULATION

Schedules

AGENCY FOR HEALTH CARE ADMINISTRATION

LEGISLATIVE BUDGET REQUEST

FISCAL YEAR 2015 - 2016

HEALTH FACILITY REGULATION

Schedule I Series

Schedule IA - Part II: Examination of Regulatory Fees

Department: **Agency for Health Care Administration**

Regulatory Service to or Oversight of Business or Profession Program: **Health Care Regulation**

Does Florida Statutes require the regulatory program to be financially self-sufficient? (Yes or No and F.S.): **Yes. 408.805, F.S. effective 10/1/06**

What percent of the regulatory cost is currently subsidized? (0 to 100%)

If the program is subsidized from other state funds, what is the source(s)? **Section 408.20, F.S. Assessments, Health Care Trust Fund**

What is the current annual amount of the subsidy?

Service / Product Regulated	Specific Fee Title	Statutory Authority for Fee	Maximum Fee Authorized (cap)	Year of Last Statutory Revision to Fee	Is Fee Set by Rule? (Yes or No)	Current Fee Assessed	Fund Fee Deposited in (indicate General Revenue or Specific Trust Fund)
Abortion Clinic	Licensure Fee	s. 390.014, F.S.	$500	Prior to 1997	Yes	$545.05	Health Care Trust Fund
Adult Day Care Centers	Licensure Fee	s. 429.907(3), F.S.	$150	Prior to 1997	Yes	$172.55	Health Care Trust Fund
Adult Family Care Homes	Licensure Fee	s. 429.67(3), F.S.	$200	Prior to 1997	No	$226.34	Department of Elderly Affairs Administrative Trust Fund
Ambulatory Surgical Centers	Licensure Fee	s. 395.004,F.S.	None	Prior to 1997	Yes	$1,679.82	Health Care Trust Fund
	Licensure/Validation Inspection Fee	s. 395.0161, F.S.	None	Prior to 1997	Yes	$400	Health Care Trust Fund
	Life Safety Inspection Fee	s. 395.0161, F.S.	None	Prior to 1997	Yes	$40	Health Care Trust Fund
Assisted Living Facility							
Standard ALF	Licensure Fee	s. 429.07(4)(a),F.S.	$300 + $50 per bed (Maximum $10,000)	2001	No	$387.73 + $64.96 per bed fee (Maximum $14,253.64)	Health Care Trust Fund
Extended Congrate Care ALF	Licensure Fee	s. 429.07(4)(b),F.S.	Additional $400 + $10 per bed fee	2001	No	Additional $546.07 + $10.15 per bed fee	Health Care Trust Fund
Limited Nursing Service ALF	Licensure Fee	s. 429.07(4)(c),F.S.	Additional $250 + $10 per bed fee	2001	No	Additional $322.77 + $10.15 per bed fee	Health Care Trust Fund
Birth Centers	Licensure Fee	s. 383.305, F.S.	None	N/A	Yes	$392.80	Health Care Trust Fund
	Licensure/Validation Survey Fee	s. 383.324, F.S.	None	N/A	Yes	$250	Health Care Trust Fund
	Life Safety Survey Fee	s. 383.324, F.S.	None	N/A	Yes	$250	Health Care Trust Fund

Service / Product Regulated	Specific Fee Title	Statutory Authority for Fee	Maximum Fee Authorized (cap)	Year of Last Statutory Revision to Fee	Is Fee Set by Rule? (Yes or No)	Current Fee Assessed	Fund Fee Deposited in (indicate General Revenue or Specific Trust Fund)
Clinical Laboratory	Licensure Fee	s. 483.172, F.S.	$3,919	Prior to 1997	Yes	$100 up to the maximum based on test & specialities	Health Care Trust Fund
Crisis Stabilization Unit & Short Term Residential Treatment Facility	Licensure Fee	s. 394.877, F.S.	None	N/A	Yes	$197.92 per bed	Health Care Trust Fund
Drug Free Workplace Lab	Licensure Fee	s. 112.0455(17), F.S.	$20,000	Prior to 1997	Yes	$16,435	Health Care Trust Fund
Exclusive Provider Organizations	Annual Assessment	s. 627.6472(14), FS	0.1% Annual Premiums Collected	Prior to 1997	No	0.000078764% 2013 Annual Premiums Collected	Health Care Trust Fund
Eye Banks	Application Fee	s. 765.544(1)(a), F.S.	$500	Prior to 1997	No	$500 initial/ CHOW	Health Care Trust Fund
	Annual Assessment Fee	s. 765.544(1)(b), F.S.	$35,000	Prior to 1997	No	The greater of $500 or 0.25% total annual revenues	Health Care Trust Fund
Health Care Clinics	Licensure Fee	s. 400.9925	$2,000		No	$2,000	Health Care Trust Fund
	Exemption Fee	s. 400.9925	$100		No	$100	Health Care Trust Fund
	Fingerprinting Fee	s. 400.9925	$47	N/A	No	$47	Health Care Trust Fund
Health Care Risk Managers	Application Fee	s. 395.10974(3), F.S.	$75	2001	No*	$52.78**	Health Care Trust Fund
	Licensure Fee	s. 395.10974(3), F.S.	$100	2001	No*	$104.54***	Health Care Trust Fund
	Fingerprinting Fee	s. 395.10974(3), F.S.	$75	2001	No*	Vendor	Health Care Trust Fund
*Fees must be set by rule but, to date, have not been. This will require promulgation of a new rule. ** Renewal fee ***Fees Initial licensure fee							
Health Care Service Pools (Temporary staff provided to health care facilities)	Registration Fee	s. 400.980(2), F.S.	None	N/A	Yes	$616	Health Care Trust Fund
Health Maintenance Organizations	Initial Application Fee	s. 641.49(3)(t), F.S.	$1,000	Prior to 1997	Yes	$1,000	Health Care Trust Fund
	Biennial Renewal Fee	s. 641.495(2), F.S.	$1,000	Prior to 1997	Yes	$1,000	Health Care Trust Fund

Service / Product Regulated	Specific Fee Title	Statutory Authority for Fee	Maximum Fee Authorized (cap)	Year of Last Statutory Revision to Fee	Is Fee Set by Rule? (Yes or No)	Current Fee Assessed	Fund Fee Deposited in (indicate General Revenue or Specific Trust Fund)
	Annual Regulatory Assessment	s. 641.58(1), F.S.	0.1% Annual Premiums Collected	Prior to 1997	No	0.000078764% 2013 Annual Premiums Collected	Health Care Trust Fund
Home Health Agency	License fee	s. 400.471(5), FS	$2,000	2005	Yes	$1,705	Health Care Trust Fund
	Renewal fee	s. 400.471(5), FS	$2,000	2005	Yes	$1,705	Health Care Trust Fund
Home Medical Equipment Providers & Services	Licensure Fee	s. 400.931(5), F.S.	$300	1999	Yes	$304.50	Health Care Trust Fund
	Survey/Inspection Fee (80% Exempt)	s. 400.931(6), F.S.	$400	1999	No	$400	Health Care Trust Fund
Homemakers, Companions & Sitters	Registration Fee	s. 400.509(3), F.S.	$50	2007 (Biennial fee)	No	$50.75	Health Care Trust Fund
Homes for Special Services	Licensure Fee	s. 400.801(3), F.S.	$2,000	Prior to 1997	No	$87.29 per bed Maximum fee of $1,114,47	Health Care Trust Fund
Hospice Services	Licensure Fee	s. 400.605(2), F.S.	$1,200	2007 (Biennial fee)	Yes	$1,218	Health Care Trust Fund
Hospitals	Licensure Fee	s. 395.004, F.S.	$30 per bed	Prior to 1997	Yes	$31 .46 Per Bed - Minimum $1565.13	Health Care Trust Fund
	Life Safety Inspections	s. 395.0161, F.S.	$1.50 per bed	Prior to 1997	Yes	$1.50 per bed Minimum $40	Health Care Trust Fund
	Licensure/Validation Survey Fee	s. 395.0161, F.S.	$12 per bed	Prior to 1997	Yes	$12 Per Bed Minimum $400	Health Care Trust Fund
Intermediate Care Facility for the Developmental Disabled	Licensure Fee	s. 400.962(3), F.S.	None	2007	No	$262.88 per bed	Health Care Trust Fund
Multiphasic Health Testing Centers	Licensure Fee	s. 483.291(2), F.S.	$2,000	Prior to 1997	Yes	$643	Health Care Trust Fund
Nurse Registry (Home health services by independent contractors)	Licensure Fee	s. 400.506(3), F.S.	$2,000	2005	Yes	$2,000	Health Care Trust Fund

Service / Product Regulated	Specific Fee Title	Statutory Authority for Fee	Maximum Fee Authorized (cap)	Year of Last Statutory Revision to Fee	Is Fee Set by Rule? (Yes or No)	Current Fee Assessed	Fund Fee Deposited in (indicate General Revenue or Specific Trust Fund)
Nursing Homes (Skilled Nursing Facilities)	Licensure Fee	s. 400.062(3), F.S.	$112.50 per community bed, $100.50 if a sheltered bed	2007	Yes	$112.50 per community bed, $100.50 if a sheltered bed	Health Care Trust Fund
	Resident Protection Fee	s. 400.062(3), F.S.	$.50 per bed	2007	Yes	$.50 per bed	Health Care Trust Fund
	Data Assessment Fee	s. 408.20, F.S.	$20 per bed	Amount not in Statute	Yes	$12 per bed	Health Care Trust Fund
	Additional survey fee	s. 400.19(3), F.S.	$6,000	2001	No	$6,000	Health Care Trust Fund
Organ Procurement Organizations	Application Fee	s. 765.544(1)(a), F.S.	$1,000	Prior to 1997	No	$1,000 initial/ CHOW	Health Care Trust Fund
	Annual Assessment Fee	s. 765.544(1)(b), F.S.	$35,000	Prior to 1997	No	The greater of $1,000 or 0.25% total annual revenues	Health Care Trust Fund
Prepaid Health Clinics	Initial Application Fee	s. 641.49(3)(t), F.S.	$1,000	Prior to 1997	Yes	$1,000	Health Care Trust Fund
	Biennial Renewal Fee	s. 641.495(2), F.S.	$1,000	Prior to 1997	Yes	$1,000	Health Care Trust Fund
	Annual Regulatory Assessment	s. 641.58(1), F.S.	0.1% Annual Premiums Collected	Prior to 1997	No	0.000078764% 2013 Annual Premiums Collected	Health Care Trust Fund
Prescribed Pediatric Extended Care Facilities	Licensure Fee	s. 400.905(2), F.S.	$3,000	2007	Yes	$1,512.35	Health Care Trust Fund
Residential Treatment Facility	Licensure Fee	s. 394.877, F.S.	None	N/A	Yes	$191.83 per bed	Health Care Trust Fund
Residential Treatment Centers for Children and Adolescents	Licensure Fee	s. 394.877, F.S.	None	N/A	Yes	$240 per bed	Health Care Trust Fund
Tissue Banks	Application Fee	s. 765.544(1)(a), F.S.	$1,000	Prior to 1997	No	$1,000 initial/ CHOW	Health Care Trust Fund
	Annual Assessment Fee	s. 765.544(1)(b), F.S.	$35,000	Prior to 1997	No	The greater of $1,000 or 0.25% total annual revenues	Health Care Trust Fund

Service / Product Regulated	Specific Fee Title	Statutory Authority for Fee	Maximum Fee Authorized (cap)	Year of Last Statutory Revision to Fee	Is Fee Set by Rule? (Yes or No)	Current Fee Assessed	Fund Fee Deposited in (indicate General Revenue or Specific Trust Fund)
Transitional Living Facility	License Fee	s. 400.805(2)(b), F.S.	None	2007	Yes	$4,588 + $90 per bed	Health Care Trust Fund
Utilization Review - 07/01/09 - Legislation repealed F.S. 395.0199 and corresponding rule 59A-15, therefore fee no longer applicable							
Workers Comp Managed Care	Initial Application Fee	s. 440.134(2), FS	$1,000	Prior to 1997	Yes	$1,000	Health Care Trust Fund
	Biennial Renewal Fee	s. 440.134(2), FS	$1,000	Prior to 1997	Yes	$1,000	Health Care Trust Fund

Schedule IA - Part I: Examination of Regulatory Fees

Department: Agency for Health Care Administration

Regulatory Service to or Oversight of Businesses or Professions Program: Health Care Facilities

1. What recent operational efficiencies have been achieved to either decrease costs or improve services? If costs have been reduced, how much money has been saved during the fiscal year?

   Response: Electronically obtained fingerprinting for all criminal background screening requirements has been in place for nearly four years and significantly increased the screening results the Agency for Health Care Administration (AHCA) can process within existing resources from 63,000 to over 200,000 annually. Additionally, AHCA continues to move forward in the development of the Care Provider Background Screening Clearinghouse (Clearinghouse). The Clearinghouse is a secure, web-based database to house and manage screening results of multiple state agencies allowing the following agencies to share those results: AHCA, Agency for Persons with Disabilities (APD), Department of Elder Affairs (DOEA), Department of Children and Families (DCF), Department of Health (DOH), Department of Juvenile Justice (DJJ), and Vocational Rehabilitation at the Department of Education (DOE/VR). For the selected agencies and persons subject to background screenings, the elimination of duplicative screenings for employees working in long-term care and other health care related provider types will result in an overall cost savings. Integration with the state agencies began in January 2013 and currently AHCA, DOH, DOE/VR, and Managed Care Health Plans are participating with the remaining agencies expected to be brought on in 2015. Approximately 800 individuals a month applying for licensure or their licensure renewals with DOH are able to use a Clearinghouse screening reducing duplicative screening and costs. AHCA's providers benefit by being able to use more than 400 screenings per month from the Clearinghouse. During Fiscal Year 2013-14, more than 14,000 background screening results were shared among participating agencies and managed care health plans resulting in an overall cost savings of $1,395,700 to AHCA providers, DOH licensees and Managed Care Health Plans.

   The passage of SB 674, Chapter 2014-84, Laws of Florida during the 2014 Legislative Session made substantial changes regarding the Clearinghouse. The bill authorized AHCA and the Department of Highway Safety and Motor Vehicles (DHSMV) to share driver's license photos with AHCA allowing for additional identity verification of individuals being screened by AHCA. The bill also requires the registration and initiation of all criminal history background checks be made through the Clearinghouse for individuals required to be

screened, providing reduced costs from duplicative screening, enhanced tracking of the screening, and a copy of the Florida public criminal history report of the applicant for providers.

2. What additional operational efficiencies are planned? What are the estimated savings associated with these efficiencies during the next fiscal year?

   Response: AHCA has been moving steadily toward the ultimate goal of a comprehensive, integrated, online licensure system. The system is expected to have intra/inter-departmental connectivity with other automated systems, such as those used by Medicaid, Medicare, the Background Screening Clearinghouse, AHCA accounts receivable, and DOH practitioner regulation. The system will allow AHCA to automate the submission of license applications and fees as well as integrate with AHCA's document management system. It will also help identify delinquent monies owed in other parts of AHCA to facilitate collection before licenses are issued or renewed.

   AHCA recently implemented online licensure renewal applications for several licensure programs during the first quarter of Fiscal Year 2014-15 and anticipates that renewal applications for the remaining licensure types will be available online by June 2015. Cost savings, as a result of implementing an online system, are inevitable as AHCA currently processes over 20,000 paper applications every year. Although applications can still be submitted by mail, the reduction in paper processing and administrative costs for providers, taxpayers, and the State of Florida are estimated to save over $200,000 annually through a decrease in provider late fines and provider efforts to submit additional documentation when applications are incomplete. There is also an expectation of a reduction in processing time by four to eight business days per application by eliminating manual intake of applications and making use of built-in validations to reduce omissions and request for additional information. This time savings will allow providers to receive licenses faster and begin operations sooner. Staff will be repurposed to handle online user help and enrollment, assist in system maintenance, and implement strategies to expand online submission.

3. Is the regulatory activity an appropriate function that the agency should continue at its current level?

   Response: Yes. Licensure of health care providers and facilities is required by Florida Statutes and serves to protect the health, safety and welfare of the patients, residents and clients receiving services in settings regulated by AHCA. These are complex health care services often provided to vulnerable populations.

4. Are the fees charged for the regulatory service or oversight to businesses or professions based on revenue projections that are prepared using generally accepted governmental accounting procedures or official estimates by the Revenue Estimating Conference, if applicable?

Response: Most fees are established in Florida Statutes and adjusted by the Consumer Price Index (CPI) annually if fees do not pay program costs. Some fees are established in the regulatory programs' administrative rules with capped maximum amounts in Florida Statutes. Fees established in rule are adjusted according to the CPI but cannot exceed the cost of administering the program. Pursuant to s. 408.05, F.S., license fees must be reasonably calculated by AHCA to cover its costs in carrying out its responsibilities under authorizing statutes and applicable rules, including the cost of licensure, inspection, and regulation of providers.

5. Are the fees charged for the regulatory service or oversight to businesses or professions adequate to cover both direct and indirect costs of providing the regulatory service or oversight?

   Response: No. Fees do not cover the total licensure expense, which includes application processing, assistance to applicants and consumers, and the on-site inspection activity required in statute. However, fees are increased each year by the CPI for those programs that do not fully pay their costs per s. 408.805, F.S.

6. Are the fees charged for the regulatory service or oversight to businesses or professions reasonable and do they take into account differences between the types of professions or businesses that are regulated? For example, do fees reflect the amount of time required to conduct inspections by using a sliding scale for annual fees based on the size of the regulated business; or do fees provide a financial incentive for regulated entities to maintain compliance with state standards by assessing a re-inspection fee if violations are found at initial inspection?

   Response: Most fees take into account the size of the provider for those with licensed beds (a per-bed fee is accessed in addition to a base licensure fee in most cases). However, some fee exemptions exist that do not equitably address size including the exemption from per bed fees for assisted living facilities that serve residents on Optional State Supplementation. In some instances, the capped amounts in the Florida Statutes are too low to cover the costs, such as the $50 fee for homemaker companion services and the $1,200 fee for a hospice license that includes all branch locations and inpatient facilities.

   There are some fees that are only imposed when AHCA has taken extra regulatory actions such as follow-up surveys. These fees are capped in statute and are only collected through legal action.

7. If the fees charged for the regulatory services or oversight to businesses or professions are **not** adequate to cover direct and indirect program costs provide either:

a) information regarding alternatives for realigning revenues or costs to make the regulatory service or program totally self-sufficient, including any statutory changes that are necessary to implement the alternative or
b) demonstrate that the service or program provides substantial benefits to the public which justify a partial subsidy from other state funds, specifically describing the benefits to the general public (statements such as 'providing consumer benefits' or 'promoting health, safety and welfare' are not sufficient justification). For example, the program produces a range of benefits to the general public, including pollution reduction, wildlife preservation, and improved drinking water supply. Alternatively, AHCA can demonstrate that requiring self-sufficiency would put the regulated entity at an unfair advantage. For example, raising fees sufficiently to cover program costs would require so high an assessment as to damage its competitive position with similar entities in other states.

Response: Regulation of health care facilities is critical to the health, welfare and safety of patients. Costs are not adequately funded by the licensure fees allowed by statute for each program independently. Suggestions for addressing underfunded programs are as follows.

Eliminate fee caps to enable full implementation of the Consumer Price Index annual increase for all provider types. This fully enables a gradual fee increase to offset underfunded programs.

Hospice – Add a separate inspection fee amount for freestanding inpatient facilities and add increased licensure amount for each branch, inpatient and residential facility.

Homemaker Companion Services, Home Medical Equipment providers and Nurse Registries – Statutory fee increase.

Assisted Living Facilities (ALFs) - Options include:

A. Require licensure fees for Optional State Supplementation (OSS) beds. Florida law exempts facilities that designate their beds as OSS. The current fee for non-OSS beds is $64.96 per private pay bed in addition to the $387.73 standard licensure fee. Some of the facilities that receive this exemption for the majority of their licensed beds require significant regulatory resources. Eliminating this exemption is an option to offset program costs. There are currently 13,772 OSS beds in Florida.

B. Increase the per-bed, per facility, and/or specialty licensure fees for all ALFs to offset program deficits.

C. Assess higher fees at renewal for those facilities that require greater regulatory oversight based on the number of complaint inspections, violations cited, follow-

up visits required to determine correction of violations and adverse sanctions, such as moratoria, suspension, fines, or other actions.

8. If the regulatory program is not self-sufficient and provides a public benefit using state subsidization, please provide a plan for reducing the state subsidy.

   Response: During the 2010 Legislative Session, AHCA requested an amendment to chapter 408, Part II, F.S., and authorized statutes to remove language that could be construed to limit licensing fees and allow fees to be adjusted to pay for the cost of regulatory activities. Pursuant to s. 408.805, F.S., licensing fees must cover AHCA's costs.

SCHEDULE 1A: DETAIL OF FEES AND RELATED PROGRAM COSTS

Department: 68 Health Care Administrati **Budget Period: 2015-16**
Program: 68700700 Health Care Regulation
Fund: 2003 Health Care Trust Fund

Specific Authority: Various Sections of the following Chapters 112, 383, 390, 394, 395, 400, 440, 483, 641, 765, F.S.

Purpose of Fees Collected: The fees are necessary to enable the Agency to administer its regulatory responsibilities.

Type of Fee or Program: (Check **ONE** Box and answer questions as indicated.)

X	Regulatory services or oversight to businesses or professions (Complete Sections I, II, and III and attach **Examination of Regulatory Fees** Form - Part I and II.)
	Non-regulatory fees authorized to cover full cost of conducting a specific program or service. (Complete Sections I, II, and III only.)

SECTION I - FEE COLLECTION	**ACTUAL FY 2013 - 14**	**ESTIMATED FY 2014 - 15**	**REQUEST FY 2015 - 16**
Receipts:			
Abortion Clinic	37,362	27,656	27,656
AFCH	60,218	75,789	75,789
ALF Facility	4,679,740	4,312,236	4,312,236
ADC Facility	30,576	24,048	24,048
Amb. Surgical Center	460,680	428,312	428,312
Birth Center	27,894	15,464	15,464
Crisis Stabilization Units	108,343	117,177	117,177
Diagnostic imaging	0	0	0
Forensic Lab	164,347	120,196	120,196
HMO	785,439	785,439	785,439
HMO-WC	0	0	0
H, C, & Ss	64,220	121,968	121,968
Health Care Clinics	2,341,918	2,681,427	2,681,427
Health Care Services Pool	151,279	155,061	155,061
Home Health	3,353,179	3,952,182	3,952,182
Home Medical Equipment	366,614	418,239	418,239
Home Spec. Service	0	0	0
Hospice	32,905	28,896	28,896
Hospital	1,017,744	1,238,060	1,238,060
ICF/DD	330,496	364,152	364,152
Laboratory	1,567,566	1,572,083	1,572,083
Multiphasic Center	85,404	4,611	4,611
Nurse Registry	738,306	756,764	756,764

Organ & Tissue Donor	60,140	0	0
Organ Procurement	646,007	0	0
PPECS	30,360	32,347	32,347
Radiation Therapy	0	0	0
Residential Treatment	229,161	254,382	254,382
Residential Treatment for Children	0	0	
Risk Management	104,476	121,040	121,040
SNF Home	6,564,248	6,728,323	6,728,323
Trans. Living	55,924	58,210	58,210
UTIL Review	0	0	0
Plans Review	4,727,198	5,159,088	5,159,088
Total Fee Collection to Line (A) - Section III	28,821,744	29,553,149	29,553,149

SECTION II - FULL COSTS

Direct Costs:			
Salaries and Benefits			
Other Personal Services			
Expenses			
Operating Capital Outlay			
Direct Cost Allocation	46,595,210	49,876,926	49,876,926
Indirect Costs Charged to Trust Fund	15,087,315	15,119,083	10,119,083
Total Full Costs to Line (B) - Section III	61,682,525	64,996,009	59,996,009

Basis Used:

SECTION III - SUMMARY

TOTAL SECTION I	(A)	28,821,744	29,553,149	29,553,149
TOTAL SECTION II	(B)	61,682,525	64,996,009	59,996,009
TOTAL - Surplus/Deficit	(C)	(32,860,781)	(35,442,860)	(30,442,860)

EXPLANATION of LINE C:

The deficits are covered by 408.20 F.S Assessments, Health Care Trust Fund.

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period : 2015-2016

Department Title: Agency for Health Care Administration
Trust Fund Title: Health Care Trust Fund
Budget Entity: Department Level
LAS/PBS Fund Number: 2003

	Balance as of 6/30/2014		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	$ 125,770,947	(A)	$ -	$ 125,770,947	
ADD: Other Cash (See Instructions)	$ 1,545,822	(B)		$ 1,545,822	
ADD: Investments	$ -	(C)		$ -	
ADD: Outstanding Accounts Receivable	$ 203,236,835	(D)	$ 1,523	$ 203,238,358	
ADD:		(D)		$ -	
ADD:		(D)		$ -	
ADD:		(E)		$ -	
Total Cash plus Accounts Receivable	**$ 330,553,605**	(F)	**$ 1,523**	**$ 330,555,128**	
LESS Allowances for Uncollectibles	$ 408,237	(G)		$ 408,237	
LESS Approved "A" Certified Forwards	$ 141,267,230	(H)		$ 141,267,230	
Approved "B" Certified Forwards	$ 286,517	(H)		$ 286,517	
Approved "FCO" Certified Forwards		(H)		$ -	
LESS: Other Accounts Payable (Nonoperating)	$ 904,307	(I)		$ 904,307	
LESS: Deferred Inflows - Unavailable Revenue	$ 49,356,082	(J)		$ 49,356,082	
LESS:		(J)		$ -	
Unreserved Fund Balance, 07/01/2014	**$ 138,331,232**	(K)	**$ 1,523**	**$ 138,332,755**	**

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2015 - 2016

Department Title: Agency for Health Care Administration

Trust Fund Title: Health Care Trust Fund

Budget Entity: Department Level

LAS/PBS Fund Number: 2003

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/2014 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**$ 146,326,070**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	$ -	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment for receivable due from DHSMV	$ 1,523	(C)
SWFS Adjustment # and Description	$ -	(C)
SWFS Adjustment # and Description	$ -	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	$ (286,517)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	$ -	(D)
A/P not C/F-Operating Categories	$ (12,109)	(D)
Current Compensated Absences Liability	$ 201,434	(D)
Other Loans and Notes Receivable and Advances less Allowance for Uncollectibles	$ (7,897,646)	(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**$ 138,332,755**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**$ 138,332,755**	(F)
DIFFERENCE:	**$ 0**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IV-B FOR ADVANCED DATA ANALYTICS AND DETECTION SERVICES

For Fiscal Year 2015-2016

October 15, 2014

AGENCY FOR HEALTH CARE ADMINISTRATION

Contents

I. Schedule IV-B Cover Sheet

Schedule IV-B Cover Sheet and Agency Project Approval	
Agency: Agency for Health Care Administration	Schedule IV-B Submission Date:
Project Name: Advanced Data Analytics and Detection Services	Is this project included in the Agency's LRPP? X Yes ____ No
FY 2015-16 LBR Issue Code:	FY 2015-16 LBR Issue Title:
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Kristen Koelle, (850) 412-4600, Kristen.koelle@ahca.myflorida.com	
AGENCY APPROVAL SIGNATURES	
I am submitting the attached Schedule IV-B in support of our legislative budget request. I have reviewed the estimated costs and benefits documented in the Schedule IV-B and believe the proposed solution can be delivered within the estimated time for the estimated costs to achieve the described benefits. I agree with the information in the attached Schedule IV-B.	
Agency Head: Printed Name: Elizabeth Dudek, Secretary	Date: 10/15/14
Agency Chief Information Officer (or equivalent): Printed Name: Scott Ward, CIO	Date: 10/15/14
Budget Officer: Printed Name: Anita Hicks, CFO	Date: 10-15-2014
Planning Officer: Kristen Koelle Printed Name: Kristen Koelle, Management Review Specialist	Date: 10-15-14
Project Sponsor: Printed Name: Eric W. Miller, Inspector General	Date: 10-15-2014

Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Kelly Bennett
Cost Benefit Analysis:	Kristen Koelle/ Kelly Bennett
Risk Analysis:	Kristen Koelle/ Michael Magnuson
Technology Planning:	Michael Magnuson
Project Planning:	Kristen Koelle/ Kelly Bennett

General Guidelines

The Schedule IV-B contains more detailed information on information technology (IT) projects than is included in the D-3A issue narrative submitted with an agency's Legislative Budget Request (LBR). The Schedule IV-B compiles the analyses and data developed by the agency during the initiation and planning phases of the proposed IT project. A Schedule IV-B must be completed for all IT projects when the total cost (all years) of the project is $1 million or more.

Schedule IV-B is not required for requests to:

- Continue existing hardware and software maintenance agreements,
- Renew existing software licensing agreements, or
- Replace desktop units ("refresh") with new technology that is similar to the technology currently in use.
- Contract only for the completion of a business case or feasibility study for the replacement or remediation of an existing IT system or the development of a new IT system .

Documentation Requirements

The type and complexity of an IT project determines the level of detail an agency should submit for the following documentation requirements:

- Background and Strategic Needs Assessment
- Baseline Analysis
- Proposed Business Process Requirements
- Functional and Technical Requirements
- Success Criteria
- Benefits Realization
- Cost Benefit Analysis
- Major Project Risk Assessment
- Risk Assessment Summary
- Current Information Technology Environment
- Current Hardware/Software Inventory
- Proposed Solution Description
- Project Management Planning

Compliance with s. 216.023(4)(a)10, F.S. is also required if the total cost for all years of the project is $10 million or more.

A description of each IV-B component is provided within this general template for the benefit of the Schedule IV-B authors. These descriptions and this guidelines section should be removed prior to the submission of the document.

Sections of the Schedule IV-B may be authored in software applications other than MS Word, such as MS Project and Visio. Submission of these documents in their native file formats is encouraged for proper analysis.

The revised Schedule IV-B includes two required templates, the Cost Benefit Analysis and Major Project Risk Assessment workbooks. For all other components of the Schedule IV-B, agencies should submit their own planning documents and tools to demonstrate their level of readiness to implement the proposed IT project. It is also necessary to assemble all Schedule IV-B components into one PDF file for submission to the Florida Fiscal Portal and to ensure that all personnel can open component files and that no component of the Schedule has been omitted.

Submit all component files of the agency's Schedule IV-B in their native file formats to the Office of Policy and Budget and the Legislature at IT@LASPBS.STATE.FL.US. Reference the D-3A issue code and title in the subject line.

II. Schedule IV-B Business Case – Strategic Needs Assessment

A. Background and Strategic Needs Assessment

The Agency for Health Care Administration (AHCA) is seeking to modernize its capability to analyze Florida Medicaid Management Information System (FMMIS) claim, encounter, provider, beneficiary, and other data for the purpose of detecting and preventing fraud, waste, program abuse, and pre and post payment and service anomalies associated with providers and recipients enrolled in the Medicaid program. To accomplish this the AHCA has procured a subscription-based advanced data analytics service that incorporates advanced detection tools and predictive modeling to provide leads, patterns, identify anomalies and outliers with the use of the AHCA data via a vendor's website/portal. The "other public benefit programs" that may be positively impacted by this funding include the State of Florida's Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF) program.

The AHCA's Office of Medicaid Program Integrity, Office of the Inspector General (MPI-OIG) historically has used a range of methods including routine and ad hoc statistical analyses to identify billing errors, claims abuse and potential fraud. The growth of data availability from local, state and federal sources has made it impossible to make use of the data without implementing advanced technologies in the form of advanced data analytics.

1. Business Need

The greatest challenge to identifying and deterring Medicaid fraud is discovery of the fraud itself. Fraud happens very quickly yet discovery can be slow, resulting in huge opportunities for criminals and huge costs for taxpayers. In FY 2012-13, MPI recovery activities resulted in recoupment of over $79.5 million dollars from improper payments to Medicaid health care providers. In FY 2013-14, that figure increased to approximately $86.2 million. These overpayments clearly represent the tip of the iceberg when it comes to the costs of fraud and abuse in Medicaid. The AHCA's Fraud and Abuse initiative seeks to find the latent fraud that remains undetected and then actively manage anti-fraud processes through a fraud case management system.

By improving the analysis of the FMMIS data the AHCA expects to improve the state's capabilities to prevent potential provider overpayments and move from a predominantly "pay and chase" model to prevention and early detection model, identifying earlier in the process providers engaging in inappropriate or fraudulent behavior from participating in the program.

2. Business Objectives

Currently, the systems and processes within MPI-OIG are built around a complaint-based investigative process. MPI-OIG has determined that a more appropriate response to the ever-changing schemes and artifices to defraud the Medicaid program requires an adaptable, multi-pronged, overlapping approach that provides internal validation of discoveries while also permitting a rapid response to identified patterns, behaviors or schemes. The addition of advanced analytic tools to identify fraud as it happens represents a significant paradigm shift towards a more aggressive approach to recovering taxpayer money lost to Medicaid fraud and abuse. This approach will complement and reduce the reliance on the "pay and chase" and complaint-based investigative model of fraud management.

Advanced data analytics capabilities allow fraud and abuse investigators to query the data in a way that reveals patterns and relationships between people, places, events, times and things, or any other discrete data points. Advanced Data Analytics capabilities also allow queries based on groups, "nearness" and other clustered or networked behavior. These varied analytic techniques offer investigators choices in how to uncover connections in seemingly unrelated data.

Specifically, the project seeks to deliver on the following:

- Preventing and decreasing improper payments associated with fraud, waste, and abuse in the Medicaid program;
- Improved availability of key provider data relevant for Medicaid provider screening for program participation and oversight;

- Identify Medicaid benefit and provider payment policy inconsistencies, as well as errors or needed enhancements within the claims processing and related systems;
- Create technical functionality that will improve the state's ability to identify and mitigate early potential payment risks and program vulnerabilities in the Medicaid program;
- Identify Medicaid recipients who need action by State resources to have recipients receive the appropriate medical services;
- Develop and implement a risk based approach using predictive analytics to identify potential fraud, waste and abuse in the Florida Medicaid program as well as other public benefits programs in the state;
- Develop leads that increase the probability of identifying parties that appear to have an increased propensity for committing fraud, waste or abuse in the Florida Medicaid program and other public benefits programs;
- Increase effective and efficient use of staff in combating fraud, waste and abuse in the Florida Medicaid program and other public benefits programs;
- Connect financial and clinical outcomes to help identify the care processes and services that produce the most effective results;
- Reduce fraud, waste and abuse, automate manual processes, and drives smarter decisions by extracting actionable insights from the data within government agencies;
- Provides actionable results to enable easy decision making;
- Minimize false positives that can overwhelm MPI and diminish existing return on investment;
- Reduce costs while improving resource allocation by focusing collection efforts to achieves a higher success rate, resulting in additional annual revenue to the state;
- More efficiently prevent and identify improper payments;
- Better manage risk;
- Streamline processes; and
- Increase job effectiveness.

B. Baseline Analysis

The AHCA currently utilizes Surveillance and Utilization Review System (SURS) furnished by the Medicaid fiscal agent contractor. SURS is used to determine possible overutilization of Medicaid services and other deviations from expected values and norms associated with reimbursement for Medicaid goods and services. SURS uses statistical methods to examine volumes of claims and determine provider outliers. The AHCA also uses data mining of the Decision Support System (DSS or data warehouse) generalized analyses or computer based examinations of the claims of many providers of a given type to determine one or a few types of abuse, chi-square analyses (a form of nonparametric statistics) to find and quantify upcoding of claims (billing a higher paying procedure code than warranted) and the early warning system (a form of regression statistics) to find and predict sudden and problematic increases in provider billings. Additionally, the AHCA relies on referrals from internal and external shareholders, consumer complaints and responses to Explanation of Medicaid Benefits (EOMB) forms submitted by recipients or reported recipients of billed Medicaid services. Additionally, in conducting audits of Medicaid providers, auditors frequently find indications of possible fraud and abuse by other providers.

1. Current Business Process(es)

The Data Detection Unit utilizes the tools, resources and reports described below in an effort to identify instances of possible Medicaid fraud and abuse. The Data Detection Unit analyzes claims data, develops leads for the case management units and works closely with MPI's Medicare partners to identify fraud and abuse issues related to claims paid by both the Medicaid and Medicare programs. The unit works with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) to coordinate data mining and detection projects, and identifies violations using multiple detection tools and methods. Apparent violations are referred to the case management units or to MFCU for further investigation. Case management units within MPI conduct audits, pursue overpayment recovery, and make referrals to outside agencies as appropriate. The Data Detection Unit also assists in the development of generalized analyses of Medicaid claims and provides programming support for other MPI units.

MPI's primary detection tools now include the following:

1. **DSS (Decision Support System)** ***Profiler*** – Serves as the basis of the Surveillance and Utilization Review System (SURS) and is used to determine possible overutilization and other deviations from expected values and norms associated with reimbursement for Medicaid goods and services. Providers that stand out based on the standard deviation analysis may be selected for auditing.

2. **FMMIS/DSS** – A comprehensive solution providing complete Fraud and Abuse Detection (FAD) and Surveillance and Utilization Review System (SURS) capabilities. The FAD/SUR system is fully integrated within the Medicaid fiscal agent's data warehouse and provides the AHCA with the ability to research Medicaid providers and recipients in order to investigate potential exploitation of the Medicaid program. The review process allows for evaluation of the delivery and utilization of medical services to safeguard the quality of care and protect against abusive use of Medicaid funds.

3. **First Health Pharmacy Reports** – Include top member rankings, top 100 prescribers by amounts prescribed, quarterly "doctor shopper" reports, prescriber ranking reports and "most utilized pharmacies" reports.

4. **Business Objects Ad Hoc Reports** – Used by auditors to access Medicaid claims information within the FMMIS and DSS. FMMIS processes and pays provider claims and contains claim-related information on Medicaid providers, recipients, drugs and medical services. The DSS stores seven years of providers' claims history and contains the DSSProfiler datamart, a type of SURS for claims utilization review and provider and recipient analysis profiling.

5. **The 1.5 Report** – Produced weekly, provides a listing of each Medicaid provider who is scheduled to receive a check for that week in an amount that exceeds 1.5 times the average amount received for the immediately prior 26 weeks. This report includes all Medicaid provider types and is useful for spotting providers that have an unusually high payment amount for a given week. The report is received by MPI at the beginning of the week and is analyzed quickly so that, if necessary, certain payments for that week can be held until a thorough review can be completed. Frequently, if a payment is stopped, it is found to have been paid in error and needs to be nullified or corrected. When the report leads to the identification of providers who are misbilling the Medicaid program, an audit is initiated.

6. **Chi-square Report** – Utilizes a nonparametric statistical analysis developed by MPI to determine possible overpayments to providers who engage in upcoding or who are using a higher-paying procedure code (in a series of codes) than warranted. The analysis yields estimates of overpayments at a very high confidence level. For providers of a given type, the analysis determines an overpayment indicator, which is proportional to an overpayment amount, for each of the providers having the largest overpayment indicators. Several types of providers are analyzed. The chi-square report is issued quarterly and lists providers in descending order of overpayment indicator, along with provider number, total payment, number of claims paid and other information.

7. **Early Warning System Reports** – Developed by MPI to determine projected rates and amounts of increase in payments to providers. Regression analyses are performed using exponential curve fitting. Very rapid increases in payments may be due to the fact that providers are new to the Medicaid program or due to other legitimate reasons. Or, rapid increases in payments may be due to unwarranted billings by providers. Payments for a number of weeks are read by the program, which calculates the equation of a curve reflecting the trend in payments. The slope of the curve is calculated at the latest week. This slope is indicative of the rate of increase in payments at that time. Total projected payments for the next year are calculated and compared to actual payments for the year just ended. Payment data are obtained from the FMMIS.

8. **The Medi-Medi Project** – Established to detect and prevent fraud, waste and abuse in the Medicare and Medicaid programs by performing computerized matching and analysis of Medicare and Medicaid data. This matching is performed to detect claims paid by Medicaid that should have been paid only by Medicare. Through this program's statistical analysis, trending activities and development of valuable potential fraud cases for referral to appropriate health care and law enforcement agencies are completed. Through these collaborative efforts, information is provided to MPI that is related to excessive billing patterns, duplicate payments, services billed in both programs with no cross-over in place and other abuses.

The detection tools described above identify outlier providers who exhibit general patterns of aberrant behavior including overutilization, upcoding, unbundling (breaking grouped services into component parts to elevate billing)and double billing. Each provider type has specific benchmarks applicable to these aberrant patterns. These tools identify providers for audits or referrals to MFCU for potential criminal investigation and help identify areas that require comprehensive reviews or prepayment reviews.

2. Assumptions and Constraints

Assumptions

- The project will receive continued support from the AHCA management;
- There are sufficient resources (staff, software, hardware) to complete the project;
- There will be sufficient budget to fund the project;
- The program office subject matter experts (SME) will be knowledgeable and experienced in their current business process and available to meet with the required parties to convey their process;
- Program office staff will be available and involved in executing test scenarios;
- The Division of Information Technology (IT) staff and augmented IT staff have the skills necessary to support implementation;
- IT staff and other staff as appropriate will receive project specific training if needed; and
- Technical standards will be uniform.

Constraints

- Access to quality data and the capacity to cross-reference data from various data sources; and
- Managing tasks and activities to complete deliverables within the desired time frame/implementation schedule.

C. Proposed Business Process Requirements

1. Proposed Business Process Requirements

- Provide a web-based user portal that provides remote access capability, navigability in a graphic environment and semi-customizable views to meet individual user needs;
- Identify and prevent improper payments associated with fraud, waste and program abuse across all recipient and provider types, encounter, claims, programs and payment systems to ensure recipients receive appropriate and quality services and care;
- Utilize timely Medicaid data from a variety of sources, to produce and monitor data driven analyses and patterns of suspect behavior;
- Generalize from the previous learning experiences and use this experience to identify new fraud, abuse, or waste schemes as they appear;
- Produce user- friendly reports/tools that increase efficiencies and maximize results;
- Provide continuously improved detection capabilities;
- Be flexible to changing state and federal requirements necessary for maintenance of the integrity and performance of the data;
- Be responsive to unique state needs related to identifying , tracking and resolving incorrect payment issues within the state;
- Enhance the capability of the state to share fraud and abuse or incorrect payment and encounter issues with other states and CMS; and
- Supports the Transformed Medicaid Statistical Information System (TMSIS) data capabilities and endures that the MMIS meets all federal reporting requirements.

2. Business Solution Alternatives

Alternatives to utilizing these new capabilities include: 1) not utilizing advanced data detection and continuing with current processes or, 2) the procurement of an inferior system to be hosted by AHCA.

3. Rationale for Selection

The AHCA will be able to streamline the detection process making more efficient use of staff time, establishing leads quicker and enhancing program efficiency by identifying cases with high probabilities of fraud, waste or program abuse prior to expending time and financial resources.

4. Recommended Business Solution

After consulting with internal information technology subject matter experts, it was determined that Florida's procurement would be related to the purchase of analytics services using a combination of the AHCA-provided data, the DCF- provided data, other state-owned data, and commercial data aggregated to produce suspicious provider and recipient alerts to the AHCA's Office of Medicaid Program Integrity. As previously stated, by improving the analysis of the data, the AHCA expects to improve the state's capabilities to prevent potential provider overpayments and move from a predominant "pay and chase" model to a model that includes prevention of improper payments and improper billings, identifying providers engaging in inappropriate or fraudulent behavior earlier in the process, thereby preventing them from participating in the Medicaid program and causing overpayments.

D. Functional and Technical Requirements

The AHCA will utilize a secure interface in order to receive vendor leads and to submit requests (i.e., Ad Hoc Reports); Access will be limited to investigators/auditors within the AHCA as well as select groups from other State Agencies. The fraud solution will be utilized/accessed by the AHCA's Division of Health Quality Assurance (HQA) (licensing) and the Division of Medicaid. Additionally, the DCF, Benefits Integrity Unit, the Agency for Persons with Disabilities (APD), and any other agency that administers public health benefits programs. All users would utilize to access vendor reports/results and to make Ad Hoc requests. The AHCA expects the portal to be available to receive Ad Hoc requests at least 95 percent of the time with no more than five percent downtime. Training will be limited to website/portal use to ensure secure transmission of vendor reports/results, data and Ad Hoc requests between the vendor and staff. Different levels of training may be required for different roles based on the design of the website/portal and the vendor's administrative support plan.

The AHCA is requiring the Vendor to meet the following functional and technical requirements:

- The Vendor shall host the advanced data analytics operation with state-owned data, uploaded to the vendor via File Transfer Protocol (FTP), going back five years and refreshed, at a minimum, monthly;
- The Vendor must provide a web-based user portal that provides remote access capability, navigability in a graphic environment and semi-customizable views to meet individual user needs;
- The Vendor shall integrate various state-owned data including, but not limited to, the following:
    - FMMIS/DSS;
    - VR licensing data (healthcare facility licensing data) including controlling interest relationships;
    - Provider Network Verification (PNV) Medicaid managed care provider networks;
    - State professional licensure data;
    - Public Record Data, i.e., Department of State's (DOS) SunBiz, Florida Department of Corrections (DOC), Florida Department of Highway Safety and Motor Vehicles (DHMSV), wage and hour data from Florida Department of Economic Opportunity (DEO), and eligibility data from Florida Department of Elder Affairs (DOEA), DCF and APD; and
    - Third Party Liability (subrogation) data.
- The Vendor shall provide private business data analysis such as financial risk scoring, provider business transactions profiles, provider demographic data cross-matched to Medicaid enrollment and state licensure;
- The Vendor shall integrate other state and federal data, at a minimum: the current U.S. General Services Administration (GSA)-administered Excluded Parties List System (EPLS) and the System for Award Management (SAM) systems; and the U.S. Health and Human Services, Office of Inspector

General (HHS OIG)-administered List of Excluded Individuals and Entities (LEIE). The Vendor shall integrate, as available; Florida Medicaid managed care company special investigative unit (SIU) reports, Internal Revenue Service, Medicaid, Medicare, and the Social Security Master Death File;

- The Vendor shall have the capability to integrate with the MPI case management system to include, at a minimum:
    - Export capability to common PC platforms such as Microsoft Word, Excel and Access plus Adobe PDF formats; and
    - Customized integration with third-party case management system software, as well as other AHCA systems.
- The Vendor shall provide graph pattern analysis capability to include, at a minimum:
    - Social relationship link analysis and visual display capability;
    - Entity relationship analysis and discovery;
    - Directed expansion of relationship mapping;
    - Geographical relationship analysis; and
    - Map integration with customization.
- The Vendor shall provide proactive detection to include, at a minimum:
    - Alert or flag user about activity the system determines anomalous based on data clusters;
    - Customizable alert thresholds based on user need;
    - Quarterly algorithm and detection model updates; and
    - Algorithm refinement based on user feedback loop.
- The Vendor shall conduct active pattern and fraud scheme analysis and provide investigation-ready leads for MPI or for MPI referral to other agencies;
- The Vendor shall develop the application jointly with state staff to optimize user interfaces before rollout;
- The Vendor shall provide maintenance and connectivity as requested by the AHCA; and
- The Vendor shall have the capability to integrate with the MPI case management system; the AHCA expects integration to be a transfer of data from the case management system to the vendor.

Note: The AHCA defines pattern analysis as an analytic approach based upon pattern matching, the definition of which is widely available from a variety of publicly available sources. Generally, it is the process of analyzing graph structured data to uncover important properties, patterns and anomalies so that they are easily recognizable. The AHCA defines link analysis as a technique to identify and evaluate relationships between various types of objects including people, organizations and transactions.

Note: The AHCA defines "investigation-ready leads" as more than simply system flags or alerts, but information referred to the AHCA that has undergone a preliminary analytic review by the Vendor, identifying suspicious behavior patterns, the reasoning or methodology for the suspicion, and recommended actions.

III. Success Criteria

SUCCESS CRITERIA TABLE				
#	**Description of Criteria**	**How will the Criteria be measured/assessed?**	**Who benefits?**	**Realization Date (MM/YY)**
1	Cost savings by keeping unqualified recipients and providers out of the system.	The AHCA will review month over month and year over year comparison to determine the effectiveness of the new solution. This will include a prior year pre-analytics list of unqualified recipients and providers list against post-data analytics detection year of unqualified recipients and providers.	The State of Florida Taxpayers and Medicaid and its recipients.	Fiscal Year 2015-2016
2	Actual recoveries of overpayments and detection of fraud as a result of the investigative leads generated by system analysts.	The AHCA will measure the total number of leads provided by the vendor against the number of leads that result in recoveries and chart performance month over month.	The state of Florida Taxpayers and Medicaid and its recipients.	Fiscal Year 2015-2016
3	Efficiency of staff by targeting reviews and audits to those cases most likely to result in higher recovery amounts.	The AHCA will measure and compare recovery amounts with historical data.	The state of Florida Taxpayers and Medicaid and its recipients.	Fiscal Year 2015-2016

IV. Schedule IV-B Benefits Realization and Cost Benefit Analysis

A. Benefits Realization Table

The AHCA anticipates using the service for monitoring program integrity in the Medicaid program. As experience and success with the service is realized, the AHCA anticipates expanding the availability of the analytics tool to other state public benefit programs.

B. Cost Benefit Analysis (CBA)

1. The Cost-Benefit Analysis Forms

The chart below summarizes the required CBA Forms which are included as Appendix A on the Florida Fiscal

Portal and must be completed and submitted with the Schedule IV-B.

Cost Benefit Analysis	
Form	**Description of Data Captured**
CBA Form 1 - Net Tangible Benefits	Agency Program Cost Elements: Existing program operational costs versus the expected program operational costs resulting from this project. The agency needs to identify the expected changes in operational costs for the program(s) that will be impacted by the proposed project. Tangible Benefits: Estimates for tangible benefits resulting from implementation of the proposed IT project, which correspond to the benefits identified in the Benefits Realization Table. These estimates appear in the year the benefits will be realized.
CBA Form 2 - Project Cost Analysis	Baseline Project Budget: Estimated project costs. Project Funding Sources: Identifies the planned sources of project funds, e.g., General Revenue, Trust Fund, Grants. Characterization of Project Cost Estimate.
CBA Form 3 - Project Investment Summary	Investment Summary Calculations: Summarizes total project costs and net tangible benefits and automatically calculates: • Return on Investment • Payback Period • Breakeven Fiscal Year • Net Present Value • Internal Rate of Return

V. Schedule IV-B Major Project Risk Assessment

A. Risk Assessment Summary

The Risk Assessment Tool and Risk Assessment Summary are included in Appendix B.

VI. Schedule IV-B Technology Planning

A. Current Information Technology Environment

1. Current System

The AHCA's issued an Invitation to Negotiate (ITN) in October of 2013. In January of 2014 the AHCA rejected all bids and re-issued the ITN in February of 2014. Ultimately, the AHCA awarded SAS Institute, Inc. (SAS) the contract to perform advanced data analytic and detection services in April of 2014. The contract was executed in August of 2014 (see Appendix C). SAS will host the solution on a secure, scalable infrastructure with premium support. The AHCA and SAS are working together to define and link source data systems.

Currently, review for fraud and abuse is predominantly performed manually and post-payment review is accomplished using a form of SURS, data mining of the DSS, chi-square analysis, the early warning system, internal and external referrals, consumer complaints and responses to EOMB forms, coupled with the auditing of Medicaid providers. The use of advanced data analytics and predictive modeling will provide a more efficient systematic approach to pre-payment claims reviews and will streamline the post-payment detection of fraud and abuse in the Medicaid program.

B. Current Hardware and/or Software Inventory

Not applicable.

C. Proposed Solution Description

1. Summary description of proposed system

The use of data analytics and predictive modeling in the detection of fraud, waste, and program abuse in healthcare programs can be a powerful tool that allows for detection and identification of patterns of fraudulent behavior not otherwise readily apparent. As an added strength, these tools have the ability to identify patterns of suspicious behavior based on historical data thereby creating an opportunity for additional system edits to prevent future overpayments or any kind of fraud, waste and abuse.

By way of their response to the ITN, SAS proposed increasing recoveries and administrative efficiency by finding and prioritizing high value investigation ready cases and automatically aggregating state owned and third party data needed to quickly make an investigatory decision. Their scoring system will prioritize leads for investigators and automatically aggregate the data from a variety of sources allowing investigators to quickly assess cases. Through streamlining the data gathering and integration process, using pattern and link analytics, and then prioritizing leads, AHCA will be able to focus on the highest value cases and improve operational efficiencies by automating time-consuming processes.

SAS proposes increasing recoveries and administrative efficiency by finding and prioritizing high value investigation ready cases and automatically aggregating state owned and third party data needed to quickly make an investigatory decision. Their scoring system will prioritize leads for investigators and automatically aggregate the data from a variety of sources allowing investigators to quickly assess cases. Through streamlining the data gathering and integration process, using pattern and link analytics, and then prioritizing leads the AHCA will be able to focus on the highest value cases and improve operational efficiencies by automating time consuming processes.

These tools combine powerful data modeling in diverse data sets to recognize patterns in providers and recipients to focus limited investigative resources. Therefore, through an oversight of claims, suspicious patterns can be identified and scrutinized for further investigation. This service will utilize state FMMIS data, as well as other data sources, to build analytical products such as peer comparison regarding payments, diagnosis cluster grouping, and other statistical comparisons to group like-providers. While states are currently performing some of these functions post-payment, predictive modeling tools can provide a more systematic approach to pre-payment claims. For example, by comparing same-provider types, the system can identify long-term trending that is indicative of abusive billing behaviors, such as upcoding or high frequency use of certain codes. These trends can then be applied to future claim submissions in a pre-payment capacity.

This is not a stand-alone tool but a paramount first tool for the investigative process. Staff investigators will use these suspicious activity alerts to direct their efforts in a more effective direction. Thus, with these tools, investigative teams have very proficient resources to efficiently monitor the integrity of the Medicaid program, leading to greater recoveries, and discouraging future abuse.

While these services are expensive, other states utilizing post-payment predictive analytics have seen positive returns in payment recoveries far exceeding the cost of purchasing the services and hiring the technical staff to successfully implement the analytical tool.

2. Resource and summary level funding requirements for proposed solution (if known)

1) Anticipated technical platform and hardware requirements – none anticipated
2) Required data center services to be provided by the state data center – none known
3) Anticipated software requirements – none anticipated
4) Anticipated staffing requirements – none

VII. Schedule IV-B Project Management Planning

The AHCA will:

- At a minimum, monitor the Contract on a weekly basis for the first nine (9) months and monthly thereafter, either on-site or by desk review to ensure Vendor compliance with contract requirements. the AHCA reserves the right to monitor the Vendor on a more frequent basis if deemed necessary by the AHCA;
- Perform timely review of all documents submitted by the Vendor by approving, denying or requiring specified revision;
- Determine whether the Vendor has violated a contractual obligation and assess liquidated damages when necessary; and
- Provide office and meeting space for specified activities of the Contract.

The Vendor will:

- The Vendor shall prepare and submit to the AHCA for approval a final project implementation plan, at no additional cost to the AHCA, no later than fifteen (15) business days following execution of the Contract. It shall be based on the preliminary implementation plan submitted with the Vendor's response to the ITN and shall be finalized in coordination with AHCA to ensure readiness to complete required tasks by dates specified in the Contract;
- The final implementation plan shall include the following, at a minimum:
    - All tasks to be performed by the Vendor and the AHCA during the implementation phase through operation;
    - Expected dates of completion of all tasks and identification of the parties responsible for each task; and
    - Identification of barriers and possible resolutions.
- The final implementation plan shall not be utilized until approved by the AHCA. Any unapproved deviation by the Vendor from the AHCA-approved final project implementation plan shall be regarded by the AHCA as a material breach and all remedies provided in Attachment I, Scope of Services, Section J, Performance Standards and Liquidated Damages, and under law shall become available to the AHCA.

VIII. Appendices

See attachments for Appendices A, B, and C.

CBAForm 1 - Net Tangible Benefits

Agency: AHCA Project: Advanced Data Analytics

Net Tangible Benefits - Operational Cost Changes (Costs of Current Operations versus Proposed Operations as a Result of the Project) and Additional Tangible Benefits -- CBAForm 1A

Agency (Operations Only -- No Project Costs)	FY 2015-16			FY 2016-17			FY 2017-18			FY 2018-19			FY 2019-20		
	(a) Existing Program Costs	(b) Operational Cost Change	(c) = (a)+(b) New Program Costs resulting from Proposed Project	(a) Existing Program Costs	(b) Operational Cost Change	(c) = (a) + (b) New Program Costs resulting from Proposed Project	(a) Existing Program Costs	(b) Operational Cost Change	(c) = (a) + (b) New Program Costs resulting from Proposed Project	(a) Existing Program Costs	(b) Operational Cost Change	(c) = (a) + (b) New Program Costs resulting from Proposed Project	(a) Existing Program Costs	(b) Operational Cost Change	(c) = (a) + (b) New Program Costs resulting from Proposed Project
A. Personnel -- Total FTE Costs (Salaries & Benefits)	$284,918	$0	$284,918	$284,918	$0	$284,918	$0	$0	$0	$0	$0	$0	$0	$0	$0
A.b Total FTE	6.25	0.00	6.25	6.25	0.00	6.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A-1.a. State FTEs (Salaries & Benefits)	$284,918	$0	$284,918	$284,918	$0	$284,918	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-1.b. State FTEs (# FTEs)	6.25	0.00	6.25	6.25	0.00	6.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A-2.a. OPS FTEs (Salaries)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-2.b. OPS FTEs (# FTEs)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A-3.a. Staff Augmentation (Contract Cost)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-3.b. Staff Augmentation (# of Contract FTEs)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
B. Data Processing -- Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-1. Hardware	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-2. Software	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-3. Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C. External Service Provider -- Costs	$0	$2,900,000	$2,900,000	$2,900,000	$0	$2,900,000	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-1. Consultant Services	$0	$207,145	$207,145	$207,145	$0	$207,145	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-2. Maintenance & Support Services	$0	$331,428	$331,428	$331,428	$0	$331,428	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-3. Network / Hosting Services	$0	$1,077,142	$1,077,142	$1,077,142	$0	$1,077,142	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-4. Data Communications Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-5. Other Purchase Third Party Data	$0	$1,284,285	$1,284,285	$1,284,285	$0	$1,284,285		$0	$0	$0	$0	$0	$0	$0	$0
D. Plant & Facility -- Costs (including PDC services)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
E. Others -- Costs	$0	$145,000	$145,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
E-1. Training	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
E-2. Travel	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
E-3. Other Legal	$0	$145,000	$145,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total of Operational Costs (Rows A through E)	$284,918	$3,045,000	$3,329,918	$3,184,918	$0	$3,184,918	$0	$0	$0	$0	$0	$0	$0	$0	$0
F. Additional Tangible Benefits:		$132,131,298			$132,131,298			$0			$0			$0	
F-1. Cost Avoidance		$28,691,298			$28,691,298			$0			$0			$0	
F-2. MPI Recoveries		$103,440,000			$103,440,000			$0			$0			$0	
F-3. Specify		$0			$0			$0			$0			$0	
Total Net Tangible Benefits:		$129,086,298			$132,131,298			$0			$0			$0	

CHARACTERIZATION OF PROJECT BENEFIT ESTIMATE -- CBAForm 1B			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous	☐	Confidence Level	
Order of Magnitude	☑	Confidence Level	75%
Placeholder	☐	Confidence Level	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	**AHCA**	**Advanced Data Analytics**																		
					CBAForm 2A Baseline Project Budget															
2	*Costs entered into each row are mutually exclusive. Insert rows for detail and modify appropriation categories as necessary, but do not remove any of the provided project cost elements. Reference vendor quotes in the Item Description where applicable. Include only one-time project costs in this table. Include any recurring costs in CBA Form 1A.*				**FY2015-16**			**FY2016-17**			**FY2017-18**			**FY2018-19**			**FY2019-20**			**TOTAL**
3				**$ -**		**$ 3,045,000**			**$ 2,900,000**			**$ -**			**$ -**			**$ -**		**$ 5,945,000**
4	**Item Description** ***(remove guidelines and annotate entries here)***	**Project Cost Element**	**Appropriation Category**	**Current & Previous Years Project-Related Cost**	**YR 1 #**	**YR 1 LBR**	**YR 1 Base Budget**	**YR 2 #**	**YR 2 LBR**	**YR 2 Base Budget**	**YR 3 #**	**YR 3 LBR**	**YR 3 Base Budget**	**YR 4 #**	**YR 4 LBR**	**YR 4 Base Budget**	**YR 5 #**	**YR 5 LBR**	**YR 5 Base Budget**	**TOTAL**
5	Costs for all state employees working on the project.	**FTE**	S&B	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ -**
6	Costs for all OPS employees working on the project.	**OPS**	OPS	$ -	0.00		$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ -**
7	Staffing costs for personnel using Time & Expense.	**Staff Augmentation**	Contracted Services	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ -**
8	Project management personnel and related deliverables.	**Project Management**	Contracted Services	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ -**
9	Project oversight (IV&V) personnel and related deliverables.	**Project Oversight**	Contracted Services	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ -**
10	Staffing costs for all professional services not included in other categories.	**Consultants/Contractors**	Contracted Services	$ -	1.00	$ -	$ 2,900,000	1.00	$ -	$ 2,900,000	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ 5,800,000**
11	Separate requirements analysis and feasibility study procurements.	**Project Planning/Analysis**	Contracted Services	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
12	Hardware purchases not included in Primary Data Center services.	**Hardware**	OCO	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
13	Commercial software purchases and licensing costs.	**Commercial Software**	Contracted Services	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
14	Professional services with fixed-price costs (i.e. software development, installation, project documentation)	**Project Deliverables**	Contracted Services	$ -		$ -			$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
15	All first-time training costs associated with the project.	**Training**	Contracted Services	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
16	Include the quote received from the state data center for project equipment and services. Only include one-time project costs in this row. Recurring, project-related data center costs are included in CBA Form 1A.	**Data Center Services - One Time Costs**	Data Center Category	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
17	Other contracted services not included in other categories.	**Other Services**	Contracted Services	$ -		$ -			$ -			$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
18	Include costs for non-state data center equipment required by the project and the proposed solution (insert additional rows as needed for detail)	**Equipment**	Expense	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
19	Include costs associated with leasing space for project personnel.	**Leased Space**	Expense	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ -**
20	Other project expenses not included in other categories.	**Other Expenses**	Expense	$ -	1.00	$ -	$ 145,000		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ 145,000**
21		**Total**		**$ -**	**2.00**	**$ -**	**$ 3,045,000**	**1.00**	**$ -**	**$ 2,900,000**	**0.00**	**$ -**	**$ -**	**0.00**	**$ -**	**$ -**	**0.00**	**$ -**	**$ -**	**$ 5,945,000**

CBAForm 2 - Project Cost Analysis

Agency	AHCA	Project	Advanced Data Analytics

PROJECT COST SUMMARY	*PROJECT COST SUMMARY (from CBAForm 2A)*					TOTAL
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	
TOTAL PROJECT COSTS (*)	$3,045,000	$2,900,000	$0	$0	$0	$5,945,000
CUMULATIVE PROJECT COSTS *(includes Current & Previous Years' Project-Related Costs)*	$3,045,000	$5,945,000	$5,945,000	$5,945,000	$5,945,000	
Total Costs are carried forward to CBAForm3 Project Investment Summary worksheet.						

PROJECT FUNDING SOURCES	*PROJECT FUNDING SOURCES - CBAForm 2B*					TOTAL
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	
General Revenue	$0	$0	$0	$0	$0	$0
Trust Fund	$870,000	$725,000	$0	$0	$0	$1,595,000
Federal Match ☑	$2,175,000	$2,175,000	$0	$0	$0	$4,350,000
Grants ☐	$0	$0	$0	$0	$0	$0
Other ☐ Specify	$0	$0	$0	$0	$0	$0
TOTAL INVESTMENT	$3,045,000	$2,900,000	$0	$0	$0	$5,945,000
CUMULATIVE INVESTMENT	$3,045,000	$5,945,000	$5,945,000	$5,945,000	$5,945,000	

Characterization of Project Cost Estimate - CBAForm 2C			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous		Confidence Level	
Order of Magnitude	x	Confidence Level	75%
Placeholder		Confidence Level	

CBAForm 3 - Project Investment Summary

Agency	AHCA	Project	Advanced Data Analytics

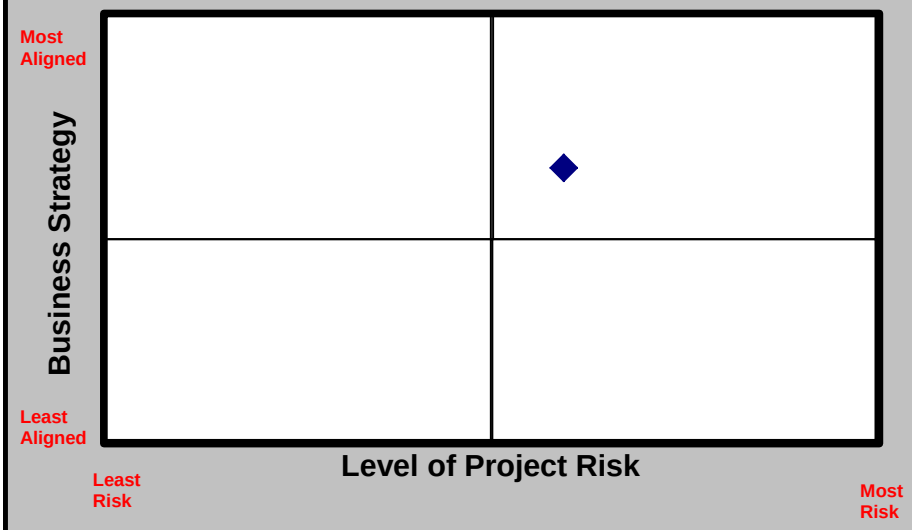
COST BENEFIT ANALYSIS -- CBAForm 3A						
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	TOTAL FOR ALL YEARS
Project Cost	$3,045,000	$2,900,000	$0	$0	$0	$5,945,000
Net Tangible Benefits	$129,086,298	$132,131,298	$0	$0	$0	$261,217,596
Return on Investment	$126,041,298	$129,231,298	$0	$0	$0	$255,272,596
Year to Year Change in Program Staffing	0	0	0	0	0	

RETURN ON INVESTMENT ANALYSIS -- CBAForm 3B		
Payback Period (years)	N/A	Payback Period is the time required to recover the investment costs of the project.
Breakeven Fiscal Year	2015-16	Fiscal Year during which the project's investment costs are recovered.
Net Present Value (NPV)	$247,685,407	NPV is the present-day value of the project's benefits less costs over the project's lifecycle.
Internal Rate of Return (IRR)	NO IRR	IRR is the project's rate of return.

Investment Interest Earning Yield -- CBAForm 3C					
Fiscal Year	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Cost of Capital	1.94%	2.07%	3.18%	4.32%	4.85%

Project	*Advanced Data Analytics and Detection Services*	
Agency	*Agency for Health Care Administration*	
FY 2015-16 LBR Issue Code:	**FY 2015-16 LBR Issue Title:**	
Issue Code	*Advanced Data Analytics*	
Risk Assessment Contact Info (Name, Phone #, and E-mail Address):		
Kristen Koelle, (850) 412-4600, kristen.koelle@ahca.myflorida.com		
Executive Sponsor	*Eric Miller*	
Project Manager	*Kristen Koelle*	
Prepared By	*Kristen Koelle/Mike Magnuson*	*9/19/2014*

Risk Assessment Summary



Project Risk Area Breakdown

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

Agency: Agency for Health Care Administration Project: Advanced Data Analytics and Detection Services

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	41% to 80% -- Some 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	No changes needed
		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	Minimal or no external use or visibility
		Moderate external use or visibility	
		Extensive external use or visibility	
1.09	What is the internal (e.g. state agency) visibility of the proposed system or project?	Multiple agency or state enterprise visibility	Multiple agency or state enterprise visibility
		Single agency-wide use or visibility	
		Use or visibility at division and/or bureau level only	
1.10	Is this a multi-year project?	Greater than 5 years	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: Advanced Data Analytics and Detection Services

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	Supported prototype or production system less than 6 months
		Supported prototype or production system less than 6 months	
		Supported production system 6 months to 12 months	
		Supported production system 1 year to 3 years	
		Installed and supported production system more than 3 years	
2.02	Does the agency's internal staff have sufficient knowledge of the proposed technology to implement and operate the new system?	External technical resources will be needed for implementation and operations	External technical resources will be needed 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: Advanced Data Analytics and Detection Services

Section 3 -- Organizational Change Management Area			
#	Criteria	Values	Answer
3.01	What is the expected level of organizational change that will be imposed within the agency if the project is successfully implemented?	Extensive changes to organization structure, staff or business processes	Minimal changes to organization structure, staff or business processes structure
		Moderate changes to organization structure, staff or business processes	
		Minimal changes to organization structure, staff or business processes structure	
3.02	Will this project impact essential business processes?	Yes	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)	Minor or no changes
		Moderate changes	
		Minor or no changes	
3.08	What is the expected change impact on other state or local government agencies as a result of implementing the project?	Extensive change or new way of providing/receiving services or information	Minor or no changes
		Moderate changes	
		Minor or no changes	
3.09	Has the agency successfully completed a project with similar organizational change requirements?	No experience/Not recently (>5 Years)	Recently completed project with greater change requirements
		Recently completed project with fewer change requirements	
		Recently completed project with similar change requirements	
		Recently completed project with greater change requirements	

Agency: Agency Name

Project: Project Name

Section 4 -- Communication Area			
#	Criteria	Value Options	Answer
4.01	Has a documented Communication Plan been approved for this project?	Yes	Yes
		No	
4.02	Does the project Communication Plan promote the collection and use of feedback from management, project team, and business stakeholders (including end users)?	Negligible or no feedback in Plan	Routine feedback in Plan
		Routine feedback in Plan	
		Proactive use of feedback in Plan	
4.03	Have all required communication channels been identified and documented in the Communication Plan?	Yes	Yes
		No	
4.04	Are all affected stakeholders included in the Communication Plan?	Yes	Yes
		No	
4.05	Have all key messages been developed and documented in the Communication Plan?	Plan does not include key messages	Plan does not include key messages
		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	All or nearly all messages have success measures
		Success measures have been developed for some messages	
		All or nearly all messages have success measures	
4.07	Does the project Communication Plan identify and assign needed staff and resources?	Yes	Yes
		No	

Agency: Agency for Health Care Administration Project: Advanced Data Analytics and Detection Services

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	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	Some project benefits have been identified but not 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)	Firm Fixed Price (FFP)
		Firm Fixed Price (FFP)	
		Combination FFP and T&E	

Agency: Agency for Health Care Administration Project: Advanced Data Analytics and Detection Services

Section 5 -- Fiscal Area			
#	Criteria	Values	Answer
5.13	What is the planned approach for procuring hardware and software for the project?	Timing of major hardware and software purchases has not yet been determined	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	Yes, bid response did/will include proof of concept or prototype
		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	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	Half of staff from in-house resources
		Half of staff from in-house resources	
		Mostly staffed from in-house resources	
		Completely staffed from in-house resources	
6.09	Is agency IT personnel turnover expected to significantly impact this project?	Minimal or no impact	Minimal or no impact
		Moderate impact	
		Extensive impact	
6.10	Does the project governance structure establish a formal change review and control board to address proposed changes in project scope, schedule, or cost?	Yes	Yes
		No	
6.11	Are all affected stakeholders represented by functional manager on the change review and control board?	No board has been established	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	Some
7.04	Have all requirements specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	41 to 80% -- Some have been defined and documented
7.05	Have all design specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	41 to 80% -- Some have been defined and documented
7.06	Are all requirements and design specifications traceable to specific business rules?	0% to 40% -- None or few are traceable 41 to 80% -- Some are traceable 81% to 100% -- All or nearly all requirements and specifications are traceable	41 to 80% -- Some 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	Some deliverables and acceptance criteria have been defined and documented
7.08	Is written approval required from executive sponsor, business stakeholders, and project manager for review and sign-off of major project deliverables?	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	Only project manager signs-off
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	41 to 80% -- Some have been defined to the work package level
7.10	Has a documented project schedule been approved for the entire project lifecycle?	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

Agency: Agency for Health Care Administration Project: Advanced Data Analytics and Detection Services

Section 7 -- Project Management Area			
#	Criteria	Values	Answer
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

Agency: Agency for Health Care Administration Project: Advanced Data Analytics and Detection Services

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	3 sites or fewer
		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	2 to 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	Similar size and complexity
		Lesser size and complexity	
		Similar size and complexity	
		Greater size and complexity	

Fiscal Year 2015-16 LBR Technical Review Checklist

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

Agency Budget Officer/OPB Analyst Name: Anita Hicks / Jack Furney

A "Y" indicates "YES" and is acceptable, an "N/J" indicates "NO/Justification Provided" - these require further explanation/justification (additional sheets can be used as necessary), and "TIPS" are other areas to consider.

		Program or Service (Budget Entity Codes)					
	Action	68200000	68500100	68500200	68501400	68501500	68700700
1. GENERAL							
1.1	Are Columns A01, A02, A04, A05, A23, A24, A25, A36, A93, IA1, IA5, IA6, IP1, IV1, 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 59 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 29)? 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 29) been followed?	Y	Y	Y	Y	Y	Y
3. EXHIBIT B (EXBR, EXB)							
3.1	Is it apparent that there is a fund shift where an appropriation category's funding source is different between A02 and A03? 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
AUDITS:							
3.2	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
3.3	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 61 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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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.						
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 2013-14 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 to be submitted 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 33 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 67-68 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 69 through 71 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 through E-6 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?	Y	Y	Y	Y	Y	Y
7.9	Does the issue narrative reference the specific county(ies) where applicable?	Y	Y	Y	Y	Y	Y
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #14-001?	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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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	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
7.16	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 28 and 88 of the LBR Instructions.)	Y	Y	Y	Y	Y	Y
7.17	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, 330010C0, 33011C0, 160E470, 160E480 or 55C01C0)?	Y	Y	Y	Y	Y	Y
7.18	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
7.19	Does the issue narrative identify the strategy or strategies in the Five Year Statewide Strategic Plan for Economic Development?	Y	Y	Y	Y	Y	Y
AUDIT:							
7.20	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
7.21	Does the General Revenue for 160XXXX (Adjustments to Current Year Expenditures) issues net to zero? **(GENR, LBR1)**	Y	Y	Y	*Y	*Y	Y
7.22	Does the General Revenue for 180XXXX (Intra-Agency Reorganizations) issues net to zero? **(GENR, LBR2)**	N/A	N/A	N/A	N/A	N/A	N/A
7.23	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? **(GENR, LBR3)**	Y	Y	Y	Y	Y	Y
7.24	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.	* The Add portion for IC 1600120 is coded under the Agency for Persons with Disabilities. The Deduct portion for IC 1700150 is coded under the Department of Children and Families.					
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 65 through 70 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 a state agency needs to include in its LBR a realignment or workload request issue to align its data processing services category with its projected FY 2015-16 data center costs, this can be completed by using the new State Data Center data processing services category (210001). (NSRC data processing services category (210022) and the SSRC data processing services category (210021) will no longer be used).						
TIP	If an appropriation made in the FY 2014-15 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.						

	Program or Service (Budget Entity Codes)					
Action	68200000	68500100	68500200	68501400	68501500	68700700
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 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**;** fixed capital outlay adjustment 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?	N/A	N/A	N/A	N/A	N/A	N/A
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?	N/A	N/A	N/A	N/A	N/A	N/A
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)? For non-grant federal revenues, is the correct revenue code identified (codes 000504, 000119, 001270, 001870, 001970)?	Y	Y	Y	Y	Y	Y
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 general revenue 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?	Y	Y	Y	Y	Y	Y
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 Has the agency properly accounted for continuing appropriations (category 13XXXX) in column A01, Section III?	N/A	N/A	N/A	N/A	N/A	N/A

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
8.28	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
8.29	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC?	Y	Y	Y	Y	Y	Y
AUDITS:							
8.30	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
8.31	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
8.32	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
8.33	Has a Schedule IB been provided for each trust fund and does total agree with line I ?	Y	Y	Y	Y	Y	Y
8.34	Have A/R been properly analyzed and any allowances for doubtful accounts been properly recorded on the Schedule IC?	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 130 of the LBR Instructions.) Transaction DFTR in LAS/PBS is also available and provides an LBR review date for each trust fund.						
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 161 of the LBR Instructions.)	Y	Y	Y	Y	Y	Y
10. SCHEDULE III (PSCR, SC3)							
10.1	Is the appropriate lapse amount applied in Segment 3? (See page 92 of the LBR Instructions.)	Y	Y	Y	Y	Y	Y
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See page 99 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? Note: FCO issues can now be included in the priority listing.	Y	Y	Y	Y	Y	Y
13. SCHEDULE VIIIB-1 (EADR, S8B1)							
13.1	**NOT REQUIRED FOR THIS YEAR**						
14. SCHEDULE VIIIB-2 (EADR, S8B2)							
14.1	Do the reductions comply with the instructions provided on pages 104 through 106 of the LBR Instructions regarding a 5% reduction in recurring General Revenue and Trust Funds, including the verification that the 33BXXX0 issue has NOT been used?	Y	Y	Y	Y	Y	Y
15. SCHEDULE VIIIC (EADR, S8C) (LAS/PBS Web - see page 107-109 of the LBR Instructions for detailed instructions)							
15.1	Agencies are required to generate this schedule via the LAS/PBS Web.	Y	Y	Y	Y	Y	Y
15.2	Does the schedule include at least three and no more than 10 unique reprioritization issues, in priority order? Manual Check.	Y	Y	Y	Y	Y	Y

Action	Program or Service (Budget Entity Codes)					
	68200000	68500100	68500200	68501400	68501500	68700700
15.3 Does the schedule display reprioritization issues that are each comprised of two unique issues - a deduct component and an add-back component which net to zero at the department level?	Y	Y	Y	Y	Y	Y
15.4 Are the priority narrative explanations adequate and do they follow the guidelines on pages 107-109 of the LBR instructions?	Y	Y	Y	Y	Y	Y
15.5 Does the issue narrative in A6 address the following: Does the state have the authority to implement the reprioritization issues independent of other entities (federal and local governments, private donors, etc.)? Are the reprioritization issues an allowable use of the recommended funding source?	Y	Y	Y	Y	Y	Y
AUDIT:						
15.6 Do the issues net to zero at the department level? **(GENR, LBR5)**	Y	Y	Y	Y	Y	Y
16. SCHEDULE XI (USCR,SCXI) (LAS/PBS Web - see page 110-114 of the LBR Instructions for detailed instructions)						
16.1 Agencies are required to generate this spreadsheet via the LAS/PBS Web. **The Final Excel version no longer has to be submitted to OPB for inclusion on the Governor's Florida Performs Website.** (Note: Pursuant to *section 216.023(4) (b), Florida Statutes*, the Legislature can reduce the funding level for any agency that does not provide this information.)	Y	Y	Y	Y	Y	Y
16.2 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:						
16.3 Does the FY 2013-14 Actual (prior year) Expenditures in Column A36 reconcile to Column A01? **(GENR, ACT1)**	Y	Y	Y	Y	Y	Y
16.4 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
16.5 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
16.6 Has the agency provided the necessary standard (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
16.7 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.						
17. MANUALLY PREPARED EXHIBITS & SCHEDULES						
17.1 Do exhibits and schedules comply with LBR Instructions (pages 115 through 158 of the LBR Instructions), and are they accurate and complete?	Y	Y	Y	Y	Y	Y
17.2 Are appropriation category totals comparable to Exhibit B, where applicable?	Y	Y	Y	Y	Y	Y
17.3 Are agency organization charts (Schedule X) provided and at the appropriate level of detail?	Y	Y	Y	Y	Y	Y
17.4 Does the LBR include a separate IV-B for each IT project over $1 million (see page 134 of the LBR instructions for exemptions to this rule)? Have all IV-B been emailed to: IT@LASPBS.state.fl.us	N/A	N/A	N/A	N/A	N/A	N/A
17.5 Are all forms relating to Fixed Capital Outlay (FCO) funding requests submitted in the proper form, including a Truth in Bonding statement (if applicable) ?	N/A	N/A	N/A	N/A	N/A	N/A
AUDITS - GENERAL INFORMATION						
TIP Review *Section 6: Audits* of the LBR Instructions (pages 160-162) 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.						

Action	Program or Service (Budget Entity Codes)					
	68200000	68500100	68500200	68501400	68501500	68700700
18. CAPITAL IMPROVEMENTS PROGRAM (CIP)						
18.1 Are the CIP-2, CIP-3, CIP-A and CIP-B forms included?	Y	Y	Y	Y	Y	Y
18.2 Are the CIP-4 and CIP-5 forms submitted when applicable (see CIP Instructions)?	Y	Y	Y	Y	Y	Y
18.3 Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	Y	Y	Y	Y	Y	Y
18.4 Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	N/A	N/A	N/A	N/A	N/A	N/A
18.5 Are the appropriate counties identified in the narrative?	Y	Y	Y	Y	Y	Y
18.6 Has the CIP-2 form (Exhibit 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.						
19. FLORIDA FISCAL PORTAL						
19.1 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