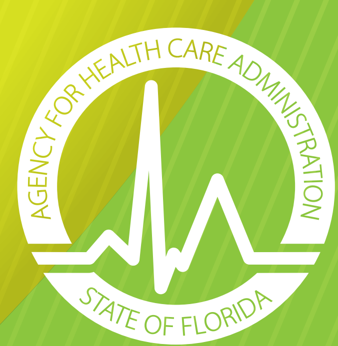
Florida Agency for Health Care Administration

Legislative Budget Request

Fiscal Year 2016-2017



Rick Scott
Governor

Elizabeth Dudek
Secretary

ELIZABETH DUDEK
SECRETARY

September 15, 2015

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

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

Cindy Kynoch, Staff Director
Senate Committee on Appropriations
201 Capitol
Tallahassee, Florida 32399-1300

Dear Directors:

Pursuant to Chapter 216, Florida Statutes, our Legislative Budget Request for the Agency for Health Care Administration is submitted in the format prescribed in the budget directions. The information provided electronically and contained herein is a true and accurate presentation of our proposed needs for the 2016-2017 Fiscal Year. This submission has been approved by Elizabeth Dudek, Secretary.

Sincerely,

Tonya Kidd
Deputy Secretary, Operations

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Temporary Special Duty – General Pay Additives Implementation Plan for Fiscal Year 2016-17

Section 110.2035(7), F.S., 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 Rule 60L-32.0012, F.A.C., 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

The 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 Family Medical Leave Act (FMLA) or authorized military leave; and
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: The AHCA will need to determine this additive on a case by case basis, assessing the proper alignment of the specifications and the reason for the additive being placed. For employees filling any vacant positions, the additive would be placed upon approval and assignment of the additional duties. However, employees who are identified as working "out-of-title" for a period of time that exceeds 22 workdays within any six consecutive months shall also be eligible to receive a temporary special duty – general pay additive beginning on the 23rd day in accordance with the Personnel Rules as stated in the American Federal State, County and Municipal Employees (AFSCME) Master Contract, Article 21.

3. Length of time additive will be used: A temporary special duties – general pay additive may be granted beginning with the first day of assigned additional duties. The additive may be in effect for up to 90 days at which time the circumstances under which the additive was implemented will be reviewed to determine if the additive should be continued based on the absence of the position incumbent or continued vacant position.

4. The amount of each type of additive: General Pay Additives will commonly be between 3 to 10 percent, but may range up to 20 percent over the employee's current salary and be will 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 the allotted 90 days (or a total of 18 cumulative weeks) which will total 720 work hours, we will use the current salary and then calculate the adjusted temporary salary by multiplying by our percentile increase. These two totals will be subtracted to get the difference, that difference will be multiplied by the 720 available hours to get the final additive amount. (See example below)

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

5. Classes and number of position affected: This pay additive could potentially affect any of our current 1193 Career Service position incumbents statewide.

6. Historical Data: Last fiscal year, a total of seven full time equivalent (FTE) career service positions received general pay additives for performing the duties of a vacant position, these positions were considered "mission critical" and played a key role in carrying out the AHCA's day-to-day operations. All additives were in effect for the allotted 90 days with three of the above mentioned seven positions being granted extensions.

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

Average Min. Annual Salaries	X 10% of Min. Annual Salaries	# of FTEs
$31,167.50	$3,116.75	7

Based on the average estimated salary stated above, the estimated calculation, based on the example formula above, is as follows: $1,078.88 X 7 = $7,552.16. **The AHCA 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

Department Level

Exhibits and Schedules

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	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 Families; 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 for the 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 State's administration of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Plaintiffs include pediatric and dental associations as well as individual plaintiffs. The named official capacity Defendants are the agency heads of the Departments of Health and Children and Family Services and the Agency for Health Care Administration. The action is brought pursuant to 42 U.S.C. §1983 and various provisions of the Social Security Act, 42 U.S.C. §1396a et seq. Plaintiffs primarily challenged the adequacy of Medicaid reimbursement rates for pediatric physician and dental services. That particular claim is no longer actionable under the United States Supreme Court opinion *Armstrong v. Exceptional Child Center, Inc.,* 135 S. Ct. 1378 (2015), but Plaintiffs are attempting to keep the rates claims alive through other claims. The Court entered Amended Findings of Fact and Conclusions of Law in favor of the Plaintiffs,

[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.

	but has not entered declaratory or injunctive relief. The Court is taking evidence on whether the Statewide Medicaid Managed Care program has changed the landscape enough that the Amended Findings are no longer viable. The Court has permitted the following claims to continue: whether Medicaid enrolled beneficiaries under the age of 21 are being denied timely access to necessary physician care and dental care; whether outreach to the uninsured about Medicaid is inadequate; and whether outreach conducted to Medicaid enrolled children is inadequate so that, as a result, parents and children do not know the Medicaid services available for Medicaid enrolled children. (Defendants argued that these claims cannot continue under *Armstrong*, but the Court disagreed.) Plaintiffs continue to seek, among other things, increased reimbursement rates to physician and dentist providers, arguing that the Court has jurisdiction over rates as the underlying "cause" of the violations.
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—a reimbursement rate 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. 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.
Specific Law(s) Challenged:	42 U.S.C. §§ 1396a(a)(8), (10), & (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 certified a class consisting 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." Defendants contend that the certified class cannot continue under the United States Supreme Court's intervening opinion in *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541 (2011) (holding all class members must have suffered same injury, not just suffered violation of same provision of law).

	The 95-day long trial on liability spanned December 7, 2009 to April 20, 2012, as the Court had time available on its docket. The Court held a hearing on July 8, 2014, on whether certain of Plaintiffs' claims were mooted because of the enhanced primary care rates and the implementation of Statewide Medicaid Managed Care and later ruled that they were not. Defendants intend to continue to argue to the trial court (and if the trial court enters a final and appealable order sometime in the future, on appeal) that the relief Plaintiffs seek is largely if not entirely moot and that the evidence relied upon by the court in its Amended Findings of Fact and Conclusion of Law was almost entirely based on circumstances that no longer exist with the implementation of Statewide Medicaid Managed Care (SMMC). In particular, very few of the 2.2 million children under the age of 21 currently served by the Medicaid program remain in Medicaid fee-for-service, and thus the physicians and dentist that serve them are not paid according to the allegedly insufficient fee-for-service rate schedule. Instead, every MMA plan (except CMSN) enters into a private contractual arrangement with physicians and dentists that individually determines the rates they will be paid In this 9-year old case, the Judge may now take further evidence over the next year before imposing a remedy. To determine a path forward, the Court ordered the parties to file offers of proof on April 22, 2015. Defendants' offer of proof included 15 declarants from AHCA, declarants from the managed care plans, and declarants from the other agencies. Plaintiffs filed a proposed declaratory judgment, and Defendants filed a response in opposition. We await the Court's next step. 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.	
Who is representing (of record) the state in this lawsuit? Check all that apply.		Agency Counsel
	X	Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel

If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).	Stuart H. Singer, Esq. Carl E. Goldfarb, Esq. Damien J. Marshall, Esq. Boies, Schiller & Flexner LLP 401 East Las Olas Blvd. Suite 1200 Fort Lauderdale, FL 33301 James Eiseman, Jr., Esq., Public Interest Law Center of Philadelphia 1709 Benjamin Franklin Parkway Second Floor Philadelphia, PA 19103 Louis W. Bullock, Esq., Bullock, Bullock, & Blakemore 110 W. 7th Street Tulsa, Oklahoma 74112

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Andrew Sheeran	Phone Number:	412-3670

Names of the Parties:	K.G., by and through his next friend, Iliana Garrido v. Elizabeth Dudek, in her official Capacity as Secretary, Florida Agency for Health Care Administration
Court with Jurisdiction:	United States 11th Circuit Court of Appeals
Case Number:	Lower Court Case No. 1:11-cv-20684-JAL; 12-13785-DD
Summary of the Complaint:	This is a lawsuit where the plaintiff seeks declaratory and injunctive relief regarding services the plaintiff argues should be covered under the state plan.
Amount of the Claim:	The plaintiffs 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 this services to all Medicaid recipients under the age of 21 for whom it is medically necessary.

Specific Law(s) Challenged:		
Status of the Case:	The trial court granted injunctive relief on March 26, 2012 and declaratory relief on June 14, 2012, purportedly 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 attorney's fees. The District Court granted Plaintiffs' motion for appellate attorney's fees in the amount of $209,999. AHCA has appealed.	
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).		

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Shena Grantham	Phone Number:	412-3691

Names of the Parties:	Petitioners: AHCA and APD Respondent: Centers for Medicaid & Medicare Services (CMS)

<table>
<tr><td colspan="1">Court with Jurisdiction:</td><td colspan="2">None, but this will be an administrative appeal through the Department of Health and Human Services (“DHHS”).</td></tr>
<tr><td>Case Number:</td><td colspan="2">None at this time. For identifying purposes, this will be an appeal of OIG Audit A-04-10-00076.</td></tr>
<tr><td>Summary of the Complaint:</td><td colspan="2">On March, 2013, CMS issued a demand letter memorializing the findings of CMS Audit A-04-10-00076 that 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 I, 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.</td></tr>
<tr><td>Amount of the Claim:</td><td colspan="2">$4,386,952 ($2, 193,476 federal share).</td></tr>
<tr><td>Specific Law(s) Challenged:</td><td colspan="2">This is an overpayment determination, and so the validity of state law is not at issue.</td></tr>
<tr><td>Status of the Case:</td><td colspan="2">On 3/6/15, CMS notified AHCA that based on their additional review, CMS will be issuing a disallowance letter with a reduced amount of FFP $1,774,798. The issuance date has not been determined yet, and this correspondence has not yet been received by the Agency.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td>X</td><td>Agency Counsel</td></tr>
<tr><td></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"></td></tr>
</table>

Schedule VII: Agency Litigation Inventory

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

Agency:	Agency for Health Care Administration		
Contact Person:	AHCA: Shena Grantham	Phone Number:	412-3691

Names of the Parties:	Petitioners: AHCA 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 Florida Department of Children and Families (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 (7/1/07 through 6/30/10), 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 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, and so the validity of state law is not at 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 2015

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:	First District Court of Appeal
Case Number:	1D15-2142
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 4 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:	$ > $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 Statutes § 86.021, .061; and 4. Breach of contract as third party beneficiary of AHCA's institutional Medicaid provider agreement.
Status of the Case:	The Court denied the Plaintiff's Renewed Motion for Class Certification and granted AHCA's motion to dismiss Count IV on the basis of sovereign immunity. Plaintiff has appealed. 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 and changed the calculation methodology for every applicant as of December 19, 2012 and later. 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). DCF's revised Rule 65A-1.7141, Florida Administrative Code, was certified as of July 23, 2015.

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).	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	

Office of Policy and Budget – July 2015

Agency:	**Agency for Health Care Administration**		
Contact Person:	Stuart F. Williams, Esquire	Phone Number:	412-3669

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:	Case No.: 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:	On November 10, 2014 the parties voluntarily dismissed this matter with prejudice. Case Closed.	
Who is representing (of	X	Agency Counsel

record) the state in this lawsuit? Check all that apply.		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	

Office of Policy and Budget – July 2015

Agency:	**Agency for Health Care Administration**		
Contact Person:	Leslei Street	Phone Number:	412-3686

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 alleged policies which purportedly limit the number of private duty nursing hours that have been approved, among other claims.
Amount of the Claim:	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:	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.
Status of the Case:	Plaintiffs' First Motion for Class Certification was denied but the Court permitted them further discovery. Their Second Motion for Class Certification was denied pending the Court ruling on AHCA's motion to dismiss, in which AHCA argued that the Plaintiffs did not have standing because no named Plaintiff resided in an NF and none of the Plaintiffs who live at home are at imminent risk of institutionalization and that the claims were moot due to policy changes. The Court denied the motion to dismiss in December 2014 and Plaintiffs filed their Second Renewed Motion for Class Certification on April 3, 2015. The Motion was heard July 14, 2015. 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. On August 7, 2015, the Magistrate Judge issued a Report and Recommendation that recommended that the Plaintiffs' Second Renewed Motion for Class Certification be denied.

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 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	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, and captioned: *A.R., by and through her next friend, Susan Root, et al., Plaintiffs vs. Elizabeth Dudek, in her official capacity as Secretary of the Agency for Health Care Administration, et al., Defendants / United States of America, Plaintiff v. State of Florida, Defendant,* Filed July 2013; consolidated with *AR et al. v. Dudek et al.* December 2013; discovery closes April 30, 2016.	
Court with Jurisdiction:	Southern District of Florida	
Case Number:	Case No. 0:12-cv-60460-RSR; Judge Zloch.	
Summary of the Complaint:	The United States asserts that the State of Florida, through AHCA, the Department of Health, the Department of Children and Families, and the Agency for Persons With Disabilities, violates Title II of the Americans With Disabilities Act (the "ADA") by unlawfully segregating children under the age of 21 in nursing facilities ("NF") and by placing children under the age of 21 who live in the community at risk of unlawful institutionalization.	
Amount of the Claim:	The United States seeks compensatory damages for pain and suffering of 182 (or more) Medicaid recipients under the age of 21 who are or were in NFs, 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:	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

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

Agency:	Agency for Health Care Administration		
Contact Person:	AHCA: Shena Grantham	Phone Number:	412-3691

Names of the Parties:	Petitioners: 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. The parties waived their right to a hearing and AHCA submitted its final Closing Arguments and Proposed Recommended Orders. The matter is currently pending before the Hearing Officer who has not yet issued an Order regarding outcome.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel

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

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	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 State 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 that 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:	1/27/15: Financial Services entered various prior period adjustments (PPAs) according to various FFY quarters being adjusted. The total is $63,539,389.51 (FFP $42,934,061.09) for FY 08-09 and FY 09-10. On 3/12/15 CMS issued an Official finding closure. This matter is closed.	
Who is representing (of	x	Agency Counsel

record) the state in this lawsuit? Check all that apply.		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 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Katharine Heyward	Phone Number:	850-412-3630

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration v. Ambi-Lingual Associates
Court with Jurisdiction:	N/A. The case is not on appeal.
Case Number:	AHCA C.I. No. 12-1083-000; MPI Case ID No. 2015-0003188
Summary of the Complaint:	Ambi-Lingual (Provider) failed to provide the necessary documentation for some of its claims submitted to AHCA for Medicaid payments; Provider billed AHCA for more units of therapy than Medicaid covers; and Provider used the wrong codes when it billed AHCA Medicaid. AHCA Medicaid paid Provider for the amount of the claims that Provider submitted. As a result, AHCA paid Provider more money than was owed for Provider's Medicaid claims. The amount that is more than the amount Provider should have been paid is considered an overpayment. AHCA is seeking to recover the amount of the overpayment and money for a fine and costs from the Provider.
Amount of the Claim:	$557,620.87
Specific Statutes or Laws (including GAA) Challenged:	No state laws or rules would be modified or overturned by an adverse court order.

Status of the Case:	The case is still at AHCA as AHCA and Provider are engaged in settlement negotiations. If settlement does not occur, the case will be forwarded to the Division of Administrative Hearings.	
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).	N/A	

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Katharine Heyward	Phone Number:	850-412-3630

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	State of Florida, Agency for Health Care Administration v. Richard B. Goodman, DDS
Court with Jurisdiction:	N/A. Case is not under appeal.
Case Number:	AHCA Case No. 15-0106-000; AHCA Case ID No. 2015-0002723
Summary of the Complaint:	When requesting Medicaid payments from the Agency for Health Care Administration (AHCA), Dr. Goodman used incorrect billing codes, which resulted in his being paid money by Medicaid money by AHCA that he was not entitled to (which is deemed to be an "overpayment)." In the complaint, AHCA is seeking to recover the overpayment, a fine and costs from Dr. Goodman.
Amount of the Claim:	$ 695,525.45

Specific Statutes or Laws (including GAA) Challenged:	No state laws and/or rules would be modified or overturned by an adverse court order.	
Status of the Case:	A conference was held on 7/20/15 in which Dr. Goodman was able to discuss his justification for billing the codes he did with the dentist who reviewed the claims ("peer") for AHCA. The peer is determining whether any changes to the overpayment amount should be made as a result of the conference. The case is in abeyance at AHCA until 8/13/15. Then, if another abeyance is not sought, the case will be sent to the Division of Administrative Hearings.	
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).	N/A	

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	Katharine Heyward	Phone Number:	850-412-3630

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration v. Mohammed T. Javed, M.D., P.A.
Court with Jurisdiction:	N/A. The case is not under appeal.
Case Number:	AHCA C.I. No. 15-0598-000; AHCA MPI Case ID No. 2015-0003232

Summary of the Complaint:	Mohammed T. Javed, M.D., P.A. ("Provider") submitted Medicaid claims to the Agency for Health Care Administration ("AHCA") in which: 1) there was insufficient documentation to justify reimbursement by AHCA Medicaid; 2) Provider double-billed AHCA Medicaid for services; 3) the claims were for services that were not medically necessary; and 4) Provider billed at the physician rate when it should have billed at the ARNP rate. Not realizing that the claims were not justified, AHCA Medicaid paid the claims. The amount that AHCA Medicaid paid Provider that was in excess of the amount Provider was owed is considered an overpayment. In this action, AHCA is seeking to recover the amount of the overpayment. In the future, it is likely that AHCA will also seek amounts for a fine and costs.
Amount of the Claim:	$508,442.64
Specific Statutes or Laws (including GAA) Challenged:	N/A. No state laws or rules would be modified or overturned by an adverse court order.
Status of the Case:	The case is still at AHCA as the parties are engaged in negotiations. If a settlement is not reached, the case will be transferred to the Division of Administrative Hearings.
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).	N/A.

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	Katharine Heyward	Phone Number:	850-412-3630

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration v. Harish J. Patel
Court with Jurisdiction:	N/A. The case is not under appeal.
Case Number:	AHCA C.I. No. 15-0342-000; MPI Case ID No. 2015-0002722
Summary of the Complaint:	Harish J. Patel ("Provider") submitted Medicaid claims to the Agency for Health Care Administration ("AHCA") in which: 1) there was insufficient documentation to justify payment by AHCA Medicaid; 2) the billing codes Provider submitted to AHCA Medicaid were not supported by the level of care that was provided; 3) the claims were not medically necessary; and 4) the claims were billed at an increased rate for the services rendered when Provider was not entitled to receive an increased rate. Not realizing that Provider had billed AHCA incorrectly, AHCA Medicaid paid the claims Provider submitted. As a result, AHCA Medicaid paid Provider more money for Medicaid claims than Provider was entitled to. This amount that Provider was not entitled to is considered an overpayment. AHCA is seeking to recover the amount of the overpayment and will likely, in the future, seek to obtain money for a fine and costs of the investigation.
Amount of the Claim:	$816,662.77
Specific Statutes or Laws (including GAA) Challenged:	N/A. No state laws or rules will be modified or overturned by an adverse court order.
Status of the Case:	The case is still at AHCA as the parties are engaged in settlement negotiations. If a settlement is not reached, the case will be forwarded to the Division of Administrative Hearings.
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).	N/A.

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Joe Goldstein	Phone Number:	(954) 847-3837

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	AHCA vs. Variety Children's Hospital d/b/a Miami Children's Hospital	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	15-3272MPI	
Summary of the Complaint:	This is a Medicaid overpayment case addressing the audit of a Medicaid hospital provider as to services rendered to undocumented aliens.	
Amount of the Claim:	$521,427.72	
Specific Statutes or Laws (including GAA) Challenged:	*Laws cited in petition*: 42 USCA 1396b(v); 42 CFR 440.255; Fla. Stat. 395.002; Fla. Stat. 409.901; Fla. Stat. 409.904; Fla. Admin. Code 59G; Fla. Stat. 120.52(8)(c); 120.54(f).	
Status of the Case:	Hearing set for November 9 through 13, 2015.	
Who is representing (of record) the state in this lawsuit? Check all that apply.		Agency Counsel
		Office of the Attorney General or Division of Risk Management
	X	Outside Contract Counsel

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

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	William Roberts/William Blocker	Phone Number:	(850) 412-3664

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	North Broward Hospital D/B/A Broward General Medical Center And North Broward Medical Center; Orlando Health, Inc.; Tallahassee Memorial Healthcare D/B/A Tallahassee Memorial Hospital; Shands Teaching Hospital And Clinics, Inc.; South Broward Hospital District D/B/A Memorial Regional Hospital And Memorial Hospital Miramar And Shands Jacksonville Medical Center, Inc. (Consolidated) v. Agency For Health Care Administration
Court with Jurisdiction:	First District Court of Appeal
Case Number:	1D14-5568; 1D14-5570; 1D14-5571; 1D14-5572; 1D14-5574 and 1D14-5575
Summary of the Complaint:	The petitioner hospitals in this case brought an administrative action challenging the Medicaid reimbursement rates AHCA established for them between the years 2000 and 2013. They claimed the methodology AHCA used for calculating their Medicaid per diem inpatient hospital reimbursement rate was flawed because of alleged errors in how depreciation figures reported by them to AHCA were used in AHCA's calculation of the rates. They claimed that these alleged errors in AHCA's accounting methodology resulted in their being undercompensated for the inpatient care of thousands of Medicaid beneficiaries between the years 2000 and 2013.
Amount of the Claim:	$45 million
Specific Statutes or Laws (including GAA) Challenged:	59G-6.020, Florida Administrative Code

Status of the Case:	In October 2014, Petitioners filed with AHCA's Agency Clerk notices of voluntary dismissal of their "substantial interests" cases "without prejudice." In early November 2014, the Agency Clerk entered final orders dismissing all of these cases with Prejudice. In October 2014, Petitioners also filed a notice with DOAH dismissing their rule challenge case without prejudice. As jurisdiction in rule challenge cases lies exclusively with DOAH (and not the Agency), the ALJ in that case entered an order closing that file and dismissing the case without prejudice to file another, similar petition in the future. In December 2014, Petitioners (with the exception of Jackson Memorial Hospital) filed Notices of Appeal with the First District Court of Appeal in the "substantial interests" cases, presumably challenging AHCA's decision to dismiss those cases with prejudice despite Petitioners' request that they be dismissed without prejudice. No appeal has been filed challenging DOAH's dismissal of the rule challenge case without prejudice. All of the aforementioned cases have been consolidated on motion by Petitioners. Opposing counsel filed its initial brief on the merits and a request for oral argument on February 18, 2015. The Agency filed its answer brief on April 9, 2015. Opposing counsel filed a reply brief and request for appellate attorneys' fees on May 14, 2015. The court has not yet ruled on the request for attorneys' fees. Oral argument was held on July 15, 2015.	
Who is representing (of record) the state in this lawsuit? Check all that apply.		Agency Counsel
		Office of the Attorney General or Division of Risk Management
	X	Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Debora Fridie/Gregory Pitt	Phone Number:	850-412-3661

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	AHCA vs. Adventist Health System/Sunbelt, Inc. (Florida Hospital Orlando)	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	Final Audit Report C.I. No.:13-0068-000 (case remanded to Agency from DOAH on 4/3/15).	
Summary of the Complaint:	This is a Medicaid overpayment case addressing the audit of a Medicaid hospital provider as to services rendered to undocumented aliens.	
Amount of the Claim:	$1,010,614.36	
Specific Statutes or Laws (including GAA) Challenged:	*Laws cited in petition*: Fla. Stat. 409.913 and F.A.C. 59G-9.070.	
Status of the Case:	Case remanded to Agency from the Division of Administrative Hearings on 4/3/15.	
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 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Debora Fridie/Gregory Pitt	Phone Number:	850-412-3661

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	AHCA vs. RONALD M. MARINI, D.M.D., P.A.,	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	Final Audit Report C.I. No.:14-1345-000 (case remanded to Agency from DOAH on 5/15/15).	
Summary of the Complaint:	The Agency has determined that this provider was overpaid for services that in whole or in part are not covered by Medicaid.	
Amount of the Claim:	$710,233.42	
Specific Statutes or Laws (including GAA) Challenged:	*Laws cited in petition*: a. Chapter 120, Florida Statutes; b. Chapter 408, Florida Statutes; c. Chapter 409, Florida Statutes; d. Rule 59G-9.070, Florida Administrative Code; e. Article I, Section 2, Florida Constitution; f. Chapter 466, Florida Statues, and the rules promulgated thereunder; g. To the extent it constitutes agency policy or precedent, the Florida Medicaid Dental Services Coverage and Limitations Handbook.	
Status of the Case:	Case remanded to Agency from the Division of Administrative Hearings on 5/15/15.	
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 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Joe Goldstein	Phone Number:	(954) 847-3837

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	AHCA vs. Variety Children's Hospital d/b/a Nicklaus Children's Hospital, formerly Miami Children's Hospital	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	Final Audit Report C.I. No.: 13-0118-000 (Case not yet assigned DOAH case number)	
Summary of the Complaint:	This is a Medicaid overpayment case addressing the audit of a Medicaid hospital provider as to services rendered to undocumented aliens.	
Amount of the Claim:	$529,165.22	
Specific Statutes or Laws (including GAA) Challenged:	*Laws cited in petition*: 42 USCA 1396b(v); 42 CFR 440.255; Fla. Stat. 395.002; Fla. Stat. 409.901; Fla. Stat. 409.904; Fla. Admin. Code 59G; Fla. Stat. 120.52(8)(c); 120.54(f).	
Status of the Case:	Awaiting transfer to the Division of Administrative Hearings.	
Who is representing (of record) the state in this lawsuit? Check all that apply.		Agency Counsel
		Office of the Attorney General or Division of Risk Management
	X	Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Ephraim Livingston	Phone Number:	850-412-3667

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Vyasa Ramcharan, DMD

Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	C.I. 15-0107-000 Record I.D. No. 2015-0002854 DOAH 15-003877	
Summary of the Complaint:	The Agency for Health Care Administration (Agency), through its Office of the Inspector General (OIG), Medicaid Program Integrity (MPI), has completed a review of claims for Medicaid reimbursement for dates of service during the period of January 1, 2011, through June 30, 2013. A preliminary audit report dated March 5, 2015 was sent indicating that AHCA determined the provider was overpaid $1,152,257.19. A fine of $176,000 was also applied. The cost assessed for the audit is $2,294.25.	
Amount of the Claim:	$1,330,551.44	
Specific Statutes or Laws (including GAA) Challenged:	*F.S. 409.913*	
Status of the Case:	Case is currently scheduled for hearing on December 3 – 4, 2015. Discovery is currently ongoing. Depositions are set for August 25th and 26th, 2015.	
	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).		

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Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Debora E. Fridie/Lourdes Naranjo	Phone Number:	(850)-412-3641

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	In Re: New Louisiana Holdings, LLC (Consolidated bankruptcy case)	
Court with Jurisdiction:	U.S. Bankruptcy Court, Western District of Louisiana, Lafayette Division.	
Case Number:	Case No. 14-50756	
Summary of the Complaint:	This is a bankruptcy case in which multiple Medicaid provider nursing home facilities have filed bankruptcy. AHCA has filed a proof of claim and anticipates filing a Motion for Relief from Stay so that Medicaid Program Finance can proceed with cost report audits.	
Amount of the Claim:	$8,270.233.94 in total Medicaid overpayments filed in the proof of claim.	
Specific Statutes or Laws (including GAA) Challenged:	11 U.S.C. §362 and other chapters of the U.S. Bankruptcy Code.	
Status of the Case:	Motion for Relief from Stay needs to be filed. U.S. Bankruptcy Court, Western District of Louisiana, Lafayette Division requires counsel and parties to appear in person.	
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).	N/A	

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**

Contact Person:	Debora E. Fridie	Phone Number:	(850) 412-3641

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	In Re: Universal Health Care (bankruptcy case)	
Court with Jurisdiction:	U.S. Bankruptcy Court, Middle District of Florida, Tampa Division	
Case Number:	Case No. 8:13-bk-1520-KRM	
Summary of the Complaint:	This is a bankruptcy case in which AHCA filed a proof of claim for carrier biller claims and Medicare Fee-For-Service Claims.	
Amount of the Claim:	$506,523.06	
Specific Statutes or Laws (including GAA) Challenged:	Bankruptcy Code (Chapter 11 of the U.S. Code).	
Status of the Case:	Proof of claim is filed. AHCA is negotiating with Managed Care Plans for payment of all or some of the monies identified.	
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).	N/A	

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Debora E. Fridie	Phone Number:	(850)-412-3641

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	AHCA v. Ronald M. Marini, D.M.D (MPI overpayment case) al. v. AHCA	
Court with Jurisdiction:	Division of Administrative Hearings (DOAH)	
Case Number:	Old DOAH Case No. 15-1888MPI, C.I. No. 14-1345-000	
Summary of the Complaint:	This is a Medicaid overpayment case as to the audit of a Medicaid dentist provider.	
Amount of the Claim:	$710,233.42, of which amount $590,008.15 is a Medicaid overpayment, $118,001.63 is a sanction fine, and $2,223.64 is costs per the Final Audit Report (FAR).	
Specific Statutes or Laws (including GAA) Challenged:	§409.913, Fla. Stat.; FAC Rules 59G-4.060, 59G-5.020, and 59G-9.070.	
Status of the Case:	A Motion to Reopen the proceeding needs to be filed with DOAH.	
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 N/A
		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).	N/A	

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Debora E. Fridie	Phone Number:	(850)-412-3641

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	AHCA v. Alfred Murciano, M.D. (MPI overpayment case)	
Court with Jurisdiction:	Division of Administrative Hearings (DOAH)	
Case Number:	DOAH Case No. 13-0795MPI, C.I. No. 12-0421-000	
Summary of the Complaint:	This is a Medicaid overpayment case as to the audit of a Medicaid physician provider.	
Amount of the Claim:	$1,061,342.85 of which amount $1,051,992.99 is a Medicaid overpayment; $6,000.00 is a sanction fine; and $3,349.86 is costs.	
Specific Statutes or Laws (including GAA) Challenged:	§409.913, Fla. Stat.; FAC Rules 59G-4.230, 59G-5.020, and 59G-9.070.	
Status of the Case:	On 7/7/2015 DOAH Judge issued a Recommended Order. Both parties have filed exceptions and are looking at responding to exceptions.	
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 N/A
		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).	N/A	

Office of Policy and Budget – July 2015

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Debora E. Fridie	Phone Number:	(850)-412-3641

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	AHCA v. Adventist Health Sys. /Sunbelt, Inc.	
Court with Jurisdiction:	Division of Administrative Hearings (DOAH)	
Case Number:	DOAH Case No. 15-1788MPI, C.I. No. 13-0068-000	
Summary of the Complaint:	This is a Medicaid overpayment case as to the audit of a Medicaid hospital provider as to services rendered to undocumented aliens.	
Amount of the Claim:	$1,044,569.53, of which amount $1,010,614.36 is a Medicaid overpayment, $2,500.00 is a sanction fine, and $2,223.64 is costs per the final audit report.	
Specific Statutes or Laws (including GAA) Challenged:	§409.913, Fla. Stat.; FAC Rules 59G-4.150, 59G-4.160, 59G-5.020, and 59G-9.070.	
Status of the Case:	On 4/3/2015 DOAH Judge issued an Order Closing File and Relinquishing Jurisdiction to AHCA.	
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 N/A
	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).	N/A	

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Debora E. Fridie	Phone Number:	(850)-412-3641

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Cross City Rehab & Health Care Center, et. al. v. AHCA	
Court with Jurisdiction:	Agency for Health Care Administration (AHCA)	
Case Number:	Case No. 11-598PH	
Summary of the Complaint:	This is a Medicaid overpayment case as to overpayments identified for Medicaid nursing home providers as a result of cost report audits and resulting adjustments to Medicaid reimbursement rates.	
Amount of the Claim:	$2,559,685.53 in total overpayment, payable in 48 installments starting from approximately May 1, 2012.	
Specific Statutes or Laws (including GAA) Challenged:	§§409.908 and 409.913, Fla. Stat.	
Status of the Case:	AHCA and Petitioner have reached a written settlement agreement as to the payment terms. Pursuant to the terms of the agreement, as long as Petitioner is in compliance, AHCA agrees not to seek final order. Once Petitioner pays overpayment in full, AHCA will enter a complied final order.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management N/A
		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).	N/A	

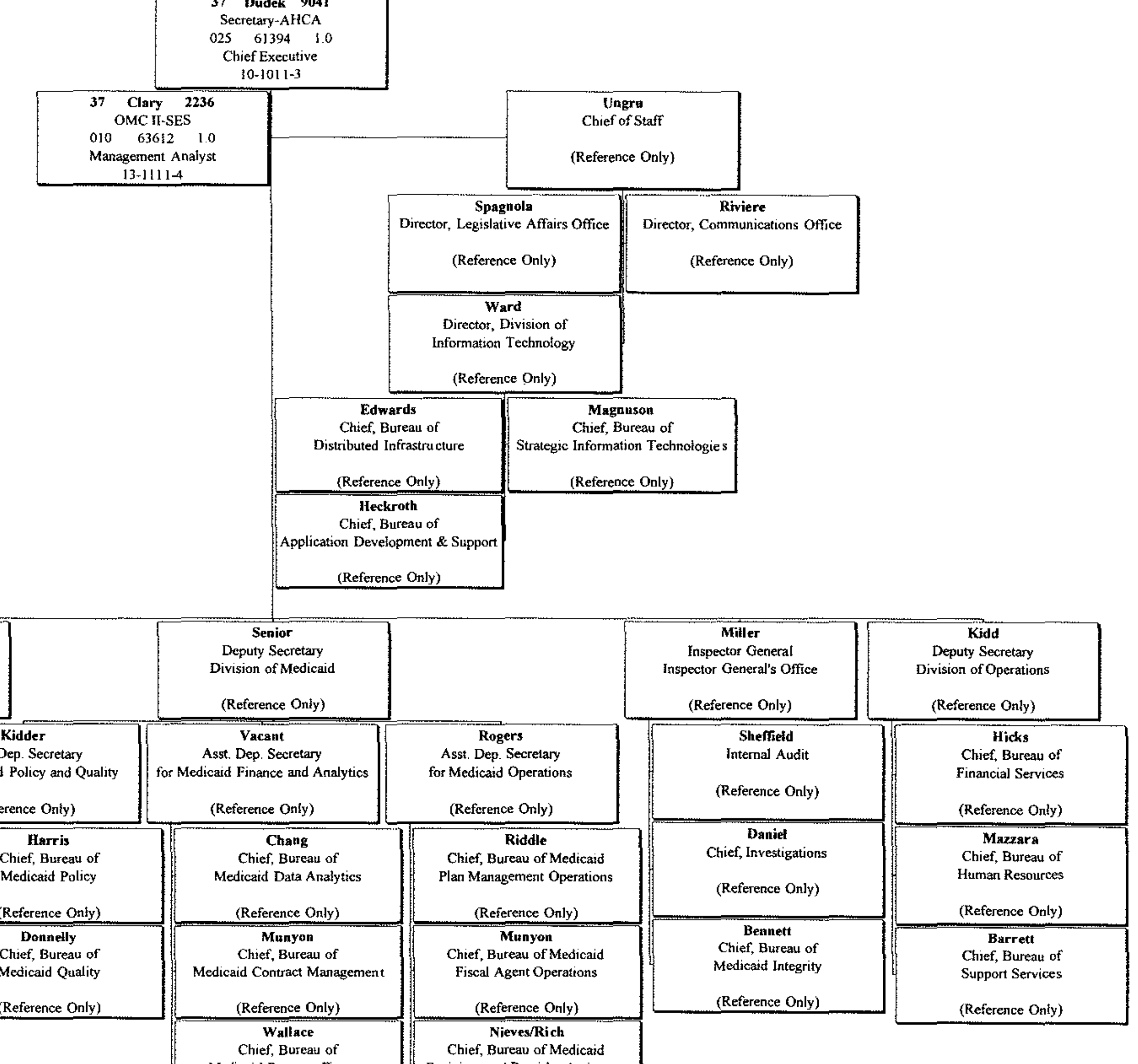
Office of Policy and Budget – July 2015

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Secretary's Office

Effective Date: July 1, 2015
Org. Level: 68-10-00-00-000
FTEs: 2 Positions: 2

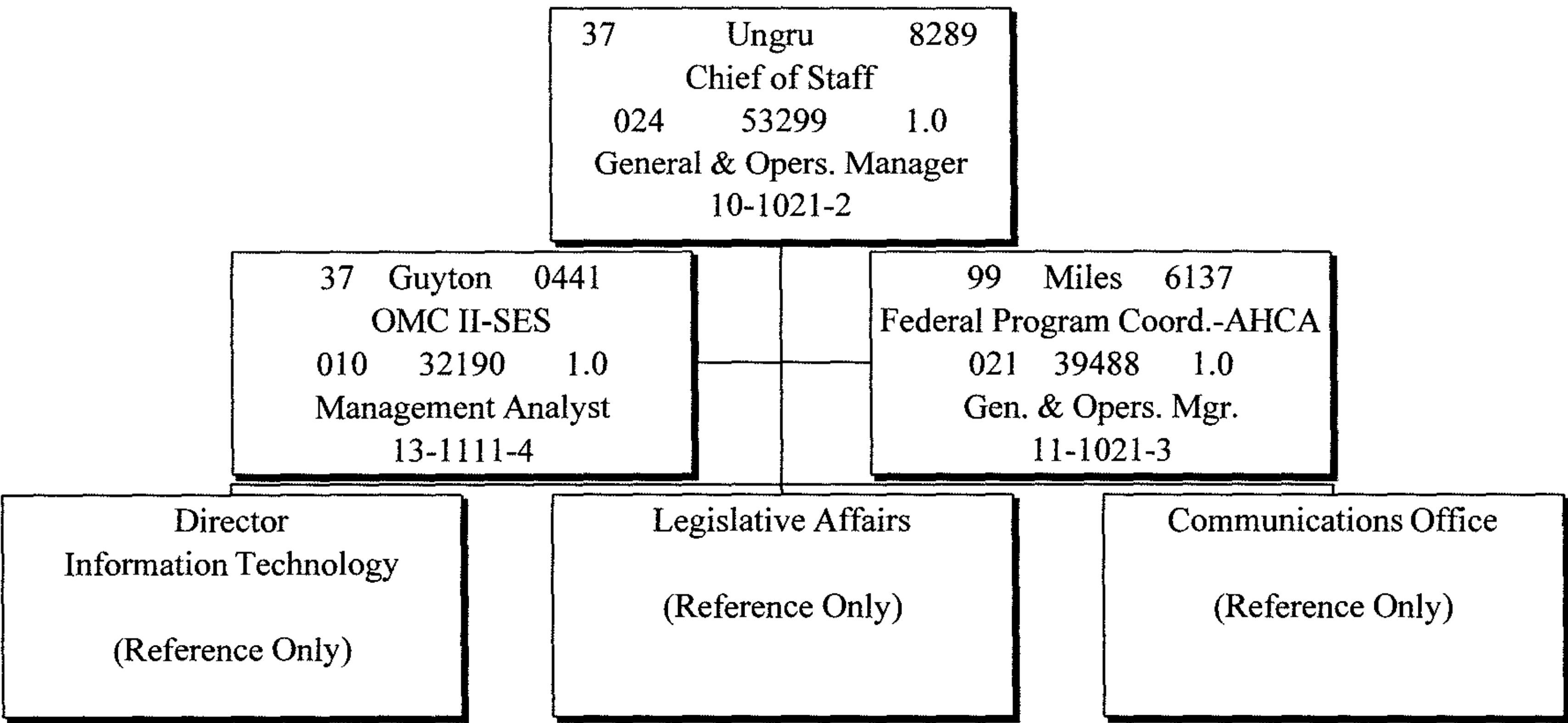
Agency Total FTE: 1527
Agency Total # Positions: 1533

Division Total FTE: 170
Division Total # Positions: 171



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief of Staff

Effective Date: July 1, 2015
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, 2015
Org Level: 68-10-10-40-000
FTEs: 2 Positions: 2

37 Ward 9204
Director of Information Technology
023 63449 1.0
Computer & Info. Systems Mgr.
10-3021-01

37 McVey 2228
SMA Supervisor-SES
010 63625 1.0
Management Analyst
13-1111-4

Magnuson
Chief of Strategic Info. Tech.
(Reference Only)

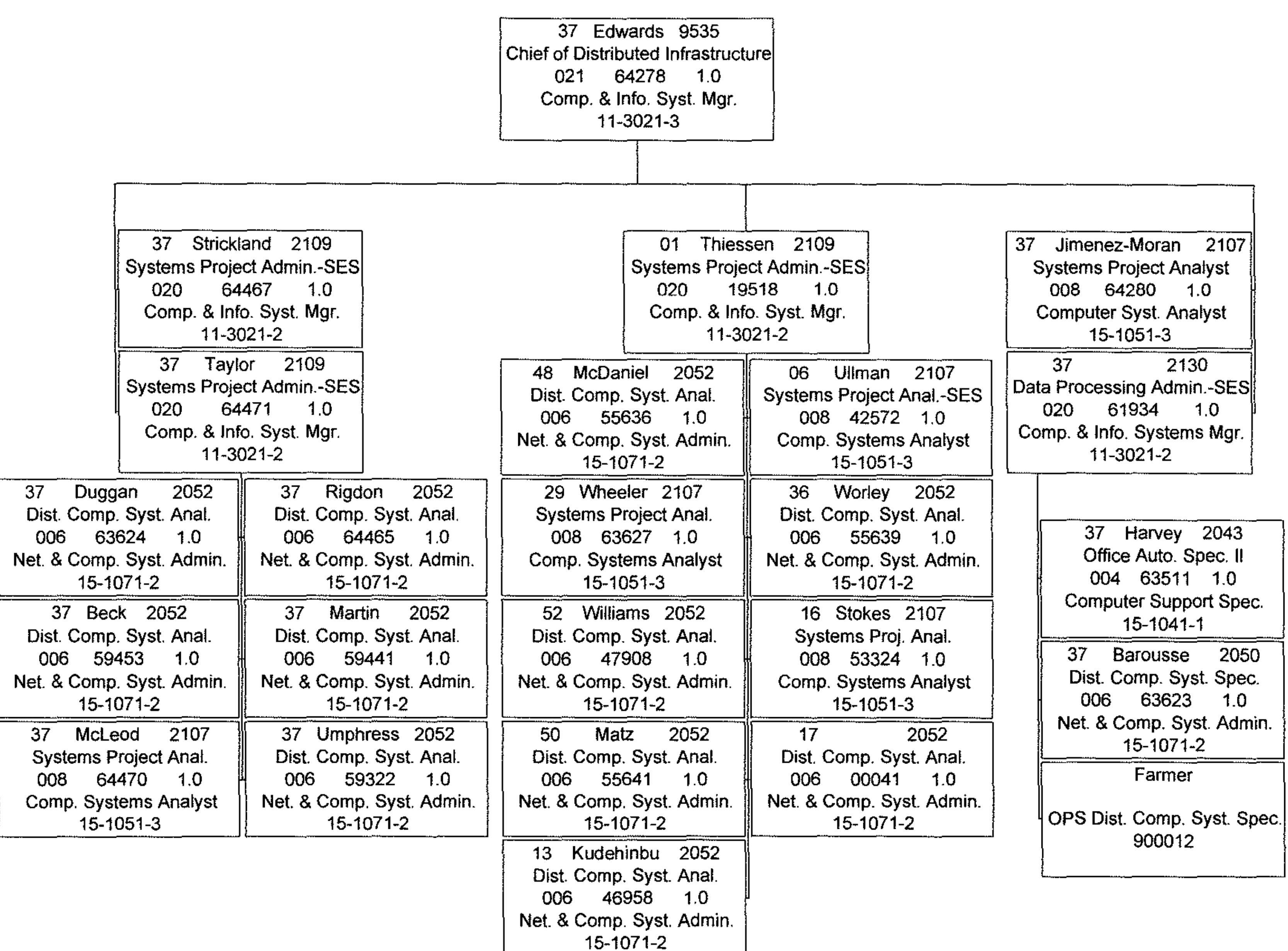
Edwards
Chief of Dist. Infrastructure
(Reference Only)

Heckroth
Chief of App. Dev. & Support
(Reference Only)

A-2-1

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

Effective Date: July 1, 2015
Org. Level: 68-10-10-40-002
FTEs: 23 Positions: 23



A-2-3

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

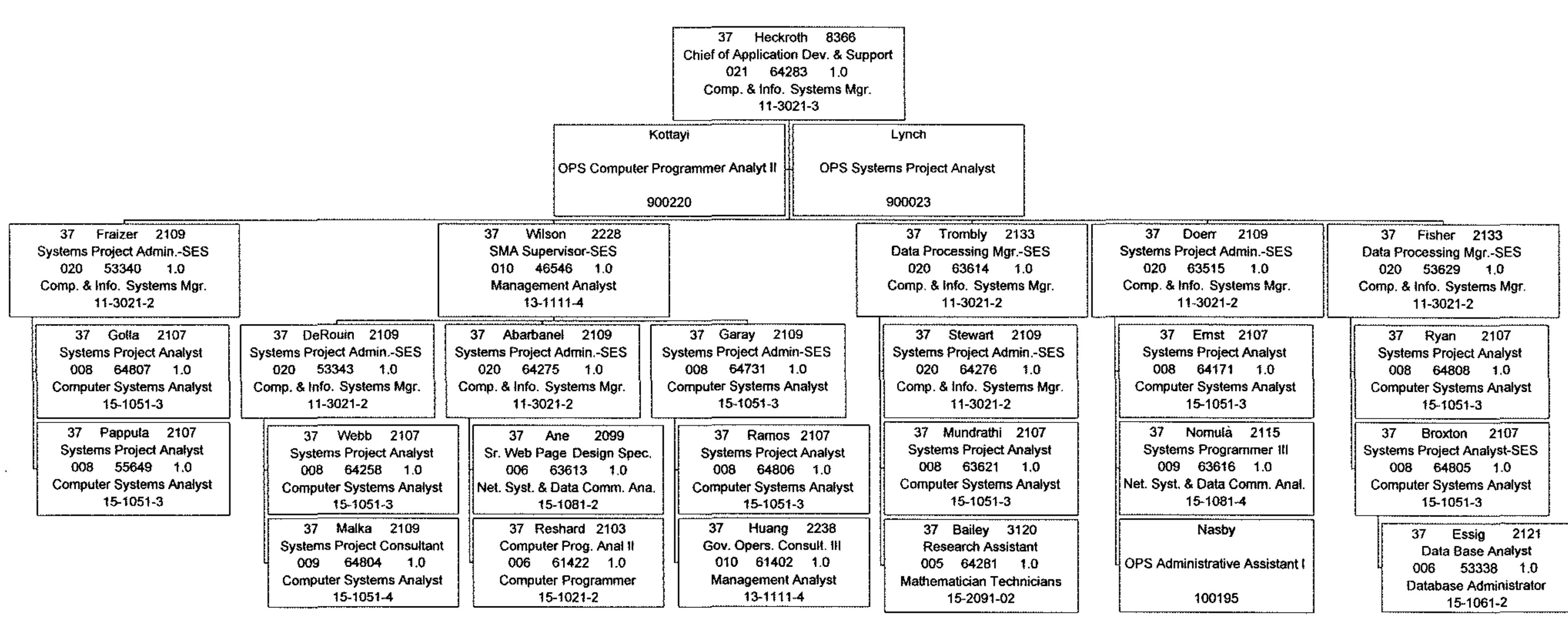
Effective Date: July 1, 2015
Org. Level: 68-10-10-40-003
FTEs: 20 Positions: 20

- 37 Magnuson 8751, Chief of Strategic Info. Technologies, 021 64169 1.0, Comp. & Info. Systems Mgr., 11-3021-3
  - 37 Tatum 2128, Network Systems Admin., 020 64468 1.0, Computer & Info. Systs. Anal., 11-3021-2
    - 37 Gallo 2109, Systems Programmer III, 009 34435 1.0, Net. Syst. & Data Comm. Anal., 11-3021-2
    - 37 Holland 2109, Systems Project Admin. -SES, 020 59440 1.0, Comp. & Info. Systems Mgr., 11-3021-2
      - 37 DeMarco 2052, Dist. Comp. Syst. Anal., 006 64459 1.0, Net. & Com. Syst. Adm., 15-1071-2
      - 37 Paige 2050, Dist. Comp. Syst. Spec., 006 64469 1.0, Net. & Com. Syst. Adm., 15-1071-2
      - 37 Wilder 2052, Dist. Comp. Syst. Anal., 006 63516 1.0, Net. & Com. Syst. Adm., 15-1071-2
  - 37 Thompson 2128, Network Systems Admin., 020 64172 1.0, Computer & Info. Systs. Anal., 11-3021-2
    - 37 Head 2107, Systems Project Analyst, 008 63620 1.0, Computer Systems Analyst, 15-1051-3
    - 37 Wilder 2107, Systems Project Analyst, 008 63619 1.0, Computer Systems Analyst, 15-1051-3
  - 37 French 2133, Data Processing Mgr.-SES, 020 63617 1.0, Comp. & Info. Systems Mgr., 11-3021-2
    - 37 Keys 2122, Sr. Data Base Analyst, 009 64279 1.0, Data Base Admin., 15-1061-4
    - 37 Foshee 2115, Systems Programmer III, 009 64282 1.0, Net. Syst. & Data Comm. Anal., 15-1081-4
  - 37 Wyman 2134, Info. Tech. Bus. Consult. Mgr., 020 53337 1.0, Computer & Info. Systs. Anal., 11-3021-2
    - 37 Dunn 2109, Systems Project Admin.-SES, 020 59804 1.0, Comp. & Info. Systems Mgr., 11-3021-2
    - 37 Martin 2109, Systems Project Admin.-SES, 020 63615 1.0, Comp. & Info. Systems Mgr., 11-3021-2
    - 37 Salib 2225, Gov. Analyst II, 010 64717 1.0, Management Analyst, 13-1111-4
    - 37 Smith 2109, Systems Project Consultant, 009 56680 1.0, Business Opers. Spec., 15-1051-4
    - Hess, OPS Systems Proj. Consultant, 900254
    - Gulley, OPS Systems Proj. Consultant, 900010
  - 37 Calhoun 2133, Data Processing Mgr.-SES, 020 80582 1.0, Comp. & Info. Systems Mgr., 11-3021-2
    - 37 McInnis 2115, Systems Programmer III, 009 64472 1.0, Net. Syst. & Data Comm. Anal., 15-1081-4

A-2-2

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

Effective: July 1, 2015
Org. Level: 68-10-10-40-004
FTEs: 25 Positions: 25



AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Legislative Affairs Office

Effective Date: July 1, 2015
Org Level: 68-10-10-50-000
FTEs: 4 Positions: 4

37 Spagnola 9051
Legislative Affairs Dir.-AHCA
021 63429 1.0
Gen. & Opers. Manager
11-1021-3

37 Pryor 2225
Sr. Mgmt. Anal. II-SES
010 63430 1.0
Management Analyst
13-1111-4

37 Gould 2234
OMC I-SES
007 24144 1.0
Management Analyst
13-1111-3

37 Moulton 2224
Sr. Mgmt. Anal. I-SES
007 64847 1.0
Management Analyst
13-1111-3

Effective Date: July 1, 2015
FTEs: 9 Positions: 9

AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff
Communications Office

68-10-10-60-000

37 Riviere 9063
Communications Director
021 53319 1.0
Public Relations Manager
11-2031-3

Coles
OPS Government Analyst I
900092

37 Coleman 2224
Senior Mgmt Anal. I-SES
007 63446 1.0
Management Analyst
13-1111-3

37 Campanile 2225
Senior Mgmt. Anal. II-SES
010 56678 1.0
Management Analyst
13-1111-4

37 Sowers 2224
Government Analyst I
007 00606 1.0
Management Analyst
13-1111-3

Multi Media Design Unit
68-10-10-60-100

37 Holland 2250
AHC Administrator-SES
020 00610 1.0
Med/Hlth Services Manager
11-9111-2

37 Goodson 2107
Systems Project Analyst
008 59710 1.0
Computer Systems Analyst
15-1051-3

37 Fincher 2107
Systems Project Analyst
008 00580 1.0
Computer Systems Analyst
15-1051-3

37 Carroccino 3718
Graphics Consultant
007 63471 1.0
Artists & Related Workers
27-1019-3

37 Marky 2107
Systems Project Analyst
008 64335 1.0
Computer Systems Analyst
15-1051-3

Mathews
OPS Senior Clerk
900224

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Effective: July 1, 2015
Org. Level: 68-10-20-00-000
FTEs: 64.5 Positions: 65

37 Williams 8538
General Counsel
024 32187 1.0
Manager
10-9199-2

37 Templeton 0712
Administrative Asst. II-SES
003 56677 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

37 Sunshine 7738
Senior Attorney
014 64733 1.0
Lawyer
23-1011-4

37 Roberts 6080
Deputy General Counsel
022 00026 1.0
Manager
11-9199-4

37 George 7738
Senior Attorney
014 63520 1.0
Lawyer
23-1011-4

37 Street 7738
Senior Attorney
014 63522 1.0
Lawyer
23-1011-4

37 Blocker 7738
Senior Attorney
014 64684 1.0
Lawyer
23-1011-4

37 Clemmons 2236
OMC II-SES
010 53297 1.0
Management Analyst
13-1111-4

37 Shoop 7738
Senior Attorney
014 53296 1.0
Lawyer
23-1011-4

37 Hain 7738
Senior Attorney
014 59457 1.0
Lawyer
23-1011-4

37 Sheeran 7738
Senior Attorney
014 63499 1.0
Lawyer
23-1011-4

37 Freeman 7738
Senior Attorney
014 64681 1.0
Lawyer
23-1011-4

Gayler OPS Senior Clerk 900007	Dupont OPS Law Clerk 900340	Perdomo OPS Law Clerk 900341	Vacant OPS Legal Assistant 900345
Vacant OPS Senior Attorney 900327	Vacant OPS Attorney 900328	Vacant OPS Senior Attorney 900329	Pitt OPS Senior Attorney 900330
Miles OPS Attorney 900331	Vacant OPS Attorney 900343	Vacant OPS Senior Attorney 900167	Vacant OPS Senior Clerk 900248
Vacant OPS Senior Clerk 900290	Vacant OPS Senior Clerk 900204	Vacant OPS Senior HSPS 900239	

37 Dyals 0714
Administrative Asst. II
005 44233 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

37 Ellis 3736
Info. Specialist III
006 53318 1.0
Comp. & Info. Systs. Mgr.
27-3031-2

37 Kazich 0120
Staff Assistant
003 61942 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

37 Robinson 0120
Staff Assistant
003 64709 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

Kever
OPS Senior Clerk
900005

Vacant
OPS Senior Clerk
900147

37 Belmont 0714
Administrative Asst. II
005 64688 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

37 Smith 0714
Administrative Asst. II
003 64689 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

37 Nam 7738
Senior Attorney
014 55643 1.0
Lawyer
23-1011-4

37 Baker 7736
Attorney
010 55643 1.0
Lawyer
23-1011-2

37 Mills 0712
Administrative Asst. II
003 64738 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Facilities Legal

Williams
General Counsel
(Reference Only)

37 Hoeler 7738
Senior Attorney
014 63529 1.0
Lawyer
23-1011-4

37 Vivo 7738 Senior Attorney 014 31145 1.0 Lawyer 23-1011-4	37 Hardy 7738 Senior Attorney 014 00005 1.0 Lawyer 23-1011-4	13 Rodney 7738 Senior Attorney 014 33761 1.0 Lawyer 23-1011-4	52 Selby 7738 Senior Attorney 014 63532 1.0 Lawyer 23-1011-4
36 7738 Senior Attorney 014 64734 1.0 Lawyer 23-1011-4	37 Granger 7738 Senior Attorney 014 64736 1.0 Lawyer 23-1011-4	13 Lopez 0714 Administrative Asst. II 005 64660 1.0 Exe. Sec. & Adm. Asst. 43-6011-3	52 Keith 0712 Administrative Asst. II 005 64659 1.0 Exe. Sec. & Adm. Asst. 43-6011-3
52 Walsh 7738 Senior Attorney 014 26215 1.0 Lawyer 23-1011-4	37 Marker 7736 Attorney 010 57506 1.0 Lawyer 23-1011-3	37 Saliba 7738 Senior Attorney 014 64787 1.0 Lawyer 23-1011-4	37 Novak 7738 Senior Attorney 014 64445 1.0 Lawyer 23-1011-4
37 Herter 7738 Senior Attorney 014 59726 1.0 Lawyer 23-1011-4	37 Alvarez 7736 Attorney 010 48275 1.0 Lawyer 23-1011-3	37 Robbins 0709 Administrative Asst. I 003 64788 1.0 Exe. Sec. & Adm. Asst. 43-6011-2	37 Garcia 0108 Administrative Secretary 003 26229 1.0 Exec. Sec. & Adm. Asst. 43-6011-2
52 White 7736 Attorney 010 64568 1.0 Lawyer 23-1011-3	52 Thornquest 7738 Senior Attorney 014 64657 1.0 Lawyer 23-1011-4	36 Lang 7738 Senior Attorney 014 64735 1.0 Lawyer 23-1011-4	37 Bird 7738 Senior Attorney 014 64595 1.0 Lawyer 23-1011-4
37 Johnson 7738 Senior Attorney 014 64786 1.0 Lawyer 23-1011-4	37 Mills 2225 Gov. Analyst II 010 61407 1.0 Management Analyst 13-1111-04	36 Rine 7703 Paralegal Specialist 005 64737 1.0 Para. & Legal Asst. 23-2011-1	37 McCallister 0709 Administrative Asst. I 003 63331 1.0 Exe. Sec. & Adm. Asst. 43-6011-2
13 Naranjo 7738 Senior Attorney 014 64658 1.0 Lawyer 23-1011-4	37 Hasani 0441 Regulatory Specialist II 006 59720 1.0 Compliance Officer 13-1041-2	13 Bradley 7738 Senior Attorney 014 64732 1.0 Lawyer 23-1011-4	
37 Haynes 0714 Administrative Asst. II 005 64661 1.0 Exe. Sec. & Adm. Asst. 43-6011-3	13 Rodriguez 7738 Senior Attorney 014 61370 1.0 Lawyer 23-1011-4	52 Davis 7703 Paralegal Specialist 005 53582 1.0 Para. & Legal Asst. 23-2011-1	

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Effective Date: July 1, 2015
Org. Level: 68-10-20-00-000
FTEs: 64.5 Positions: 65

Medicaid Legal

Williams
General Counsel
(Reference Only)

37 Kellum 7738
Senior Attorney
014 61937 1.0
Lawyer
23-1011-4

37 Grantham 7738
Senior Attorney
014 64682 1.0
Lawyer
23-1011-4

37 Smith 7738
Senior Attorney
014 64825 1.0
Lawyer
23-1011-4

37 Goldstein 7738
Senior Attorney
014 59301 1.0
Lawyer
23-1011-4

37 Dewar 7738
Senior Attorney
014 63521 1.0
Lawyer
23-1011-4

37 Thompson 0712
Administrative Asst. II
005 64687 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

37 Thompson 0709
Administrative Asst. I
005 64823 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

37 Livingston 7738
Senior Attorney
014 64824 1.0
Lawyer
23-1011-4

37 Fridie 7738
Senior Attorney
014 63523 1.0
Lawyer
23-1011-4

37 Davis 7703
Paralegal Specialist
005 55644 1.0
Paralegal & Legal Asst.
23-2011-1

37 Hall 0709
Administrative Asst. I
003 59458 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

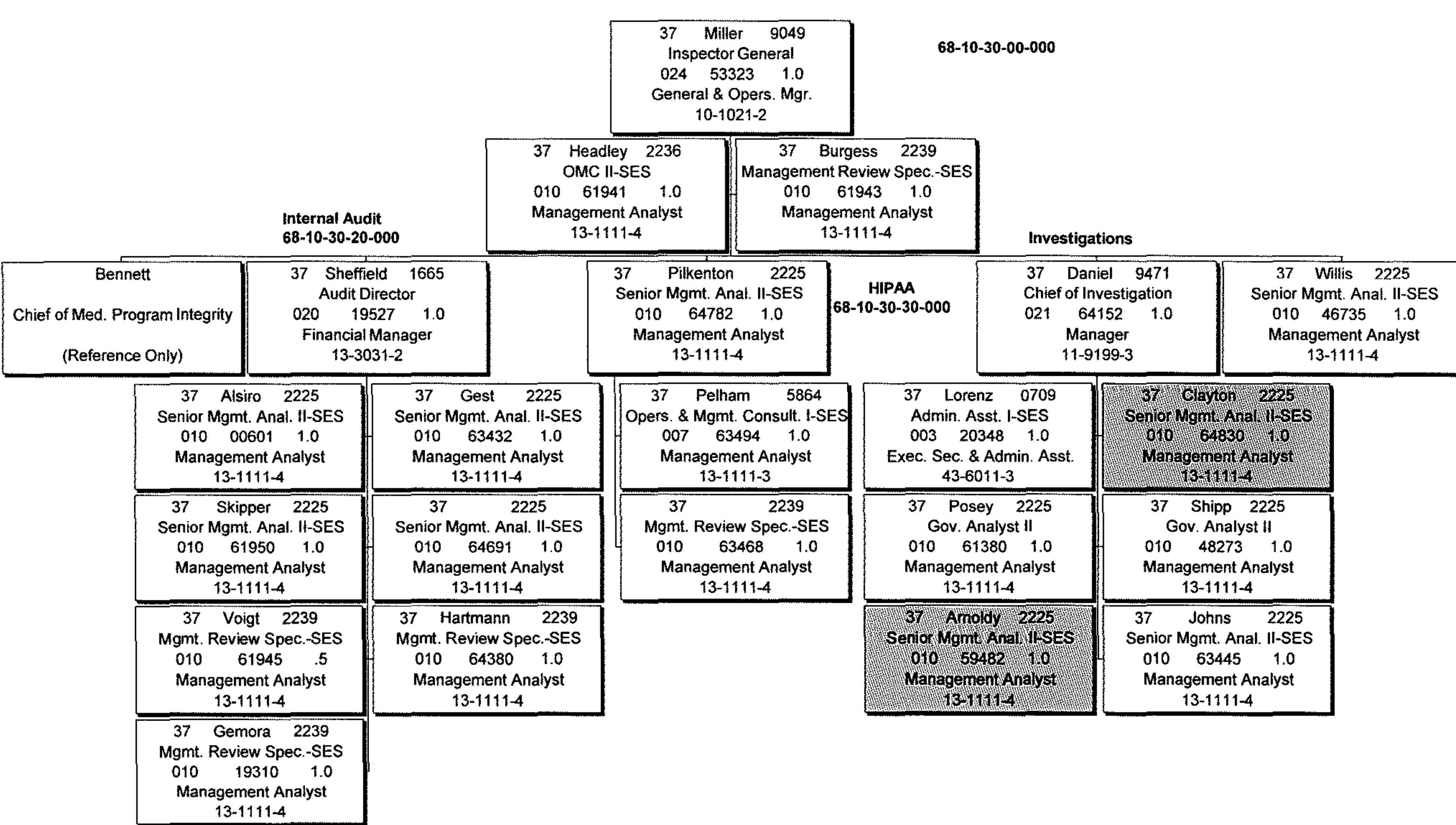
37 Heyward 7738
Senior Attorney
014 64685 1.0
Lawyer
23-1011-4

37 Melvin 7738
Senior Attorney
014 64683 1.0
Lawyer
23-1011-4

Vacant
OPS Attorney
900342

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General

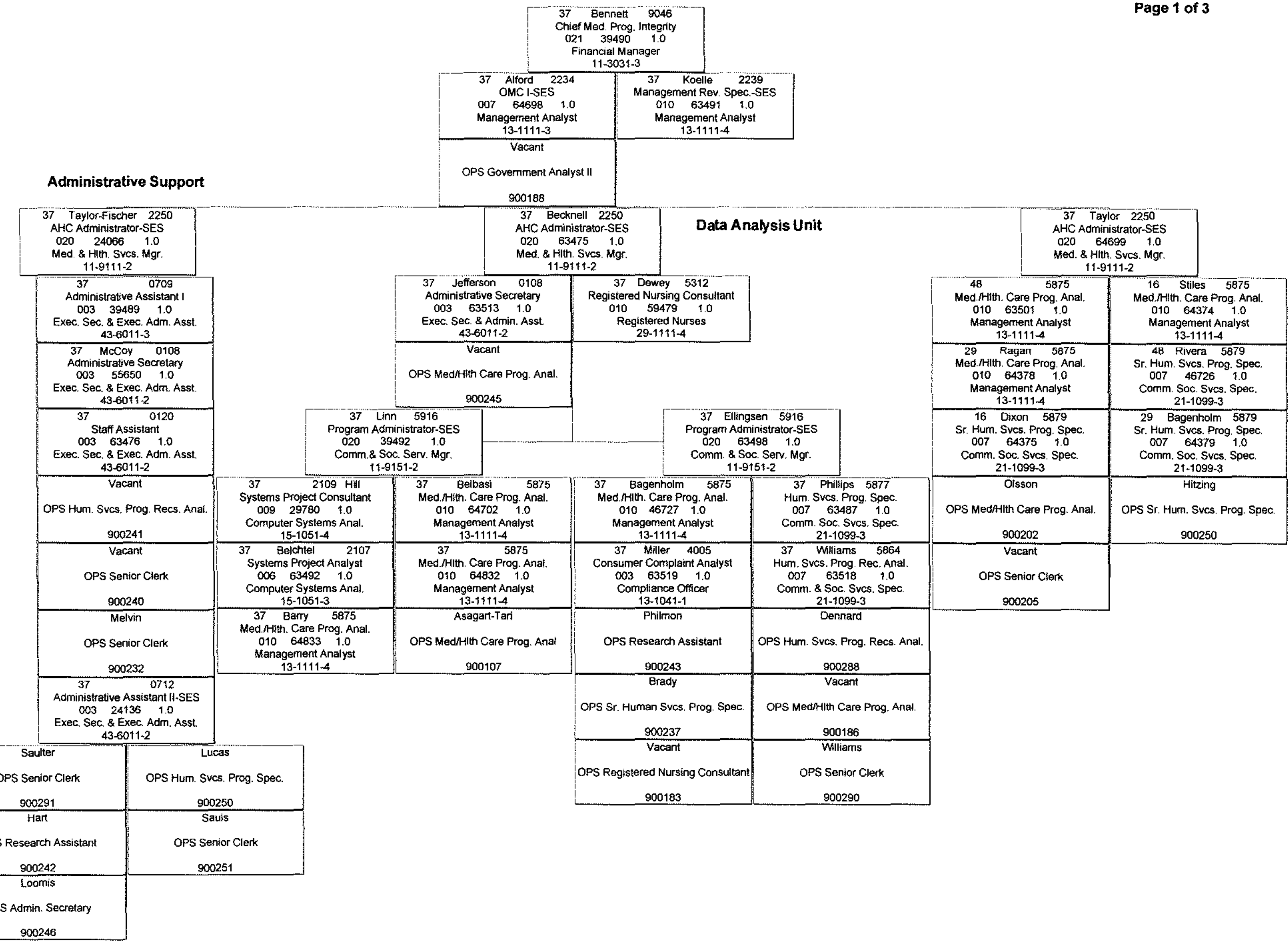
Effective Date: July 1, 2015
FTEs: 19.5 Positions: 20



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

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

Effective Date: July 1, 2015
Org. Level: 68-10-30-10-000
FTEs: 90.5 Positions: 91



Chief
Medicaid Prog. Integrity
Financial Manager
(Reference Only

37 Yon 7644
Asst. Chief Med. Prog. Integ.
020 64694 1.0
Financial Manager
11-3031-2

37 Miller 1668
Audit Eval. & Review Anal.-SES
008 64692 1.0
Accountant & Auditor
13-2011-3

37 Gustafsson-Yoon 2239
Mgmt. Review Spec.-SES
010 64831 1.0
Management Analyst
13-1111-4

Machado
OPS Senior Physician
900106

37 Shepherd 5916
Program Administrator-SES
020 64695 1.0
Comm. & Soc. Serv. Mgr.
11-9151-2

- 37 0108 / Administrative Secretary / 003 63507 1.0 / Exec. Sec. & Adm. Asst. / 43-6011-2
- 48 Ryder 5312 / Registered Nursing Cons. / 010 55652 1.0 / Registered Nurse / 29-1111-4
- 37 Livingston 5879 / Sr. Hum. Serv. Prog. Ana. / 007 55647 1.0 / Comm. & Soc. Svc. Spec. / 21-1099-3
- 37 Davis 5875 / Med./Hlth. CareProg. Ana. / 010 64376 1.0 / Management Analyst / 13-1111-4
- 37 3120 / Research Assistant / 005 63478 1.0 / Mathematician Tech. / 15-2091-2
- 37 MacDonnell 5875 / Med./Hlth. CareProg. Ana. / 010 55653 1.0 / Management Analyst / 13-1111-4
- 37 Notman 5312 / Registered Nursing Cons. / 010 22758 1.0 / Registered Nurse / 29-1111-4
- 37 Scileppi 5875 / Med./Hlth. CareProg. Ana. / 010 64829 1.0 / Management Analyst / 13-1111-4
- 37 Graves 5875 / Med./Hlth. CareProg. Ana. / 010 63490 1.0 / Management Analyst / 13-1111-4
- 37 Hansen 5312 / Registered Nursing Cons. / 010 59480 1.0 / Registered Nurse / 29-1111-4

37 Olmstead 2250
AHC Administrator-SES
020 64696 1.0
Med. & Hlth. Svc. Mgr.
11-9111-2

- 37 Riley 5875 / Med./Hlth. CareProg. Ana. / 010 64300 1.0 / Management Analyst / 13-1111-4
- 37 Creel 5875 / Med./Hlth. CareProg. Ana. / 010 46736 1.0 / Management Analyst / 13-1111-4
- 37 Robinson 5875 / Med./Hlth. CareProg. Ana. / 010 64299 1.0 / Management Analyst / 13-1111-4
- 37 Strickland 5875 / Med./Hlth. CareProg. Ana. / 010 63493 1.0 / Management Analyst / 13-1111-4
- 37 Reynolds 5312 / Registered Nursing Cons. / 010 47909 1.0 / Registered Nurse / 29-1111-4
- 37 Kinser 5312 / Registered Nurse Cons. / 010 63495 1.0 / Registered Nurse / 29-1111-4
- 37 Calderon 5875 / Med./Hlth. CareProg. Ana. / 010 61965 1.0 / Management Analyst / 13-1111-4
- Vacant / OPS Med./Hlth. CareProg.Anal. / 900244
- Griffith / OPS Sr. Hum. Svcs. Prog. Spec. / 900292
- Curry-Mays / OPS Computer Prog.Anal I / 900238

37 Stewart 2250
AHC Administrator-SES
020 63483 1.0
Med. & Hlth. Svc. Mgr.
11-9111-2

- 37 Holland 5248 / Senior Pharmacist / 011 55651 1.0 / Pharmacist / 29-1051-5
- 37 Herold 5248 / Senior Pharmacist / 011 55646 1.0 / Pharmacist / 29-1051-5
- 37 Humphries 5875 / Med./Hlth. CareProg. Ana. / 010 64697 1.0 / Management Analyst / 13-1111-4
- 37 Anderson 5248 / Senior Pharmacist / 011 64819 1.0 / Pharmacist / 29-1051-5
- 37 Caston 0108 / Administrative Secretary / 003 59481 1.0 / Exec. Sec. & Adm. Asst. / 43-6011-2
- 37 Jackson 5248 / Senior Pharmacist / 011 61960 .75 / Pharmacist / 29-1051-5

37 Fante 5916
Program Administrator-SES
020 63506 1.0
Comm. & Soc. Serv. Mgr.
11-9151-2

- 37 Waddill 0108 / Administrative Secretary / 003 63477 1.0 / Exec. Sec. & Adm. Asst. / 43-6011-2
- 37 4005 / Consumer Complaint Anal. / 003 63476 1.0 / Compliance Officer / 13-1041-1
- 37 Canfield 5312 / Registered Nursing Consultant / 010 64818 1.0 / Registered Nurses / 29-1111-4
- 37 Creel 5875 / Med./Hlth. CareProg. Anal. / 010 46733 1.0 / Management Analyst / 13-1111-4
- 37 Coste 5875 / Med./Hlth. CareProg. Anal. / 010 19486 1.0 / Management Analyst / 13-1111-4
- 37 5879 / Sr. Hum. Svcs. Prog. Spec. / 007 64377 1.0 / Comm. & Soc. Svc. Spec. / 21-1099-3

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

Effective Date: July 1, 2015
FTEs: 90.5 Positions: 91

Field Operations - Miami Office
68-10-30-10-011

Chief
Medicaid Program Integrity
Financial Manager
(Reference Only)

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37 Helms 2250
AHC Administrator-SES
020 39486 1.0
Med.& Hlth. Svcs. Mgr.
11-9111-2

- 37 Jackson 3120 — Research Assistant — 005 63514 1.0 — Mathematician Tech. — 15-2091-2
- Vacant — OPS Professional Acct. Spec. — 900223
- 37 LeBlanc 2239 — Mgmt. Review Spec.-SES — 010 63502 1.0 — Management Analyst — 13-1111-04
- 37 Barker 1668 — Audit Eval. & Review Anal.-SES — 008 64693 1.0 — Accountant & Auditor — 13-2011-3
- Hostetter — OPS Med/Hlth Care Prog. Anal. — 900228
- Vacant — OPS Med/Hlth Care Prog. Anal. — 900186
- Swan — OPS Med/Hlth Care Prog. Anal. — 900226

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37 Kaperak 2250
AHC Administrator-SES
020 59484 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

- 37 5312 — Registered Nursing Consult — 010 63496 1.0 — Registered Nurse — 29-1111-4
- 37 Divens 5312 — Registered Nursing Consult — 010 25874 1.0 — Registered Nurse — 29-1111-4
- 37 Mendie 3120 — Research Assistant — 005 39491 1.0 — Mathematician Tech. — 15-2091-2
- 37 Legear 5864 — Hum. Svcs. Prog. Recs. Analyst — 005 64820 1.0 — Mathematician Tech. — 15-2091-2
- Chastain — OPS Med/Hlth Care Prog. Anal. — 900008
- Givens — OPS Sr. Human Svcs. Prog. Spec. — 900141
- Dixon — OPS Med./Hlth. Care Prog. Anal. — 900289

13 Isch 5916
Program Administrator-SES
020 63485 1.0
Comm. & Soc. Serv. Mgr.
11-9151-2

- 37 Bailey 5875 — Med./Hlth. Care Prog. Anal. — 010 39493 1.0 — Management Analyst — 13-1111-4
- 37 Hughes-Poole 5879 — Sr. Human Svcs. Prog. Spec — 007 63497 1.0 — Comm. & Soc. Svcs. Spec. — 21-1099-3
- 37 Reshard 3120 — Research Assistant — 005 19462 1.0 — Mathematician Tech. — 15-2091-2

37 5916
Program Administrator-SES
020 59483 1.0
Comm. & Soc. Serv. Mgr.
11-9151-2

- 37 Hansen 5312 — Registered Nursing Consult — 010 59480 1.0 — Registered Nurse — 29-1111-4
- 37 Alexandre 5875 — Med./Hlth. Care Prog. Anal. — 010 63510 1.0 — Management Analyst — 13-1111-4
- 13 Peoples 5879 — Sr. Human Svcs. Prog. Spec. — 007 63484 1.0 — Comm & Soc. Svcs. Spec. — 21-1099-3
- Swan — OPS Med/Hlth Care Prog. Anal. — 900179
- Alsiro — OPS Sr. Human Svcs. Prog. Spec. — 900184
- Tharp — OPS Sr. Human Svcs. Prog. Spec. — 900087

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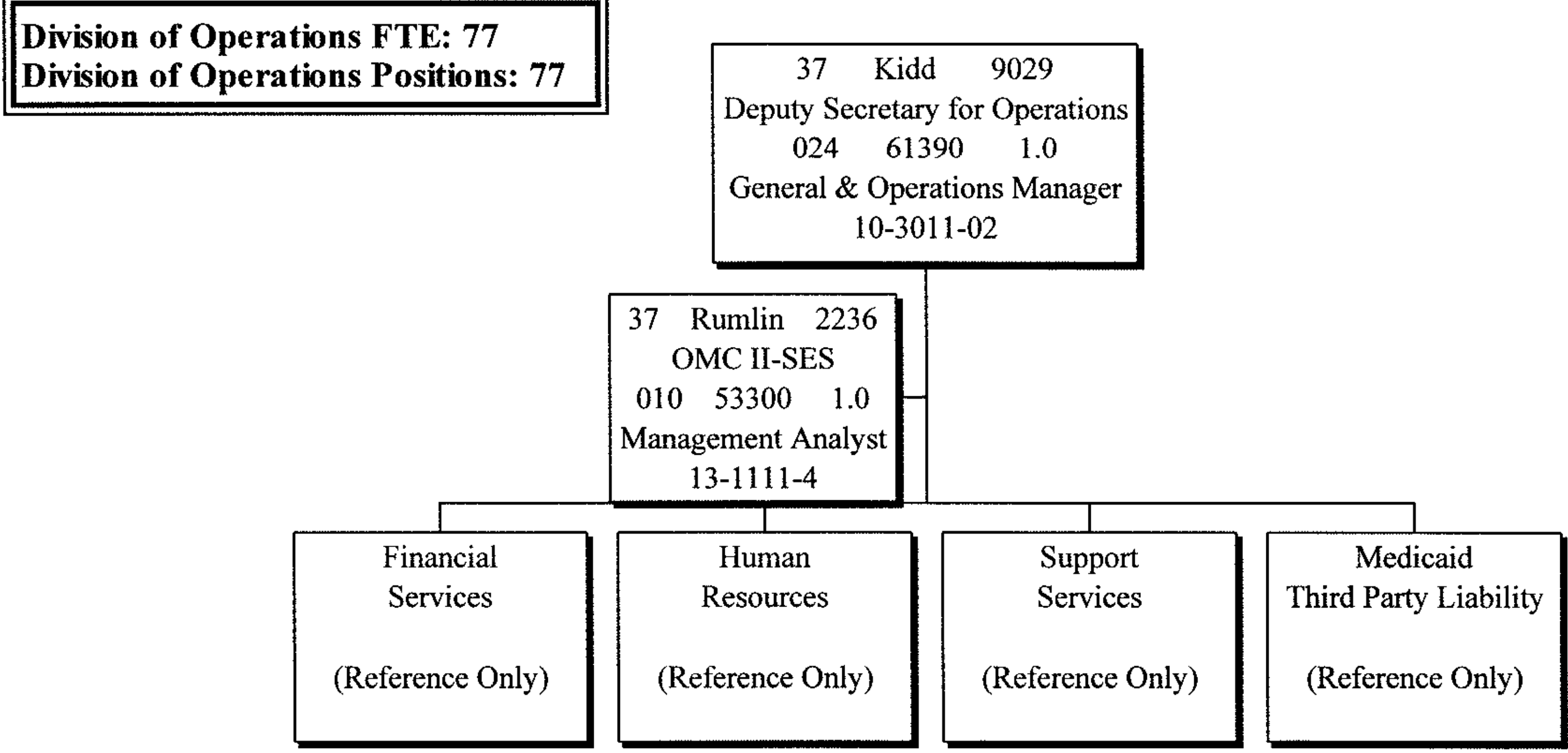
13 Rossello 2250
AHC Administrator-SES
020 63509 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

- 13 Scarlata 0108 — Administrative Secretary-SES — 003 63508 1.0 — Exec. Sec. & Admin. Asst. — 43-6011-2
- 13 Lucrezi 2240 — Inspector Specialist — 010 63482 1.0 — Compliance Officer — 13-1041-4
- 13 Solomon 5312 — Registered Nursing Consult — 010 63479 1.0 — Registered Nurse — 29-1111-4
- 13 Hollis-Stancil 5312 — Registered Nursing Consult. — 010 63481 1.0 — Registered Nurse — 29-1111-4
- Vacant — OPS Admin. Secretary — 900247
- 13 Cedeno 2240 — Inspector Specialist — 010 63500 1.0 — Compliance Officer — 13-1041-4
- 13 Blandino 2240 — Inspector Specialist — 010 64821 1.0 — Compliance Officer — 13-1041-4
- 13 Perpina 2240 — Inspector Specialist — 010 64822 1.0 — Compliance Officer — 13-1041-4
- 13 Ribera 2240 — Inspector Specialist — 010 64701 1.0 — Compliance Officer — 13-1041-4
- 13 Morales 2240 — Inspector Specialist — 010 63488 1.0 — Compliance Officer — 13-1041-4
- 13 Nerey 2240 — Inspector Specialist — 010 63480 1.0 — Compliance Officer — 13-1041-4

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

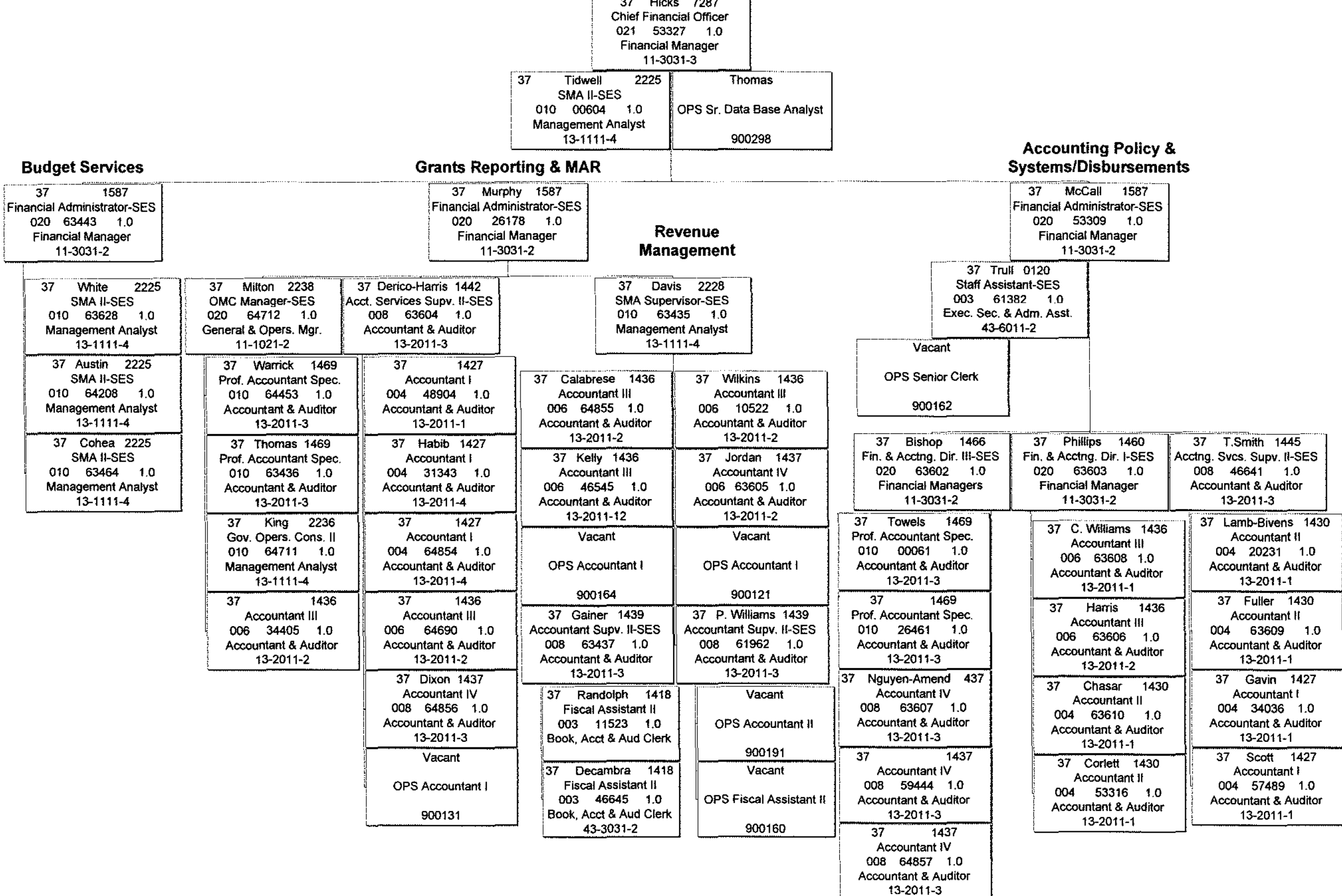
Effective Date: July 1, 2015
Org Level: 68-20-00-00-000
FTEs: 2 Positions: 2



B-0

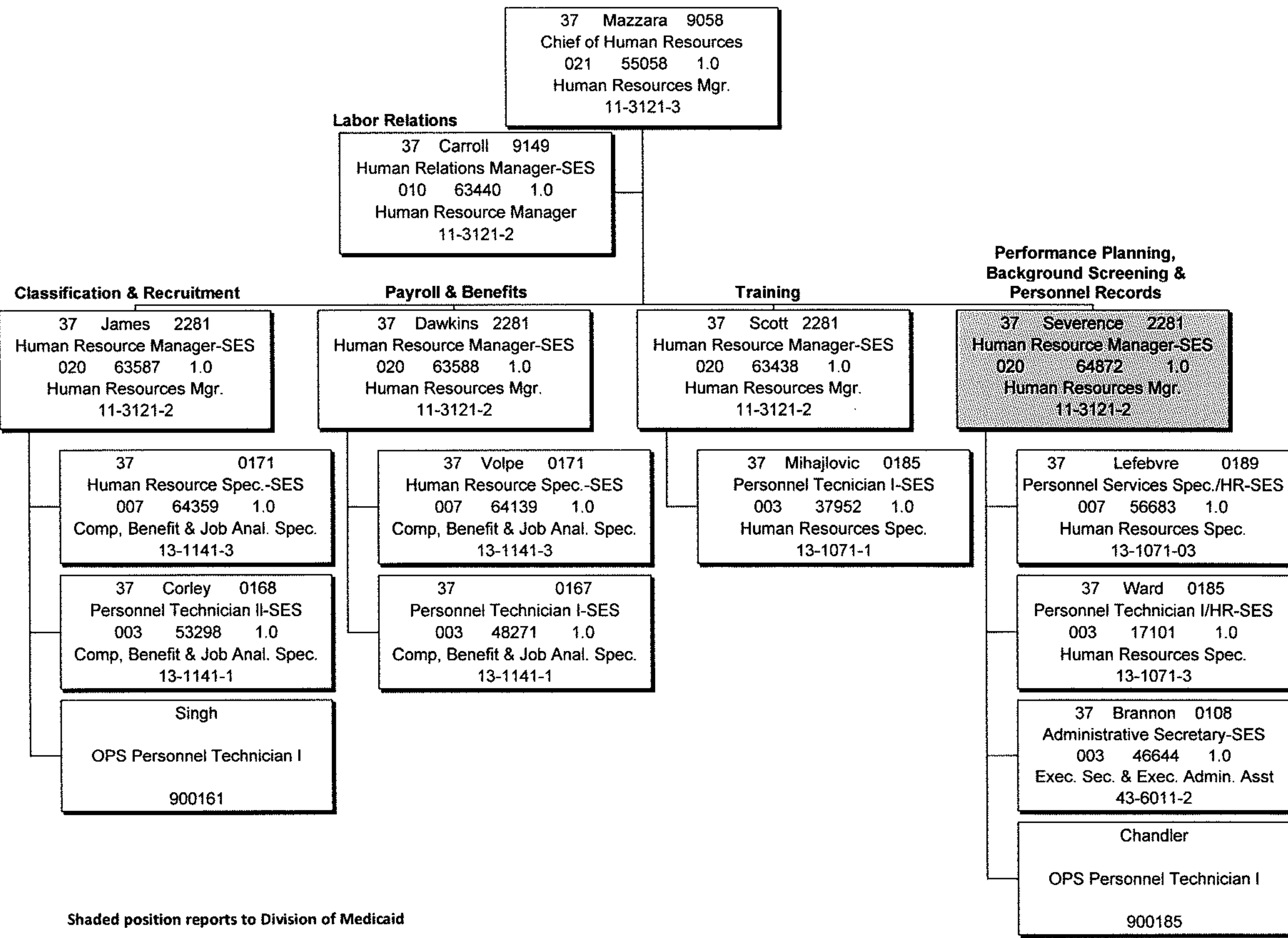
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Financial Services

Effective Date: July 1, 2015
Org. Level: 68-20-15-00-000
FTEs: 41 Positions: 41



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

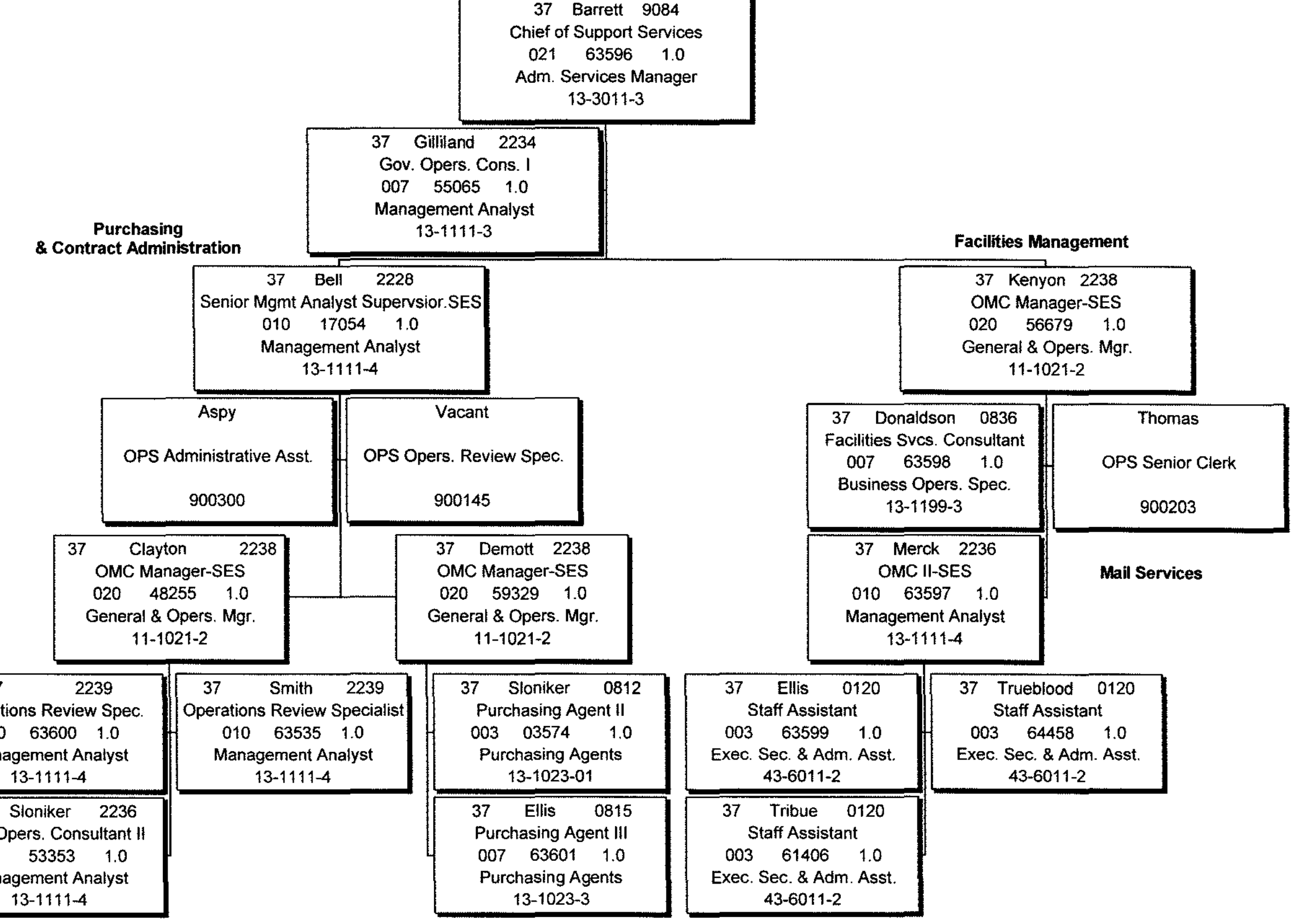
Effective Date: July 1, 2015
Org. Level: 68-20-20-00-000
FTEs: 13 Positions: 13



Shaded position reports to Division of Medicaid

Effective Date: July 1, 2015
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
Medicaid Third Party Liability

Effective Date: July 1, 2015
Org. Level: 68-20-50-00-000
FTEs: 5 Positions: 5

37 Dichio 2250
AHC Administrator-SES
020 64251 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

37 Peacock 2238
Opers. Mgmt. Cons. Mgr.-SES
020 00159 1.0
Gen. & Opers. Mgr.
11-1021-2

37 Bland 2239
Opers. Review Spec.
010 64253 1.0
Management Analyst
13-1111-4

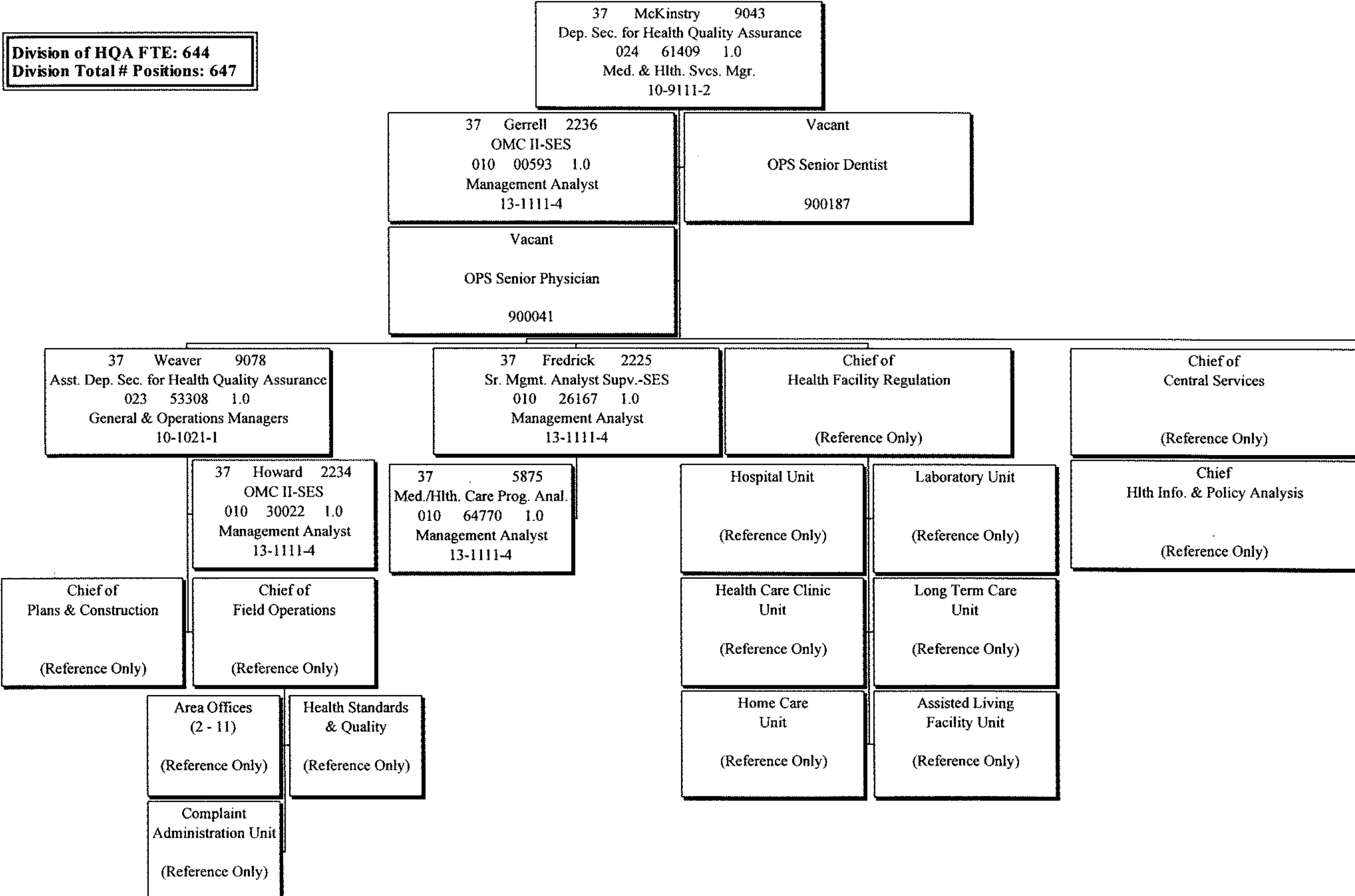
37 Roy 2239
Opers. Review Spec.
010 64254 1.0
Management Analyst
13-1111-4

37 Strickland 5864
HSP Records Analyst-SES
003 61016 1.0
Management Analyst
13-1111-1

Merchant
OPS Admin. Secretary
900212

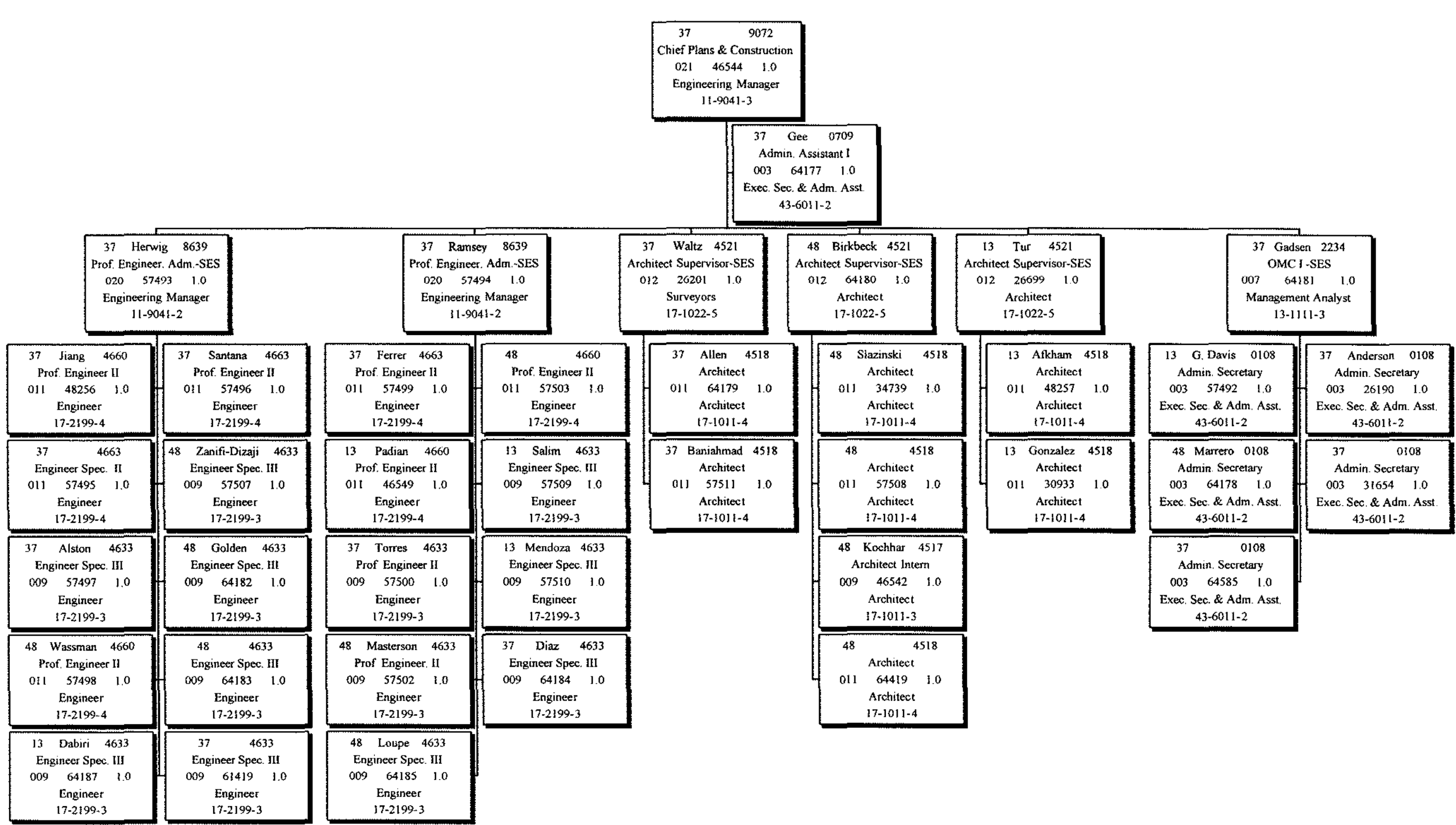
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance - Deputy Secretary's Office

Effective Date: July 1, 2015
Org. Level: 68-30-00-00-000
FTEs: 7 Positions: 7



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

Effective Date: July 1, 2015
Org. Level: 68 30 10 00 000
FTEs: 41 Positions: 41



C-2

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

Effective Date: July 1, 2015
Org Code: 68-30-30-00-000
FTEs: 17 Positions: 17

37 Smoak 9065
Chief, Field Operations
021 26175 1.0
Gen. & Op. Manager
11-1021-3

37 Lovejoy 0709
Admin. Assistant I-SES
003 51310 1.0
Ex. Sec. & Admin. Assist
43-6011-2

Area Office 2 37
Tallahassee
(29 FTEs)
Ref. Only

Area Office 3 01
Gainesville
(31 FTEs)
Ref. Only

Area Office 4 16
Jacksonville
(34 FTEs)
Ref. Only

Area Office 5 52
St. Petersburg
(82 FTEs)
Ref. Only

Area Office 7 48
Orlando
(37 FTEs)
Ref. Only

Area Office 8 36
Fort Myers
(37 FTEs)
Ref. Only

Area Office 9 50
West Palm Beach
(60 FTEs)
Ref. Only

Area Office 11 13
Miami
(55 FTEs)
Ref. Only

37 Hart 2228
Sr. Mgmt. Anal. Supv.-SES
010 64652 1.0
Management Analyst
13-1111-4

37 Ennis 0444
Regulatory Specialist III
007 64644 1.0
Compliance Officer
13-1041-3

37 Morthier 5312
Registered Nursing Cons.
010 64643 1.0
Registered Nurse
29-1141-4

37 Sepulveda 0440
Regulatory Specialist I
003 64645 1.0
Compliance Officer
13-1041-1

37 Martin-Gilliam 5312
Registered Nursing Cons.
010 64793 1.0
Registered Nurse
29-1141-4

37 Strait 2236
Gov. Operations Cons. II
010 64640 1.0
Management Analyst
13-1111-4

37 Smith 0441
Regulatory Specialist II
00 29751 1.0
Compliance Officer
13-1041-2

37 Sailor 5312
Registered Nursing Cons.
010 64639 1.0
Registered Nurse
29-1141-4

37 Largent 0108
Admin. Secretary
003 61388 1.0
Exec. Sec. & Admin. Sec.
43-6011-2

Williams
OPS Administrative Secretary
900091

37 Pollock 5916
Program Admin.-SES
020 64214 1.0
Comm. &Soc. Svcs. Mgr.
11-9151-2

37 Anifowoshe 5894
Hlth. Svcs. & Fac. Consult.
010 46547 1.0
Business Opers. Spec.
13-1199-4

37 Foster 5894
Hlth. Svcs. & Fac. Consult.
010 48473 1.0
Business Opers. Spec.
13-1199-4

37 St Jean 5894
Hlth. Svcs. & Fac. Consult.
010 61379 1.0
Business Opers. Spec.
13-1199-4

37 Adams 5894
Hlth. Svcs. & Fac. Consult.
010 64225 1.0
Business Opers. Spec.
13-1199-4

37 Knerr 5894
Hlth. Svcs. & Fac. Consult.
010 64648 1.0
Business Opers. Spec.
13-1199-4

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

Effective Date: July 1, 2015
Org Level: 68-30-30-30-000
FTEs: 30.5 Position: 31

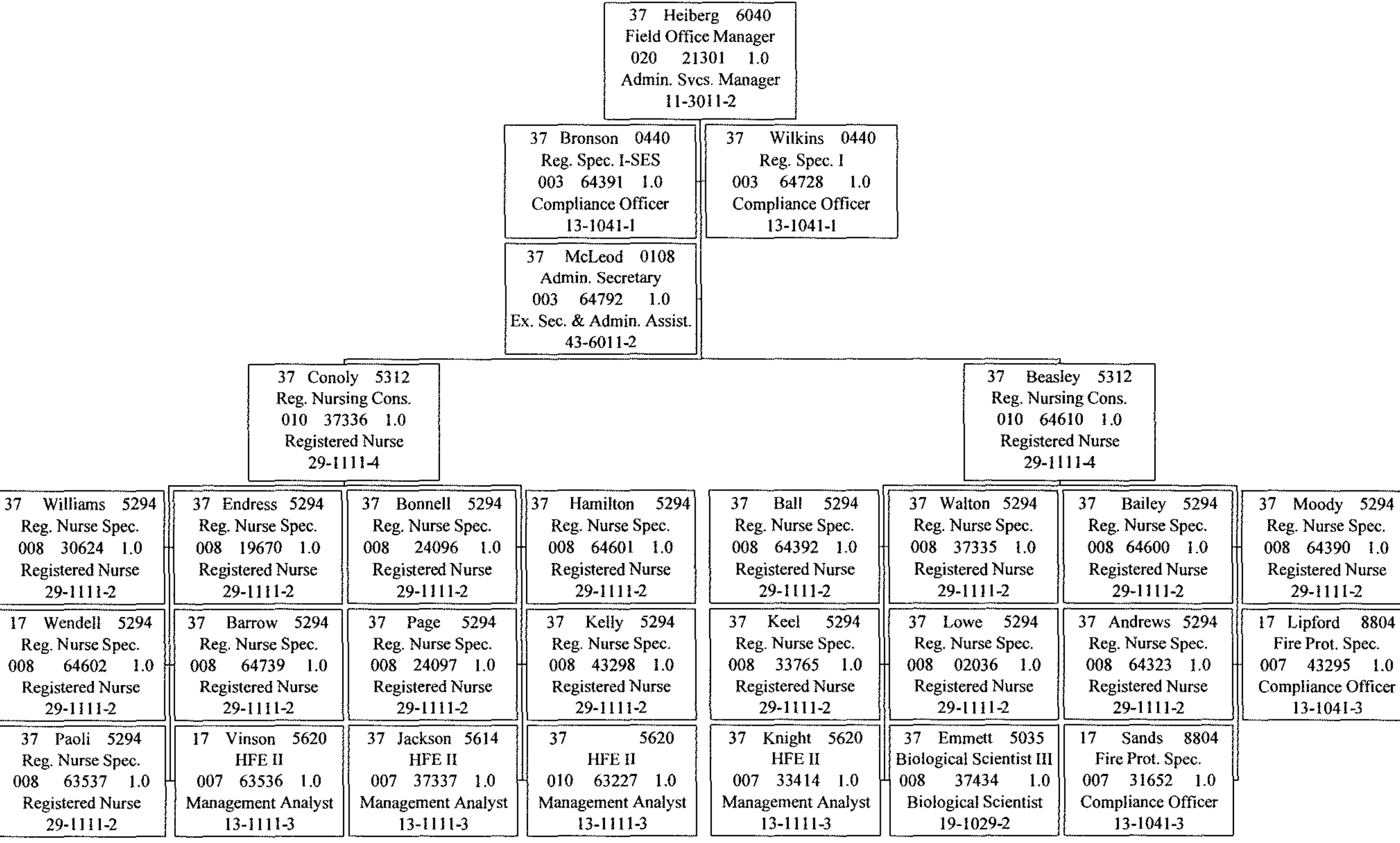
Survey & Certification Support Branch

Weaver
Chief of Field Operations
26175
(Reference Only)

- 37 Beagles 6040 — Field Office Manager — 020 33416 1.0 — Admin. Svcs. Manager — 11-3011-2
  - 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 0108 — Admin. Secretary — 003 26191 1.0 — Ex. Sec. & Admin. Assist. — 43-6011-2
    - 36 Faison 2225 — Government Analyst II — 010 48813 1.0 — Business Operations — 13-1111-4
    - 29 Caswell 5312 — Registered Nursing Consult. — 010 63234 1.0 — Registered Nurse — 29-1141-4
  - 37 Kaczmarek 5312 — Registered Nursing Consult. — 010 64569 1.0 — Registered Nurse — 29-1141-4
    - 37 Alday 2225 — Government Analyst II — 010 64633 1.0 — Management Analyst — 13-1111-4
    - 16 Hill 5312 — Registered Nursing Consult. — 010 25997 1.0 — Registered Nurse — 29-1141-4
    - 52 Maloney 2225 — Government Analyst II — 010 64161 1.0 — Business Operations — 13-1111-4
    - 37 Lander-Yorns 5312 — Registered Nursing Consult. — 010 53519 1.0 — Registered Nurse — 29-1141-4
  - 37 Koch 2225 — Senior Mgmt Anal. Supv.-SES — 010 30613 1.0 — Management Analyst — 13-1111-4
    - 37 Babcock 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 Cooke 2236 — Government Opers. Cons. II — 010 48715 1.0 — Management Analyst — 13-1111-4
    - 37 Howard 5894 — Hlth. Svcs. & Fac. Cons. — 010 4556 1.0 — Business Opers. Spec. — 13-1199-4
    - 48 Wells 5894 — Hlth. Svcs. & Fac. Cons. — 010 64162 1.0 — Business Opers. Spec. — 13-1199-4
  - 37 Manville 2238 — OMC Manager-SES — 020 28050 1.0 — General & Opers. Mgr. — 11-1021-2
    - 50 Frias 5875 — Med/Hlth Care Prog. Anal. — 010 34834 1.0 — Management Analyst — 13-1111-4
    - 48 Kruppenbacher 5879 — Sr. HSPS — 007 58472 1.0 — Comm. & Soc. Svcs. Spec. — 21-1099-3
    - 37 Sanders 0108 — Admin. Secretary — 003 64730 .5 — Exec. Sec. & Admin. Asst. — 43-6011-2
    - 29 Evans 5875 — Med/Hlth Care Prog. Anal. — 010 29840 1.0 — Management Analyst — 13-1111-4
    - 29 Johnston 5879 — Sr. HSPS — 007 48234 1.0 — Comm. & Soc. Svcs. Spec. — 21-1099-3
    - 01 5294 — Registered Nurse Spec. — 008 11520 1.0 — Registered Nurse — 29-1141-2
    - 13 Bailey 5875 — Med/Hlth Care Prog. Anal. — 010 61418 1.0 — Management Analyst — 13-1111-4
    - 37 Byrd 5879 — Sr. HSPS — 007 31496 1.0 — Comm. & Soc. Svcs. Spec. — 21-1099-3
    - 50 Sosiak 5294 — Registered Nurse Spec. — 008 64771 1.0 — Registered Nurse — 29-1141-2
    - 16 Standifer 5879 — Sr. HSPS — 007 53581 1.0 — Comm. & Soc. Svcs. Spec. — 21-1099-3
    - 01 Sabat 5879 — Sr. HSPS — 007 20678 1.0 — Comm. & Soc. Svcs. Spec. — 21-1099-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 2 - Tallahassee

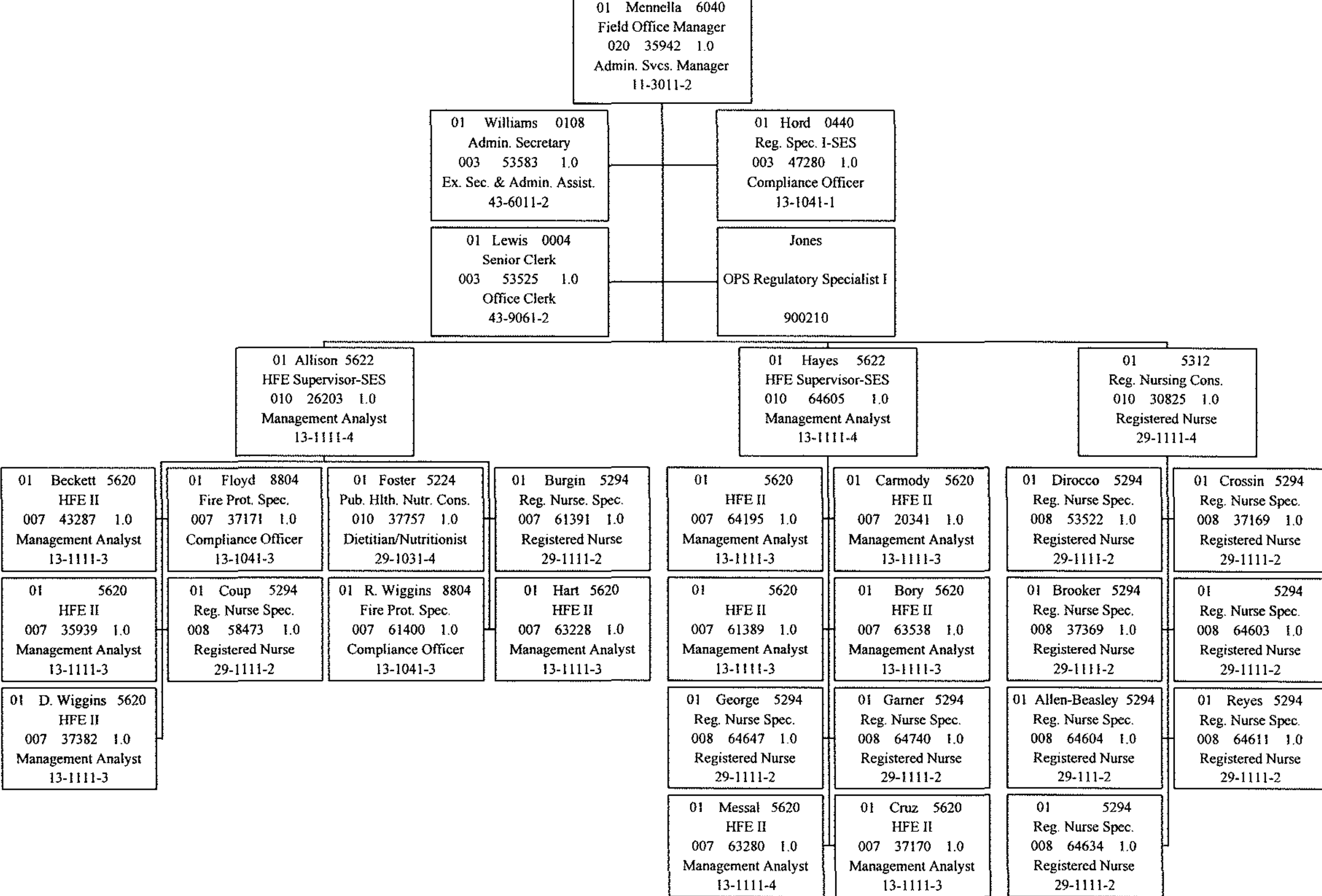
Effective Date: July 1, 2015
Org. Level: 68-30-30-02-000
FTEs: 29 Positions: 29



C-4-2

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 3 Alachua

Effective Date: July 1, 2015
Org. Level: 68-30-30-03-000
FTEs: 31 Positions: 31



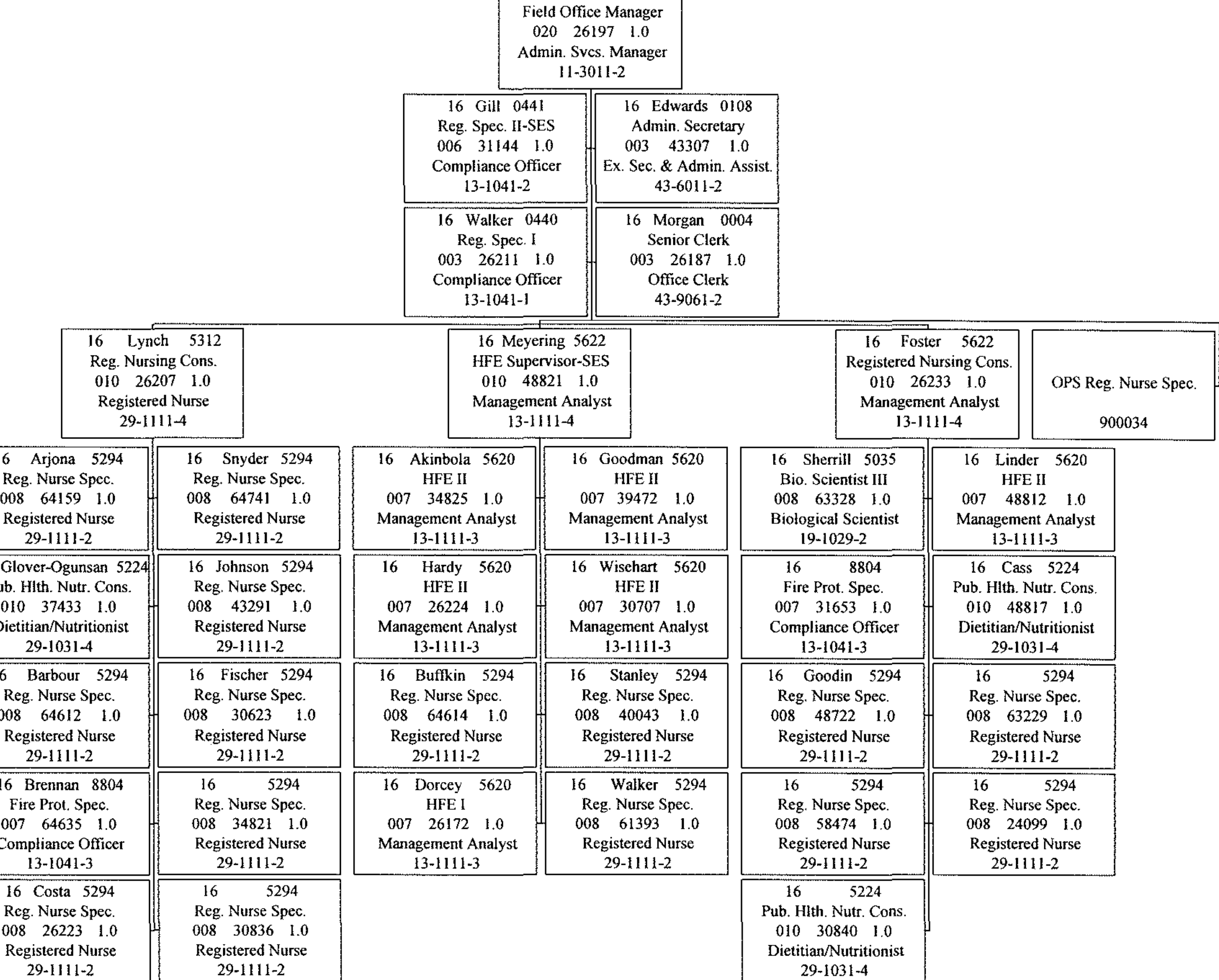
C-4-3

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Quality Assurance

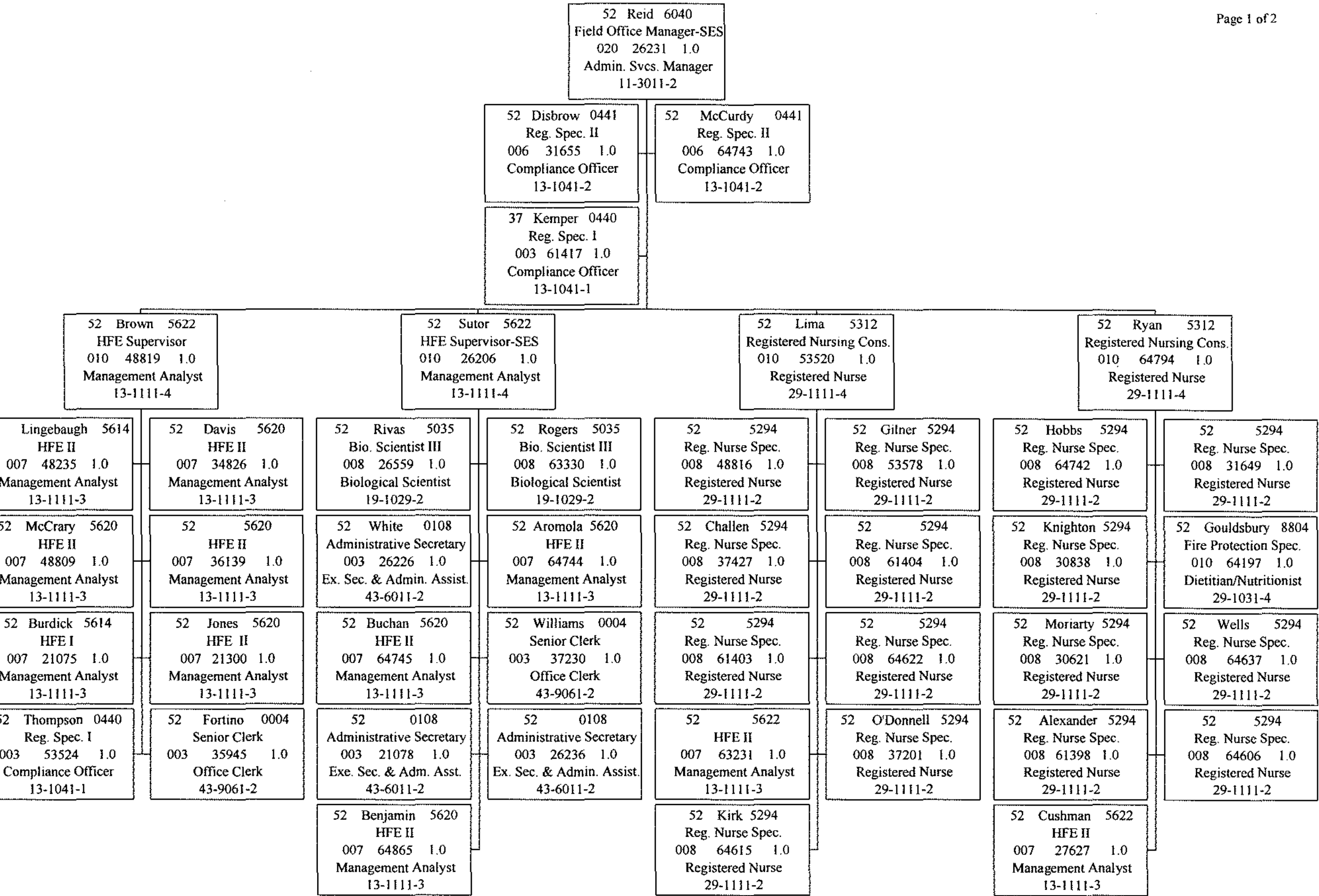
Area 4 - Jacksonville

Effective Date: July 1, 2015
Org. Level: 68-30-30-04-000
FTEs: 34 Positions: 35



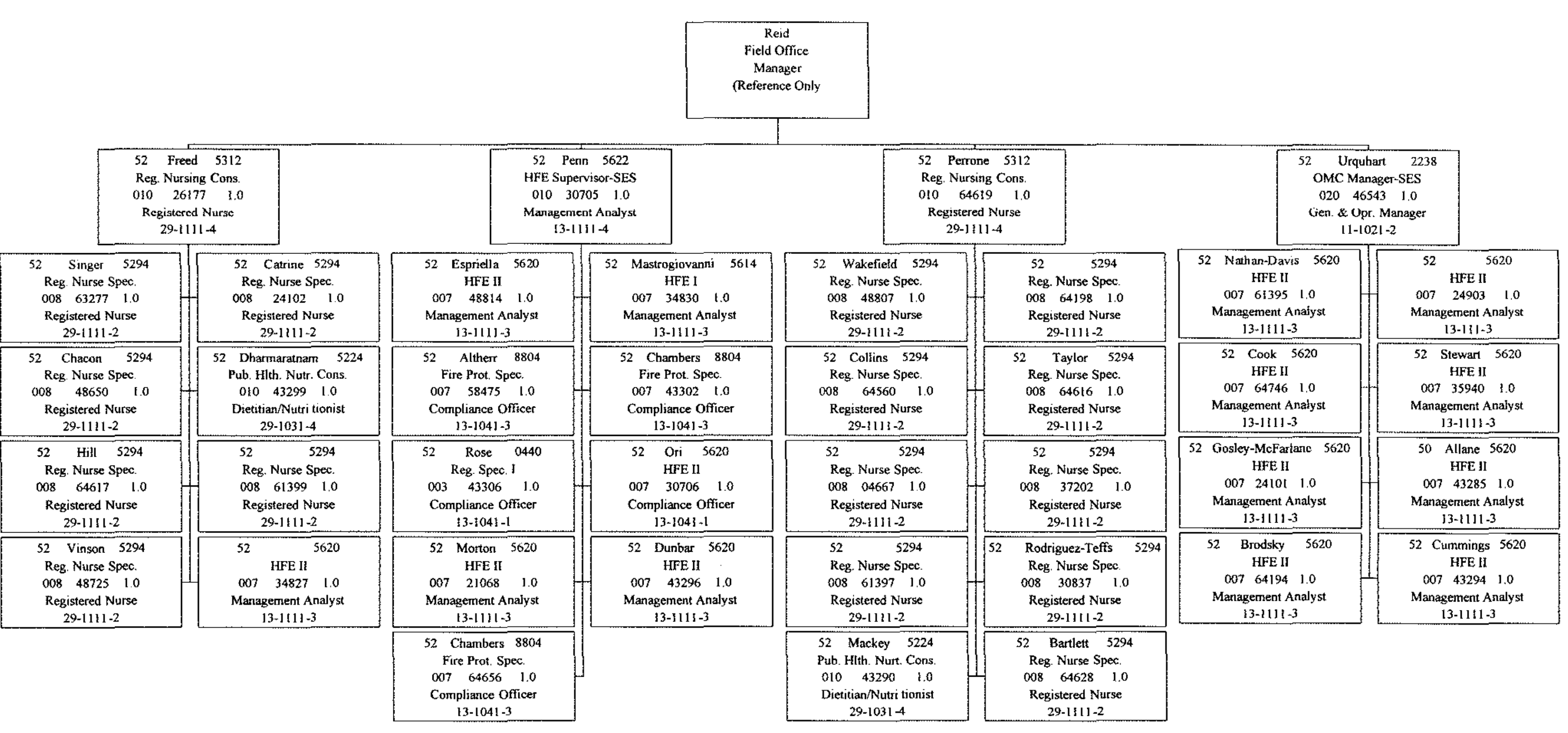
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 5 - St. Petersburg

Revised Date: July 1, 2015
Org Level: 68-30-30-05-000
FTEs: 82 Positions: 82



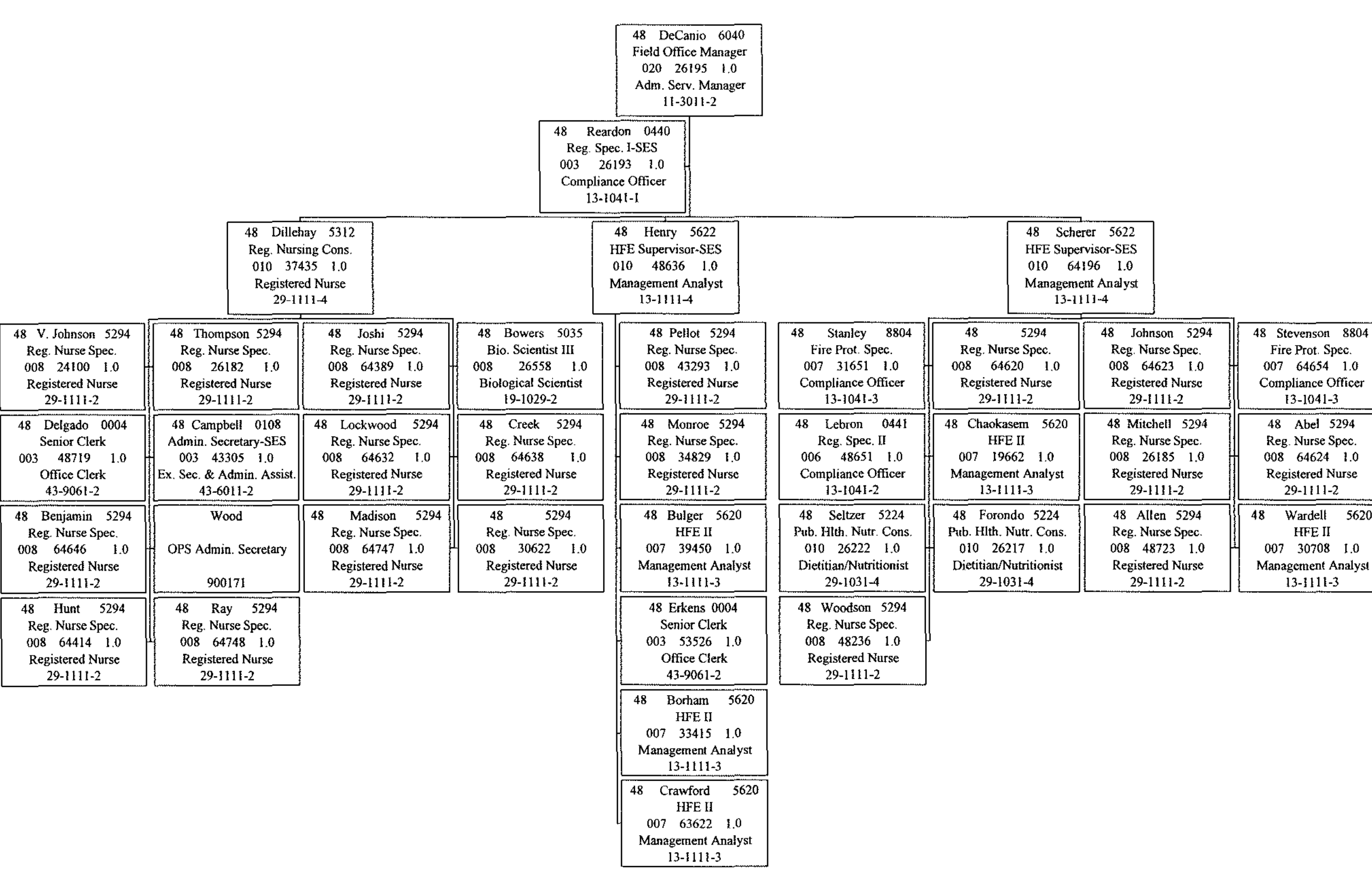
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 5 - St. Petersburg

Effective Date: July 1, 2015
Org. Level: 68-30-30-05-000
FTEs: 82 Positions: 82



Effective Date: July 1, 2015
Org. Level: 68-30-30-07-000
FTEs: 37 Positions: 37

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 7 - Orlando



C-4-7

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

Effective Date: July 1, 2015
Org. Level: 68-30-30-08-000
FTEs: 37 Positions: 37

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

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

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

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

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

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

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

Allebach
OPS Admin. Secretary
900035

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 Stuckey 8804
Fire Protection Spec
007 26225 1.0
Compliance Officer
13-1041-3

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

36 Leinert/Scavella 5294
Reg. Nurse Spec. (shared)
008 63276 1.0
Registered Nurse
29-1111-2

36 Heckscher 0440
Reg. Spec. I
003 64388 1.0
Compliance Officer
13-1041-1

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

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

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

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

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

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

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

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

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

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

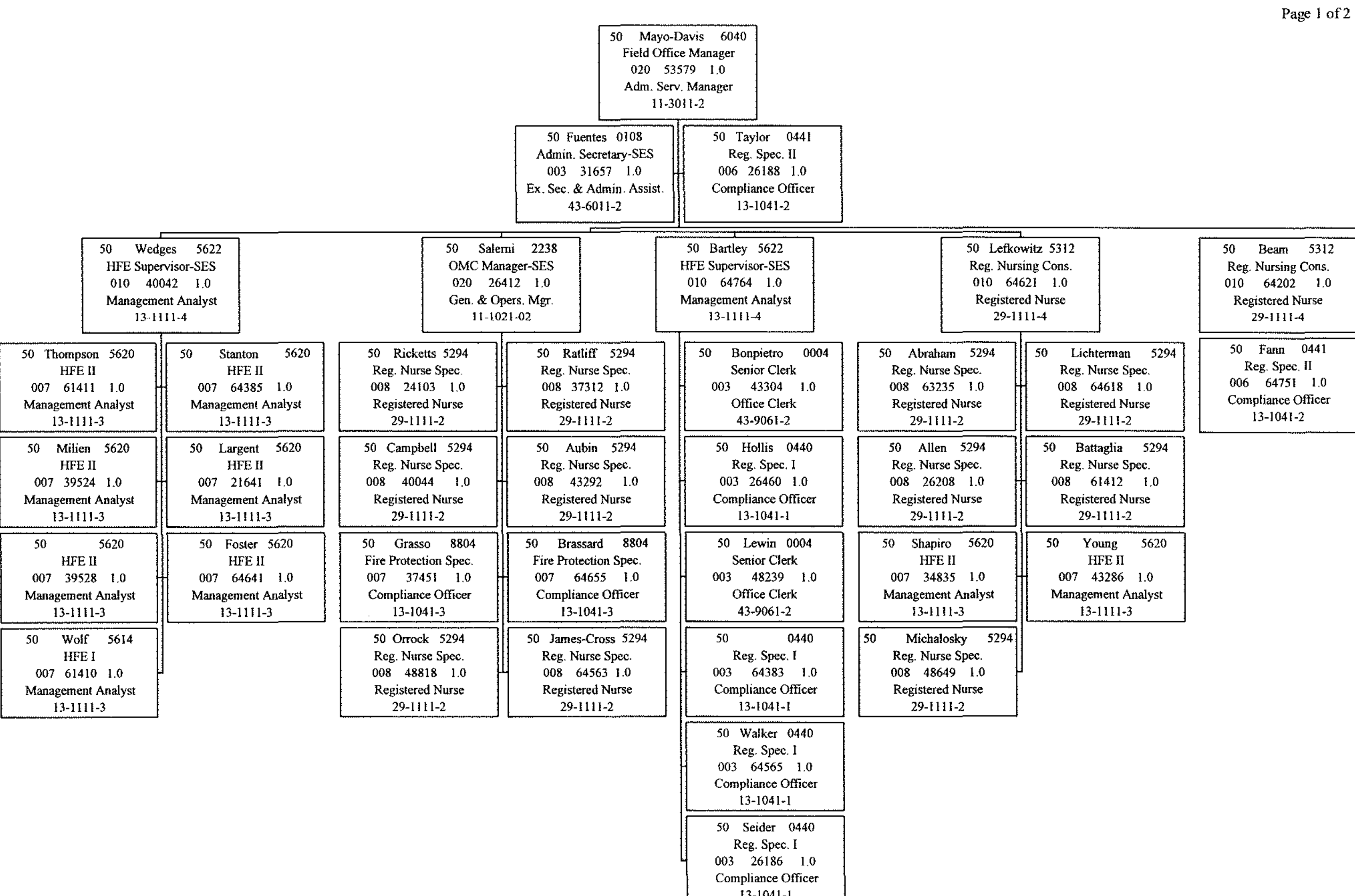
36 Taylor 5294
Reg. Nurse Spec.
008 64627 1.0
Registered Nurse
29-1111-2

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

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

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

Effective Date: July 1, 2015
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, 2015
Org Code: 68-30-30-09-000
FTEs: 60 Positions: 60

Mayo-Davis
Field Office
Manager
(Reference Only)

50 Thurman-Smith 5622
HFE Supervisor-SES
010 63278 1.0
Management Analyst
13-1111-4

50 Golphin 5620
HFE II
007 48712 1.0
Management Analyst
13-1111-3

50 Ramos 5620
HFE II
007 39453 1.0
Management Analyst
13-1111-3

50 Edwards 5620
HFE II
007 64752 1.0
Management Analyst
13-1111-3

50 McKee 5620
HFE II
007 63539 1.0
Management Analyst
13-1111-3

50 Ferguson 5620
HFE II
007 39466 1.0
Management Analyst
13-1111-3

50 Berry 5620
HFE II
007 64754 1.0
Management Analyst
13-1111-3

50 Prussing 5620
HFE II
007 64753 1.0
Management Analyst
13-1111-3

50 Deldotto 5312
Reg. Nursing Cons.
010 64203 1.0
Registered Nurse
29-1111-4

50 Garrison 5294
Reg. Nurse Spec.
008 64750 1.0
Registered Nurse
29-1111-2

50 Singh 5224
Pub. Hlth. Nut. Cons.
010 43297 1.0
Dietitian/Nutritionist
29-1031-4

50 Warnock 5224
Pub. Hlth. Nut. Cons.
010 30839 1.0
Dietitian/Nutritionist
29-1031-4

50 MacPherson 5294
Reg. Nurse Spec.
008 26180 1.0
Registered Nurse
29-1111-2

50 Conklin 5224
Pub. Hlth. Nut. Cons.
010 58480 1.0
Dietitian/Nutritionist
29-1031-4

50 Gravely 5224
Pub. Hlth. Nut. Cons.
010 19467 1.0
Dietitian/Nutritionist
29-1031-4

50 Carroll 5620
HFE II
007 26196 1.0
Management Analyst
13-1111-3

50 Aponte 5294
Reg. Nurse Spec.
008 64384 1.0
Registered Nurse
29-1111-2

50 Howell 5312
Reg. Nursing Cons.
010 64795 1.0
Registered Nurse
29-1111-4

50 Motta 5294
Reg. Nurse Spec.
008 24105 1.0
Registered Nurse
29-1111-2

50 Rizzuto 5294
Reg. Nurse Spec.
008 58478 1.0
Registered Nurse
29-1111-2

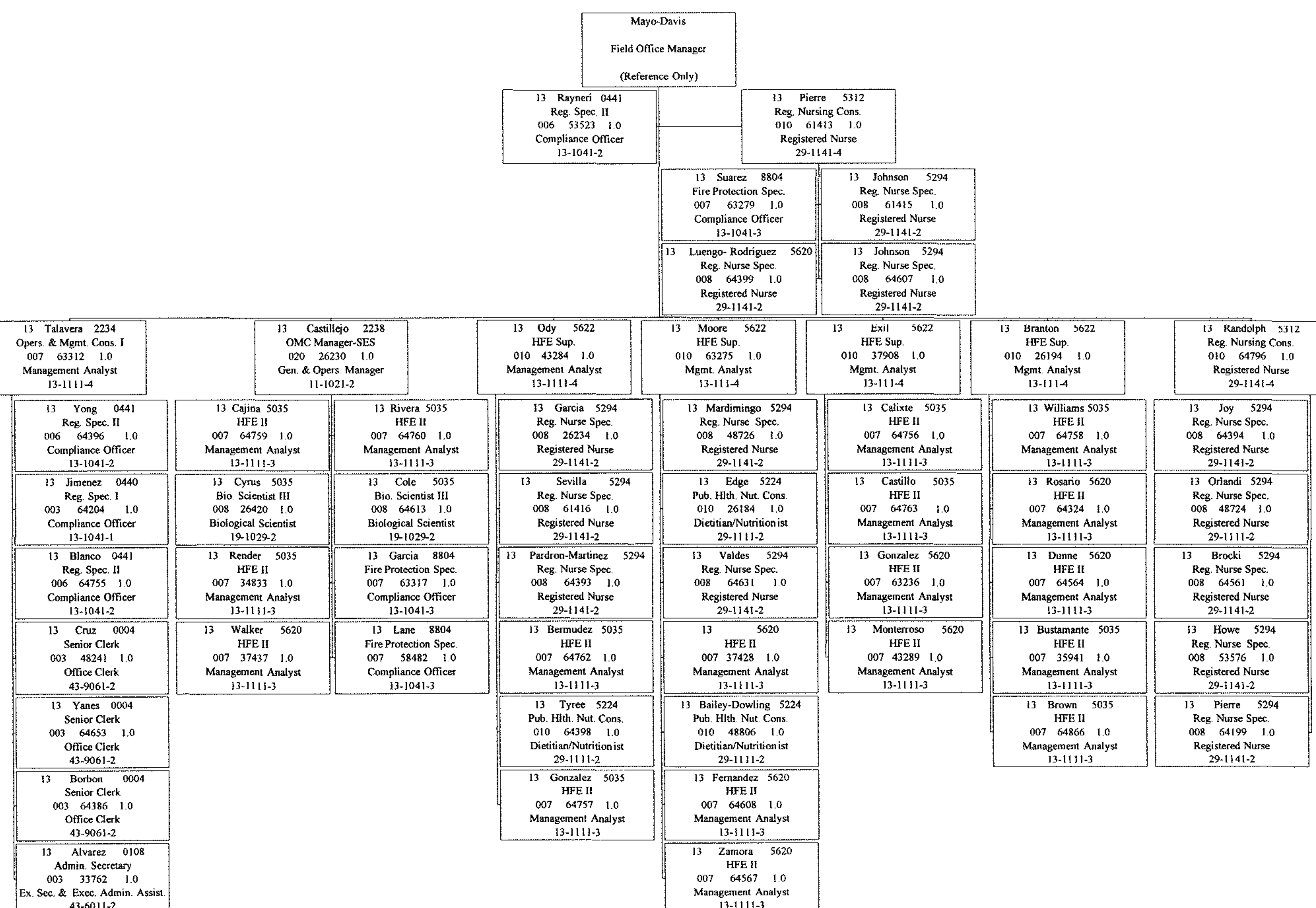
50 Vanderhorst 5294
Reg. Nurse Spec.
008 58479 1.0
Registered Nurse
29-1111-2

50 Wilson 5294
Reg. Nurse Spec.
008 64562 1.0
Registered Nurse
29-1111-2

50 Dixon-Brown 5294
Reg. Nurse Spec.
008 48711 1.0
Registered Nurse
29-1111-2

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

Effective Date: July 1, 2015
Org. Level: 68 30 30 11 000
FTEs: 55 Positions: 55



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

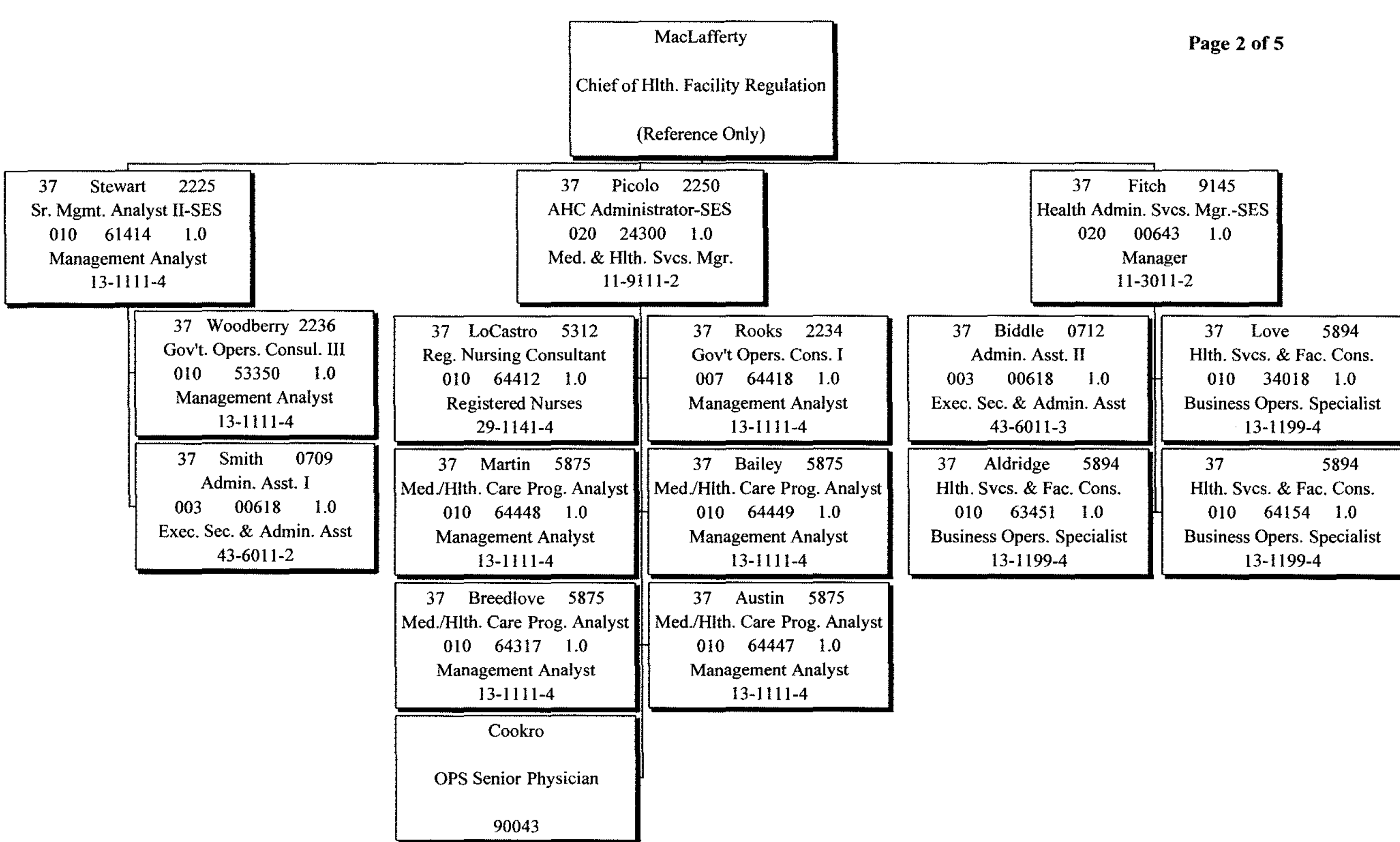
Org. Level: 68 30 20 00 000
Revised Date: July 1, 2015
FTEs: 96.5 Positions: 98

37 MacLafferty 9071
Chief Health Facility Regulation-AHCA
021 00616 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-3

- Hospital Unit (Reference Only)
- Laboratory Unit (Reference Only)
- Health Care Clinic Unit (Reference Only)
- Long Term Care Unit (Reference Only)
- Home Care Unit (Reference Only)
- Assisted Living Facility Unit (Reference Only)

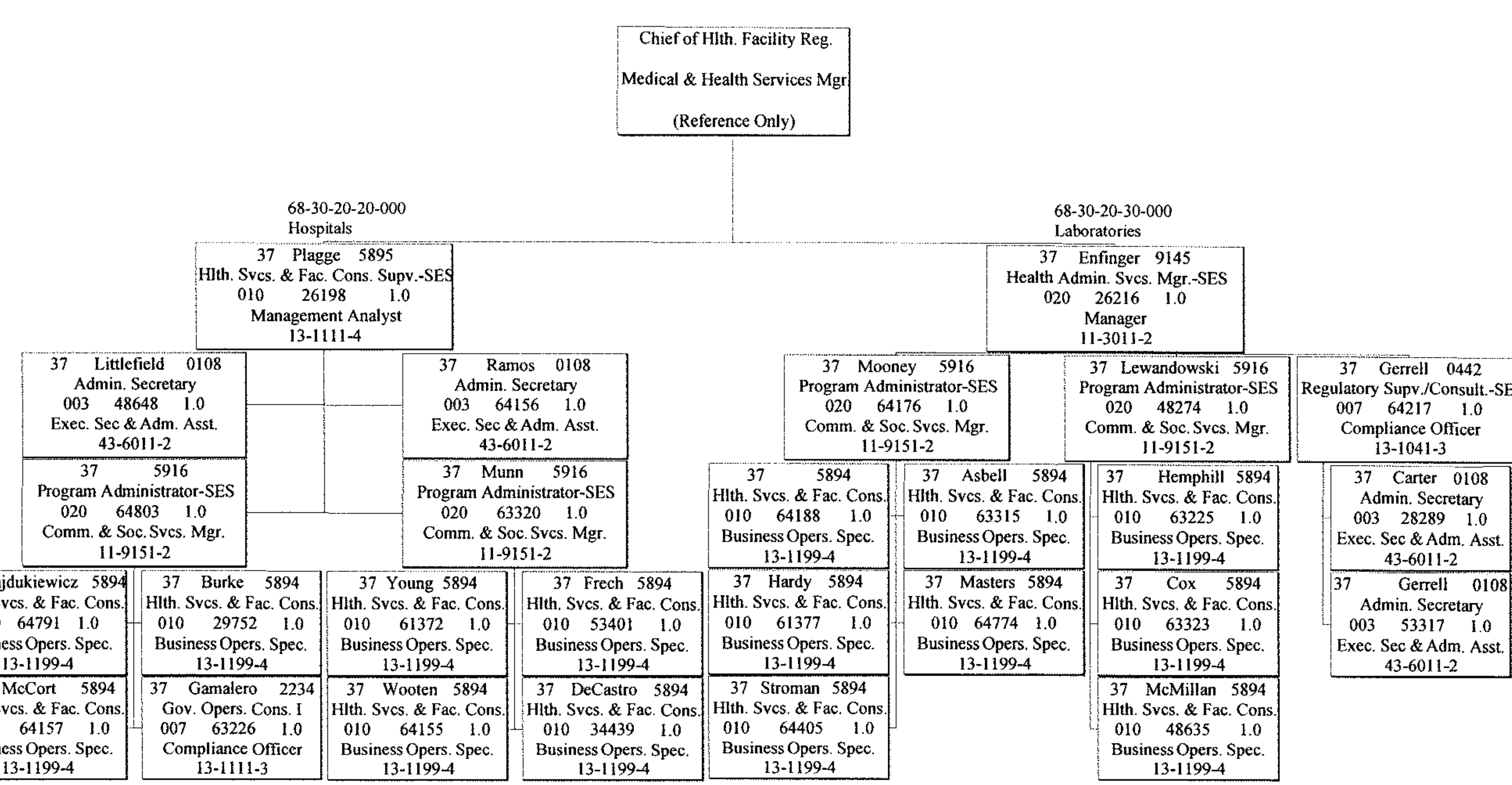
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Revised Date: July 1, 2015
Org. Level: 68 30 20 00 000
FTEs: 96.5 Positions: 98



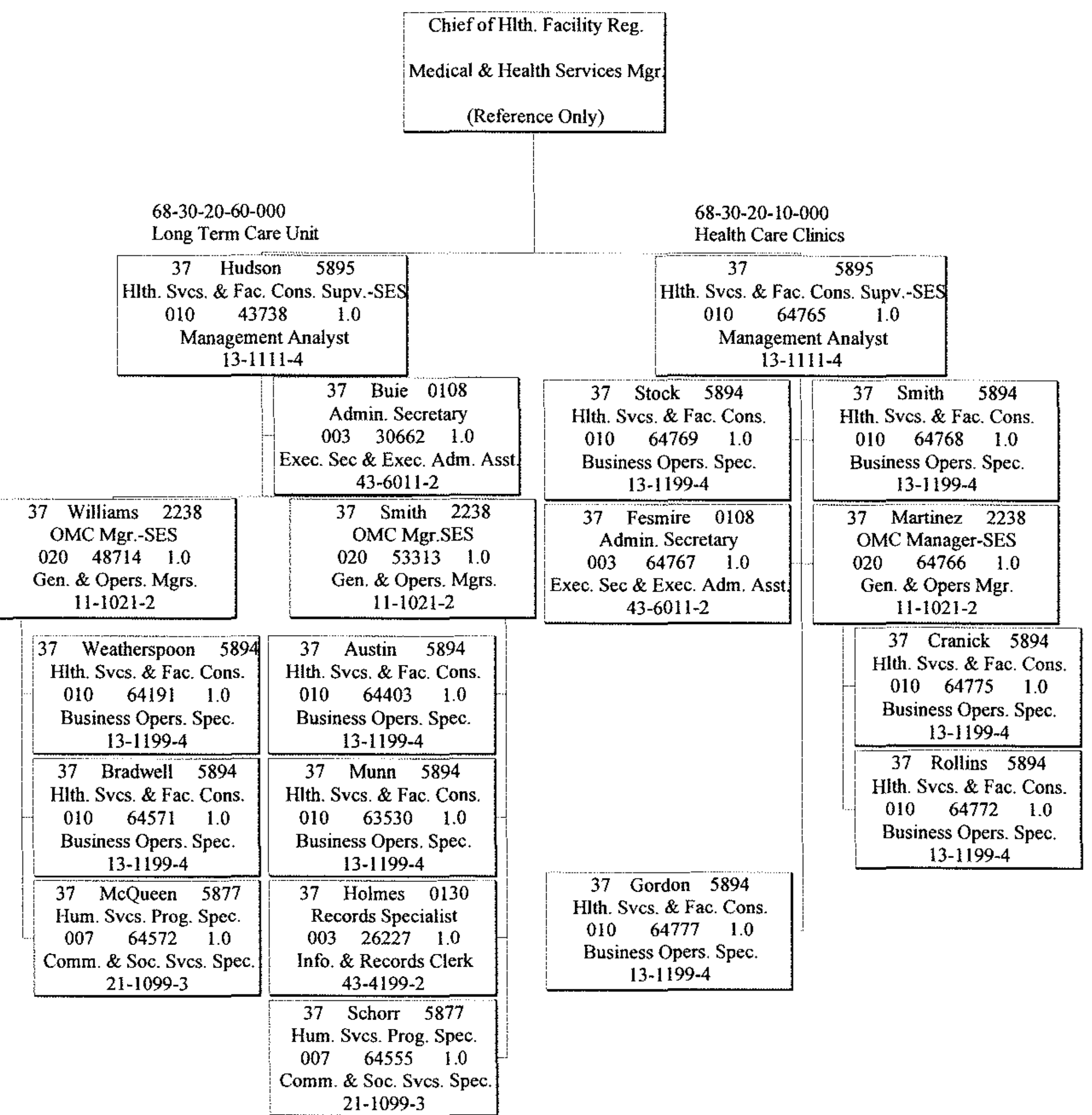
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Effective Date: July 1, 2015
FTEs: 96.5 Positions: 98



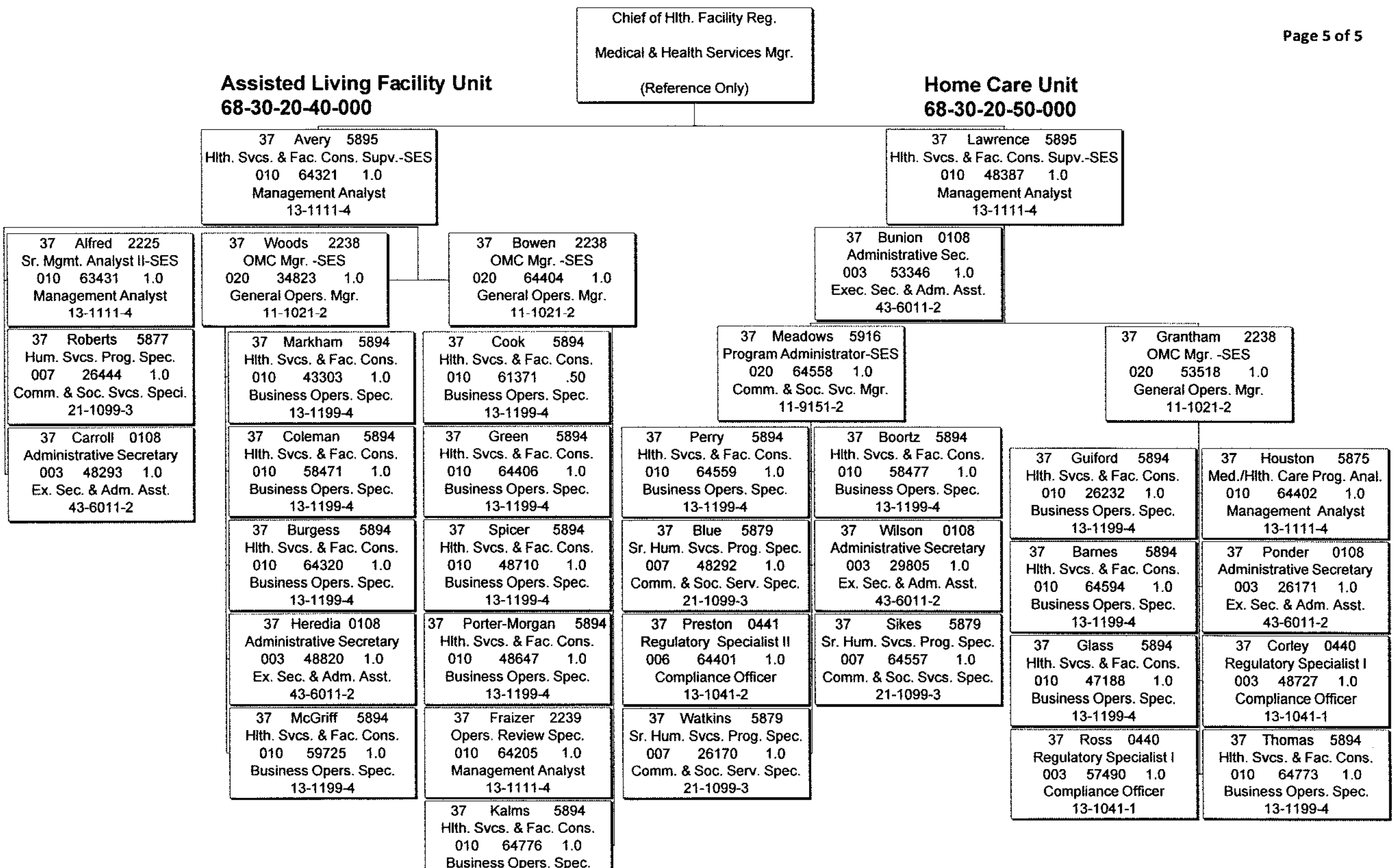
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Health Facility Regulation

Effective Date: July 1, 2015
FTEs: 96.5 Positions: 98



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

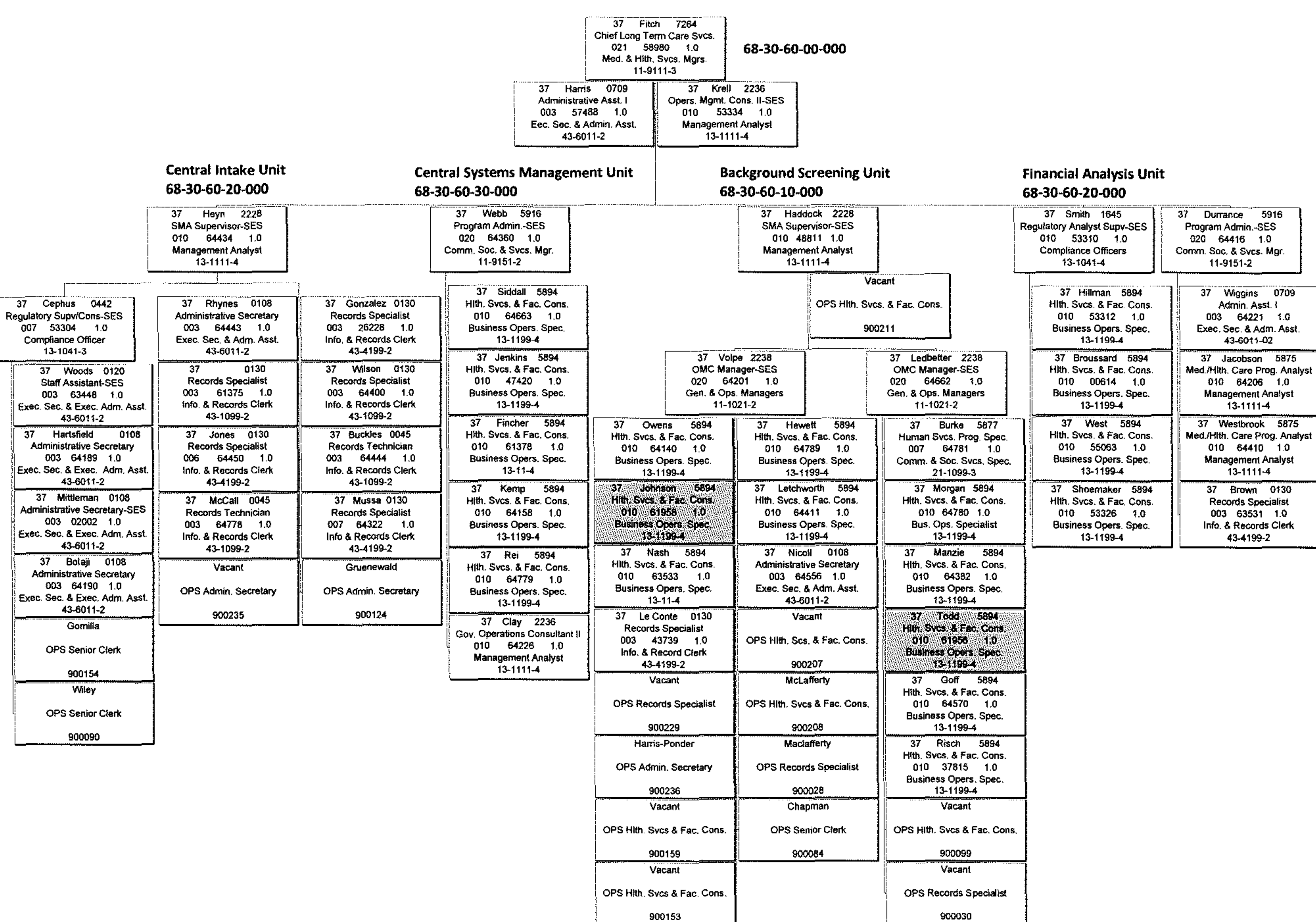
Effective Date: July 1, 2015
FTEs: 96.5 Positions: 98



C-3-3

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

Effective Date: July 1, 2015
FTEs: 47 Positions: 47



Shaded positions report to the Division of Medicaid

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

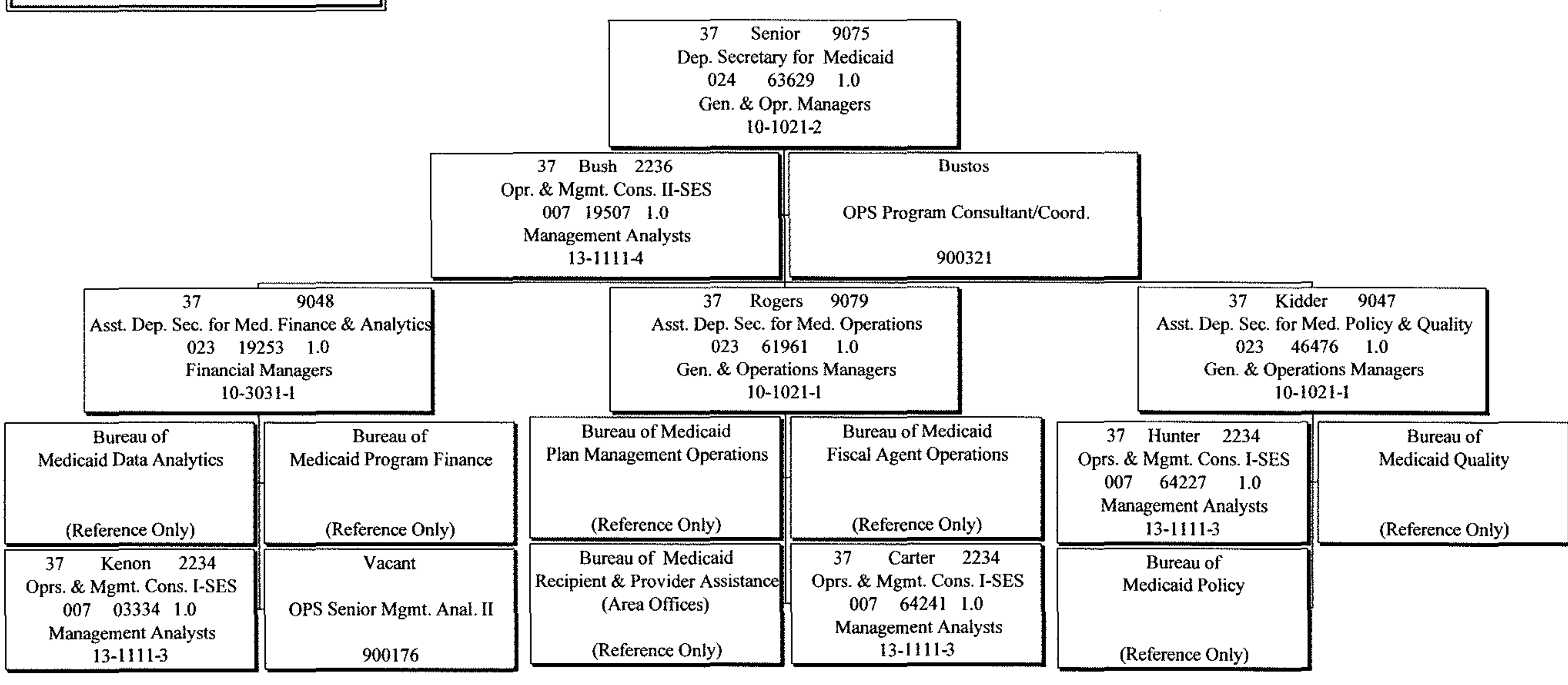
Effective Date: July 1, 2015
Org Level: 68-30-70-00-000
FTEs: 40 Positions: 40

- 37 Helvey 6822 — Chief of Hlth Info & Policy Anal-AHCA — 021 63541 1.0 — Med. & Hlth. Svcs. Mgrs. — 11-911-3
  - 37 Schmidt 2234 — OMC I-SES — 007 63442 1.0 — Management Analyst — 13-1111-3
  - 37 Fox 2250 — AHC Administrator-SES — 020 63453 1.0 — Med. & Hlth. Svcs. Mgr. — 11-9111-2
    - 37 Watson 2225 — Government Analyst II — 010 64800 1.0 — Management Analyst — 13-1111-4
    - 37 Phinney 2238 — Gov. Opers. Cons. III — 010 64834 1.0 — Management Analyst — 13-1111-4
    - 37 Priest 3122 — Research Associate — 008 59711 1.0 — Mathematician — 15-2021-3
    - Vacant — OPS Research Associate — 900168
    - Bucci — OPS Senior Analyst — 900214
    - Maurer — OPS Records Analyst — 900216
    - Hardin — OPS Gov't Analyst I — 900317
    - Schrenker — OPS Program Coord. — 900316
    - Dunlap — OPS Gov't Analyst II — 900318
    - 37 Long 2209 — Opers. Analyst I — 005 53341 1.0 — Management Analyst — 13-1111-2
    - 37 2225 — Government Analyst II — 010 59722 1.0 — Management Analyst — 13-1111-4
    - 37 King 2225 — Government Analyst II — 010 53351 1.0 — Management Analyst — 13-1111-4
    - Vacant — OPS Plan. & Eval. Spec. — 900255
    - Parsons — OPS Program Coordinator — 900013
    - Gaudio — OPS Hlth. Info. Network Spec. — 900109
    - Pearce — OPS Gov't Analyst II — 900320
    - Reifinger — OPS Gov't Analyst II — 900319
  - 37 Eastman 2250 — AHC Administrator-SES — 020 55059 1.0 — Med. & Hlth. Svcs. Mgr. — 11-9111-2
    - 37 Knoble 2225 — Sr. Mgmt. Anal. Supv.-SES — 010 53351 1.0 — Management Analyst — 13-1111-4
      - 37 Kinman 3215 — Economic Analyst — 008 53336 1.0 — Economist — 19-3011-3
      - 37 Cook 2225 — Government Analyst II — 010 63644 1.0 — Management Analyst — 13-1111-4
      - 37 Styrcula 2225 — Government Analyst II — 010 64848 1.0 — Management Analyst — 13-1111-4
    - 37 Schwahn 3150 — Market Research Analyst — 006 53349 1.0 — Market Research Analyst — 19-3021-2
    - 37 Barker 2225 — Government Analyst II — 010 53306 1.0 — Management Analyst — 13-1111-4
    - 37 1644 — Regulatory Analyst IV — 008 53348 1.0 — Accountant & Auditor — 13-2011-3
    - 37 Henderson 2225 — Government Analyst II — 010 64799 1.0 — Management Analyst — 13-1111-4
    - 37 Conrad 2225 — Government Analyst II — 010 53347 1.0 — Management Analyst — 13-1111-4
    - 37 Miller 2225 — Government Analyst II — 010 64798 1.0 — Management Analyst — 13-1111-4
    - 37 Sheppard 2225 — Government Analyst II — 010 00641 1.0 — Management Analyst — 13-1111-4
    - 37 Hand 5894 — Hlth. Svcs. & Fac. Cons. — 010 48276 1.0 — Business Opers. Spec. — 13-1199-4
  - 37 Tamariz 2250 — AHC Administrator-SES — 020 55061 1.0 — Med. & Hlth. Svcs. Mgr. — 11-9111-2
    - 37 Kucheman 5912 — Program Opers. Admin.-SES — 009 53322 1.0 — Comm. & Social Svc. Spec. — 21-1099-4
      - 37 Pittman 1644 — Regulatory Analyst IV — 008 59439 1.0 — Accountant & Auditor — 13-2011-3
      - 37 Allen 2208 — Records Analyst — 003 53301 1.0 — Management Analyst — 13-1111-1
      - 37 Spikes 2208 — Records Analyst — 003 56684 1.0 — Management Analyst — 13-1111-1
      - 37 2208 — Records Analyst — 003 59716 1.0 — Management Analyst — 13-1111-1
      - 37 Battles 3150 — Market Research Analyst — 006 64801 1.0 — Market Research Analyst — 19-3021-2
      - 37 Shupard 3150 — Market Research Analyst — 006 56685 1.0 — Market Research Analyst — 19-3021-2
      - 37 Torbert 3150 — Market Research Analyst — 007 53352 1.0 — Market Research Analyst — 19-3021-2
      - 37 Stokes 2234 — Government Opers. Cons. I — 007 64325 1.0 — Management Analyst — 13-1111-3
    - 37 Folmar 2225 — Government Analyst II — 010 63444 1.0 — Management Analyst — 13-1111-4
    - Mathews — OPS Plan. & Eval. Spec. — 68900163
    - 37 Herring 1644 — Regulatory Analyst IV — 008 55060 1.0 — Accountant & Auditor — 13-2011-3
    - 37 Mooney 1644 — Regulatory Analyst IV — 008 64144 1.0 — Accountant & Auditor — 13-2011-3
  - 37 Vidal 5916 — Program Administrator-SES — 020 64790 1.0 — Comm. & Soc. Svcs. Mgr. — 11-9151-2
    - 37 Sneed 3120 — Research Assistant — 005 63450 1.0 — Mathematician Tech. — 15-2091-2
    - 37 Francis 5312 — Reg. Nursing Consultant — 010 64664 1.0 — Registered Nurse — 29-1111-4
    - 37 Lord 0441 — Regulatory Spec. II — 006 64665 1.0 — Compliance Officer — 13-1041-2

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

Effective Date: July 1, 2015
Org. Level: 68-40-00-00-000
FTEs: 28 Positions: 28

Division of Medicaid FTE: 636
Division Total # Positions: 638



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

Effective Date: July 1, 2015
Org. Level: 68-40-00-00-000
FTEs: 28 Positions: 28

Senior
Deputy Secretary for Medicaid
(Reference Only)

37 Sokoloski 2250
AHC Administrator-SES
020 64590 1.0
Medical & Health Svcs. Mgrs.
11-9111-02

37 Wolf 2228
Sr. Mgmt. Analyst Supv.-SES
010 64715 1.0
Management Analysts
13-1111-4

37 Wilson 2225
Gov. Analyst II
010 64812 1.0
Management Analyst
13-1111-4

37 Pigott 2239
Opers. Review Spec.
010 36243 1.0
Management Analyst
13-1111-4

37 Jones 2225
Sr. Mgmt. Analyst II-SES
010 64706 1.0
Management Analyst
13-1111-4

37 2238
Gov. Opers. Cons. III
010 64840 1.0
Management Analyst
13-1111-4

Skidmore
OPS Research Assistant
900137

37 Rudasill 2225
Gov. Analyst II
010 63582 1.0
Management Analyst
13-1111-4

37 Williams 2234
Gov. Opers Cons. I
010 20040 1.0
Management Analyst
13-1111-3

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

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

37 Hart 2234
OMC II - SES
010 64588 1.0
Management Analyst
13-1111-4

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

Newman
OPS Sr. Management Analyst
900044

Waldron
OPS Administrative Secretary.
68900169

Bruner
OPS Administrative Secretary.
68900146

37 Ryals 5916
Program Administrator-SES
020 46480 1.0
Comm. & Soc. Svcs. Mgr.
11-91-51-2

37 Wright 2212
Operations Analyst II
007 24405 1.0
Management Analysts
13-1111-3

37 Schmidt 5875
Med/Hlth Care Program Analyst
010 24407 1.0
Management Analyst
13-1111-4

37 Maloney 2238
Gov. Opers Cons. III
010 36278 1.0
Management Analysts
13-1111-04

Vacant
OPS Sr. HSPS
900256

Vacant
OPS Med/Hlth Care Prog. Analyst
900059

37 Sacipa 5916
Program Consultant
010 , 64863 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance

Effective Date: July 1, 2015
Org Level: 68-40-10-00-000
FTEs: 9 Positions: 9

37 Nieves/Rich 9065
Chief of Med. Recipient & Provider Asst.
021 64837 1.0
General and Operations Mgrs.
11-1021-3

37 McFarland 0108
Admin. Secretary
003 64871 1.0
Exec. Sec. & Exec. Adm. Asst.
43-6011-2

37 Smith 5875
Med./Hlth. Care Prog. Anal
010 19096 1.0
Management Analyst
13-1111-4

Wallace
Field Office Manager
Pensacola Office
(20 FTEs)
Reference Only

D. Fuller
Field Office Manager
St. Pete/Tampa Office
(39 FTEs)
Reference Only

Cole
Field Office Manager
Fort Myers Office
(28 FTEs)
Reference Only

Stokes
Field Office Manager
Jacksonville Office
(22 FTEs)
Reference Only

Jacobs
Field Office Manager
Orlando Office
(21 FTEs)
Reference Only

Gray
Field Office Manager
Miami Office
(28 FTEs)
Reference Only

06 Albury 2225
Senior Mgmt. Analyst II-SES
010 39526 1.0
Management Analyst
13-1111-4

06 Rodney 5864
Hum. Svcs. Prog. Recs. Anal.
003 58976 1.0
Management Analyst
13-1111-1

06 Hamblin 5912
Program Opers. Admin.-SES
007 63565 1.0
Comm. & Soc. Svcs. Spec.
21-1099-4

06 Mieszkowski 5875
Med./Hlth. Care Prog. Anal
010 19096 1.0
Management Analyst
13-1111-4

06 Allen-Brinson 5912
Program Opers. Admin.-SES
007 48393 1.0
Comm. & Soc. Svcs. Spec.
21-1099-4

06 Beneby 5877
Hum. Svcs. Prog. Spec.
007 48502 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance
Enrollment Broker Operations

Effective Date: July 1, 2015
Org Level: 68-40-20-00-000
FTEs: 11 Positions: 11

37 Diaz-Santiago 2225
Senior Mgmt. Analyst Supv.-SES
010 20784 1.0
Management Analyst
13-1111-4

37 Hand 5875
Med./Hlth. Care Prog. Anal
010 48520 1.0
Management Analyst
13-1111-4

37 Sisk 5875
Med./Hlth. Care Prog. Anal
010 64229 1.0
Management Analyst
13-1111-4

37 5875
Med./Hlth. Care Prog. Anal
010 64270 1.0
Management Analyst
13-1111-4

37 Trull 5879
Sr. Hum. Svcs. Prog. Spec.
007 64309 1.0
Comm. & Soc. Svcs. Spec.
21-1099-4

Gaston
OPS Mgmt. Review Specilast
900117

37 Nelson 5916
Program Administrator-SES
020 47474 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

37 Martin 2241
Medicaid Mgmt. Review Monitor
010 47266 1.0
Management Analyst
13-1111-4

37 Hampton 5875
Med./Hlth. Care Prog. Anal
010 24145 1.0
Management Analyst
13-1111-4

37 Meeks 5875
Med./Hlth. Care Prog. Anal
010 48205 1.0
Management Analyst
13-1111-4

37 Walker 5875
Med./Hlth. Care Prog. Anal
010 61957 1.0
Management Analyst
13-1111-1

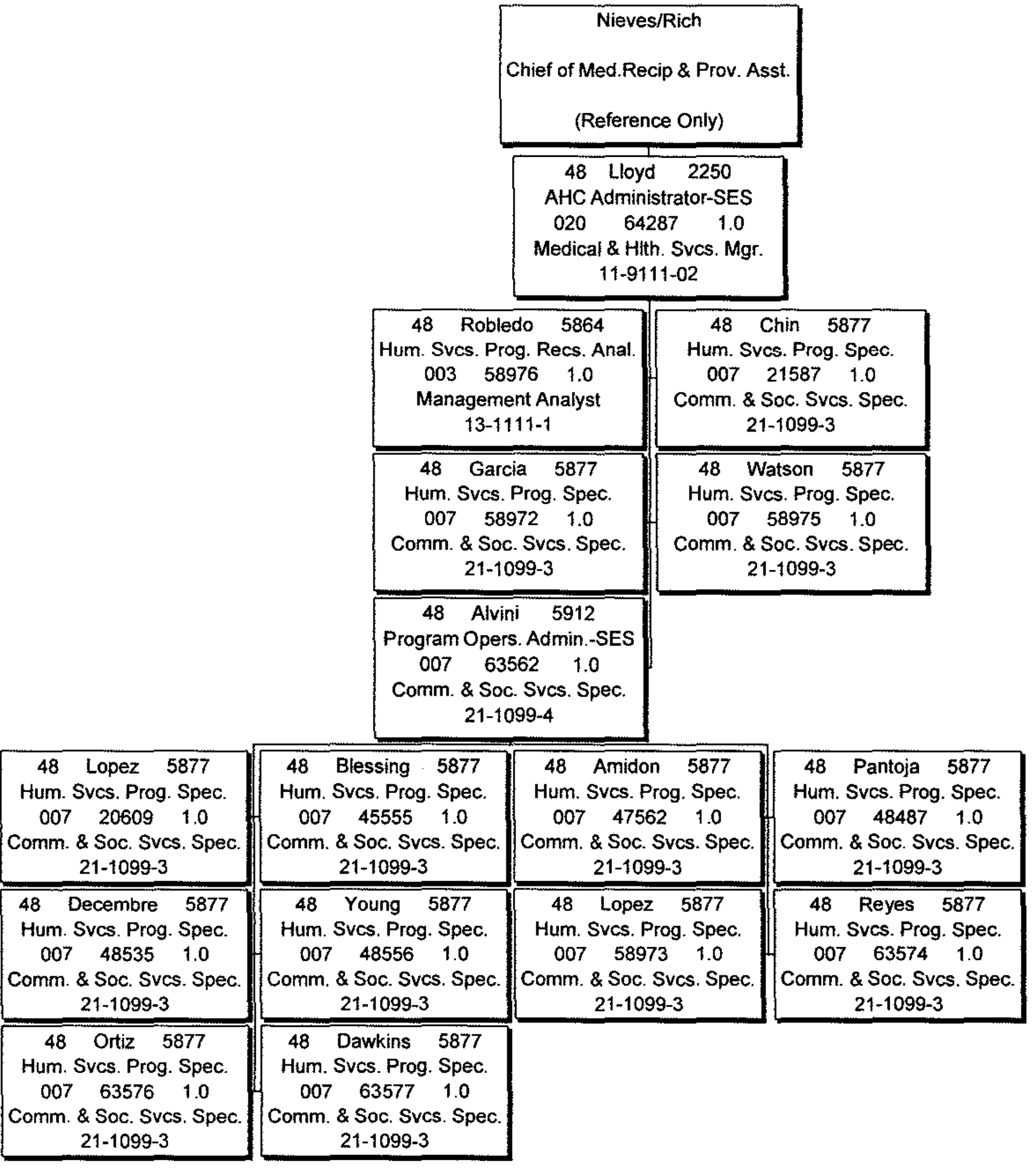
37 5875
Med./Hlth. Care Prog. Anal
010 63489 1.0
Management Analyst
13-1111-1

Vacant
OPS Med./Hlth. Care Prog. Anal.
900192

D-2-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Enrollment Broker Operations - Contact Center Orlando

Effective Date: July 1, 2015
Org Level: 68-40-20-07-000
FTEs: 20 Positions: 20



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Enrollment Broker Operations - Contact Center Miami

Effective Date: July 1, 2015
Org Level: 68-40-20-11-000
FTEs: 18 Positions: 18

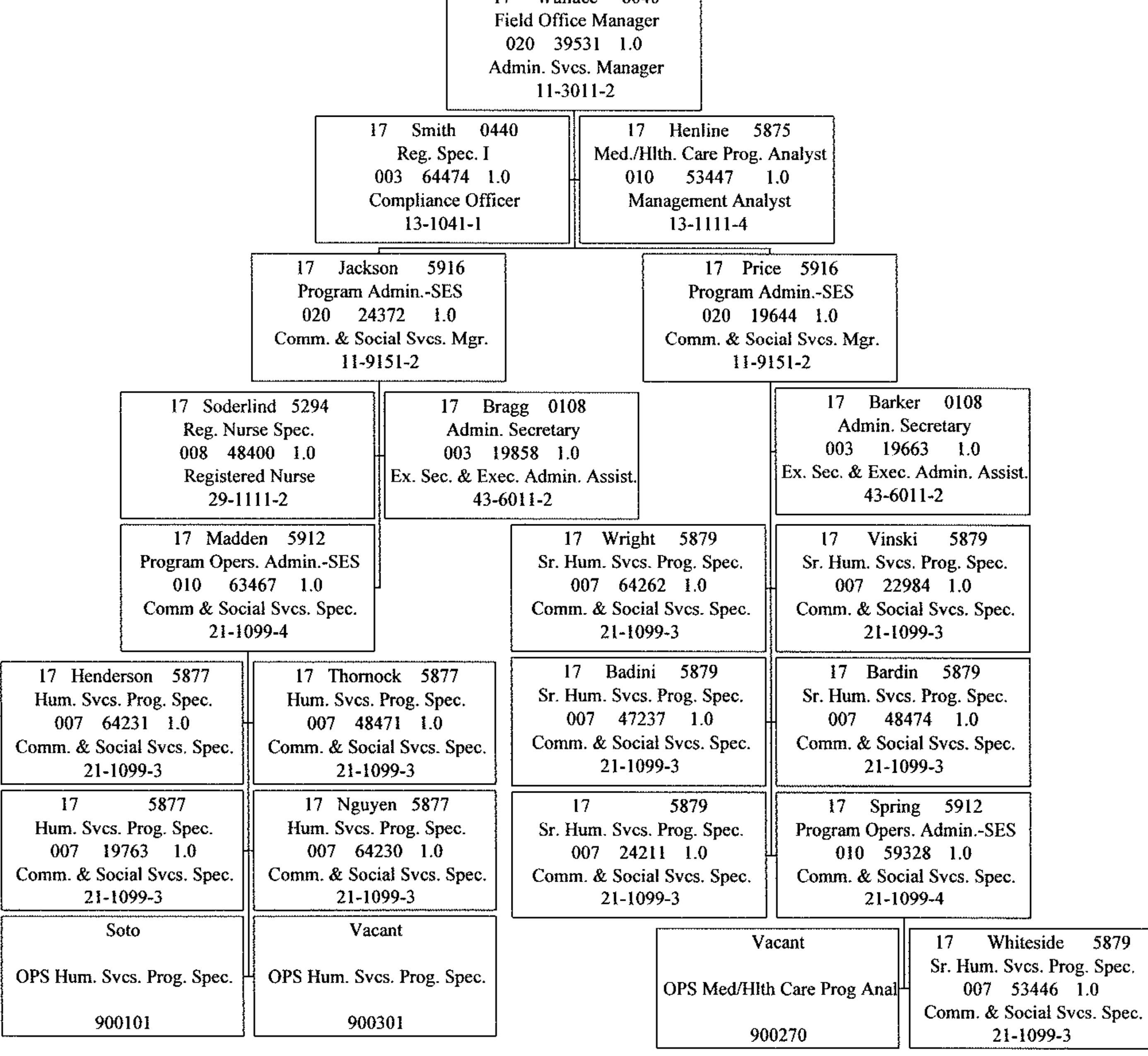
Nieves/Rich
Chief of Med. Recip. & Prov. Asst.
(Reference Only)

13 Marcos 5912
Program Operations Admin.-SES
007 47155 1.0
Comm. & Soc. Svcs. Spec.
21-1099-4

13 Lezcano 5864 Hum. Svcs. Prog. Recs. Anal. 003 25183 1.0 Management Analyst 13-1111-1	13 Haupt 5868 Hum. Services Analyst 007 64243 1.0 Comm. & Soc. Svcs. Spec. 21-1099-2	13 Alphonse 5877 Hum. Svcs. Prog. Spec. 007 24419 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3	13 Leon 5877 Hum. Svcs. Prog. Spec. 007 48494 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3
13 Pagan 5877 Hum. Svcs. Prog. Spec. 007 24925 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3	13 Rapaport 5877 Hum. Svcs. Prog. Spec. 007 63583 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3	13 Vieira 5877 Hum. Svcs. Prog. Spec. 007 48505 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3	13 Yanez 5877 Hum. Svcs. Prog. Spec. 007 59208 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3
13 Grasso 5877 Hum. Svcs. Prog. Spec. 007 48482 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3	13 Lovinsky 5877 Hum. Svcs. Prog. Spec. 007 64242 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3	13 Alvarez-Buylla 5877 Hum. Svcs. Prog. Spec. 007 64244 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3	13 5877 Hum. Svcs. Prog. Spec. 007 64248 1.0 Comm. & Soc. Svcs. Spec. 21-1099-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Bureau of Medicaid Recipient and Provider Assistance - Pensacola

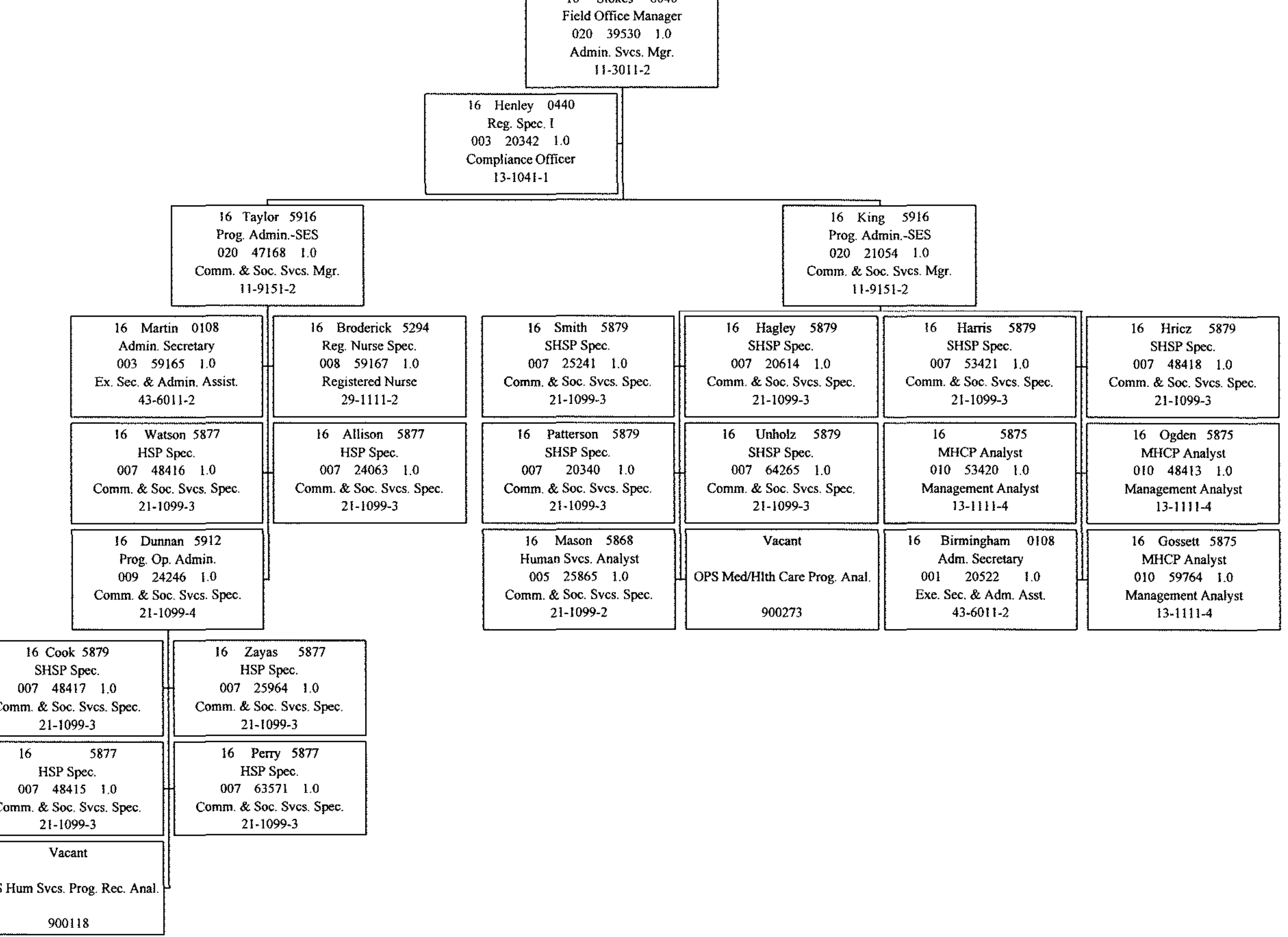
Effective Date: July 1, 2015
Org. Level: 68-50-10-01-000
FTEs: 20 Positions: 20



D-3

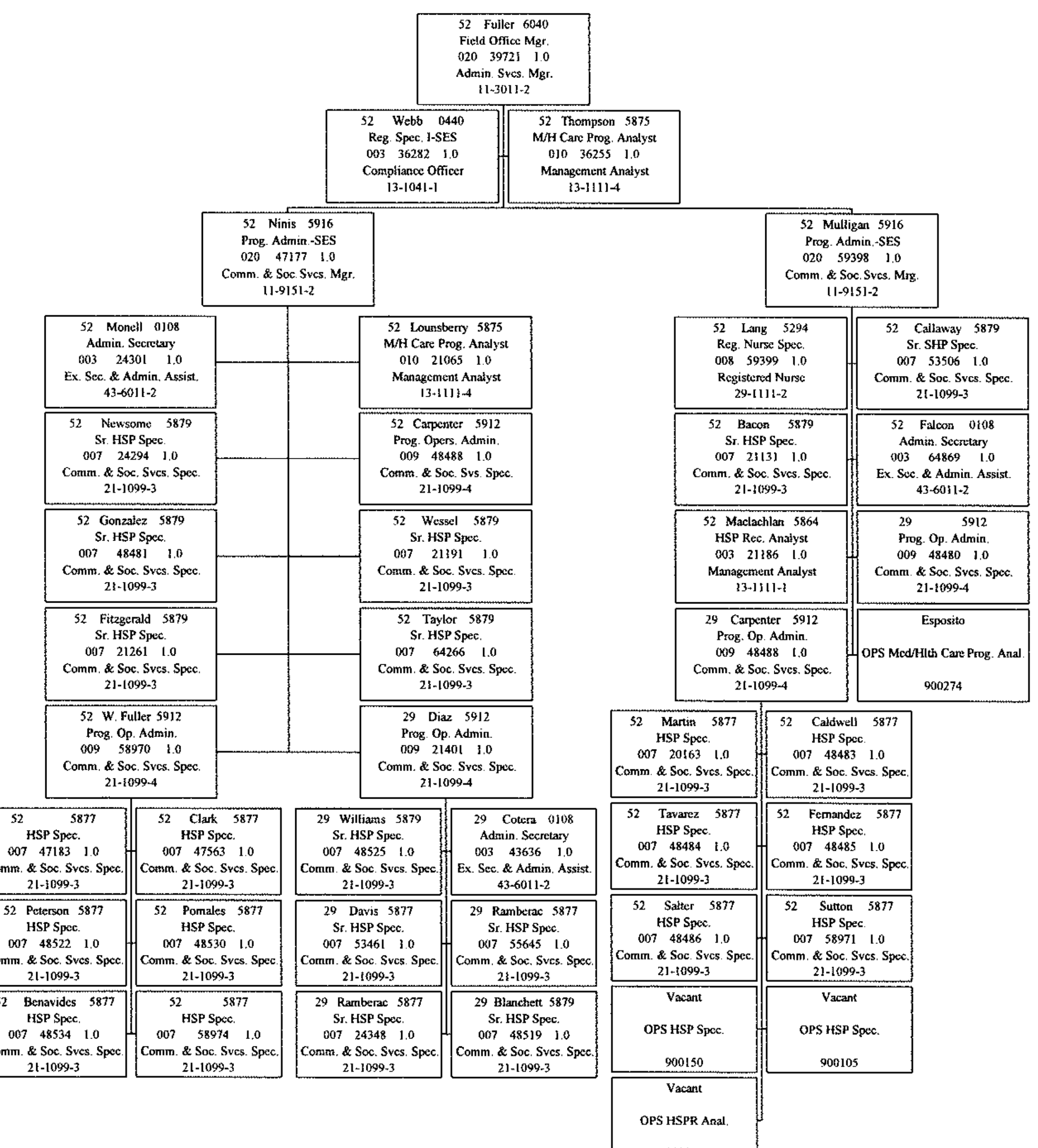
AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid
Bureau of Medicaid Recipient & Provider Assistance - Jacksonville

Effective Date: July 1, 2015
Org. Level: 68-50-10-04-000
FTEs: 22 Positions: 22



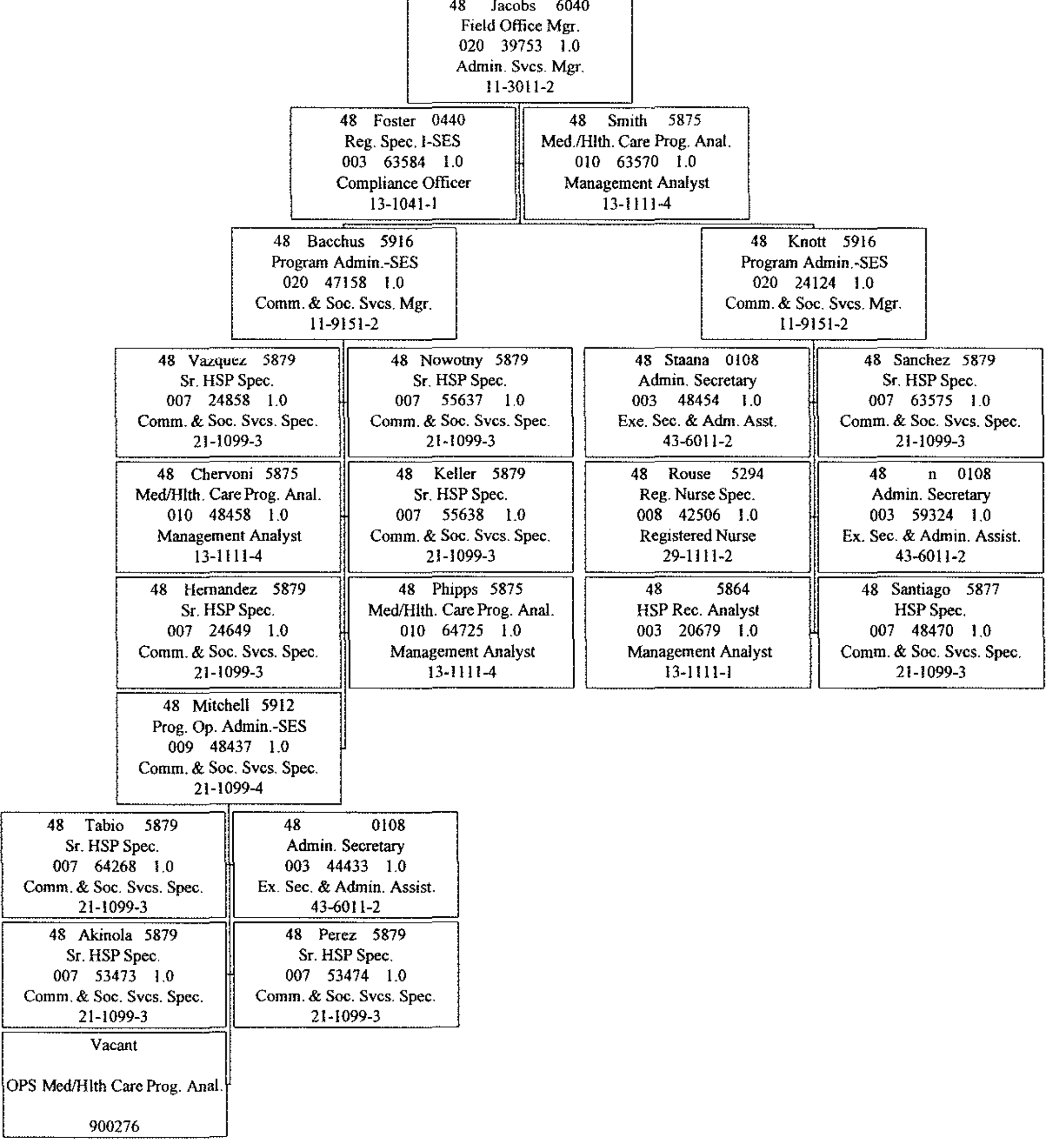
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient & Provider Assistance - St. Petersburg

Effective Date: July 1, 2015
Org. Level: 68-40-10-05-000
FTEs: 39 Positions: 39



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance - Orlando

Effective Date: July 1, 2015
Org. Level: 68-40-10-07-000
FTE: 21 Positions: 21



D-3-4

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance - Ft. Myers

Effective Date: July 1, 2015
Org. Level: 68-40-10-08-000
FTEs: 28 Positions: 28

36 Cole 6040
Field Office Mgr.
020 47182 1.0
Admin. Svcs. Mgr.
11-3011-2

36 Kloszewski 0440
Reg. Spec. I-SES
003 20069 1.0
Compliance Officer
13-1041-1

36 Portman 2238
GOC III.
010 21581 1.0
Management Analyst
13-1111-4

36 Perez 5877
HSP Spec.
007 63579 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Paige 5916
Program Admin.
020 59308 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

36 Brooks 5916
Program Admin.
020 24053 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

36 5912
Prog. Opers. Admin.
010 25502 1.0
Comm. & Soc. Svcs. Spec.
21-1099-4

36 Davis 0108
Admin. Secretary
003 63585 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

36 5877
HSP Spec.
007 63569 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Cabrera 5879
Sr. HSP Spec.
007 59456 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Urban 5877
HSP Spec.
007 48426 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Chillari 5879
Sr. HSP Spec.
007 21869 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Patterson 5879
Sr. HSP Spec.
007 48527 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Dennard 5879
Sr. HSP Spec.
007 48477 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Olivencia 5864
HSP Rec. Analyst
003 47262 1.0
Management Analyst
13-1111-1

36 5294
Reg. Nurse Spec.
008 59287 1.0
Registered Nurse
29-1111-2

36 0108
Admin. Secretary
001 21592 1.0
Exe. Sec. & Admin. Asst.
43-6011-2

36 Acevedo 5877
HSP Spec.
007 63578 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Chillari 5875
Med./Hlth. Care Prog. Anal.
010 48404 1.0
Management Analyst
13-1111-4

36 Gomes 5879
Sr. HSP Spec.
007 53500 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Martinez 5875
Med./Hlth. Care Prog. Anal.
010 63564 1.0
Management Analyst
13-1111-4

36 Medrano 0108
Admin. Secretary
001 37829 1.0
Exe. Sec. & Admin. Asst.
43-6011-2

36 Bryan 5879
Sr. HSP Spec.
007 53468 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 5877
HSP Spec.
007 48478 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Martinez 5879
Sr. HSP Spec.
007 64269 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

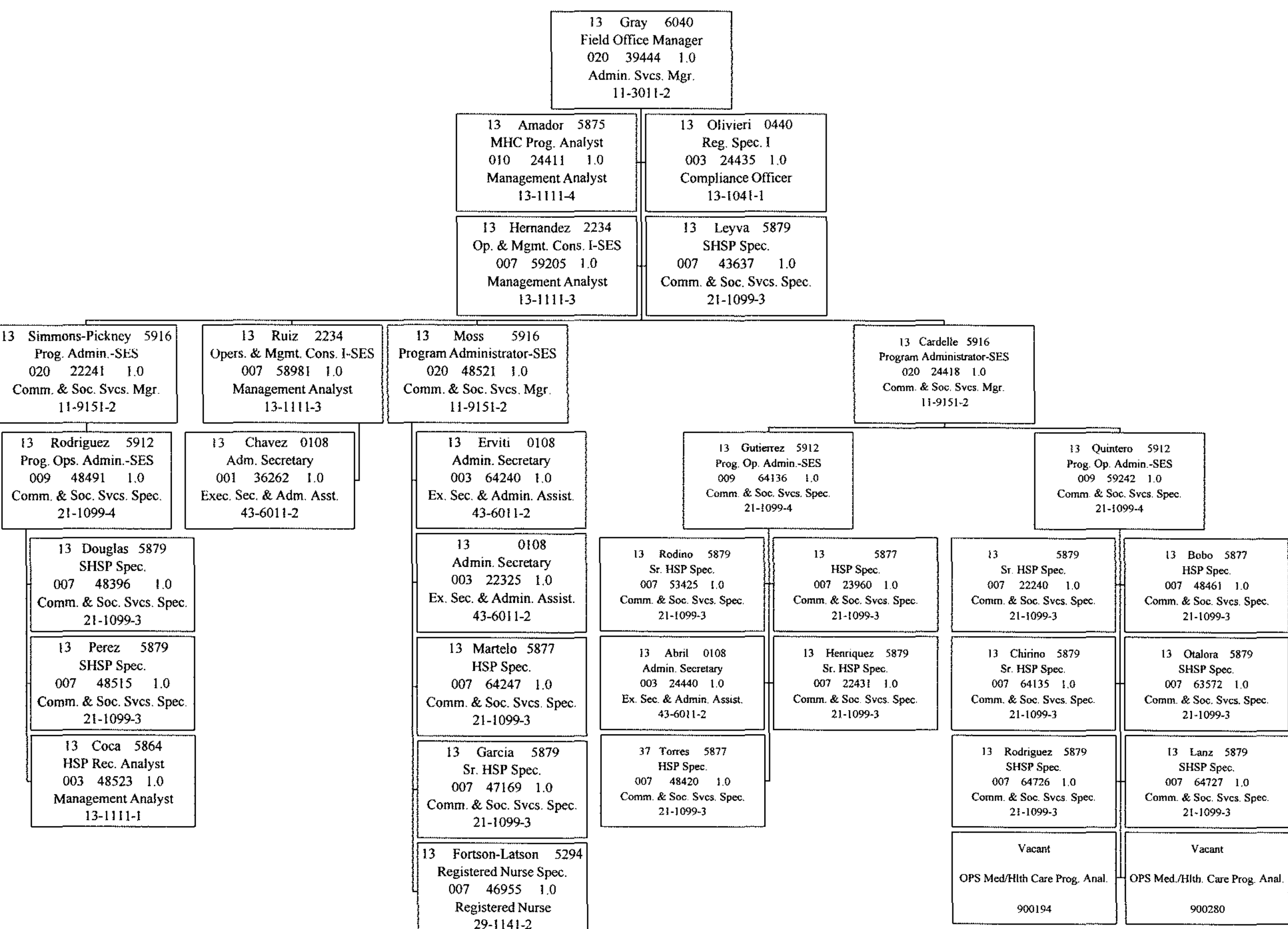
36 Bryson 5879
Sr. HSP Spec.
007 53469 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 5877
HSP Spec.
007 48475 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

36 Bryan 5879
Sr. HSP Spec.
007 63568 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Divison of Medicaid
Bureau of Medicaid Recipient and Provider Assistance - Miami

Effective Date: July 1, 2015
Org. Level: 68-40-10-11-000
FTEs: 28 Positions: 28



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Data Analytics

Effective Date: July 1, 2015
Org Level: 68-40-40-00-000
FTE: 28 Positions: 28

37 Chang 8861
Chief of Medicaid Data Analytics
021 39495 1.0
Financial Manager
11-3031-3

37 Bouteiller 5875
MHCP Analyst
010 24095 1.0
Management Analysts
13-1111-4

37 Simmons 0120
Staff Assistant
003 19476 1.0
Ex. Sec. & Admin. Asst.
43-6011-2

Buckingham
OPS Research Assistant
900323

37 Walker 0108
Administrative Secretary
003 00252 1.0
Ex. Sec. & Admin. Asst.
43-6011-2

Business Intelligence

37 Reid 3221
Economist Supervisor-SES
011 46114 1.0
Economists
19-3011-4

37 Tillery 3215
Economic Analyst
008 00142 1.0
Economists
19-3011-3

37 Lopez 2250
Sr. Mgmt. Anal. II-SES
020 64703 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

Holden
OPS Research Assistant
900133

37 Churchill 2122
Sr. Data Base Analyst
009 64228 1.0
Database Admin.
15-1061-4

Maynard
OPS Research Assistant
900119

Data Solutions

37 Shi 2127
Data Base Admin.-SES
020 48409 1.0
Comp. & Info. Sys. Mgr.
11-3021-2

37 5875
MHCP Analyst
010 64827 1.0
Management Analyst
13-1111-4

37 Ying 2225
Gov. Analyst II
010 64705 1.0
Management Analyst
13-1111-4

37 Baugh 2225
Sr. Mgmt. Analyst II-SES
010 56425 1.0
Management Analysts
13-1111-04

37 Starn 2122
Sr. Data Base Analyst
009 64842 1.0
Database Admin.
15-1061-4

37 Shah 2122
Sr. Data Base Analyst
009 64475 1.0
Database Admin.
15-1061-4

37 2122
Sr. Data Base Analyst
009 40795 1.0
Database Admin.
15-1061-4

37 Hinton 2107
Systems Project Analyst
008 40635 1.0
Computer Systems Analyst
15-1051-3

37 Malison 2109
Systems Project Consultant
009 64707 1.0
Computer Systems Analyst
15-1051-04

37 Oneal 2107
Systems Project Analyst
008 48411 1.0
Computer Systems Analyst
15-1051-3

37 Lawrence 2238
Gov. Oper. Consult. III
008 64473 1.0
Management Analysts
13-1111-04

Vacant
OPS Research Assistant
900307

Federal Reporting & Focused Studies

37 Bosque 2228
Sr. Mgmt. Analyst Sup.-SES
010 64151 1.0
Management Analyst
13-1111-4

37 Collins 2225
Gov. Analyst II
010 64813 1.0
Management Analyst
13-1111-4

37 Rhodes 2122
Sr. Data Base Analyst
009 64839 1.0
Database Admin.
15-1061-4

37 Rhodes 2107
Systems Project Analyst
008 61963 1.0
Computer Systems Analyst
15-1051-3

37 3215
Economic Analyst
008 64841 1.0
Economists
19-3011-3

37 Rhodes 2122
Sr. Data Base Analyst
009 64256 1.0
Database Admin.
15-1061-4

Actuarial Services

37 3221
Economist Supervisor-SES
011 61955 1.0
Economists
19-3011-4

37 Duguid 8701
Senior Acturial Analyst
012 64716 1.0
Actuaries
15-2011-4

37 Lui 2122
Sr. Data Base Analyst
009 64839 1.0
Database Admin.
15-1061-4

37 Duguid 6701
Sr. Acturial Analyst
010 64716 1.0
Acturaries
15-2011-4

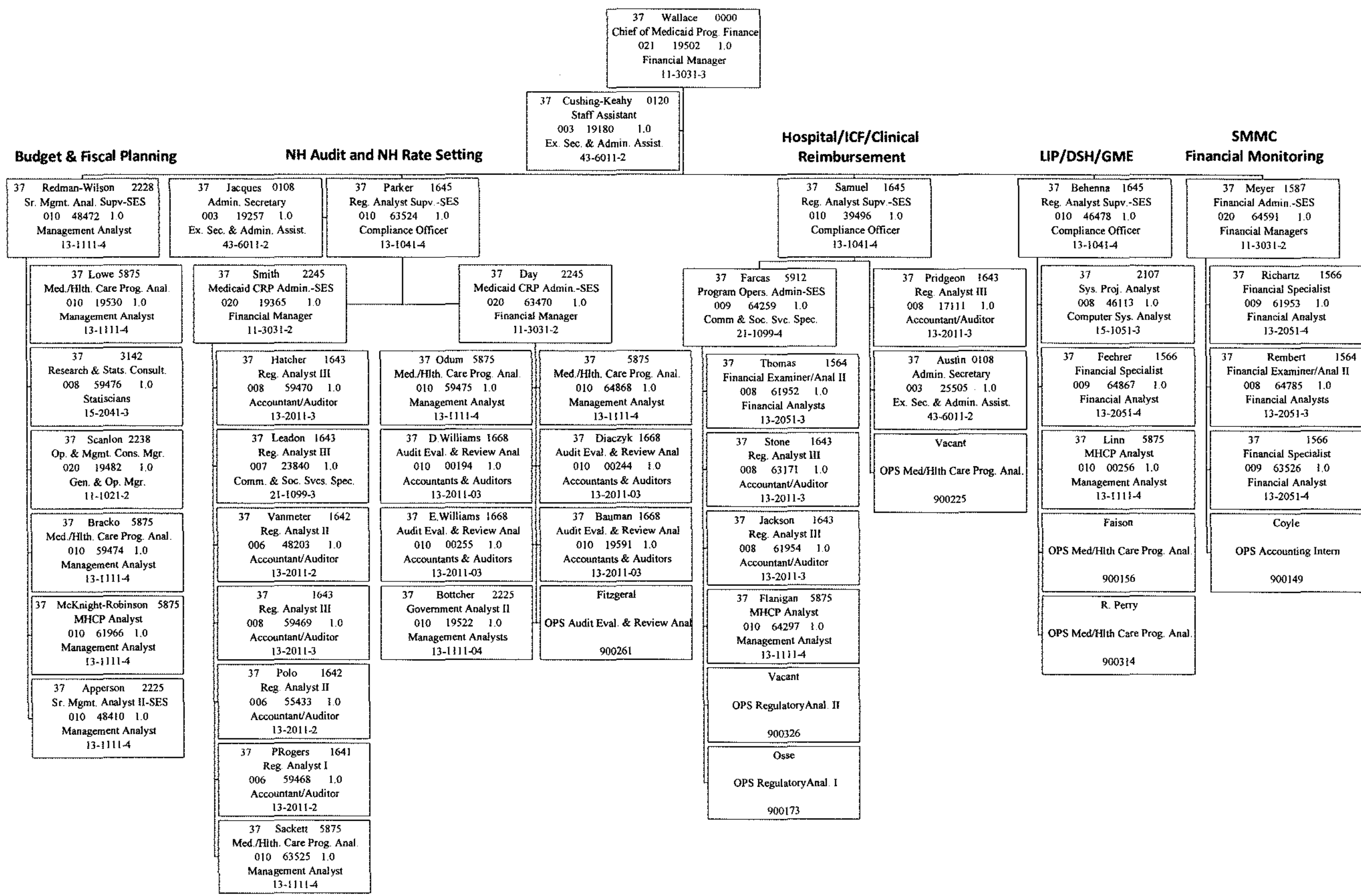
37 Pace 3142
Research & Stats. Consult
008 19523 1.0
Statisticians
15-2041-3

Vacant
OPS Actuarial Intern
900324

D-4

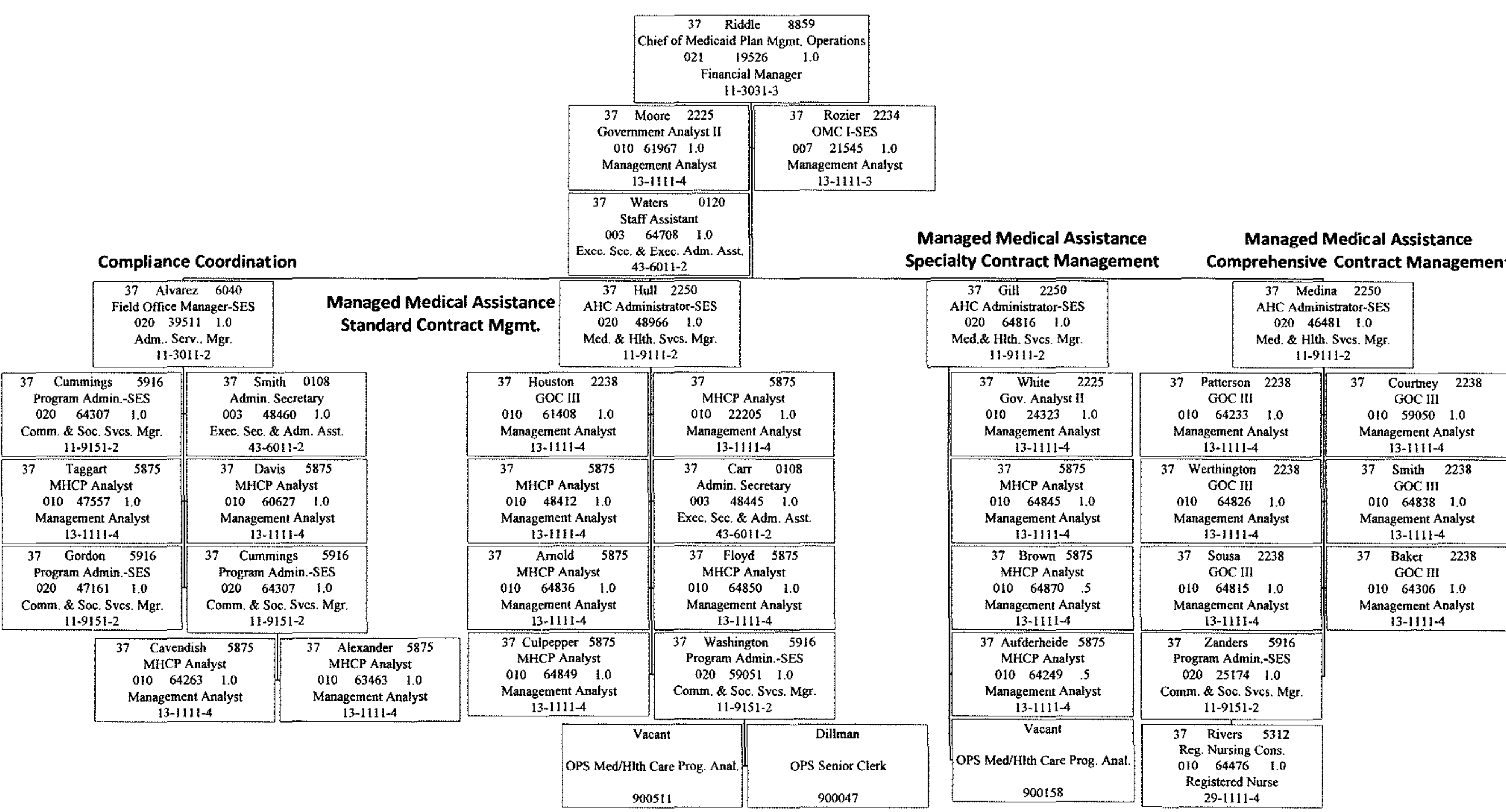
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Program Finance

Effective Date: July 1, 2015
Org. Level: 68-40-50-00-000
FTEs: 43 Positions: 43



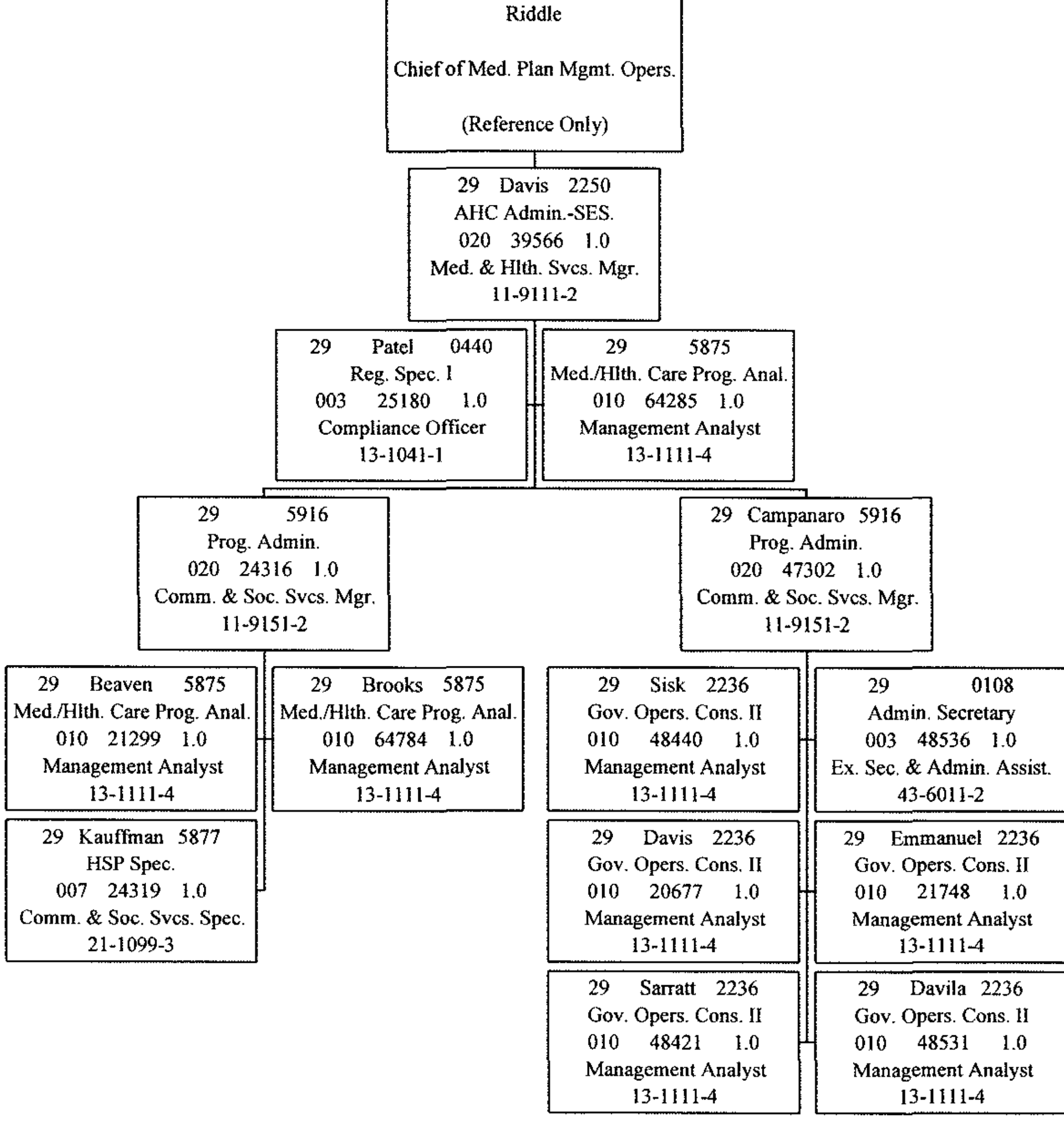
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Plan Management Operations

Effective Date: July 1, 2015
Org. Level: 68-40-30-00-000
FTEs: 33 Positions: 34



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Plan Management Operations - Tampa

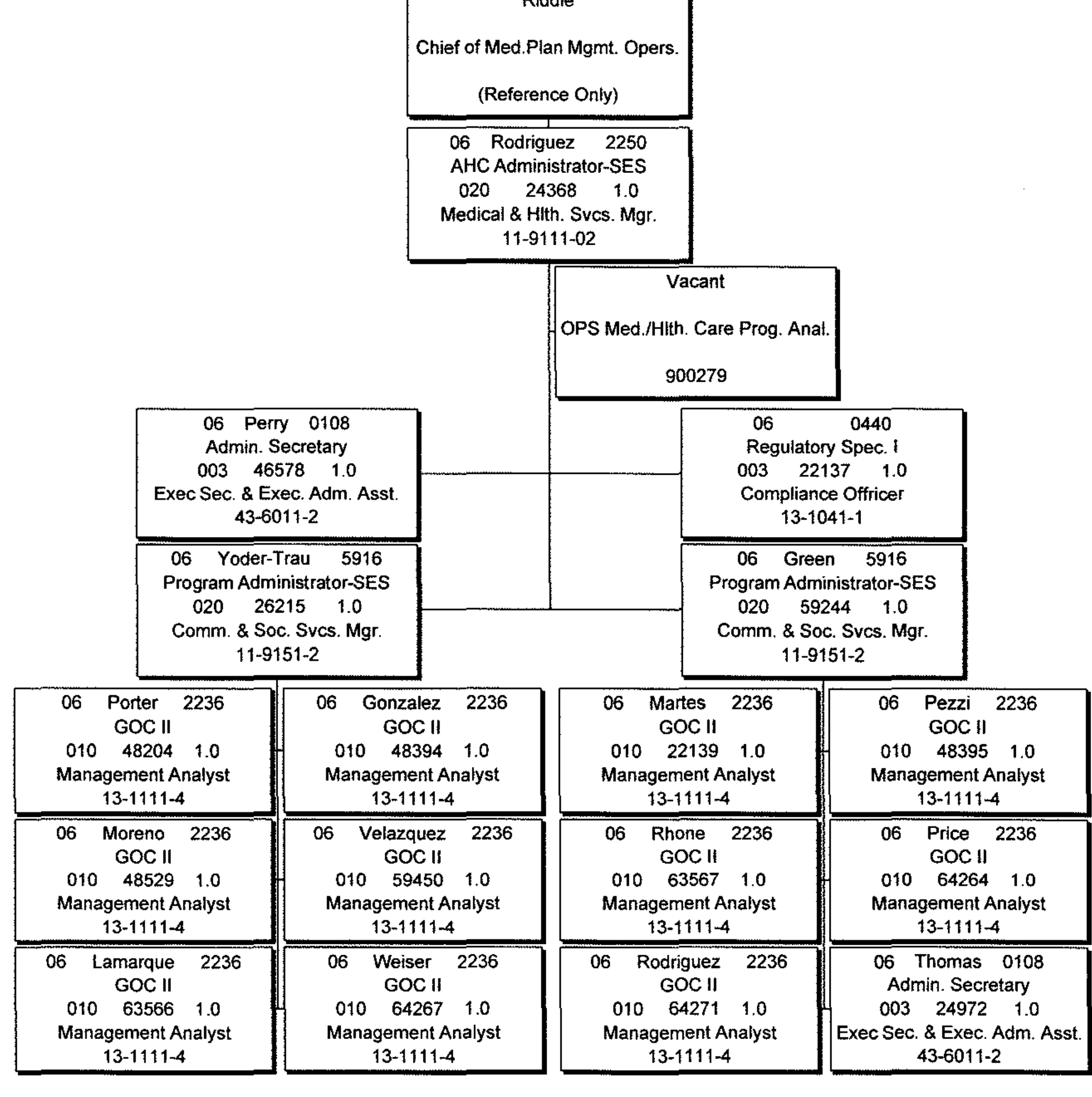
Effective Date: July 1, 2015
Org. Level: 68-40-30-06-000
FTEs: 14 Positions: 14



D-6-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Plan Management Operations - Ft. Lauderdale

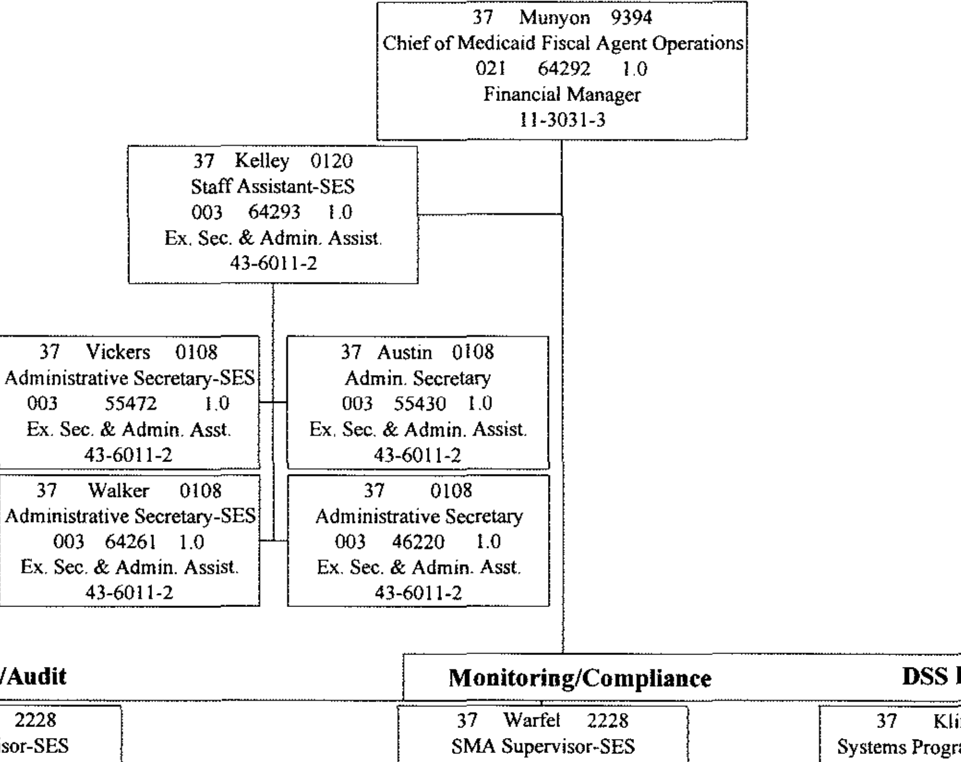
Org Level: 68-40-30-10-000
Effective Date: July 1, 2015
FTEs: 17 Positions: 17



D-6-2

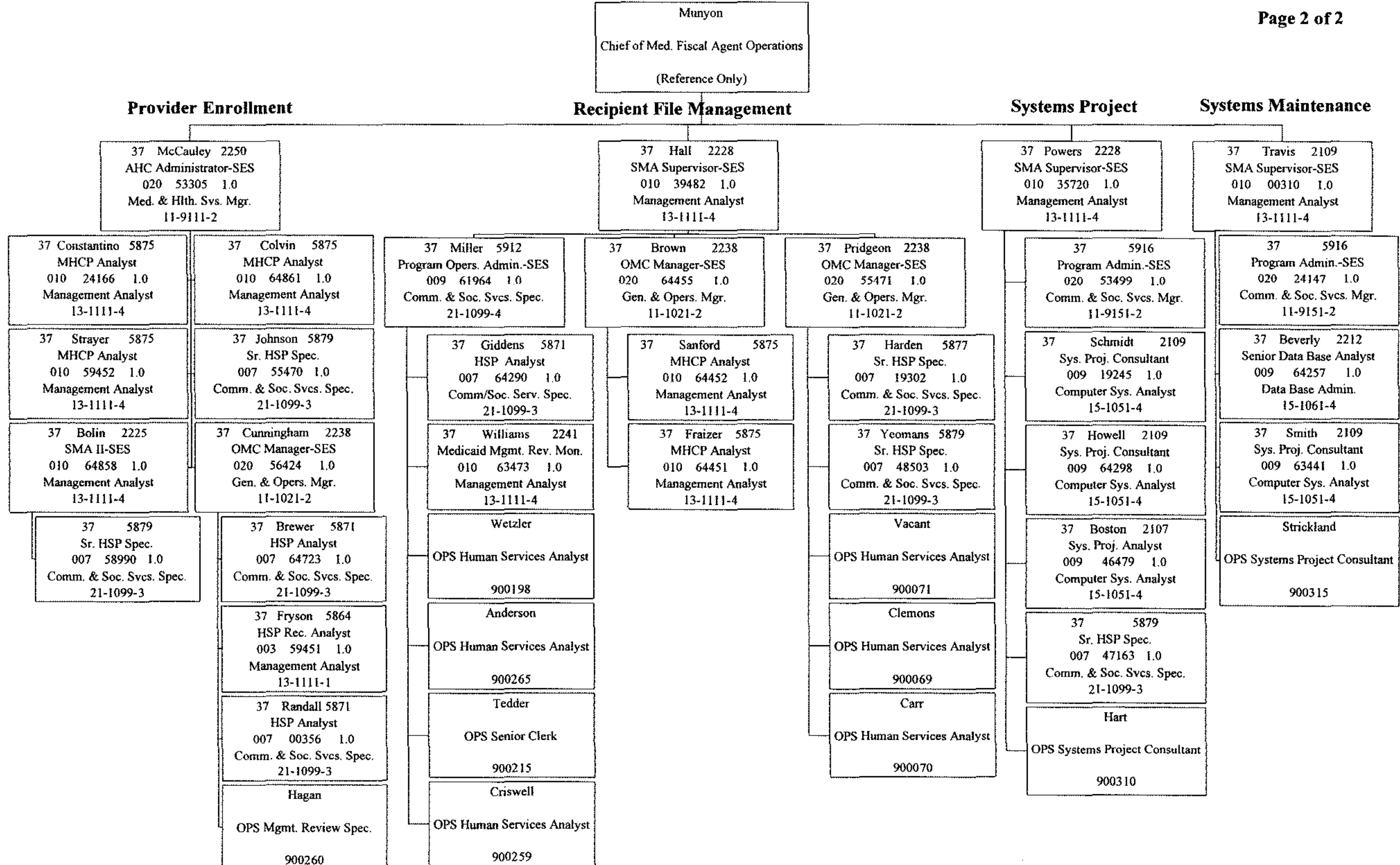
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Fiscal Agent Operations

Effective Date: July 1, 2015
Org. Level: 68-40-70-00-000
FTEs: 52 Positions: 52



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Fiscal Agent Operations

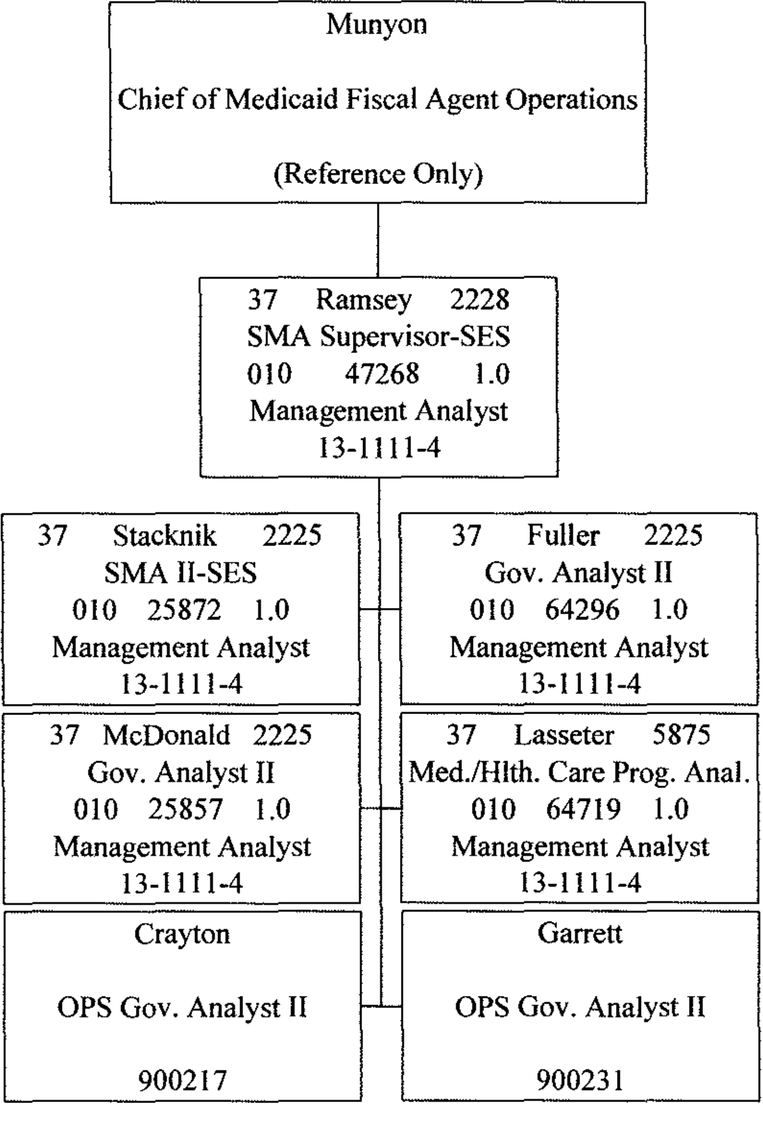
Revised Date: July 1, 2015
Org. Level: 68-40-70-00-000
FTEs: 52 Positions: 52



D-7-1

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Fiscal Agent Operations - Procurement

Effective Date: July 1, 2015
Org. Level: 68-40-70-15-000
FTEs: 5 Positions: 5



AGENCY FOR HEALTH CARE ADMINISTRATION
Bureau of Medicaid Policy

Effective Date: July 1, 2015
Org. Level: 68-40-60-00-000
FTEs: 65 Positions: 65

37 Harris 8863
Chief of Medicaid Policy
021 19298 1.0
Financial Managers
11-3031-3

37 Campbell 2234
OMC I-SES
007 64260 1.0
Management Analyst
13-1111-3

37 Reeves 2225
Government Analyst II
010 59323 1.0
Management Analyst
13-1111-4

Rules & Bills Analysis Coordination

37 Carter-Jones 2225
Sr. Mgmt. Analyst II-SES
010 64288 1.0
Management Analyst
13-1111-4

37 Warmka 2238
GOC III
010 19512 1.0
Management Analyst
13-1111-4

37 Hamrick 2238
GOC III
010 46253 1.0
Management Analyst
13-1111-4

37 2238
GOC III
020 55434 1.0
Gen. & Opers. Mgrs.
11-1021-2

Senesac
OPS Physical Therapy Consult.
900311

Scott
OPS Speech Pathologist
900193

Vacant
OPS Speech Therapist
900313

Vacant
OPS Med/Hlth Care Prog Analyst
900233

McFadden-Russ
OPS Administrative Secretary
900222

Federal Authorities

37 MacDonald 2250
AHC Administrator-SES
020 59049 1.0
Med. & Hlth. Svcs. Mgrs.
11-9111-2

37 Young 2225
Government Analyst II
010 64592 1.0
Management Analyst
13-1111-4

37 Cook 2225
Government Analyst II
010 64810 1.0
Management Analyst
13-1111-4

37 Morrison 2225
Government Analyst II
010 64846 1.0
Management Analyst
13-1111-4

37 Austin 2238
GOC III
010 59502 1.0
Management Analyst
13-1111-4

Vacant
OPS Med/Hlth Care Prog Analyst
900234

Vacant
OPS Administrative Secretary
900201

Warner
OPS Med./Hlth. Care Prog. Anal.
900285

37 Storey 5916
Program Administrator-SES
020 64277 1.0
Comm. & Soc. Svcs. Mgrs.
11-9151-2

37 Hardcastle 5875
Med/Hlth Care Prog Analyst
010 57052 1.0
Management Analyst
13-1111-4

37 Jefferson 5875
Med/Hlth Care Prog Analyst
010 64192 1.0
Management Analyst
13-1111-4

37 Orr 5875
Med/Hlth Care Prog Analyst
010 64843 1.0
Management Analyst
13-1111-4

37 Yon 5875
Med/Hlth Care Prog Analyst
010 46957 1.0
Management Analyst
13-1111-4

37 Rawlins 5875
Med/Hlth Care Prog Analyst
010 64852 1.0
Management Analyst
13-1111-4

Stinson
OPS Med/Hlth Care Prog Analyst
900129

Vacant
OPS Med/Hlth Care Prog Analyst
900283

Managed Care Policy & Contracts

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

37 Dorceus 5875
Med/Hlth Care Prog Analyst
010 64853 1.0
Management Analyst
13-1111-4

Swingle
OPS Med/Hlth Care Prog Analyst
900142

37 Simmons 0108
Administrative Secretary
003 19525 1.0
Exec. Sec. & Admin. Asst.
43-6011-2

37 Jones 2238
GOC III
010 21778 1.0
Management Analyst
13-1111-4

37 Whaley 5916
Program Administrator-SES
020 24162 1.0
Comm. & Soc. Svcs. Mgrs.
11-9151-2

37 Davis 5875
Med/Hlth Care Prog Analyst
010 19532 1.0
Management Analyst
13-1111-4

37 Raborn 5875
Med/Hlth Care Prog Analyst
010 63528 1.0
Management Analyst
13-1111-4

37 Rinaldi 5875
Med/Hlth Care Prog Analyst
010 64274 1.0
Management Analyst
13-1111-4

37 Clarke 5875
Med/Hlth Care Prog Analyst
010 64828 1.0
Management Analyst
13-1111-4

AGENCY FOR HEALTH CARE ADMINISTRATION
Bureau of Medicaid Policy

Effective Date: July 1, 2015
Org. Level: 68-40-60-00-000
FTEs: 65 Positions: 65

Harris
Chief of Medicaid Policy
(Reference Only)

Medical & Behavioral Health Care Policy

37 Floyd-Thomas 2250
AHC Administrator-SES
020 39484 1.0
Med. & Hlth. Svcs. Mgrs.
11-9111-2

37 Richardson 5877
Hum.Svcs.Prog.Spec.
007 59460 1.0
Comm./Soc.Serv.Spec./All Other
21-1099-2

37 Glaze 0108
Administrative Secretary
003 24021 1.0
Exec. Sec. & Admin. Asst.
43-6011-2

37 Reddick 5916
Program Administrator-SES
020 19394 1.0
Comm. & Soc. Svcs. Mgrs.
11-9151-2

37 Gabric 2238
GOC III
010 59503 1.0
Management Analyst
13-1111-4

37 5312
Registered Nursing Consultant
010 59504 1.0
Registered Nurses
29-1111-4

37 Anthony-Davis 5312
Registered Nursing Consultant
010 63527 1.0
Registered Nurses
29-1111-4

37 Smith 5875
Med/Hlth Care Prog. Analyst
010 19470 1.0
Management Analyst
13-1111-4

37 Cascio 5875
Med/Hlth Care Prog. Analyst
010 24167 1.0
Management Analyst
13-1111-4

Steward
OPS Med/Hlth Care Prog Analyst
900196

37 Eddleman 5916
Program Administrator-SES
020 56423 1.0
Comm. & Soc. Svcs. Mgrs.
11-9151-2

37 Allman 2238
GOC III
010 46732 1.0
Management Analyst
13-1111-4

37 Toussaint 2238
GOC III
010 64255 1.0
Management Analyst
13-1111-4

37 Trull 5875
Med/Hlth Care Prog. Analyst
010 64851 1.0
Management Analyst
13-1111-4

37 Thompson 5875
Med/Hlth Care Prog. Analyst
010 64844 1.0
Management Analyst
13-1111-4

Vacant
OPS Med/Hlth Care Prog Analyst
900209

Vacant
OPS Med./Hlth. Care Prog. Anal.
900287

37 Johnson 5916
Program Administrator-SES
020 59463 1.0
Comm. & Soc. Svcs. Mgrs.
11-9151-2

37 Kumar 5312
Registered Nursing Consultant
010 19531 1.0
Registered Nurses
29-1111-4

37 Core 5312
Registered Nursing Consultant
010 64814 1.0
Registered Nurses
29-1111-4

37 Reifinger 2238
GOC III
010 39485 1.0
Management Analyst
13-1111-4

Vacant
OPS Dental Consultant
900252

Boyle
OPS Physician
900178

Jones
OPS Senior Physician
900052

Klein
OPS Seniior Physician
900063

37 Cofer 5312
Registered Nursing Consultant
010 59462 1.0
Registered Nurses
29-1111-4

37 5875
Med/Hlth Care Prog. Analyst
010 25870 1.0
Management Analyst
13-1111-4

37 Davis 5875
Med/Hlth Care Prog. Analyst
010 59466 1.0
Management Analyst
13-1111-4

Fifer
OPS Physician
900064

Deeb
OPS Senior Physician
900051

Sheppard
OPS Senior Physican
900054

Program Policy

37 McCullough 2250
AHC Administrator-SES
020 20476 1.0
Med. & Hlth. Svcs. Mgrs.
11-9111-2

37 Cobb 5312
Registered Nursing Consultant
010 48467 1.0
Registered Nurses
29-1111-4

37 Risech 5875
Med/Hlth Care Prog. Analyst
010 59460 1.0
Management Analyst
13-1111-4

Vacant
OPS Senior Mgmt. Analyst II
900065

37 Scorsone 2238
GOC III
020 59478 1.0
Management Analyst
13-1111-4

Vacant
OPS Med/Hlth Care Prog Analyst
900050

37 Aldridge 2225
Government Analyst II
010 64783 1.0
Managemennt Analyst
13-1111-4

37 Kimball 0108
Administrative Secretary-SES
003 21558 1.0
Management Analyst
13-1111-4

Vacant
OPS Senior Mgmt. Analyst II
900303

37 Hansen 5916
Program Administrator-SES
020 64371 1.0
Comm. & Soc. Svcs. Mgrs.
11-9151-2

37 Sanchez 5875
Med/Hlth Care Prog Analyst
010 64372 1.0
Management Analyst
13-1111-4

37 Wiggins 5875
Med/Hlth Care Prog Analyst
010 64192 1.0
Management Analyst
13-1111-4

37 Clayton 5875
Med/Hlth Care Prog Analyst
010 64456 1.0
Management Analyst
13-1111-4

Pharmacy Policy

37 Elliott 2250
AHC Administrator
020 19357 1.0
Med. & Hlth. Svcs. Mgrs.
11-9111-2

37 Holcomb 2225
Government Analyst II
010 61968 1.0
Managemennt Analyst
13-1111-4

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

37 Craig 5248
Senior Pharmacist
011 61947 1.0
Pharmacist
29-1051-5

37 Hamilton 2225
Government Analyst II
010 64811 1.0
Managemennt Analyst
13-1111-4

37 Freeman 5879
Senior Hum.Svcs.Prog.Spec.
007 64289 1.0
Comm./Soc.Serv.Spec.
21-1099-2

S. Williams
OPS Health Care Practitioner
900076

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Quality

Effective Date: July 1, 2015
Org Level: 68-40-80-00-000
FTE: 42.5 Positions: 43

37 Donnelly 8951
Chief of Medicaid Quality
021 64589 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-3

37 Allen 0120
Staff Assistant
003 48500 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

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

Clinical Consultation/ Compliance Management

37 Barr-Platt 2250
AHCA Administrator-SES
020 64212 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

37 McGillen 5875
Med./Hlth. Care Prog. Anal.
010 24120 1.0
Management Analyst
13-1111-4

37 Scanlon 5875
Med./Hlth. Care Prog. Anal.
010 61383 1.0
Management Analyst
13-1111-4

37 Harkness 5875
Med./Hlth. Care Prog. Anal.
010 64219 1.0
Management Analyst
13-1111-4

37 Grace 5916
Program Administrator-SES
020 40631 1.0
Comm.&Soc.Serv.Mgrs.
11-9151-2

37 McIntire 5312
Reg. Nursing Cons.
008 46956 1.0
Registered Nurse
29-1111-4

37 Calhoun 5312
Reg. Nursing Cons.
008 64215 1.0
Registered Nurse
29-1111-4

37 Wilson 5312
Reg. Nursing Cons.
008 64446 1.0
Registered Nurse
29-1111-4

Medicaid Clinical Quality Review

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

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

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

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

37 Svec 2225
Government Analyst II
010 64573 1.0
Management Analyst
13-1111-4

Vacant
OPS Senior Pharmacist
900073

Thompson
OPS Senior Pharmacist
900174

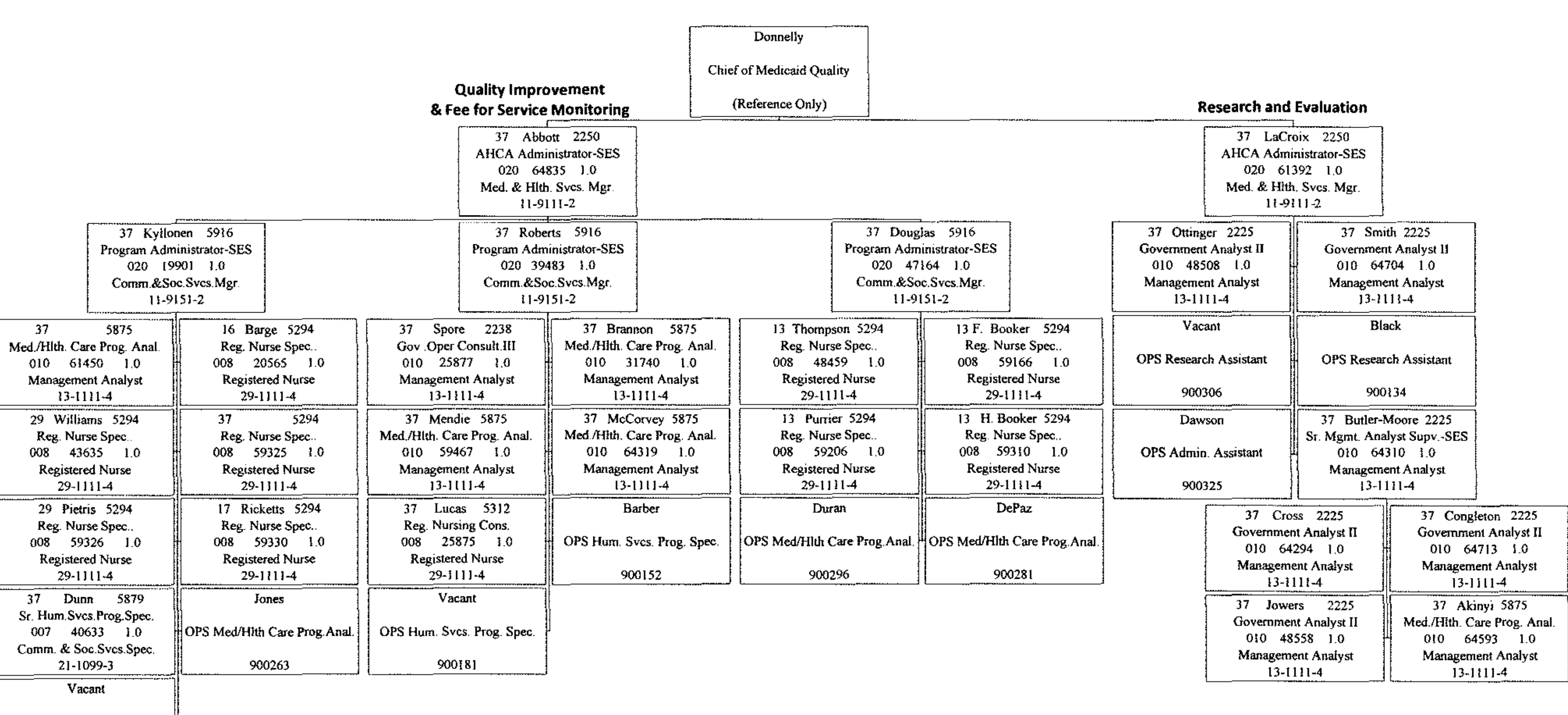
Boylen
OPS Senior Pharmacist
900175

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

Vacant
OPS Gov't Analyst II
900177

AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Quality

Effective Date: July 1, 2015
Org Level: 68-40-80-00-000
FTE: 42.5 Positions: 43



AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET	FISCAL YEAR 2014-15 OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	24,586,090,660	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)	-801,987,032	0
FINAL BUDGET FOR AGENCY	23,784,103,628	0

SECTION II: ACTIVITIES * MEASURES	Number of Units	(1) Unit Cost	(2) Expenditures (Allocated)	(3) FCO
Executive Direction, Administrative Support and Information Technology (2)				0
Prepaid Health Plans - Elderly And Disabled *	559,662	11,354.41	6,354,629,830	
Prepaid Health Plans - Families *	2,794,530	1,608.94	4,496,228,322	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	64,612	4,907.77	317,100,789	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	88,365	4,326.45	382,307,174	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased	151,484	1,779.35	269,542,737	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	151,484	734.42	111,253,019	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	769,476	1,435.86	1,104,860,719	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	28,166	536.10	15,099,734	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased	151,484	74.33	11,259,723	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased	708,819	59.55	42,207,045	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased	64,612	272.53	17,608,707	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased	86,872	615.30	53,452,401	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	7	4,278,598.14	29,950,187	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased	131,545	451.70	59,419,004	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	64,612	8,764.33	566,280,917	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	356,875	724.34	258,497,182	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	390,597	298.99	116,785,689	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased	356,875	6.54	2,332,607	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	356,875	423.11	150,997,016	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	1,187	170,091.67	201,898,814	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	232,794	95.46	22,222,917	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased	257,722	37.54	9,674,143	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased	2,569,846	0.22	553,841	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased	356,875	78.16	27,893,231	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased	356,875	85.76	30,604,779	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	242,623	562.59	136,497,689	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	26,647	1,754.82	46,760,733	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	26,647	1,917.55	51,097,032	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	32,231	2.19	70,685	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	32,231	658.79	21,233,617	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	3,331	2,050.64	6,830,669	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	32,231	12.63	407,063	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	32,231	2.53	81,417	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	26,647	17.44	464,794	
Medically Needy - Other * Number of case months Medicaid program services purchased	26,647	82,777.45	2,205,770,610	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	6,129	49.53	303,583	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	6,129	74,441.23	456,250,287	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	6,129	30.19	185,026	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	33	220.97	7,292	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	6,129	1.02	6,234	
Refugees - Case Management * Number of case months Medicaid program services purchased	14,131	1.15	16,274	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	6,129	5.16	31,631	
Refugees - Other * Number of case months Medicaid program services purchased	6,129	43.52	266,760	
Nursing Home Care * Number of case months Medicaid program services purchased	45,644	64,611.27	2,949,116,769	
Home And Community Based Services * Number of case months Medicaid program services purchased	39,629	29,356.91	1,163,384,977	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program services purchased	680	491,299.00	334,083,317	
Purchase Medikids Program Services * Number of case months Medicaid Program services purchased	29,492	1,837.10	54,179,609	
Purchase Children's Medical Services Network Services * Number of case months	13,108	8,273.48	108,448,776	
Purchase Florida Healthy Kids Corporation Services * Number of case months	148,689	1,741.62	258,960,089	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	3,356	537.52	1,803,913	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification applications	44,355	333.52	14,793,244	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations	43,006	1,109.60	47,719,596	
Health Standards And Quality * Number of transactions	2,976,087	1.22	3,617,943	
Plans And Construction * Number of reviews performed	4,599	1,372.99	6,314,375	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys	182	6,425.75	1,169,486	
Background Screening * Number of requests for screenings	255,833	3.61	922,562	
Subscriber Assistance Panel * Number of cases	238	1,637.94	389,828	
TOTAL			22,523,846,407	

SECTION III: RECONCILIATION TO BUDGET		
PASS THROUGHS		
TRANSFER - STATE AGENCIES		
AID TO LOCAL GOVERNMENTS		
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS		
OTHER	1,099,164,352	
REVERSIONS	161,092,956	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	23,784,103,715	

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.

Agency for Health Care Administration

Legislative Budget Request

Administration and Support Schedules

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS **Budget Period: 2016-17 FY**

Department: Agency for Health Care Administration **Chief Internal Auditor:** Mary Beth Sheffield

Budget Entity: Inspector General/Internal Audit **Phone Number:** (850) 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 2014-15					
14-17	**7/2013 to 5/2014**	**Review of TLO**	**Finding 1** User Access. The Fraud Prevention and Control Unit (FPCU) does not have a documented process for adding and deleting TLO (a data aggregator service) users.		
			Recommendation 1. FPCU should develop written procedures to address user access and termination requests, and distribute them to identified parties. All requests should be documented in writing.	1. Completed. Medicaid FPCU amended its policy to read as follows: "User access and termination must be submitted in writing (via email) by the unit manager to the Account Manager. If the user anticipates being out of the office in excess of ten business days, he/she should notify the unit manager so that accounts can be managed appropriately. A file of all requests must be maintained for no less than five years."	
			2. The Account Administrator should maintain written documentation for no less than five years for each TLO addition or termination.	2. Completed. A shared drive folder for TLO has been created to store administrative items and it will be maintained consistent with Agency record retention requirements.	
			Finding 2 Confidentiality and Security. FPCU may not be complying with the Driver's Privacy Protection Act (DPPA) and related state laws.		
			Recommendation 1. FPCU should develop written procedures to ensure TLO users and any associated personnel understand the confidentiality/security of data obtained from TLO. These procedures should also address the consistent and secure storage of TLO related information.	1. Completed. The TLO user protocol was amended in June to include protocols for securing query results.	
			2. FPCU should develop and implement a Confidentiality Acknowledgement form for all TLO users to sign when given access. These forms should be in a central file maintained by the Account Administrator for documentation purposes.	2. Completed. FPCU no longer exist. As part of the reorganization of the Division of Medicaid, the staff who were using TLO have been moved to the Bureau of Medicaid Fiscal Agent Operations. They continue to use TLO. All current users have signed user agreement protocols which are on file and available for review upon request. In addition, the current TLO contract expires in April 2015 and Medicaid will not be renewing it. The Bureau of Medicaid Program Integrity (MPI) will hold the contract, and Medicaid will pay for the portion of the contract proportional to its number of users.	
			Finding 3 Use of TLO Software. Some users do not use TLO on a routine basis.		
			Recommendation 1. The Unit Supervisor should periodically monitor TLO usage reports and determine how many licenses are necessary to perform the intended function.	1. Completed. A quarterly review of the TLO usage logs indicates the current number of licenses and TLO usage is appropriate and cost effective. Copies of utilization logs are available for review upon request. In addition, the current TLO contract expires in April 2015 and Medicaid will not be renewing it. Any further use of this tool will be done through agreement with MPI in compliance with any currently written MPI protocols for the use of said tools.	
			2. FPCU should develop written procedures to address the Unit Supervisor's periodic monitoring of staff TLO usage.	2. Completed. The protocols for reviewing and monitoring staff's usage have been drafted.	
			Finding 4 Maintaining Documentation Support and Conducting Reviews. The FPCU does not have adequate internal controls to ensure TLO is used for identified purposes and that there is no misuse of information.		
			Recommendation 1. FPCU should develop written procedures to address TLO use. The procedures should also require TLO users to document the reason(s) for each search; for example, reference number, reason for search and the name of requestor.	1. Completed. The user protocol has been amended and a formal tracking log template created along with a document explaining how to track usage, further elaborating on usage and describing the protocol for review of usage.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			2. FPCU should ensure reviews of TLO searches are performed by an independent person on a quarterly basis. All reviews should be documented and maintained for no less than five years.	2. Completed. TLO searches are reviewed periodically by the contract manager to ensure compliance with currently written and approved protocols; however Medicaid will not be renewing this contract after it expires in April.	
			3. FPCU should develop written desk procedures for quarterly usage reviews.	3. Completed. The procedure for conducting the reviews has been documented.	
			4. Overall Recommendation: FPCU should ensure all staff are trained in the proper use of TLO, maintaining documentation of searches and any other procedures addressed in this report.	4. Completed. Staff training has been conducted and will be a routine (at least annually) topic for training.	
15-18	**Report Date 5/2015**	**Pre-Admission Screening and Resident Review Process**	**Findings** The Department of Elder Affairs (DOEA) is claiming cost reimbursement at the enhanced 75 percent rate for both Pre-Admission Screening and Resident Review Process (PASRR) and non-PASRR related activities [i.e. Level of Care (LOC) assessments and determinations for individuals seeking services in the community.] The Cooperative Agreement between the Agency for Healthcare Administration (AHCA) and DOEA does not require DOEA to submit an annual budget to AHCA. AHCA did not adequately monitor DOEA's claiming of administrative and program costs, which allowed non-PASRR-related costs to be reimbursed to DOEA at the 75 percent rate. The total cost for direct services claimed at the 75 percent rate on the invoice is used for reporting Pre-admission Screening expenditures on the Federal CMS-64 Quarterly Expense Report. However, costs for PASRR-related activities are not specifically identified on the DOEA CARES invoice. The invoice is for Medicaid Administration and does not separately list PASRR and non-PASRR-related activities. There is not a comprehensive interagency agreement that addresses current PASRR requirements and funding. The Cooperative Agreement has not been updated since 2008 and does not reference the Interagency PASRR Agreement. Not all of AHCA's PASRR-related activities are claimed at the 75 percent enhanced Federal Financial Participation (FFP) rate.		
			Recommendation We recommend that AHCA review DOEA's proposed cost allocation methodology to ensure it identifies CARES PASRR and non-PASRR-related activities that qualify for different FFP funding rates and submit the approved plan to the United States (U.S.) Department of Health and Human Services (HHS) for federal approval.	The AHCA Bureau of Medicaid Policy has worked with the DOEA CARES representatives to establish an updated cost allocation plan (CAP) to ensure that activities related to PASRR and non-PASRR work are correctly identified, and AHCA has approved this CAP. AHCA plans to submit the updated CAP to the federal Department of Health and Human Services, Division of Cost Allocation (DCA.)	
			We recommend that AHCA update its Cooperative Agreement with DOEA to: • Include the approved CARES' cost allocation methodology which identifies CARES PASRR and non-PASRR activities; • Require submission of an annual budget (Exhibit "A") that includes the total agreement amount and that is consistent with DOEA's CAP; • Require invoices to identify PASRR-related activities consistent with the approved cost allocation methodology and for claiming on the HHS Centers for Medicare and Medicaid Services (CMS) 64 form; and • Clearly address the monitoring and oversight responsibilities of AHCA in its predominant fiduciary duties related to Medicaid funding and the avoidance of payments for unallowable activities.	AHCA has developed, and is close to execution of, an updated memorandum of understanding that includes the information listed.	
			We recommend that AHCA consider combining the Cooperative Agreement and the Interagency PASRR Agreement and update such consolidated agreement as necessary to provide a comprehensive agreement that addresses all current responsibilities of each state agency concerning the administration of the CARES program.	AHCA has undertaken a project to compile all interagency agreements into one for each state agency. The comprehensive agreement with DOEA is underway.	

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CIG 2014-01	**FY10-11- FY11-12**	**Assessment of Managed Care Anti-Fraud Plans**	**Finding 1** Managed Care Organization (MCO)s report significantly low recovery rates for overpayments identified as fraud and abuse.		
			Recommendation We recommend MPI propose statutory and contractual language that will require MCOs to review a period beyond one year when conducting preliminary reviews of fraud, abuse, and overpayments.	Completed. Section 641.3155, F.S., limits an MCO's recoveries to "within 30 months after the health maintenance organization's payment of the claim. . . [and] all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. . . except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234." This statutory restriction on otherwise recoverable overpayments is a disincentive for MCOs to review a period beyond one year when conducting preliminary reviews of fraud, abuse, and overpayments. MPI drafted proposed statutory language to address this disincentive and furnished the language to the Agency's Inspector General for review and approval in 2014. The proposal served to amend s. 641.3155, Florida Statutes, and create an exception to the statutory limitations (on overpayment recover) for Medicaid MCOs. The approved language is being submitted to the Agency's Legislative Affairs Office for consideration at the next regular session of the Florida Legislature. Ultimately, however, the Agency does not control the statute amendment process and is dependent upon the Legislature to agree with and process any statutory changes. Such recommended language was not advanced in the 2014 Regular Session. Additionally, on May 26, 2015, CMS issued a proposed rule that is more than 600-pages in length. The proposed rule directly impacts managed care regulations and overpayment recoveries. Although not final, the proposed rule is likely to have a direct impact on the issue of overpayment recoveries, the expectations on the States and their Medicaid health plans, and the manner in which overpayments are taken into account in the determination of capitation rates.	
			In addition, we recommend MPI develop contract language to require MCOs to periodically report (e.g. annually or quarterly) on the effectiveness of their Special Investigative Unit (SIU)'s performance in Florida's Medicaid program. The report should include a description of what activity is being measured, how it is being measured, how often it is being measured, and the goals or standards established for each measure.	Completed. In order to implement an extended mandatory review period for MCOs when MCOs are conducting preliminary reviews of fraud, abuse, and overpayments and having such extended review period result in collectable overpayments from all provider types, statutory change to ss. 627.6131 and 641.3155, Florida Statutes, would be required. An associated contract revision will be developed, based upon controlling language in ss. 627.6131 and 641.3155, Florida Statutes, and will be routed in accordance with Agency protocols. MCO contractual provisions that take effect January 1, 2015, require MCOs to report the total amount of all dollars identified as lost to overpayment, abuse, and fraud during the State Fiscal Year being reported, total overpayments recovered, total number of referrals by the MCO to MPI and "an explanation in the narrative field describing the actual steps and efforts taken to recover the identified overpayments and …reasons why remaining overpayments could not be reported." The Agency does not believe that further contractual requirements, beyond those imposed effective January 1, 2015, are necessary.	
			Finally, we recommend that MPI require MCOs to describe their efforts taken to recover the identified overpayments and provide the reasons why remaining overpayments could not be recovered. This information can be provided as a supplement to the Annual Fraud and Abuse Activity Report (AFAAR.)	Completed on January 1, 2015. Effective January 1, 2015, the MCO Contract "Report Guide" required that MCOs furnish additional information regarding overpayments identified and unrecovered and why outstanding overpayments could not be recovered. This information is now published in the Report Guide.	
			Finding 2 MCOs' annual and quarterly activity reports do not reconcile, calling into question the accuracy of these reports.		
			Recommendation We recommend that MPI develop contract language that requires the MCOs to provide a reconciliation of the numbers reported on the two reports and, when applicable, provide written explanations for any variances and discrepancies between the reported numbers.	Completed. The MCO Contract "Report Guide" was amended to require MCOs to report Quarterly Fraud and Abuse Activity Report (QFAAR) activities in the same quarter as the suspected fraud (15-day) reporting.	
			Finding 3 Anti-fraud plans do not always provide the information necessary to assess investigations and the reporting structure within an MCO.		

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			Recommendation We recommend that MPI develop legislation to modify Section 409.91212(1)(a), F.S. to require both a written description and chart outlining the organizational arrangement of personnel who are responsible for investigating and reporting possible overpayment, abuse, or fraud.	Completed. MPI has subsequently met with Medicaid staff regarding the Statewide Medicaid managed Care contract revisions and it was determined that the current contract was satisfactory to require and enforce the recommended documentation. Consequently, MPI now believes neither statutory revision, nor a rule amendment, is necessary.	
			We also recommend that MPI develop contract language requiring MCOs' anti-fraud plans include detailed information (i.e., reporting structure, lines of authority, staffing numbers, staff responsibilities, etc.) about the personnel responsible for investigating and reporting possible overpayment, abuse, or fraud in Florida's Medicaid program.		
			Finding 4 MCOs' anti-fraud plans do not always adequately explain their systems and analytical techniques used for detecting fraud and abuse. Also, MCOs are not required to include detection and investigation procedures for possible acts of fraud committed by employees.		
			Recommendation We recommend MPI develop contract language requiring the MCOs to provide more specific information on systems and analytical techniques that are or will be used in their detection efforts.	Completed. MPI has subsequently met with Medicaid staff regarding contract revisions and it was determined that the current contract was satisfactory to require the recommended documentation and activities.	
			We also recommend MPI develop contract language that explicitly requires MCOs' anti-fraud plans include detection and investigation procedures not only for providers and recipients, but also for the employees of the organization.	Completed. MPI has subsequently met with Medicaid staff regarding contract revisions and it was determined that the current contract was satisfactory to require the recommended documentation and activities.	
			Finding 5 MCOs are not required to provide sufficient detail when reporting suspected or confirmed instances of provider or recipient Medicaid fraud or abuse.		
			Recommendation We recommend MPI develop contract language that will require MCOs to provide additional case information similar to the information that is currently required under Texas law.	Completed. MPI has subsequently met with Medicaid staff regarding contract revisions and it was determined that the current contract was satisfactory to require the recommended documentation and activities.	
			Finding 6 MCOs are not required to provide customized anti-fraud training for specific specialized positions based on the positions' duties and responsibilities.		
			Recommendation We recommend MPI develop contract language be expanded requiring MCOs to implement training that is customized to the various positions throughout their organizations. We also recommended that MPI require MCOs to provide training to their personnel on potential fraud risks and the associated "red flags."	Completed. MPI has subsequently met with Medicaid staff regarding contract revisions and it was determined that the current contract was satisfactory to require the recommended documentation and activities.	
			Finding 7 Few MCOs complied with the statutory requirement to include a summary of investigations for the previous year in the anti-fraud plan. In addition, the reported information varied in the summaries that were provided.		
			Recommendation We recommend MPI continue to pursue modifications to Section 409.91212(1)(f), F.S. to read "prior state fiscal year" instead of "previous year." This modification will make it consistent with other subsections of the statute, such as Section 409.91212(4), F.S. This modification will also provide greater clarity to the MCOs and possibly create greater consistency in the information provided.	Completed. The MCO Contract "Report Guide" was amended effective January 1, 2015, to require MCOs to report QFAAR activities in the same quarter as the suspected fraud (15-day) reporting. The directions indicate the need to reconcile and explain discrepancies on page 65 of the Report Guide, which reads: "Note: New records should be entered in the same calendar quarter as the date reported to MPI using the online fraud and abuse report form. The Managed Care Plan should be cognizant of the need to reconcile numbers reported to MPI and be able to provide explanations for any variances and discrepancies between reports and reported numbers (See Chapters "Annual Fraud and Abuse Activity Report", "Quarterly Fraud and Abuse Activity Report", and the "Suspected/Confirmed Fraud and Abuse Reporting.)"	
			Finding 8 MPI does not have written policies and procedures for the review of the anti-fraud plans.		

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			Recommendation We recommend MPI immediately develop and establish written procedures for the review of the anti-fraud plans that will address the completeness of reviews, timeliness of the reviews, supervisory approval, and documenting correspondence between MPI and the MCOs. This will aid in providing consistency in the review of the anti-fraud plans, continuity when the unit experiences staff turnover, and can be used as a training tool. MPI should also further develop the review tool and, at a minimum, include a field for the supervisor's initials and review date. The tool should be considered a central file to document the complete review of the anti-fraud plan including the review of supporting documentation received from the MCO that leads to the approval or disapproval of the submitted anti-fraud plan.	Due to personnel changes, including the hiring of a new Administrator over the Managed Care Unit that was not finalized until after the anticipated completion date of March 1, 2015, the written procedures are scheduled to be completed on or before September 1, 2015.	
			Finding 9 Not all Managed Care Unit (MCU) staff members have received external training related to Medicaid fraud prevention, detection, and investigation.		
			Recommendation We recommend that MPI develop a plan to provide MCU staff training on more insurance and public assistance fraud-related topics that will aid them in their review of the anti-fraud plans and conducting field site visits.	MPI's training processes have been amended. This includes: (1) The creation of SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goal requirements for professional development: Employees will share in the responsibility for their own professional development as well as that of colleagues and coworkers. Professional development includes increasing skills and knowledge to optimize effectiveness within MPI. It includes learning opportunities as an attendee as well as trainer, facilitator, and developer of training. Rating of 3: On an annual basis, the employee develops (individually or collectively) and presents more than one substantive topic for MPI staff's overall professional development. Rating of 4: On an annual basis, the employee develops and presents more than one substantive topic for MPI staff's overall professional development and the employee assists others with the development, facilitation, and presentation of professional development materials. Rating of 5: In addition to the criteria for a rating of "4," the employee also identifies and attends seminars, workshops, or trainings related to the MPI activities. Creation of a training program for MPI staff that will afford opportunities to improve competency in key areas. The training program includes internal training classes (e.g. resulting from staff and managers creating relevant trainings), external (commercial and other government agency) trainings, and accreditation/certification attainment. We have created a process to encourage staff to help identify available external trainings and to seek permission to attend. We have requested, through AHCA internal processes, additional funds to meet these needs. The managers are also assisting with updating our internal operating procedures. This is a first step to the training seminar development process related to these procedures. Finally, we have developed an assessment process to determine staff with minimum required competencies. Staff are expected to study specified resources and be able to pass a test designed to measure these minimal competencies. We are currently in the process of testing staff to assess their competencies to prioritize training.	
			Finding 10 MPI does not utilize a risk-based methodology for determining the priority in which the anti-fraud plan reviews are conducted or determining which MCOs are selected for onsite visits.		
			Recommendation In identifying best practices, we noted that the State of Texas conducts its audits based on an annual risk-based audit plan. Therefore, we recommend MPI establish a risk based assessment to identify which MCOs require onsite visits. MPI does review certain documents in addition to those needed for the approval or disapproval of the anti-fraud plan. These documents can be used to perform desk reviews to determine if an onsite visit is necessary. We also recommend that MPI: • Develop procedures/checklists for desk reviews in addition to the review tool that is currently being used. • Develop a plan of utilizing MPI field office staff to aid MCU in the monitoring of MCOs and conducting onsite visits. • Develop a plan to conduct unannounced onsite visits.	Due to personnel changes, including the hiring of a new Administrator over the Managed Care Unit that was not finalized until after the anticipated completion date of March 1, 2015, the written procedures are anticipated to be completed on or before September 1, 2015.	

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AG 2015-011	**7/2009 - 4/2014**	**Operational Audit of AHCA - Prior Audit Follow-up and Selected Administrative Activities**	**Finding 1** Medicare Outpatient Hospital Crossover Claims. The Agency should continue efforts to reprocess the estimated $117.66 million in Medicare outpatient hospital crossover claims identified in our report No. 2012-021, finding No. 3, and recoup any payments made that were not consistent with State law.		
			Recommendation We recommend that Agency management review the Medicare outpatient hospital crossover claims identified in our report No. 2012-021, finding No. 3, as well as outpatient hospital crossover claims processed subsequent to the 2009-10 fiscal year, and initiate recoupment efforts for any payments made that were not consistent with State law.	Partially Corrected. Prior period adjustments to the CMS-64 report entries to refund the federal share of the audit amount for State Fiscal Years (SFY) 2008-2009 and 2009-2010 were made and confirmed on January 27, 2015. No adjustment has been made for SFY 2007-2008 because the Agency disagrees with the audit findings for that period. Provider notifications for SFY 2008-09 and SFY 2009-10 were mailed in late 2014 but were rescinded due to discrepancies identified in the data. Prior to the letters being rescinded, an extremely high percentage of providers appealed the findings. The Agency is now re-evaluating the recoupment approach and will make a final determination about next steps later in the spring.	
			Finding 2 Provider Participation. Agency policies and procedures need strengthening to ensure that providers are timely suspended or terminated from Medicaid Program participation upon the Agency's discovery that the Federal Government or another state has excluded the provider from Federally funded health care program participation.		
			Recommendation We recommend that Agency management revise procedures to require that, upon discovering that a provider has been excluded from participation by the Federal Government or another state, Agency staff take immediate actions to suspend or terminate the provider's participation in the Medicaid Program and timely remove the provider's active status in Florida Medicaid Management Information System (FMMIS.)	Partially Corrected. Automated data match of List of Excluded Individuals and Entities (LEIE) and System for Award Management (SAM) data against all provider records was installed into production January 15, 2015. • All newly submitted initial and renewing provider enrollment applications are screened against the exclusion databases upon submission. • All active Medicaid providers are screened monthly. • A daily batch processing job identifies all persons or entities added to existing provider records so that possible exclusions can be reviewed prior to the monthly screening, thus avoiding a period wherein an excluded person could be paid. New or renewing provider enrollment applications that have been flagged by the data match as possible exclusions are reviewed by Agency staff to validate the identities of the persons or entities with possible exclusions. Agency staff is reviewing the first report from the monthly match of all active providers to validate those matches. We anticipate this process to take six months to complete. After the identification is validated, the person or entity's record is updated to reflect whether the identity positively matches an exclusion record or has been cleared. Cleared persons or entities will not appear on a subsequent exclusion match report unless the incoming LEIE or SAM records reflect a change, new or updated record, resulting in a new possible match.	
			Finding 3 Performance Measures and Monetary Sanctions. The Agency should revise the methodology used to monitor the performance of the Medicaid fiscal agent and, to encourage the timely correction of performance deficiencies; the Agency should consider increasing the monetary penalties in its contract with the fiscal agent.		
			Recommendation We again recommend that Agency management take the steps necessary to revise the Medicaid fiscal agent performance scoring methodology. The revised methodology should subject each individual performance measure to a monetary penalty, or assign a greater weight to the more critical performance measures, and allow scores below the lowest established scores when warranted.	Partially Corrected. Revised performance measure scoring methodology has been developed for all report cards. The new report card scoring methodology has an escalated risk of damages, including a fine, for each item that scores below standards. Previous report cards were averaging all items on a card which caused the potential for risk of a penalty to be low.	

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			We also recommend that Agency management continue to consider amending the contract with HP Enterprise Services, LLP (HPES) to provide for an escalation of monetary penalties for continued failure to achieve satisfactory levels of performance. The escalation of penalties should increase to an amount sufficient to encourage the timely correction of any performance deficiencies.	The new report card scoring methodology will be implemented for the February Report Card month. In addition, the Agency has been fining the Medicaid fiscal agent for any item(s) that score below standards for two consecutive months. The revised scoring methodology was implemented with the July and August 2014 Report Card months.	
			Finding 4 Collection of Social Security Numbers. The Agency had not established policies and procedures for the collection and use of social security numbers or evaluated the collection and use of social security numbers (SSN) to ensure and demonstrate compliance with State law.		
			Recommendation To demonstrate compliance with applicable statutory requirements, we recommend that Agency management establish written policies and procedures regarding the collection and use of individuals' SSNs, develop a means to properly notify each individual regarding the purpose for collecting his or her SSN, and conduct periodic assessments of the Agency's SSN collection activities.	Fully Corrected. The Agency's forms management policy, #4016, was updated on October 29, 2014 to include the process described below. The Agency currently has procedures in place to ensure that: (i) SSNs are collected only when legally appropriate; (ii) it properly notifies individuals regarding the purpose for collecting their SSNs; and (iii) SSN collection activities are periodically monitored.	
			Additionally, we recommend that Agency management enhance the Form Number Request to address whether the Agency form subject to approval will be used to collect individuals' SSNs and, if so, express the Agency's statutory authority to do so.	All forms by which the Agency requests SSNs are reviewed by the General Counsel's Office to assure compliance with applicable statutory requirements prior to the form being implemented. The forms must contain the necessary notifications to the individuals before they are approved for use. By means of this process, the Agency's collection activities are monitored on a continuous basis. Any unit of the Agency requesting approval of a form that requires a SSN must explain in writing the statutory authority for collection or why collection is necessary for the performance of the Agency's duties as prescribed by law; the Office of the General Counsel will then review the form request, staff justifications and basis for SSN collection, and decide whether it meets applicable federal and state law applicable to same prior to the form being authorized for use. The form that is eventually generated must also contain the explanation for why the collection of the SSN is needed.	
			Finding 5 Information Technology Access Controls. Agency controls over employee access to Florida Accounting Information Resource Subsystem (FLAIR) need improvement.		
			Recommendation We recommend that Agency management limit FLAIR user access privileges to only those functions needed for the performance of the user's job duties, and ensure that each user is assigned a unique FLAIR user ID. We also recommend that Agency management ensure that reviews of FLAIR access privileges are routinely performed to aid in the identification and resolution of any instances where excess or incompatible access privileges have been granted or FLAIR access is no longer needed.	Fully Corrected. The Bureau of Financial Services updated its FLAIR Access Control policy again in September 2014 to expand upon the Bureau's responsibilities, access restrictions, and to further address the procedure for handling new access requests, access modifications, access terminations, password resets, and the biannual reviews. The profile matrix was completed in September 2014. The Bureau also developed a bi-annual memo that is provided to supervisors to review access granted to their direct reports.	
AG 2015-045	FY 12-14	**Operational Audit of AHCA - Financial Management**	**Finding 1** The Bureau had not established sufficiently comprehensive policies and procedures or developed a Bureau-specific training program to ensure that staff were provided appropriate guidance and training related to the Agency's complex accounting and budgeting tasks.		
			Recommendation We recommend that Bureau management enhance existing policies and procedures to ensure that the Bureau's responsibilities and unique operations are sufficiently addressed. The enhanced policies and procedures should promote compliance with applicable laws, rules, regulations, and accounting standards, and provide sufficient guidance to staff to ensure consistency in the event of staff turnover.	The Bureau continues to provide guidance and instructions to staff on its complex financial operations through topic specific workshops, joint meetings with other program areas, individual meetings, and one-on-one and group trainings. The Bureau has reviewed several of its financial operations and found opportunities to improve the process resulting in better efficiency, effectiveness, and accountability. The Bureau is continuing to document formal and informal training on the training log.	

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			In addition, we recommend that Bureau management develop a staff training program that is specifically tailored to address the complexity of the Agency's financial operations and that Bureau management consider revising the Bureau's position descriptions to specify the relevant education and experience needed to perform the Agency's complex accounting and budgeting tasks.	The following processes have been reviewed and changes implemented: Federal Draw Process, Logging and Reconciliation of Federal Draws, Cash Management Improvement Act (CMIA) Reporting, Schedule of Expenditures of Federal Awards (SEFA) Reporting, and OCA (data element table) Naming and Tracking Matrix.	
			Finding 2 The Bureau had not established appropriate controls to ensure that sufficient documentation was always maintained to support accounting transactions or to ensure that transactions were timely and correctly entered in the State's accounting system.		
			Recommendation We recommend that Bureau management ensure that sufficient documentation is maintained to support the amount, purpose, timeliness, and approval of all Agency accounting transactions. We also recommend that Bureau management take appropriate actions to improve the accuracy and timeliness of FLAIR accounting transactions.	The Bureau has initiated a committee to review the documentation process. The committee will develop a procedure to ensure appropriate documentation is maintained to support the amount, purpose, timeliness, and approval of all Agency accounting transactions.	
			Such actions should include enhancing Bureau policies and procedures to promote the proper recording of accounting transactions and to provide for the thorough scrutiny of transactions and support during the approval process. In addition, Bureau management should ensure that Bureau staff receives the training necessary to fully implement the enhanced policies and procedures.	Supervisory staff has conducted group trainings with their staff to ensure each employee is aware of best practices in regards to documentation of accounting transactions. In addition, the Bureau Chief has created process improvement workgroups to review certain processes for effectiveness and efficiency.	
				The Bureau began using a new automated FLAIR reconciliation system in June of 2014. With the automated system, the Bureau is able to provide reconciling items to the Bureau supervisors within 5 workdays of closing each month. As a result of implementing the automated system, policies are currently in place to ensure and verify that pending reconciliation items are reviewed and corrected in a timely manner.	
			Finding 3 The Bureau's year-end closing process needs enhancement to ensure timely, accurate, and complete financial reporting in compliance with applicable accounting standards and State and Federal requirements.		
			Recommendation We recommend that Bureau management continue efforts to enhance the policies and procedures for the year-end closing and preparation of financial statements. Additionally, we recommend that Agency management provide sufficient training and guidance to Bureau staff to ensure accurate, complete, and timely financial reporting, in compliance with applicable accounting standards and State and Federal requirements.	The process for year-end closing and preparation of financial statements starts in late May/early June. The supervisor of the Policy and Systems unit will take the lead and ensure all staff involved in this process are adequately trained. All training will be documented in the Bureau's training log.	
AG 2015-166	**FYE 6/30/14**	**State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards**	**2014-001** During the Florida Agency for Health Care Administration (FAHCA) Bureau of Finance and Accounting (Bureau) supervisory review, various errors, which had a direct and material effect on the calculated year-end receivable balance due from the Federal Government, were inadvertently overlooked.		
			Recommendation We recommend that the Bureau perform a more rigorous supervisory review of fiscal year-end receivable balance calculations to ensure that all errors are identified and appropriately corrected.	The calculation for the receivable balance due from federal government is prepared manually using FLAIR data. To enhance reporting capabilities of the receivable, the Bureau of Financial Services (Bureau) is updating its OCA Matrix (data element table) which identifies the federal participation rate (FFP), where the state match is charged, and other critical data elements.	
				The work on the OCA Matrix will aid in the accurate capture of financial information and analysis. The policy for titling OCAs is being changed to better distinguish between state and federal share; which will allow better use of the FLAIR reporting tools available. The new structure will be implemented by July 1, 2015. The Bureau will implement a quarterly review of the FLAIR data in September, December, March, and June, which will validate how we capture and identify state and federal share.	

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				The receivable balance due to the federal government will be prepared within the Grants Unit and the secondary review will be conducted by the Policy and Systems Unit Finance and Accounting Director. In preparation for 2014-2015 year-end, the Bureau will begin the analysis of data quarterly as of March and June to alert staff of any abnormalities prior to the Bureau's year-end submission timeline.	
			2014-002 The FAHCA Bureau of Finance and Accounting (Bureau) did not reclassify drug rebates (refunds) from Other Revenue to a reduction of the corresponding expenditure account.		
			Recommendation We recommend that the Bureau follow the refunds guidance provided by the FDFS to ensure that current year refunds are identified and appropriately reclassified at fiscal year-end to reduce the applicable expenditures.	The Agency sought guidance from FDFS regarding the reclassification of all refunds in General Ledger Code (GLC) 61800 for financial statements. Per our conversation, we were advised that reclassifying was not a requirement but a preference among agencies.	
				After further discussion with the Auditor General, it was determined that the portion of refunds from Drug Rebates which could be tied to current year expenditures should have been reclassified for financial statements.	
				The agency will ensure that all future Drug Rebates received for current year expenditures will be reclassified at fiscal year-end to reduce the applicable expenditures.	
			2014-005 FAHCA procedures for preparing the Schedule of Expenditures of Federal Awards (SEFA) data form were not sufficient to ensure the accuracy of reported amounts. As a result, amounts reported on the State's SEFA were materially misstated before adjustment.		
			Recommendation We recommend that the FAHCA enhance its procedures to ensure that amounts reported on the SEFA data form are complete and accurate and provided in accordance with FDFS instructions.	The Schedule of Expenditures of Federal Awards (SEFA) is prepared manually using FLAIR data. The Bureau of Financial Services (Bureau) has consulted with other state agencies on their SEFA process. The Bureau plans to implement a similar process to the Florida Department of Health (FDOH).	
				Updating its OCA Matrix (data element table), which identifies the federal participation rate (FFP); where the state match is charged; and other critical data elements will assist in the Bureau's reporting responsibilities. Changing the policy for titling OCAs will allow better use of the FLAIR reporting tools available. The new structure will be implemented by July 1, 2015. The SEFA will be prepared within the Grants Unit and the secondary review will be conducted by the Policy and Systems Unit.	
			2014-033 The FAHCA did not ensure that payments made to the Florida Healthy Kids Corporation (FHKC) for Florida Healthy Kids Program dental services were accurate.		
			Recommendation We recommend that the FAHCA ensure that Florida Healthy Kids Program dental service payments do not exceed the established per member per month rate.	Proviso language in the SFY 2013-14 General Appropriations Act limited Healthy Kids dental plan payments to $12.57 per member per month. Florida Healthy Kids Corporation (FHKC) negotiates a dental rate with each plan and projects that the average rate at the end of the fiscal year will be within the allocated amount. FHKC contracted with three dental plans during SFY 2013-14. Previously, FHKC had only contracted with two dental plans. The negotiated rate for the new plan was $12.32 per member, less than the $12.59 rate paid to the two older plans.	
				The new plan has fewer members, but FHKC projected the growth of enrollment in the new plan, coupled with the Affordable Care Act (ACA) requirement that children 6 through 18 with income under 133% FPL would transition to Medicaid effective January 1, 2014. The projection was that approximately 50,000 Healthy Kids enrollees would transfer to Medicaid and most of these children would have been enrolled in the more costly plans. If the ACA transition had progressed as projected, the average dental rate should have been $12.57 or less.	
				Due in large part to the Agency's roll out of the Medicaid Managed Medical Assistance Program, the transition of the 50,000 Healthy Kids enrollees identified for transition to Medicaid was delayed, with federal approval, until after July 2014. As a result, these children remained in their more costly dental plans for the entire fiscal year, and the average dental rate at the end of the year was $12.58 per member per month, or $0.01 higher than allowed. The total Healthy Kids dental expenditures were within the Healthy Kids dental appropriations.	

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				FHKC has repaid the dental overage of $19,095.71. This represents the questioned costs of $19,978.93 less the $883.22 adjustment to dental service payments. A repayment adjustment was included in the FHKC February 2015 Total invoice received on February 11, 2015. Due to the uniqueness of events in SFY 2013-14, this overage should not recur.	
			2014-036 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.	Physician Claims – The initial request for the ACA rate change provided to FAHCA from the Centers for Medicare and Medicaid Services (CMS) on March 4, 2014, was incomplete and required further clarification. Final clarification was received on June 2, 2014. Change Order (CO) #64164 implemented the new ACA rates on July 2, 2014. All Medicaid claims reprocessing for the ACA rate change between the dates of January 1, 2014, and July 2, 2014, were identified and processed under CO #64165 which was completed on January 13, 2015. Nurse Practitioner Claim – CO #59553 was generated to complete the coding for the rate segment update for Child Health Check-Up program (CHCUP) and created a new rate type specific to CHCUP. CO #59553 was implemented on July 24, 2014. Reprocessing of the Nurse Practitioner underpayment was performed under change order #65758 and was completed on November 11, 2014. Physician Medicare Crossover Claim – Change Order (CO) #73223 was created to exclude the Qualified Medicare Beneficiary (QMB) benefit plan from copay processing logic. CO #73223 was implemented on January 13, 2015. CO #74982 is currently in an "open" status and will identify and complete the reprocessing of the claims. Date of Death Claims - In response to the 245 paid claims for services claimed to have been rendered after the recipient's date of death, the Agency's Third Party Liability (TPL) vendor identifies potential claims for recovery under the date of death project on a monthly basis for institutional and physician claims, while pharmacy claims are analyzed quarterly. The project compares recipient dates of death in FLMMIS to claim dates of service in order to identify overpayments. Once an individual provider's total overpayment amount for all recovery projects exceeds $750.00, the results are forwarded to MPI where a tracking match is performed to exclude any providers or claims that may be under MPI review. Upon receipt of the tracking match results, an audit letter is generated. Provider audit letters are mailed monthly. Regarding the 89 claims that had previously been identified with audit letters mailed to the providers, $1,805.33 has been recovered and providers are appealing eight (8) claims totaling $2,515.36. For the remaining 156 claims where audit letters had not been mailed to date, once the claims thresholds are reached and tracking matches have been completed, audit letters will also be mailed to those providers. Durable Medical Equipment (DME) - It appears as though the referenced DME payments may have not been made in accordance with section 409.908(13), Florida Statutes. The Agency for Health Care Administration will further research and take appropriate action to correct these DME payments, if necessary.	
			2014-037 General computer controls for the Florida Medicaid Management Information System (FMMIS) need improvement.		
			Recommendation We recommend that the FAHCA ensure the State's Medicaid fiscal agent takes timely and appropriate corrective action to resolve the deficiencies noted in the SSAE 16 SOC 1 Type II report.	The Agency has reviewed the issues surrounding this finding and concurs with HPES' management that there is a business need for the control exceptions noted in the SSAE 16 SOC 1 Type II report. CO #65277 - 2014 SSAE16 Audit Support was implemented on November 6, 2014, and identifies when authorized software developers switched to an HP Global ID. Daily system activity reports are generated showing the date, time, production system, HP Global ID and developer's name. The daily report is routed to all Technical Leads. All Oracle changes made while under HP Global ID access must be reviewed and verified to be completed. The individual Technical Leads must specify the reason for the HP Global ID access. The daily report and reasons for the HP Global ID access are kept in a log by the Cycle Monitors.	

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				Hardware and Software constraints limit the number of HP Global ID's that can be created within the FL MMIS and therefore these ID's must be "checked out" before a given software developer can gain access to the FL MMIS using the HP Global ID.	
			2014-038 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.	The FAHCA has taken the following steps to ensure that medical assistance related payments are accurately recorded in the State's accounting records:	
				1. As a result of implementing Statewide Medicaid Managed Care, a budget amendment was submitted and approved on December 10, 2014, to establish new categories, realign budget between existing categories, and delete obsolete categories in order to properly capture expenditures.	
				2. The FAHCA discontinued its practice of recording medical assistance related payments to a few medical services appropriation categories and then journal transferring the expenditures to the correct appropriation categories in accordance with the weekly FMMIS appropriation reports. Effective February 23, 2015, the FAHCA implemented an Electronic Fund Transfer (EFT) process for the payment of the medical assistance related payments. Payments are now recorded in the correct category from the onset if release, budget, and cash are sufficient.	
				3. The FAHCA will submit a budget amendment, at least annually, to realign the Medicaid Services categories to reflect the results of the latest Medicaid Expenditures Social Services Estimating Conference (SSEC).	
			2014-039 The FAHCA did not always limit Federal funds draws to amounts needed for immediate cash needs.		
			Recommendation We recommend that the FAHCA ensure draw amounts are only for immediate cash needs.	The overdraw/double draw of funds was caused when a computer program froze in the middle of the transaction. Attempts were made to cancel and resubmit the request; however, the efforts taken inadvertently caused the request to be submitted twice. Staff immediately identified the duplication in the draw request and implemented a plan to offset the overdraw of funds by reducing the draws for two subsequent weeks. In addition, the FAHCA has taken the following steps to ensure that draw amounts are only for the immediate cash needs:	
				1. The draw request responsibility has been reassigned to the Accountant IV from the Revenue Unit Supervisor.	
				2. The Revenue Unit Supervisor performs a secondary review to ensure that the request is entered into the Federal Payment Management System (PMS) and in our State's accounting records accurately. Once approved by the Revenue Unit Supervisor, the entry is then transmitted to the State Treasury.	
				3. The Accountant Supervisor II performs a daily audit of all draw requests entered in PMS and our State's accounting records to ensure that all entries in PMS and our State's accounting records match the backup documentation and that all notifications are transmitted.	
			2014-040 The FAHCA did not always ensure that facilities receiving Medicaid payments met required health and safety standards.		
			Recommendation We recommend that the FAHCA increase efforts to ensure Life Safety Surveys and the follow-up surveys for Life Safety and Health/Standard Surveys with noted deficiencies are conducted within the established time frames.	HQA Bureau of Field Operations continues to ensure Life Safety Code (LSC) surveys are conducted annually, but no later than 15.9 months from the previous annual licensure and/or recertification survey. Also, if it is determined an onsite revisit is necessary, the onsite revisit will be conducted no later than 90 days following the survey for which noncompliance was determined. Revisits can be conducted by desk review; however, the same timeframe of no more than 90 days must be followed. There are times in which exceptions to the revisit timeframes may be appropriate, such as a waiver (which is a process to waive the correction of noncompliance for an established timeframe but no more than one year from the original approval) or if a provider fails to submit a timely plan of correction. The field offices would maintain the documentation in these instances.	

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				In October 2013, the Bureau of Field Operations implemented the timeframes as noted above and incorporated into the Life Safety Code section of the HQA-Licensure and Certification Procedures Manual. Although the entire Licensure and Certification Procedures Manual has not been fully updated and approved, this section has been updated and should be considered the official process for LSC survey completion. This is the timeframe currently followed by HQA's eight field offices.	
				While reviewing our process for monitoring LSC survey activity, we identified errors in the "Tickler" Report used by the field offices to schedule LSC surveys. Therefore, Field Operations has re-built the reports used for scheduling, monitoring, and tracking the completion of LSC surveys within the established timeframes for both annual and revisit surveys. Additionally, Field Operations has revised the Performance Standards for the Field Office Managers to expand the standard of completion of survey activity to include, specifically, Agency audit reviews, such as Fire Safety surveys, which must be completed within the timeframes noted in audit responses and as mandated in Agency Protocols.	
				Staff within the Bureau's Survey and Certification Support Branch (SCSB) continue to monitor compliance. The specific staff within SCSB who are responsible for tracking timely survey completion conduct monthly conference calls with the Field Office Manager and Field Office Scheduler. The purpose of these calls is to discuss the specific offices' survey activity to ensure that not only LSC surveys are conducted within the established timeframes, but all other state and federal survey activities are conducted within the required timeframes as mandated by the federal government through the Mission and Priority Document and/or State statues or rules. Performance Standards for these Quality Assurance staff will also include specific reference to monitoring survey activity related to audit responses in addition to other mandated workload.	
			2014-041 The FAHCA's established policies and procedures did not provide for the timely assignment and issuance of cost report audits of nursing homes or the timely assignment of cost report audits of Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). Additionally, 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 specify an adequate number of cost reports to be audited annually, as well as to address the timely issuance of cost report audits. We also recommend that the FAHCA ensure that the performance of the hospital cost report auditor be timely monitored.	According to the Florida Title XIX Long-term Care Reimbursement Plan, Section I., cost reports are to be submitted to the Agency by the cost report due date, which is five months after the fiscal year end of the cost report. To be considered timely for rate setting purposes, a cost report must be received by April 30th. A cost report with a fiscal year end of September 30th is not due until February of the following calendar year, and is not late for rate setting purposes until April 30th of that year.	
				By the time the cost report is received by the Agency, it has been over seven months since the cost report fiscal year end. After the cost report is received, it is reviewed for rate setting acceptance before the audit review can begin. Currently, the Audit Services unit is attempting to select cost reports for audit within two years of the fiscal year end in order to expedite the audit process.	
				Several steps have been taken by the Agency to shorten the timeline associated with cost report audits. The Agency has revised the Long Term-care Reimbursement Plan to begin sanctioning providers for failure to submit timely cost reports. Effective July 1, 2014 providers are subject to sanctions for cost reports not submitted within 60 days after the cost report due date. A cost report with a fiscal year end of June 30th is due to the Agency by November 30th, and if not received by January 29th the provider would be subject to sanctions. This should have the desired effect of causing cost reports to be submitted more timely, allowing the audit process to begin sooner.	
				The Audit Services unit also cleared a backlog of 400 audits during calendar year 2014 which should free resources to work towards completing current period audits more timely. The Agency also contracted with the Office of the Attorney General to assist in closing the backlog of audit appeals. The Office of the Attorney General began working on audit appeals in October 2013. Again, cleaning up this backlog should free resources to work on current period audits. Going forward, the Audit Services unit will attempt to identify cost reports to audit and assign them in a more timely fashion, and in accordance with State and Federal guidelines.	

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				Hospital Audits The current policies and procedures that are in place do provide for an adequate number of cost reports to be audited annually. The cost report is a combination of Medicare Title XVIII & V and Medicaid Title XIX. The Medicaid portion of the audit process cannot begin until the audit is completed for the Medicare program. The completion of the Medicare audit may take more than a year depending on the scope of the audit. In addition, the scope of the Medicaid audit may take a year or longer to finalize. At the beginning of each federal fiscal year, the Agency and the Medicaid contractor perform a reconciliation of pending audits to ensure audits are completed within a reasonable timeframe. Also, there are legislative budget restraints which only allow for a certain number of audit hours to be performed each state fiscal year. The Agency's current contract with a Certified Public Accountant (CPA) vendor to perform the hospitals audits, effective January 2014, calls for a monthly status report of all examinations that are current and ongoing. The Agency has weekly status update calls with the vendor in which an agenda and the previous weekly meeting minutes are provided.	
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 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.	1. Completed. 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 FPCU to assist.	
			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.	2. Completed. Reorganization efforts are now focusing on FPCU, with changes to the structure beginning in June 2014 and continuing into Fall 2014.	
			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.	Completed. The Provider Eligibility and Compliance Unit (PECU) (formerly known as Fraud Prevention and Compliance Unit (FPCU)) is now fully integrated within the Bureau of Medicaid Fiscal Agent Operations (MFAO). The unit has developed written protocols and procedures, as recommended, to instruct staff on the process for contractual terminations and pre- payment review (PPR). The function of recommending contractual termination remains with PECU; however, the PPR functions are statutorily required to be assigned to the Bureau of Medicaid Program Integrity.	
			Finding 3 Policies on Approving Contractual Termination, Deactivation, and Stacking Requests.		

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			We recommend Medicaid develop a written policy for approving contractual termination, deactivation, and stacking requests.	Completed. PECU (formerly known as FPCU) is now fully integrated within the Bureau of Medicaid Fiscal Agent Operations (MFAO). The unit has developed written protocols and procedures as recommended, to instruct staff on the process for performing contractual terminations, deactivating, and stacking termination requests. The PECU manager has obtained written delegation authority from the Medicaid Director to process deactivations of registered managed care providers and for stacking of a termination or denial code on already terminated or denied applicants.	
			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.	1. Completed. PECU (formerly known as FPCU) is now fully integrated within the Bureau of Medicaid Fiscal Agent Operations (MFAO). The unit has developed written protocols, as recommended to serve as guide to assist staff on the process for contractual terminations.	
			2. We recommend that FPCU document the decision making process for contractual terminations.	2. Completed. All contractual terminations are carried out through the instructions of written memorandum. No further/additional documentation will be prepared unless requested by the Medicaid Director (or other Agency management) on a case by case basis. Auditor's Note: Medicaid has accepted the risk of not documenting 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.	1. Completed. PECU (formerly known as FPCU) is now fully integrated within the Bureau of Medicaid Fiscal Agent Operations (MFAO). The unit has developed a written communications policy to assist in the prevention of premature information disclosure to third parties regarding with cause and without cause terminations.	
			2. We recommend that Medicaid educate all employees on inappropriate information disclosure to third parties.	2. Completed. Protocols have been developed for educating staff on how to appropriately handle third party inquiries. This will allow for consistent and accurate dissemination of information. PECU protocols are located in the Medicaid Director's share drive and can be accessed by the PECU staff.	
			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.	The PECU will be submitting written recommendations for Medicaid management's approval regarding procedures for evaluating the enrollment of providers with previous contractual terminations.	
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.	Completed. Investigations will develop a draft of recommended policies and procedures for inclusion in the Investigations Unit Data Aggregator Use Policy.	
			Finding 2 The MOU did not cover the purpose of monitoring Agency parking for improper use of handicapped and visitor spaces.		

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			Recommendation Investigations should amend the Agency's MOU with DHSMV to include the purpose for Support Services' access.	Completed. Investigations Response: Investigations and Support Services agreements were separated, with Secretary Dudek signing the Investigations MOU on October 6, 2014. Support Services Response: Support Services can perform their functions without access to the DAVE system. Access has been terminated for all Support Services staff	
			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.	Completed. Investigations will develop 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.	Completed. 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.	Completed. 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.	Completed. 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.	
			Recommendation Any DAVE-related information in Investigations should be contained where it is not accessible to any person coming into the common areas.	Completed. 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.	Completed. 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.	Completed. Investigations will ensure user access permissions for DAVE Users in Investigations 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.	
			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	Completed. The Inspector General has appointed a direct reporting person independent of the DAVE process to conduct the quarterly reviews.	

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			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.	Completed. 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.).	Completed. 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.	Completed. Investigations will draft recommended procedures for addressing public record requests received by the Investigations Unit for inclusion in the Data Aggregator Policy.	
			Recommendation All Investigations' staff should be trained about public records and understand the confidentiality of DAVE information, whether they access DAVE or not.	Completed. 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.	Completed. 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.		
			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.	Completed. 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.	Completed. Complete. Most recent Annual Affirmation Statement was dispatched to DHSMV on March 12, 2014. Most recent quarterly review was submitted to DHSMV on October 8, 2014.	

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			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	Completed. Most recent Annual Affirmation Statement was dispatched to DHSMV on March 12, 2014. Most recent quarterly review was submitted to DHSMV on October 8, 2014.	
			The Staff Person should incorporate all responsibilities addressed in this report, including performing the annual audit and quarterly monitoring, in written desk procedures.	Completed. The appointed staff person within the Office of Inspector General who is independent of the DAVE process will develop a process and maintain documentation to ensure compliance with the MOU requirements for on-going monitoring, performing an annual audit, and submitting an Annual Affirmation Statement.	
			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.	Completed. Revised MOU signed and approved by the Agency head on October 6, 2014.	
			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.	Completed. 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.	
			Recommendation Any Agency user of DHSMV driver license data should be required to access only DAVE.	Completed. Support Services has contacted DHSMV's Technical Assistance Center to request the KDC access be cancelled. Support Services staff is only accessing DAVE.	
13-06	**CYE 12/31/12**	**Adverse Incident Report Process Division of HQA Florida Center**	**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 1. We recommend that RMPS develop policies and procedures to monitor the timely submission of reports.	1. It has been determined the fining process for late submissions of Adverse incident reports will be handled by the Enforcement Unit of HQA. The Enforcement Unit will develop policies and procedures to monitor the timely submission of reports.	
			2. We recommend RMPS 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.	2. Completed. Facilities may be fined for being out of compliance with reporting requirements. In such cases the RMPS unit will issue a Request for Sanction.	
			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.	Removed.	
			Finding 3 RMPS does not adequately document and track report referrals to Complaint Administration Unit (CAU).		
			Recommendation 1. We recommend RMPS and CAU jointly periodically reconcile report referrals to ensure that all incidents referred by RMPS are actually received.	1. Completed. A report was developed for reconciliation purposes. Regular meetings are scheduled to conduct reconciliations.	

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			2. We recommend that RMPS document the date reviewed on the hospital form.	2. Two Program System Request (PSR)s have been submitted: PSR411- Re-write Federal and State NH Adverse Incident Report System and PSR459-SSO for Adverse Incident Reports.	
			3. We recommend that RMPS request that the Assisted Living Facilities (ALF) form be modified to include a date of review.	3. Two PSRs have been submitted: PSR411- Re-write Federal and State NH Adverse Incident Report System and PSR459-SSO for Adverse Incident Reports.	
			4. We recommend that RMPS request that the Nursing Homes (NH) form include a date of receipt and date of review.	4. Two PSRs have been submitted: PSR411- Re-write Federal and State NH Adverse Incident Report System and PSR459-SSO for Adverse Incident Reports.	
			5. We recommend that RMPS, 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.	5. Two PSRs have been submitted: PSR411- Re-write Federal and State NH Adverse Incident Report System and PSR459-SSO for Adverse Incident Reports.	
			6. We recommend that RMPS update the policy outlining the criteria for referring reports to CAU.	6. Completed as per policy 11-18. This policy has been adopted by RMPS and shared with CAU staff.	
			7. We recommend that RMPS consider an automated method to notify CAU that there is a report for review.	7. This notification will be included in the new online reporting system. Two PSRs have been submitted: PSR411- Re-write Federal and State NH Adverse Incident Report System and PSR459-SSO for Adverse Incident Reports.	
			8. We recommend that CAU 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 audit recommendations and added the appropriate fields in the adverse incident database.	
			Finding 4 Adverse incident reports were not referred to DOH timely or securely.		
			Recommendation 1. We recommend that the Agency work with DOH to update the MOU to address the security, method and frequency of report transfer to DOH.	1. A new MOU draft is routing for review and signature. (This new MOU includes the updated criteria regarding practitioner involvement referrals and the shared data process via a secure Electronic File Transfer Protocol site.)	
			2. We recommend that 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.	2. Completed. Submitted PSR524 - NH Adverse Incident Report data to be shared with DOH. Auditor's note: DOH and AHCA now share report information using secure Electronic File Transfer Protocol.	
			Finding 5 The referral of litigation notices to RMPS does not appear to serve a useful purpose.		
			Recommendation 1. We recommend that the Florida Center consult with OGC, CAU, and HQA Field Office management to determine the purpose and intended results of reviewing these documents.	1. A legislative proposal related to the referral of Litigation Notices to the agency was submitted to leadership for consideration in the 2016 session.	
			2. Further, 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.	2. Submitted PSR 598 requesting electronic filing (e-File system) for submitting Litigation Notices to the Agency. This system will accommodate the current need to receive and review the Litigation Notices. It will allow the documents to be scanned directly into Laserfiche and generate a report for tracking purposes.	
			Finding 6 The receipt and review of annual reports from facilities does not appear to be a cost effective use of Agency resources.		
			Recommendation 1. We recommend that Agency 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.	1. A legislative proposal recommending deleting the requirement for facilities to send the annual reports to the Agency was submitted to leadership for consideration in the 2016 session.	

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			2. We recommend that RMPS publish the required malpractice claims statistics for hospitals and ASCs as required by law.	2. Completed. The 2012 reports have recently been added: http://ahca.myflorida.com/SCHS/RiskMgtPubSaftey/annual_report.shtml The 2013 reports will not arrive until April and will be posted by the end of May.	
			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.	RMPS is currently in the process of updating and aligning rules, policies, and forms with current statutory provisions regarding Adverse Incidents to ensure congruence among these documents.	
13-12	**7/1/12 - 12/31/12**	**MCM Provider Enrollment Process Audit**	**Finding 1** Delay in background screening review.		
			Finding 2 Non-institutional subunit review or File Maintenance (FM) delay.		
			Finding 3 Fiscal agent referral delay/ "orphan" tasks.		
			Finding 4 File Mix-ups.		
			Recommendation 1 (for Findings 1-4) We recommend that the MCM Provider Enrollment Unit require a monthly report or establish performance measures to track MCM review processing times.	Completed - Risk Accepted by Management. 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. Analysis was completed regarding the impact of additional status codes on applications in MCM review. As expected, new status tracking codes will not shorten the time required for outside review of applications so the solution was not pursued. Instead, processors will enter expanded comments on the pending application records to better describe the reasons the applications were forwarded to the state for review. The entire Medicaid Public Portal is under a major redesign. The enrollment Status page will be uploaded as part of that project.	
			Recommendation 2 (for Findings 1-4) We recommend that the MCM Provider Enrollment Unit establish a written policy for MCM review processing times.	Desk Levels were completed - September 2014. 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.	
			Recommendation 3 (for Findings 1-4) We recommend that the MCM Provider Enrollment Unit 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) We recommend that the MCM Provider Enrollment Unit 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.	

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			Recommendation 5 (for Findings 1-4) We recommend that the MCM Provider Enrollment Unit 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.	Completed. 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) We recommend that the MCM Provider Enrollment Unit 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.	
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.	1. Completed. The Investigations Unit and MPI will review and update, as necessary, their 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.	2. Completed. The OIG will adopt a policy requiring at least a triennial review of the LexisNexis/State of Florida agreement.	
			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. Completed. 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.	
			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. Completed. 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. Completed. 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. Completed. 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. Completed. All staff members within OIG associated with Accurint queries for case support will receive training on Accurint allowances, documentation, and restrictions.	
			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.	

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			4. The appointed staff person should also work with the Inspector General to develop desk procedures for quarterly usage reviews.	4. Completed. 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. Completed. 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. Completed. 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. Completed. A 5-year retention period for records associated with Accurint user additions and user deletions will be included in policy.	
			Finding 5 Confidentiality and Security. MPI may not be complying with the 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. Completed. 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. Completed. 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. Completed. 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. Completed. 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.		
			Recommendation 1. The Accurint Administrator should terminate the Bureau of Financial Services staff's access and discontinue payment for that user's access.	1. Completed. Bureau of Financial Services' Accurint access will be terminated no later than May 30, 2014.	
			2. The OIG should reevaluate 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. Completed. 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. Completed. All Accurint users were trained in the use of all applicable Accurint services.	

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AG 2014-001	7/2010 - 2/2012 through 3/2013	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 that the Agency ensure that manual profile sheets evidence 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.	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.	
			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.		
			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. Concerning the nine ICF-DDs identified in the finding that did not have their claims reprocessed at the revised rates, a system issue prevented the reprocessing of claims for certain time periods. However, CO 18065 was implemented in January 2013, and the Agency has since reprocessed the claims for the affected time period.	
			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.		
			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.		

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			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.		
			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.	
			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.		
			Recommendation We recommend that the Agency continue efforts to ensure that property records are timely and accurately updated for property acquisitions and transfers.	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.	
AG 2014-057	**7/2010 - 2/2012**	**Operational Audit of AHCA - Health Care Facility Licensing Function and IT Controls**	**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 judgements.		
			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.	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	
			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.		

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			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. 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 Information Technology (IT) program VERSA so that the late fee assessments are added automatically to late applications.	
			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.	
			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)	
AG 2014-173	**FYE 6/30/13**	**State of Florida 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.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	Fully Corrected. 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	
			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.	Fully Corrected. The Bureau has developed a process to reconcile the data received from the program office on a quarterly basis. This quarterly reconciliation process will identify errors earlier in the process allowing more time for research and resolution. The Bureau is working on a written procedure for this process. 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.	
			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.	Fully Corrected. 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.	Partially Corrected. First Bullet: 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. Finding No Longer Valid. Second Bullet: The audit report listed one claim where the FAHCA did not charge a co-pay for a MediPass recipient. In researching the proposed system fix it was determined that based on the Procedure Code and Diagnosis Code on the claim, the rule used to bypass the copayment was the exemption for "Recipients receiving services or supplies related to Family Planning." 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.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	Partially Corrected Medicaid/Medicare Crossover Claims: Customer Service Request (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. 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. Copayment issue: CSR 2250 was implemented April 17, 2014 to make this correction. Inpatient stays greater than 45 days: CSR 2052 (Balanced Budget Act of 1997 (BBA) Claims Edits) was implemented in multiple stages beginning on 06/02/2011. The final portion of this CSR was implemented on 05/23/2013. Currently CMS is reviewing documentation provided by the Agency, for each of the 98 identified claims, which shows that the claims correctly paid in accordance with AHCA policy. The reviewers who originally determined that the claims were paid in error did not take into consideration that the claims are allowed, if they have an approved Prior Authorization associated with them. Payment to Retro-terminated provider: We are still awaiting a decision from the Agency's General Counsel's Office on the providers' appeal rights concerning our ability to recoup funds from retro terminations. This information is required before the procedures for recouping monies can be completed. Once the decision has been rendered, procedures will be implemented to notify these providers of amounts due to the Agency for claims paid for services subsequent to the date for which the provider lost Medicaid eligibility.	
			2013-051 The FAHCA continued to record medical assistance related payments to incorrect appropriation categories in the State's accounting records.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendation We recommend that 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.	Partially 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.	
			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.		
			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.	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.	
			2013-054 The FAHCA made payments to an ineligible provider.		
			Recommendation We recommend that the FAHCA ensure that payments are made only to providers with Medicaid Provider Agreements in effect.	Partially Corrected. 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.	Partially Corrected. 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.	

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

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			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.	Fully Corrected. On October 27, 2014, the Agency submitted to the Department of Management Services a request for approval of changes proposed as part of the reorganization necessary to implement and oversee the Statewide Medicaid Managed Care program. In addition, the Agency has submitted several issues on October 15, 2014 as part of the State Fiscal Year 2015-2016 budget process related to the reorganization. Please see pages 8-10; 32-36, 50-64, 124-129, 142-146 of the document available through the following link: http://floridafiscalportal.state.fl.us/Document.aspx?ID=11318&DocType=PDF Please see pages 9-19 of the document available through the following link: http://floridafiscalportal.state.fl.us/Document.aspx?ID=11322&DocType=PDF Please see pages 3-6 of the document available through the following link: http://floridafiscalportal.state.fl.us/Document.aspx?ID=11321&DocType=PDF	

Agency for Health Care Administration

Legislative Budget Request

Department Level

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:	**Departmental Level**
LAS/PBS Fund Number:	**2021**

	Balance as of 6/30/____		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	2,910,395	(A)		2,910,395
ADD: Other Cash (See Instructions)	16	(B)		16
ADD: Investments		(C)		0
ADD: Outstanding Accounts Receivable	3,070,361	(D)	-120	3,070,241
ADD: Reimbursements		(E)		0
Total Cash plus Accounts Receivable	**5,980,772**	(F)	**-120**	**5,980,652**
LESS Allowances for Uncollectibles		(G)		0
LESS Approved "A" Certified Forwards	1,650,672	(H)		1,650,672
Approved "B" Certified Forwards	341,873	(H)		341,873
Approved "FCO" Certified Forwards		(H)		0
LESS: Other Accounts Payable (Nonoperating)		(I)		0
LESS: ______________________________		(J)	-99,003	-99,003
Unreserved Fund Balance, 07/01/__	**3,988,227**	(K)	**98,883**	**4,087,111** **

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 2015

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/___ Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**4,370,570**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	(55,122)	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	(120)	(C)
SWFS Adjustment # and Description	99,003	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	(341,873)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	29,546	(D)
Certified Forward Difference	(14,894)	(D)
Current Compensated Absences Liability		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**4,087,111**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**4,087,111**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

	Budget Period: 2016 - 2017
Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Medical Care Trust Fund**
Budget Entity:	**Department Level**
LAS/PBS Fund Number:	**2474**

	Balance as of 6/30/2015		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	381,311,844	(A)		381,311,844
ADD: Other Cash (See Instructions)	218,715	(B)		218,715
ADD: Investments	5,700,706	(C)		5,700,706
ADD: Outstanding Accounts Receivable	746,878,832	(D)		746,878,832
ADD: ______________________		(E)		0
Total Cash plus Accounts Receivable	**1,134,110,098**	(F)	**0.00**	**1,134,110,098**
LESS Allowances for Uncollectibles	7,389,911	(G)		7,389,911
LESS Approved "A" Certified Forwards	486,052,952	(H)		486,052,952
Approved "B" Certified Forwards	283,076	(H)		283,076
Approved "FCO" Certified Forwards	0	(H)		0
LESS: Other Accounts Payable (Nonoperating)	56,840,729	(I)	1,194,534.00	58,035,263
LESS: SWFS - Non-Op AP		(I)	63,674.00	63,674
LESS: Deferred Inflows - Unavailable Revenue	241,249,156	(J)		241,249,156
Unreserved Fund Balance, 07/01/15	**342,294,274**	(K)	**(1,258,208.00)**	**341,036,066** **

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 2015

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2016 - 2017

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, 07/01/2015 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**324,937,127**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	(34,455)	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	(892,865)	(C)
SWFS Adjustment # and Description	(301,669)	(C)
SWFS Adjustment # and Description	(63,674)	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	(283,076)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	0	(D)
A/P not C/F-Operating Categories	22,797,812	(D)
Certified Forward Approved "A" Carry Forward Adjustment	(2,795,141)	(D)
Long Term Receiveables Less Allowance for Uncollectibles	(2,327,993)	(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**341,036,066**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**341,036,066**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

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 6/30/2015		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	12,739,381	(A)		12,739,381
ADD: Other Cash (See Instructions)		(B)		
ADD: Investments		(C)		
ADD: Outstanding Accounts Receivable		(D)		
ADD: ______________________________		(E)		
Total Cash plus Accounts Receivable	**12,739,381**	(F)		**12,739,381**
LESS Allowances for Uncollectibles		(G)		
LESS Approved "A" Certified Forwards	11,428	(H)		11,428
Approved "B" Certified Forwards		(H)		
Approved "FCO" Certified Forwards		(H)		
LESS: Other Accounts Payable (Nonoperating)		(I)		
LESS: ______________________________		(J)		
Unreserved Fund Balance, 07/01/__	**12,727,953**	(K)		**12,727,953** **

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 2015

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, 07/01/2015 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**12,727,953**	(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:	**12,727,953**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**12,727,953**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2016 - 2017

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 6/30/2015		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance		(A)		0	
ADD: Other Cash (See Instructions)		(B)		0	
ADD: Investments		(C)		0	
ADD: Outstanding Accounts Receivable		(D)		0	
ADD: ________________		(E)		0	
Total Cash plus Accounts Receivable	**0**	(F)	**0**	**0**	
LESS Allowances for Uncollectibles		(G)		0	
LESS Approved "A" Certified Forwards		(H)		0	
Approved "B" Certified Forwards		(H)		0	
Approved "FCO" Certified Forwards		(H)		0	
LESS: Other Accounts Payable (Nonoperating)		(I)		0	
LESS: ________________		(J)		0	
Unreserved Fund Balance, 07/01/2015	**0**	(K)	**0**	**0**	**

Notes:

***SWFS = Statewide Financial Statement**

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

Office of Policy and Budget - July 2015

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

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

	Budget Period: 2016 - 2017
Department Title:	**Agency for Health Care Administration**
Trust Fund Title:	**Grants and Donations Trust Fund**
Budget Entity:	**Departmental**
LAS/PBS Fund Number:	**2339**

	Balance as of 6/30/2015		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	279,562,132	(A)		279,562,132	
ADD: Other Cash (See Instructions)	45,224,717	(B)		45,224,717	
ADD: Investments		(C)		0	
ADD: Outstanding Accounts Receivable	289,149,040	(D)	10,130	289,159,170	
ADD: BE TNFR from 68200000	0	(E)		0	
Total Cash plus Accounts Receivable	**613,935,888**	(F)	**10,130**	**613,946,018**	
LESS Allowances for Uncollectibles	1,447,196	(G)		1,447,196	
LESS Approved "A" Certified Forwards	310,300,300	(H)		310,300,300	
Approved "B" Certified Forwards		(H)		0	
Approved "FCO" Certified Forwards		(H)		0	
LESS: Other Accounts Payable (Nonoperating)	163,562,367	(I)		163,562,367	
LESS: BE TNFR to 68501400	0	(J)		0	
LESS: Deferred Inflows - Unavailable Revenue	12,889,040	(J)	0	12,889,040	
LESS: BE TNFR to 68500200	0	(J)		0	
LESS:	0	(J)	328,359	328,359	
Unreserved Fund Balance, 07/01/2015	**125,736,985**	(K)	**(318,229)**	**125,418,757**	**

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 2015

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2016 - 2017

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

BEGINNING TRIAL BALANCE:

Item	Amount	Line
Total Fund Balance Per FLAIR Trial Balance, 07/01/2015 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**120,763,594**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	(328,359)	(C)
SWFS Adjustment # and Description	10,130	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS		(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	5,551,590	(D)
Transfer to BE 685014	0	(D)
Transfer to BE 68500200	0	(D)
Transfer from BE 6820000	0	(D)
Transfer from BE 68500200	0	(D)
Other loans & Notes Receivable	(578,199)	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**125,418,757**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**125,418,757**	(F)
DIFFERENCE:	**(0)**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

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:	Departmental Level
LAS/PBS Fund Number:	2565

	Balance as of 6/30/____		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	46,618,302	(A)		46,618,302	
ADD: Other Cash (See Instructions)	5,119,300	(B)		5,119,300	
ADD: Investments		(C)		0	
ADD: Outstanding Accounts Receivable	7,602,281	(D)		7,602,281	
ADD: ________________________________		(E)		0	
Total Cash plus Accounts Receivable	**59,339,883**	(F)	**0**	**59,339,883**	
LESS Allowances for Uncollectibles	140,113	(G)		140,113	
LESS Approved "A" Certified Forwards		(H)		0	
Approved "B" Certified Forwards		(H)		0	
Approved "FCO" Certified Forwards		(H)		0	
LESS: Other Accounts Payable (Nonoperating)		(I)		0	
LESS: ________________________________	2,581,187	(J)		2,581,187	
Unreserved Fund Balance, 07/01/15__	**56,618,583**	(K)	**0**	**56,618,583**	**

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 2015

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/___ Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**56,618,583**	(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:	**56,618,583**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**56,618,583**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

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 6/30/15____		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	1,762,829	(A)		1,762,829
ADD: Other Cash (See Instructions)		(B)		0
ADD: Investments		(C)		0
ADD: Outstanding Accounts Receivable	7,765,116	(D)		7,765,116
ADD: ______________________		(E)		0
Total Cash plus Accounts Receivable	**9,527,944**	(F)	**0**	**9,527,944**
LESS Allowances for Uncollectibles		(G)		0
LESS Approved "A" Certified Forwards	9,527,944	(H)		9,527,944
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/__	**0**	(K)	**0**	**0** **

Notes:

***SWFS = Statewide Financial Statement**

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

Office of Policy and Budget - July 2015

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

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

	Budget Period: 2015 - 2016
Department Title:	Agency for Health Care Administration
Trust Fund Title:	Heath Care Trust Fund
Budget Entity:	Departmental
LAS/PBS Fund Number:	2003

	Balance as of 6/30/15____		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	132,053,617	(A)		132,053,617	
ADD: Other Cash (See Instructions)	177,825	(B)		177,825	
ADD: Investments		(C)		0	
ADD: Outstanding Accounts Receivable	79,281,753	(D)		79,281,753	
ADD: ______________________________		(E)		0	
Total Cash plus Accounts Receivable	**211,513,195**	(F)	**0**	**211,513,195**	
LESS Allowances for Uncollectibles	7,482,585	(G)		7,482,585	
LESS Approved "A" Certified Forwards	50,841,632	(H)		50,841,632	
Approved "B" Certified Forwards	651,434	(H)		651,434	
Approved "FCO" Certified Forwards		(H)		0	
LESS: Other Accounts Payable (Nonoperating)	3,171,163	(I)		3,171,163	
LESS: Deferred Inflows - Unavailable Revenue	9,964,743	(J)		9,964,743	
LESS: BE TNFR from 68501400	(755,334,640)	(J)		(755,334,640)	
LESS: BE TNFR to 68501500	755,334,640	(J)		755,334,640	
Unreserved Fund Balance, 07/01/__	**139,401,638**	(K)	**0**	**139,401,638**	**

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 2015

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
LAS/PBS Fund Number:	2003

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/___ Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**139,944,895**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	(12,231)	(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	(651,434)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	135,408	(D)
Advances from Other Funds	(15,000)	(D)
BE TNFR from 68501400	755,334,640	(D)
BE TNFR to 68501500	(755,334,640)	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**139,401,638**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**139,401,638**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2015

Agency for Health Care Administration

Legislative Budget Request

Health Facility Regulation

Schedules

SCHEDULE 1A: DETAIL OF FEES AND RELATED PROGRAM COSTS

Department: 68 Health Care Administrati **Budget Period: 2016-17**
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 2014 - 15**	**ESTIMATED FY 2015 - 16**	**REQUEST FY 2016 - 17**
Receipts:			
Abortion Clinic	20,227	55,413	40,110
Adult Family Care Home (AFCH)	46,501	81,687	66,384
Assist Living Facility (ALF)	4,119,937	4,823,657	4,517,598
Adult Day Care Facility (ADC)	24,273	59,459	44,156
Amb. Surgical Center	410,701	494,674	458,153
Birth Center	11,783	46,969	31,666
Crisis Stabilization Units	153,092	184,394	170,780
Forensic Lab	32,945	68,131	52,828
H, C, & Ss	45,007	80,193	64,890
Health Care Clinics	2,328,325	2,785,743	2,586,805
Health Care Services Pool	181,432	218,528	202,394
Home Health	1,451,966	1,748,836	1,619,723
Home Medical Equipment	168,027	202,382	187,441
Hospice	48,999	84,185	68,882
Hospital	1,371,442	1,617,744	1,510,624
ICF/DD	165,371	199,183	184,478
Laboratory	1,271,307	1,482,423	1,390,606
Managed Care	277,433	334,158	309,487
Multiphasic Center	28,923	64,109	48,806
Nurse Registry	546,350	658,057	609,474

Organ & Tissue Donor	22,350	57,536	42,233
PPECS	54,544	89,730	74,427
Residential Treatment	214,263	258,071	239,018
Residential Treatment for Children	62,407	97,593	82,290
Risk Management	44,887	80,073	64,770
SNF Home	4,067,171	4,780,149	4,470,064
Trans. Living	39,461	74,647	59,344
Total Fee Collection to Line (A) - Section III	17,209,124	20,727,724	19,197,432

SECTION II - FULL COSTS

Direct Costs:			
Salaries and Benefits			
Other Personal Services			
Expenses			
Operating Capital Outlay			
Direct Cost Allocation	48,287,355	51,805,955	50,275,663
Indirect Costs Charged to Trust Fund	21,705,025	25,223,625	23,693,333
Total Full Costs to Line (B) - Section III	69,992,380	77,029,580	73,968,996

Basis Used:

SECTION III - SUMMARY

TOTAL SECTION I	(A)	17,209,124	20,727,724	19,197,432
TOTAL SECTION II	(B)	69,992,380	77,029,580	73,968,996
TOTAL - Surplus/Deficit	(C)	(52,783,256)	(56,301,856)	(54,771,564)

EXPLANATION of LINE C:

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

Office of Policy and Budget - July, 2013

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: The Agency for Health Care Administration (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 background screening results of operators and staff of providers regulated by health and human service agencies in Florida. Agencies specified in statute to share criminal history results include: 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 participating providers and persons subject to background screenings, the elimination of duplicative employment screenings have resulted in an overall cost savings. Clearinghouse integration of other state agencies began in January 2013 and currently includes AHCA licensure and Medicaid, DOH, DOE/VR, Managed Health Care Plans, DCF and APD. DOEA and DJJ will be implemented in the Clearinghouse in 2015/16. Each month approximately 1,200 individuals licensed by DOH are able to use a Clearinghouse screening reducing duplicative screening and costs. AHCA licensed providers view more than 1,000 screenings per month through the Clearinghouse. During Fiscal Year 2014-15, more than 55,000 background screening results were shared among participating agencies and managed health care plans resulting in an overall cost savings of $4,125,000 to these providers.

   AHCA recently completed implementation of online licensure renewal applications for all licensure types (completed 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 become licensed faster and begin operations sooner. The Agency is implementing measurement tools to evaluate the success of online licensing and to determine what additional outreach is necessary to encourage and increase participation.

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

   Response: With the addition of online licensing and the success of the background screening Clearinghouse, the Agency is shifting job duties away from paper processing to the management of these two systems and is able to absorb workload growth without additional resources. Measurement tools are being put in place to evaluate needs and maximize limited resources. The Division is expanding transparency of information collected and maintained by the Agency using reporting tools to publish data online through online resources such as FloridaHealthFinder.gov. Transparency of information improves consumer and public access and reduces the manual labor associated with response to public records request which take a significant amount of Agency resources. In addition, the Agency will be implementing an online submission tool for the Florida Hospital Uniform Reporting System (FHURS). The concept is similar to online licensing and is expected to generate similar efficiencies.

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) if fees do not pay program costs. Some fees are established in the regulatory programs' administrative rules with maximum or minimum amounts defined in Florida Statutes. 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. Not all fees 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 may be increased annually by the CPI for those programs that do not fully pay their costs per s. 408.805, F.S., within statutory maximums.

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 $50.75 fee for homemaker companion services and the $1,218 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, the agency 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 13,309 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 next Legislative Session, AHCA could request 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 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

RVSD: 8/21/2015

*408.805(2) The agency shall annually adjust licensure fees, including fees paid per bed, by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase.

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 & specialties	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. 400.9935(6)	$100		No	$100	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
	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

RVSD: 8/21/2015

*408.805(2) The agency shall annually adjust licensure fees, including fees paid per bed, by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase.

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)
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

RVSD: 8/21/2015

*408.805(2) The agency shall annually adjust licensure fees, including fees paid per bed, by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase.

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

RVSD: 8/21/2015

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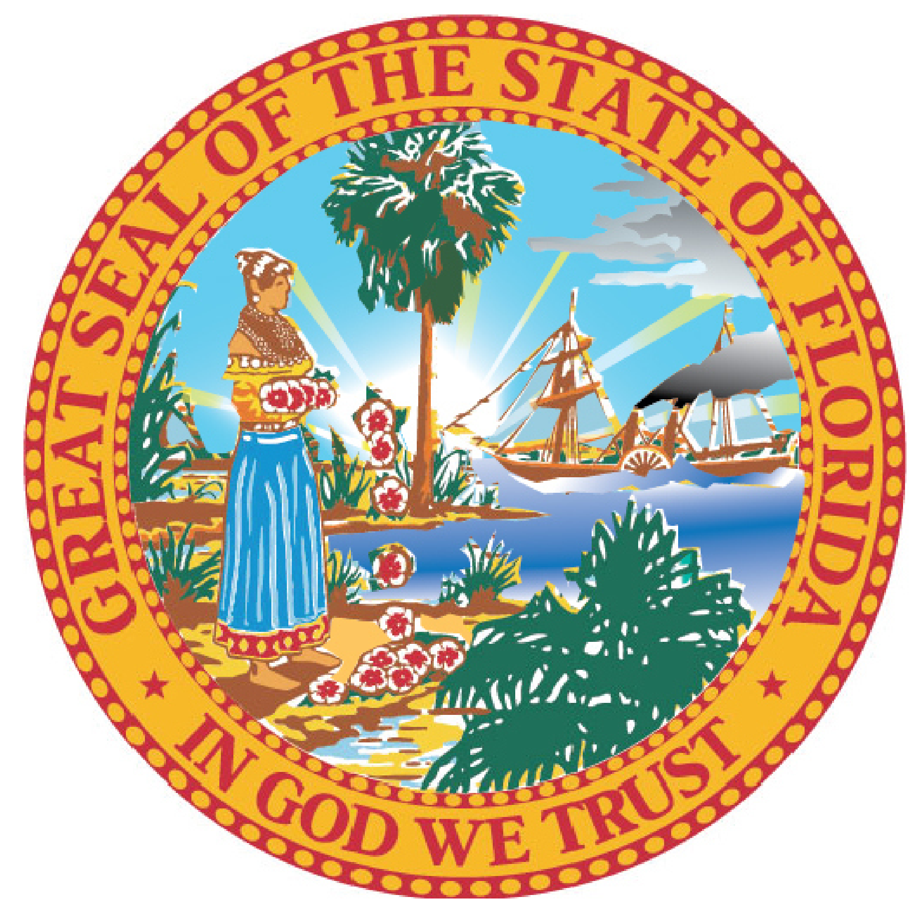
Service / Product Regulated	Specific Fee Title	Statutory Authority for Fee	Maximum Fee Authorized (cap)	Year of Last Statutory Revision to Fee	Is Fee Set by Rule? (Yes or No)	Current Fee Assessed	Fund Fee Deposited in (indicate General Revenue or Specific Trust Fund)
Transitional Living Facility	License Fee	s. 400.9972(2), 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

RVSD: 8/21/2015

*408.805(2) The agency shall annually adjust licensure fees, including fees paid per bed, by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase.

SCHEDULE IV-B FOR ADVANCED DATA ANALYTICS AND DETECTION SERVICES

For Fiscal Year 2016-17



August 21, 2015

AGENCY FOR HEALTH CARE ADMINISTRATION

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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: August 21, 2015
Project Name: Advanced Data Analytics and Detection Services	Is this project included in the Agency's LRPP? X Yes ____ No
FY 2016-17 LBR Issue Code:	FY 2016-17 LBR Issue Title: Medicaid Program Integrity Advanced Data Analytics and Detection Services
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Kristen Koelle, (850) 412-4591 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: [signature] Printed Name: Elizabeth Dudek, Secretary	Date: 9/15/15
Agency Chief Information Officer (or equivalent): [signature] Printed Name: Scott Ward, CIO	Date: 9/11/15
Budget Officer: [signature] Printed Name: Anita Hicks, CFO	Date: 9/15/15
Planning Officer: [signature] Printed Name: Kristen Koelle, Management Review Specialist	Date: 9/14/15
Project Sponsor: [signature] Printed Name: Eric W. Miller, Inspector General	Date: 9/11/2015
Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Kelly Bennett
Cost Benefit Analysis:	Kelly Bennett/Kristen Koelle
Risk Analysis:	Kristen Koelle/ Michael Magnuson
Technology Planning:	Michael Magnuson
Project Planning:	Kelly Bennett/ Kristen Koelle

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 continue efforts and activities designed to modernize its capability to analyze information in the Florida Medicaid Management Information System (FMMIS) claim, encounter, provider, and beneficiary files, and other data for the purposes of detecting and preventing fraud, waste, program abuse, and pre and post-payment service anomalies associated with Medicaid 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, identified anomalies, and outliers via a vendor's website/portal.

At the time of this Schedule IV-B's publication, funds secured for Fiscal Year 2014-2015 were certified to allow payment for deliverables through September 30, 2015. Previous years' funds not spent and were reverted[1]. Final expenses for Fiscal Year 2014-2015 for development and initial implementation will be below the amount secured. While Fiscal Year 2015-2016 will not include the "heavy lifting" of the development and initial implementation, it is expected to include the integration of a multitude of additional data sources as well as the development and testing of additional analytics (algorithms) which will continue to aid the fraud-fighting efforts of the AHCA while also affording an opportunity for increased collaboration with other public benefits programs throughout the state. Project funding is as follows: Fiscal Year 2014-2015 (Year 1), Fiscal Year 2015-2016 (Year 2), and Fiscal Year 2016-2017 (Year 3). Funding into Year 3 will ensure that efforts during Year 2 are realized through successful integration and actionable outcomes.

During Year 2, analytics related to recipients will be further developed. The purpose of these processes is two-fold: One, provider fraud is often linked to recipient activities, and; two, recipient activities that lead to loss of benefits (conviction for fraud or determination of ineligibility) can be a benefit to not only the Medicaid program, but also to other public benefit programs. The other public benefit programs that may be positively impacted by this funding and project include the State of Florida's Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF) program, since the identification of ineligible or disqualified Medicaid recipients can translate to identification of parties ineligible for other public benefits funded by taxpayers.

The AHCA's Office of the Inspector General, Office of Medicaid Program Integrity (MPI), historically has used a range of methods including routine and ad hoc statistical analyses of internal data to identify billing errors, claims abuse, and potential fraud. The growth of data availability from external local, state and federal sources that could enhance overpayment detection methods has made it impractical to make use of this now-available data without implementing advanced technologies in the form of advanced data analytics to examine providers, recipients, payments, trends, and outliers with the benefit of both internal and external (to FMMIS) data sets.

At the time of this Schedule IV-B's publication, Year 1 (the contract was signed in August 2014 and extended through September 2015) is nearing its end. Year 2 contract discussions are well underway and will continue the efforts that have already been completed. Year 1 included development, data acquisition, and data integration as well as an initial deployment of the user interface (UI), user acceptance testing, and the initial refinement of the scoring and weighting of the algorithms. During Year 2, MPI will continue to collaborate with the Vendor and other state agency

[1] Previous Years Project-Related Cost (Cost Benefit Analysis (Appendix A) are not included for Fiscal Year 2013-2014 because there were no expenditures related to the project in Fiscal Year 2013-2014.

partners to develop additional algorithms, continue and further the refinement of the scoring and weighting, integrate additional data sources, increase functionality and uses for the system, as well as work with other public benefit programs and fraud-fighting partners regarding expansion of the system. The specific details about these anticipated accomplishments and deliverables will be further defined by the AHCA by way of ongoing communication with the Vendor. These efforts will continue throughout Year 2 and will place the system in a position for optimal use in Year 3, thus this request for continued funding for advanced data analytics.

1. Business Need

Computerized data analytics is an essential component of any large-scale anti-fraud program that involves complex payment processes, thousands of billing sources, and millions of service recipients. It was noted in the Office of Program Policy Analysis and Government Accountability's (OPPAGA) report of January 2014, written after the AHCA received its first appropriation for advanced data analytics, that "the AHCA should ensure that the [data analytics] procurement is sustainable and that it enhances the AHCA's current detection of abuse and fraud and recoupment of overpayments." Sustainability of the data analytics initiative by the AHCA is dependent upon continued legislative funding.

As reported in the January 2014 OPPAGA report, "the AHCA uses several methods, including statistical analyses, to identify potential cases of Medicaid overpayment to fee-for-service (FFS) providers. The AHCA has continued to reduce the time it takes to recoup overpayments and has increased the number of sanctions imposed on providers who overbill." The AHCA's prevention and recovery efforts returns millions of dollars back to the Medicaid program annually with an average return of investment from Fiscal Year 2010-2011 through Fiscal Year 2013-2014 of 6.8:1, for every dollar spent on fraud prevention and recoveries, six dollars and eighty cents are collected.

Florida's transition to managed care as the dominant Medicaid service delivery model will not eliminate fraud and abuse in the Medicaid program, but will provide fiscal pressure and better internal payment controls over fraud and abuse than exists in the FFS model. As reported in Florida Senate Interim Project Report 2006-133, Identification and Prevention of Fraud and Abuse in Medicaid Managed Care, "Medicaid fraud and abuse still occur in capitated managed care plans, they simply change form. " This same report also stated, "Based on the findings in this review, [Senate] staff has determined that the ability of managed care plans to adequately prevent fraud and abuse is not supported….The AHCA should be required to develop a system to validate the information collected through the encounter data system currently being developed to collect utilization information from providers (in lieu of claims data)." The AHCA plans to use encounter data to monitor fraud and abuse in managed care and anticipates analyzing encounter data on network providers much like it analyzes Medicaid FFS provider claims data to identify abusive or fraudulent activities.

Not funding this issue would result in a missed opportunity to significantly enhance a program (MPI) that not only pays for itself but also generates revenue back to the state in terms of recovering Medicaid money lost to fraud, waste and abuse. 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 Fiscal Year 2013-2014 and Fiscal Year 2014-2015, MPI recovery activities resulted in recoupment of over $168.9 million dollars from improper payments to Medicaid health care providers. These overpayments – at any amount – 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 identify and collect latent provider overpayments and prevent potential future overpayments, moving from a predominantly "pay and chase" model to a prevention and early detection model; identifying fraud, waste and abuse earlier in the process.

2. Business Objectives

Historically, the systems and processes within MPI were built around a complaint-based investigative process. MPI 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 latent fraud and 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 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, through its continuance into a third year,[2] seeks to deliver on the following:

- Preventing and decreasing improper payments associated with fraud, waste, and abuse in the Medicaid program at levels heretofore unrealized;
- Improved availability of key provider data relevant for Medicaid provider screening for Medicaid program participation and oversight;
- Identifying Medicaid benefit and provider payment policy inconsistencies, as well as errors or needed enhancements within the claims processing and related systems;
- Creating technical functionality that will improve the state's ability to identify and mitigate early potential payment risks and program vulnerabilities in the Medicaid program;
- Developing and implementing a risk-based approach using predictive analytics to identify potential fraud, waste, and program abuse in the Florida Medicaid program as well as in other public benefits programs in the state;
- Developing 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 in other public benefits programs;
- Increasing effective and efficient use of staff resources in combating fraud, waste and abuse in the Florida Medicaid program and in other public benefits programs;
- Reducing fraud, waste and program abuse, while automating manual processes and driving smarter decisions by extracting actionable insights from the data within government agencies;

[2] The initial contract with the data analytics vendor was executed in August 2014. An amendment to that contract extended the Year 1 contract period to September 2015. At the time of this Schedule IVB's publication, a Year 2 contract renewal was under development, but not in place.

- Providing actionable results to enable easy decision making related to anti-fraud activities;
- Minimizing false positives on audit or investigative leads that can overwhelm MPI and diminish the existing return on investment;
- Reducing costs while improving resource allocation by focusing Medicaid overpayment collection efforts to achieve a higher collection and recovery success rate, resulting in reduced expenditures and the collection of revenue due back to the state;
- More efficiently preventing and identifying improper Medicaid payments (and related public assistance payments);
- Better management of risk;
- Streamlining processes; and
- Increasing the job effectiveness of Medicaid Program Integrity personnel.

B. Baseline Analysis

The AHCA currently utilizes a 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 with the Decision Support System (DSS or data warehouse) for 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 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 DSS Profiler 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. Alternatively, 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, as 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.

9. **Other tools** – Including the data analytics tool that is the subject of this Schedule IV-B, are created or procured and, as needed, the "list" of MPI detection tools is updated. The data analytics tool will be included in future versions of MPI's detection tool list.

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
- Support the Transformed Medicaid Statistical Information System (TMSIS) data capabilities and ensure that the FMMIS meets all federal reporting requirements.

2. Business Solution Alternatives

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

3. Rationale for Selection

The AHCA will be able to streamline the detection process, making more efficient use of staff time, establishing fraud and program abuse investigative 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 Department of Children & Families (DCF) provided data, other state-owned data, and commercial data aggregated to produce suspicious provider and recipient alerts to the AHCA's MPI office. As previously stated, by improving the analysis of the data, the AHCA is improving the state's capabilities to prevent potential provider overpayments and move from an exclusive "pay and chase" model to a model that also 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 state agency that administers public health benefits programs. All users would utilize the secure interface 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. For purposes of this project, the use of the terminology of advanced data analytics is used to describe the integration of multiple business intelligence tools, including claims-based outlier algorithms, customizable fraud and abuse risk indicators, human resources, and statistical models, utilizing a variety of data sources, to identify and deter emerging trends of fraud, abuse, and waste.
- The Vendor must provide a web-based user interface (UI) provides remote access capability. The UI must be customizable to meet the needs of the AHCA's Bureau of Medicaid Program Integrity (MPI). Specifically, the UI must include the capability to display summary-level alerts, interact with MPI's Fraud and Abuse Case Tracking System (FACTS), display details of each alert, including labeled graphs and charts, social networks, and multi-sort tables, and the detailed information must be exportable.
- The Vendor shall integrate various state-owned data including, but not limited to, the following:
  - FMMIS/DSS for Medicaid reimbursement and provider/applicant information;
  - VR facility licensure data (healthcare facility licensing data) including controlling interest relationships;
  - Provider Network Verification (PNV) Medicaid managed care provider networks;
  - State professional licensure data, related both to licensure status and disciplinary/complaint history, from the Department of Health, Department of Business and Professional Regulations, Department of Financial Services, Agriculture and Consumer Services, and other state agencies as identified by the AHCA or Vendor;
  - Department of State's (DOS) SunBiz corporation, partnership, and fictitious name data;
  - Florida Department of Corrections data regarding incarcerated providers and recipients;
  - Florida Department of Highway Safety and Motor Vehicles driver's license data;
  - Florida Department of Economic Opportunity wage and hour data;
  - Department of Financial Services worker's compensation data;
  - Department of Revenue tax data;
  - The DCF recipient eligibility data;
  - The DCF provider data (e.g., adult protective services complaint information);
  - Florida Department of Elder Affairs (DOEA) recipient eligibility data (including level of care, waiver program eligibility, and service authorization);
  - The APD recipient eligibility data (including level of care, waiver program eligibility, and service authorization);
  - FACTS: the MPI case tracking system will be integrated such that audit and referral history information is integrated into any provider risk models and to ensure that, upon approval by the AHCA that the leads are sufficient to be integrated, leads are directly integrated into a complaint in FACTS; and
  - Third Party Liability (subrogation) data, including recoupment information.

- The Vendor shall integrate additional data sources and create a fraud and abuse risk score that includes subcomponents that may be independently analyzed. The additional data sources must include information sufficient to identify relationships between organizations, corporations, and individuals such as association by marriage, familial relation, common business ownership, professional associations. The subcomponents must include risks

related to finances (e.g., judgments, liens, foreclosures, bankruptcies, UCC filings), criminal history, association with other high-risk individuals or entities, as well as other adverse findings such as a loss of a professional license or discipline history.

- Additionally, the Vendor shall integrate additional data sources for the purpose of supplemental verification of Medicaid provider and recipient identity and eligibility. Such identity verification will include: (a) revalidation of provider eligibility (e.g., verification that the provider is not on a federal exclusion list and does not have a disqualifying criminal offense) and notifying the AHCA of providers who are suspected of being ineligible, with the basis for the suspected ineligibility, (b) comparison of publically available information about provider demographic information in state databases and notification to the AHCA of inconsistencies, (c) the identification of suspected recipient ineligibility by way of asset verification through alternate data sources, and (d) the identification of suspected recipient ineligibility by way of validation (or invalidation) of a medical condition(s) through analysis of Medicaid claims data as well as other data sources.
- 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 visual representation of the analysis of integrated data that includes, at a minimum:
    - Social relationship link analysis;
    - Entity relationship link analysis;
    - Geographical relationship analysis; Mapping with customization capabilities with the visual representation tool which allows, minimally:
        i. Zoom in and out capabilities;
        ii. Turning on and off indicators and alerts; and
        iii. Filters for each scenario.

      Mapping with customization capabilities shall be provided both within an alert as well as external to an alert.
- The Vendor shall provide proactive detection to include, at a minimum:
    - Alert or flag user about activity the service 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 implement the analytics service to conduct analysis of Medicaid claims data and fraud risk elements, as well as any other models developed, to detect and deter fraud, abuse, and waste, and to identify emerging trends of fraud and abuse in the Florida Medicaid program. Through the alert service, the Vendor will provide investigation-ready leads for MPI or for MPI referral to other agencies.
- The Vendor shall modify the application on an ongoing basis in consultation with state staff to optimize user interface and analytic models.
- The Vendor shall provide maintenance and connectivity as requested by the AHCA.
- 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 "investigation-ready leads" as more than simply flags or alerts. An investigation-ready lead has undergone a preliminary analytic review by the Vendor. The review may be way of human intelligence/resources, or by way of MPI approved scoring matrix that prioritizes the leads based upon the severity of the potential billing anomaly and the level of risk that the provider has or will commit fraud or abuse. The investigation-ready lead will include the vendor's theory of the violations, conclusions that Vendor draws from the factors presented, and the Vendor's recommended action for the AHCA to pursue.

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 will result in refinement of the application following implementation. Anticipated actionable leads: 06/16
2	Actual recoveries of overpayments and detection of fraud because of the investigative leads generated by vendor 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 will result in refinement of the application following implementation. Anticipated actionable leads: 06/16
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 will result in refinement of the application following implementation. Anticipated actionable leads: 06/16

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 AHCA 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 issued an Invitation to Negotiate (ITN) in October of 2013. In January of 2014, the AHCA rejected all bids and, in February 2014, re-issued the ITN. 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 2014. SAS will host the solution on a secure, scalable infrastructure with premium support. As we near the end of the contract for Year 1 and prepare contract amendments to move forward with a Year 2 contract, 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 alerts, 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, once fully operational, 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 service

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 edits to prevent future overpayments or any kind of fraud, waste, and abuse.

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 visual representations of the analysis of integrated data such as social and entity relationship link analysis, 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 service 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

After the initial implementation during year one of the contract, Vendor will only be required to submit an implementation plan (preliminary and final) if there is a substantial change to the service that warrants the plan. See Appendix C for the current project implementation plan.

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 2016-17			FY 2017-18			FY 2018-19			FY 2019-20			FY 2020-21		
	(a)	(b)	(c) = (a)+(b)	(a)	(b)	(c) = (a) + (b)	(a)	(b)	(c) = (a) + (b)	(a)	(b)	(c) = (a) + (b)	(a)	(b)	(c) = (a) + (b)
	Existing Program Costs	Operational Cost Change	New Program Costs resulting from Proposed Project	Existing Program Costs	Operational Cost Change	New Program Costs resulting from Proposed Project	Existing Program Costs	Operational Cost Change	New Program Costs resulting from Proposed Project	Existing Program Costs	Operational Cost Change	New Program Costs resulting from Proposed Project	Existing Program Costs	Operational Cost Change	New Program Costs resulting from Proposed Project
A. Personnel -- Total FTE Costs (Salaries & Benefits)	$284,918	$0	$284,918	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A.b Total FTE	6.25	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-1.a. State FTEs (Salaries & Benefits)	$284,918	$0	$284,918	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-1.b. State 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-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 Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C. External Service Provider -- Costs	$2,900,000	$0	$2,900,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-1. Consultant Services	$207,145	$0	$207,145	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-2. Maintenance & Support Services	$331,428	$0	$331,428	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-3. Network / Hosting Services	$1,077,142	$0	$1,077,142	$0	$0	$0	$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	$1,284,285	$0	$1,284,285	$0	$0	$0	$0	$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	$145,000	$0	$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	$145,000	$0	$145,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total of Operational Costs (Rows A through E)	$3,329,918	$0	$3,329,918	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
F. Additional Tangible Benefits:		$120,068,342			$0			$0			$0			$0	
F-1. Cost Avoidance		$25,248,342			$0			$0			$0			$0	
F-2. MPI Recoveries		$94,820,000			$0			$0			$0			$0	
F-3. Specify		$0			$0			$0			$0			$0	
Total Net Tangible Benefits:		$120,068,342			$0			$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.*				FY2016-17			FY2017-18			FY2018-19			FY2019-20			FY2020-21			TOTAL
3				$ -	$ 3,045,000			$ -			$ -			$ -			$ -			$ 3,045,000
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	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	$ 2,900,000
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**	**0.00**	**$ -**	**$ -**	**0.00**	**$ -**	**$ -**	**0.00**	**$ -**	**$ -**	**0.00**	**$ -**	**$ -**	**$ 3,045,000**

CBAForm 2 - Project Cost Analysis

Agency AHCA

Project Advanced Data Analytics

PROJECT COST SUMMARY	PROJECT COST SUMMARY (from CBAForm 2A)					TOTAL
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	
TOTAL PROJECT COSTS (*)	$3,045,000	$0	$0	$0	$0	$3,045,000
CUMULATIVE PROJECT COSTS (includes Current & Previous Years' Project-Related Costs)	$3,045,000	$3,045,000	$3,045,000	$3,045,000	$3,045,000	
Total Costs are carried forward to CBAForm3 Project Investment Summary worksheet.						

PROJECT FUNDING SOURCES	PROJECT FUNDING SOURCES - CBAForm 2B					TOTAL
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	
General Revenue	$0	$0	$0	$0	$0	$0
Trust Fund	$870,000	$0	$0	$0	$0	$870,000
Federal Match ☑	$2,175,000	$0	$0	$0	$0	$2,175,000
Grants ☐	$0	$0	$0	$0	$0	$0
Other ☐ Specify	$0	$0	$0	$0	$0	$0
TOTAL INVESTMENT	$3,045,000	$0	$0	$0	$0	$3,045,000
CUMULATIVE INVESTMENT	$3,045,000	$3,045,000	$3,045,000	$3,045,000	$3,045,000	

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 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	TOTAL FOR ALL YEARS
Project Cost	$3,045,000	$0	$0	$0	$0	$3,045,000
Net Tangible Benefits	$120,068,342	$0	$0	$0	$0	$120,068,342
Return on Investment	$117,023,342	$0	$0	$0	$0	$117,023,342
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	2016-17	Fiscal Year during which the project's investment costs are recovered.
Net Present Value (NPV)	$114,796,294	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 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Cost of Capital	1.94%	2.07%	3.18%	4.32%	4.85%

Project	*Advanced Data Analytics*	
Agency	*AHCA*	
FY 2016-17 LBR Issue Code:	FY 2016-17 LBR Issue Title:	
Issue Code	*Issue Title*	
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*	*8/18/2015*

Risk Assessment Summary

Most Aligned

Business Strategy

Least Aligned

Level of Project Risk

Least Risk

Most Risk

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: AHCA

Project: Advanced Data Analytics

#	Criteria	Values	Answer
		Section 1 -- Strategic Area	
1.01	Are project objectives clearly aligned with the agency's legal mission?	0% to 40% -- Few or no objectives aligned	81% to 100% -- All or nearly all objectives aligned
		41% to 80% -- Some objectives aligned	
		81% to 100% -- All or nearly all objectives aligned	
1.02	Are project objectives clearly documented and understood by all stakeholder groups?	Not documented or agreed to by stakeholders	Documented with sign-off by stakeholders
		Informal agreement by stakeholders	
		Documented with sign-off by stakeholders	
1.03	Are the project sponsor, senior management, and other executive stakeholders actively involved in meetings for the review and success of the project?	Not or rarely involved	Most regularly attend executive steering committee meetings
		Most regularly attend executive steering committee meetings	
		Project charter signed by executive sponsor and executive team actively engaged in steering committee meetings	
1.04	Has the agency documented its vision for how changes to the proposed technology will improve its business processes?	Vision is not documented	Vision is completely documented
		Vision is partially documented	
		Vision is completely documented	
1.05	Have all project business/program area requirements, assumptions, constraints, and priorities been defined and documented?	0% to 40% -- Few or none defined and documented	81% to 100% -- All or nearly all defined and documented
		41% to 80% -- Some defined and documented	
		81% to 100% -- All or nearly all defined and documented	
1.06	Are all needed changes in law, rule, or policy identified and documented?	No changes needed	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: AHCA

Project: Advanced Data Analytics

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: AHCA

Project: Advanced Data Analytics

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 No	Yes
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 Proactive use of 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 No	Yes
4.04	Are all affected stakeholders included in the Communication Plan?	Yes No	Yes
4.05	Have all key messages been developed and documented in the Communication Plan?	Plan does not include key messages Some key messages have been developed All or nearly all messages are documented	Plan does not include key messages
4.06	Have desired message outcomes and success measures been identified in the Communication Plan?	Plan does not include desired messages outcomes and success measures Success measures have been developed for some messages All or nearly all messages have success measures	Plan does not include desired messages outcomes and success measures
4.07	Does the project Communication Plan identify and assign needed staff and resources?	Yes No	Yes

Agency: AHCA Project: Advanced Data Analytics

Section 5 -- Fiscal Area			
#	Criteria	Values	Answer
5.01	Has a documented Spending Plan been approved for the entire project lifecycle?	Yes No	Yes
5.02	Have all project expenditures been identified in the Spending Plan?	0% to 40% -- None or few defined and documented 41% to 80% -- Some defined and documented 81% to 100% -- All or nearly all 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 Greater than $10 M Between $2 M and $10 M Between $500K and $1,999,999 Less than $500 K	Between $2 M and $10 M
5.04	Is the cost estimate for this project based on quantitative analysis using a standards-based estimation model?	Yes No	Yes
5.05	What is the character of the cost estimates for this project?	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%	Detailed and rigorous (accurate within ±10%)
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 local government agencies Funding from other state agencies	Funding from single agency
5.08	If federal financial participation is anticipated as a source of funding, has federal approval been requested and received?	Neither requested nor received Requested but not received Requested and received Not applicable	Requested and received
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 Most project benefits have been identified but not validated All or nearly all project benefits have been identified and validated	Most project benefits have been identified but not validated
5.10	What is the benefit payback period that is defined and documented?	Within 1 year Within 3 years Within 5 years More than 5 years No payback	Within 1 year
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 not been consulted re: procurement strategy Stakeholders have reviewed and approved the proposed 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) Combination FFP and T&E	Firm Fixed Price (FFP)

Agency: AHCA Project: Advanced Data Analytics

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	

Agency: AHCA Project: Advanced Data Analytics

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 No	Yes
6.02	Have all roles and responsibilities for the executive steering committee been clearly identified?	None or few have been defined and documented Some have been defined and documented All or nearly all have been defined and documented	All or nearly all have been defined and documented
6.03	Who is responsible for integrating project deliverables into the final solution?	Not yet determined Agency System Integrator (contractor)	System Integrator (contractor)
6.04	How many project managers and project directors will be responsible for managing the project?	3 or more 2 1	2
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 Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented	Some or most staff roles and responsibilities and needed skills have been identified
6.06	Is an experienced project manager dedicated fulltime to the project?	No experienced project manager assigned No, project manager is assigned 50% or less to project No, project manager assigned more than half-time, but less than full-time to project Yes, experienced project manager dedicated full-time, 100% to project	Yes, experienced project manager dedicated full-time, 100% to project
6.07	Are qualified project management team members dedicated full-time to the project	None No, business, functional or technical experts dedicated 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	None
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 Mostly staffed from in-house resources Completely staffed from in-house resources	Half of staff from in-house resources
6.09	Is agency IT personnel turnover expected to significantly impact this project?	Minimal or no impact Moderate impact Extensive impact	Minimal or no 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 No	Yes
6.11	Are all affected stakeholders represented by functional manager on the change review and control board?	No board has been established No, only IT staff are on change review and control board No, all stakeholders are not represented on the board Yes, all stakeholders are represented by functional manager	No board has been established

Agency: AHCA Project: Advanced Data Analytics

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	Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables
7.09	Has the Work Breakdown Structure (WBS) been defined to the work package level for all project activities?	0% to 40% -- None or few have been defined to the work package level 41 to 80% -- Some have been defined to the work package level 81% to 100% -- All or nearly all have been defined to the work package level	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

Agency: AHCA Project: Advanced Data Analytics

Section 7 -- Project Management Area			
#	Criteria	Values	Answer
7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints), critical milestones, and resources?	Yes No	Yes
7.12	Are formal project status reporting processes documented and in place to manage and control this project?	No or informal processes are used for status reporting Project team uses formal processes Project team and executive steering committee use formal status reporting processes	Project team and executive steering committee use formal status reporting processes
7.13	Are all necessary planning and reporting templates, e.g., work plans, status reports, issues and risk management, available?	No templates are available Some templates are available All planning and reporting templates are available	All planning and reporting templates are available
7.14	Has a documented Risk Management Plan been approved for this project?	Yes No	Yes
7.15	Have all known project risks and corresponding mitigation strategies been identified?	None or few have been defined and documented Some have been defined and documented All known risks and mitigation strategies have been defined	All known risks and mitigation strategies have been defined
7.16	Are standard change request, review and approval processes documented and in place for this project?	Yes No	Yes
7.17	Are issue reporting and management processes documented and in place for this project?	Yes No	Yes

Agency: AHCA

Project: Advanced Data Analytics

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 Similar complexity Less complex	More complex
8.02	Are the business users or end users dispersed across multiple cities, counties, districts, or regions?	Single location 3 sites or fewer More than 3 sites	3 sites or fewer
8.03	Are the project team members dispersed across multiple cities, counties, districts, or regions?	Single location 3 sites or fewer More than 3 sites	3 sites or fewer
8.04	How many external contracting or consulting organizations will this project require?	No external organizations 1 to 3 external organizations More than 3 external organizations	1 to 3 external organizations
8.05	What is the expected project team size?	Greater than 15 9 to 15 5 to 8 Less than 5	9 to 15
8.06	How many external entities (e.g., other agencies, community service providers, or local government entities) will be impacted by this project or system?	More than 4 2 to 4 1 None	2 to 4
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 Statewide or multiple agency business process change	Agency-wide business process change
8.08	Has the agency successfully completed a similarly-sized project when acting as Systems Integrator?	Yes No	Yes
8.09	What type of project is this?	Infrastructure upgrade Implementation requiring software development or purchasing commercial off the shelf (COTS) software Business Process Reengineering Combination of the above	Combination of the above
8.10	Has the project manager successfully managed similar projects to completion?	No recent experience Lesser size and complexity Similar size and complexity Greater size and complexity	Similar 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 Lesser size and complexity Similar size and complexity Greater size and complexity	Similar size and complexity

ID	Indicators	Task Mode	% Complete	Task Name	Requirement IDs	Duration
1			**98%**	**State of FL -ACHA**		**375 days?**
24			**97%**	**Receipt of Data**		**345 days?**
50			**88%**	**SAM Data**	**4.0**	**136 days**
56			50%	Automate Data Feeds	4.0.5	15 days
57			75%	Data Validation	4.6	2 days
58			0%	Signoff on Data / Handoff of Data to Analytics Team	4.6	3 days
66			80%	Deadline: 120 days from receipt of data		0 days
92			**71%**	**Analytic Checkpoints & AHCA Feedback**		**84 days**
100			**97%**	**Analytics**	**5.0; 5.1; 5.2**	**81 days?**
151			0%	Incremental data loads		5 days
152			0%	Scheduled loads		2 days
153			0%	Deliverable 16 - Final Report and Lessons Learned		35 days
154			**43%**	**Case Management Integration**		**2 days**
155			0%	Design Sessions with AHCA		2 days
156			0%	Initial Development	1.3; 1.4	8 days
157			0%	Test Development		2 days
158			0%	Updates Based on Testing		3 days
159			0%	Review with AHCA		3 days
160			0%	UAT		5 days
161			0%	Remediation Based on UAT		3 days
162			0%	AHCA Signoff on Integration		2 days
163			0%	Promotion to Prod		1 day
164			**77%**	**Post Deployment Analytic Refinements**		**10 days**
165			**34%**	**Recipient Analytics**		**11 days**

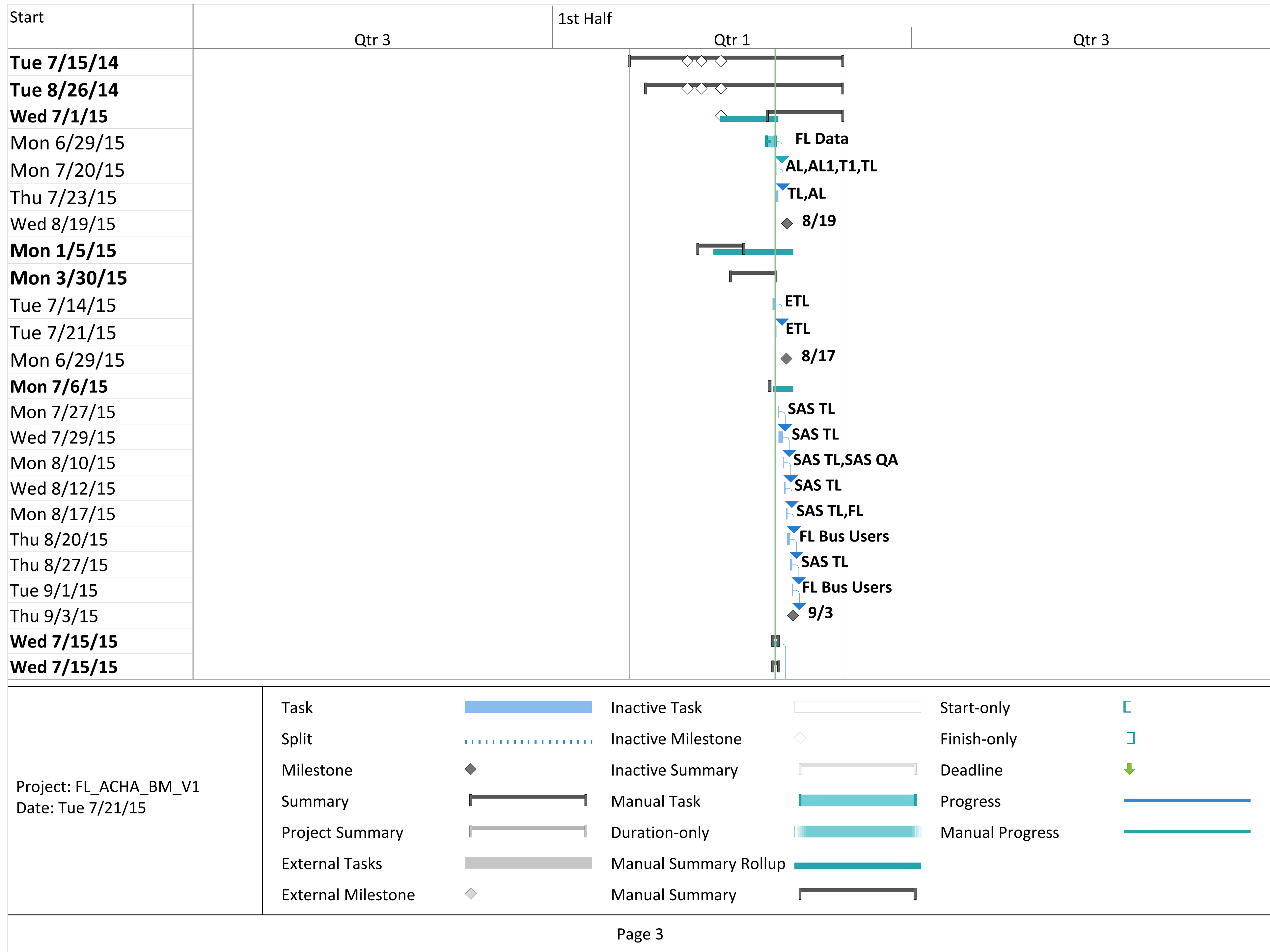
Project: FL_ACHA_BM_V1
Date: Tue 7/21/15

Task	Inactive Task	Start-only
Split	Inactive Milestone	Finish-only
Milestone	Inactive Summary	Deadline
Summary	Manual Task	Progress
Project Summary	Duration-only	Manual Progress
External Tasks	Manual Summary Rollup	
External Milestone	Manual Summary	

ID		Task Mode	% Complete	Task Name	Requirement IDs	Duration
166			25%	Initial implement rules		5 days
168			0%	Initial scoring		1 day
169			**91%**	**Medical / Facility Claim Analytics**		**11 days**
170			100%	Initial implement rules		5 days
171			100%	Initial implement outlier detection models		5 days
172			0%	Initial scoring		1 day
173			**91%**	**Pharmacy Claim Analytics**		**11 days**
174			100%	Initial implement rules		5 days
175			100%	Initial implement outlier detection models		5 days
176			0%	Initial scoring		1 day
177			**91%**	**Dental Claim Analytics**		**11 days**
178			100%	Initial implement rules		5 days
179			100%	Initial implement outlier detection models		5 days
180			0%	Initial scoring		1 day
181			**80%**	**Provider Analytics**		**11 days**
182			100%	Initial implement outlier detection models		5 days
183			75%	Initial implement predictive models		5 days
184			0%	Initial scoring		1 day
185			**13%**	**QA & UAT - Refinements**		**20 days**
186			50%	QA		5 days
187			0%	UAT 1		3 days
188			0%	Remediation Based on UAT 1		3 days
189			0%	UAT 2		3 days
190			0%	Remediation Based on UAT 2		3 days
191			0%	Promotion to Prod		3 days

Project: FL_ACHA_BM_V1
Date: Tue 7/21/15

Task		Inactive Task		Start-only	
Split		Inactive Milestone		Finish-only	
Milestone		Inactive Summary		Deadline	
Summary		Manual Task		Progress	
Project Summary		Duration-only		Manual Progress	
External Tasks		Manual Summary Rollup			
External Milestone		Manual Summary			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1st Half
Qtr 3
Qtr 1
Qtr 3
Tue 7/15/14
Tue 8/26/14
Wed 7/1/15
Mon 6/29/15
Mon 7/20/15
Thu 7/23/15
Wed 8/19/15
Mon 1/5/15
Mon 3/30/15
Tue 7/14/15
Tue 7/21/15
Mon 6/29/15
Mon 7/6/15
Mon 7/27/15
Wed 7/29/15
Mon 8/10/15
Wed 8/12/15
Mon 8/17/15
Thu 8/20/15
Thu 8/27/15
Tue 9/1/15
Thu 9/3/15
Wed 7/15/15
Wed 7/15/15
FL Data
AL,AL1,T1,TL
TL,AL
8/19
ETL
ETL
8/17
SAS TL
SAS TL
SAS TL,SAS QA
SAS TL
SAS TL,FL
FL Bus Users
SAS TL
FL Bus Users
9/3
Project: FL_ACHA_BM_V1
Date: Tue 7/21/15
Task
Split
Milestone
Summary
Project Summary
External Tasks
External Milestone
Inactive Task
Inactive Milestone
Inactive Summary
Manual Task
Duration-only
Manual Summary Rollup
Manual Summary
Start-only
Finish-only
Deadline
Progress
Manual Progress
Page 3

Start
Wed 7/15/15
Wed 7/29/15
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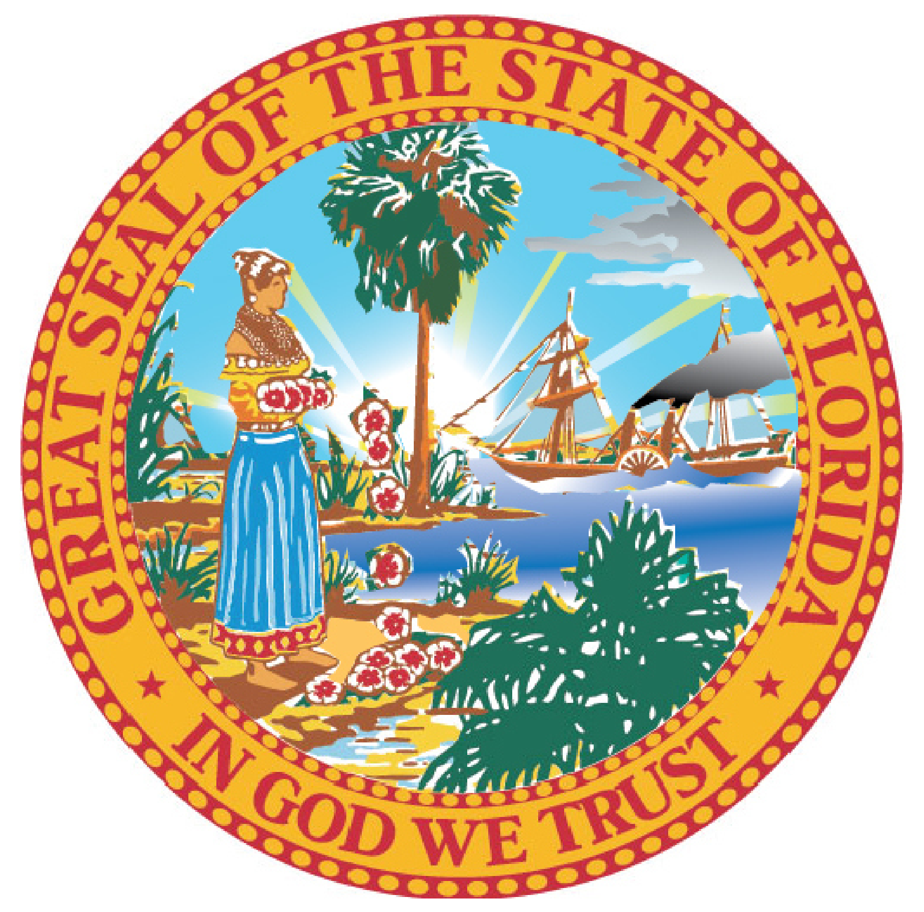
Wed 7/29/15
Thu 7/16/15
Thu 7/16/15
Thu 7/23/15
Tue 7/28/15
Fri 7/31/15
Wed 8/5/15
Mon 8/10/15

Project: FL_ACHA_BM_V1
Date: Tue 7/21/15

Task	Inactive Task	Start-only
Split	Inactive Milestone	Finish-only
Milestone	Inactive Summary	Deadline
Summary	Manual Task	Progress
Project Summary	Duration-only	Manual Progress
External Tasks	Manual Summary Rollup	
External Milestone	Manual Summary	

SCHEDULE IV-B FOR MEDICAID MANAGEMENT INFORMATION SYSTEM RE-PROCUREMENT

For Fiscal Year 2016-17



August 2015

AGENCY FOR HEALTH CARE ADMINISTRATION

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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: Florida Systems Integrator, Medicaid Management Information System, Decision Support System and Fiscal Agent Services Reprocurement	Is this project included in the Agency's LRPP? _ ___ Yes __X__ No
FY 2016-17 LBR Issue Code:	FY 2016-17 LBR Issue Title: Medicaid Systems Planning and Research --Year 3 of 5
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Angela Ramsey, 850-688-9321, Angela.Ramsey@ahca.myflorida.com	
AGENCY APPROVAL SIGNATURES	
I am submitting the attached Schedule IV-B in support of our legislative budget request. I have reviewed the estimated costs and benefits documented in the Schedule IV-B and believe the proposed solution can be delivered within the estimated time for the estimated costs to achieve the described benefits. I agree with the information in the attached Schedule IV-B.	
Agency Head: Printed Name: Elizabeth Dudek	Date: 9/10/11
Agency Chief Information Officer (or equivalent): Printed Name: Scott Ward	Date: 9/10/15
Budget Officer: Printed Name: Anita Hicks	Date: 9/15/15
Planning Officer: Printed Name:	Date:
Project Sponsor: Printed Name: Gay Munyon	Date: 9/15/2015
Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
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Technology Planning:	Angela Ramsey, 850-688-9321, Angela.Ramsey@ahca.myflorida.com
Project Planning:	Angela Ramsey, 850-688-9321, Angela.Ramsey@ahca.myflorida.com

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

1. Business Need

HP Enterprise Services (HPES) is the Florida Medicaid fiscal agent for the current contract period, July 2008 through June 2018. The planning, preparation and eventual transition of a fiscal agent contract is a costly and time intensive project that historically has spanned several years. Due to the complexity of the current health care industry landscape and Florida Medicaid's many initiatives, especially statewide managed care, research and evaluation of national innovative models, as well as Florida Medicaid's needs, is essential to determine the extent and type of the Florida Medicaid Management Information System (FMMIS) and Decision Support System (DSS) procurement.

Using the results of the Research and Planning Vendor's analyses, Florida selected a system takeover with upgrades and major enhancements as its FMMIS solution. This option involves significant modification or replacement of components of the existing FMMIS, and support of the existing solution is assumed or retained by the successful bidding vendor. Additionally, the Agency for Health Care Administration (AHCA) has selected the design, development, and implementation of a replacement DSS solution. The AHCA will enlist the services of a systems integrator to ensure that both systems and any additional modular components function together appropriately.

Several factors contributed to the AHCA's decision, including:

- Move toward modularity: The base operations of the current system, which was implemented in 2008, are adequate, yet there are opportunities to move the baseline FMMIS toward a more modular solution through major enhancements.
- Reduced implementation risk: The solutions selected by the AHCA allows Florida to accomplish its FMMIS/FA and DSS objectives at far lower risk to the State versus, for example, custom built solutions.
- Composition of service delivery: Following the recent transition to statewide managed care for recipients, the need for enhanced data analytics may overtake the need for traditional capabilities inherent in the existing systems.
- FMMIS Replacement/Modification Cost: The system takeover with enhancements option is estimated to have the least expense immediately, with a solid return on investment and a competitive break-even year. The financial performance of this option is due to a small initial investment and savings associated with lowered operating costs.

As can sometimes occur with large scale implementation projects, AHCA goals for this procurement continue to develop and mature following the conclusion of the formal alternatives analysis, resulting in a procurement decision that may differ somewhat from the alternatives analyzed. The procurement option ultimately selected by the AHCA – takeover of the FMMIS with upgrades and enhancements and replacement of the DSS – aligns most closely with, respectively, the Two-Phase Systems Integrator Option and Off the Shelf Complete Solution or COTS.

The successful Vendor will serve in the important role of systems integrator for the SI/FMMIS/FA/DSS Project, responsible for bringing together the FMMIS, DSS, and any additional systems supporting the Medicaid program at their appropriate integration points.

2. Business Objectives

The current Medicaid fiscal agent contract with HPES ends on June 30, 2018; Florida Medicaid must, at a minimum, procure a new fiscal agent contract. Historically, procurement of a new fiscal agent has signaled either enhancement of the existing FMMIS during the turnover to the new fiscal agent contract or a full design and implementation of a new FMMIS.

Moreover, Florida has recently installed significant changes that will have an impact on the operation of Florida Medicaid and its FMMIS.

- Florida's transition to full state-wide managed care: The AHCA has completed the implementation of the long term care managed care program and the managed medical assistance program in August 2014.
- Conversion to Diagnosis-Related Groups (DRG) inpatient hospital reimbursement methodology on July 1, 2013. The AHCA continues post-implementation analysis of the impacts associated with this critical methodology change as well as ongoing installation of updated DRG editions.
- A study has been undertaken to explore moving outpatient reimbursement methodology to a DRG based methodology in State Fiscal Year 16-17.

In addition to state projects, there are several very critical federal initiatives that impact Florida and must be considered. Some of the more high-profile initiatives that Florida will be working on during the next several years include:

- Installation of Affordable Care Act (ACA)-mandated operating rules necessary for the electronic exchange of information, which are meant to realize administrative simplification of HIPAA standard transactions
- Enhancements needed to implement Transformed-Medicaid Statistical Information System (T-MSIS) which will provide CMS with expanded enrollment, utilization and expenditure data for Medicaid and CHIP programs
- New requirements for Medicaid as a result of ACA, including the concept of the health insurance exchange and increased provider enrollment and screening capability
- Transition to the mandated ICD-10 codes by October 2015

Also, there are several issues to be considered regarding the Decision Support System (DSS). Many States are looking to their data warehouses to provide users with a greater range of analytical possibilities beyond canned reporting of aggregated data. To achieve that goal, States are integrating external data sources (e.g., immunization and public health records) into their Medicaid data warehouses and supplying more advanced analytical tools to detect fraud and abuse and measure health outcomes. States are looking for comprehensive databases that allow users to perform link analysis, predictive modeling, and anomaly detection across many disparate data sources on an ad hoc basis. Ideally, those comprehensive databases are securely hosted online (without the need for proxy access or multiple platforms), are structured and hosted with enough hardware to support several hundred users, and are designed to accommodate ad hoc querying, large volume data extraction, as well as canned state and federal reporting.

After careful research and planning, the AHCA will solicit responses from vendors to establish a replacement Fiscal Agent contract, takeover the current FMMIS and the Design, Development, and Implementation of major modules of the FMMIS, and the Design, Development, and Implementation of a DSS new to Florida Medicaid. The AHCA FMMIS/DSS State Management Team is comprised of AHCA state staff, who are supported by the following contracted vendor consulting teams.

Research and Planning Consulting Team

The AHCA contracted with CSG, Government Solutions (CSG) for research and planning services to update the MITA State Self-Assessment through analysis of the enterprise-wide business needs and conduct comprehensive research to identify available alternatives that will meet the AHCA's needs and advance its MITA Maturity Levels.

Following thorough consideration of alternatives, the AHCA, in conjunction with CSG, recommended the most beneficial and cost-effective solutions which will be used as the basis for the development of a competitive solicitation to enhance and operate the FMMIS, perform fiscal agent operations, and install a replacement DSS. This recommendation was approved by the established Medicaid Enterprise Systems Steering Committee and Governance Committee.

Project Management Office (PMO) Consulting Team

The AHCA contracted with The North Highland Company (NH), for PMO consulting services to provide professional project management office (PMO) services. The PMO consultant provides comprehensive project management services during the planning phase of the project and will continue through implementation of the selected FMMIS/DSS solution and takeover of fiscal agent operations. NH is also a key participant in the development of the solicitation documents that will result from this project.

Independent Verification and Validation Consulting Team

The AHCA, in accordance with 45 CFR Part 95.626, contracted with KPMG to provide Independent Verification and Validation (IV&V) services for project management oversight. The IV&V consulting team is responsible for the overall evaluation of the project's efficacy in fulfilling the targeted business needs and will provide periodic project assessments to the Executive Steering and Governance Committees and to the federal CMS. The IV&V consultant will use the CMS Medicaid Enterprise Certification Toolkit checklists to document compliance with the certification criteria as part of the IV&V review criteria.

User Acceptance Testing Consulting Team

The AHCA will contract with a vendor who is required to develop a User Acceptance Testing (UAT) Plan that describes the approach, timing, and activities involved in coordinating and conducting UAT, as well as the recommended depth and breadth of coverage from a functional perspective that needs to be exercised during UAT testing. The vendor will develop UAT Protocols and a Training Manual that describes the goals and objectives of UAT, roles and responsibilities of the UAT Team, test methods and techniques, testing tools and templates, identified testing scenarios, and sample test cases and will execute UAT testing activities including training testers, coordinating/facilitating the UAT testing, and the logging and reporting of test case results on a weekly basis. These activities are essential to ensure that the enhanced FMMIS and "new to Florida" DSS are functioning as expected and that the State has achieved a successful outcome to the Design, Development, and Implementation of the fiscal agent contract and supporting systems. This vendor comes on board to the team during the Design, Development, and Implementation period, after the start of State Fiscal Year 2017-2018.

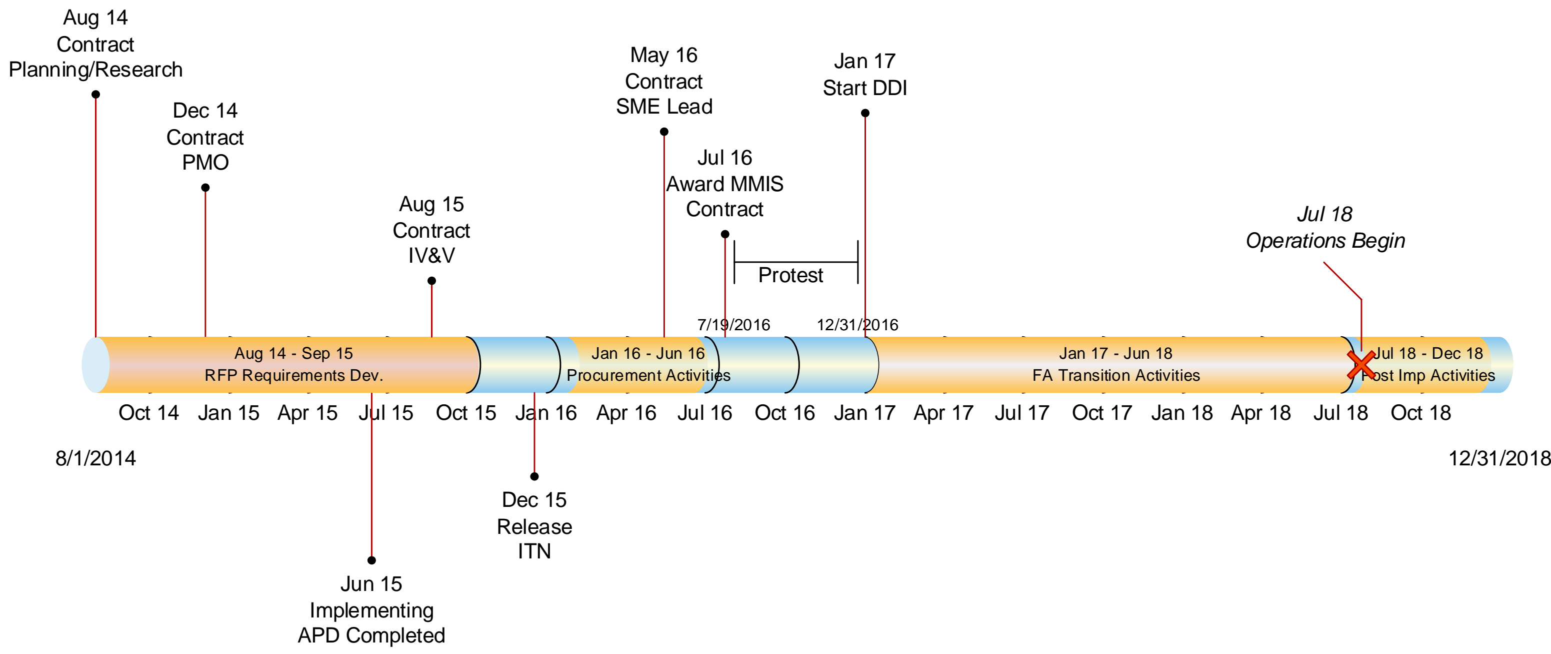
Organization Change Management Consulting Team

The AHCA will contract with a vendor who is required to address a comprehensive Organizational Change Management (OCM) strategy to prepare for implementation of the AHCA's choice for the FMMIS/DSS solicitation. This vendor will coordinate with the FMMIS/DSS Vendor to document all operational impacts of system enhancements or changes and organize the plan to acclimate staff to the changes in the systems around the MITA business processes and the seven conditions and standards. Using OCM best practices, the vendor will coach the AHCA in the areas of Communication, Sponsorship, Coaching, Training, Resistance Management and Reinforcement to facilitate change readiness and system adoption. This vendor comes on board to the team during the Design, Development, and Implementation period, after the start of State Fiscal Year 2017-2018.

Subject Matter Lead Consulting Team

The AHCA will contract with a Subject Matter Lead consulting team to oversee input and participation of the AHCA Subject Matter Experts. These consultants will become an integral to ensuring the design and development phase addresses the business needs of the AHCA. This vendor comes on board to the team before the beginning of the Design, Development, and Implementation period, just prior to the start of State Fiscal Year 2016-2017.

The AHCA developed the following timeline for this long-term project in order to plan appropriately for each phase of the process.



B. Baseline Analysis

1. Current Business Process(es)

In August 2014 Florida Medicaid hired a research and planning consultant, CSG Government Solutions, to assist the AHCA in business needs analysis through a Medicaid Information and Technology Architecture State Self-Assessment (MITA SS-A) developed by the federal Centers for Medicare and Medicaid (CMS) for state Medicaid identification of business needs and the data and technology solutions to address the business needs. The MITA SS-A provided a process for identifying a roadmap for the state to use in advancing the systems needed to support the Medicaid program. The CSG contract also required alternatives research, as well as, requirements analysis for the preparation of a procurement document for the next fiscal agent contract. Important tasks for the consultant are as follows:

- Research available technologies that will address the impacts from the factors outlined above, including national innovative models and collaborative options with other states
- Research DSS and data analytics products and services
- Conduct an assessment of the current FMMIS and DSS functionality and operations
- Plan and conduct business requirements gathering sessions organized by the federal Medicaid Information Technology Architecture (MITA) 3.0 structure and used to update to the current Florida MITA State Self-Assessment (SS-A)
- Develop a gap analysis of the current FMMIS/DSS environment/MITA maturity level and the updated "To Be" maturity level
- Plan and conduct technical and operations requirements gathering sessions for the anticipated Fiscal Agent-FMMIS/DSS solicitation

In collaboration with stakeholders, Florida Medicaid staff lead and participated in necessary business need identification sessions to understand the current and projected state and national environments and to select the options that best meet the AHCA's business needs and support the Florida MITA SS-A.

For functions and capabilities that do not currently exist in the FMMIS or DSS, the capability will be designed, developed, and implemented through a standard System Life Cycle Development methodology during the Design, Development, and Implementation Phase of the project. All potential solutions will be analyzed to determine the most effective and efficient implementation of the required functions.

The Requirement Analysis and Development (RAD) sessions yielded more than 2,000 validated requirements for the FMMIS, Fiscal Agent, and DSS solicitation. AHCA Subject Matter Experts (SMEs) were engaged in the identification, verification, and validation of the requirements over a five month period. Requirements are identified in several categories based on functions and Medicaid business areas:

FMMIS/Fiscal Agent

- Systems Integrator
- System Architecture
- FMMIS User Interface
- Security
- Change Management
- Quality Management
- System and User Documentation
- Testing
- Workflow Management
- Automated Letter Generator

- Document Imaging and Data Entry System
- Call Center Management System
- Automated Voice Response System
- Report and Image Repository
- Web Portal
- Web-based Survey Tools
- Electronic Data Interchange
- Learning Management System
- Desktop Publishing
- Eligibility and Enrollment Management
- Member Management
- Provider Management
- Care Management
- Plan Management
- Operations Management
- Business Relationship Management
- Financial Management
- Performance Management
- Contractor Management
- Clinical Consulting Enhancements
- Provider Enrollment and Management Enhancements
- Enhanced Encounter Processing Rules Enhancements

Decision Support System/Data Warehouse

- Security
- Reporting and Analytics
- Fraud and Abuse Reporting
- Quality Reporting
- Federal and Financial Reporting
- Decision Support System/Data Warehouse
- Interfaces
- Data Quality Control
- Change Management
- Operations Testing
- Quality Management
- System and User Documentation
- Work Flow Management
- Web-based Survey Tools

2. Assumptions and Constraints

For the purposes of the project, assumptions are circumstances and events that need to occur for the project to be successful, but are outside the total control of the project team. The following assumptions are identified:

- AHCA and Vendor staff and other project Stakeholders will be available and actively participate in the project activities and will respond to requests in a timely manner.
- The FMMIS/DSS/Fiscal Agent project solicitations will result in the timely onboarding of the planned project consulting teams with little to no impact to the master project schedule critical path.
- The AHCA Medicaid Enterprise System governance structure will provide timely decision making and FMMIS/DSS project guidance to facilitate an integrated approach to the prioritization of time, resources and budget across all of the AHCA initiatives currently in progress and for any new initiatives over the life of the project.

For the purposes of the project, constraints are defined as the conditions or circumstances limiting the project relative to scope, quality, schedule, budget, and resources.

- Project funding for the FMMIS/DSS/Fiscal Agent Procurement project is contingent upon the timely completion, submission and approval of the required advanced planning documentation by the Centers for Medicare and Medicaid Services (CMS).
- The completion of the implementation of the FMMIS, DDS and Fiscal Agent operations and continued enhanced Federal Financial Participation (FFP) for operations is contingent upon certification by the Centers for Medicare and Medicaid Services (CMS).
- AHCA resources are managed by the AHCA Project Director and the Vendor team resources are managed by the Vendor Project Manager.
- Contractual relationships of supporting vendors may create conflicting goals and motivations that must be identified and managed as risks and issues.

This list of constraints will serve to inform the initial list of project risks and be documented and managed as part of the FMMIS Procurement Project PM Plan over the life of the project. Any changes to the project constraints will be updated as part of the process of updating the PM Plan deliverable of the PMO Vendor, North Highland.

C. Proposed Business Process Requirements

1. Proposed Business Process Requirements

The business requirements are currently under finalization. In order to preserve the confidentiality needs of this procurement until the release of the ITN, the AHCA has not included the draft of these requirements in the August 2015 version of this report. The requirements will be released with the ITN in December 2015. The following preparation work has been completed in order to arrive at a description the business needs of the AHCA, through the Florida Medicaid Information and Technology Architecture State Self-Assessment (MITA SS-A) project. The purpose of the project (the Project) was to identify the 'As-Is' operations and the To-Be environment of the business, information and technical capabilities of Florida's Medicaid program.

Using a variety of tools and techniques, the Florida MITA team (the team), comprised of AHCA and CSG staff, as well, as one hundred ninety-nine (199) Subject Matter Experts (SMEs), assessed how Florida currently conducts the business processes of the Medicaid program. Each Medicaid business area along with the associated information and technical capabilities were assessed to determine the current maturity as measured by what is known as MITA maturity capabilities. Assembled into SS-A artifacts, the information about the Florida Medicaid program is required by the Centers for Medicare and Medicaid Services (CMS) when Florida seeks enhanced federal financial participation (FFP) related to development of Medicaid information technology through an Advance Planning Document (APD). The development of the SS-A comprised of the required artifacts, will enable AHCA as the State Medicaid AHCA (SMA) to enhance Florida's Medicaid technical and operational infrastructure and help shape the future vision of the Florida Medicaid Enterprise.

The SS-A is part of AHCA's strategic plan for Medicaid systems modernization; the centerpiece of the strategic plan is a modernization roadmap that identifies the activities and timelines for maturing the Medicaid information systems. An annual SS-A update is required by CMS to identify how progress is being made to move the Florida Medicaid Enterprise forward along this roadmap. Given the annual update approach to the SS-A, while striving towards five (5) year goals, areas of the SS-A will address annual activities that need to be accomplished. Building on this first iteration as the baseline, and with years of refinement, the SS-A will meet the goal of guiding the Florida Medicaid Enterprise to meet the ever changing health care needs of Florida Medicaid recipients.

The MITA initiative is built upon a framework that supports the Medicaid program. The MITA framework itself involves three architectures that relate to each other as the foundation for any Medicaid program. These architectures are:

- Business Architecture
- Information Architecture
- Technical Architecture

These three architectures define the business processes used by Florida, the information or data consumed and produced from those processes and the technical infrastructure to manage the data.

The Business Architecture of MITA is comprised of ten (10) generalized business areas, such as Operations Management or Contractor Management. Each one of these business areas is further broken down into business processes. For example the Business area of Operations Management contains processes such as Apply Mass Adjustment or Process a Claim. There are a total of eighty (80) business processes. The Information Architecture is driven by the Business Architecture's Business Process Model and the Technical Architecture has sub groupings to Technical Service Areas that support both the Business and Information Architectures.

In April of 2011, under the Social Security Act, CMS issued new conditions and standards that must be met by states to be eligible for enhanced federal funding for FMMIS-related systems development and operations and must be taken into account in an SS-A. These seven (7) conditions and standards include the following:

- Modularity Standard – The use of a modular, flexible approach to IT systems development;
- MITA Condition – The development of Medicaid IT solutions to align with increasingly advanced MITA maturity guidelines;
- Industry Standards Condition – Alignment with, and incorporation of, industry standards in Medicaid IT development;
- Leverage Condition – Promotion of the leverage and reuse of Medicaid technologies and systems
- Business Results Condition – Enactment of performance standards to insure accurate, efficient and effective management of the Medicaid business processes;
- Reporting Condition – Production of data, reports and performance information to improve management of the Medicaid program; and
- Interoperability Condition – Integration of new Medicaid IT systems with Health Information Exchange initiatives.

Profiles for each business area are attached to this document in Attachment A for reference. The rankings on the profiles represent maturity levels of one (1) through five (5). Level 1 is generally low maturity with manual processes and little or no automation; level 5 is high maturity with complete, or near complete automation of the business process.

2. Business Solution Alternatives

CSG Government Solutions was contracted to conduct research in the area of alternatives in Medicaid systems across the country. The description of the results of this research is in Attachment B - Report on Research Tasks.

3. Rationale for Selection

A solution selection has not been made at this point of the planning phase of the project. The evaluation criteria are under development. After a solution is procured, this section can be updated.

4. Recommended Business Solution

A solution selection has not been made at this point of the planning phase of the project. The negotiation strategy

are under development. After a solution is procured, this section can be updated.

D. Functional and Technical Requirements

The discussion of MITA is inclusive of Information (data) and Technical (functional) Architectures, as well as the expectations for adhering to the seven conditions and standards set by federal regulation. Profiles for these requirements are attached to this document for reference in Attachment A. The rankings on the profiles represent maturity levels of one (1) through five (5). Level 1 is generally low maturity with manual processes and little or no automation; level 5 is high maturity with complete, or near complete automation of the business process.

Functional and technical requirements have not be identified at this point of the planning phase of the project. After a solution is procured, this section can be updated.

III. Success Criteria

SUCCESS CRITERIA TABLE				
#	**Description of Criteria**	**How will the Criteria be measured/assessed?**	**Who benefits?**	**Realization Date (MM/YY)**
1	Issue solicitation (s) as planned.	Measured through the Project Schedule	• The AHCA, • Medicaid Providers, • Medicaid Recipients, • Potential Vendors.	12/15
2	Begin Design, Development and Implementation as planned.	Measured through the Project Schedule	• The AHCA, • Medicaid Providers, • Medicaid Recipients, • Potential Vendors	01/17
3	Implement the new Fiscal Agent contract with a start date of July 1, 2018.	Assessed through the Project Schedule and the Independent Validation and Verification Vendor	• The AHCA, • Medicaid Providers, • Medicaid Recipients, • Contracted DDI Vendor(s)	07/18
4	Certification of the FMMIS and DSS to ensure continued enhanced Federal Financial Participation in the operation of the FMMIS and DSS.	Measured and assessed by CMS through the CMS-prescribed certification process	• The AHCA, • Florida state government	01/19

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

A. Benefits Realization Table

Tangible benefits cannot be identified at this point of the planning phase of the project. After a solution is procured, this section can be updated.

B. Cost Benefit Analysis (CBA)

1. The Cost-Benefit Analysis Forms

A cost benefit analysis of the re-procurement cannot be identified at this point of the planning phase of the project. After a solution is procured, this section can be updated. Preliminary versions of the CBA forms have been completed and will be updated as the project progresses.

V. Schedule IV-B Major Project Risk Assessment

A. Risk Assessment Summary

A complete risk assessment summary of the re-procurement cannot be identified at this point of the planning phase of the project. After a solution is procured, this section can be updated. Preliminary versions of Appendix B forms have been completed and will be updated as the project progresses.

VI. Schedule IV-B Technology Planning

This section cannot be completed at this point of the planning phase of the project. After the planning phase has been completed and a solution is procured, this section can be updated.

A description of the preparation work done to develop business and functional requirements is contained in the MITA State Self-Assessment summary that is included as an Attachment C to this schedule.

A. Current Information Technology Environment

1. Current System

a. Description of current system

A description of the current system and the gaps present in the desired state is contained in the MITA State Self-Assessment summary that is included as an Attachment D to this schedule.

b. Current system resource requirements

The HP organizational chart for July 2015 is Attachment E.

c. Current system performance

The System Performance Report Card for November 2014 is Attachment F.

2. Information Technology Standards

Medicaid systems are bound by Federal regulations regarding technical conditions and standards in order to obtain enhanced Federal Financial Participation (FFP). The Centers for Medicare and Medicaid Services (CMS) have mandated the following conditions and standards:

- Modularity Standard
- MITA Condition
- Industry Standards Condition
- Leverage Condition
- Business Results Condition
- Reporting Condition
- Interoperability Condition

The Seven Conditions and Standards are described in detail in Attachment G.

B. Current Hardware and/or Software Inventory

The current hardware and software inventory of the Florida FMMIS and DSS is being gathered as part of the development of the solicitation document(s) that are being prepared. An update to this section will be submitted when the inventory has been completed.

C. Proposed Solution Description

The proposed solution cannot be described at this point of the planning phase of the project. After a solution is procured, this section can be updated.

D. Capacity Planning

The AHCA tracks a number of metrics in the Medicaid program to access capacity trends. Attachment H contains some examples of historical charts for recipients, claims and providers. More information will be available after the planning phase of the project to add to this section.

VII. Schedule IV-B Project Management Planning

The AHCA is under contract with The North Highland Company for establishing and maintaining a Project Management Office (PMO) for the procurement preparation, Design, Development, and Implementation phases, as well as providing support for state staff during the six months after go-live of the system on July 1, 2018. The PMO plans developed by North Highland are included in this report in Attachment I. North Highland is responsible developing the following documentation to establish the PMO.

Task/Service Requirements	Description
Project Charter	• Title of Project • Name of the Project Manager • Authority of the Project Manager • Result/Product of the Project • Constraints • Assumptions • Executing Authority

Task/Service Requirements	Description
	• Date Approved
Stakeholder Analysis	• Identification of stakeholders • Stakeholder role/ interests/expectations • Stakeholder contact information
Communications Management Plan	• Feedback loops • Method and frequency of reports for each stakeholder • Project contact list • Frequency of meetings and Status Reports • Meeting facilitation and minutes production • Project electronic repository
Work Breakdown Structure (WBS)	• Identify all tasks, deliverables and milestones • Start date, end date, and work effort for all tasks • Task dependencies • Resource allocation by task and role
Risk Management Plan	• Identification of risks • Develop and execute a process for tracking and monitoring risks • Assignment of risk management responsibility
Project Change Management Plan	• Project change control process • Assessment and tracking tools
Project Schedule	• Task duration estimates • Task sequence
Project Management Plan	• Details of project processes

VIII. Attachments

Attachment A MITA SS-A Profiles

Attachment B Report on Research Tasks

Attachment C MITA SS-A Report Update – 2014

Attachment D Gap Analysis Report

Attachment E HP Organizational Chart

Attachment F System Performance Report Card

Attachment G CMS Seven Conditions and Standards

Attachment H Medicaid Metric Tracking

Attachment I PMO Documentation

CBAForm 1 - Net Tangible Benefits

Agency ncy for Health Care Administra | Project ıgement Information System I

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	FY 2016-17			FY 2017-18			FY 2018-19			FY 2019-20			FY 2020-21		
Agency *(Operations Only -- No Project Costs)*	(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)	$3,784,000	$0	$3,784,000	$3,784,016	$0	$3,784,016	$0	$0	$0	$0	$0	$0	$0	$0	$0
A.b Total FTE	64.00	0.00	64.00	48.00	0.00	48.00	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)	$3,117,375	$0	$3,117,375	$3,117,375	$0	$3,117,375	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-1.b. State FTEs (# FTEs)	48.00	0.00	48.00	48.00	0.00	48.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A-2.a. OPS FTEs (Salaries)	$666,625	$0	$666,625	$666,625	$0	$666,625	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-2.b. OPS FTEs (# FTEs)	16.00	0.00	16.00	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	$16	$0	$16	$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 Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C. External Service Provider -- Costs	$52,830,132	$0	$52,830,132	$57,478,445	$0	$57,478,445	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-1. Consultant Services	$964,865	$0	$964,865	$920,353	$0	$920,353	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-2. Maintenance & Support Services	$47,114,748	$0	$47,114,748	$52,342,616	$0	$52,342,616	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-3. Network / Hosting Services	$2,650,519	$0	$2,650,519	$2,115,476	$0	$2,115,476	$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
C-5. Other Specify	$2,100,000	$0	$2,100,000	$2,100,000	$0	$2,100,000	$0	$0	$0	$0	$0	$0	$0	$0	$0
D. Plant & Facility -- Costs (including PDC services)	$2,189,592	$0	$2,189,592	$2,041,046	$0	$2,041,046	$0	$0	$0	$0	$0	$0	$0	$0	$0
E. Others -- Costs	$717,941	$0	$717,941	$743,911	$0	$743,911	$0	$0	$0	$0	$0	$0	$0	$0	$0
E-1. Training	$543,234	$0	$543,234	$564,928	$0	$564,928	$0	$0	$0	$0	$0	$0	$0	$0	$0
E-2. Travel	$132,990	$0	$132,990	$132,990	$0	$132,990	$0	$0	$0	$0	$0	$0	$0	$0	$0
E-3. Other Specify	$41,717	$0	$41,717	$45,993	$0	$45,993	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total of Operational Costs (Rows A through E)	$59,521,665	$0	$59,521,665	$64,047,418	$0	$64,047,418	$0	$0	$0	$0	$0	$0	$0	$0	$0
F. Additional Tangible Benefits:		$0			$0			$0			$0			$0	
F-1. Specify		$0			$0			$0			$0			$0	
F-2. Specify		$0			$0			$0			$0			$0	
F-3. Specify		$0			$0			$0			$0			$0	
Total Net Tangible Benefits:		$0			$0			$0			$0			$0	

CHARACTERIZATION OF PROJECT BENEFIT ESTIMATE -- CBAForm 1B			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous	☐	Confidence Level	
Order of Magnitude	☐	Confidence Level	
Placeholder	☑	Confidence Level	100%

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Agency for Health Care Administration	Medicaid Management Information System Reprocurement			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.*				FY2016-17			FY2017-18			FY2018-19			FY2019-20			FY2020-21			TOTAL
3				$ 5,939,678		$ 17,927,530			$ 30,364,602			$ 3,444,246			$ -			$ -		$ 57,676,056
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	$ 410,937	20.15	$ 410,937	$ -	20.15	$ 410,937	$ -	20.15	$ 410,937	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ 1,643,746**
6	Costs for all OPS employees working on the project.	**OPS**	OPS	$ 83,200	0.00	$ 83,200	$ -	0.00	$ 83,200	$ -	0.00	$ 83,200	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ 332,800**
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	$ 3,069,202	0.00	$ 2,521,665	$ -	0.00	$ 3,358,498	$ -	0.00	$ 2,405,477	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ 11,354,841**
9	Project oversight (IV&V) personnel and related deliverables.	**Project Oversight**	Contracted Services	$ 991,557	0.00	$ 871,728	$ -	0.00	$ 982,825	$ -	0.00	$ 544,632	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ 3,390,742**
10	Staffing costs for all professional services not included in other categories.	**Consultants/Contractors**	Contracted Services	$ 153,174	0.00	$ 2,438,307	$ -	0.00	$ 2,438,307	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	**$ 5,029,789**
11	Separate requirements analysis and feasibility study procurements.	**Project Planning/Analysis**	Contracted Services	$ 1,191,608		$ 233,823	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ 1,425,431**
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	$ -		$ 11,117,870	$ -		$ 22,235,740	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ 33,353,610**
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	$ -		$ -	$ -		$ 855,096	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ 855,096**
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	$ 40,000		$ 250,000	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	**$ 290,000**
21		**Total**		**$ 5,939,678**	**20.15**	**$ 17,927,530**	**$ -**	**20.15**	**$ 30,364,602**	**$ -**	**20.15**	**$ 3,444,246**	**$ -**	**0.00**	**$ -**	**$ -**	**0.00**	**$ -**	**$ -**	**$ 57,676,056**
22																				
23																				
24																				
25	**AHCA NOTES:** (1) Row 17 includes costs for contracted services for User Acceptance Testing and Organizational Change Management (2) Row 14 provides costs for the Fiscal Agent Design, Development, and Implementation (DDI) costs for the MMIS and DSS (3) These DDI costs end when the new Fiscal Agent 5-year contract for MMIS and DSS operations begins FY 18-19.																			

CBAForm 2 - Project Cost Analysis

Agency ncy for Health Care Administra   Project Management Information System Repro

PROJECT COST SUMMARY	PROJECT COST SUMMARY (from CBAForm 2A)					TOTAL
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	
TOTAL PROJECT COSTS (*)	$17,927,530	$30,364,602	$3,444,246	$0	$0	$57,676,056
CUMULATIVE PROJECT COSTS *(includes Current & Previous Years' Project-Related Costs)*	$23,867,208	$54,231,810	$57,676,056	$57,676,056	$57,676,056	
Total Costs are carried forward to CBAForm3 Project Investment Summary worksheet.						

PROJECT FUNDING SOURCES	PROJECT FUNDING SOURCES - CBAForm 2B					TOTAL
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	
General Revenue	$2,045,079	$3,036,460	$344,425	$0	$0	$5,425,964
Trust Fund	$0	$0	$0	$0	$0	$0
Federal Match ☑	$16,082,451	$27,328,142	$3,099,821	$0	$0	$46,510,415
Grants ☐	$0	$0	$0	$0	$0	$0
Other ☐ Specify	$0	$0	$0	$0	$0	$0
TOTAL INVESTMENT	$18,127,530	$30,364,602	$3,444,246	$0	$0	$51,936,379
CUMULATIVE INVESTMENT	$18,127,530	$48,492,133	$51,936,379	$51,936,379	$51,936,379	

Characterization of Project Cost Estimate - CBAForm 2C			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous	x	Confidence Level	98%
Order of Magnitude		Confidence Level	
Placeholder		Confidence Level	

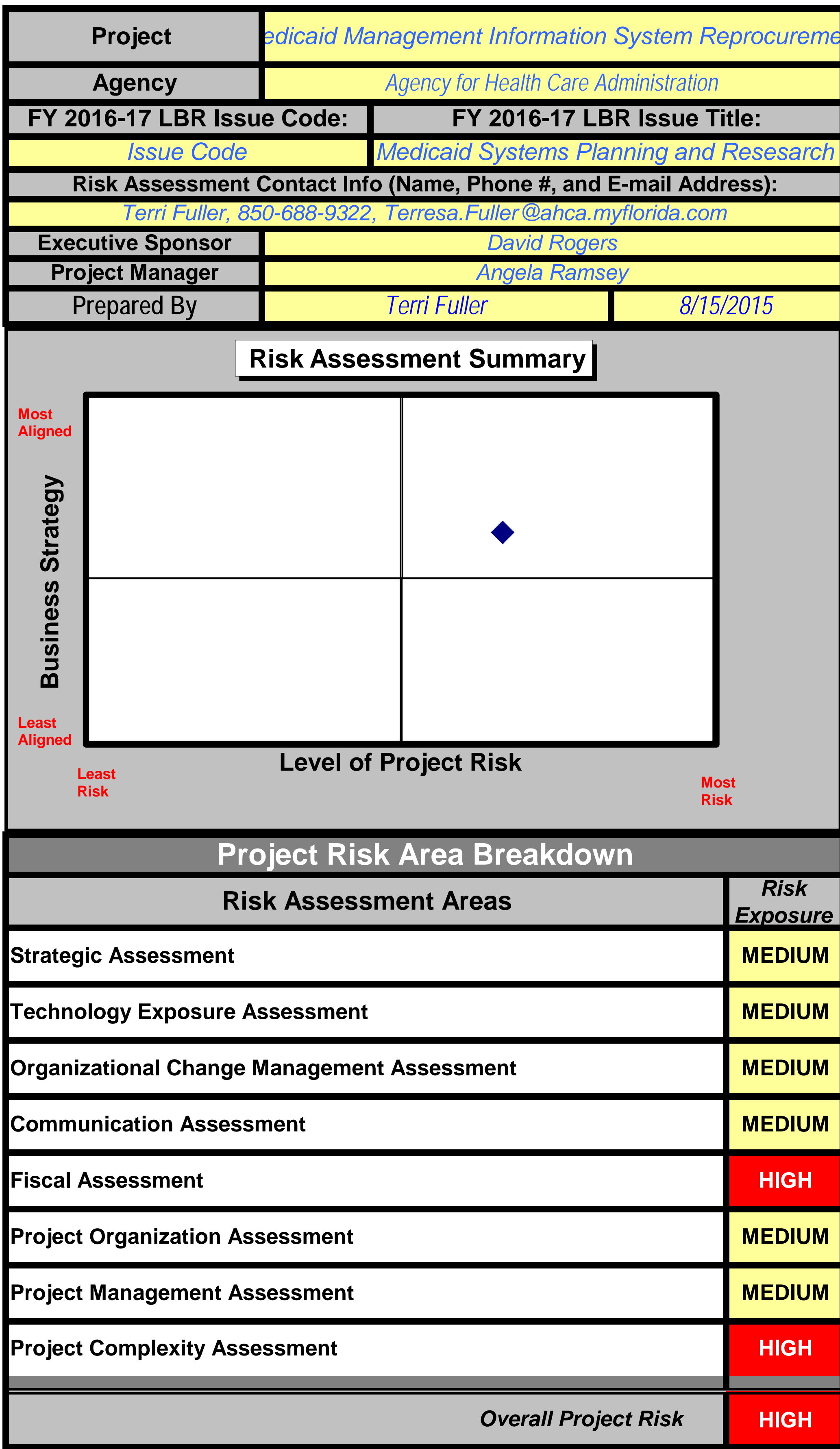
CBAForm 3 - Project Investment Summary

Agency	jency for Health Care Administrati	Project	jement Information System

COST BENEFIT ANALYSIS -- CBAForm 3A						
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	TOTAL FOR ALL YEARS
Project Cost	$17,927,530	$30,364,602	$3,444,246	$0	$0	$57,676,056
Net Tangible Benefits	$0	$0	$0	$0	$0	$0
Return on Investment	($23,867,208)	($30,364,602)	($3,444,246)	$0	$0	($57,676,056)
Year to Year Change in Program Staffing	0	0	0	0	0	

RETURN ON INVESTMENT ANALYSIS -- CBAForm 3B		
Payback Period (years)	NO PAYBACK	Payback Period is the time required to recover the investment costs of the project.
Breakeven Fiscal Year	NO PAYBACK	Fiscal Year during which the project's investment costs are recovered.
Net Present Value (NPV)	($55,693,992)	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 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Cost of Capital	1.94%	2.07%	3.18%	4.32%	4.85%



Project	edicaid Management Information System Reprocureme
Agency	Agency for Health Care Administration
FY 2016-17 LBR Issue Code:	FY 2016-17 LBR Issue Title:
Issue Code	Medicaid Systems Planning and Resesarch

Risk Assessment Contact Info (Name, Phone #, and E-mail Address):
Terri Fuller, 850-688-9322, Terresa.Fuller@ahca.myflorida.com

Executive Sponsor	David Rogers	
Project Manager	Angela Ramsey	
Prepared By	Terri Fuller	8/15/2015

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	HIGH
Project Organization Assessment	MEDIUM
Project Management Assessment	MEDIUM
Project Complexity Assessment	HIGH
Overall Project Risk	HIGH

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

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	Informal agreement by stakeholders
		Informal agreement by stakeholders	
		Documented with sign-off by stakeholders	
1.03	Are the project sponsor, senior management, and other executive stakeholders actively involved in meetings for the review and success of the project?	Not or rarely involved	Most regularly attend executive steering committee meetings
		Most regularly attend executive steering committee meetings	
		Project charter signed by executive sponsor and executive team actively engaged in steering committee meetings	
1.04	Has the agency documented its vision for how changes to the proposed technology will improve its business processes?	Vision is not documented	Vision is completely documented
		Vision is partially documented	
		Vision is completely documented	
1.05	Have all project business/program area requirements, assumptions, constraints, and priorities been defined and documented?	0% to 40% -- Few or none defined and documented	81% to 100% -- All or nearly all defined and documented
		41% to 80% -- Some defined and documented	
		81% to 100% -- All or nearly all defined and documented	
1.06	Are all needed changes in law, rule, or policy identified and documented?	No changes needed	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	Some
		Some	
		All or nearly all	
1.08	What is the external (e.g. public) visibility of the proposed system or project?	Minimal or no external use or visibility	Minimal or no external use or visibility
		Moderate external use or visibility	
		Extensive external use or visibility	
1.09	What is the internal (e.g. state agency) visibility of the proposed system or project?	Multiple agency or state enterprise visibility	Multiple agency or state enterprise visibility
		Single agency-wide use or visibility	
		Use or visibility at division and/or bureau level only	
1.10	Is this a multi-year project?	Greater than 5 years	Between 3 and 5 years
		Between 3 and 5 years	
		Between 1 and 3 years	
		1 year or less	

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

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 production system 6 months to 12 months Supported production system 1 year to 3 years Installed and supported production system more than 3 years	Installed and supported production system more than 3 years
2.02	Does the agency's internal staff have sufficient knowledge of the proposed technology to implement and operate the new system?	External technical resources will be needed for implementation and operations External technical resources will be needed through implementation only Internal resources have sufficient knowledge for implementation and operations	External technical resources will be needed for implementation and operations
2.03	Have all relevant technology alternatives/ solution options been researched, documented and considered?	No technology alternatives researched Some alternatives documented and considered All or nearly all 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 Some relevant standards have been incorporated into the 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
2.05	Does the proposed technology require significant change to the agency's existing technology infrastructure?	Minor or no infrastructure change required Moderate infrastructure change required Extensive infrastructure change required Complete infrastructure replacement	Moderate infrastructure change required
2.06	Are detailed hardware and software capacity requirements defined and documented?	Capacity requirements are not understood or defined Capacity requirements are defined only at a conceptual level Capacity requirements are based on historical data and new system design specifications and performance requirements	Capacity requirements are based on historical data and new system design specifications and performance requirements

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

Section 3 -- Organizational Change Management Area			
#	Criteria	Values	Answer
3.01	What is the expected level of organizational change that will be imposed within the agency if the project is successfully implemented?	Extensive changes to organization structure, staff or business processes	Moderate changes to organization structure, staff or business processes
		Moderate changes to organization structure, staff or business processes	
		Minimal changes to organization structure, staff or business processes structure	
3.02	Will this project impact essential business processes?	Yes	Yes
		No	
3.03	Have all business process changes and process interactions been defined and documented?	0% to 40% -- Few or no process changes defined and documented	81% to 100% -- All or nearly all processes defiined and documented
		41% to 80% -- Some process changes defined and documented	
		81% to 100% -- All or nearly all processes defiined and documented	
3.04	Has an Organizational Change Management Plan been approved for this project?	Yes	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	1 to 10% 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	Moderate changes
		Moderate changes	
		Minor or no changes	
3.09	Has the agency successfully completed a project with similar organizational change requirements?	No experience/Not recently (>5 Years)	Recently completed project with similar change requirements
		Recently completed project with fewer change requirements	
		Recently completed project with similar change requirements	
		Recently completed project with greater change requirements	

Agency: Agency Name

Project: Project Name

Section 4 -- Communication Area			
#	Criteria	Value Options	Answer
4.01	Has a documented Communication Plan been approved for this project?	Yes No	Yes
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 Proactive use of 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 No	Yes
4.04	Are all affected stakeholders included in the Communication Plan?	Yes No	Yes
4.05	Have all key messages been developed and documented in the Communication Plan?	Plan does not include key messages Some key messages have been developed All or nearly all messages are documented	Some key messages have been developed
4.06	Have desired message outcomes and success measures been identified in the Communication Plan?	Plan does not include desired messages outcomes and success measures Success measures have been developed for some messages All or nearly all messages have success measures	Plan does not include desired messages outcomes and success measures
4.07	Does the project Communication Plan identify and assign needed staff and resources?	Yes No	Yes

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

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	41% to 80% -- Some 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	Greater than $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 other state agencies
		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 but not 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	Most 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	More than 5 years
		Within 3 years	
		Within 5 years	
		More than 5 years	
		No payback	
5.11	Has the project procurement strategy been clearly determined and agreed to by affected stakeholders?	Procurement strategy has not been identified and documented	Stakeholders have reviewed and approved the proposed procurement strategy
		Stakeholders have not been consulted re: procurement strategy	
		Stakeholders have reviewed and approved the proposed procurement strategy	
5.12	What is the planned approach for acquiring necessary products and solution services to successfully complete the project?	Time and Expense (T&E)	Firm Fixed Price (FFP)
		Firm Fixed Price (FFP)	
		Combination FFP and T&E	

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

#	Criteria	Values	Answer
	Section 5 -- Fiscal Area		
5.13	What is the planned approach for procuring hardware and software for the project?	Timing of major hardware and software purchases has not yet been determined	Purchase all hardware and software at start of project to take advantage of one-time discounts
		Purchase all hardware and software at start of project to take advantage of one-time discounts	
		Just-in-time purchasing of hardware and software is documented in the project schedule	
5.14	Has a contract manager been assigned to this project?	No contract manager assigned	No contract manager assigned
		Contract manager is the procurement manager	
		Contract manager is the project manager	
		Contract manager assigned is not the procurement manager or the project manager	
5.15	Has equipment leasing been considered for the project's large-scale computing purchases?	Yes	Yes
		No	
5.16	Have all procurement selection criteria and outcomes been clearly identified?	No selection criteria or outcomes have been identified	All or nearly all selection criteria and expected outcomes have been defined and documented
		Some selection criteria and outcomes have been defined and documented	
		All or nearly all selection criteria and expected outcomes have been defined and documented	
5.17	Does the procurement strategy use a multi-stage evaluation process to progressively narrow the field of prospective vendors to the single, best qualified candidate?	Procurement strategy has not been developed	Multi-stage evaluation 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	No, bid response did/will not require 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	

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

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 No	Yes
6.02	Have all roles and responsibilities for the executive steering committee been clearly identified?	None or few have been defined and documented Some have been defined and documented All or nearly all have been defined and documented	All or nearly all have been defined and documented
6.03	Who is responsible for integrating project deliverables into the final solution?	Not yet determined Agency System Integrator (contractor)	System Integrator (contractor)
6.04	How many project managers and project directors will be responsible for managing the project?	3 or more 2 1	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 Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented	Some or most staff roles and responsibilities and needed skills have been identified
6.06	Is an experienced project manager dedicated fulltime to the project?	No experienced project manager assigned No, project manager is assigned 50% or less to project No, project manager assigned more than half-time, but less than full-time to project Yes, experienced project manager dedicated full-time, 100% to project	Yes, experienced project manager dedicated full-time, 100% to project
6.07	Are qualified project management team members dedicated full-time to the project	None No, business, functional or technical experts dedicated 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	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 Mostly staffed from in-house resources Completely staffed from in-house resources	Few or no staff from in-house resources
6.09	Is agency IT personnel turnover expected to significantly impact this project?	Minimal or no impact Moderate impact Extensive impact	Minimal or no 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 No	Yes
6.11	Are all affected stakeholders represented by functional manager on the change review and control board?	No board has been established No, only IT staff are on change review and control board No, all stakeholders are not represented on the board Yes, all stakeholders are represented by functional manager	No, all stakeholders are not represented on the board

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

Section 7 -- Project Management Area			
#	**Criteria**	**Values**	**Answer**
7.01	Does the project management team use a standard commercially available project management methodology to plan, implement, and control the project?	No Project Management team will use the methodology selected by the systems integrator Yes	Yes
7.02	For how many projects has the agency successfully used the selected project management methodology?	None 1-3 More than 3	More than 3
7.03	How many members of the project team are proficient in the use of the selected project management methodology?	None Some All or nearly all	All or nearly all
7.04	Have all requirements specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	81% to 100% -- All or nearly all have been defined and documented
7.05	Have all design specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	0% to 40% -- None or few 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	0% to 40% -- None or few are traceable
7.07	Have all project deliverables/services and acceptance criteria been clearly defined and documented?	None or few have been defined and documented Some deliverables and acceptance criteria have been defined and documented All or nearly all deliverables and acceptance criteria have been defined and documented	All or nearly all deliverables and acceptance criteria have been defined and documented
7.08	Is written approval required from executive sponsor, business stakeholders, and project manager for review and sign-off of major project deliverables?	No sign-off required Only project manager signs-off Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables	Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables
7.09	Has the Work Breakdown Structure (WBS) been defined to the work package level for all project activities?	0% to 40% -- None or few have been defined to the work package level 41 to 80% -- Some have been defined to the work package level 81% to 100% -- All or nearly all have been defined to the work package level	0% to 40% -- None or few have been defined to the work package level
7.10	Has a documented project schedule been approved for the entire project lifecycle?	Yes No	No

Agency: Agency for Health Care Administration Project: Medicaid Management Information System Reprocurement

Section 7 -- Project Management Area			
#	Criteria	Values	Answer
7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints), critical milestones, and resources?	Yes No	No
7.12	Are formal project status reporting processes documented and in place to manage and control this project?	No or informal processes are used for status reporting Project team uses formal processes Project team and executive steering committee use formal status reporting processes	Project team and executive steering committee use formal status reporting 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: Medicaid Management Information System Reprocurement

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 Similar complexity Less complex	Similar complexity
8.02	Are the business users or end users dispersed across multiple cities, counties, districts, or regions?	Single location 3 sites or fewer More than 3 sites	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 More than 3 sites	3 sites or fewer
8.04	How many external contracting or consulting organizations will this project require?	No external organizations 1 to 3 external organizations More than 3 external organizations	More than 3 external organizations
8.05	What is the expected project team size?	Greater than 15 9 to 15 5 to 8 Less than 5	Greater than 15
8.06	How many external entities (e.g., other agencies, community service providers, or local government entities) will be impacted by this project or system?	More than 4 2 to 4 1 None	More than 4
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 Statewide or multiple agency 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 No	Yes
8.09	What type of project is this?	Infrastructure upgrade Implementation requiring software development or purchasing commercial off the shelf (COTS) software Business Process Reengineering Combination of the above	Combination of the above
8.10	Has the project manager successfully managed similar projects to completion?	No recent experience Lesser size and complexity Similar size and complexity Greater 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 Lesser size and complexity Similar size and complexity Greater size and complexity	Greater size and complexity

Fiscal Year 2016-17 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Administration/68

Agency Budget Officer/OPB Analyst Name: Anita B. Hicks/Sonya Smith

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

	Action	Program or Service (Budget Entity Codes)					
		68200000	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. **A security control feature has been added to the LAS/PBS Web upload process that will require columns to be in the proper status before uploading.**						
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.	Y	Y	Y	Y	Y	Y
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.						

Action		Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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
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 2014-15 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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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 #16-002?	Y	Y	Y	Y	Y	Y
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A	N/A	N/A	N/A	N/A	N/A
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A	N/A	N/A	N/A	N/A	N/A
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	Y	Y	Y	Y	Y	Y
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 90 of the LBR Instructions.)	N/A	N/A	N/A	N/A	N/A	N/A
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)**	N/A	N/A	N/A	N/A	N/A	N/A
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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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.						
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 2016-17 data center costs, this can be completed by using the new State Data Center data processing services category (210001).						
TIP	If an appropriation made in the FY 2015-16 General Appropriations Act duplicates an appropriation made in substantive legislation, the agency must create a unique deduct nonrecurring issue to eliminate the duplicated appropriation. Normally this is taken care of through line item veto.						
8. SCHEDULE I & RELATED DOCUMENTS (SC1R, SC1 - Budget Entity Level *or* SC1R, SC1D - Department Level)							
8.1	Has a separate department level Schedule I and supporting documents package been submitted by the agency?	Y	Y	Y	Y	Y	Y
8.2	Has a Schedule I and Schedule IB been completed in LAS/PBS for each operating trust fund?	Y	Y	Y	Y	Y	Y
8.3	Have the appropriate Schedule I supporting documents been included for the trust funds (Schedule IA, Schedule 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?	Y	Y	Y	Y	Y	Y
8.8	If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to *section 215.32(2)(b), Florida Statutes* - including the Schedule ID and applicable legislation?	Y	Y	Y	Y	Y	Y

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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 Section 215.20, Florida Statutes 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?	N/A	N/A	N/A	N/A	N/A	N/A
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?	Y	Y	Y	Y	Y	Y
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

	Action	68200000	68500100	68500200	68501400	68501500	68700700
		Program or Service (Budget Entity Codes)					
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

	Action	68200000	68500100	68500200	68501400	68501500	68700700
		Program or Service (Budget Entity Codes)					
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
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 2014-15 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**	Y	Y	Y	Y	Y	Y
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

Action	Program or Service (Budget Entity Codes)					
	68200000	68500100	68500200	68501400	68501500	68700700
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.						
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)?	Y	Y	Y	Y	Y	Y
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