Florida Agency for Health Care Administration

Legislative Budget Request
Fiscal Year 2017-2018

Rick Scott
Governor

Justin M. Senior
Interim Secretary

October 14, 2016

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

Tim Sadberry, Deputy 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 (AHCA) is submitted in the format prescribed in the budget instructions. The information provided electronically and contained herein is a true and accurate presentation of our proposed needs for the 2017-18 Fiscal Year. This submission has been approved by Justin M. Senior, Interim Secretary.

Sincerely,

Tonya Kidd
Deputy Secretary, Operations

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RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

Temporary Special Duty – General Pay Additives Implementation Plan for Fiscal Year 2017-18

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

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

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

<u>Temporary Special Duties – General Pay Additive</u>

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

1. Justification and Description:

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

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

3. Length of time additive will be used: A temporary special duties – general pay additive may be granted beginning with the first day of assigned additional duties. The additive may be in effect

for up to 90 days at which time the circumstances under which the additive was implemented will be reviewed to determine if the additive should be continued based on the absence of the position incumbent or continued vacant position.

4. The amount of each type of additive: General Pay Additives will 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 1,129 Career Service position incumbents statewide.

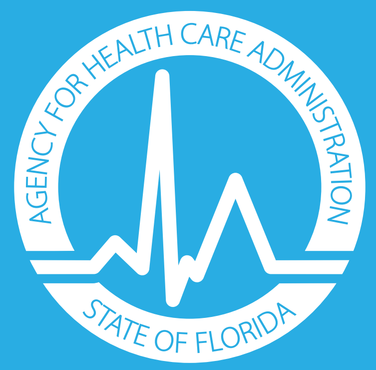
6. Historical Data: Last fiscal year, a total of two (2) full time equivalent (FTE) career service positions received general pay additives for performing the duties of a vacant position, both positions were considered "mission critical" and played a key role in carrying out the Agency's day-to-day operations.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

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

Average Min. Annual Salaries	X 10% of Min. Annual Salaries	# of FTEs
$61,696.75	$6,169.67	2

Based on the average estimated salaries stated above, the estimated calculation is as follows: $2,135.66 X 2 = $4,271.32. **The agency is not requesting any additional rate or appropriations for this additive.**

8. Additional Information: The classes included in this plan are represented by AFSCME Council 79. The relevant collective bargaining agreement language states as follows: "Increases to base rate of pay and salary additives shall be in accordance with state law and the Fiscal Year 2017-2018 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.



Florida Agency for Health Care Administration

Legislative Budget Request

Fiscal Year 2017-2018

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:	AHCA: Stuart Williams	Phone Number:	412-3669

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 class action for declaratory and injunctive relief challenged the State's administration of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements of the Medicaid Act.	
Amount of the Claim:	The settlement included a payment of Plaintiffs' attorney's fees and costs in the amount of $12 million. The cost of implementing the settlement agreement is unknown.	
Specific Law(s) Challenged:	Alleged violations of 42 U.S.C. §§ 1396a(a)(8), (10), & (43).	
Status of the Case:	This case settled and Judge Jordan approved the settlement agreement on June 28, 2016. The case is closed until September 30, 2022 or until a party files a motion to re-open. The parties are cooperating in implementing the terms of the settlement agreement and a motion to re-open is not anticipated at this time.	
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
	X	Outside Contract Counsel

[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.

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Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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

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Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

Names of the Parties:	K.G., by and through his next friend, Iliana Garrido, et al. 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:	Plaintiffs seek declaratory and injunctive relief regarding applied behavior analysis services they claimed should be covered under the state plan.	
Amount of the Claim:	Plaintiffs did not seek monetary damages. Plaintiffs prevailed in obtaining injunctive relief requiring AHCA to provide applied behavior analysis services to the named Plaintiffs. Since the Court's grant of injunctive relief, AHCA has amended its policy regarding applied behavior analysis and now provides thes services to all Medicaid recipients under the age of 21 for whom it is medically necessary.	
Specific Law(s) Challenged:	The Medicaid Act.	
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, the issue has been fully briefed, oral argument was held May 18, 2016, and AHCA awaits the appellate court order.	
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

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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		

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Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

Names of the Parties:	Petitioners: AHCA and APD Respondent: U.S. Centers for Medicare & Medicaid Services (CMS)
Court with Jurisdiction:	None. This is an administrative appeal through the U.S. Department of Health and Human Services ("DHHS").
Case Number:	None at this time. For identifying purposes, this will be an appeal of OIG Audit A-04-10-00076.
Summary of the Complaint:	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.
Amount of the Claim:	$4,386,952 ($2,193,476 federal share).
Specific Law(s) Challenged:	This is an overpayment determination, and so the validity of state law is not at issue.
Status of the Case:	On July 1, 2016, CMS notified AHCA of a disallowance in the amount of $1,774,798 federal financial participation for claims submitted by AHCA on the CMS 64 forms for fiscal years 2007 through 2009 for Medicaid administrative costs. The Agency has sixty days from the date of the letter to determine if it will appeal the findings through federal administrative procedures and is currently in consultation with the overseeing Agency, APD, and outside counsel, Covington Burling, to determine strategy going forward.

Who is representing (of record) the state in this	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management

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lawsuit? Check all that apply.	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	

Office of Policy and Budget – July 2016

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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; Mike Carroll, Secretary, Florida Department of Children and Families	
Court with Jurisdiction:	The First District Court of Appeal recently affirmed the circuit court and the case will be remanded to the circuit court	
Case Number:	Appellate No. 1D15-2142; Circuit Court No. 12-CA-2935	
Summary of the Complaint:	Plaintiff alleges the patient responsibility amount for those in nursing homes is not calculated correctly. The Complaint identifies a 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:	Unknown, but less than it would have been if the class had been certified; possible breach of contract damages; attorney's fees if Plaintiff is prevailing party	
Specific Law(s) Challenged:	1. § 1983 claim alleges violation of the 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:	On remand to the Circuit Court for the Second Judicial Circuit in and for Leon County	
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

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Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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

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Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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; Dr. Celeste Philip, in her official capacity as the State Surgeon General and Secretary of the Florida Department of Health; Cassandra G. Pasley, in her official capacity as Deputy Secretary of the Florida Department of Health and Director of Children's Medical Services	
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 allege that policies limit the number of private duty nursing hours that have been approved, thereby unlawfully forcing children into nursing facilities (NF) or placing them at risk of having to enter NFs.	
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:	Plaintiffs' Second Amended Consolidated Complaint, filed August 23, 2013, alleges violations of the Medicaid Act, Title II of the Americans With Disabilities Act, § 1983, and § 504 of the Rehabilitation Act.	
Status of the Case:	The Court has denied Plaintiffs' motions for class certification and the case continues with six named Plaintiffs, due to death and relocation of other initial named Plaintiffs. On December 6, 2013, this case was consolidated with the civil action *United States v. State of Florida,* also filed in the Southern District of Florida.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
	X	Outside Contract Counsel

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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).	Putative class action, where the class was not certified. Law Offices of Matthew W. Dietz

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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., 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. Cases were consolidated December 2013; discovery closed 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 closed April 30, 2016. The Judge cancelled the pretrial conference and the Parties await a substantive order. There is no trial date at this time.	
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

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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.

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Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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:	This matter has closed.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

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Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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:	Division of Administrative Hearings	
Case Number:	AHCA C.I. No. 12-1083-000; MPI Case ID No. 2015-0003188; DOAH No. 16-000423	
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 Respondent filed a Notice of Voluntary Dismissal, and the Division of Administrative Hearings relinquished jurisdiction. The Final Order is in routing within the Agency.	
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	

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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:	First District Court of Appeal
Case Number:	DCA No. 1D-16-3447; DOAH Case No. 15-5656MPI; 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:	$667,174.05
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:	Final Order was rendered on July 5, 2016 for overpayment of $574,174.05, plus sanction of $88,000.00, plus costs to be determined. Provider filed Notice of Appeal on August 1, 2016.

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

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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:	On August 3, 2016 MPI issued a Settlement Authorization in which the Agency demanded a total payment of $333,941.39 inclusive of the overpayment, costs and fines. That authorization terminates on August 19, 2016. If no settlement is reached, Agency Counsel will send the matter to DOAH for further litigation.	
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.	

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: Stuart Williams	Phone Number:	412-3669

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. Harish J. Patel, M.D.	
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:	When requesting Medicaid payments from the Agency for Health Care Administration (AHCA), Dr. Patel presented claims for reimbursement at a level of service not supported by the documentation, the documentation was deemed incomplete or not provided, the goods and services that were claimed were deemed not medically necessary, and that Dr. Patel did not meet the eligibility requirements for increased reimbursement based on the submitted claims which resulted in 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. Patel.	
Amount of the Claim:	$ 645,547.39	
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:	Dr. Patel has requested a conference to discuss the justification for billing the codes he used with the physician who reviewed the claims ("peer") for AHCA. The conference is scheduled for 10/4/2016. The case is in abeyance at AHCA until 9/12/16. 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.	

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: Stuart Williams	Phone Number:	412-3669

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).		

Office of Policy and Budget – July 2016

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: Stuart Williams	Phone Number:	412-3669

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 2016

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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:	Agency is reviewing additional information subsequent to discovery.	
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

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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).		

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Vyasa Ramcharan, DMD	
Court with Jurisdiction:	N/A Final Order entered Appeal dismissed, notified of potential bankruptcy proceedings	
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:	Final Ordered entered, appeal filed subsequently dismissed, notified of potential bankruptcy filing.	
	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 2016

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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 may file a Motion for Relief from Stay so that Medicaid Program Finance can proceed with cost report audits.	
Amount of the Claim:	$7,748,662.83 in total Medicaid overpayments filed in the proof of claim. This amount is a rough estimate based on cost report audits that have not been completed.	
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:	Outside counsel is preparing a motion seeking equitable relief from the bankruptcy court in the form of permission to treat the incorrectly-filed proof of claim as informal proofs of claim to which amended proofs of claim may relate back.	
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).	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:	AHCA: Stuart Williams	Phone Number:	412-3669

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	

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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	

Office of Policy and Budget – July 2016

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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:	DCA 3D15-2092; 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. Appeal from an AHCA Amended Final Order rendered on August 18, 2015, ordering Appellant to repay $1,051,992.99 in overpayment plus a fine of $6,000.00 and costs of $3,349.86 for a total due of $1,061.342.85. The Amended Final Order grants AHCA's exception to paragraphs 19 of the Recommended Order, finding Dr. O'Hearn was not a "peer" as defined in section 409.9131(2)(c), based in part on AHCA's previous ruling in the Partial Final Order. It denies all other exceptions filed by the parties.	
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:	Appellant's Initial Brief and Motion for Attorneys' Fees were filed on February 16, 2016. AHCA's Answer Brief was filed on April 13, 2016. Appellant's Reply Brief was filed on June 3, 2016. Oral argument was held on July 12, 2016, in Miami. Awaiting the Court's decision on the merits.	
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

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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. Adventist Health System/Sunbelt	
Court with Jurisdiction:	Division of Administrative Hearings (DOAH)	
Case Number:	DOAH Case No. 15-1788MPI, C.I. No. 13-0068-000; DOAH No. 16-4410MPI; AHCA Case No. 13-0068-000; AHCA Case ID No. 2015-0001957	
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	
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:	Case was re-opened at DOAH on August 3, 2016. An Order Placing Case in Abeyance was entered the same day which expires on October 14, 2016.	
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	

Office of Policy and Budget – July 2016

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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. Petitioner has satisfied obligations of payment terms and has rescinded their request for informal hearing. AHCA has filed a motion to relinquish jurisdiction to complete a final order and close the case.	
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

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration v. Pediatric Gastroenterology Associates	
Court with Jurisdiction:	N/A. The case is not on appeal.	
Case Number:	MPI Case ID No. 2015-0003808	
Summary of the Complaint:	Pediatric Gastroenterology Associates (Provider) failed to provide the necessary documentation for some of its claims submitted to AHCA for Medicaid payments. Provider billed AHCA for services which lacked proper documentation for the level of service provided, service codes were billed without sufficient documentation, and documentation provided did not meet the criteria for consultation services. 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:	$555,757.65	
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 2016

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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. Douglas Kent Powelson	
Court with Jurisdiction:	N/A. Case is currently in abeyance	
Case Number:	MPI Case ID 2015-0004342	
Summary of the Complaint:	When requesting Medicaid payments from the Agency for Health Care Administration (AHCA), Dr. Powelson used incorrect billing codes, which resulted in his being paid money by Medicaid through 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. Powelson.	
Amount of the Claim:	$ 3,119,660.84	
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:	Dr. Powelson has requested a conference to discuss the justification for billing the codes he used with the dentist who reviewed the claims ("peer") for AHCA. The case is in abeyance at AHCA until 9/27/16. 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 2016

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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. Cecilia M. Crosby	
Court with Jurisdiction:	N/A. Case is currently abated	
Case Number:	MPI Case ID No. 2015-0005032	
Summary of the Complaint:	When requesting Medicaid payments from the Agency for Health Care Administration (AHCA), Dr. Crosby presented claims for goods and services that were deemed not medically necessary, used incorrect billing codes and did not provide adequate documentation to support the submitted claims which resulted in 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. Crosby.	
Amount of the Claim:	$ 913,352.01	
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:	Dr. Crosby requested an abeyance on 7/20/15 in order to discuss the case with his client and review and expert opinion regarding the case. The case is in abeyance at AHCA. 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	

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

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. Ason Maxillofacial Surgery, P.A.	
Court with Jurisdiction:	N/A. The case has not yet been referred to the Division of Administrative Hearings.	
Case Number:	AHCA Case No. 2015-0004172	
Summary of the Complaint:	When requesting Medicaid payments from the Agency for Health Care Administration (AHCA), the provider used incorrect billing codes, which resulted in his being paid money by Medicaid that he was not entitled to (which is deemed to be an "overpayment"). In the Petition, AHCA is seeking to recover the overpayment, a fine and costs from the provider.	
Amount of the Claim:	$ 774,374.64	
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:	Petition for Administrative Hearing filed July 26, 2016.	
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	

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Low Income Pool Overpayments for Demonstration Years 1 through 7
Court with Jurisdiction:	N/A. The case is not on appeal.
Case Number:	N/A. This case does not have a case number.
Summary of the Complaint:	On October 8, 2015, the Centers for Medicare and Medicaid Services (CMS) sent Florida an email indicating the self-reported Low Income Pool (LIP) payments exceeded the provider's cost for LIP years 1-7. According to CMS, the Special Terms and Conditions (STC for Years 1-5 and STC 80 for Years 6-8) state that "The state agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost" and RFMD Section IV.6 submitted June 26, 2009, states, "In the event of an overpayment, the State will return the federal share through the standard process currently used by the State." Accordingly, CMS notified Florida it would need to do a Q4-15 CMS-64 Line 10B prior period adjustment and refund these identified self-reported LIP overpayments. Florida allegedly owed $114,311,352 in Federal Financial Participation (FFP). Florida informed CMS they had reviewed the alleged overpayments and did not intend to immediately refund the alleged overpayments on the Q4-15 CMS-64. On November 18, 2015, CMS issued a Demand Letter and requested a refund of $172,934,884 (FFP $98,399,783). On November 23, 2015, Florida responded to the Demand Letter and requested that CMS provide it a Disallowance Letter which complies with the notice requirements set forth in 42 C.F.R. 430.42. On June 9, 2016, CMS stated they were proceeding with the disallowance and would notify Florida. The LIP disallowance amounts were increased to $254,139,556 (FFP $146,113,363), plus interest, to include, DY 8. As of August 5, 2016, CMS had not issued a disallowance letter.
Amount of the Claim:	As of June 9, 2016, the LIP disallowance amounts were increased to $254,139,556 ($146,113,363 Federal Share)
Specific Statutes or Laws (including GAA) Challenged:	No state laws or rules would be modified or overturned by an adverse court order.

Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

Status of the Case:	On June 9, 2016, CMS stated they were proceeding with the disallowance. As of August 5, 2016, CMS had not issued a formal disallowance letter.	
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 2016

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: Stuart Williams	Phone Number:	412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Villa Health & Rehabilitation Center v. Agency for Health Care Administration	
Court with Jurisdiction:	N/A. The case is not on appeal.	
Case Number:	AHCA Case Number: 16-012-MPF	
Summary of the Complaint:	Villa Health & Rehabilitation Center ("Provider") was notified by AHCA's Bureau of Medicaid Program Finance of adjustments made to the Provider's Medicaid reimbursement rates on the Retroactive Per Diem Rates Memo dated January 28, 2015. The adjustments resulted from changes in the Provider's cost report and resulted in a balance due to the Provider in the amount of $98,989.80. This amount was calculated using Medicaid long-term care days paid by managed care plans. This adjustment does not include fee-for-service claims. The Provider submitted a Petition for Administrative Hearing alleging that additional funds are due to the Provider in the amount of $631,752.80. The Provider further alleges that Medicaid claims processed by various Managed Care Plans under contract with AHCA were initially paid at the Medicaid rate of the prior owner of the facility and should have been processed based on the Medicaid rate from the Provider's cost report filed by the current ownership.	
Amount of the Claim:	$631,752.80	
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	

Schedule VII: Agency Litigation Inventory

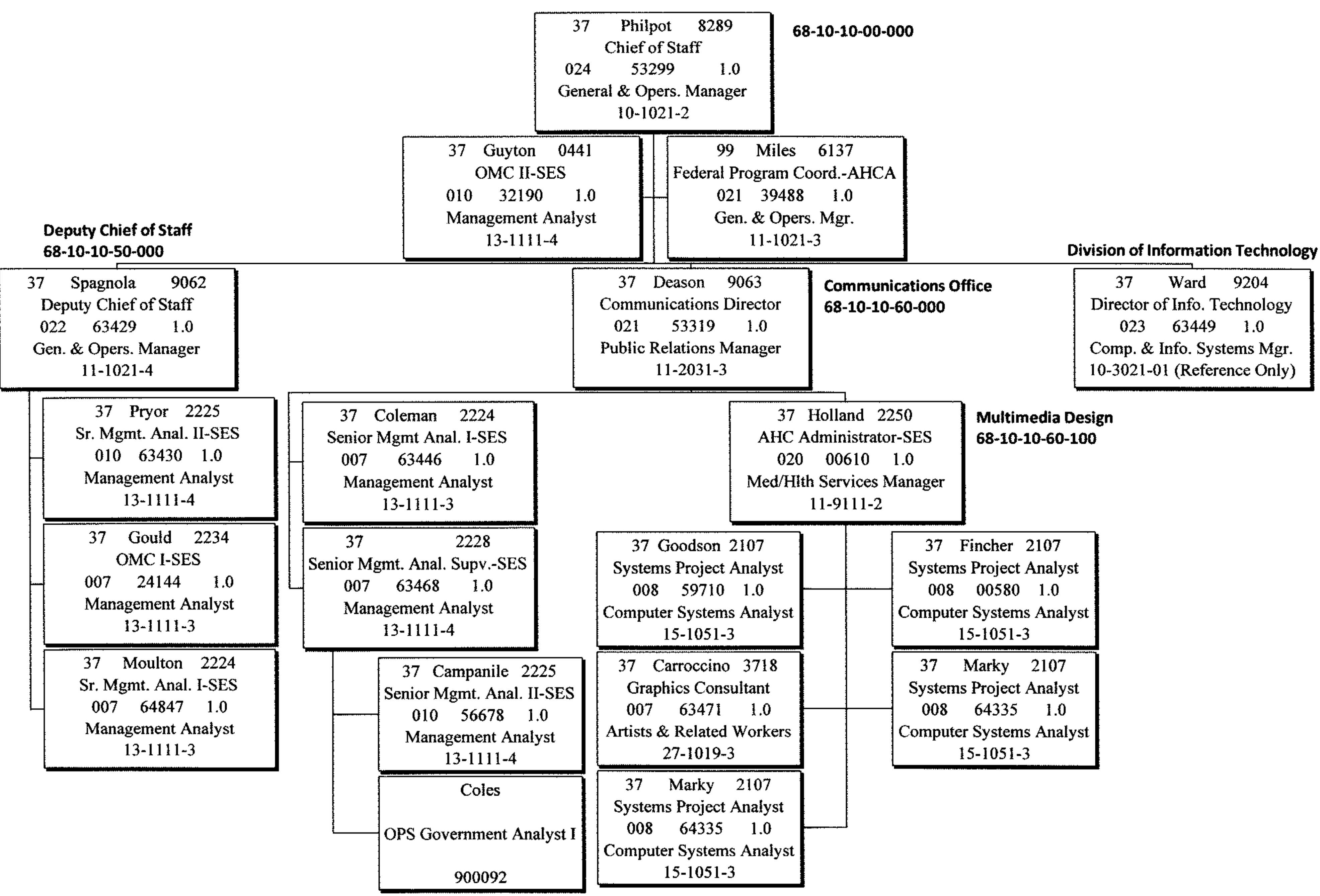
For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.

Agency:	**Agency for Health Care Administration**		
Contact Person:	AHCA: Stuart Williams	Phone Number:	412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Multiple Hospitals; from Adventist through Wuesthoff Medical Center.	
Court with Jurisdiction:	Agency for Health Care Administration (AHCA)	
Case Number:	Relinquished to Agency	
Summary of the Complaint:	The petitioner hospitals in this case brought an administrative action challenging Final Orders issued Feb 2015 closing out all Final Audited rates for each Hospital subject to the In-Patient and Out-Patient Hospital Reimbursement Plans.	
Amount of the Claim:	In excess of $1 million	
Specific Statutes or Laws (including GAA) Challenged:	§§409.905 and 409.908, Fla. Stat. Title XIX Inpatient and Outpatient Reimbursement Plans	
Status of the Case:	Relinquished to Agency for purposes of settlement discussions. Currently settlement agreements are being negotiated with several hospitals (primarily the clients of Joanne Erde). Once these cases are resolved then the remaining cases will be resolved by motion, settlement or hearing.	
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 – Joe Goldstein, Esq., Shutts and Bowen
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	

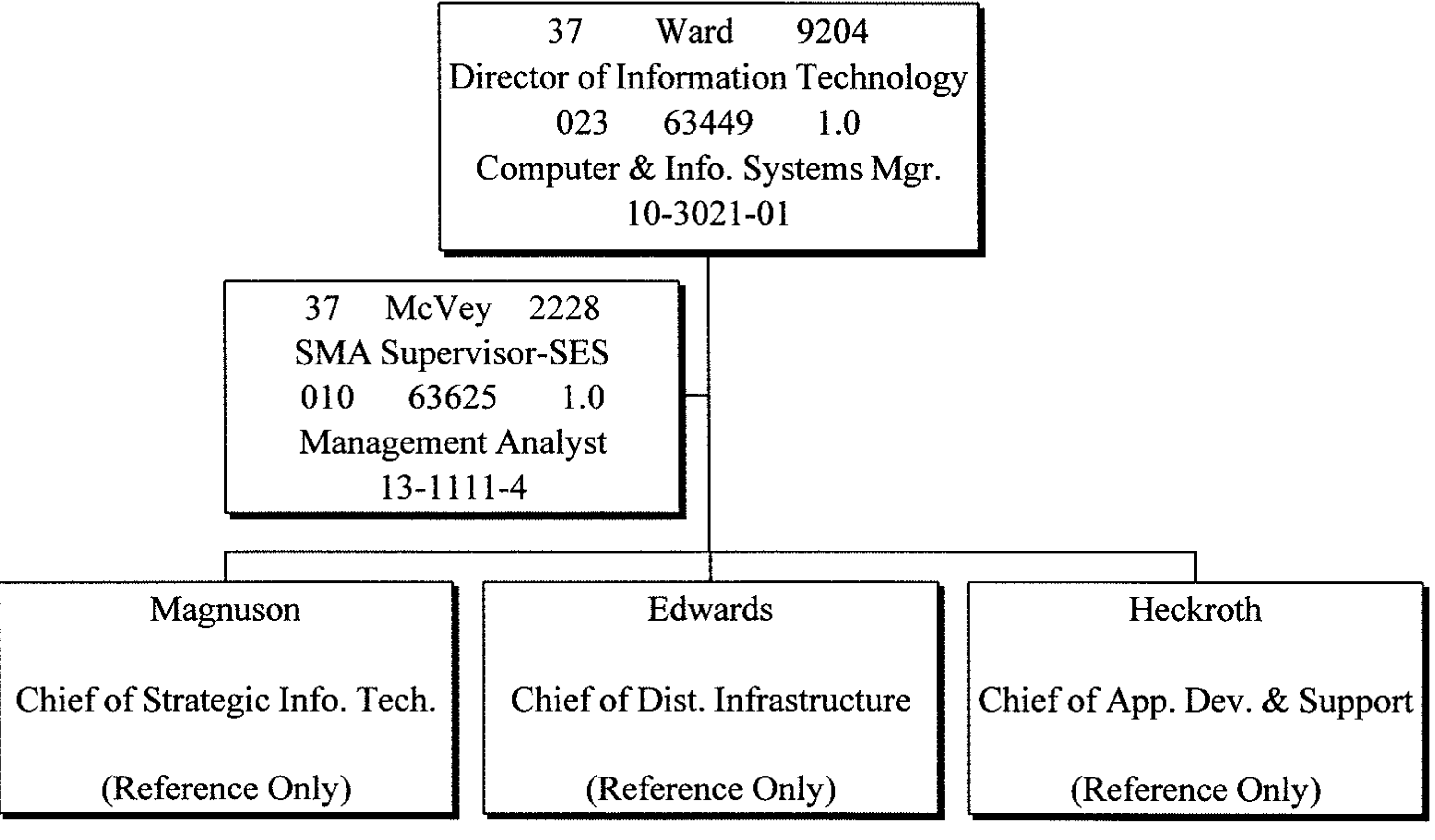
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff

Effective Date: July 1, 2016
FTEs: 17 Positions: 17



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

Effective Date: July 1, 2016
Org Level: 68-10-10-40-000
FTEs: 2 Positions: 2



A-2-1

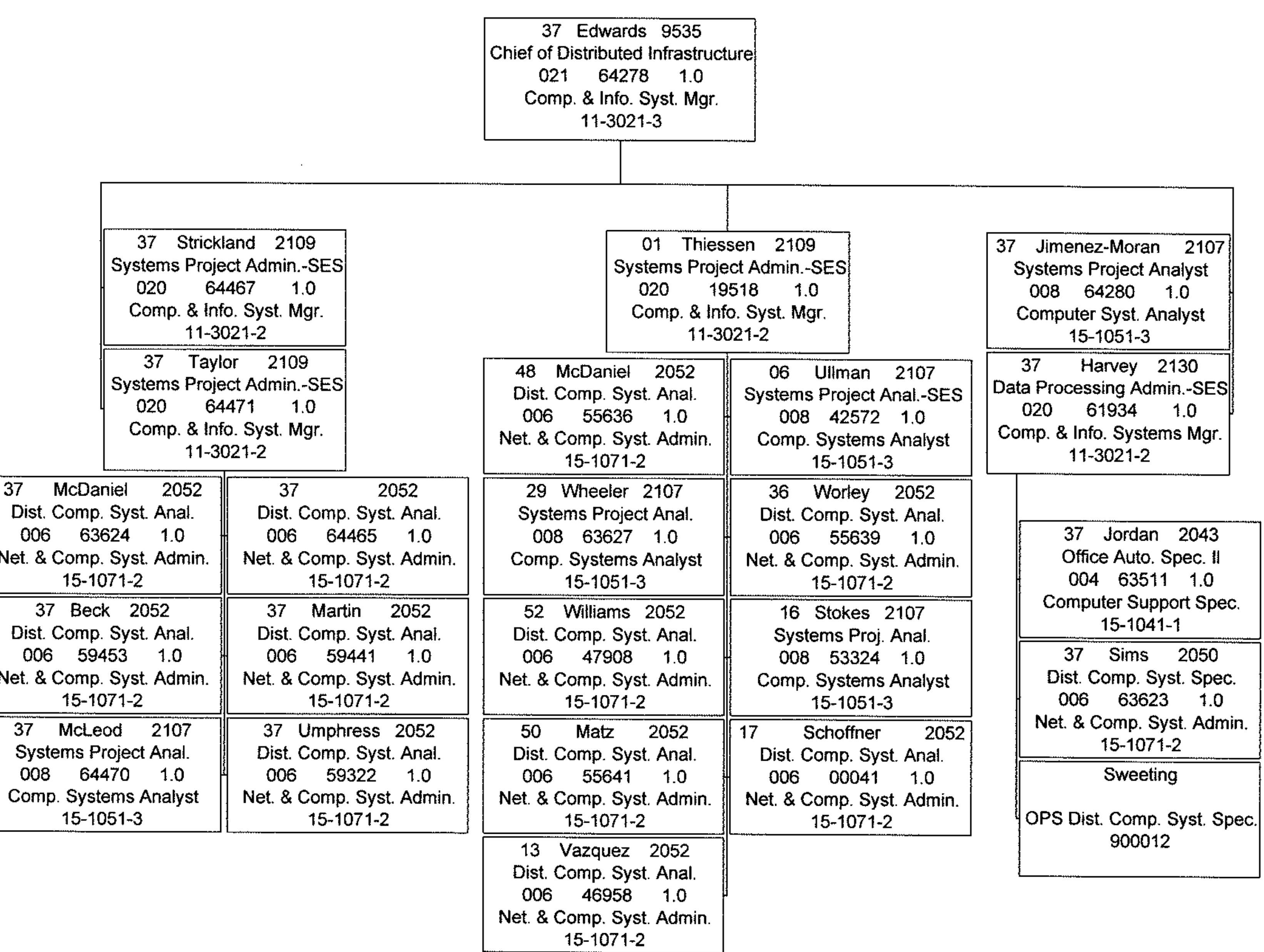
AGENCY FOR HEALTH CARE ADMINISTRATION
Chief of Staff - Division of Information Technology
Bureau of IT Strategic Planning and Security

Effective Date: July 1, 2016
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 Boatwright 2109 — Systems Programmer III — 009 34435 1.0 — Net. Syst. & Data Comm. Anal. — 11-3021-2
    - 37 Alley 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 Martin 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 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
  - **37 Alley 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

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

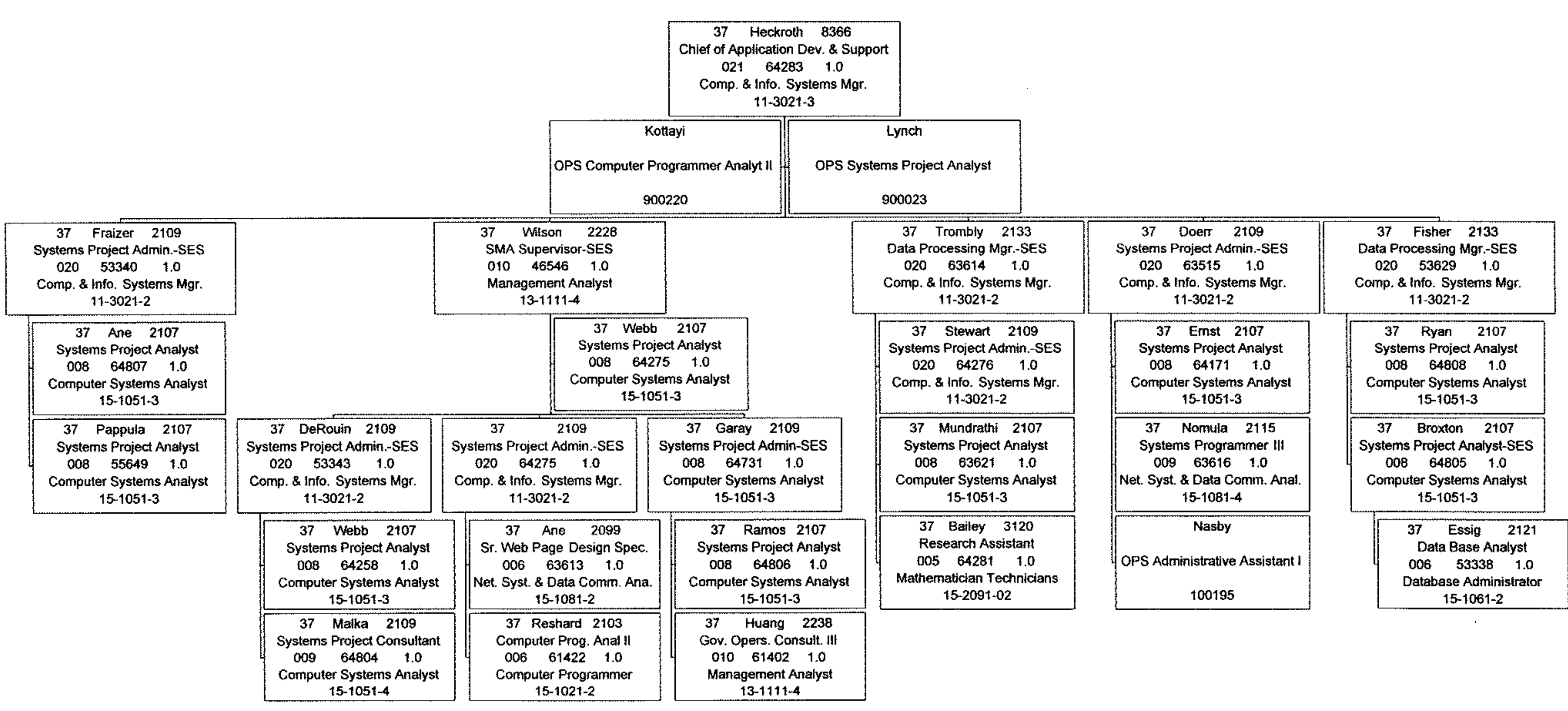
Effective Date: July 1, 2016
Org. Level: 68-10-10-40-002
FTEs: 23 Positions: 23



A-2-3

Effective: July 1, 2016
Org. Level: 68-10-10-40-004
FTEs: 25 Positions: 25

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



A-2-4

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Effective: July 1, 2016
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

Office of Fair Hearings

37 7738
Senior Attorney
014 64873 1.0
Lawyer
23-1011-4

37 7738
Senior Attorney
014 64874 1.0
Lawyer
23-1011-4

Name	Title	Position
Gayler	OPS Senior Clerk	900007
Stephen	OPS Law Clerk	900340
Patel	OPS Law Clerk	900341
Vacant	OPS Legal Assistant	900345
Vacant	OPS Senior Attorney	900327
Vacant	OPS Attorney	900328
Miles	OPS Senior Attorney	900329
Goldstein	OPS Senior Attorney	900330
Nguyen	OPS Attorney	900331
Ross	OPS Attorney	900343
Vacant	OPS Senior Attorney	900167
Yawn	OPS Law Clerk	900248
Kamel	OPS Law Clerk	900290
Donald	OPS Law Clerk	900204
Vacant	OPS Law Clerk	900239
Vacant	OPS Attorney	900139

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

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

Agency Clerk

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

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

Kever
OPS Senior Clerk
900005

McDonald
OPS Senior Clerk
900147

Appellate Unit

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

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

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

Litigation Unit

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

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

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

Medicaid Managed Care Unit

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

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

37 7736
Attorney
010 64686 1.0
Lawyer
23-1011-2

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

A-4

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - General Counsel

Effective Date: July 1, 2016
Org. Level: 68-10-20-00-000
FTEs: 64.5 Positions: 65

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

36 Marker 7738
Senior Attorney
014 64734 1.0
Lawyer
23-1011-4

52 Walsh 7738
Senior Attorney
014 26215 1.0
Lawyer
23-1011-4

37 Herter 7738
Senior Attorney
014 59726 1.0
Lawyer
23-1011-4

52 Fritts 7736
Attorney
010 64568 1.0
Lawyer
23-1011-3

37 Barrera 7736
Attorney
010 64786 1.0
Lawyer
23-1011-3

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 Rodriguez 7738
Senior Attorney
014 61370 1.0
Lawyer
23-1011-4

37 Hardy 7738
Senior Attorney
014 00005 1.0
Lawyer
23-1011-4

37 Granger 7738
Senior Attorney
014 64736 1.0
Lawyer
23-1011-4

37 Miller 7736
Attorney
010 57506 1.0
Lawyer
23-1011-3

37 Desai 7736
Attorney
010 48275 1.0
Lawyer
23-1011-3

52 Thornquest 7738
Senior Attorney
014 64657 1.0
Lawyer
23-1011-4

37 Mills 2225
Gov. Analyst II
010 61407 1.0
Management Analyst
13-1111-04

37 Haynes 0712
Administrative Asst. I
005 64660 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

37 Haynes 0714
Administrative Asst. II
005 64661 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

13 Rodney 7738
Senior Attorney
014 33761 1.0
Lawyer
23-1011-4

13 Bogart 0714
Administrative Asst. II
005 64660 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

52 Selby 7738
Senior Attorney
014 63532 1.0
Lawyer
23-1011-4

52 Keith 0712
Administrative Asst. II
005 64659 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

37 Saliba 7738
Senior Attorney
014 64787 1.0
Lawyer
23-1011-4

37 Enfinger 7738
Senior Attorney
014 64445 1.0
Lawyer
23-1011-4

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

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

36 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 Bradley 7738
Senior Attorney
014 64732 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, 2016
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 Thompson 0712
Administrative Asst. II
005 64687 1.0
Exe. Sec. & Adm. Asst.
43-6011-3

Vacant
OPS Senior Attorney
900167

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

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

37 Paez 0709
Administrative Asst. I
003 64823 1.0
Exe. Sec. & Adm. Asst.
43-6011-2

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

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

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

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

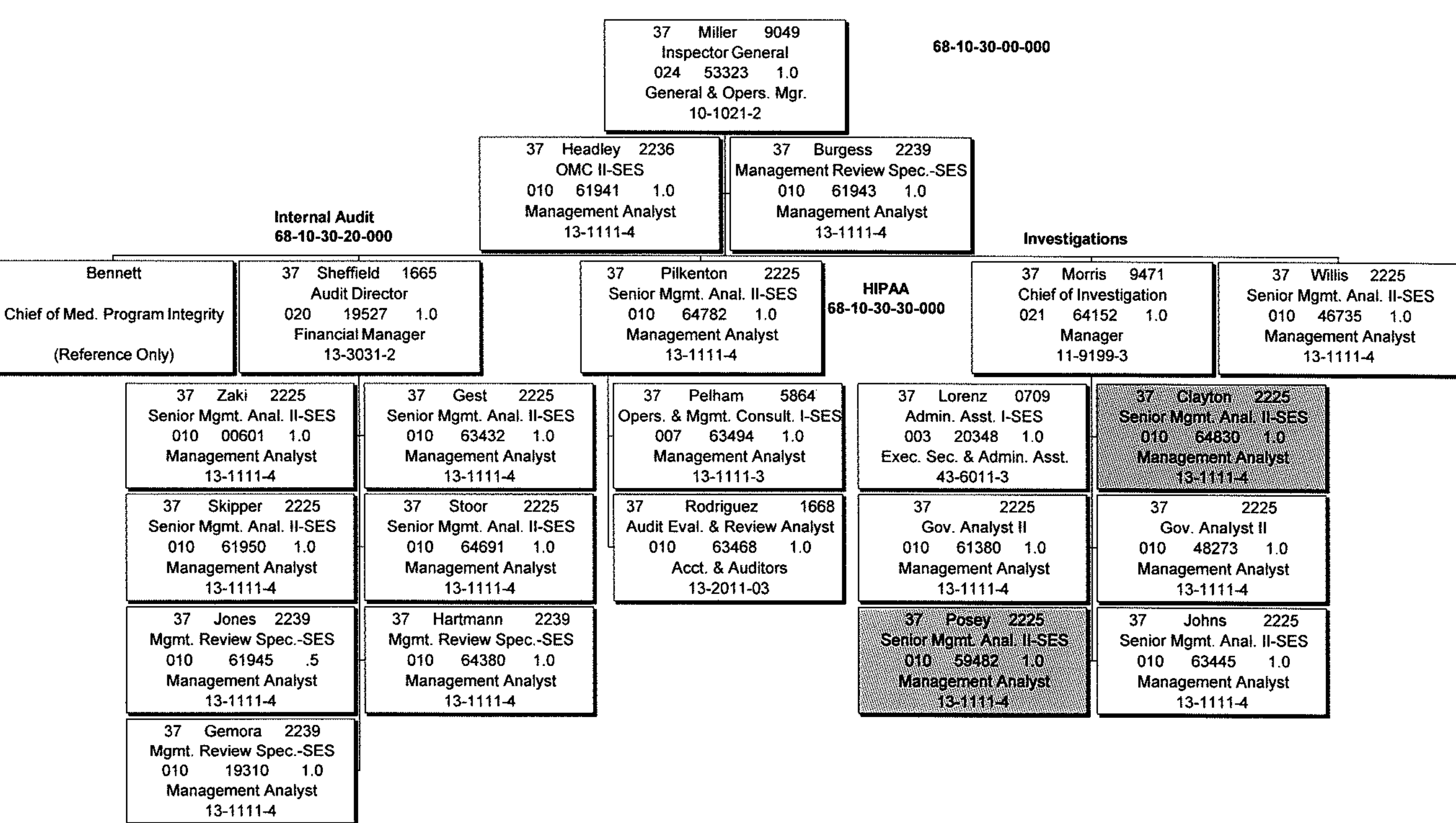
37 Davis 7703
Paralegal Specialist
005 55644 1.0
Paralegal & Legal Asst.
23-2011-1

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

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

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General

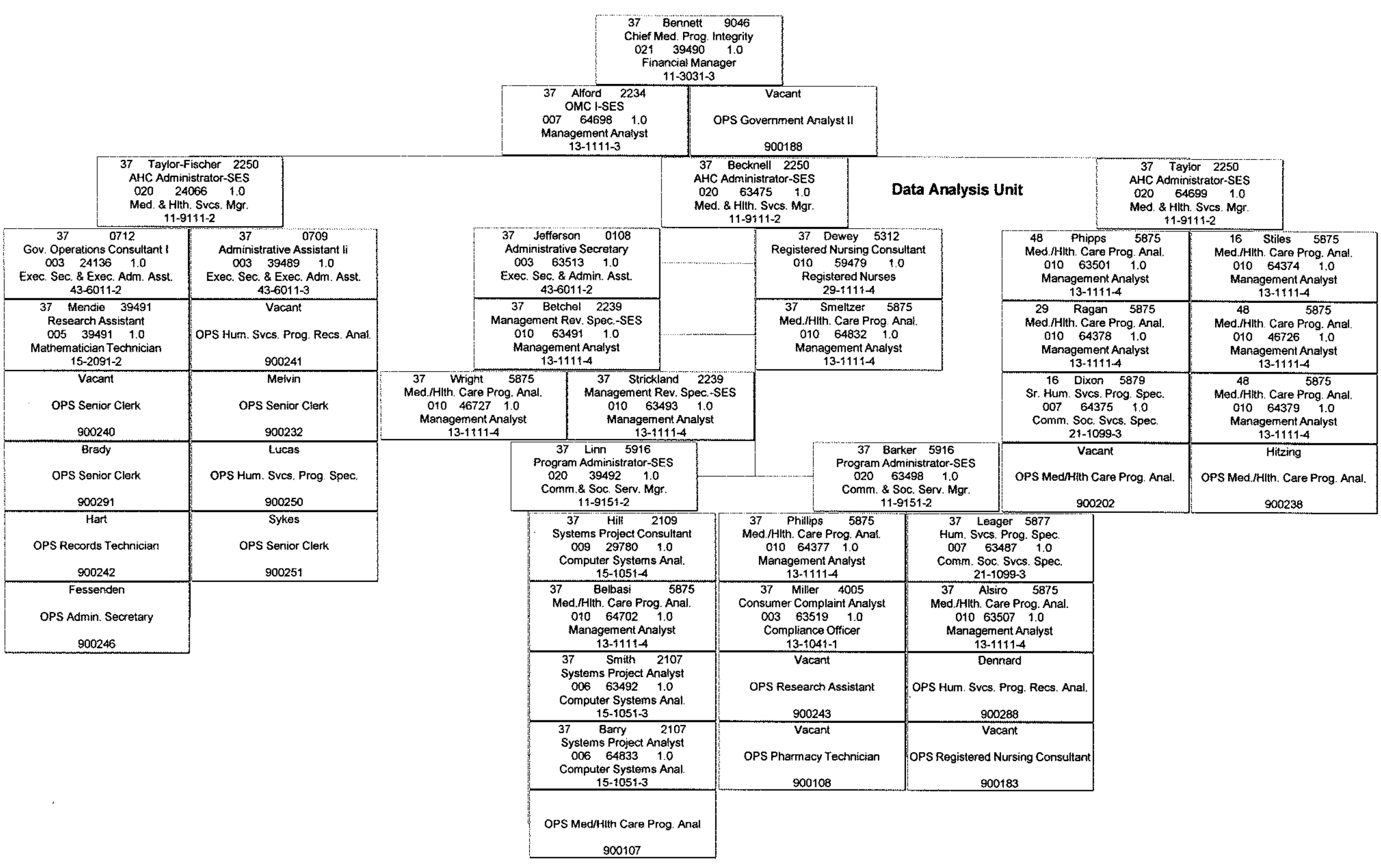
Effective Date: July 1, 2016
FTEs: 19.5 Positions: 20



***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, 2016
Org. Level: 68-10-30-10-000
FTEs: 88.5 Positions: 89



A-6

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

Effective Date: July 1, 2016
Org. Level: 68-10-30-10-000
FTEs: 88.5 Positions: 89

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

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

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

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

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

- 37 Luckower 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. Care Prog. Ana. — 010 64697 1.0 — Management Analyst — 13-1111-4
- 37 Anderson 5248 — Senior Pharmacist — 011 64819 1.0 — Pharmacist — 29-1051-5
- 37 Jackson 5248 — Senior Pharmacist — 011 61960 .75 — Pharmacist — 29-1051-5

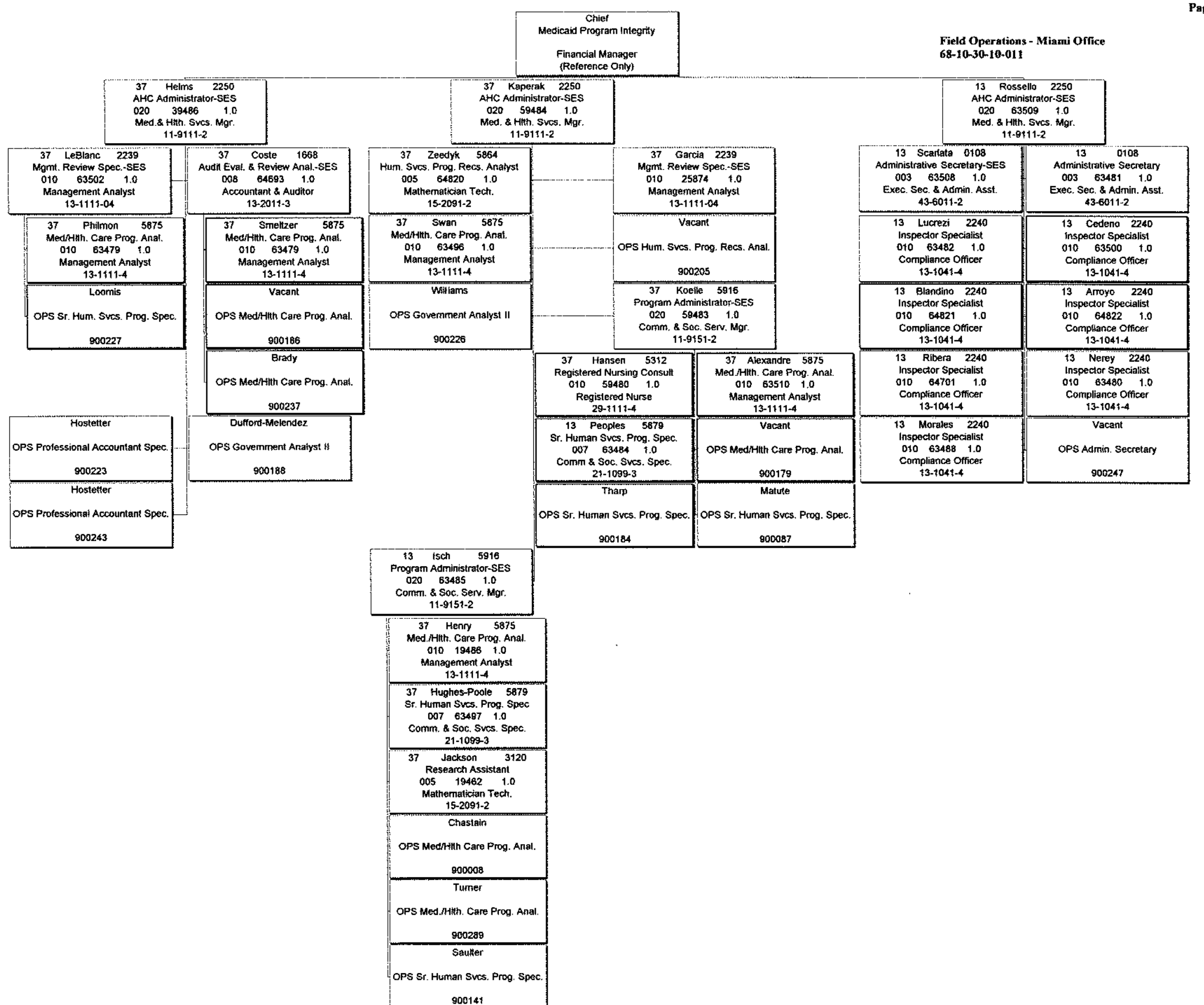
37 5916
Program Administrator-SES
020 63506 1.0
Comm. & Soc. Serv. Mgr.
11-9151-2

- 37 Williams 5864 — Hum. Svcs. Prog. Recs. Analyst — 003 63518 1.0 — Management Analyst — 13-1111-1
- 37 5875 — Med./Hlth. Care Prog. Anal. — 010 46733 1.0 — Management Analyst — 13-1111-4
- 37 Bailey 5875 — Med./Hlth. Care Prog. Anal. — 010 39493 1.0 — Management Analyst — 13-1111-4
- 37 Canfield 5312 — Registered Nursing Consultant — 010 64818 1.0 — Registered Nurses — 29-1111-4
- Sauls — OPS Med./Hlth. Care Prog. Anal. — 900245

A-6-1

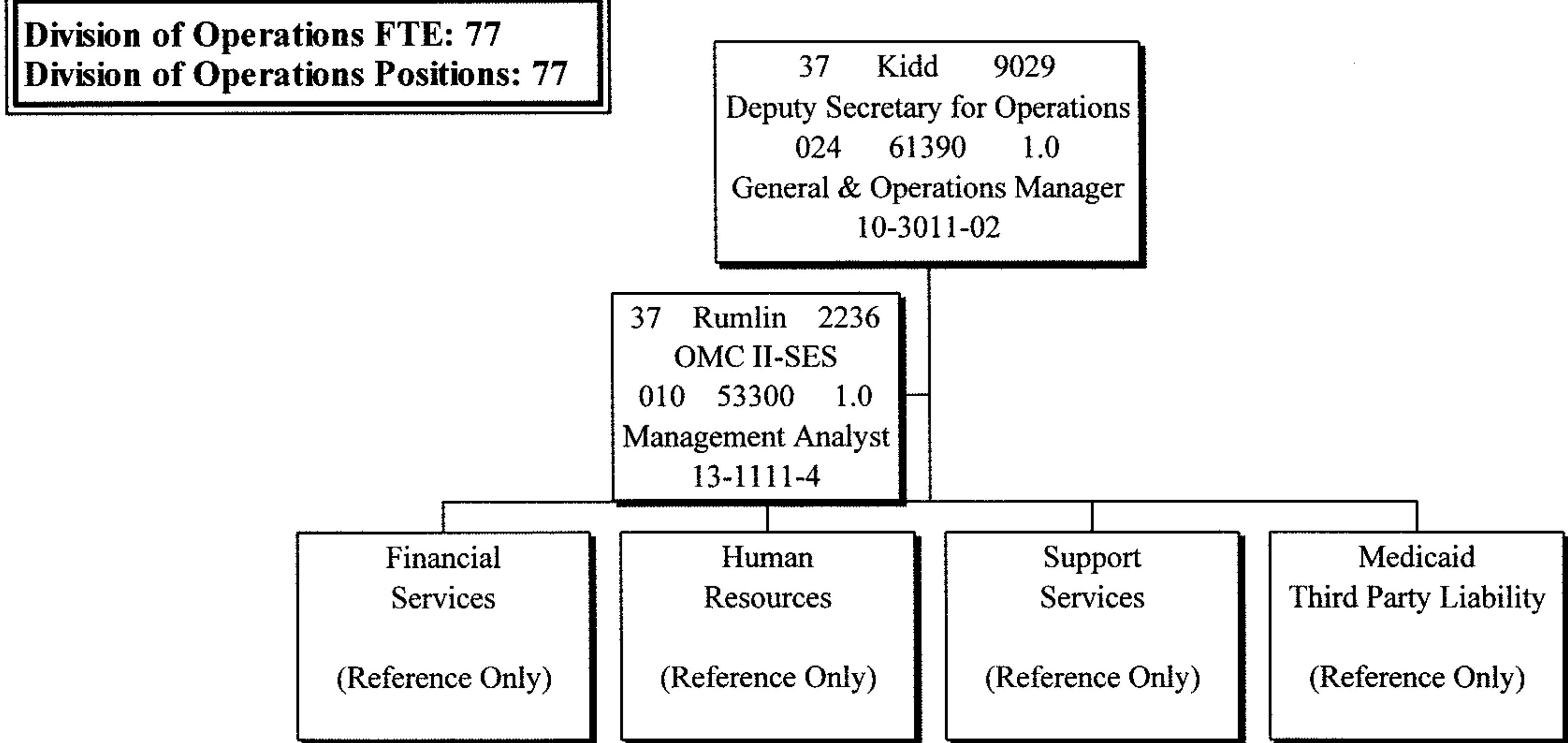
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction - Inspector General
Medicaid Program Integrity - Field Operations

Effective Date: July 1, 2016
FTEs: 88.5 Positions: 89



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

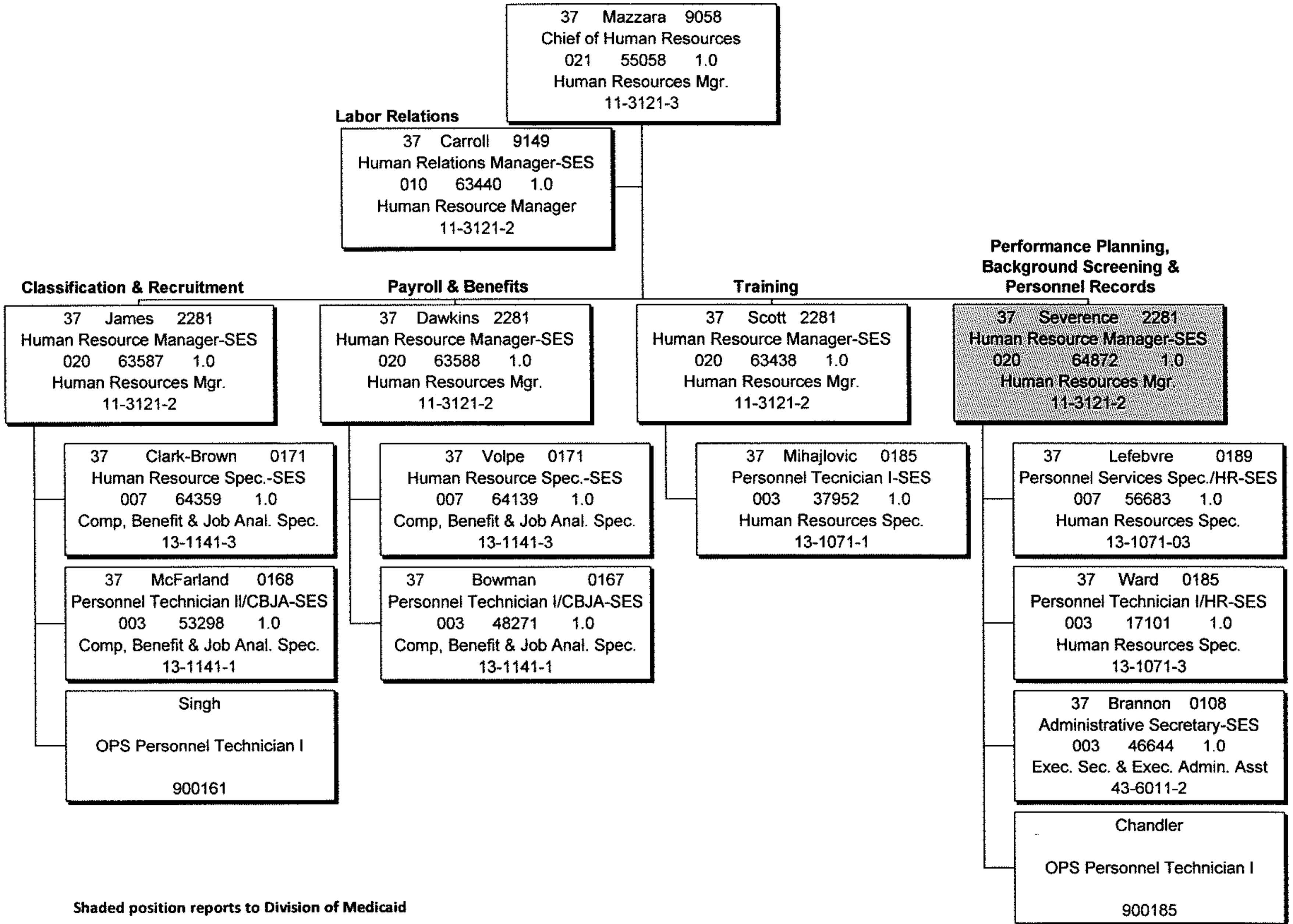
Effective Date: July 1, 2016
Org Level: 68-20-00-00-000
FTEs: 2 Positions: 2



B-0

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

Effective Date: July 1, 2016
Org. Level: 68-20-20-00-000
FTEs: 13 Positions: 13

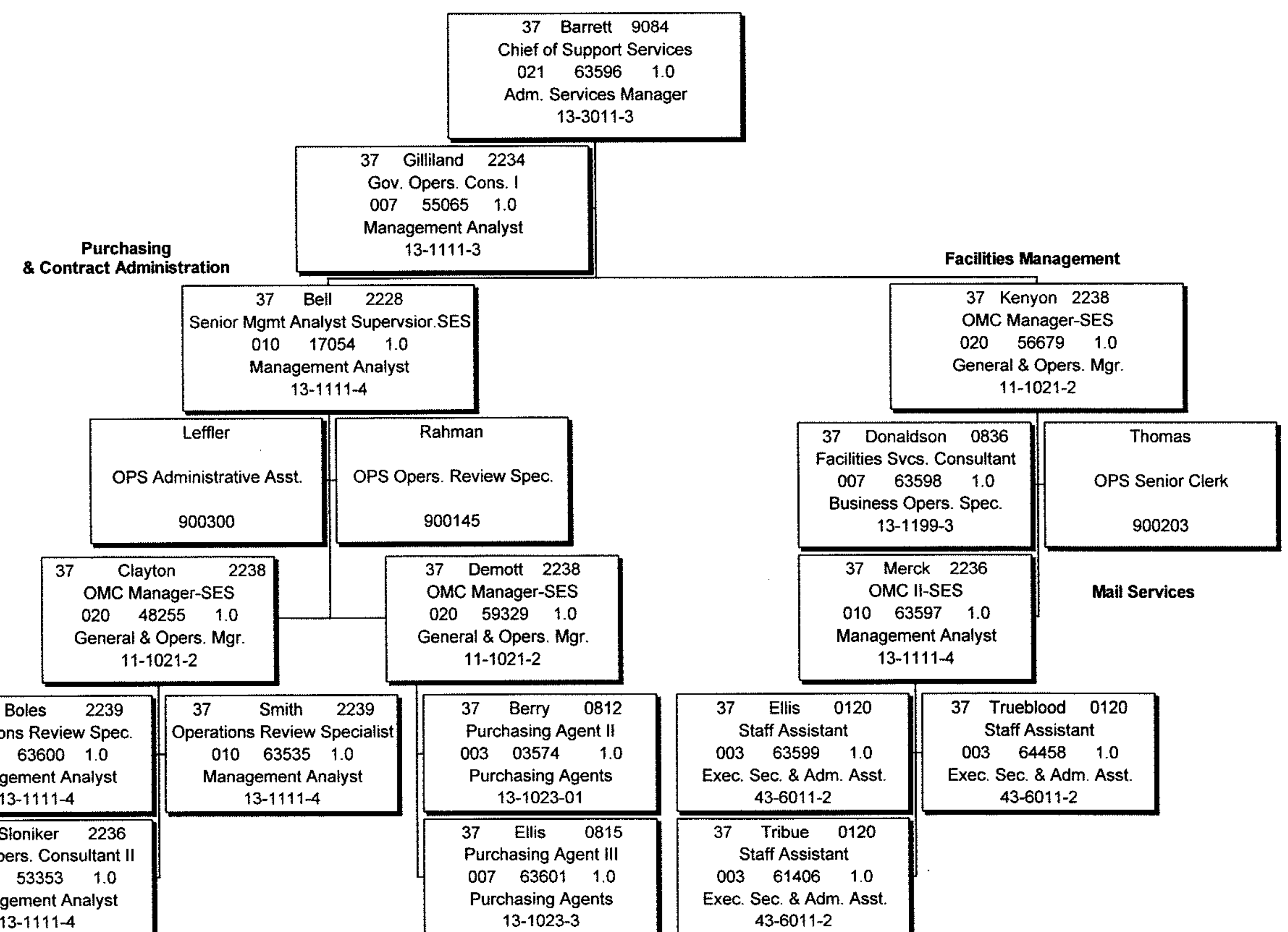


Shaded position reports to Division of Medicaid

B-2

Effective Date: July 1, 2016
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, 2016
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

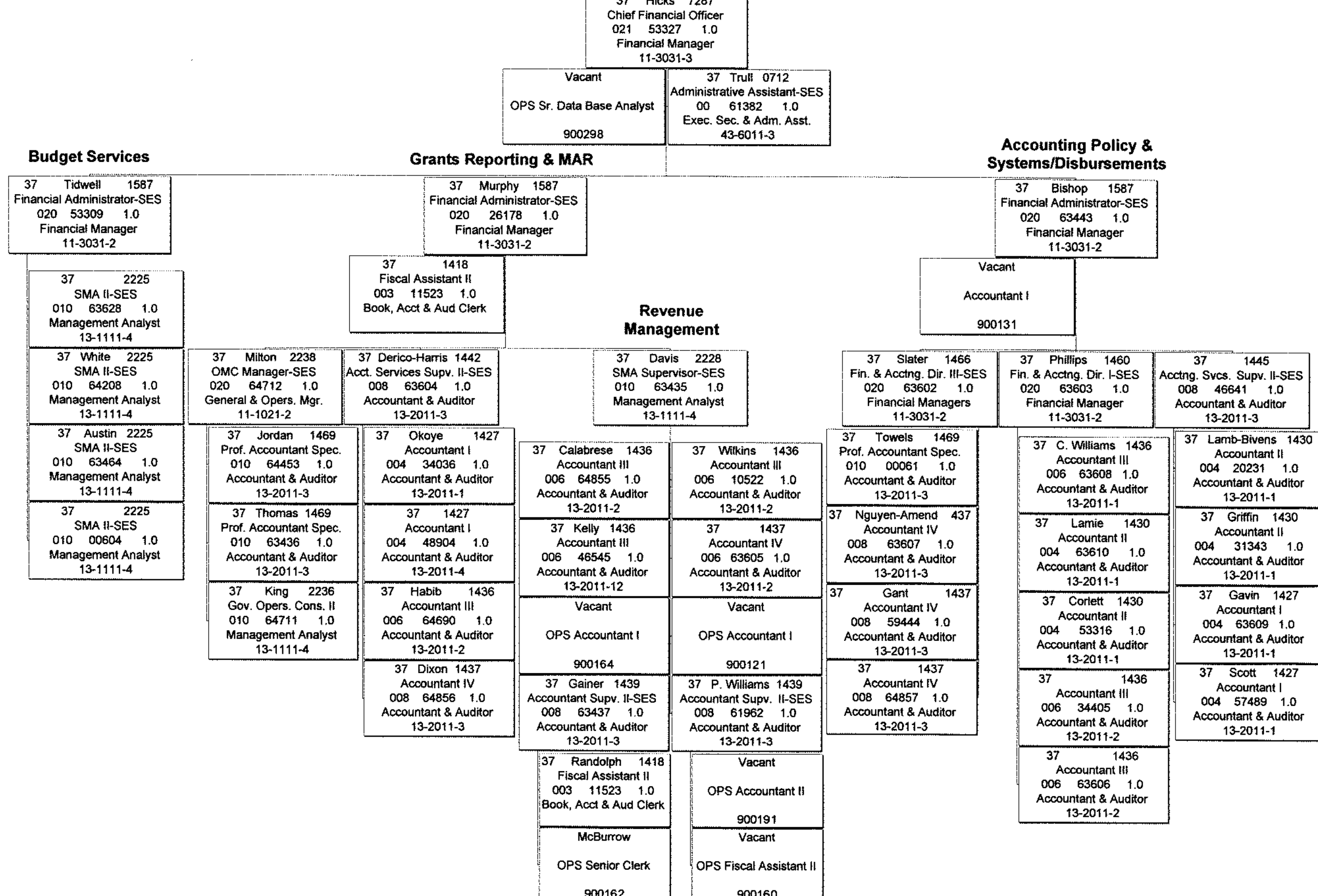
37 Roy 2239
Opers. Review Spec.
010 64254 1.0
Management Analyst
13-1111-4

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

Merchant
OPS Admin. Secretary
900212

Effective Date: July 1, 2016
Org. Level: 68-20-15-00-000
FTEs: 43 Positions: 43

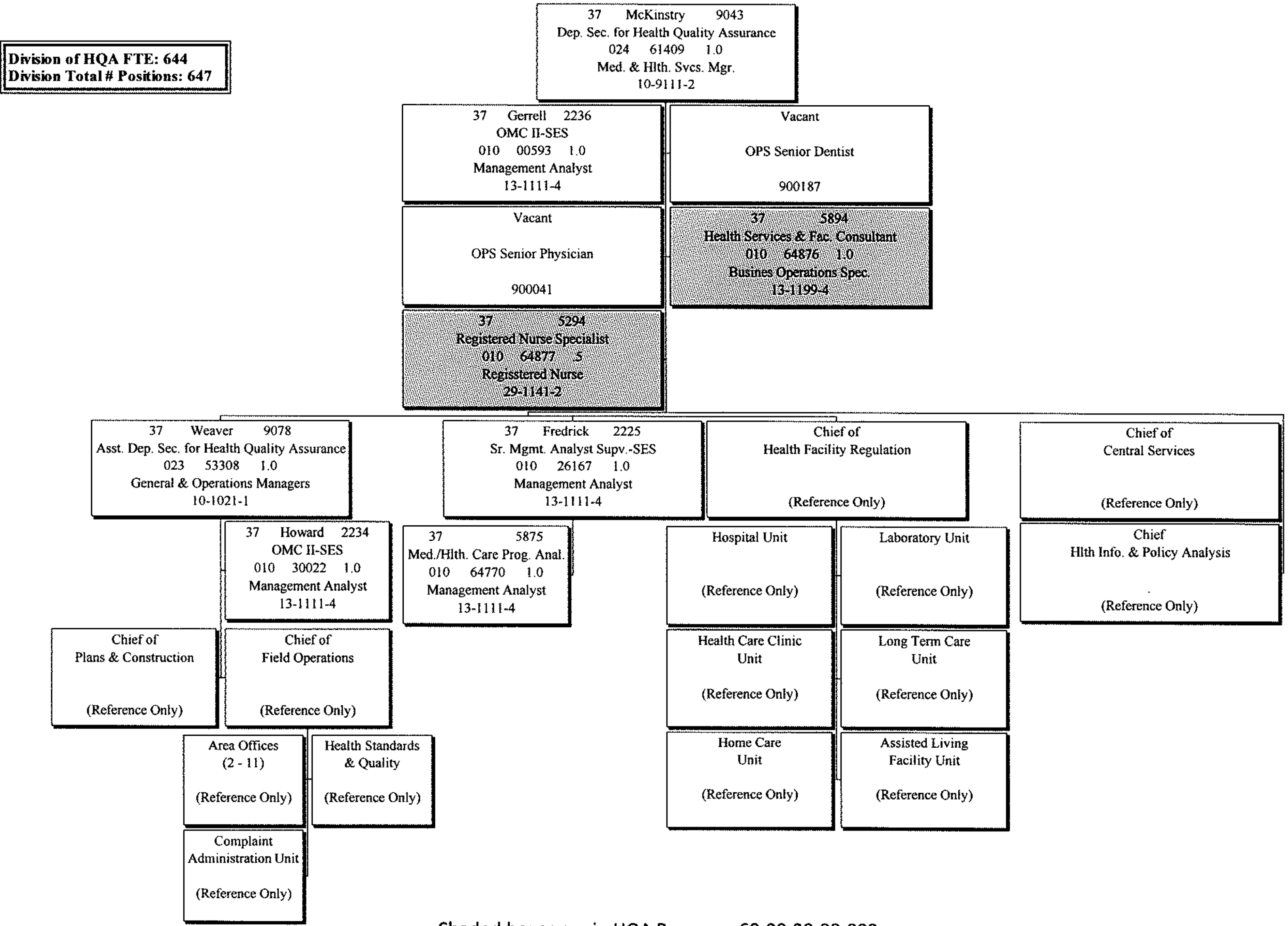
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Operations
Bureau of Financial Services



B-1

Effective Date: July 1, 2016
Org. Level: 68-30-00-00-000
FTEs: 7 Positions: 7

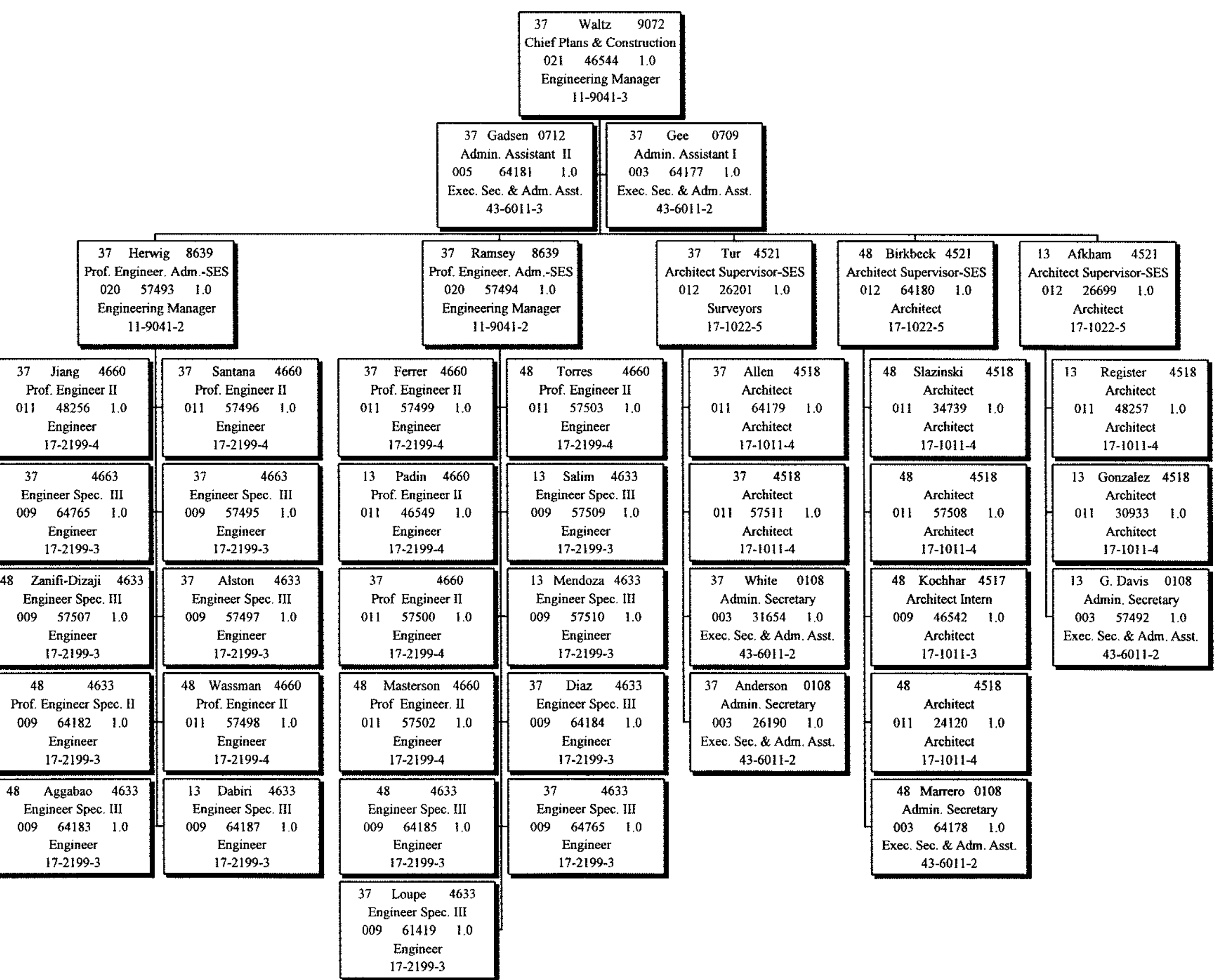
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance - Deputy Secretary's Office



Shaded boxes are in HQA Reserve - 68-90-30-00-000

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

Effective Date: July 1, 2016
Org. Level: 68 30 10 00 000
FTEs: 40 Positions: 40



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

Effective Date: July 1, 2016
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 0709
Admin. Assistant I
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 Grace 2225
Gov. Analyst II
010 33417 1.0
Management Analyst
13-1111-4

37 Alday 2225
Gov. Analyst
010 64633 1.0
Management Analyst
13-1111-4

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

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

Williams
OPS Administrative Secretary
900091

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

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

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

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

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

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

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

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

37 Knerr 5894
Hlth. Svcs. & Fac. Consult.
010 64585 1.0
Business Opers. Spec.
13-1199-4

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

Weaver
Chief of Field Operations
26175
(Reference Only)

Survey & Certification Support Branch

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

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 Sanders 0108
Admin. Secretary
003 64730 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

37 Kaczmarek 5312
Registered Nursing Consult.
010 64569 1.0
Registered Nurse
29-1141-4

37 Fitzgerald 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 Willis 5312
Registered Nursing Consult.
010 63234 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 Largent 0440
Regulatory Spec. I
003 64642 1.0
Compliance Officer
13-1041-1

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

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

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

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

01 Sosiak 5294
Registered Nurse Spec.
008 11520 1.0
Registered Nurse
29-1141-2

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

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

13 5875
Med/Hlth Care Prog. Anal.
010 24300 1.0
Management Analyst
13-1111-4

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

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

Effective Date: July 1, 2016
Org. Level: 68-30-30-02-000
FTEs: 29 Positions: 29

37 Heiberg 6040
Field Office Manager
020 21301 1.0
Admin. Svcs. Manager
11-3011-2

37 Bronson 0440
Reg. Spec. I-SES
003 64391 1.0
Compliance Officer
13-1041-1

37 Wilkins 0440
Reg. Spec. I
003 64728 1.0
Compliance Officer
13-1041-1

37 Manning 0108
Admin. Secretary
003 64792 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

37 Conoly 5312
Reg. Nursing Cons.
010 37336 1.0
Registered Nurse
29-1111-4

37 Williams 5294
Reg. Nurse Spec.
008 30624 1.0
Registered Nurse
29-1111-2

17 Wendell 5294
Reg. Nurse Spec.
008 64602 1.0
Registered Nurse
29-1111-2

37 Paoli 5294
Reg. Nurse Spec.
008 63537 1.0
Registered Nurse
29-1111-2

37 Endress 5294
Reg. Nurse Spec.
008 19670 1.0
Registered Nurse
29-1111-2

37 Bastian 5294
Reg. Nurse Spec.
008 64739 1.0
Registered Nurse
29-1111-2

17 Vinson 5620
HFE II
007 63536 1.0
Management Analyst
13-1111-3

37 Bonnell 5294
Reg. Nurse Spec.
008 24096 1.0
Registered Nurse
29-1111-2

37 Page 5294
Reg. Nurse Spec.
008 24097 1.0
Registered Nurse
29-1111-2

37 Jackson 5614
HFE II
007 37337 1.0
Management Analyst
13-1111-3

37 Johnson 5294
Reg. Nurse Spec.
008 64601 1.0
Registered Nurse
29-1111-2

37 5294
Reg. Nurse Spec.
008 43298 1.0
Registered Nurse
29-1111-2

37 Castello 5620
HFE II
010 63227 1.0
Management Analyst
13-1111-3

37 Beasley 5312
Reg. Nursing Cons.
010 64610 1.0
Registered Nurse
29-1111-4

37 Ball 5294
Reg. Nurse Spec.
008 64392 1.0
Registered Nurse
29-1111-2

37 Keel 5294
Reg. Nurse Spec.
008 33765 1.0
Registered Nurse
29-1111-2

37 White 5620
HFE II
007 33414 1.0
Management Analyst
13-1111-3

37 Walton 5294
Reg. Nurse Spec.
008 37335 1.0
Registered Nurse
29-1111-2

37 5294
Reg. Nurse Spec.
008 02036 1.0
Registered Nurse
29-1111-2

37 Emmett 5035
Biological Scientist III
008 37434 1.0
Biological Scientist
19-1029-2

37 Bailey 5294
Reg. Nurse Spec.
008 64600 1.0
Registered Nurse
29-1111-2

37 Andrews 5294
Reg. Nurse Spec.
008 64323 1.0
Registered Nurse
29-1111-2

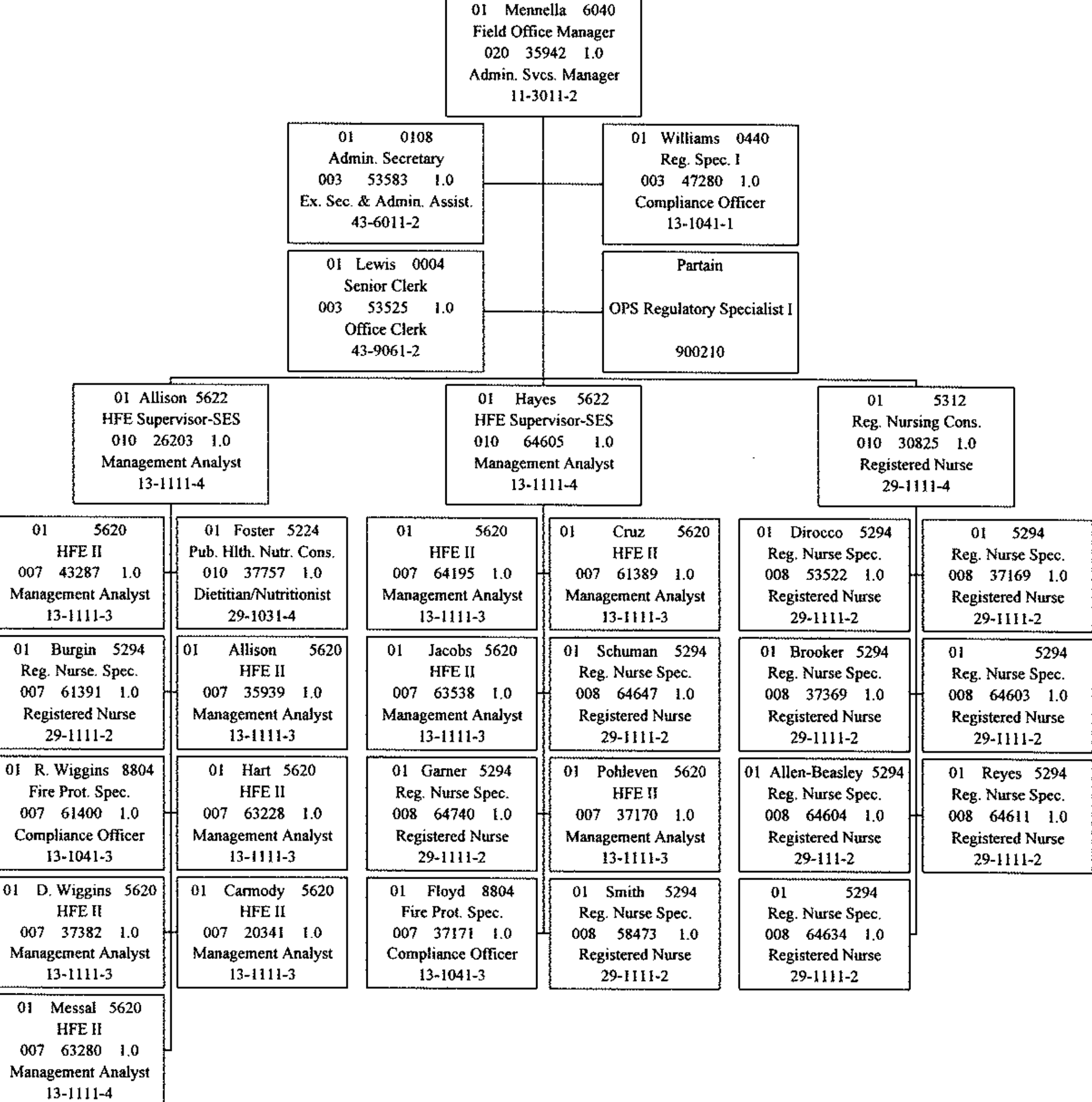
17 Eddins 8804
Fire Prot. Spec.
007 31652 1.0
Compliance Officer
13-1041-3

37 5294
Reg. Nurse Spec.
008 64390 1.0
Registered Nurse
29-1111-2

17 Lipford 8804
Fire Prot. Spec.
007 43295 1.0
Compliance Officer
13-1041-3

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 3 Alachua

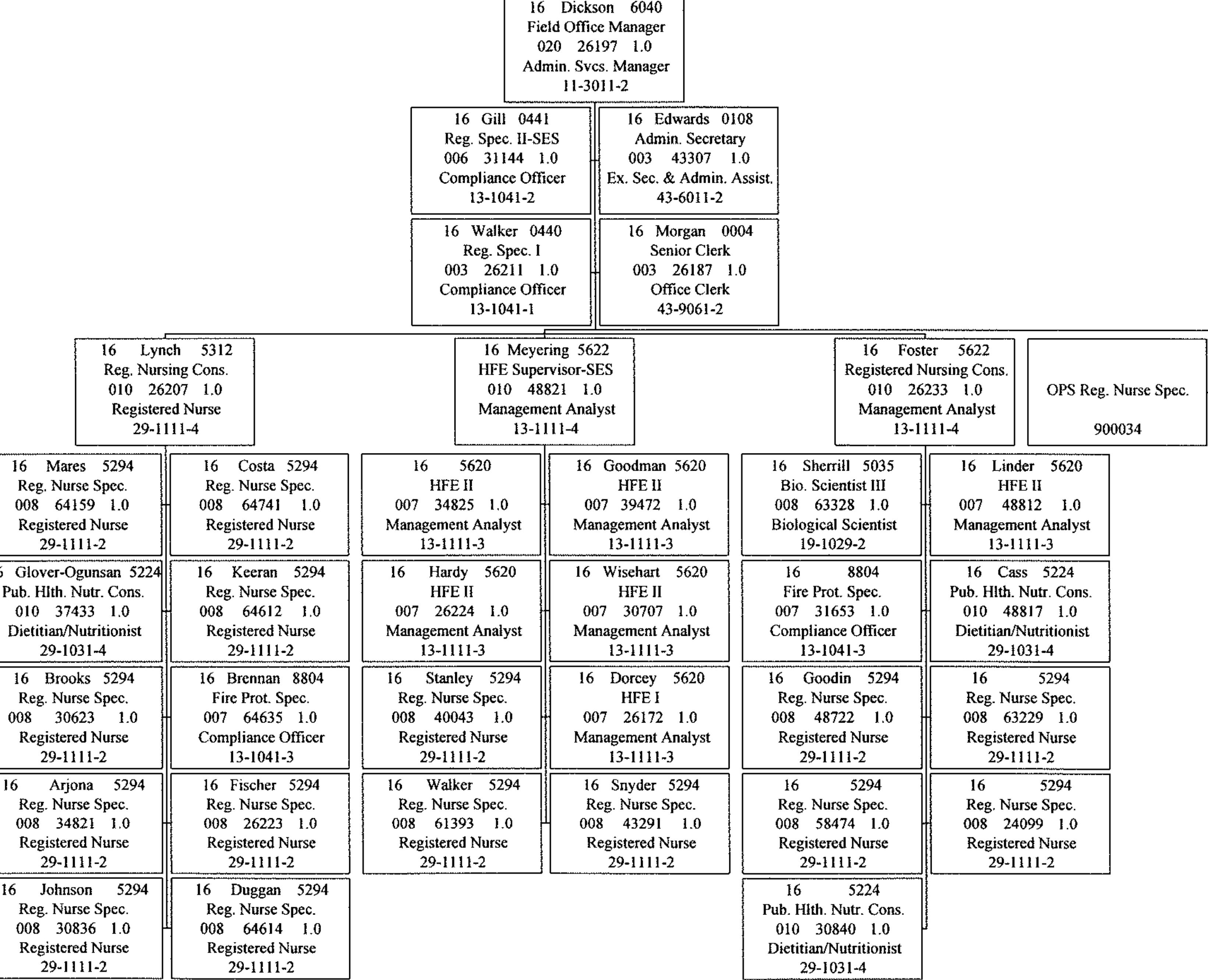
Effective Date: July 1, 2016
Org. Level: 68-30-30-03-000
FTEs: 31 Positions: 31



C-4-3

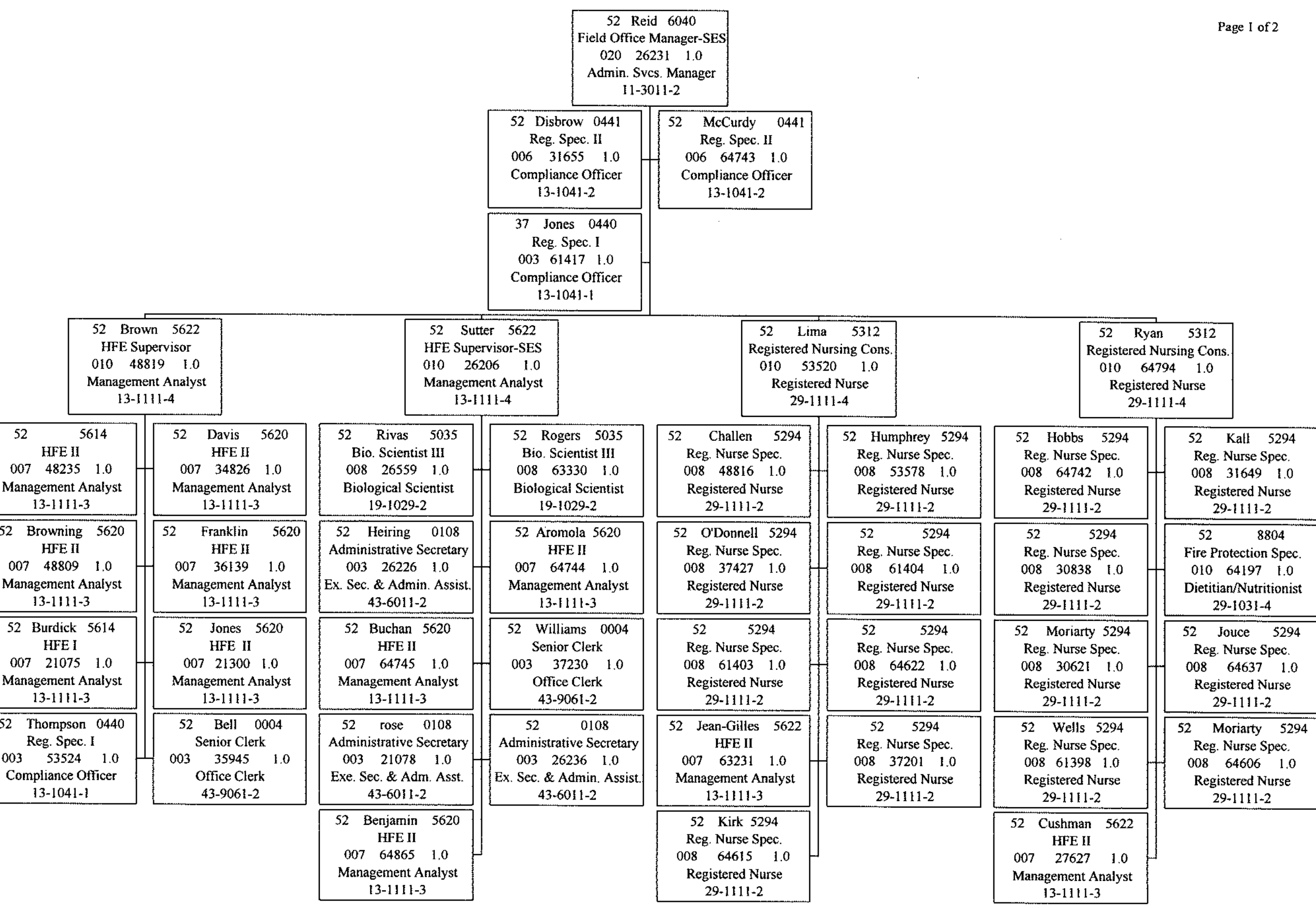
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 4 - Jacksonville

Effective Date: July 1, 2016
Org. Level: 68-30-30-04-000
FTEs: 34 Positions: 34



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

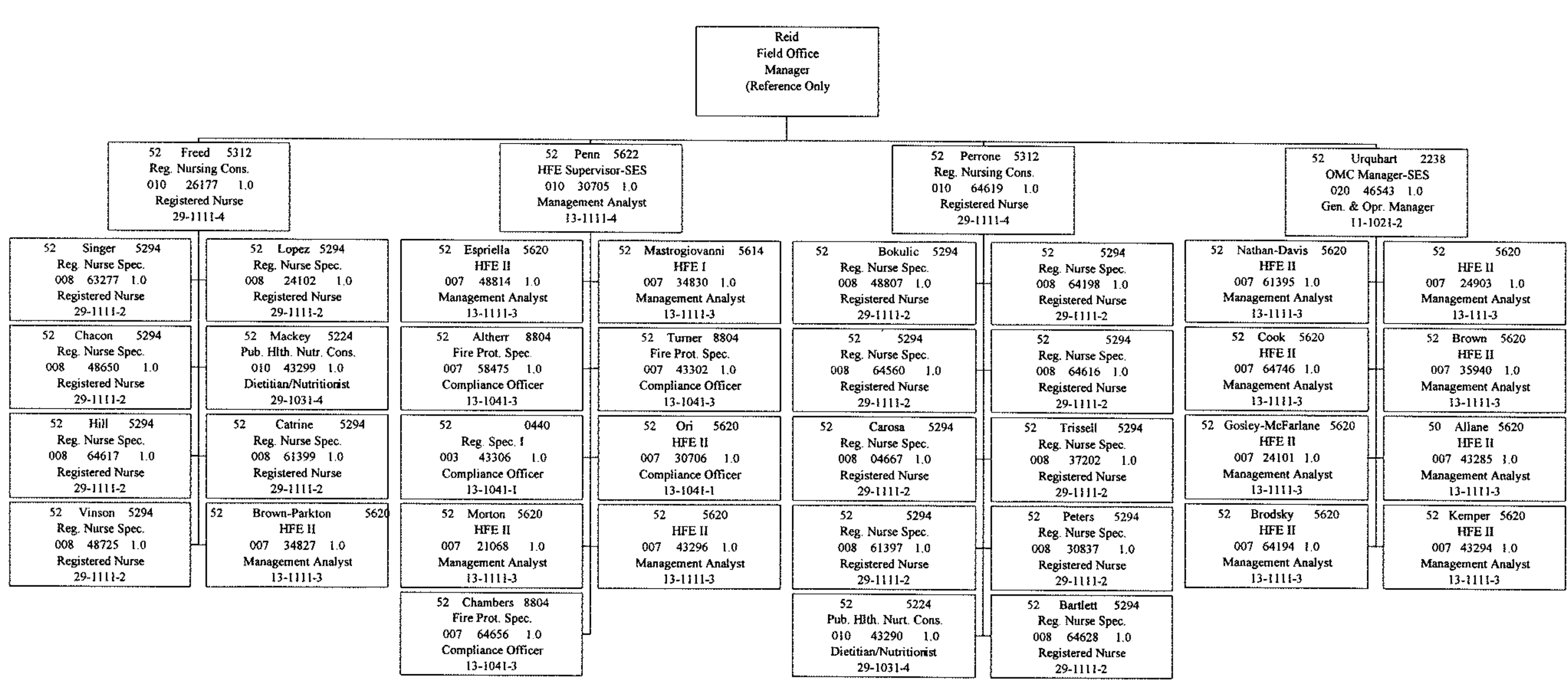
Revised Date: July 1, 2016
Org Level: 68-30-30-05-000
FTEs: 81 Positions: 81



C-4-5

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

Effective Date: July 1, 2016
Org. Level: 68-30-30-05-000
FTEs: 81 Positions: 81



C-4-6

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

48 DeCanio 6040
Field Office Manager
020 26195 1.0
Adm. Serv. Manager
11-3011-2

48 Reardon 0440
Reg. Spec. I-SES
003 26193 1.0
Compliance Officer
13-1041-1

48 Dillebay 5312
Reg. Nursing Cons.
010 37435 1.0
Registered Nurse
29-1111-4

- 48 5294 / Reg. Nurse Spec. / 008 24100 1.0 / Registered Nurse / 29-1111-2
- 48 Delgado 0004 / Senior Clerk / 003 48719 1.0 / Office Clerk / 43-9061-2
- 48 Benjamin 5294 / Reg. Nurse Spec. / 008 64646 1.0 / Registered Nurse / 29-1111-2
- 48 Hunt 5294 / Reg. Nurse Spec. / 008 64414 1.0 / Registered Nurse / 29-1111-2
- 48 Thompson 5294 / Reg. Nurse Spec. / 008 26182 1.0 / Registered Nurse / 29-1111-2
- 48 Campbell 0108 / Admin. Secretary-SES / 003 43305 1.0 / Ex. Sec. & Admin. Assist. / 43-6011-2
- Wood / OPS Admin. Secretary / 900171
- 48 Ray 5294 / Reg. Nurse Spec. / 008 64748 1.0 / Registered Nurse / 29-1111-2
- 48 Joshi 5294 / Reg. Nurse Spec. / 008 64389 1.0 / Registered Nurse / 29-1111-2
- 48 Lockwood 5294 / Reg. Nurse Spec. / 008 64632 1.0 / Registered Nurse / 29-1111-2
- 48 Glosi 5294 / Reg. Nurse Spec. / 008 64747 1.0 / Registered Nurse / 29-1111-2
- 48 Merchant 5035 / Bio. Scientist III / 008 26558 1.0 / Biological Scientist / 19-1029-2
- 48 Creek 5294 / Reg. Nurse Spec. / 008 64638 1.0 / Registered Nurse / 29-1111-2
- 48 5294 / Reg. Nurse Spec. / 008 30622 1.0 / Registered Nurse / 29-1111-2

48 Henry 5622
HFE Supervisor-SES
010 48636 1.0
Management Analyst
13-1111-4

- 48 Pellot 5294 / Reg. Nurse Spec. / 008 43293 1.0 / Registered Nurse / 29-1111-2
- 48 Williams 5294 / Reg. Nurse Spec. / 008 34829 1.0 / Registered Nurse / 29-1111-2
- 48 Gulian-Andrew 5620 / HFE II / 007 39450 1.0 / Management Analyst / 13-1111-3
- 48 Erkens 0004 / Senior Clerk / 003 53526 1.0 / Office Clerk / 43-9061-2
- 48 Bulger 5620 / HFE II / 007 33415 1.0 / Management Analyst / 13-1111-3
- 48 Crawford 5620 / HFE II / 007 63622 1.0 / Management Analyst / 13-1111-3

48 Scherer 5622
HFE Supervisor-SES
010 64196 1.0
Management Analyst
13-1111-4

- 48 Stanley 8804 / Fire Prot. Spec. / 007 31651 1.0 / Compliance Officer / 13-1041-3
- 48 Lebron 0441 / Reg. Spec. II / 006 48651 1.0 / Compliance Officer / 13-1041-2
- 48 Seltzer 5224 / Pub. Hlth. Nutr. Cons. / 010 26222 1.0 / Dietitian/Nutritionist / 29-1031-4
- 48 Boyum 5294 / Reg. Nurse Spec. / 008 48236 1.0 / Registered Nurse / 29-1111-2
- 48 Rodriguez 5294 / Reg. Nurse Spec. / 008 64620 1.0 / Registered Nurse / 29-1111-2
- 48 Chaokasem 5620 / HFE II / 007 19662 1.0 / Management Analyst / 13-1111-3
- 48 Forondo 5224 / Pub. Hlth. Nutr. Cons. / 010 26217 1.0 / Dietitian/Nutritionist / 29-1031-4
- 48 Johnson 5294 / Reg. Nurse Spec. / 008 64623 1.0 / Registered Nurse / 29-1111-2
- 48 Mitchell 5294 / Reg. Nurse Spec. / 008 26185 1.0 / Registered Nurse / 29-1111-2
- 48 Allen 5294 / Reg. Nurse Spec. / 008 48723 1.0 / Registered Nurse / 29-1111-2
- 48 Stevenson 8804 / Fire Prot. Spec. / 007 64654 1.0 / Compliance Officer / 13-1041-3
- 48 5294 / Reg. Nurse Spec. / 008 64624 1.0 / Registered Nurse / 29-1111-2
- 48 Wardell 5620 / HFE II / 007 30708 1.0 / Management Analyst / 13-1111-3

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

Effective Date: July 1, 2016
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

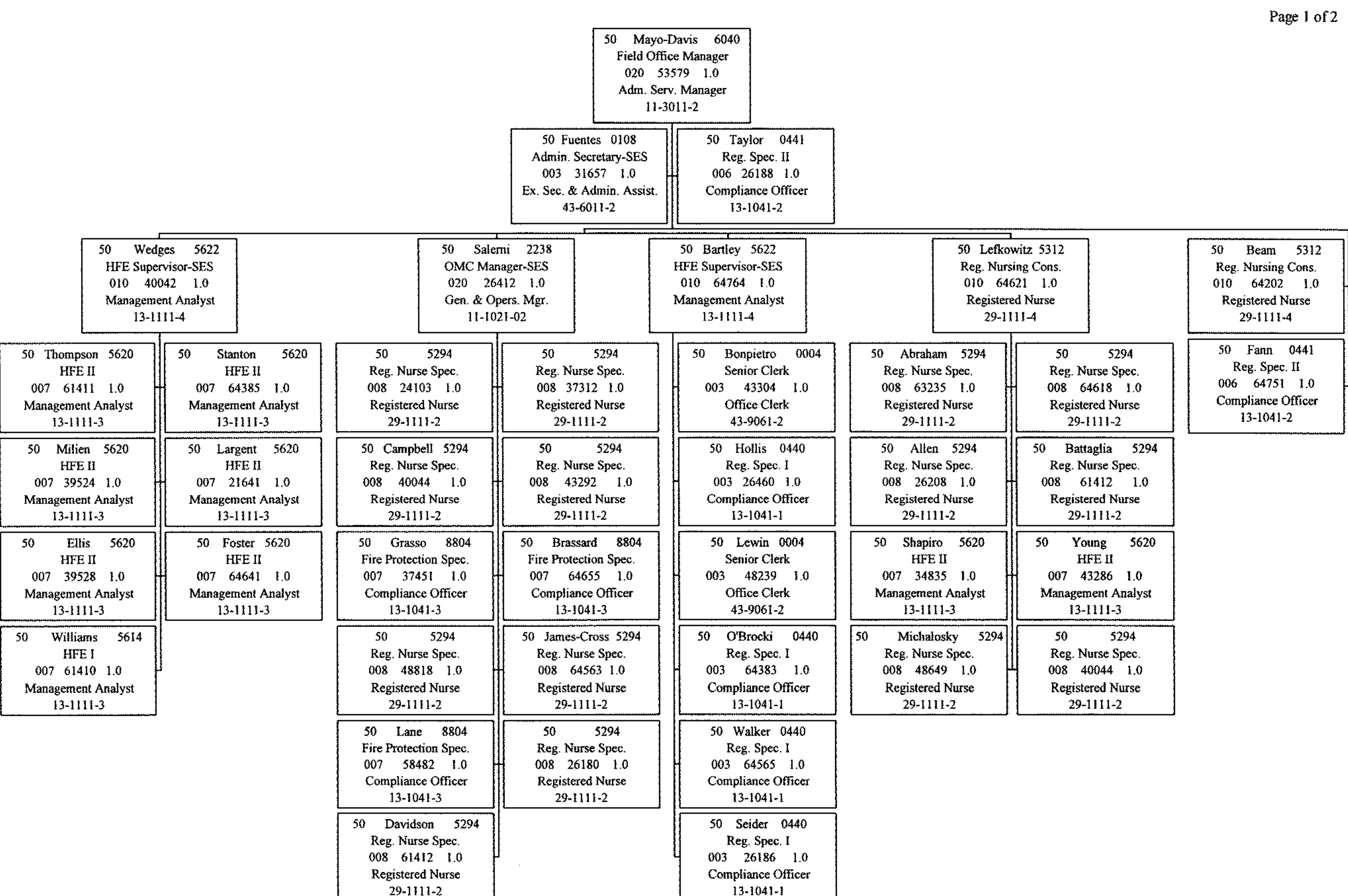
36 Brandt 5312
Reg. Nursing Cons.
010 64650 1.0
Registered Nurse
29-1111-4

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

Allebach OPS Admin. Secretary 900035	36 Olivo 5294 Reg. Nurse Spec. 008 61405 1.0 Registered Nurse 29-1111-2	36 Pettigrew 5035 Bio. Scientist III 008 37436 1.0 Biological Scientist 19-1029-2	36 Furdell 8804 Fire Prot. Spec. 007 48808 1.0 Compliance Officer 13-1041-3	36 B. Birch 5294 Reg. Nurse Spec. 008 24104 1.0 Registered Nurse 29-1111-2	36 Strachan 5294 Reg. Nurse Spec. 008 37828 1.0 Registered Nurse 29-1111-2
36 Humphreys 5294 Reg. Nurse Spec. 008 64625 1.0 Registered Nurse 29-1111-2	36 K. Smith 5620 HFE II 007 64387 1.0 Management Analyst 13-1111-3	36 Pescatrice 8804 Fire Prot. Spec. 007 43301 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 White 5294 Reg. Nurse Spec. 008 43283 1.0 Registered Nurse 29-1111-2	36 Turbyfill 5294 Reg. Nurse Spec. 008 31574 1.0 Registered Nurse 29-1111-2
36 Elias 5620 HFE II 007 33417 1.0 Management Analyst 13-1111-3	36 Corrales 0004 Senior Clerk 003 25178 1.0 Office Clerk 43-9061-2	36 Heimann 5294 Reg. Nurse Spec. 008 30625 1.0 Registered Nurse 29-1111-2	36 Heckscher 0440 Reg. Spec. I 003 64388 1.0 Compliance Officer 13-1041-1	36 Snyder 5294 Reg. Nurse Spec. 010 34822 1.0 Registered Nurse 29-1111-2	36 Taylor 5294 Reg. Nurse Spec. 008 64627 1.0 Registered Nurse 29-1111-2
36 Birch 5294 Reg. Nurse Spec. 008 24104 1.0 Registered Nurse 29-1111-2	36 Furdell 5620 HFE II 007 19457 1.0 Management Analyst 13-1111-3	36 Kadera 5294 Reg. Nurse Spec. 008 63232 1.0 Registered Nurse 29-1111-2	36 Alter 5620 HFE II 007 21873 1.0 Management Analyst 13-1111-3	36 Asdale 5294 Reg. Nurse Spec. 008 21982 1.0 Registered Nurse 29-1111-2	36 5294 Reg. Nurse Spec. 008 64626 1.0 Registered Nurse 29-1111-2
36 Mozen 5294 Reg. Nurse Spec. 008 63230 1.0 Registered Nurse 29-1111-2	36 McGillivray 5294 Reg. Nurse Spec. 008 63233 1.0 Registered Nurse 29-1111-2	36 Stuckey 8804 Fire Protection Spec 007 26225 1.0 Compliance Officer 13-1041-3	36 Sarros 5620 HFE II 007 64761 1.0 Management Analyst 13-1111-3	36 Elias 0440 Reg. Spec. I 003 00567 1.0 Compliance Officer 13-1041-1	36 Fradenburg 0108 Admin. Secretary 003 25182 1.0 Ex. Sec. & Admin. Assist. 43-6011-2
				36 5294 Reg. Nurse Spec. 008 61396 1.0 Registered Nurse 29-1111-2	36 5294 Reg. Nurse Spec. 008 11160 1.0 Registered Nurse 29-1111-2

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

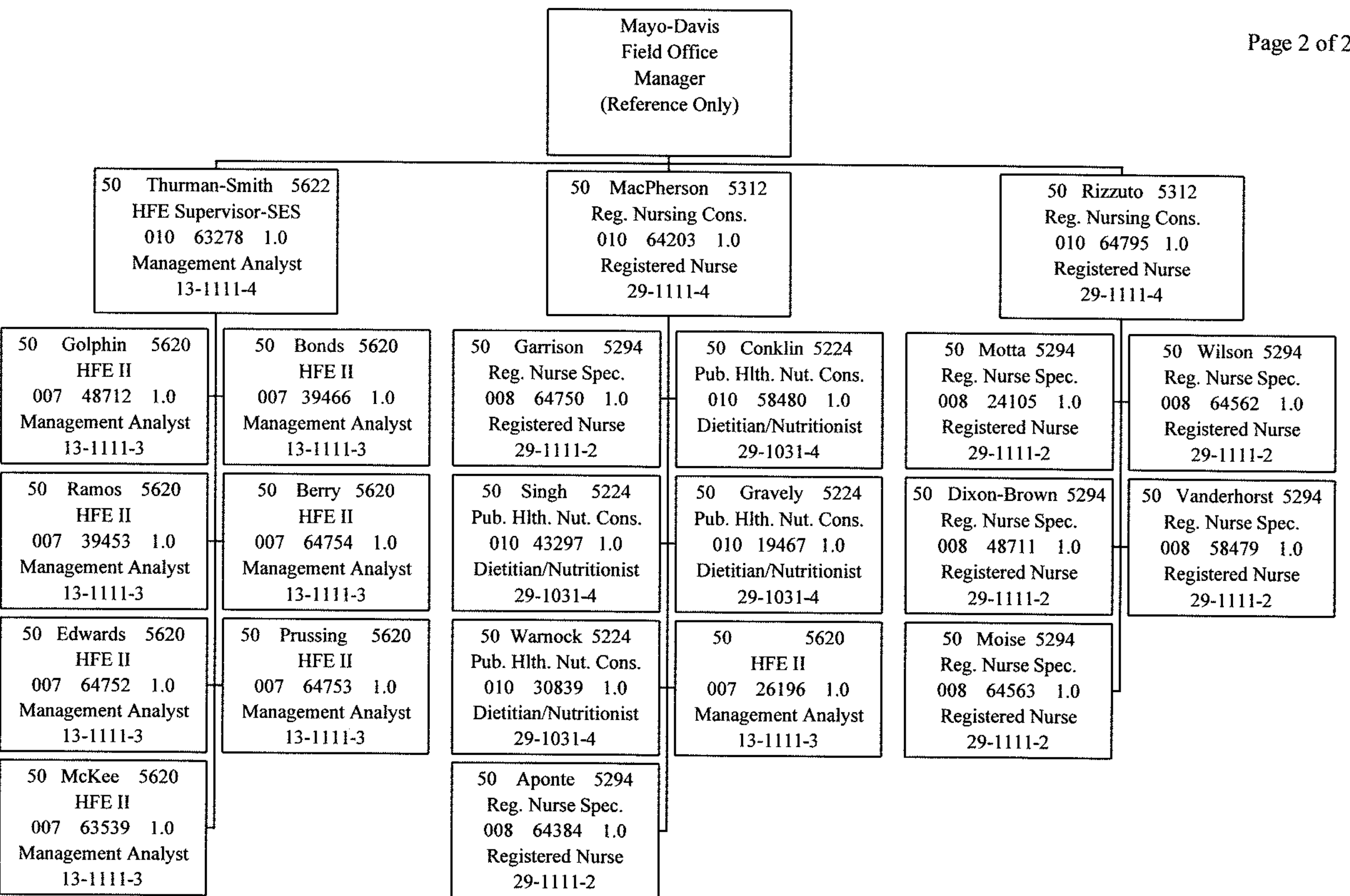
Effective Date: July 1, 2016
Org. Level: 68-30-30-09-000
FTEs: 61 Positions: 61



C-4-9

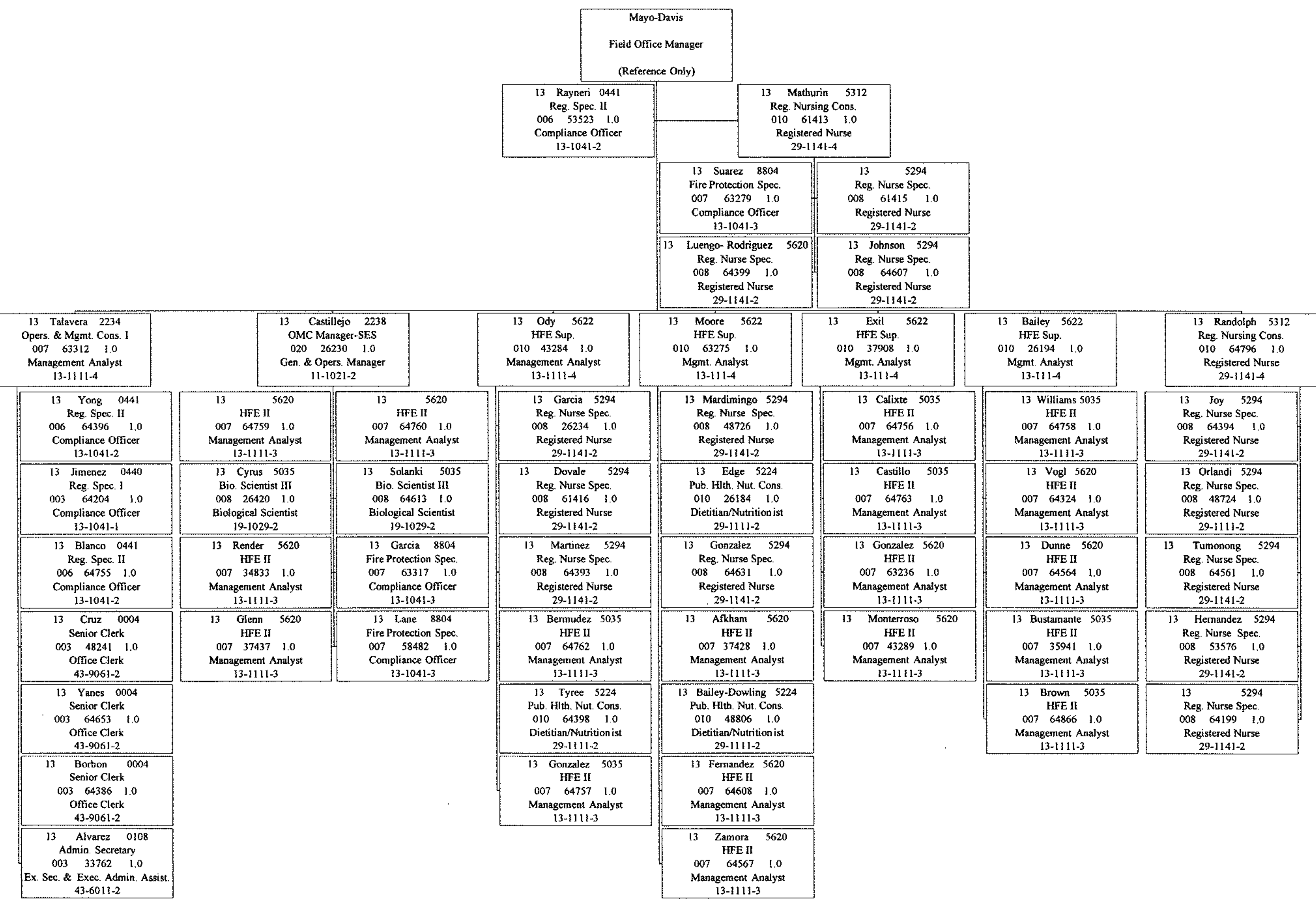
AGENCY FOR HEALTH CARE ADMINISTRATION
Health Quality Assurance
Area 9 - Delray Beach

Effective Date: July 1, 2016
Org Code: 68-30-30-09-000
FTEs: 61 Positions: 61



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

Effective Date: July 1, 2016
Org. Level: 68 30 30 11 000
FTEs: 54 Positions: 54



C-4-11

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

Org. Level: 68 30 20 00 000
Revised Date: July 1, 2016
FTEs: 96.5 Positions: 98

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

- Hospital and Outpatient Services (Reference Only)
- Laboratories (Reference Only)
- Long Term Care (Reference Only)
- Home Care (Reference Only)
- Assisted Living Facilities (Reference Only)

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

Org. Level: 68 30 20 00 000
Revised Date: July 1, 2016
FTEs: 96.5 Positions: 98

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

- Hospital and Outpatient Services (Reference Only)
- Laboratories (Reference Only)
- Long Term Care (Reference Only)
- Home Care (Reference Only)
- Assisted Living Facilities (Reference Only)

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

Revised Date: July 1, 2016
Org. Level: 68 30 20 00 000
FTEs: 96.5 Positions: 98

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

37 Stewart 2225
Sr. Mgmt. Analyst II-SES
010 61414 1.0
Management Analyst
13-1111-4

37 Willis 2236
Gov't. Opers. Consul. III
010 63431 1.0
Management Analyst
13-1111-4

37 Woodberry 2236
Gov't. Opers. Consul. III
010 53350 1.0
Management Analyst
13-1111-4

37 Smith 0709
Admin. Asst. I
003 00618 1.0
Exec. Sec. & Exec. Admin. Asst
43-6011-2

37 Fitch 9145
Health Admin. Svcs. Mgr.-SES
020 00643 1.0
Manager
11-3011-2

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

37 Aldridge 5894
Hlth. Svcs. & Fac. Cons.
010 63451 1.0
Business Opers. Specialist
13-1199-4

37 Eugene 5894
Hlth. Svcs. & Fac. Cons.
010 64154 1.0
Business Opers. Specialist
13-1199-4

37 LoCastro 5312
Reg. Nursing Consultant
010 64412 1.0
Registered Nurses
29-1141-4

37 Rooks 2234
Gov't Opers. Cons. I
007 64418 1.0
Management Analyst
13-1111-4

37 Martin 5875
Med./Hlth. Care Prog. Analyst
010 64448 1.0
Management Analyst
13-1111-4

37 Bailey 5875
Med./Hlth. Care Prog. Analyst
010 64449 1.0
Management Analyst
13-1111-4

37 Breedlove 5875
Med./Hlth. Care Prog. Analyst
010 64317 1.0
Management Analyst
13-1111-4

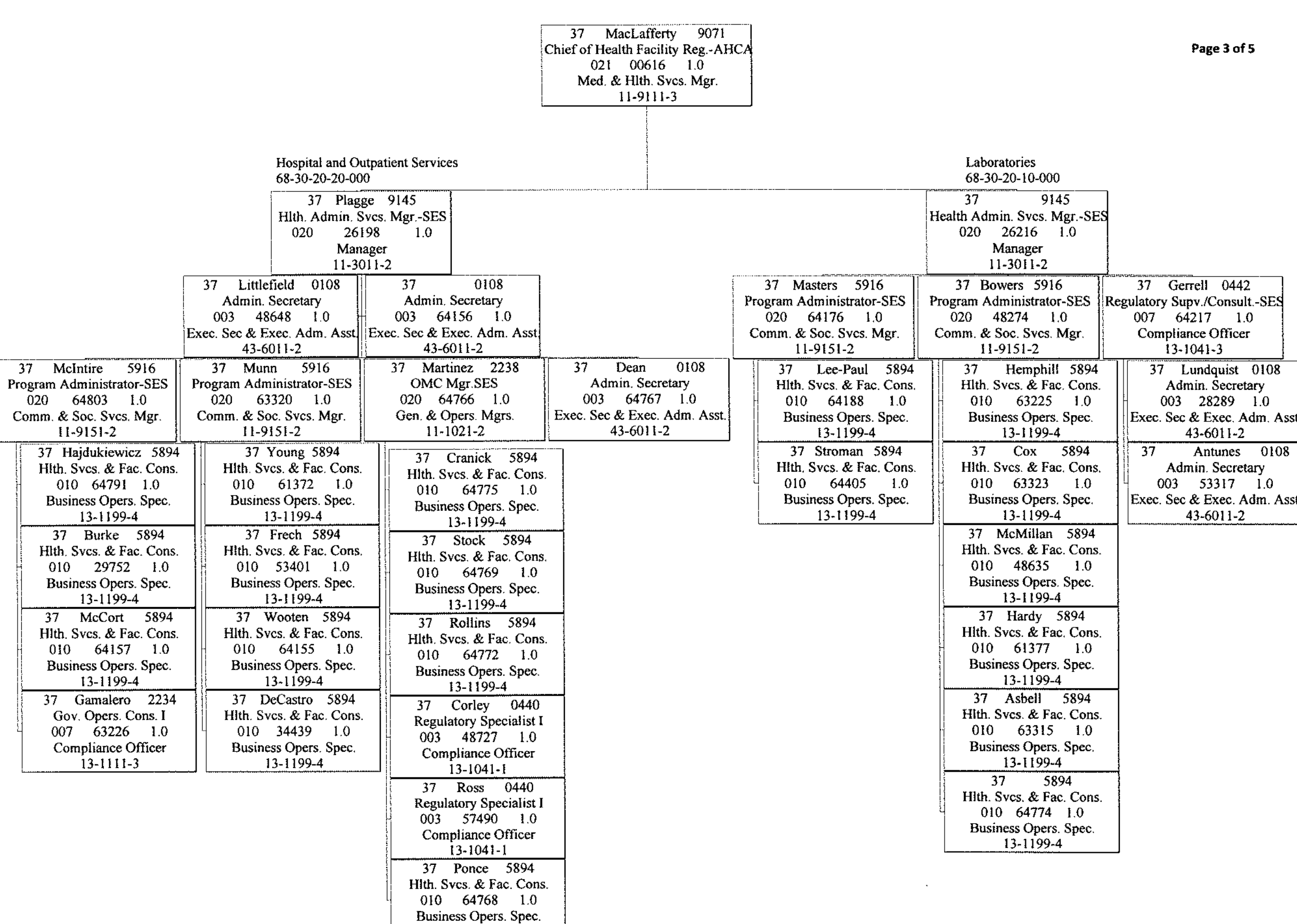
37 Austin 5875
Med./Hlth. Care Prog. Analyst
010 64447 1.0
Management Analyst
13-1111-4

Cookro
OPS Senior Physician
90043

37 Picolo 5312
Registered Nursing Consultant
010 37433 1.0
Registered Nurse
29-1141-04

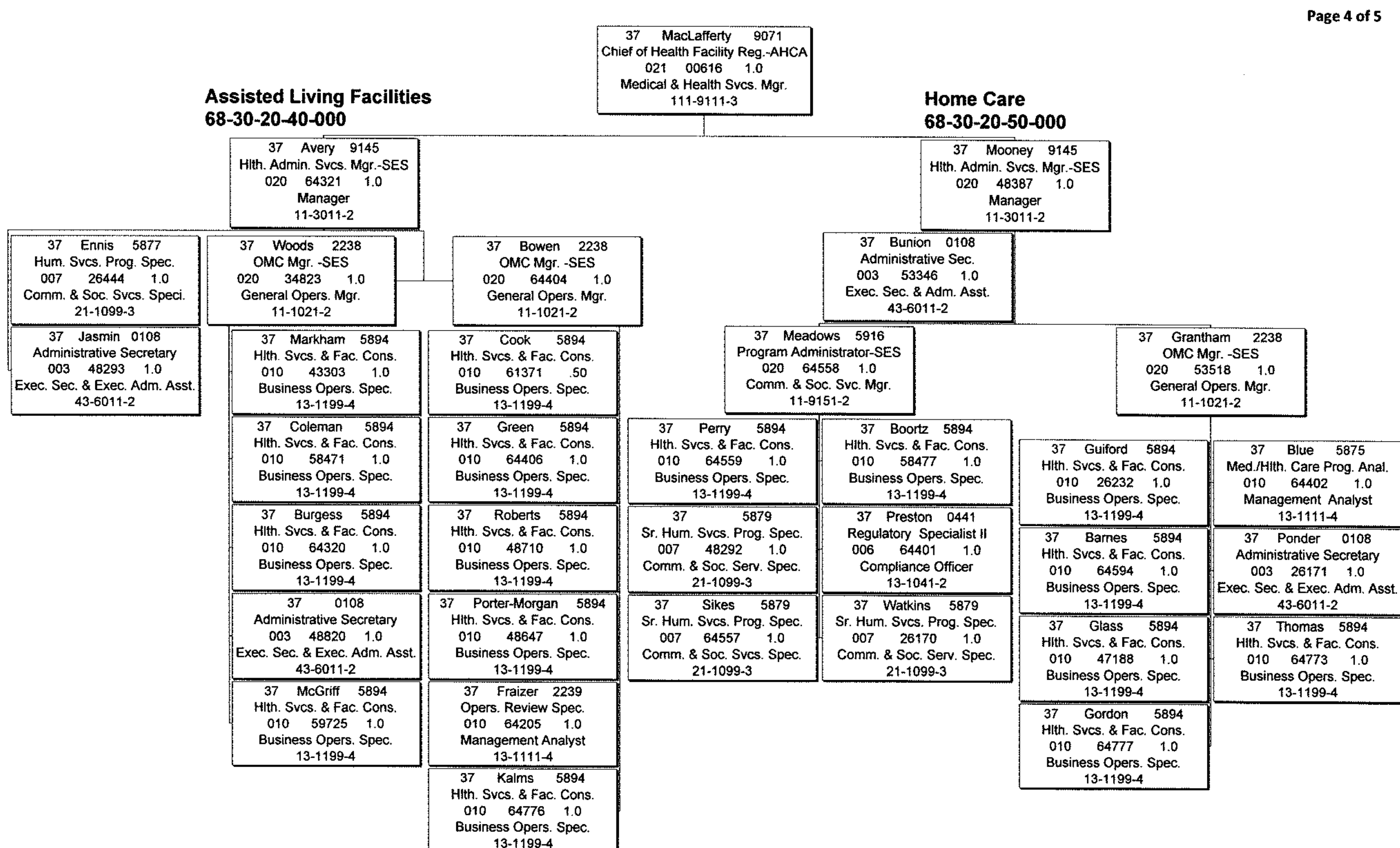
37 Locastro 5312
Registered Nursing Consultant
010 37433 1.0
Registered Nurse
29-1141-04

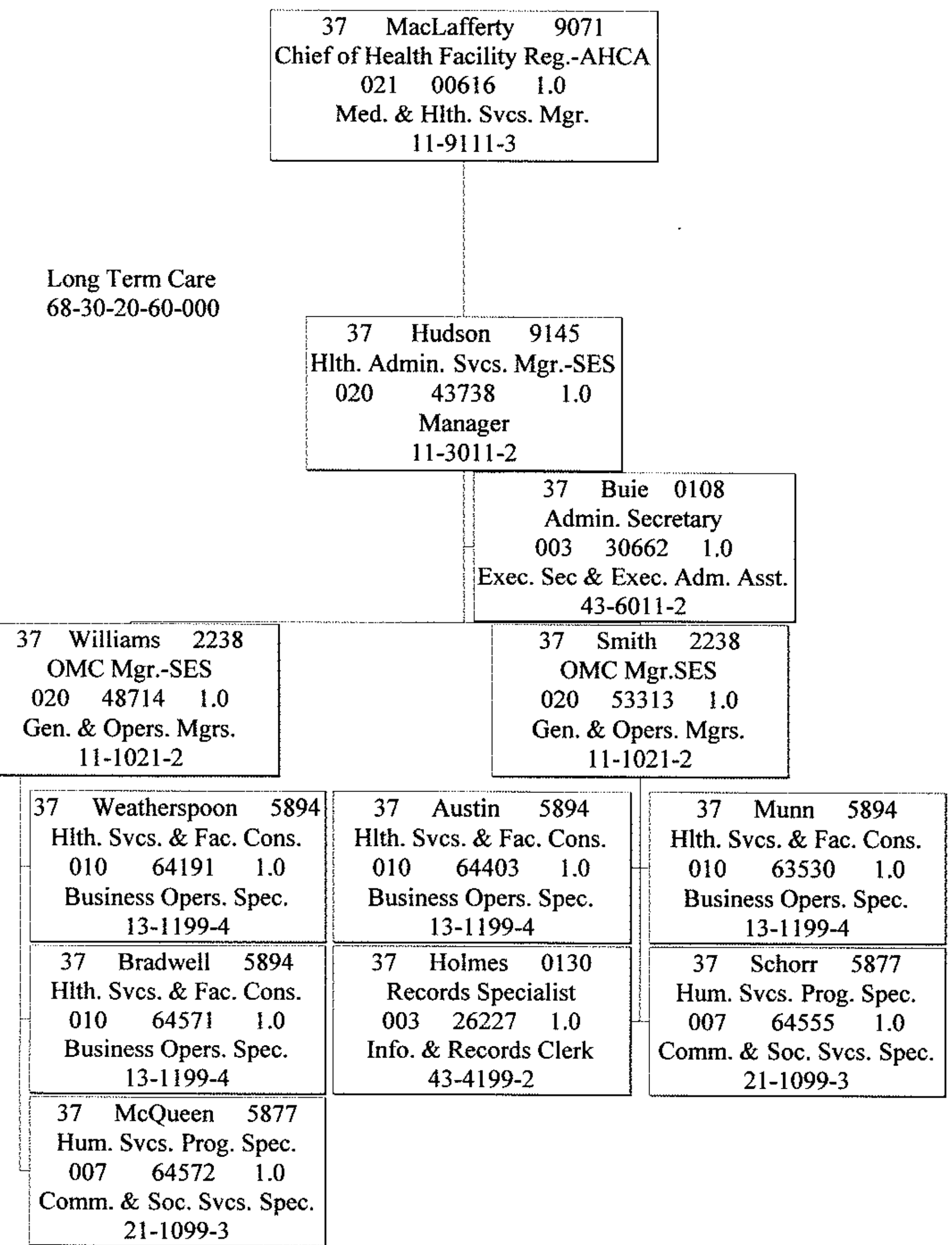
37 0440
Regulatory Specialist I
003 29805 1.0
Compliance Officer
13-1041-01


37 MacLafferty 9071
Chief of Health Facility Reg.-AHCA
021 00616 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-3
Hospital and Outpatient Services
68-30-20-20-000
37 Plagge 9145
Hlth. Admin. Svcs. Mgr.-SES
020 26198 1.0
Manager
11-3011-2
37 Littlefield 0108
Admin. Secretary
003 48648 1.0
Exec. Sec & Exec. Adm. Asst
43-6011-2
37 0108
Admin. Secretary
003 64156 1.0
Exec. Sec & Exec. Adm. Asst
43-6011-2
37 McIntire 5916
Program Administrator-SES
020 64803 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2
37 Munn 5916
Program Administrator-SES
020 63320 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2
37 Martinez 2238
OMC Mgr.SES
020 64766 1.0
Gen. & Opers. Mgrs.
11-1021-2
37 Dean 0108
Admin. Secretary
003 64767 1.0
Exec. Sec & Exec. Adm. Asst.
43-6011-2
37 Hajdukiewicz 5894
Hlth. Svcs. & Fac. Cons.
010 64791 1.0
Business Opers. Spec.
13-1199-4
37 Burke 5894
Hlth. Svcs. & Fac. Cons.
010 29752 1.0
Business Opers. Spec.
13-1199-4
37 McCort 5894
Hlth. Svcs. & Fac. Cons.
010 64157 1.0
Business Opers. Spec.
13-1199-4
37 Gamalero 2234
Gov. Opers. Cons. I
007 63226 1.0
Compliance Officer
13-1111-3
37 Young 5894
Hlth. Svcs. & Fac. Cons.
010 61372 1.0
Business Opers. Spec.
13-1199-4
37 Frech 5894
Hlth. Svcs. & Fac. Cons.
010 53401 1.0
Business Opers. Spec.
13-1199-4
37 Wooten 5894
Hlth. Svcs. & Fac. Cons.
010 64155 1.0
Business Opers. Spec.
13-1199-4
37 DeCastro 5894
Hlth. Svcs. & Fac. Cons.
010 34439 1.0
Business Opers. Spec.
13-1199-4
37 Cranick 5894
Hlth. Svcs. & Fac. Cons.
010 64775 1.0
Business Opers. Spec.
13-1199-4
37 Stock 5894
Hlth. Svcs. & Fac. Cons.
010 64769 1.0
Business Opers. Spec.
13-1199-4
37 Rollins 5894
Hlth. Svcs. & Fac. Cons.
010 64772 1.0
Business Opers. Spec.
13-1199-4
37 Corley 0440
Regulatory Specialist I
003 48727 1.0
Compliance Officer
13-1041-1
37 Ross 0440
Regulatory Specialist I
003 57490 1.0
Compliance Officer
13-1041-1
37 Ponce 5894
Hlth. Svcs. & Fac. Cons.
010 64768 1.0
Business Opers. Spec.
13-1199-4
Laboratories
68-30-20-10-000
37 9145
Health Admin. Svcs. Mgr.-SES
020 26216 1.0
Manager
11-3011-2
37 Masters 5916
Program Administrator-SES
020 64176 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2
37 Bowers 5916
Program Administrator-SES
020 48274 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2
37 Gerrell 0442
Regulatory Supv./Consult.-SES
007 64217 1.0
Compliance Officer
13-1041-3
37 Lee-Paul 5894
Hlth. Svcs. & Fac. Cons.
010 64188 1.0
Business Opers. Spec.
13-1199-4
37 Stroman 5894
Hlth. Svcs. & Fac. Cons.
010 64405 1.0
Business Opers. Spec.
13-1199-4
37 Hemphill 5894
Hlth. Svcs. & Fac. Cons.
010 63225 1.0
Business Opers. Spec.
13-1199-4
37 Cox 5894
Hlth. Svcs. & Fac. Cons.
010 63323 1.0
Business Opers. Spec.
13-1199-4
37 McMillan 5894
Hlth. Svcs. & Fac. Cons.
010 48635 1.0
Business Opers. Spec.
13-1199-4
37 Hardy 5894
Hlth. Svcs. & Fac. Cons.
010 61377 1.0
Business Opers. Spec.
13-1199-4
37 Asbell 5894
Hlth. Svcs. & Fac. Cons.
010 63315 1.0
Business Opers. Spec.
13-1199-4
37 5894
Hlth. Svcs. & Fac. Cons.
010 64774 1.0
Business Opers. Spec.
13-1199-4
37 Lundquist 0108
Admin. Secretary
003 28289 1.0
Exec. Sec & Exec. Adm. Asst
43-6011-2
37 Antunes 0108
Admin. Secretary
003 53317 1.0
Exec. Sec & Exec. Adm. Asst
43-6011-2

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

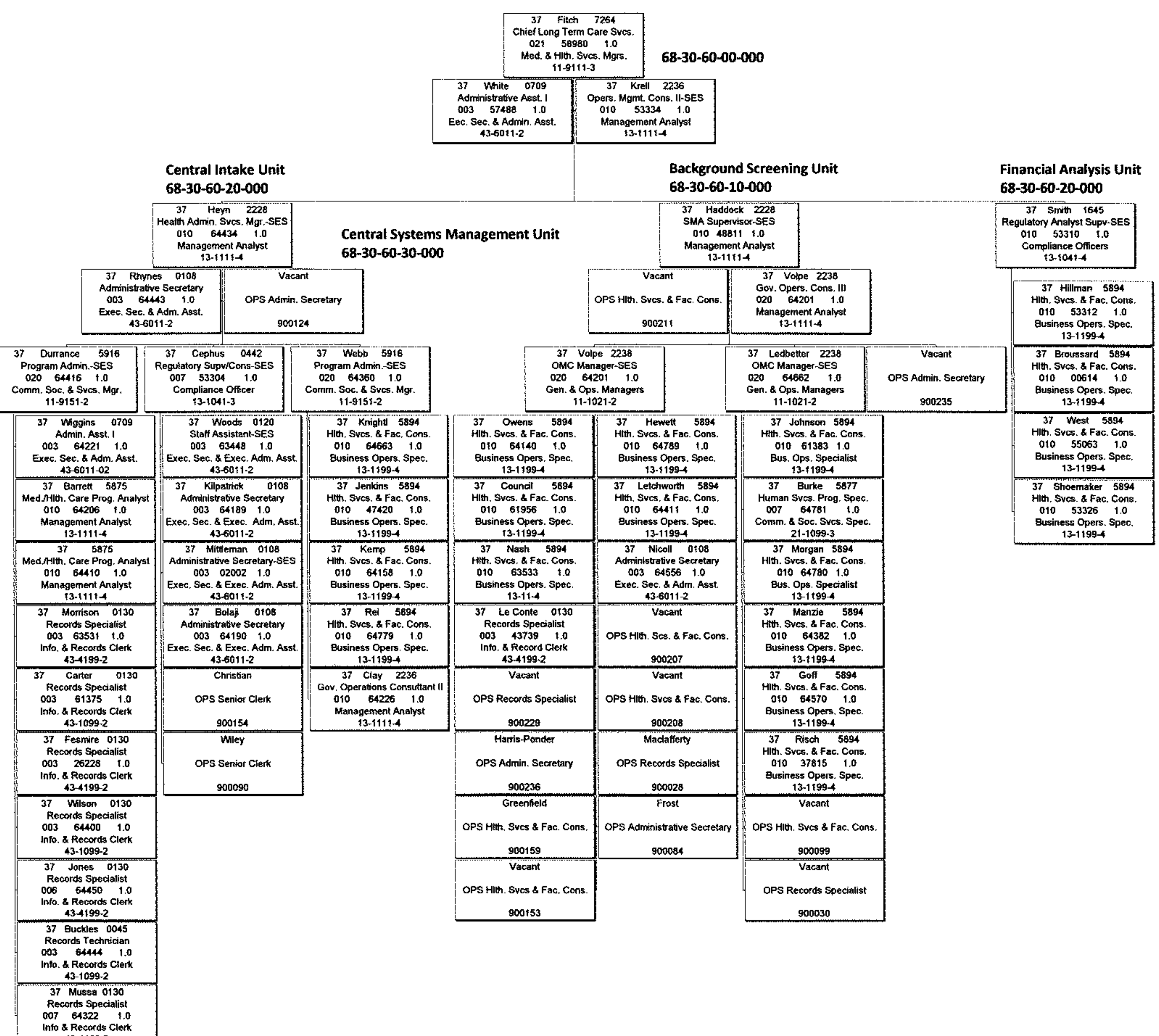
Effective Date: July 1, 2016
FTEs: 96.5 Positions: 98




37 MacLafferty 9071
Chief of Health Facility Reg.-AHCA
021 00616 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-3
Long Term Care
68-30-20-60-000
37 Hudson 9145
Hlth. Admin. Svcs. Mgr.-SES
020 43738 1.0
Manager
11-3011-2
37 Buie 0108
Admin. Secretary
003 30662 1.0
Exec. Sec & Exec. Adm. Asst.
43-6011-2
37 Williams 2238
OMC Mgr.-SES
020 48714 1.0
Gen. & Opers. Mgrs.
11-1021-2
37 Smith 2238
OMC Mgr.SES
020 53313 1.0
Gen. & Opers. Mgrs.
11-1021-2
37 Weatherspoon 5894
Hlth. Svcs. & Fac. Cons.
010 64191 1.0
Business Opers. Spec.
13-1199-4
37 Austin 5894
Hlth. Svcs. & Fac. Cons.
010 64403 1.0
Business Opers. Spec.
13-1199-4
37 Munn 5894
Hlth. Svcs. & Fac. Cons.
010 63530 1.0
Business Opers. Spec.
13-1199-4
37 Bradwell 5894
Hlth. Svcs. & Fac. Cons.
010 64571 1.0
Business Opers. Spec.
13-1199-4
37 Holmes 0130
Records Specialist
003 26227 1.0
Info. & Records Clerk
43-4199-2
37 Schorr 5877
Hum. Svcs. Prog. Spec.
007 64555 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3
37 McQueen 5877
Hum. Svcs. Prog. Spec.
007 64572 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

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

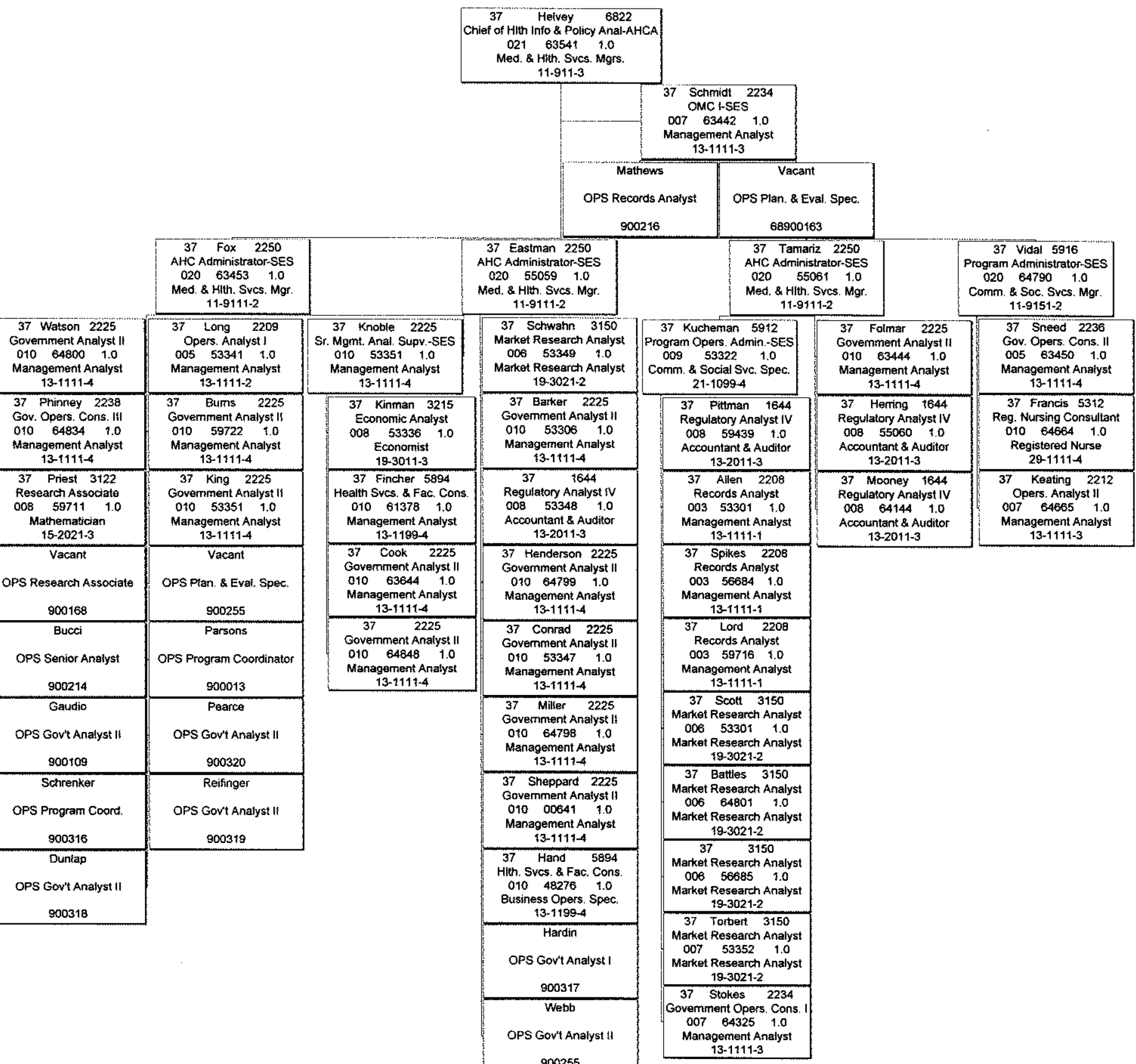
Effective Date: July 1, 2016
FTEs: 47 Positions: 47



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

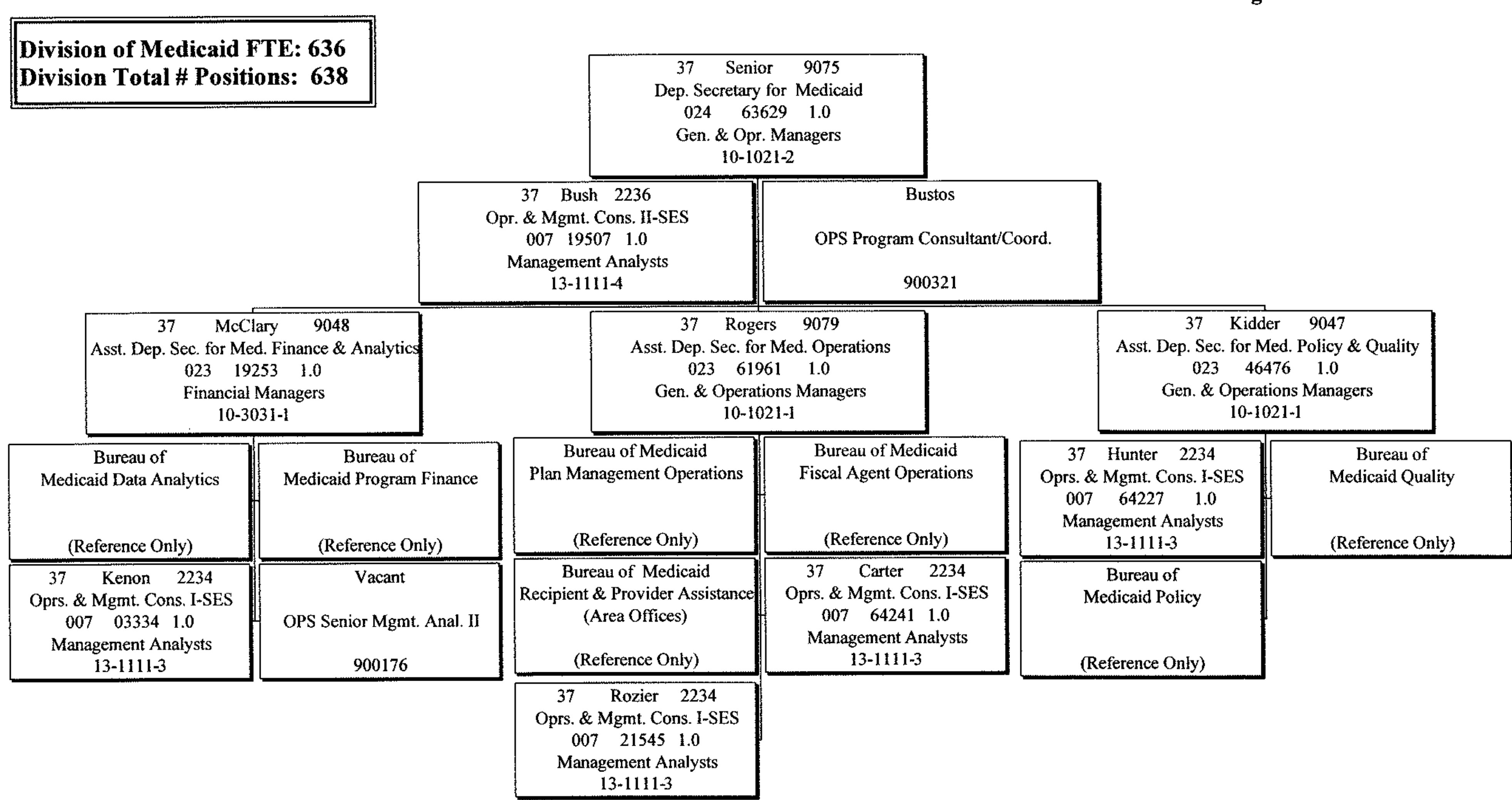
Effective Date: July 1, 2016
Org Level: 68-30-70-00-000
FTEs: 39 Positions: 39



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

Effective Date: July 1, 2016
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, 2016
Org. Level: 68-40-00-00-000
FTEs: 28 Positions: 28

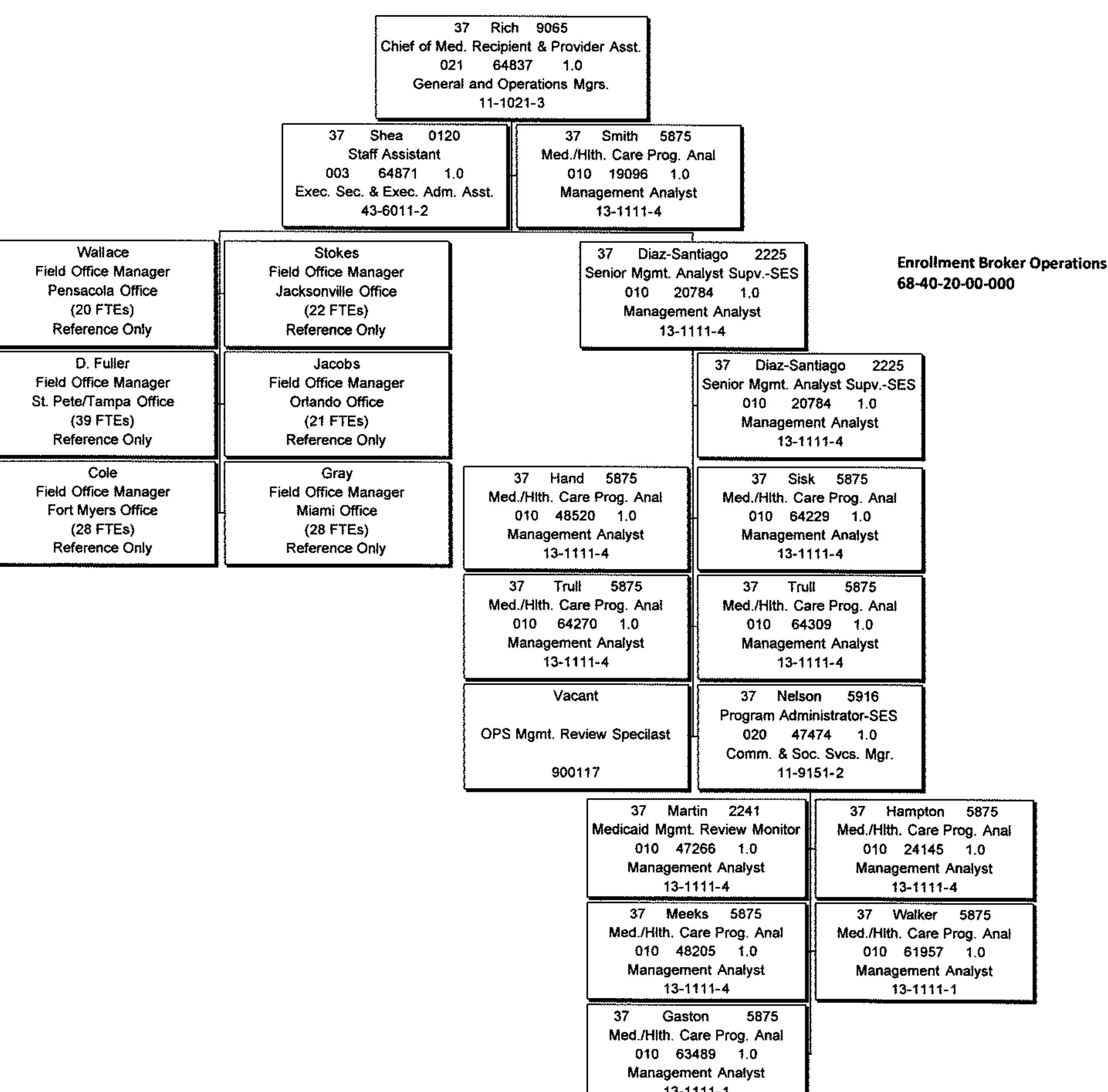
Senior
Deputy Secretary for Medicaid
(Reference Only)

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 5912 — Prog. Opers. Admin.; 009 53422 1.0; Comm. & Soc. Svcs Spec.; 21-1099-04
    - 37 Skidmore 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
  - Waldron — OPS Administrative Secretary.; 68900169
  - Vacant — OPS Administrative Secretary.; 68900146
- **37 Ryals 5916** — Program Administrator-SES; 020 46480 1.0; Comm. & Soc. Svcs. Mgr.; 11-91-51-2
  - 37 Wright 2234 — Gov. Opers. Consultant I; 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 Bruner 5875** — Medical/Health Care Prog. Analyst; 010 64863 1.0; Management Analyst; 13-1111-4

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

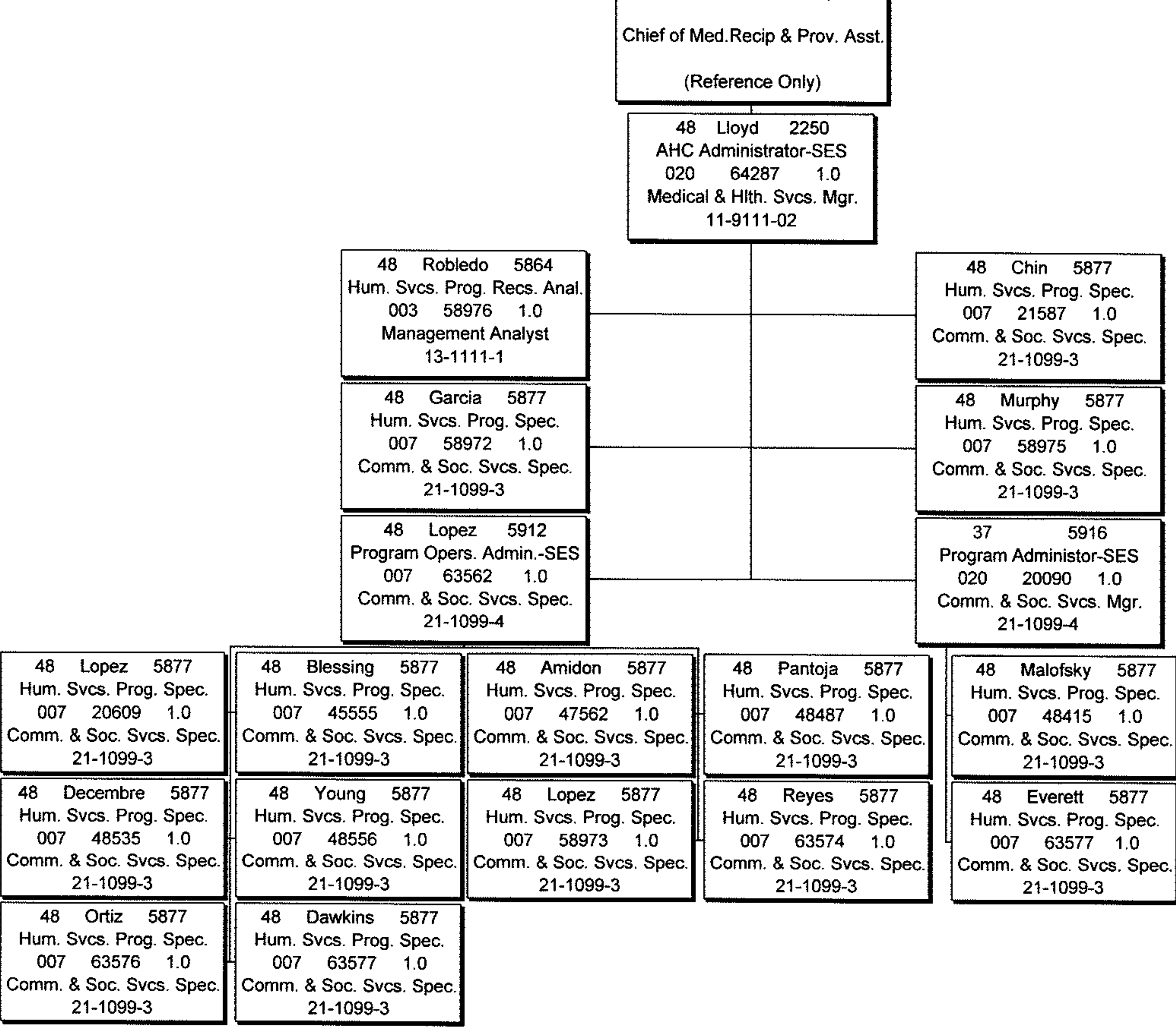
Effective Date: July 1, 2016
Org Level: 68-40-10-00-000
FTEs: 11 Positions: 11



D-2

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

Effective Date: July 1, 2016
Org Level: 68-40-20-07-000
FTEs: 20 Positions: 20



D-2-2

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

Effective Date: July 1, 2016
Org Level: 68-40-20-11-000
FTEs: 26 Positions: 26

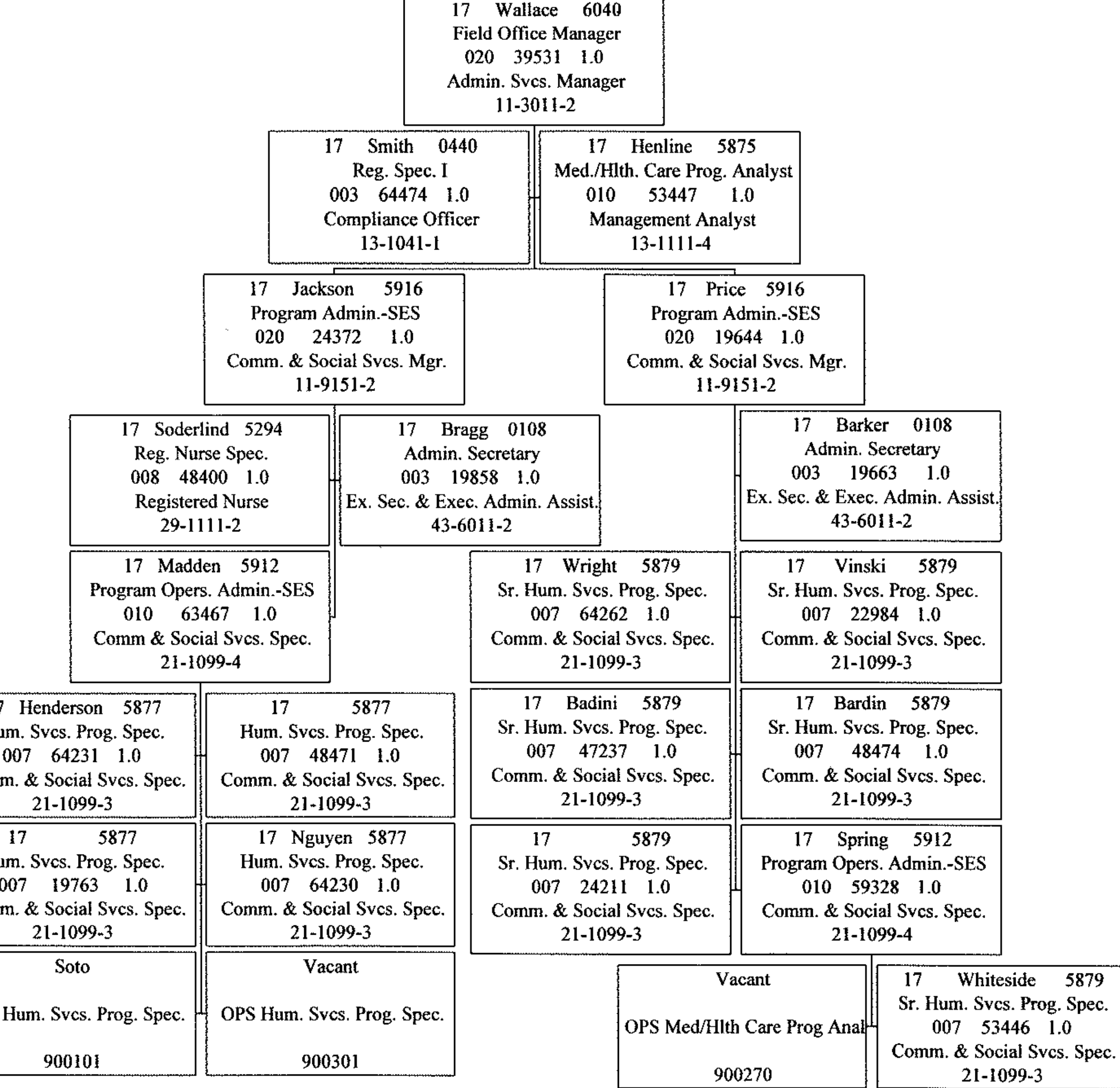
Rich
Chief of Med. Recip. & Prov. Asst.
(Reference Only)

13 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

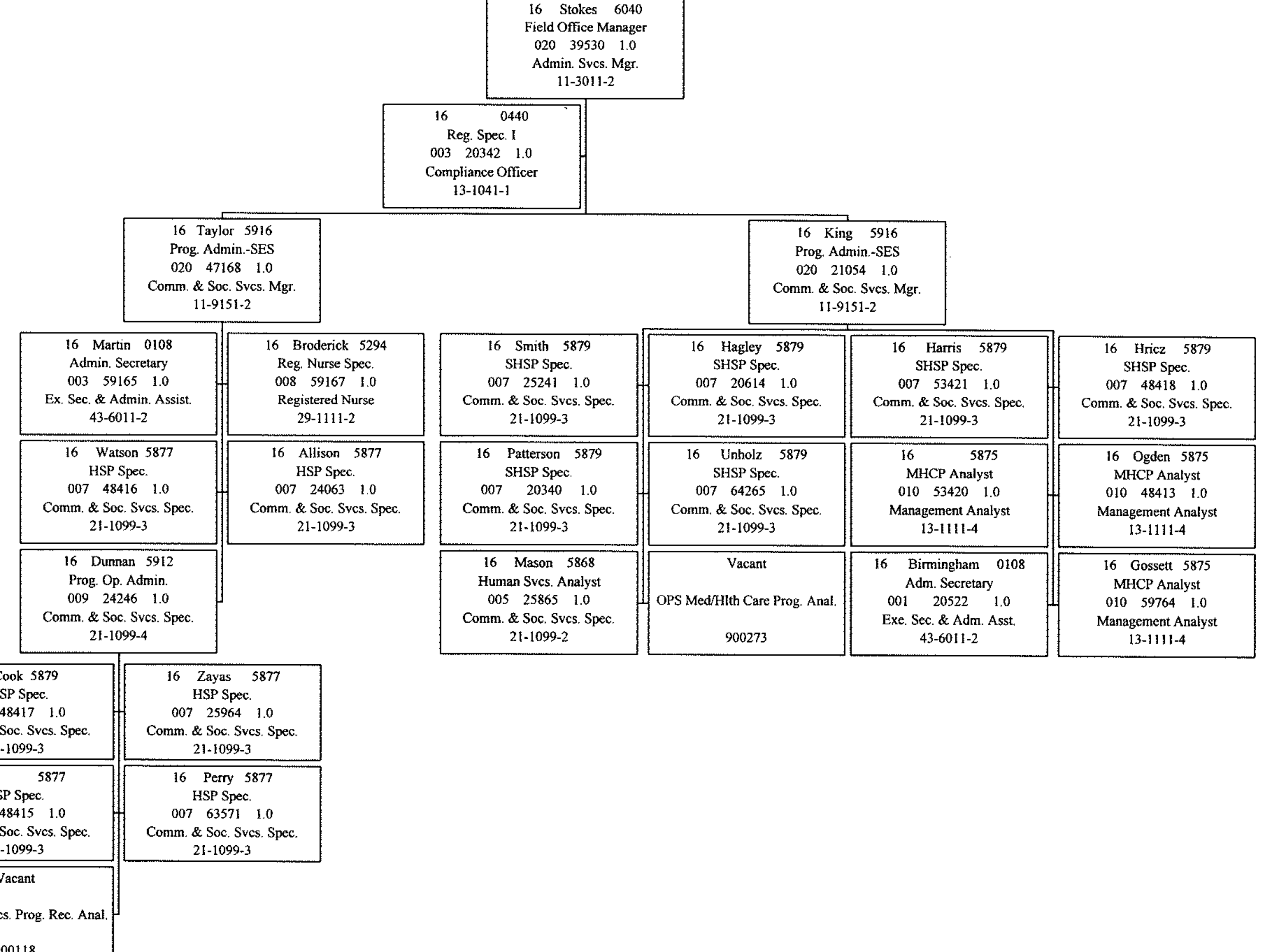
Effective Date: July 1, 2016
Org. Level: 68-50-10-01-000
FTEs: 19 Positions: 19



D-3

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

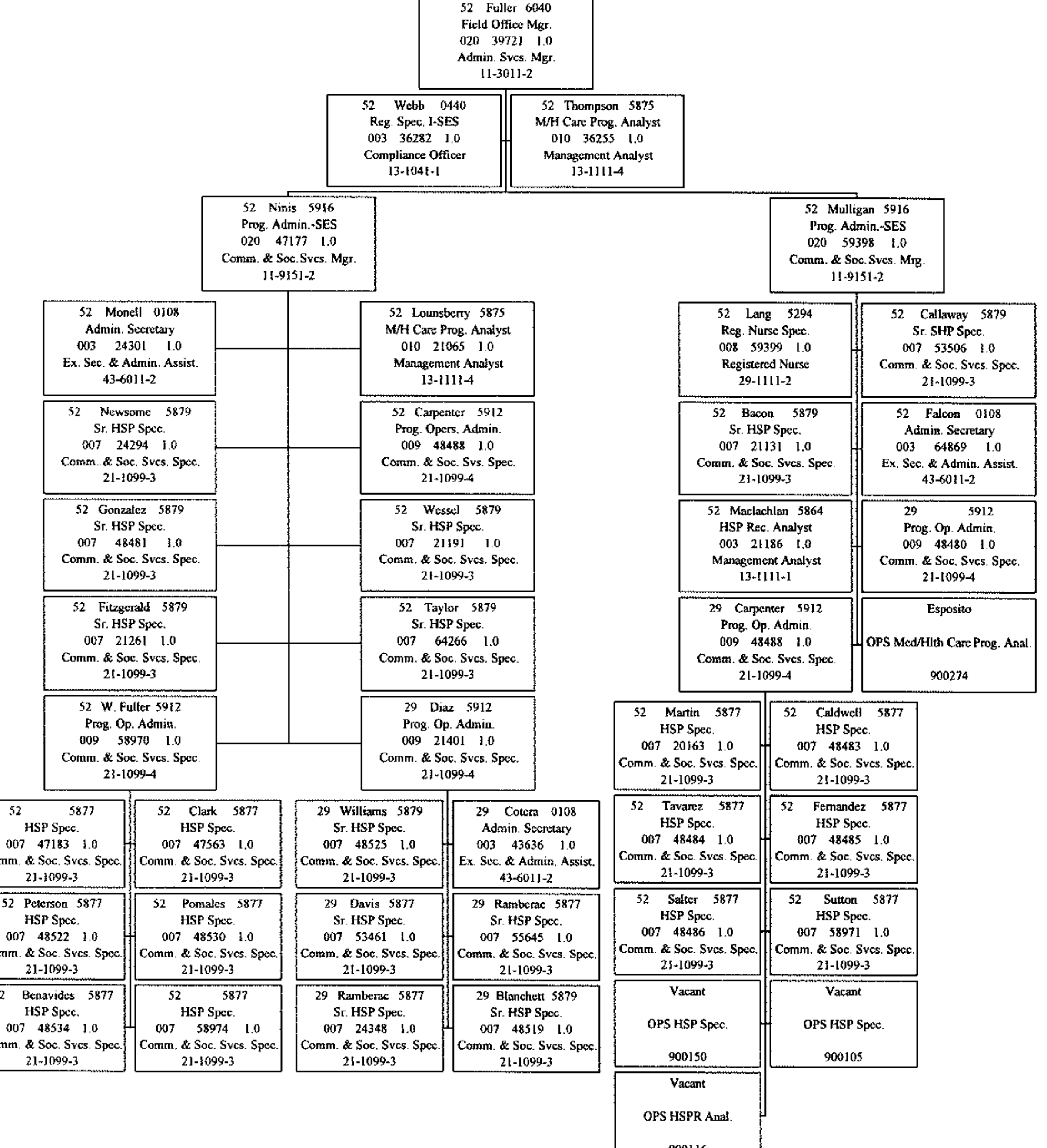
Effective Date: July 1, 2016
Org. Level: 68-50-10-04-000
FTEs: 22 Positions: 22



D-3-1

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

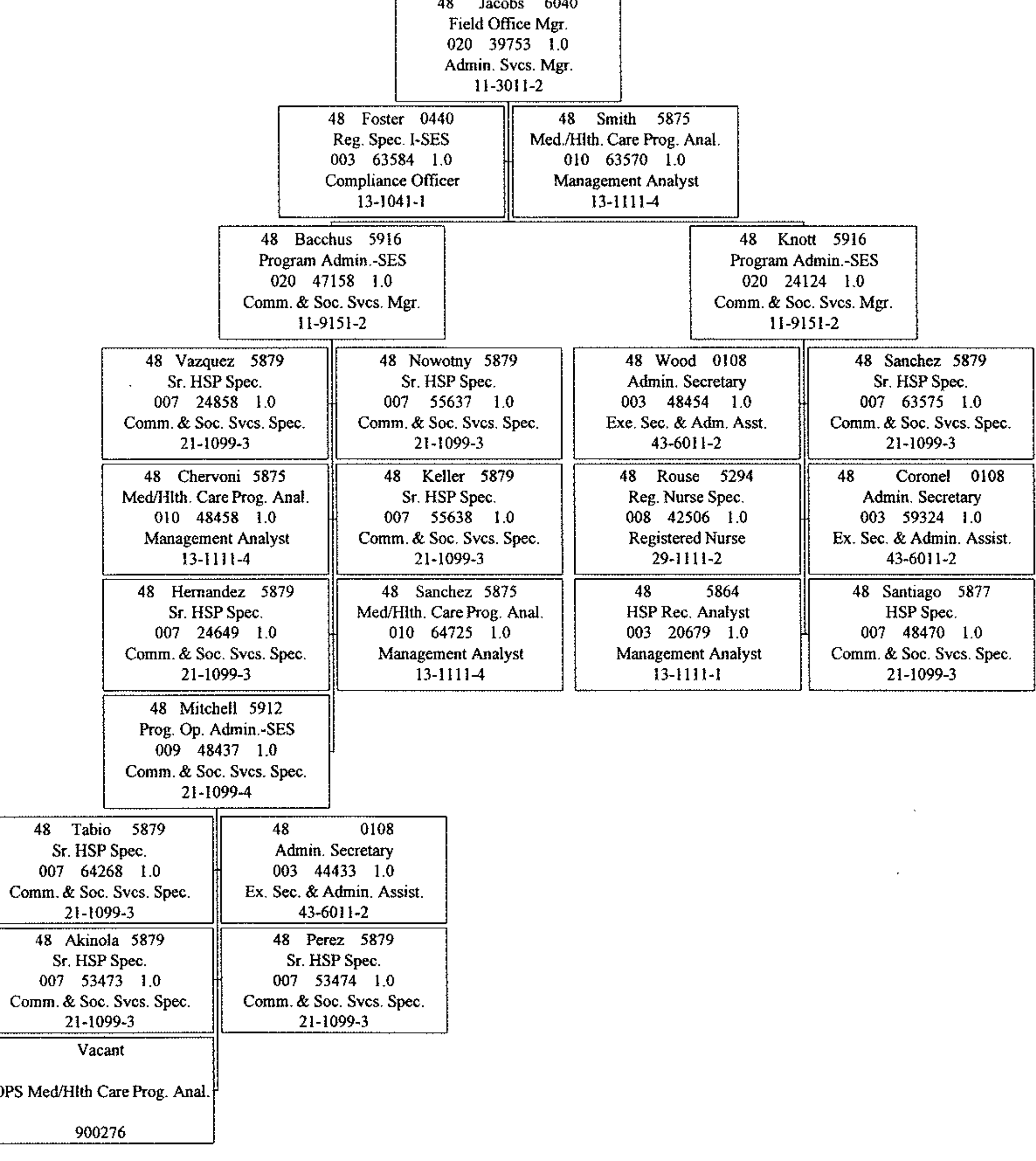
Effective Date: July 1, 2016
Org. Level: 68-40-10-05-000
FTEs: 39 Positions: 39



D-3-3

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

Effective Date: July 1, 2016
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, 2016
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 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 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 Brooks 5916
Program Admin.
020 24053 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

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

36 Chillari 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

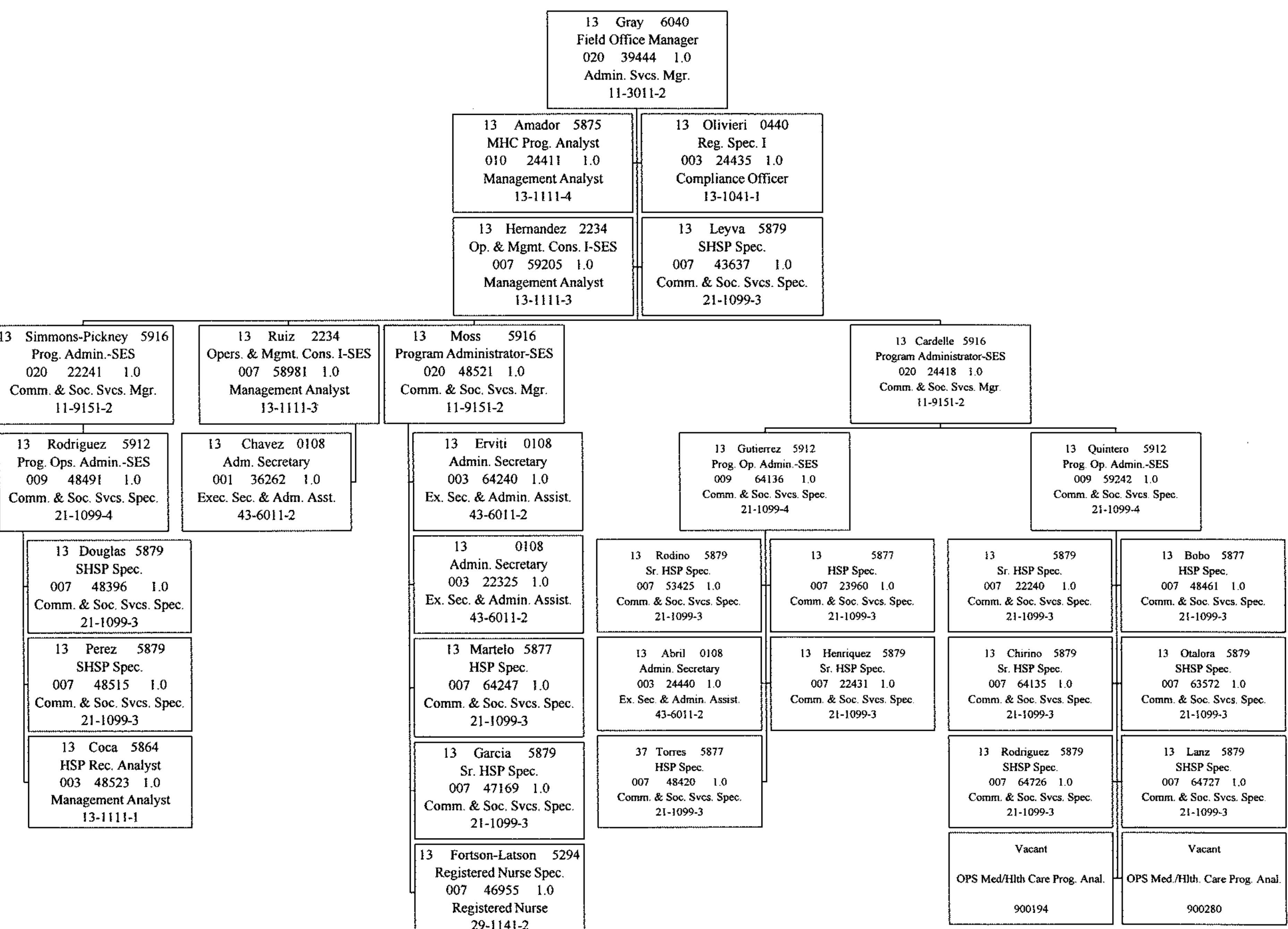
36 Bryson 5879
Sr. HSP Spec.
007 53469 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

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, 2016
Org. Level: 68-40-10-11-000
FTEs: 21 Positions: 21



D-3-6

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

Effective Date: July 1, 2016
Org. Level: 68-40-30-00-000
FTEs: 36 Positions: 36

37 Riddle 8859 — Chief of Medicaid Plan Mgmt. Operations — 021 19526 1.0 — Financial Manager — 11-3031-3

- 37 Moore 2225 — Government Analyst II — 010 61967 1.0 — Management Analyst — 13-1111-4
- 37 Rozier 2234 — OMC I-SES — 007 21545 1.0 — Management Analyst — 13-1111-3
- 37 Waters 0120 — Staff Assistant — 003 64708 1.0 — Exec. Sec. & Exec. Adm. Asst. — 43-6011-2
- 37 0003 — Clerk Specialist — 004 53427 1.0 — Office Clerk — 4-9061-1

Compliance Coordination

37 Alvarez 6040 — Field Office Manager-SES — 020 39511 1.0 — Adm.. Serv.. Mgr. — 11-3011-2

- 37 Cummings 5916 — Program Admin.-SES — 020 64307 1.0 — Comm. & Soc. Svcs. Mgr. — 11-9151-2
- 37 Smith 0108 — Admin. Secretary — 003 48460 1.0 — Exec. Sec. & Adm. Asst. — 43-6011-2
- 37 Taggart 5875 — MHCP Analyst — 010 47557 1.0 — Management Analyst — 13-1111-4
- 37 Davis 5875 — MHCP Analyst — 010 60627 1.0 — Management Analyst — 13-1111-4
- 37 Gordon 5916 — Program Admin.-SES — 020 47161 1.0 — Comm. & Soc. Svcs. Mgr. — 11-9151-2
- 37 Cummings 5916 — Program Admin.-SES — 020 64307 1.0 — Comm. & Soc. Svcs. Mgr. — 11-9151-2
- 37 Cavendish 5875 — MHCP Analyst — 010 64263 1.0 — Management Analyst — 13-1111-4
- 37 Alexander 5875 — MHCP Analyst — 010 63463 1.0 — Management Analyst — 13-1111-4

Managed Medical Assistance Standard Contract Mgmt.

37 Hull 2250 — AHC Administrator-SES — 020 48966 1.0 — Med. & Hlth. Svcs. Mgr. — 11-9111-2

- 37 Houston 2238 — GOC III — 010 61408 1.0 — Management Analyst — 13-1111-4
- 37 5875 — MHCP Analyst — 010 22205 1.0 — Management Analyst — 13-1111-4
- 37 5875 — MHCP Analyst — 010 48412 1.0 — Management Analyst — 13-1111-4
- 37 Carr 0108 — Admin. Secretary — 003 48445 1.0 — Exec. Sec. & Adm. Asst. — 43-6011-2
- 37 Arnold 5875 — MHCP Analyst — 010 64836 1.0 — Management Analyst — 13-1111-4
- 37 Floyd 5875 — MHCP Analyst — 010 64850 1.0 — Management Analyst — 13-1111-4
- 37 Culpepper 5875 — MHCP Analyst — 010 64849 1.0 — Management Analyst — 13-1111-4
- 37 Washington 5916 — Program Admin.-SES — 020 59051 1.0 — Comm. & Soc. Svcs. Mgr. — 11-9151-2
- Vacant — OPS Med/Hlth Care Prog. Anal. — 900511
- Dillman — OPS Senior Clerk — 900047

Managed Medical Assistance Specialty Contract Management

37 Gill 2250 — AHC Administrator-SES — 020 64816 1.0 — Med.& Hlth. Svcs. Mgr. — 11-9111-2

- 37 White 2225 — Gov. Analyst II — 010 24323 1.0 — Management Analyst — 13-1111-4
- 37 5875 — MHCP Analyst — 010 64845 1.0 — Management Analyst — 13-1111-4
- 37 Brown 5875 — MHCP Analyst — 010 64870 .5 — Management Analyst — 13-1111-4
- 37 Aufderheide 5875 — MHCP Analyst — 010 64249 .5 — Management Analyst — 13-1111-4
- Vacant — OPS Med/Hlth Care Prog. Anal. — 900158

Managed Medical Assistance Comprehensive Contract Management

37 Medina 2250 — AHC Administrator-SES — 020 46481 1.0 — Med. & Hlth. Svcs. Mgr. — 11-9111-2

- 37 Patterson 2238 — GOC III — 010 64233 1.0 — Management Analyst — 13-1111-4
- 37 Courtney 2238 — GOC III — 010 59050 1.0 — Management Analyst — 13-1111-4
- 37 Werthington 2238 — GOC III — 010 64826 1.0 — Management Analyst — 13-1111-4
- 37 Smith 2238 — GOC III — 010 64838 1.0 — Management Analyst — 13-1111-4
- 37 Sousa 2238 — GOC III — 010 64815 1.0 — Management Analyst — 13-1111-4
- 37 Baker 2238 — GOC III — 010 64306 1.0 — Management Analyst — 13-1111-4
- 37 Zanders 5916 — Program Admin.-SES — 020 25174 1.0 — Comm. & Soc. Svcs. Mgr. — 11-9151-2
- 37 Rivers 5312 — Reg. Nursing Cons. — 010 64476 1.0 — Registered Nurse — 29-1111-4

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

Effective Date: July 1, 2016
Org. Level: 68-40-30-06-000
FTEs: 13 Positions: 13

Riddle
Chief of Med. Plan Mgmt. Opers.
(Reference Only)

29 Davis 2250
AHC Admin.-SES.
020 39566 1.0
Med. & Hlth. Svcs. Mgr.
11-9111-2

29 Patel 0440
Reg. Spec. I
003 25180 1.0
Compliance Officer
13-1041-1

29 5875
Med./Hlth. Care Prog. Anal.
010 64285 1.0
Management Analyst
13-1111-4

29 Beaven 5875
Med./Hlth. Care Prog. Anal.
010 21299 1.0
Management Analyst
13-1111-4

29 Brooks 5875
Med./Hlth. Care Prog. Anal.
010 64784 1.0
Management Analyst
13-1111-4

29 Kauffman 5877
HSP Spec.
007 24319 1.0
Comm. & Soc. Svcs. Spec.
21-1099-3

29 Campanaro 5916
Prog. Admin.
020 47302 1.0
Comm. & Soc. Svcs. Mgr.
11-9151-2

29 Sisk 2236
Gov. Opers. Cons. II
010 48440 1.0
Management Analyst
13-1111-4

29 0108
Admin. Secretary
003 48536 1.0
Ex. Sec. & Admin. Assist.
43-6011-2

29 Davis 2236
Gov. Opers. Cons. II
010 20677 1.0
Management Analyst
13-1111-4

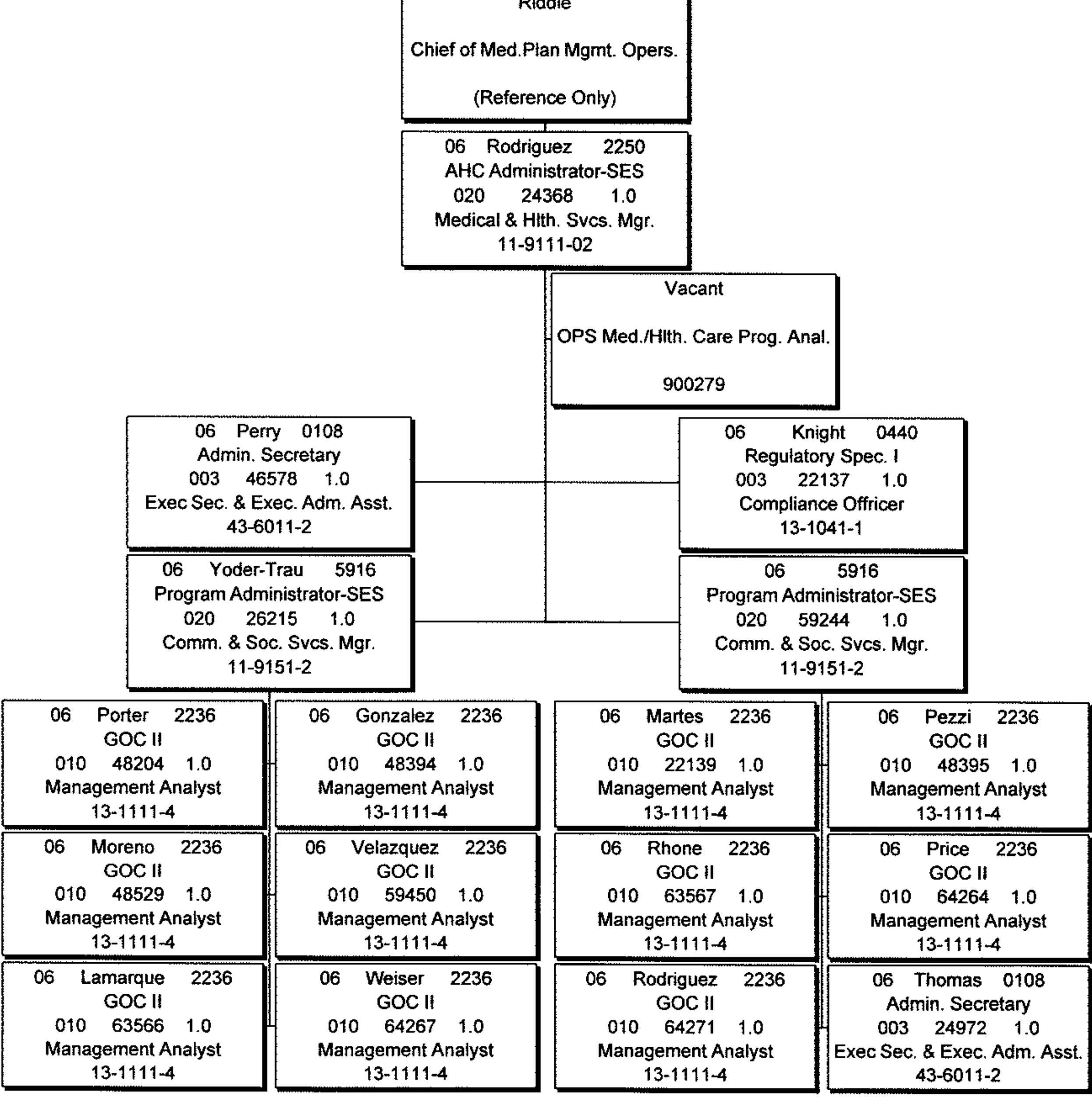
29 Emmanuel 2236
Gov. Opers. Cons. II
010 21748 1.0
Management Analyst
13-1111-4

29 Sarratt 2236
Gov. Opers. Cons. II
010 48421 1.0
Management Analyst
13-1111-4

29 Davila 2236
Gov. Opers. Cons. II
010 48531 1.0
Management Analyst
13-1111-4

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

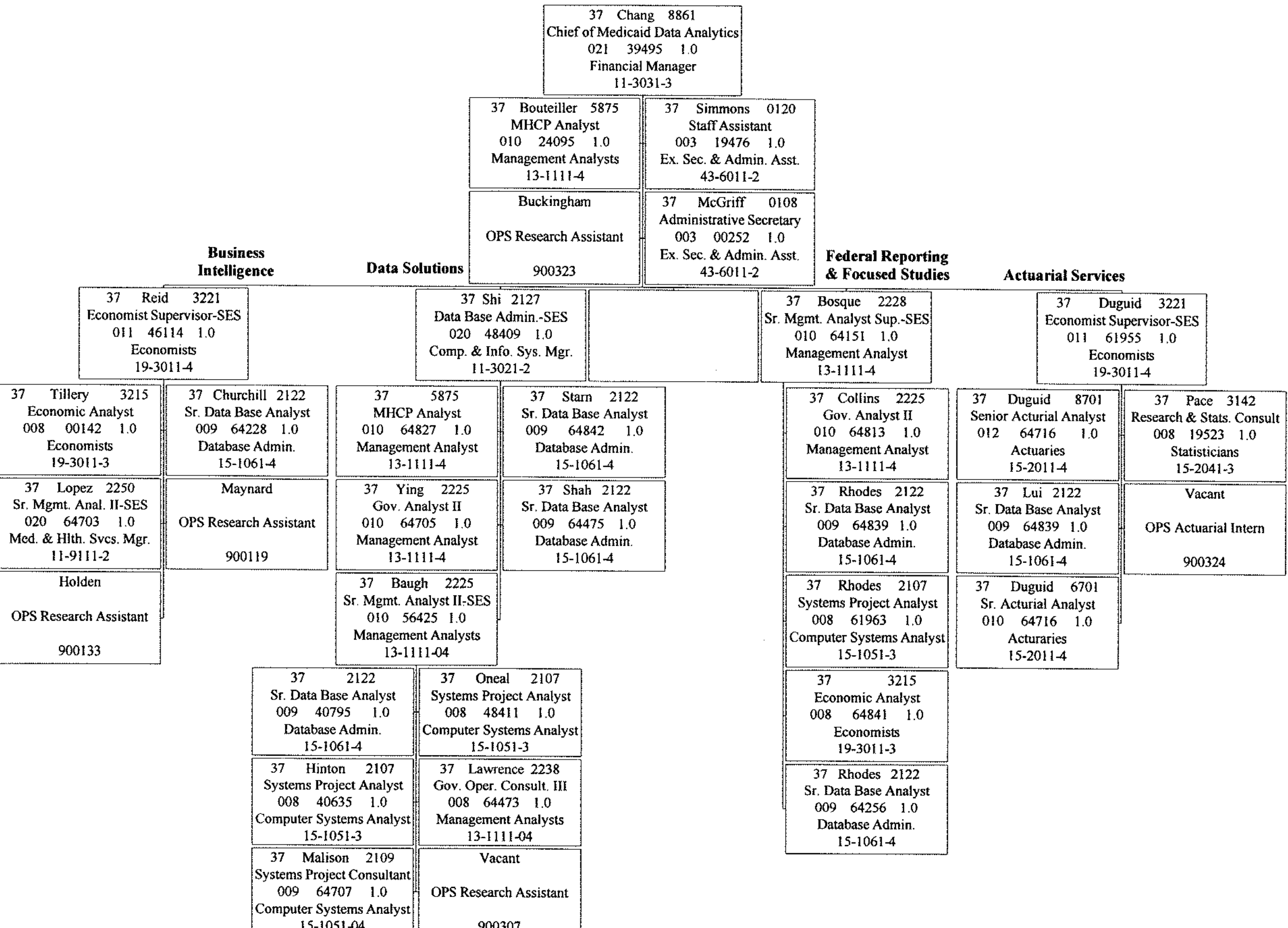
Org Level: 68-40-30-10-000
Effective Date: July 1, 2016
FTEs: 17 Positions: 17



D-6-2

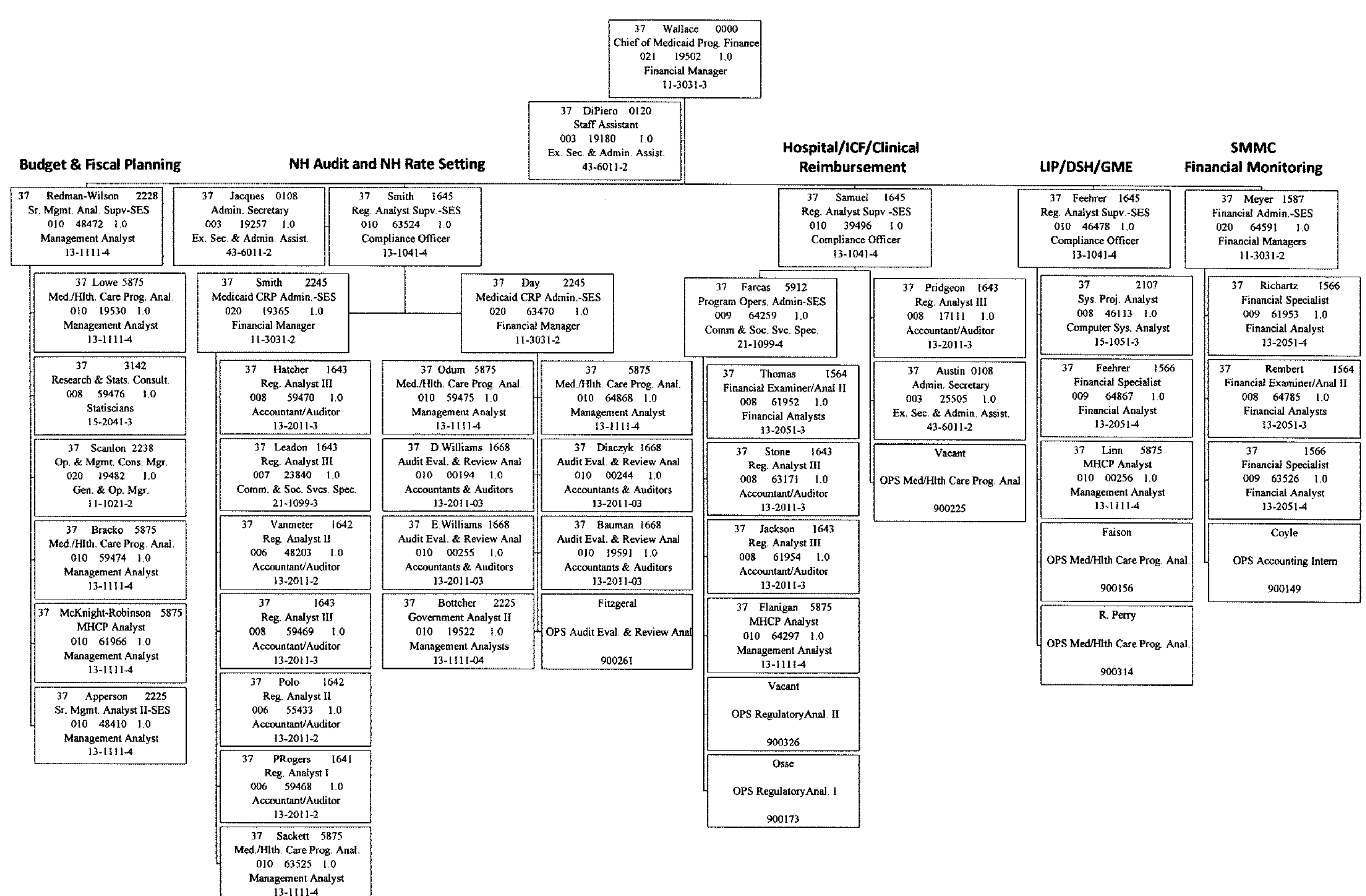
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Data Analytics

Effective Date: July 1, 2016
Org Level: 68-40-40-00-000
FTE: 30 Positions: 30



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

Effective Date: July 1, 2016
Org. Level: 68-40-50-00-000
FTEs: 45 Positions: 45



D-5

AGENCY FOR HEALTH CARE ADMINISTRATION
Bureau of Medicaid Policy

Effective Date: July 1, 2016
Org. Level: 68-40-60-00-000
FTEs: 67 Positions: 67

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 Muhammad 2225
Sr. Mgmt. Analyst II-SES
010 64288 1.0
Management Analyst
13-1111-4

37 Warnka 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 Carter-Jones 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, 2016
Org. Level: 68-40-60-00-000
FTEs: 67 Positions: 67

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, Management 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 Fiscal Agent Operations

Effective Date: July 1, , 2016
Org. Level: 68-40-70-00-000
FTEs: 54 Positions: 54

37 Munyon 9394
Chief of Medicaid Fiscal Agent Operations
021 64292 1.0
Financial Manager
11-3031-3

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

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

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

37 Walker 0108
Administrative Secretary-SES
003 64261 1.0
Ex. Sec. & Exec. Admin. Assist.
43-6011-2

37 0108
Administrative Secretary
003 46220 1.0
Ex. Sec. & Exec. Admin. Asst.
43-6011-2

Finance/Audit

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

37 Smith 2238
Gov. Opers. Cons. III
010 64720 1.0
Management Analyst
13-1111-4

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

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

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

Monitoring/Compliance

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

37 Vega-Alicea 2241
Medicaid Mgmt. Rev. Mon.
010 00346 1.0
Management Analyst
13-1111-4

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

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

37 Gray 2225
Gov. Analyst II
010 64714 1.0
Management Analyst
13-1111-4

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

DSS Freedom

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

37 Hebenthal 2107
Systems Project Analyst
008 55648 1.0
Computer Systems Analyst
15-1121-3

37 2225
Gov. Analyst II
010 47261 1.0
Management Analyst
13-1111-4

Garvin
OPS Med./Hlth. Care Prog. Anal.
900282

Vacant
OPS Research Assistant
900221

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

Revised Date: July 1, 2016
Org. Level: 68-40-70-00-000
FTEs: 54 Positions: 54

Munyon
Chief of Med. Fiscal Agent Operations
(Reference Only)

Provider Enrollment

37 McCauley 2250
AHC Administrator-SES
020 53305 1.0
Med. & Hlth. Svs. Mgr.
11-9111-2

- 37 Constantino 5875 / MHCP Analyst / 010 24166 1.0 / Management Analyst / 13-1111-4
- 37 Strayer 5875 / MHCP Analyst / 010 59452 1.0 / Management Analyst / 13-1111-4
- 37 Bolin 2225 / SMA II-SES / 010 64858 1.0 / Management Analyst / 13-1111-4
  - 37 5879 / Sr. HSP Spec. / 007 58990 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-3
- 37 Colvin 5875 / MHCP Analyst / 010 64861 1.0 / Management Analyst / 13-1111-4
- 37 Johnson 5879 / Sr. HSP Spec. / 007 55470 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-3
- 37 Cunningham 2238 / OMC Manager-SES / 020 56424 1.0 / Gen. & Opers. Mgr. / 11-1021-2
  - 37 Brewer 5871 / HSP Analyst / 007 64723 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-3
  - 37 Fryson 5864 / HSP Rec. Analyst / 003 59451 1.0 / Management Analyst / 13-1111-1
  - 37 Randall 5871 / HSP Analyst / 007 00356 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-3
  - Hagan / OPS Mgmt. Review Spec. / 900260

Recipient File Management

37 Hall 2228
SMA Supervisor-SES
010 39482 1.0
Management Analyst
13-1111-4

- 37 Miller 5912 / Program Opers. Admin.-SES / 009 61964 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-4
  - 37 Giddens 5871 / HSP Analyst / 007 64290 1.0 / Comm/Soc. Serv. Spec. / 21-1099-3
  - 37 Williams 2241 / Medicaid Mgmt. Rev. Mon. / 010 63473 1.0 / Management Analyst / 13-1111-4
  - Wetzler / OPS Human Services Analyst / 900198
  - Anderson / OPS Human Services Analyst / 900265
  - Tedder / OPS Senior Clerk / 900215
  - Criswell / OPS Human Services Analyst / 900259
- 37 Brown 2238 / OMC Manager-SES / 020 64455 1.0 / Gen. & Opers. Mgr. / 11-1021-2
  - 37 Sanford 5875 / MHCP Analyst / 010 64452 1.0 / Management Analyst / 13-1111-4
  - 37 Fraizer 5875 / MHCP Analyst / 010 64451 1.0 / Management Analyst / 13-1111-4
- 37 Pridgeon 2238 / OMC Manager-SES / 020 55471 1.0 / Gen. & Opers. Mgr. / 11-1021-2
  - 37 Harden 5877 / Sr. HSP Spec. / 007 19302 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-3
  - 37 Yeomans 5879 / Sr. HSP Spec. / 007 48503 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-3
  - Vacant / OPS Human Services Analyst / 900071
  - Clemons / OPS Human Services Analyst / 900069
  - Carr / OPS Human Services Analyst / 900070

Systems Project

37 Powers 2228
SMA Supervisor-SES
010 35720 1.0
Management Analyst
13-1111-4

- 37 2109 / Sys. Proj. Consultant / 009 53499 1.0 / Computer Sys. Analyst / 15-1121-4
- 37 Schmidt 2109 / Sys. Proj. Consultant / 009 19245 1.0 / Computer Sys. Analyst / 15-1121-4
- 37 Howell 2109 / Sys. Proj. Consultant / 009 64298 1.0 / Computer Sys. Analyst / 15-1121-4
- 37 Boston 2107 / Sys. Proj. Analyst / 009 46479 1.0 / Computer Sys. Analyst / 15-1121-3
- 37 5879 / Sr. HSP Spec. / 007 47163 1.0 / Comm. & Soc. Svcs. Spec. / 21-1099-3
- Hart / OPS Systems Project Consultant / 900310

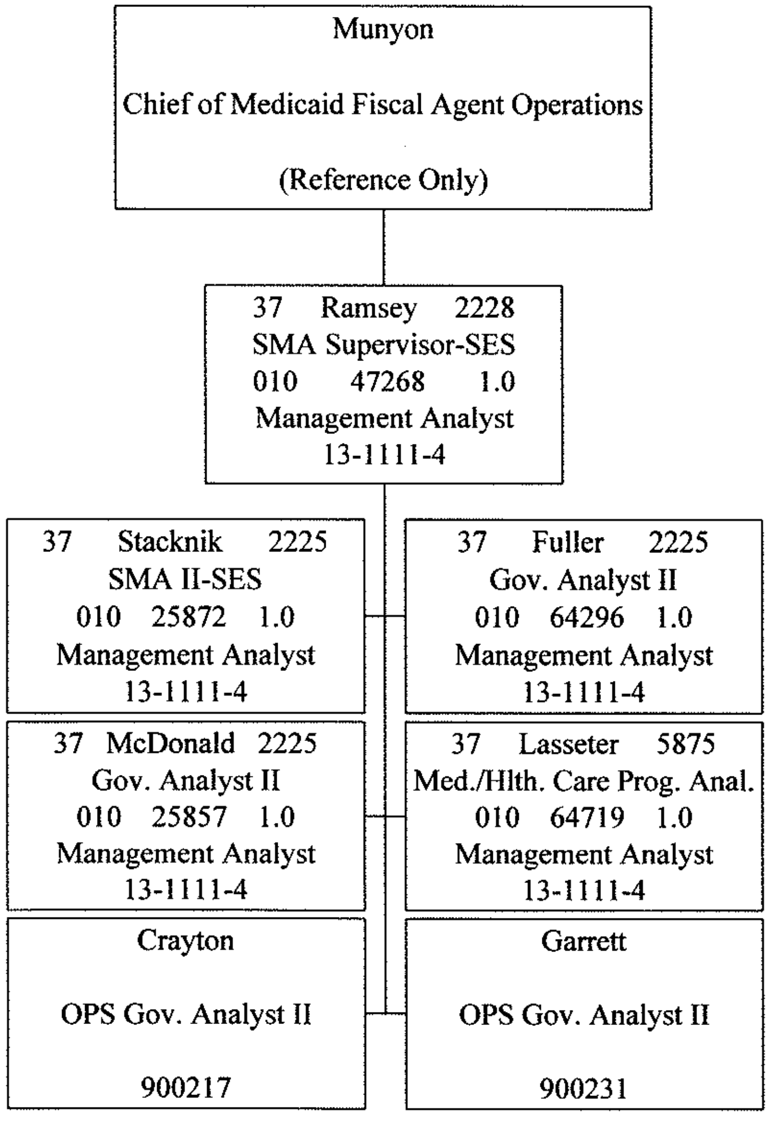
Systems Maintenance

37 Travis 2109
SMA Supervisor-SES
010 00310 1.0
Management Analyst
13-1111-4

- 37 2109 / Sys. Proj. Consultant / 009 24147 1.0 / Computer Sys. Analyst / 15-1121-4
- 37 Beverly 2212 / Senior Data Base Analyst / 009 64257 1.0 / Data Base Admin. / 15-1141-4
- 37 Smith 2109 / Sys. Proj. Consultant / 009 63441 1.0 / Computer Sys. Analyst / 15-1121-4
- Strickland / OPS Systems Project Consultant / 900315

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

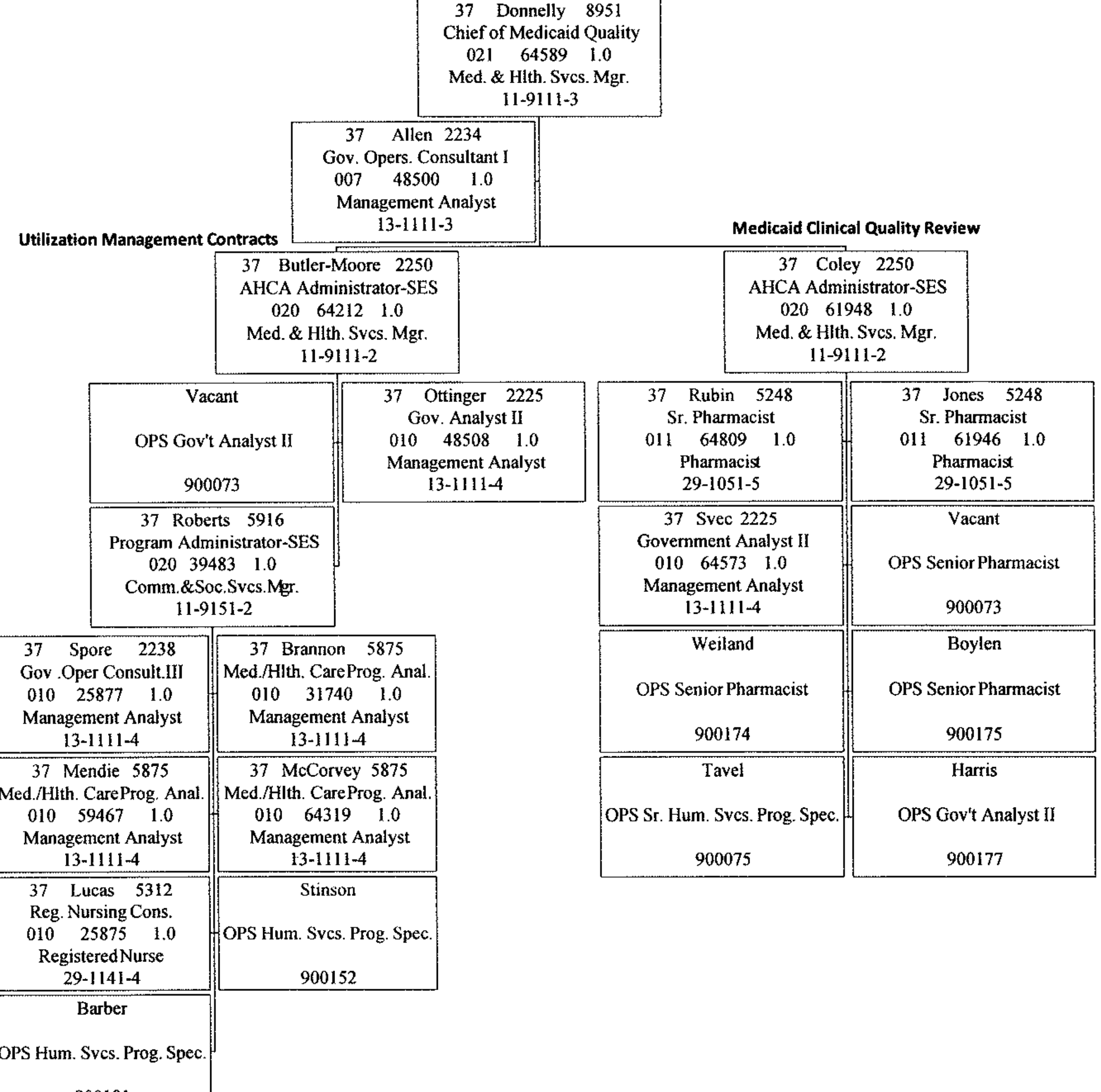
Effective Date: July 1, 2016
Org. Level: 68-40-70-15-000
FTEs: 5 Positions: 5



D-7-2

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

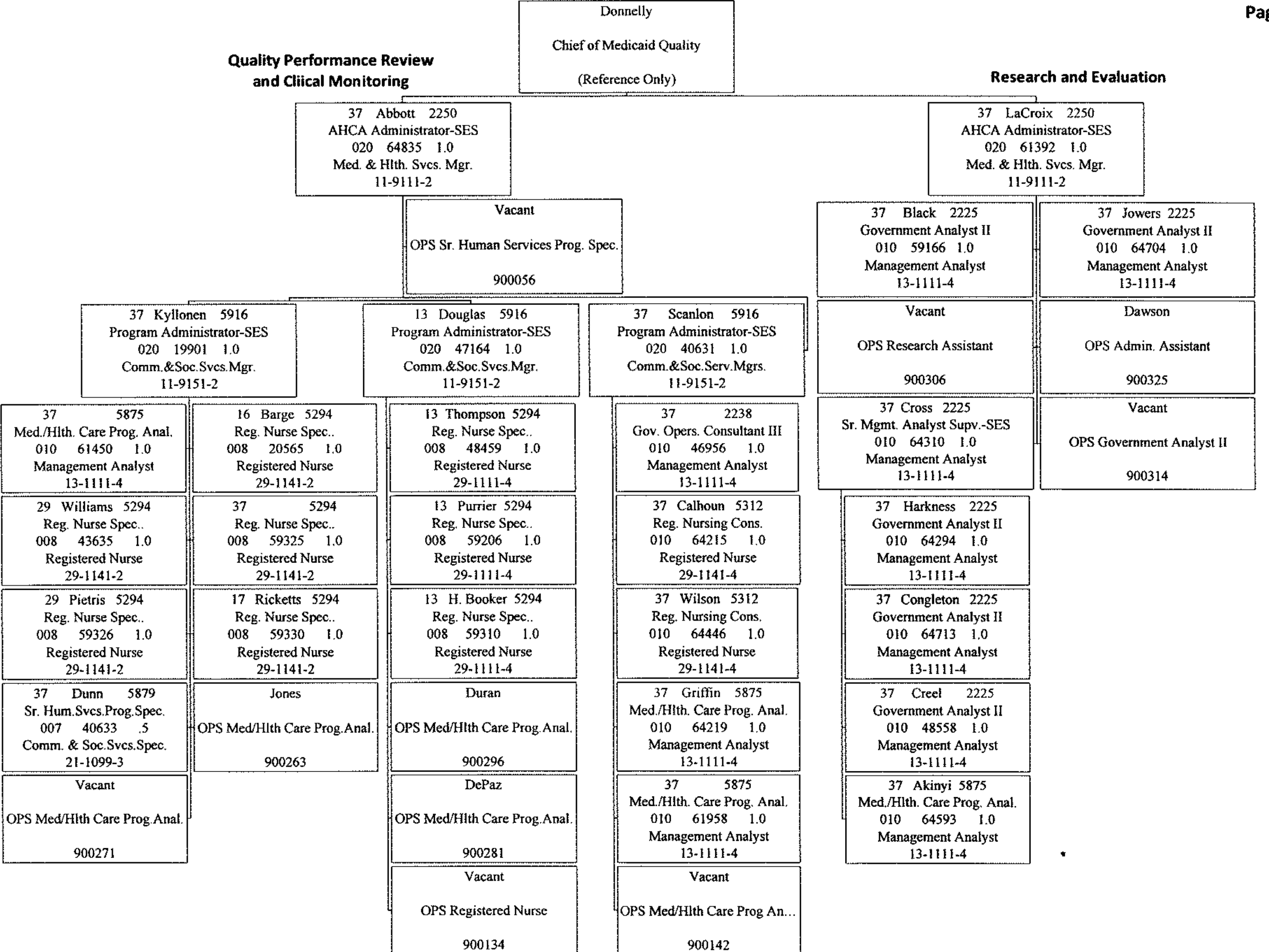
Effective Date: July 1, 2016
Org Level: 68-40-80-00-000
FTE: 43.5 Positions: 44



D-9

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

Effective Date: July 1, 2016
Org Level: 68-40-80-00-000
FTE: 43.5 Positions: 442



D-9-1

AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET		FISCAL YEAR 2015-16 OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT		25,436,381,011	200,000
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)		-1,071,939,599	-200,000
FINAL BUDGET FOR AGENCY		24,364,441,412	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	11,924.81	6,673,864,529	
Prepaid Health Plans - Families *	2,620,250	1,852.66	4,854,431,777	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	25,378	18,330.88	465,201,154	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	51,534	6,116.54	315,209,917	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * **Number of case months Medicaid program services purchased**	129,606	2,015.47	261,217,617	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	129,606	1,065.56	138,102,853	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	1,528,378	786.73	1,202,415,393	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	259,213	37.03	9,597,486	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months Medicaid program services purchased**	731,355	28.09	20,545,137	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	25,378	339.38	8,612,901	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case months Medicaid program services purchased**	104,228	552.38	57,573,804	
Elderly And Disabled/Fee For Service/Medipass - Hospice * **Number of case months Medicaid program services purchased**	129,606	175.94	22,803,259	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * **Number of case months Medicaid program services purchased**	23,450	1,846.47	43,299,700	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid program services purchased**	76,136	8,576.25	652,960,990	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	220,804	1,565.53	345,676,250	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	258,472	367.36	94,951,752	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	451,799	407.91	184,295,546	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	6,368,089	34.50	219,725,651	
Women And Children/Fee For Service / Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	903,598	9.63	8,703,011	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months Medicaid program services purchased**	3,072,048	0.23	701,304	
Women And Children/Fee For Service / Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	220,804	75.41	16,649,888	
Women And Children/Fee For Service / Medipass - Clinic Services * **Number of case months and Medicaid program services purchased**	5,899,420	24.48	144,429,080	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid program services purchased**	662,412	247.04	163,639,677	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid program services purchased**	24,075	2,865.21	68,980,046	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid program services purchased**	24,075	1,725.61	41,544,069	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid program services purchased**	29,085	925.91	26,930,198	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	58,170	128.00	7,445,878	
Medically Needy - Patient Transportation * **Number of case months Medicaid program services purchased**	58,170	5.96	346,969	
Medically Needy - Case Management * **Number of case months Medicaid program services purchased**	29,085	3.54	103,095	
Medically Needy - Home Health Services * **Number of case months Medicaid program services purchased**	24,075	9.44	227,344	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	72,226	15,914.63	1,149,449,934	
Refugees - Hospital Inpatient * **Number of case months Medicaid program services purchased**	5,649	306.67	1,732,404	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services purchased**	5,649	82,319.26	465,021,499	
Refugees - Hospital Outpatient * **Number of case months Medicaid program services purchased**	5,649	157.81	891,460	
Refugees - Patient Transportation * **Number of case months Medicaid program services purchased**	11,299	13.42	151,619	
Refugees - Case Management * **Number of case months Medicaid program services purchased**	21,724	3.39	73,608	
Refugees - Home Health Services * **Number of case months Medicaid program services purchased**	5,649	7.89	44,582	
Refugees - Other * **Number of case months Medicaid program services purchased**	16,948	80.56	1,365,361	
Nursing Home Care * **Number of case months Medicaid program services purchased**	47,441	67,550.61	3,204,668,476	
Home And Community Based Services * **Number of case months Medicaid program services purchased**	43,921	28,050.26	1,231,995,335	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * **Number of case months Medicaid program services purchased**	680	486,296.62	330,681,704	
Purchase Medikids Program Services * **Number of case months Medicaid Program services purchased**	29,492	1,826.07	53,854,598	
Purchase Children's Medical Services Network Services * **Number of case months**	13,556	8,166.25	110,701,641	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	148,689	1,705.88	253,645,884	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial reviews conducted**	2,488	805.45	2,003,972	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of licensure/certification applications**	39,029	456.69	17,824,232	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys and complaint investigations**	39,110	1,423.49	55,672,528	
Health Standards And Quality * **Number of transactions**	2,950,581	1.51	4,457,463	
Plans And Construction * **Number of reviews performed**	5,282	1,349.00	7,125,435	
Managed Health Care * **Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys**	259	6,490.62	1,681,070	
Background Screening * **Number of requests for screenings**	350,297	2.63	921,416	
Subscriber Assistance Panel * **Number of cases**	350	1,601.02	560,357	
TOTAL			22,944,710,853	

SECTION III: RECONCILIATION TO BUDGET		
PASS THROUGHS		
TRANSFER - STATE AGENCIES		
AID TO LOCAL GOVERNMENTS		
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS		
OTHER	1,221,054,011	
REVERSIONS	198,504,947	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	24,364,269,811	

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.
(5) For FY 2015-2016, the total in Section III differs from the total in Section I because of payables and receivables set up in the OPS (030000) and Expenses (040000) categories totaling $171,622. A01 accurately reflects total expenditures as paid by fund.

SCHEDULE XII: OUTSOURCING OR PRIVATIZATION OF A SERVICE OR ACTIVITY

Schedule XII Cover Sheet and Agency Project Approval	
Agency: Agency for Health Care Administration	**Schedule XII Submission Date:** 10/14/2016
Project Name: PASRR Outsourcing	**Is this project included in the Agency's LRPP?** ____ **Yes** __X__ **No**
FY 2017 - 2018 LBR Issue Code: 33I0100	**FY 2017 -2018 LBR Issue Title:** Preadmission Screening and Resident Review (PASRR)
Agency Contact for Schedule XII (Name, Phone #, and E-mail address): Monty McCullough 412-4234, Mary.McCullough@ahca.myflorida.com	

AGENCY APPROVAL SIGNATURES	
I am submitting the attached Schedule XII in support of our legislative budget request. I have reviewed and agree with the information in the attached Schedule XII.	
Agency Head: **Printed Name:** Justin M. Senior, Interim Secretary	**Date:** 10/12/16
Agency Chief Information Officer: ***(If applicable)*** **Printed Name:** Scott Ward, CIO	**Date:** 10/12/16
Budget Officer: **Printed Name:** Anita B. Hicks, CFO	**Date:** 10/12/16
Planning Officer: **Printed Name:** Kristin Sokoloski	**Date:** 10/12/16
Project Sponsor: **Printed Name:** Shevaun Harris	**Date:** 10/12/16

SCHEDULE XII: OUTSOURCING OR PRIVATIZATION OF A SERVICE OR ACTIVITY

I. Background Information
1. Describe the service or activity proposed to be outsourced or privatized.
The Agency for Healthcare Administration (AHCA) is requesting legislative authority to procure a vendor to implement, operate, and coordinate all aspects of the federally mandated Preadmission Screening and Resident Review (PASRR) process, including Level I screenings and Level II evaluations and determinations. Congress created the PASRR requirement in 1987, when it amended the Medicaid Act to require each State that participates in the Medicaid program to establish a PASRR program (see 42 U.S.C. § 1396r(e)(7)(A)). The purpose of the PASRR program is to prevent the admission into nursing facilities of mentally ill and intellectually disabled individuals who do not require the level of services that nursing facilities provide. Florida's PASRR program is established in accordance with Title 42 Code of Federal Regulations, Subpart C, section 409.912, Florida Statutes, and Rule 59G-1.040, Florida Administrative Code. The PASRR program is a comprehensive plan for assessing individuals for evidence of a serious mental illness (SMI), intellectual disability and related conditions (ID), or both, prior to admission to a Medicaid-certified nursing facility (NF), or upon a significant change in the individual's physical or mental status (resident review), regardless of payer source. The PASRR Level I is a preliminary screening that must be conducted on all individuals prior to admission into an NF. Based on the results from the PASRR Level I screening, an individual may be referred to have a PASRR Level II evaluation. The PASRR Level II evaluation is a more comprehensive assessment, involving collection of information from multiple sources and often a face-to-face interview with the individual when a suspicion, diagnosis, SMI, or ID has been identified. A determination, based upon the evaluation, is made as to whether: • The individual requires the level of services provided by an NF (including whether the individual's long-term care service needs can be met in a less restrictive environment). • Specialized services are needed. A resident review is an evaluation conducted when a nursing facility resident experiences a significant change in his or her physical or mental status. The resident review is also required if a resident is transferred to a hospital for care and the stay lasts longer than 90 consecutive days, prior to readmission to nursing facility.
2. How does the service or activity support the agency's core mission? What are the agency's desired goals and objectives to be achieved through the proposed outsourcing or privatization and the rationale for such goals and objectives?
The PASRR requirement is an essential component of Florida's policy, required by Title II of the Americans with Disabilities Act, ensuring that individuals are provided medically necessary health care services "in the most integrated setting appropriate" to their needs. PASRR is an important tool that helps to ensure that individuals are not inappropriately placed in nursing homes when their needs can be met at a lower level of care. It also helps to identify any specialized services that are needed for an individual with an SMI or ID – this information is both useful for the individual in selecting a nursing facility that can meet their needs, as well as the nursing facility in their care coordination efforts. Maintaining a PASRR process

that ensures the greatest amount of efficiency, performance, and transparency aligns with the AHCA's mission, "Better Health Care for Floridians" and supports the AHCA's vision which is, "A health care system that empowers consumers, that rewards personal responsibility and where patients,
providers and payers work for better outcomes at the best price."

Five state agencies are responsible for fulfilling various aspects of Florida's PASRR program. Currently, there is not a uniform process utilized by all of the state agencies involved in the PASRR process for sharing information. Parties are sharing protected health information and data utilizing antiquated methods such as fax and email, resulting in increased risks related to fulfilling HIPAA requirements and increased manual processes. It is also difficult to comprehensively monitor the program, as there is little uniformity in how each state agency is fulfilling its obligation (from an administrative perspective). Outsourcing the PASRR process will create better administrative efficiencies.

Consolidation of the PASRR functions under one vendor presents an opportunity to facilitate quicker decision-making related to nursing facility admissions as one entity would be responsible for coordinating all aspects of the process, reducing opportunities for delays in sharing information with involved parties. By transitioning individuals from more acute care settings (i.e., hospitals) sooner, Medicaid (and other insurers) costs can be reduced. Outsourcing the PASRR process will increase the state's performance and responsiveness to health care providers and consumers.

3. Provide the legal citation authorizing the agency's performance of the service or activity.

- Title 42 Code of Federal Regulations, Section 438, Subpart C;
- Sections 409.912 and 409.985, Florida Statutes; and
- Rule 59G-1.040, Florida Administrative Code

4. Identify the service's or activity's major stakeholders, including customers, clients, and affected organizations or agencies.

- The Agency for Health Care Administration;
- Florida Agency for Persons with Disabilities (APD);
- Florida Department of Children and Families (DCF);
- Florida Department of Elder Affairs (DOEA);
- Florida Department of Health (DOH);
- Nursing Facilities;
- Acute Inpatient Hospitals; and
- Individuals (both children and adults) seeking admission into Nursing Facilities.

5. Describe and analyze how the agency currently performs the service or activity and list the resources, including information technology services and personnel resources, and processes used.

The following illustrates the clinical and administrative requirements related to the PASRR process, with a brief summary of each state agency's responsibilities:

Florida' Agency for Health Care Administration
Federal regulations require the single state Medicaid agency to coordinate and have oversight for the PASRR program in its state. In Florida, the AHCA is the single state Medicaid agency and as such, maintains administrative oversight of the PASSR program. The AHCA policy staff is responsible for the following:

- Oversight of the PASRR process and coordination of delegated entities;
- Rule promulgation for PASRR (including PASRR forms);
- Monitoring PASRR reports from delegated entities. Reports are obtained through a secured data site;
- Holding quarterly meetings with delegated entities; and
- Promoting and performing PASRR training.

The AHCA, along with four state agencies, are currently responsible for facilitating various aspects of Florida's PASRR program. The AHCA is primarily Florida's Level I screening entity, and delegates the Level I screening duties to DOEA and DOH:

- For adults ages 21 years and older, the Level I screening responsibilities are delegated to the DOEA; and
- For children under the age of 21 years, the Level I screening responsibilities are delegated to the DOH. The DOH does not sub-delegate this responsibility and utilizes existing state agency personnel.

Florida Department of Elder Affairs and Department of Health
The screening process entails collecting clinical information from the individual's treating providers, and when necessary, conducting an interview with the individual and/or their authorized representative to determine if there is a suspicion or confirmed diagnosis of SMI or ID. In addition, these entities are responsible for coordinating referrals to the appropriate agency described below for a Level II PASRR evaluation and determination, when applicable, and conducting ongoing quality assessments and monitoring of Level II PASRR evaluations. The DOEA has the authority to sub-delegate their responsibility for performing the Level I screening to hospital and nursing facilities. However, DOEA still performs some PASRR Level I screenings and is required to collect the results and verify the accuracy of the screenings performed by these sub-delegated entities. The DOH does not sub-delegate this responsibility and utilizes existing state agency personnel.

Florida Department of Children and Families
The state authority for SMI is the DCF. The DCF is responsible for performing Level II PASRR determinations for individuals suspected of, or diagnosed with SMI prior to their admission into an NF, or as the result of a resident review. In accordance with federal regulations, DCF, as the state mental health authority, may not perform the evaluations, but is responsible for reviewing the evaluation and making the ultimate determination. The DCF maintains a contract with a vendor (currently KEPRO) to perform independent physical and mental evaluation(s) to assist in fulfilling their PASRR Level II responsibilities.

Florida Agency for Persons with Disabilities
As the state PASRR authority for ID, the APD provides both Level II PASRR evaluation(s) and determination(s) for individuals suspected or diagnosed with ID, prior to admission to an NF, or as the result of a resident review. Using existing state personnel, the APD performs an evaluation and either rules out or confirms a diagnosis of ID. The APD is currently in the process of procuring a contract with a vendor to perform these functions.

6. Provide the existing or needed legal authorization, if any, for outsourcing or privatizing the service or activity.

42 CFR §483.106(e)
Sections 216.023(4)(a)7 and 287.0571, F.S.

7. Provide the reasons for changing the delivery or performance of the service or activity. What is the current cost of service and revenue source?

While the State of Florida complies with federal PASRR regulations – such compliance is extremely labor intensive and costly to document in a manner that can be tracked and accurately reflected on a real time basis. Thus, in the event of ADA or Medicaid Act litigation, under the existing multi-agency and primarily paper driven process, it would be extremely costly to prove and document compliance for the nearly 150,000 PASRR assessments that are conducted each year. In contrast, a contractual vendor with focused, dedicated PASRR staff, utilizing a web-based application, tracking, and noticing process, could timely respond to prove compliance when needed (thus potentially avoiding lawsuits entirely). And, in the event that a suit could not be avoided, would make it easier and less costly to prevail in any claims alleging a failure to comply with PASRR. Successfully defending ADA integration mandate litigation is extremely costly to the State. For example, Florida had to expend in excess of $8 million dollars in attorneys' fees and costs prior to prevailing through entry of an order dismissing the United States' claims in United States v. Florida, Case No. 12-cv-60460-WJZ (S.D. Fla.).

Five state agencies are responsible for fulfilling various aspects of Florida's PASRR program. Currently, there is not a uniform process utilized by all of the state agencies involved in the PASRR process for sharing information. Parties are sharing protected health information and data utilizing antiquated methods such as fax and email, resulting in increased risks related to fulfilling HIPAA requirements and increased manual processes. It is also difficult to comprehensively monitor the program, as there is little uniformity in how each state agency is fulfilling its obligation (from an administrative perspective). Outsourcing the PASRR process will create better administrative efficiencies.

Consolidation of the PASRR functions under one vendor presents an opportunity to facilitate quicker decision-making related to nursing facility admissions as one entity would be responsible for coordinating all aspects of the process, reducing opportunities for delays in sharing information with involved parties. By transitioning individuals from more acute care settings (i.e., hospitals) sooner, Medicaid (and other insurers) costs can be reduced. Outsourcing the PASRR process will increase the state's performance and responsiveness to health care providers and consumers.

Further, the state would be able to leverage enhanced federal match for contracting with a vendor to perform these functions (75 percent federal match). The general revenue costs would be offset by the reduced need for full-time equivalent (FTE) staff and contract service budget in other state agencies dedicated to this purpose and administrative savings (overhead) achieved by contracting with one vendor as opposed to multiple vendors.

Currently, the AHCA has one staff person who utilizes 50 percent of her time dedicated to PASRR policy activities. The AHCA will continue to need to maintain policies (rules) related to PASRR and will have to manage the contract with the vendor, so it is not anticipated that AHCA will have a reduction in FTEs as a result of this outsourcing initiative.

The table below includes staff from other agencies dedicated to PASRR:

Agency/Department	Staff Position	Number of FTE's	Salaries/Contract Funding
APD	N/A	N/A	TBD
DCF	N/A	N/A	$900,786
DOEA	CARES Assessors (Medical Personnel)	18	$942,000
DOH	TBD	TBD	TBD

II. Evaluation of Options

1. Provide a description of the available options for performing the service or activity and list for each option the general resources and processes needed to perform the service or activity. If state employees are currently performing the service or activity, provide at least one option involving maintaining state provision of the service or activity.

Option a: State agencies continue to perform the PASRR functions

Currently, the state performs PASRR responsibilities with the following resources:

- DOEA has 18 FTEs as PASRR assessors, and 85 medical personnel FTEs devote 4 percent of their time to perform PASRR functions. A cost breakdown is as follows:

Summary of PASRR Estimated Costs

CARES Assessors	**$**	**785,000**
Medical Personnel	**$**	**157,000**
Total PASRR Related Costs	**$**	**942,000**

- The DCF has a contract with KePRO costing $900,786.00 per Fiscal Year (FY).
- The APD is currently in process to procure a vendor for the Level II evaluations for PASRR. Based on the percentage of Level II evaluations performed by the APD compared to the DCF (11 percent), an estimate of this portion of the amount of the DCF's contract is $99,086.46.
- The DOH has staff partly devoted to PASRR but with only 96 children served, this cost is likely to be absorbed by the DOH.
- The AHCA currently has one staff resource with 50 percent of this FTE devoted to PASRR.
- Hospital and nursing facility staff perform Level I screens for adults.

Option b: Contract with a vendor that is capable of performing PASRR functions

Procuring a vendor contract includes:

- Implementation:
  - State: Procurement activities and hiring a contract manager
  - Vendor:
    - Hold meetings with state agency personnel to process map current workflows and to discuss/finalize the proposed approach for Florida. This includes finalizing communication protocols for how PASSRR Level II determinations

will be received from the APD and the DCF after the vendor has performed the assessments.
- Make modifications to their existing system to align with the approved workflows and Florida-specific requirements for the PASRR program (this will be limited to no more than $950,000 of the implementation costs).
- Develop/update policies and procedures and operational manuals.
- Develop/update clinical assessment tools in consultation with the state agencies currently involved in the process.
- Recruit and train qualified staff who will be responsible for performing the assessments/evaluations and operating the intake/referral processes.
- Implement a communication and outreach strategy for state agency staff and providers (nursing facilities/hospitals). This includes hosting face-to-face and web based training sessions.
- Implement or expanding the vendor's call center.

Implementation for the first six (6) month of the contract is estimated to cost $1,500,000. Ongoing costs for the contract are estimated to be $1,943,978.40 annually.

The hospital and nursing facility will continue to perform Level I screens for adults and provide this information to the vendor (the vendor must perform quality checks on these submissions to ensure compliance with all laws and rules).

2. For each option, describe its current market for the service or activity under consideration for outsourcing or privatizing. How many vendors are currently providing the specific service or activity on a scale similar to the proposed option? How mature is this market?

Option a: State agencies continue to perform the PASRR functions

Each respective agency would maintain the state agency personnel dedicated to performing this function and any contract funding dollars that are being proposed to transfer to AHCA to offset the ongoing operational costs of this outsourcing initiative.

Option b: Contract with a vendor that is capable of performing PASRR functions

The AHCA issued a Request for Information (RFI) in 2014 to solicit information from interested vendors regarding the outsourcing of PASRR Level I screenings. The AHCA received responses from five potential vendors. Each response demonstrated that there is a mature market of vendors available and poised to address the State's needs.

3. List the criteria used to evaluate the options. Include a cost-benefit analysis documenting the direct and indirect specific baseline costs, savings, and qualitative and quantitative benefits involved in or resulting from the implementation of the recommended option(s).

Option a: State agencies continue to perform the PASRR functions

There will be no change in costs with this option.

Option b: Contract with a vendor that is capable of performing PASRR functions

The AHCA's 2014 RFI resulted in receiving information on options to improve the PASRR process. The

AHCA is also able to draw federal funds at a 75 percent match for PASRR administration. Additionally, the AHCA has contract information for entities performing these duties in Florida and other states, to estimate costs.

DCF has already outsourced its Level II responsibilities, and APD is actively working on entering into a contract with a vendor to outsource their Level II responsibilities based upon additional funding authority provided during the 2016 Legislative session. DCF's annual contract expenses for its PASRR contract is $900,786.

Since APD performs approximately 11 percent of the number of evaluations that DCF performs, a cost estimate of $99,086.46 is established.

The AHCA should be able to achieve some administrative savings (overhead) from consolidating these outsourcing efforts through a contract with one entity/vendor. Further, DOEA has identified 18 FTE positions that are fully dedicated to supporting the PASRR process, which will no longer be needed. DOEA has estimated these expenses to be approximately $942,000.

See the attached Cost-Benefit Analysis spreadsheet and the information in section II.2.

4. Based upon the evaluation criteria, identify and analyze the advantages and disadvantages of each option, including potential performance improvements and risks.

Option a: State agencies continue to perform the PASRR function

Advantages:

1. Less disruptive for stakeholders involved in the process as there is an understanding of the current process.

Disadvantages:

1. The current process allows for antiquated communication across agencies. This may result in longer hospital stays and slower nursing facility admissions from the community.
2. It is difficult to comprehensively monitor the program, as there is little uniformity in how each state agency is fulfilling its obligation.
3. It can be difficult to maintain qualified clinical/medical personnel to perform the duties.
4. If areas of non-compliance are identified, there are fewer remedies that can be utilized to compel compliance among the state agency partners then would be available if this process were outsourced.
5. Risk of audit findings and litigation.

Option b: Contract with a vendor that is capable of performing PASRR functions

Advantages:

1. Reduced need for state agency personnel to perform these functions. Each respective agency can focus its human resources where they are needed most and on mission critical functions.
2. The ability to achieve a greater level of accountability through the imposition of performance standards/measures in the contract with the vendor that can be tied to monetary penalties for non-compliance (e.g., sanctions, liquidated damages, etc.).
3. The ability to achieve greater efficiencies resulting in faster outputs.
4. Implementation of a more streamlined and transparent process for involved stakeholders.
5. Greater ability to recruit qualified personnel to perform the duties, even in more remote or rural parts of the state.
6. Less risk to AHCA for auditing and litigation purposes.
7. Assurance that federal funding is applied appropriately with less need to conduct activities such as random moment sampling for staff who have other duties other than PASRR.

Disadvantages:
1. Stakeholders will need to be trained on the new process.
2. AHCA will need to updates its policies (rules and Medicaid State Plan) to reflect this change.
3. There is an initial one-time cost for implementation.
4. There could be delays in the implementation timeline if there are any challenges to the process used by the AHCA to procure the vendor.

5. For each option, describe the anticipated impact on the agency and the stakeholders, including impacts on other state agencies and their operations.

Option a: **State agencies continue to perform the PASRR functions**

No changes/impact.

Option b: Contract with a vendor that is capable of performing PASRR functions

If the PASRR process is outsourced, there will be a reduction in the state agency personnel needed to perform PASRR related activities (DOEA). There would also be a need to transfer contracting dollars (APD and DCF) to support this consolidation/outsourcing effort. The AHCA would also need to identify an FTE position to serve as the contract manager for this new contract.

Nursing facility and hospital personnel involved in the PASRR process would need to be trained by the vendor.

6. Identify changes in cost and/or service delivery that will result from each option. Describe how the changes will be realized. Describe how benefits will be measured and provide the annual cost.

Option a: State agencies continue to perform the PASRR functions

No change in cost or service delivery.

Option b: Contract with a vendor that is capable of performing PASRR functions

Service Delivery Changes:
The vendor would be responsible for:

- Receiving referrals for Level I screenings and either forwarding the request to a delegated Level 1 screening entity for completion (hospital or nursing facility) or completing the request using qualified clinical personnel.
- Receiving completed Level I screenings from delegated hospital and nursing facility screening entities and providing a quality assurance review to ensure all federal and state requirements are met.
- Communicating the results of the screening to the individual (or their authorized representative) and the nursing facility (if one has already been selected).
- Conducting the Level II evaluations for the individuals diagnosed with or suspected of having an SMI or ID.
- Coordinating with APD and DCF to receive the determinations on any PASRR Level II evaluations performed.
- Maintaining all PASRR related information, which can be accessed by all state agency personnel involved in the process.
- Assisting with any state and/or federal reporting requirements related to the PASRR process.

It is not anticipated that the AHCA would be able to execute a contract with a vendor until January 1, 2018. During the six-month implementation timeframe, vendor would be expected to complete the following activities:

- Hold meetings with state agency personnel to process map current workflows and to discuss/finalize the proposed approach for Florida. This includes finalizing communication protocols for how PASSRR Level II determinations will be received from APD and DCF after the vendor has performed the assessments.
- Make modifications to their existing system to align with the approved workflows and Florida-specific requirements for the PASRR program (this will be limited to no more than $950,000 of the implementation costs).
- Develop/update policies and procedures and operational manuals.
- Develop/update clinical assessment tools in consultation with the state agencies currently involved in the process.
- Recruit and train qualified staff who will be responsible for performing the assessments/evaluations and operating the intake/referral processes.
- Implement a communication and outreach strategy for state agency staff and providers (nursing facilities/hospitals). This includes hosting face-to-face and web based training sessions.
- Implement or expanding the vendor's call center.

Cost of vendor implementation is outlined as follows:

Level I Preadmission Screens

Table 1 represents the number of individuals served and a cost estimate of each service based on information submitted in the previous RFI responses and contracts in other states.

Entity Performing PASRR Level I Screens	Number of Individuals Served 2015 - 2016	Vendor Cost (*Number Served x $30 **Number Served x $6.00)
CARES	3,176	$95,280*
DOH	96	$2,880*
Hospital	123,558	$741,348**
Nursing facility	17,433	$104,598**
Resident Reviews		$0.00
	Total	**$944,106**

Table 1

Level II Evaluations

Table 2 below represents DCF's actual contract costs per SFY and an estimate of APD's costs based on the percentage of individuals served.

Entity Performing PASRR Level II And Number of Individuals Served	Vendor Cost (based on current DCF contract 2015 – 2016)
DCF Vendor – 5160	$900,786.00
APD – 480	$99,086.46*
Total	**$999,872.46**

Table 2

In Table 3 below, the one-time vendor implementation cost is displayed for SFY 2017 and then an annualization of ongoing costs based on the information in Table 1 and 2.

	RECURRING	NON-RECURRING	TOTAL	ANNUALIZATION
	FY 2017-18	FY 2017-18	FY 2017-18	FY 2018-2019
Contracted Services (100777				
General Revenue (1000 - 2)	$0	$ 375,000	$ 375,000	$ 485,944.60
Medical Care Trust Fund (2474 - 3	$0	$1,125,000	$1,125,000	$1,457,983.80
Issue Total	$0	$1,500,000	$1,500,000	$1,943,978.40

Table 3

Refer to the attached Cost-Benefit Analysis spreadsheet and sections II.1 and II.3 above.

7. List the major risks for each option and how the risks could be mitigated.

Option a: State agencies continue to perform the PASRR functions

Risks:
- Potential audits and litigation (evidenced by previous lawsuits).

Mitigation:
- Enhance oversight and monitoring of the PASRR process.
- Provide additional training opportunities.

Option b: Contract with a vendor that is capable of performing PASRR functions

Risks:
- There could be delays in the implementation timeline if there are any challenges to the process used by the AHCA to procure the vendor.
- Poor performance by the vendor
- As a result of the transition, there could be confusion among existing stakeholders if the training is not adequate in meeting their needs.

Mitigation:
- Account for any potential challenges in the project timeline and resolve challenges quickly.
- Develop a robust contract monitoring plan that mitigates the risk of vendor poor performance and implements swift corrective action if issues arise.
- Ensure the selected vendor has a good understanding of existing Florida- specific PASRR policies and procedures.
- Work with the vendor to provide adequate training for all stakeholders who will be submitting

information and documentation.

8. Describe any relevant experience of other agencies, other states, or the private sector in implementing similar options.

Other states have implemented an all-inclusive PASRR vendor process. Florida currently has (through the DCF) a contract with a vendor to perform a portion of the PASRR process.

III. Information on Recommended Option

1. Identify the proposed competitive solicitation including the anticipated number of respondents.

The AHCA anticipates publishing either an Invitation to Negotiate or a Request for Proposals. The AHCA anticipates receiving responses/bids from at least four – five vendors.

2. Provide the agency's projected timeline for outsourcing or privatization of the service or activity. Include key events and milestones from the beginning of the procurement process through the expiration of a contract and key events and milestones for transitioning the service or activity from the state to the vendor. Provide a copy of the agency's transition plan for addressing changes in the number of agency personnel, affected business processes, employee transition issues including reemployment and retraining assistance plan for employees who are not retained by the agency or employed by the contractor, and communication with stakeholders such as agency clients and the public.

Task Name	Start	Finish
1. Program change assessment completed	**07/01/2017**	**7/31/2017**
1.1. State change assessment completed	07/01/2017	7/31/2017
1.2. Current program change assessment completed	7/1/2017	7/31/2017
2. Resources and methods approved to develop ITN	**8/1/2017**	**8/31/2017**
2.1. Procurement team formed	8/1/2017	8/15/2017
2.2. Sub-teams and supporting resources approved	8/16/2017	8/31/2017
3. Contract awarded	**9/1/2017**	**1/8/2018**
3.1. Procurement posted	9/1/2017	9/1/2017
3.2. Addenda posted	9/1/2017	11/1/2017
3.3. Responses received	9/15/2017	11/11/2017
3.4. Responses evaluated	9/15/2017	11/25/2017
3.5. Negotiations completed	9/15/2017	12/20/2017
3.6. Award posted	12/21/2017	1/8/2018
4. Contract executed	**1/9/2018**	**7/1/2018**
4.1. 72 hour waiting period completed	1/9/2018	1/11/2018
4.2. All ITN challenges settled/dismissed	1/11/2018	
4.3. Contract drafts finalized	2/1/2018	4/1/2018
4.4. Vendor's pre-execution contract documentation completed	4/2/2018	4/7/2018
4.5. Contract executed		7/1/2018

5. Vendor On-Boarding Completed	4/2/2018	7/2/2018
5.1. Data-Sharing Agreement executed by vendor	4/2/2018	4/7/2018
5.2. Vendor informed of required forms and actions needed for onboarding	4/2/2018	4/2/2018
5.3. Post-execution documentation completed	4/2/2018	7/2/2018
5.4. On-boarding (kick-off) meeting completed and documented	7/2/2018	7/15/2018
6. Program goes live	**7/2/2018**	**7/2/2018**

3. Identify all forms of compensation to the vendor(s) for performance of the service or activity, including in-kind allowances and state resources to be transferred to the vendor(s). Provide a detailed cost estimate of each.

- January to June 2018: $1,500,000 for implementation costs (federal and state percentages are il below in Table 4). This will be a one-time cost to the state with no in-kind allowances or transfer resources. See Table 1 below.
- Recurring annual cost of $1,941,872.46. See Table 5 below.
- Offsetting expenses of staff reduction and current contract terminations. See Table 6 below.

Time Period	Overall Cost	State Share (25%)	Federal Match (75%)
January to June 2018	$1,500,000	$375,000	$1,125,000

Table 4

Time Period	Overall Cost	State Share (25%)	Federal Match (75%)
July 2018 to June 2019	$1,943,928.40	$485,944.60	$1,457,983.80

Table 5

Staff Reduction	Cost Saving per Fiscal Year
CARES Assessors Medical Personnel	$942,000
DOH	
DCF Vendor	$900,786.00
APD Vendor	$99,086.46 Cost estimate based on DCF vendor costs, not APD actuals.
Total (per year)	($1,941,872.46)

Table 6

4. Provide an analysis of the potential impact on federal, state, and local revenues, and expenditures. If federal dollars currently fund all or part of the service or activity, what has been the response of the federal funding agency(ies) to the proposed change in the service delivery method? If federal dollars currently fund all or part of the service or activity, does the change in the service delivery method meet federal requirements?

Currently the State receives federal funding for PASRR activities. The AHCA does not anticipate a significant response from federal authorities related to outsourcing PASRR. Federal regulations allow the State to delegate or subcontract the PASRR activities (see 42 CFR §483.106 (e)). Further, other states have chosen this option as well, without federal interference. The proposed outsourcing initiative will be implemented in compliance with all federal and state requirements.

5. What responsibilities, if any, required for the performance of the service or activity will be retained and performed by the agency? What costs, including personnel costs, will the agency continue to incur after the change in the service delivery model? Provide these cost estimations. Provide the method for monitoring progress in achieving the specified performance standards within the contract.
The AHCA will maintain the oversight of the PASRR program. The AHCA will continue to retain a one-half (1/2) FTE position dedicated to maintaining all rules and policies related to Florida's PASRR process. In addition, the AHCA will need to identify one FTE position to serve as a contract manager. AHCA intends to absorb this responsibility using existing resources. The AHCA contract manager will implement a robust monitoring that includes the receipt of monthly and quarterly reports from the vendor validating activities related to the Level I and Level II PASRR screens/evaluations. These monitoring standards shall incorporate at a minimum the standards specified in the Florida Medicaid State Plan and Rule 59G-1.040 F.AC. for the PASRR process. In addition, AHCA will perform quarterly desk-reviews and annual on-site monitoring visits to ensure the vendor is performing in accordance with the contractual requirements.
6. Describe the agency's contract management process for the outsourced or privatized service or activity, including a description of the specific performance standards that must be met to ensure adequate performance and how the agency will address potential contractor non-performance. Attach a copy of any competitive solicitation documents, requests for quote(s), service level agreements, or similar documents issued by the agency for this competitive solicitation if available.
The AHCA contract manager will implement a robust monitoring that includes the receipt of monthly and quarterly reports from the vendor validating activities related to the Level I and Level II PASRR screens/evaluations. These monitoring standards shall incorporate at a minimum the standards specified in the Florida Medicaid State Plan and Rule 59G-1.040 F.AC. for the PASRR process. In addition, AHCA will perform quarterly desk-reviews and annual on-site monitoring visits to ensure the vendor is performing in accordance with the contractual requirements. In addition, the contract manager will maintain regular contact with the vendor to provide ongoing technical assistance, as needed. Performance standards include and are not limited to: • Ensure that 100 percent of Level I PASRR screenings are conducted prior to the individual's admission into the nursing facility • Complete 100 percent of Level I PASRR screening within two business days of receiving the application for admission to a nursing facility. • Complete 100 percent of the Level II evaluations and determinations within seven business days of the completed Level I PASRR screening. • Complete 100 percent of the resident reviews within seven business days of request.
7. Provide the agency's contingency plan(s) that describes the tasks involved in and costs required for its implementation and how the agency will resume the in-house provision of the service or activity in the event of contract termination/non-renewal.

In the event of contract termination or non-renewal, the AHCA may designate the Level I PASRR screen responsibilities to sister agencies while maintaining the oversight of the PASRR program. The state mental health and intellectual disability authorities would be required to retain the responsibility for performance of their statuary obligation pertaining to PASRR.

8. Identify all other Legislative Budget Request issues that are related to this proposal.
None.

9. Explain whether or not the agency can achieve similar results by a method other than outsourcing or privatization and at what cost. Please provide the estimated expenditures by fiscal year over the expected life of the project.
The AHCA does not believe that it can achieve similar results by a method other than outsourcing.
10. Identify the specific performance measures that are to be achieved or that will be impacted by changing the service's or activity's delivery method.
See section III.6. above.
11. Provide a plan to verify vendor(s) compliance with public records laws.
The AHCA has standard language that is included in all vendor contracts that requires compliance with Florida public record laws.
12. If applicable, provide a plan to verify vender compliance with applicable federal and state law ensuring access by persons with disabilities.
The AHCA will include language in the vendor contract that the vendor will comply with ADA requirements, the Medicaid Act, and state law to ensure that reasonable accommodations are in place for persons with disabilities.
13. If applicable, provide a description of potential differences among current agency policies or processes and a plan to standardize, consolidate, or revise current policies or processes.
Currently, there is not a uniform process utilized by all of the state agencies involved in the PASRR process for sharing information. Parties are sharing protected health information and data utilizing antiquated methods such as fax and email, resulting in increased risks related to fulfilling HIPAA requirements and increased manual processes supported by state agency human resources. The vendor would be required to have policies and practices in place that address these concerns.
14. If the cost of the outsourcing is anticipated to exceed $10 million in any given fiscal year, provide a copy of the business case study (and cost benefit analysis if available) prepared by the agency for the activity or service to be outsourced or privatized pursuant to the requirements set forth in s. 287.0571, F.S.
Not applicable.

SCHEDULE XIIA-1: COST/BENEFIT ANALYSIS - PROJECTED COST AND COMPENSATION

Function Costs for Preadmission Screening and Resident Review* **Option:** 1

Produced 10/10/2016 **For** Agency for Health Care Adminis **By** Monty McCullough **F Y 2017-2018**

BUDGET WORKSHEET

	BUDGET									REVENUES / COMPENSATION				NET IMPACT	
	(a) Current			(b) Proposed Option			(c)=(b)-(a) Incremental Effect of Option				(d)	(e)	(f)=(e)-(d) Incremental	COMPENSATION LESS	CUMULATIVE
	General Revenue	Trust Fund	Total	General Revenue	Trust Fund	Total	General Revenue	Trust Fund	Total		Current	Proposed option	Effect of Option	COSTS	IMPACT
FY 2016-17															
FTE'S	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Salaries and Wages	$235,500	$706,500	$942,000	$235,500	$706,500	$942,000	$0	$0	$0	General Revenue	$0	$0	$0		
OPS	$0	$0	$0	$0	$0	$0	$0	$0	$0	Fees	$0	$0	$0		
Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	Federal Funds	$0	$0	$0		
Contracted Services	$281,447	$844,340	$1,125,786	$281,447	$844,340	$1,125,786	$0	$0	$0	Other -	$0	$0	$0		
Special Categories	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
TOTAL FY 2016-17	$516,947	$1,550,840	$2,067,786	$516,947	$1,550,840	$2,067,786	$0	$0	$0		$0	$0	$0	$0	$0
FY 2017-18															
FTE'S	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Salaries and Wages	$235,500	$706,500	$942,000	$235,500	$706,500	$942,000	$0	$0	$0	General Revenue	$0	$0	$0		
OPS	$0	$0	$0	$0	$0	$0	$0	$0	$0	Fees	$0	$0	$0		
Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	Federal Funds	$0	$0	$0		
Contracted Services	$281,447	$844,340	$1,125,786	$656,447	$1,969,340	$2,625,786	$375,000	$1,125,000	$1,500,000	Other -	$0	$0	$0		
Special Categories	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
TOTAL FY 2017-18	$516,947	$1,550,840	$2,067,786	$891,947	$2,675,840	$3,567,786	$375,000	$1,125,000	$1,500,000		$0	$0	$0	($1,500,000)	($1,500,000)
FY 2018-19															
FTE'S	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Salaries and Wages	$0	$0	$0	($235,500)	($706,500)	($942,000)	($235,500)	($706,500)	($942,000)	General Revenue	$0	$0	$0		
OPS	$0	$0	$0	$0	$0	$0	$0	$0	$0	Fees	$0	$0	$0		
Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	Federal Funds	$0	$0	$0		
Contracted Services	$0	$0	$0	($281,447)	($844,340)	($1,125,786)	($281,447)	($844,340)	($1,125,786)	Other -	$0	$0	$0		
Special Categories	$0	$0	$0	$485,995	$1,457,984	$1,943,978	$485,995	$1,457,984	$1,943,978	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
TOTAL FY 2018-19	$0	$0	$0	($30,952)	($92,856)	($123,808)	($30,952)	($92,856)	($123,808)		$0	$0	$0	$123,808	($1,376,192)

SCHEDULE XIIA-1: COST/BENEFIT ANALYSIS - PROJECTED COST AND COMPENSATION

Function Costs for Preadmission Screening and Resident Review* **Option:** 1

Produced 10/10/2016 For **Agency for Health Care Adminis** By **Monty McCullough** **F Y 2017-2018**

BUDGET WORKSHEET

	BUDGET									REVENUES / COMPENSATION				NET IMPACT	
	(a) Current			(b) Proposed Option			(c)=(b)-(a) Incremental Effect of Option				(d)	(e)	(f)=(e)-(d) Incremental	COMPENSATION	
	General Revenue	Trust Fund	Total	General Revenue	Trust Fund	Total	General Revenue	Trust Fund	Total		Current	Proposed option	Effect of Option	LESS COSTS	CUMULATIVE IMPACT
FY 2019-20															
FTE'S	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Salaries and Wages	$0	$0	$0	($235,500)	($706,500)	($942,000)	($235,500)	($706,500)	($942,000)	General Revenue	$0	$0	$0		
OPS	$0	$0	$0	$0	$0	$0	$0	$0	$0	Fees	$0	$0	$0		
Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	Federal Funds	$0	$0	$0		
Contracted Services	$0	$0	$0	($281,447)	($844,340)	($1,125,786)	($281,447)	($844,340)	($1,125,786)	Other -	$0	$0	$0		
Special Categories	$0	$0	$0	$485,995	$1,457,984	$1,943,978	$485,995	$1,457,984	$1,943,978	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
TOTAL FY 2019-20	$0	$0	$0	($30,952)	($92,856)	($123,808)	($30,952)	($92,856)	($123,808)		$0	$0	$0	$123,808	($1,376,192)
FY 2020-21															
FTE'S	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Salaries and Wages	$0	$0	$0	($235,500)	($706,500)	($942,000)	($235,500)	($706,500)	($942,000)	General Revenue	$0	$0	$0		
OPS	$0	$0	$0	$0	$0	$0	$0	$0	$0	Fees	$0	$0	$0		
Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	Federal Funds	$0	$0	$0		
Contracted Services	$0	$0	$0	($281,447)	($844,340)	($1,125,786)	($281,447)	($844,340)	($1,125,786)	Other -	$0	$0	$0		
Special Categories	$0	$0	$0	$485,995	$1,457,984	$1,943,978	$485,995	$1,457,984	$1,943,978	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
Other -	$0	$0	$0	$0	$0	$0	$0	$0	$0	Other -	$0	$0	$0		
TOTAL FY 2020-21	$0	$0	$0	($30,952)	($92,856)	($123,808)	($30,952)	($92,856)	($123,808)		$0	$0	$0	$123,808	($1,252,384)
GRAND TOTAL	$1,033,893	$3,101,679	$4,135,572	$1,316,037	$3,948,111	$5,264,148	$282,144	$846,432	$1,128,576		$0	$0	$0	($1,128,576)	($1,252,384)

Include One-Time Costs
Include on-going agency costs - Direct and Indirect

Include all forms of compensation whether or not the funds pass through state coffers, whether or not the compensation is cash.

SCHEDULE XIIA-2: COST/BENEFIT ANALYSIS - BENEFITS AND ADDITIONAL COSTS

Function Costs for **Preadmission Screening and Resident Review*** **Option:** **1**

Produced **10/10/2016** For **Agency for Health Care Admi** By **Monty McCullough** **FY 2017-18**

List and describe any Benefits not captured on Schedule XIIA-1, such as improved customer service, which could not be quantified:

1	Easier level one submission processes and less disruption for hospital and nursing facility staff
2	PASRR data would be maintained in a centralized location and reduces stakeholder confusion on various state roles in the PASRR process.
3	Increases the Agency for Health Care Administration's ability to monitor the PASRR program.
4	Easier to maintain qualified staff for PASRR program roles.
5	Less risk of audit findings and litigation.
6	Greater level of accountability in PASRR activities due to one vendor performing these functions as compared to several state agencies.
7	Achievement of greater efficiencies resulting in faster outputs.
8	
9	
10	
11	
12	
13	
14	
15	

List and describe any expected costs not captured on Schedule XIIA-1 because they could not be quantified:

1	The Agency proposes to procure a vendor and will utilize negotiation tactics to keep costs for this activity below current costs.
2	
3	
4	
5	
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14	
15	

Office of Policy and Budget - June 2016

SCHEDULE XIIA-3: COST/BENEFIT ANALYSIS - ASSUMPTIONS

Function Costs for <Project Name>	Option: <Option Number>		
Produced <Date>	For <Agency>	By <Name>	FY 2017-18

BUDGET - ASSUMPTIONS

OPERATIONAL COSTS	(a) Current	(b) Proposed option
Salaries and Wages	These figures represent salary and benefits of staff who perform PASRR activiteis at Department Of Elder Affairs	
OPS		
Expenses		
Contracted Services	These figures are comprised of contracted services budget at Department of Chilren and Families and Agency for Persons with Disab	
Special Categories		The Agency proposes to procure a vendor and will utilize negotiation tactics to keep costs for this activity below current costs.
Other -		
Other -		
Other -		
Other -		
FTE'S	18	

List all assumptions made in calculating and projecting the figures shown on the "Projections" sheet (Schedule XIIA-1)

COMPENSATION - ASSUMPTIONS

REVENUES / COMPENSATION	(a) Current	(b) Proposed option
General Revenue	N/A	N/A
Fees	N/A	N/A
Federal Funds	N/A	N/A
Other -	N/A	N/A
Other -	N/A	N/A
Other -	N/A	N/A
Other -	N/A	N/A

List all assumptions made in calculating and projecting the figures shown on the "Projections" sheet (Schedule XIIA-1)

BENEFITS AND ADDITIONAL COSTS - ASSUMPTIONS

	The Agency does not anticipate additional costs, however the benefits will be a streamlined, accountable and consolidated process for Pre-Admission Screening and Resident Review.

List all assumptions made in deriving the benefits and additional costs shown on the "Additional Information" sheet (Schedule XIIA-2)

Office of Policy and Budget - June 2016

Schedule XIV
Variance from Long Range Financial Outlook

Agency: Agency for Health Care Administration   Contact: Anita B. Hicks, CFO

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

1) Does the long range financial outlook adopted by the Joint Legislative Budget Commission in September 2016 contain revenue or expenditure estimates related to your agency?

Yes [X]   No [ ]

2) If yes, please list the estimates for revenues and budget drivers that reflect an estimate for your agency for Fiscal Year 2017-2018 and list the amount projected in the long range financial outlook and the amounts projected in your Schedule I or budget request.

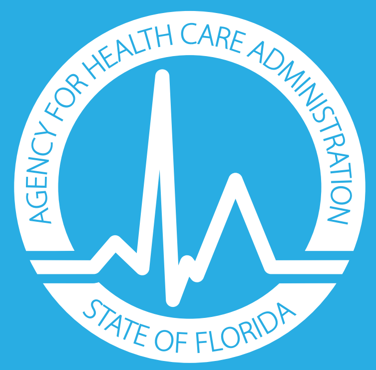
			FY 2017-2018 Estimate/Request Amount	
	Issue (Revenue or Budget Driver)	R/B*	Long Range Financial Outlook	Legislative Budget Request
a	Medicaid Price Level and Workload	B	735.3	735.3
b	KidCare	B	60.5	60.5
c	Medicaid Provider Rate Increases	B	18.8	0
d	Medicaid Waivers	B	8.0	0
e	Hospital Provider Rate Increases	B	136.6	0
f	ICF/DD Provider Rate Increases	B	4.8	0
g	Fiscal Agent FMMIS Reprocurement	B	6.0	7.5

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

c. Agency's request does not include a funding increase to adjust reimbursement rates for Medicaid Providers.
d. Agency's request does not include a funding increase for Medicaid waivers.
e. Agency's request does not include a funding increase to adjust reimbursement rates for Hospital Providers.
f. Agency's request does not inlcude a funding increase to adjust reimbursement rates for ICF/DD Providers.
g. Agency's request includes issue for Fiscal Agent FMMIS Reprocurement.

* R/B = Revenue or Budget Driver

Office of Policy and Budget - June 2016



Florida Agency for Health Care Administration

Legislative Budget Request

Fiscal Year 2017-2018

Department Level Schedule I Series

Florida Agency for Health Care Administration

Legislative Budget Request

Fiscal Year 2017-2018

Administration and Support Schedules

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 -2018

Department Title:	Agency for Healthcare Administration
Trust Fund Title:	Administration Trust Fund
Budget Entity:	Departmental
LAS/PBS Fund Number:	2021

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	5,421,170	(A)		5,421,170
ADD: Other Cash (See Instructions)		(B)		-
ADD: Investments		(C)		-
ADD: Outstanding Accounts Receivable	1,117,728	(D)		1,117,728
ADD: ______________________________		(E)		-
Total Cash plus Accounts Receivable	**6,538,898**	(F)	**-**	**6,538,898**
LESS Allowances for Uncollectibles		(G)		-
LESS Approved "A" Certified Forwards	1,931,035	(H)		1,931,035
Approved "B" Certified Forwards	834,491	(H)		834,491
Approved "FCO" Certified Forwards		(H)		-
LESS: Other Accounts Payable (Nonoperating)	-	(I)		-
LESS: ______________________________		(J)	-	-
Unreserved Fund Balance, 07/01/16	**3,773,372**	(K)	**-**	**3,773,372** **

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 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2017 -2018

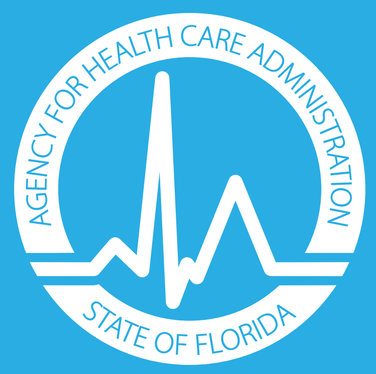
Department Title:	Agency for Healthcare Administration
Trust Fund Title:	Administration Trust Fund
LAS/PBS Fund Number:	2021

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	**4,496,830**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	(46,012)	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	0	(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	(834,491)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	0	(D)
A/P not C/F-Operating Categories	157,045	(D)
Certified Forward Approved "A" Carry Forward Adjustment	0	(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**3,773,372**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**3,773,372**	(F)
DIFFERENCE:	**(0)**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2016



Florida Agency for Health Care Administration

Legislative Budget Request

Fiscal Year 2017-2018

Health Care Services Schedules

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 - 2018

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

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	628,752,857	(A)		628,752,857	
ADD: Other Cash (See Instructions)	40,391	(B)		40,391	
ADD: Investments	2,574,630	(C)		2,574,630	
ADD: Outstanding Accounts Receivable	222,231,578	(D)	19,125,865.24	241,357,443	
ADD: SW Adjustment	-	(E)		-	
ADD: BE Transfer to 68500100/68501400	8,706,269,457	(E)		8,706,269,457	
Total Cash plus Accounts Receivable	**9,559,868,913**	(F)	**19,125,865**	**9,578,994,778**	
LESS Allowances for Uncollectibles	7,991,037	(G)		7,991,037	
LESS Approved "A" Certified Forwards	343,175,795	(H)		343,175,795	
Approved "B" Certified Forwards	4,516,641	(H)		4,516,641	
Approved "FCO" Certified Forwards	-	(H)		-	
LESS: Other Accounts Payable (Nonoperating)	36,061,105	(I)	40,278,653	76,339,759	
LESS: Deferred Inflows - Unavailable Revenue	67,314,783	(J)		67,314,783	
LESS: BE Transfer from 2474 68501500	8,706,269,457	(J)		8,706,269,457	
LESS:		(J)		-	
LESS: Supply Inventory		(J)		-	
Unreserved Fund Balance, 07/01/__	**394,540,094**	(K)	**(21,152,788)**	**373,387,306**	**

Notes:

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Office of Policy and Budget - July 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

	Budget Period: 2017 - 18
Department Title:	Agency for Health Care Administration
Trust Fund Title:	Medical Care Trust Fund
LAS/PBS Fund Number:	2474

BEGINNING TRIAL BALANCE:

Item	Amount	Ref
Total Fund Balance Per FLAIR Trial Balance, 07/01/___ Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**394,072,016**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	(19,462)	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	7,508,896	(C)
SWFS Adjustment # and Description	(37,410,924)	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	(4,516,641)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS		(D)
A/P not C/F-Operating Categories	8,181,862	(D)
BE Fund Adjustment	0	(D)
Long Term Receivables Less Allowance for Uncollectibles	(3,177,681)	(D)
BE Transfer 68500100/68501400	8,706,269,457	(D)
BE Transfer 68500100/68501400	(8,706,269,457)	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**364,638,066**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**373,387,306**	(F)
DIFFERENCE:	**(8,749,240)**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2016

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 -2018

Department Title:	Agency for Healthcare Administration
Trust Fund Title:	Tobacco Settlement Trust Fund
Budget Entity:	Departmental
LAS/PBS Fund Number:	2122

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	368,276	(A)		368,276
ADD: Other Cash (See Instructions)		(B)		-
ADD: Investments		(C)		-
ADD: Outstanding Accounts Receivable		(D)		-
ADD: ______________		(E)		-
Total Cash plus Accounts Receivable	**368,276**	(F)	**-**	**368,276**
LESS Allowances for Uncollectibles		(G)		-
LESS Approved "A" Certified Forwards	368,276	(H)		368,276
Approved "B" Certified Forwards		(H)		-
Approved "FCO" Certified Forwards		(H)		-
LESS: Other Accounts Payable (Nonoperating)		(I)		-
LESS: ______________		(J)	0	0
Unreserved Fund Balance, 07/01/16	**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 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2017 -2018

Department Title:	Agency for Healthcare 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	**0**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)		(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	0	(C)
SWFS Adjustment # and Description		(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	0	(D)
A/P not C/F-Operating Categories	0	(D)
		(D)
		(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**0**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**(0)**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2016

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 - 2018

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

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	15,366,493	(A)		15,366,493
ADD: Other Cash (See Instructions)		(B)		-
ADD: Investments		(C)		-
ADD: Outstanding Accounts Receivable		(D)		-
ADD: ______________________________		(E)		-
Total Cash plus Accounts Receivable	**15,366,493**	(F)	**-**	**15,366,493**
LESS Allowances for Uncollectibles		(G)		-
LESS Approved "A" Certified Forwards	111,888	(H)		111,888
Approved "B" Certified Forwards	26,740	(H)		26,740
Approved "FCO" Certified Forwards		(H)		-
LESS: Other Accounts Payable (Nonoperating)		(I)		-
LESS: ______________________________		(J)		-
Unreserved Fund Balance, 07/01/16	**15,227,865**	(K)	**-**	**15,227,865** **

Notes:

***SWFS = Statewide Financial Statement**

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Office of Policy and Budget - July 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2017 - 2018

Department Title: Agency of Healthcare 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, 07/01/16 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**15,254,604**	(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	(26,740)	(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:	**15,227,865**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**15,227,865**	(F)
DIFFERENCE:	**(0)**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2016

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 -2018

Department Title:	Agency for Healthcare Administration
Trust Fund Title:	Grants & Donations Trust Fund
Budget Entity:	Departmental
LAS/PBS Fund Number:	2339

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	621,307,502	(A)		621,307,502
ADD: Other Cash (See Instructions)	34,664,134	(B)		34,664,134
ADD: Investments		(C)		-
ADD: Outstanding Accounts Receivable	277,209,788	(D)		277,209,788
ADD: ______________		(E)		-
Total Cash plus Accounts Receivable	**933,181,424**	(F)	**-**	**933,181,424**
LESS Allowances for Uncollectibles	2,632,967	(G)		2,632,967
LESS Approved "A" Certified Forwards	372,259,833	(H)		372,259,833
Approved "B" Certified Forwards	855,957	(H)		855,957
Approved "FCO" Certified Forwards		(H)		-
LESS: Other Accounts Payable (Nonoperating)	154,340,284	(I)		154,340,284
LESS: Deferred Inflows	20,085,276	(J)		20,085,276
Unreserved Fund Balance, 07/01/16	**383,007,107**	(K)	**-**	**383,007,107** **

Notes:

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Office of Policy and Budget - July 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2017-2018

Department Title: Agency for Healthcare Administration
Trust Fund Title: Grants & Donations Trust Fund
LAS/PBS Fund Number: 2339

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	**383,992,816**	(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	(855,957)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	0	(D)
A/P not C/F-Operating Categories	348,351	(D)
Other Loans and Notes Receivable	(478,106)	(D)
Rounding	3	(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**383,007,107**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**383,007,107**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2016

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 -2018

Department Title:	Agency for Healthcare Administration
Trust Fund Title:	Public Medical Assistance Trust Fund
Budget Entity:	Departmental
LAS/PBS Fund Number:	2565

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	97,365,405	(A)		97,365,405
ADD: Other Cash (See Instructions)	546,984	(B)		546,984
ADD: Investments		(C)		-
ADD: Outstanding Accounts Receivable	41,083,395	(D)		41,083,395
ADD: ________________________________		(E)		-
Total Cash plus Accounts Receivable	**138,995,784**	(F)	**-**	**138,995,784**
LESS Allowances for Uncollectibles	3,998,404	(G)		3,998,404
LESS Approved "A" Certified Forwards	10,398,406	(H)		10,398,406
Approved "B" Certified Forwards		(H)		-
Approved "FCO" Certified Forwards		(H)		-
LESS: Other Accounts Payable (Nonoperating)		(I)		-
LESS: Deferred Inflows	7,631,696	(J)		7,631,696
Unreserved Fund Balance, 07/01/__	**116,967,278**	(K)	**-**	**116,967,278** **

Notes:

***SWFS = Statewide Financial Statement**

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Office of Policy and Budget - July 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2017 - 2018

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/16 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**116,967,278**	(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:	**116,967,278**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**116,967,278**	(F)
DIFFERENCE:	**0**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2016

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 -2018

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

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	1,444	(A)		1,444	
ADD: Other Cash (See Instructions)		(B)		-	
ADD: Investments		(C)		-	
ADD: Outstanding Accounts Receivable	25,123,180	(D)		25,123,180	
ADD: ________________________________		(E)		-	
Total Cash plus Accounts Receivable	**25,124,624**	(F)	**-**	**25,124,624**	
LESS Allowances for Uncollectibles		(G)		-	
LESS Approved "A" Certified Forwards	25,124,624	(H)		25,124,624	
Approved "B" Certified Forwards		(H)		-	
Approved "FCO" Certified Forwards		(H)		-	
LESS: Other Accounts Payable (Nonoperating)		(I)		-	
LESS: ________________________________		(J)		-	
Unreserved Fund Balance, 07/01/16	**0**	(K)	**-**	**0**	**

Notes:

***SWFS = Statewide Financial Statement**

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Office of Policy and Budget - July 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2017 -2018

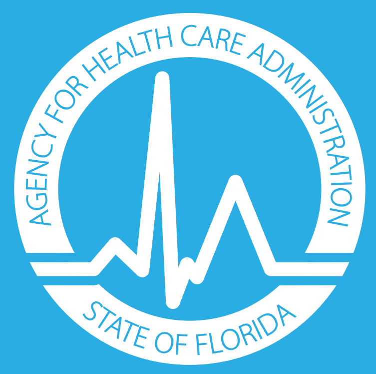
Department Title: Agency for Healthcare Administration
Trust Fund Title: Refugee Assistance Trust Fund
LAS/PBS Fund Number: 2579

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		(C)
SWFS Adjustment # and Description		(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 2016



Florida Agency for Health Care Administration

Legislative Budget Request

Fiscal Year 2017-2018

Health Facility Regulation Schedules

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2017 -2018

Department Title:	Agency for Healthcare Administration
Trust Fund Title:	Healthcare Trust Fund
Budget Entity:	Departmental
LAS/PBS Fund Number:	2003

	Balance as of 6/30/2016		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	93,790,516	(A)		93,790,516	
ADD: Other Cash (See Instructions)	149,039	(B)		149,039	
ADD: Investments	-	(C)		-	
ADD: Outstanding Accounts Receivable	26,920,751	(D)		26,920,751	
ADD: ______________		(E)		-	
Total Cash plus Accounts Receivable	**120,860,306**	(F)	**-**	**120,860,306**	
LESS Allowances for Uncollectibles	2,743,955	(G)		2,743,955	
LESS Approved "A" Certified Forwards	1,942,128	(H)		1,942,128	
Approved "B" Certified Forwards	870,293	(H)		870,293	
Approved "FCO" Certified Forwards		(H)		-	
LESS: Other Accounts Payable (Nonoperating)	2,107,873	(I)	65,730	2,173,603	
LESS: Deferred Inflows	11,336,530	(J)	13,732	11,350,262	
LESS: BE TNFR TO 68501400	(1,036,294,043)	(K)	-	(1,036,294,043)	**
LESS: BE TNFR TO 68501500	1,036,294,043	(K)	-	1,036,294,043	**
Unreserved Fund Balance, 07/01/16	**101,859,527**	(K)	**(79,462)**	**101,780,065**	**

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 2016

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2017-2018

Department Title:	Agency for Healthcare Administration
Trust Fund Title:	Healthcare Trust Fund
LAS/PBS Fund Number:	2003

BEGINNING TRIAL BALANCE:

Item	Amount	Ref
Total Fund Balance Per FLAIR Trial Balance, 07/01/___ Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**102,723,647**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	(8,040)	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	(6,588)	(C)
SWFS Adjustment # and Description	(72,874)	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	(870,293)	(D)
Approved "C" Carry Forward Total (FCO) per LAS/PBS	0	(D)
A/P not C/F-Operating Categories	28,537	(D)
Advances from Other Funds	(15,000)	(D)
Certified Forward Approved "A" Carry Forward Adjustment	677	(D)
BE TNFR TO 68501400	1,036,294,043	(D)
BE TNFR TO 68501500	(1,036,294,043)	(D)
ROUNDING	(1)	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**101,780,065**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**101,780,065**	(F)
DIFFERENCE:	**(0)**	(G)*

***SHOULD EQUAL ZERO.**

Office of Policy and Budget - July 2016

SCHEDULE 1A: DETAIL OF FEES AND RELATED PROGRAM COSTS

Department:	68	Health Care Administrati	**Budget Period: 2017-18**
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 2015 - 16**	**ESTIMATED FY 2016 - 17**	**REQUEST FY 2017 - 18**
Receipts:			
Abortion Clinic	18,616	17,967	20,881
Adult Family Care Home (AFCH)	51,822	50,016	58,127
Assist Living Facility (ALF)	4,145,731	4,001,268	4,650,146
Adult Day Care Facility (ADC)	32,697	31,558	36,675
Amb. Surgical Center	372,106	359,139	417,380
Birth Center	8,531	8,234	9,569
Crisis Stabilization Units	133,325	128,679	149,547
Forensic Lab	115,045	111,036	129,043
H, C, & Ss	54,302	52,410	60,909
Health Care Clinics	2,376,150	2,293,351	2,665,259
Health Care Services Pool	145,488	140,419	163,190
Home Health	2,422,213	2,337,808	2,716,926
Home Medical Equipment	212,095	204,704	237,901
Hospice	24,018	23,181	26,940
Hospital	863,715	833,618	968,804
ICF/DD	353,899	341,567	396,958
Laboratory	1,385,563	1,337,282	1,554,146
Managed Care	54,375	52,481	60,991
Multiphasic Center	12,042	11,622	13,507
Nurse Registry	743,567	717,656	834,037

Organ & Tissue Donor	30,200	29,148	33,874
PPECS	44,508	42,957	49,924
Residential Treatment	196,591	189,740	220,510
Residential Treatment for Children	90,340	87,192	101,332
Risk Management	67,415	65,066	75,617
SNF Home	6,233,544	6,016,330	6,991,987
Trans. Living	63,972	61,743	71,756
Total Fee Collection to Line (A) - Section III	20,251,867	19,546,170	22,715,935

SECTION II - FULL COSTS

Direct Costs:			
Salaries and Benefits			
Other Personal Services			
Expenses			
Operating Capital Outlay			
Direct Cost Allocation	45,471,014	44,765,317	47,935,081
Indirect Costs Charged to Trust Fund	21,481,616	20,775,919	23,945,683
Total Full Costs to Line (B) - Section III	66,952,630	65,541,235	71,880,764

Basis Used:

SECTION III - SUMMARY

TOTAL SECTION I	(A)	20,251,867	19,546,170	22,715,935
TOTAL SECTION II	(B)	66,952,630	65,541,235	71,880,764
TOTAL - Surplus/Deficit	(C)	(46,700,763)	(45,995,065)	(49,164,830)

EXPLANATION of LINE C:

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

Office of Policy and Budget - July, 2016

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) completed implementation 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). During Fiscal Year 2015-16, more than 91,000 background screening results were shared among participating agencies and managed health care plans resulting in an overall cost savings of $6,858,375 to these providers by eliminating duplicative employment screenings.

   AHCA completed implementation of online licensure renewal applications for all licensure types at the end of Fiscal Year 2015-16. Cost savings accrue through the reduction in state paper processing and administrative costs, and for provider's savings through a decrease in late application fines and reduced provider effort necessary to submit additional documentation when applications are incomplete. Faster processing times allow providers to become licensed faster and begin operations sooner. The Agency has implemented measurement tools to evaluate the impact of online licensing and is continually evaluating additional outreach necessary to encourage and increase online participation.

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

   Response: Expansion of online licensing to include "Changes" to licensure information between renewal applications is planned during fiscal year 2016/17. It is expected that a significant reduction in mail will occur once implemented reducing the staff needed to process mail. This will allow the Agency to continue to shift job duties away from paper processing to the management of these two

systems (Online Licensing and Clearinghouse) and absorb caseload growth without additional FTE resources.

The Division is also expanding transparency of information collected and maintained by the Agency using reporting tools to publish data online such as FloridaHealthFinder.gov and tools such as Tableau. Transparency of information improves consumer and public access and reduces the manual labor associated with report production and response to public record requests. For example, the Agency is developing an online Hospital Financial Data Book report which will eliminate a 3-month publication process. The Agency is nearing completion of an online submission tool for the Florida Hospital Uniform Reporting System (FHURS) data. The cost savings associated with these reports are similar to online licensing and expected to generate similar efficiencies.

3. Is the regulatory activity an appropriate function that the agency should continue at its current level?
4.

   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.

5. 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. 408.805, 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.

6. 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.

7. 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.

8. 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. Although some fees do not fully cover regulatory costs at the provider level, overall, revenues in the Health Care Trust Fund are sufficient to cover the aggregate cost of Agency regulation.

9. 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: Aggregate revenues in the Health Care Trust Fund are sufficient to cover Agency regulatory 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 Clinics	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	Health Care 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 Facilities							
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

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)
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
Certificare of Need	Batch Application Fee	s. 408.038, F.S.	$50,000	2004	Yes	Minimum of $10,000 + 0.015% of total project costs	Health Care Trust Fund
	Expedited Application Fee	s. 408.038, F.S.	$50,000	2004	Yes	Minimum of $10,000 + 0.015% of total project costs	Health Care Trust Fund
	Exemption Fee	s. 408.036(4), F.S.	$250	Prior to 1997	No	$250	Health Care Trust Fund
Clinical Laboratories	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 Units & Short Term Residential Treatment Facilities	Licensure Fee	s. 394.877, F.S.	None	N/A	Yes	$197.92 per bed	Health Care Trust Fund
Drug Free Workplace Laboratories	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	0.000072182% 2015 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

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)
Health Care Clinics	Licensure Fee	s. 400.9925	$2,000	2003	No	$2,000	Health Care Trust Fund
	Exemption Fee	s. 400.9935(6)	$100	2004	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	0.000072182% 2015 Annual Premiums Collected	Health Care Trust Fund
Home Health Agencies	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	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
Homemaker & Companion Services Providers	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

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)
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 Facilities for the Developmentally 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 Registries	Licensure Fee	s. 400.506(3), F.S.	$2,000	2005	Yes	$2,000	Health Care 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

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)
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	0.000072182% 2015 Annual Premiums Collected	Health Care Trust Fund
Prescribed Pediatric Extended Care Centers	Licensure Fee	s. 400.905(2), F.S.	$3,000	2007	Yes	$1,512.35	Health Care Trust Fund
Residential Treatment Facilities	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
Transitional Living Facilities	License Fee	s. 400.9972(2), F.S.	None	2007	Yes	$4,588 + $90 per bed	Health Care Trust Fund
Workers' Comp Managed Care Arrangements	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 BUREAU OF FINANCIAL SERVICES ENTERPRISE FINANCIAL SYSTEM

For Fiscal Year 2017-18

October 15, 2016

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: October 15, 2016
Project Name: Bureau of Financial Services Enterprise Financial System	Is this project included in the Agency's LRPP? ____ Yes X No
FY 2017-18 LBR Issue Code: 36308C0	FY 2017-18 LBR Issue Title: Bureau of Financial Services Enterprise Financial System
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Anita B. Hicks, Chief Financial Officer , (850) 412-3815, anita.hicks@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: Justin M. Senior, Interim Secretary	Date: 10/12/16
Agency Chief Information Officer (or equivalent): [signature] Printed Name: Scott Ward, Chief Information Officer	Date: 10/13/16
Budget Officer: [signature] Printed Name: Anita B. Hicks, Chief Financial Officer	Date: 10/12/16
Planning Officer: [signature] Printed Name: Anita B. Hicks, Chief Financial Officer	Date: 10/12/16
Project Sponsor: Tonya Kidd Printed Name: Tonya Kidd, Deputy Secretary - Operations	Date: 10/12/16
Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Anita B. Hicks, (850) 412-3815, Anita.Hicks@ahca.myflorida.com
Cost Benefit Analysis:	Anita B. Hicks, (850) 412-3815, Anita.Hicks@ahca.myflorida.com
Risk Analysis:	Anita B. Hicks, (850) 412-3815, Anita.Hicks@ahca.myflorida.com
Technology Planning:	Anita B. Hicks, (850) 412-3815, Anita.Hicks@ahca.myflorida.com
Project Planning:	Anita B. Hicks, (850) 412-3815, Anita.Hicks@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 that are similar to the service level agreements currently in use, 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 Technical Solution
- 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 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. Business Case – Strategic Needs Assessment

A. Background and Strategic Needs Assessment

1. Business Need

The Agency for Health Care Administration *(hereinafter "AHCA" or "Agency")*, Bureau of Financial Services *(hereinafter "Bureau")* currently utilizes, and relies upon, a mission-critical, but outdated client-server, Visual FoxPro 9.0 database financial system *(hereinafter "Enterprise System")* in conjunction with a few stand-alone, outdated Visual FoxPro applications and manual processes to:

- Interface with the State accounting system (Florida Accounting Information Resource [FLAIR]);
- Manage Medicaid Accounts Receivable;
- Manage Hospital Accounts Receivable;
- Calculate statewide Medicaid assessments and fees;
- Run detailed and summary management reports to monitor daily, monthly, and year-end financial activities, including, but not limited to *(Trust Funds, Budgeting, Accounts Receivable, Payroll, and Cost Allocations);*
- Identify and track expenditures for federal and state reporting purposes;
- Allocate overhead and other administrative costs, to reconcile expenditures to various accounting systems;
- Store financial and budgeting transactional data;
- Perform federal reporting and allocation of personnel hours;
- Process federal grants;
- Manage, track and report trust fund activities;
- Perform cash analysis;
- Perform budgeting activities;
- Track and allocate payroll and phone expenditures; and
- Monitor performance statistics.

The current, mission-critical Enterprise System, and a few remaining stand-alone financial applications utilized by the Bureau for the purposes as described above, were developed exclusively in the "Visual FoxPro" programming language. Although "Xbase" languages were ubiquitous in the 1980's and 1990's, Visual FoxPro is definitively an aging client-server *(non web-based)* Xbase programming language that is no longer supported by Microsoft, and in general, the overall Information Technology community. The last/final Visual FoxPro version (9.0) was released by Microsoft in **2004**. Microsoft had an "extended support" timeframe for the language, applicable only to some of its older operating systems. However, that final support period ended January 13, 2015. Supported software includes a monthly and an ad hoc cycle of patching for bugs and vulnerabilities. Unsupported software will not receive the necessary security and vulnerability patches needed to prevent cybersecurity threats and attacks.

Due to age, increased state and federal Health Insurance Portability and Accountability Act (HIPAA) requirements, data security and encryption requirements, decreased internal AHCA institutional knowledge, emerging technologies, and lack of technical support by Microsoft and the Information Technology community; the Visual FoxPro programming language, integrated database and end-user interface architecture are considered a "legacy" solution. The knowledge and maintenance support base for this language and database architecture is almost obsolete in the Information Technology industry.

An inverse relationship currently exists between maintenance costs and programmer/consultant availability. In other words, maintenance costs will continue to increase due to the increasing scarcity of programming expertise for this legacy architecture. In addition, because of federal guidelines related to HIPAA; internal Agency security procedures; internal institutional knowledge, and increased data sharing requirements between agencies and reporting requirements with other public entities, the ongoing maintenance and enhancement of these legacy Visual FoxPro systems have become unadvisable, imprudent, risky, as well as costly.

Pursuant to chapter 20.42, Florida Statutes, wherein the Agency is tasked as the chief health policy maker and planning entity for the State of Florida. The risks, concerns, and issues of relying upon this existing legacy architecture are herein being addressed.

Beginning in the Fiscal Year 2014-2015, the Agency procured a vendor that consolidated numerous, existing and disparate FoxPro applications; *(some written as early as 1989),* since then the Agency has received specific appropriations for Years 2 and 3 totaling $300,000 in non-recurring funds for Fiscal Years 2015-2016 and 2016-2017 respectively. With that funding the Agency has stabilized the Enterprise System data structures and ensured the accurate reconciliation between the Agency's internal databases with FLAIR. The Enterprise System stabilization and consolidation initiative accomplished the following:

- Using Visual FoxPro, the client-server Enterprise System now currently and accurately manages over **$1 billion** in annual Agency Accounts Receivables *(not including all Medicaid dollars)*;
- Annual database transactions exceed 1 million;
- Capitalized on twenty-five years of Agency FoxPro programming past efforts while simultaneously improving the end-user interfaces; database structures; reporting; external interfaces to third party systems; and detailed and aggregate reporting;
- Averted a crisis wherein most mission-critical, outdated, disparate Visual FoxPro systems were failing due to incompatibility with the local-area and wide-area network, software upgrades and current network security technologies *(i.e. antivirus software)*; and
- Avoided the costs associated with a two to three-year "Business Process & Needs Analysis."

The Fiscal Year 2014-2015 stabilization and consolidation initiative of disparate Visual FoxPro financial systems was considered by the Agency as a short-term solution and success. As stated above, the strategic, **short-term** goal of creating a consolidated Visual FoxPro Enterprise system was to capitalize on historical programming efforts and avoid a reconciliation and audit crisis due to the failure of existing legacy financial systems and related external interface failures.

The consolidation and reconciliation initiative was successful; the Visual FoxPro Enterprise System is currently in production; financial transactions reconcile with FLAIR and Department of Health Financial Information System (DOH FIS); external interfaces are now functioning correctly; end-user screen interfaces have stabilized; data indexing problems have been eliminated; detailed and aggregate financial reporting of Agency expenditures is accurate; **the short-term crisis was averted**.

Although the short-term crisis was averted, the need to convert this non-supported, aging environment to a newer, scalable, industry supported, web-based technology, with improved security protocols, and data and report sharing capabilities, still remains.

Any/all Agency Visual FoxPro systems, including the Enterprise System, are not expected to accommodate the Agency's information technology, third party interfaces, and budgeting and financial reconciliation long-term needs. **Should this existing system cease to function, over $1 billion in annual cash flows would be in jeopardy.**

2. Business Objectives

The Agency is seeking a long-term, cost effective, client-server to web-based transition plan and implementation solution. **The end result of that plan will be to implement a secure, feature-rich, web-based financial solution that adheres to best practice information technology and security protocols.** One of the project's strategic priorities will be to create a scalable financial system that is better able to accommodate the expected long-term needs of the Agency. The Agency intends to seek a qualified Information Technology consulting vendor to assist the Agency with the accomplishment of this goal. During the transitionary phases of this effort the Agency will ensure that Subject Matter Experts (SMEs) will be available to work with the selected vendor.

The selected vendor will:

- **Document** current Bureau manual and automated processes, system architectures and third party interfaces;
- **Maintain** the existing Visual FoxPro Enterprise solution and remaining disparate Visual FoxPro applications;
- **Work in conjunction** with Agency budgeting staff, managers, financial administrators, and information technology staff to **develop a transition plan** that will include the sunsetting and conversion of all existing features of the Visual FoxPro Enterprise System;
- **Propose** a recommendation for a long-term, web-based enterprise level financial solution that successfully replaces all Enterprise System features and meets current technology standards as well as internal Agency information technology governance standards;
- **Develop** a scalable, approved web-based financial solution and ensure a smooth transition of the Bureau's current capabilities through the inclusion of ALL features of the existing Enterprise financial system;
- **Convert ALL existing Enterprise System features** *(including ALL financial data)* to the new web-based system;
- **Maintain HIPAA compliance** and integrity of all data;
- **Implement a solution** within an Agency approved timeframe;
- **Provide training** *(via in-house workshops)* of the new web-based system to all relevant Bureau, Agency and third party personnel;
- **Provide adequate documentation** on the new web-based system; and
- **Develop a long-term maintenance plan** of the new web-based solution.

In summary, the proposed web-based financial solution must include the following:

- Seamless transition from the existing client/server relational database environment to a web-based relational database environment with Agency and state required security features and protocols.
- A single sign-on that is trackable by IP (Internet Protocol) address.
- A robust access model that allows for the following *(or similar)* user roles:
    - Administrator
    - Manager
    - Interim Manager
    - Budget
    - Security Officer
    - Local Agencies / Outside User Access
    - Guest

- A web-based solution that utilizes an agreed upon architecture with hosing to be determined at a later time. However, as information becomes available, the Agency will ensure that any systems developed will include the ability to integrate with the enterprise solution that replaces the current statewide accounting system.

B. Baseline Analysis

1. Current Business Processes

Pursuant to chapter 216, Florida Statutes, regarding the responsibilities outlined in chapter 40.24 Florida Statutes, the Bureau is actively engaged in completing its Long Range Program Plan (LRPP). The most present task is: "To ensure the operation of an efficient and effective government agency."

The Agency core values are:

- Accountability
- Fairness
- Responsiveness
- Teamwork

From a high-level perspective, the long-term goal of this client-server to web-based information technology conversion initiative must be in alignment with the Agency's core values.

Accountability

It is imperative that the implemented solution ensures that the Agency remains 100 percent confident in its ability to accurately report Medicaid, Budgeting, and other financial data.

Fairness

To ensure the fair and proper usage of funds.

Responsiveness

This initiative is predicated upon the requirement that quick and accurate responses to public entities that need access to the Agency's financial statistics are met.

Teamwork

To ensure that all Agency short-term and long-term needs are met, and that all existing features of the existing Enterprise System are successfully converted and implemented, internal Agency personnel will work closely with the selected vendor for the entire life-cycle of this conversion project.

****

External Interfaces

The third party data interfaces of the existing Enterprise System are critical to data accuracy, reconciliation, detailed and aggregate reporting. The external interfaces include:

- FLAIR
- PeopleFirst,
- SunCom,
- DOH FIS, and
- FACTS – Fraud and Abuse Case Tracking System

Interfaces are always an important component of any financial system because interfaces facilitate the data standardization and normalization between two or more disparate information technology architectures. For example, the FLAIR interface is particularly important to the existing Enterprise System due to the amount of granular data that is stored on the State mainframe that must be transferred to the Bureau daily. Much of the transactional, financial and budgeting data in the existing Enterprise System is predicated upon the data derived from FLAIR via the daily interface. It is imperative that ALL existing, external interfaces *(listed above)* continue to function as currently designed (or an improved design) in the implemented web-based solution. Firewall and other server security issues will become more of an issue in a web-based system than they currently are in the existing client-server environment because the existing client-server Visual FoxPro systems resides on an Agency internal file server – a web-based solution may not. These issues, where applicable, must be quickly identified and resolved *during* the conversion.

a. Connections/Interfaces to Other Systems

System Name	Description	Connects To
FLAIR	The Florida Accounting Information Resource (FLAIR) is the backbone of all of Enterprise. More data goes to and from FLAIR than between any other connection in the system.	Daily Downloads
FACTS	The FACTS system is managed by a vendor and is hosted in the cloud for AHCA's use. MAR exports a transactional file to this system.	MAR
PeopleFirst	The Enterprise System utilizes the PeopleFirst Oracle connection for two areas: Time Validation and Health Care Trust Fund. The interface is accomplished via an ODBC connection. The HCTF uses PeopleFirst timesheet data calculate FTE related expenses.	Yes
SunCom	SunCom provides the State of Florida's Voice Services, Data Services, Wiring and Cabling Services, Conference Services, Emergency Support Function - Communications (ESF 2), and E-rate needs, as well as tracking. The Enterprise System performs a direct FTP connection to this server to acquire transactional SunCom data.	Yes

2. Assumptions and Constraints

Assumptions

The following assumptions about this client-server to web-based conversion project are as follows:

- AHCA administrative support (management and non-management) will be available to the vendor to facilitate the conversion and answer specifics related to the business areas being converted.
- Required and necessary resources will be available for utilization within a reasonable timeframe and amount.
- The specific appropriation will be sufficient to complete funding of the project.
- The conversion is expected to take between 2.5 and 3 years.
- The business units' Subject Matter Experts (SME) will be knowledgeable and experienced in their

current business process and available to meet with vendor personnel to communicate their expertise.
- Bureau Staff will be available for any testing necessitated (especially parallel reconciliation testing).
- Vendor Staff will provide appropriate levels of training to Bureau Staff.
- Agency IT will be engaged and support the vendor throughout the project – especially as it relates to firewalls, servers, and third party interfaces.
- Agency IT staff, or IT staff augmented with vendor, have the skills necessary to develop the system.
- Agency IT staff, or IT staff augmented with vendor, will receive project specific training, if needed.
- Agency IT standards in software development will be followed.
- **The conversion will be deliverable-based.**
- Agency IT will assist to ensure that all security protocols are met; especially HIPAA protocols.
- Technical standards will be uniform and adhered to.

Constraints

- The budget to complete the conversion will **NOT** exceed $4.6 million.
-
- All deliverables will be agreed upon via the Approved Conversion Plan.
- Each deliverable will require stakeholders' approval.
- Migrating interfaces from client-server to web-based system may require automated job configuration changes.

C. Business Process Requirements

1. Proposed

The existing Enterprise System is a stable, client-server Visual FoxPro system that is no longer supported from a programming language or database perspective. In the Fiscal Years 2014-2015 and 2015-2016, numerous, disparate Visual FoxPro systems were combined into this, now functioning, Enterprise System. During this legacy consolidation and reconciliation endeavor, existing Bureau process flows were taken into account. Therefore, it is not expected that existing business processes that are associated with the existing system features will need to significantly change to accommodate the conversion to a web-based system. In fact, because current business processes were thoroughly reviewed, a "Business Needs Analysis" vendor contract was not needed, thereby resulting in explicit savings to the Agency over the course of the last three years.

The conversion of the client-server Enterprise System to an approved web-based solution, from a business process requirements perspective, is expected to be straight-forward. The selected vendor will be required to take ALL existing features of the existing Enterprise System *(including all data)* and convert those features, along with implicit business processes to a functioning web-based solution. This will be accomplished through deliverables. The Agency will not pay for the deliverable until it has been approved by Bureau staff.

Should changes to business processes be required during the conversion timeframe (2.5 – 3 years), these changes will be categorized as: Critical or Non-Critical as agreed to by the Executive Governance Committee. Critical changes will need to be incorporated into the new system. Any additional costs associated with the critical change will need to be agreed upon between the Agency and the selected vendor. Non-critical changes will be documented, prioritized and decisions regarding their implementation AFTER the successful conversion of the Enterprise System *(all existing features)* will be decided upon by the Agency.

The web-based system must have the business and technical requirements (deliverables) as outlined in the following table:

a. Business and Technical Requirements

Business Requirements / Deliverables	Technical Requirements
Daily FLAIR FTP Import/Update	See Attachment (Req Matrix), Requirement 2
Daily Cash Import/Update	See Attachment (Req Matrix), Requirement 3
Daily Report Coding Tables Import/Update	See Attachment (Req Matrix), Requirement 4
POS95 & List Tables	See Attachment (Req Matrix), Requirements 6-22
Medicaid Accounts Receivable (MAR)	See Attachment (Req Matrix), Requirements 23-89
Hospital Accounts Receivable (HAR)	See Attachment (Req Matrix), Requirements 90-128
Automated Journal Transfers (AJT)	See Attachment (Req Matrix), Requirement 129
Overpayment Fraud Recoupment (OFR) Personnel	See Attachment (Req Matrix), Requirement 130
Overpayment Fraud Recoupment (OFR) Account Code & Rate Setup	See Attachment (Req Matrix), Requirement 131
Overpayment Fraud Recoupment (OFR) Memo	See Attachment (Req Matrix), Requirement 132
Post Budget	See Attachment (Req Matrix), Requirement 133
SunCom	See Attachment (Req Matrix), Requirements 134-141
HCTF	See Attachment (Req Matrix), Requirements 142-145
Administrative Trust Fund (ATF) Rates	See Attachment (Req Matrix), Requirement 146
Administrative Trust Fund (ATF) Memo	See Attachment (Req Matrix), Requirement 147
General Ledger Reports	See Attachment (Req Matrix), Requirement 150
Encumbrances	See Attachment (Req Matrix), Requirement 151
Medicaid Refund Totals	See Attachment (Req Matrix), Requirement 152
Time Validation	See Attachment (Req Matrix), Requirements 153-173
Payroll	See Attachment (Req Matrix), Requirements 174-186
Transaction History	See Attachment (Req Matrix), Requirement 187
Payroll	See Attachment (Req Matrix), Requirement 189

Account Balance Inquiry	See Attachment (Req Matrix), Requirement 190
Database to Spreadsheet	See Attachment (Req Matrix), Requirement 191
Daily Cash Reports	See Attachment (Req Matrix), Requirement 196
Summary Trial Balance	See Attachment (Req Matrix), Requirement 201
Various System Components	See Attachment (Req Matrix), Requirement 202-207

2. Business Solution Alternatives

A. Continue with existing system
The existing client-server, Visual FoxPro Enterprise solution is not expected to meet the Agency's long-term needs. Due to lack of support in the IT industry, continuing with the existing system is NOT considered a viable option. The legacy system must be sunsetted or the Agency must plan to face the potential of cybersecurity and other risks associated with unsupported operating systems.

B. Commercial Off-The-Shelf-Software (COTS)
Because of the unique Agency business financial processes, FLAIR integration, and other unique third party interfaces *(i.e. SunCom and PeopleFirst)*, a COTS system is not available. The proposed solution will have to be a custom solution designed specifically around the current business process needs of the Bureau and Agency.

C. Implement a Solution from another State Agency
While there ARE some similarities between the Agency's FLAIR financial queries and other state agencies financial queries, the uniqueness of AHCA's programs (i.e. Medicaid Accounts Receivable, Federal Grant requirements, etc.) prohibit the "borrowing" or "copying" of a system from another State agency.

3. Rationale for Selection

The rationale for selecting the development of a customized, scalable web-based financial solution versus one of the business solution alternatives listed above is predicated upon the optimal satisfaction and adherence to existing Bureau business processes, satisfaction of long-term needs, cost mitigation, adherence to HIPAA standards, maximization of security protocols, and growth.

4. Recommended Business Solution

The recommended business solution is to convert ALL features *(documentation, data, screens and reports)* of the existing client-server Visual FoxPro Enterprise System to a scalable, custom, web-based ASP.NET, SQL Server solution.

D. Functional and Technical Requirements

Please See Attached Appendix G – Requirements Traceability Matrix

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III. Success Criteria

The existing Visual FoxPro Enterprise System is utilized daily by almost all Bureau staff. It satisfies the FLAIR daily data query and other third party data transfer needs of the Bureau. The web-based solution will be considered a success if it does the same with the following augmentations:

- The existing Visual FoxPro Enterprise system has limited user security profiles. Because limited information is expected to be shared with other third parties, security profiles in the new web-based solution need to accommodate multiple levels and capabilities.
- Relationships between relational databases *(primary, secondary keys)* will be better established in the database container.
- Designated detailed and aggregate reports will be made available to outside agencies so that constant spreadsheet transmissions via email and the Intranet are eliminated.
- All reports must be downloadable to PDF or Microsoft Excel.
- Minor enhancements due to newer technologies (i.e. ability to edit within grids) should be implemented.
- Formal training for all users *(at the AHCA location)* should be performed as each deliverable is placed into production.
- Existing documentation must be changed to accommodate the new screen structures and features of the web-based solution.
- Implemented solution must adhere to Agency Information Technology standards.
- Best practice website and database encryption standards must be incorporated.

SUCCESS CRITERIA TABLE				
#	**Description of Criteria**	**How will the Criteria be measured/assessed?**	**Who benefits?**	**Realization Date (MM/YY)**
1	System is developed in a more modern language	Bureau leadership will be presented with this information at Vendor's Presentation	AHCA	TBD
2	System is web-based	System will be accessible via agency-accepted browser versions	AHCA	TBD
3	Health Care Trust Fund Module (HCTF) will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
4	Time Validation Module (TVM) will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
5	Medicaid Accounts Receivable Module (MAR) will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
6	Hospital Accounts Receivable Module (HAR) will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD

7	Automated Journal Transfer (AJT) feature will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
8	Administrative Trust Funds (ATF) feature will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
9	Overpayment Fraud Recoupment (OFR) will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
10	SunCom feature will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
11	Payroll Module will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
12	Budget Spend Plan feature will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
13	Encumbrances will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
14	Cash Reports will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
15	New web-based system will connect to FLAIR and will be functional as in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
16	New web-based system will connect to PeopleFirst and the queries will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
17	System will send relevant data to FACTS and will be functional as is in Enterprise System	Vendor Testing; User Acceptance Testing (UAT)	Bureau Staff	TBD
18	Staff is satisfied with all deliverables in the new system web-based system	Simple Survey	Vendor; Bureau Staff	08/2019
19	80% of deliverables delivered within their established timeframes	Review of Project Plan	Bureau; Vendor	08/2019
20	The project is delivered within 10% of its total agreed-upon	Contract Quotes vs. Invoices & Final	AHCA	08/2019

	budget.	Invoice		
21	Usability on IE 11, IE 10, and Google Chrome browsers (or agreed-upon browsers)	Vendor Testing	Bureau	04/2019
22	User security profiles conform to State and Agency best-practice standards	AHCA IT; Vendor Testing	AHCA	04/2019
23	End-user training to be provided to all relevant Bureau and Agency personnel	Survey within AHCA	Bureau Staff	TBD
24	All data from the Enterprise System is accurately transferred to the new web-based system	Vendor Testing	Bureau Staff	TBD
25	Stakeholders outside of the Agency are allowed reasonable access to the system, as deemed applicable by Bureau management	Bureau Testing	Agency at large	TBD
26	Security roles are accessed, defined, applied and enforced	Vendor; Bureau Testing	Bureau Staff	TBD
27	Data is stable and financial reports, based upon the data, reconcile between the web-based system and the existing Enterprise System	Vendor; Bureau Testing	Bureau; Agency Staff	TBD
28	System is documented, and documentation will be provided to AHCA IT staff	Bureau Testing	Bureau Staff	TBD

IV. Benefits Realization and Cost Benefit Analysis

A. Benefits Realization Table

BENEFITS REALIZATION TABLE					
#	Description of Benefit	Who receives the benefit?	How is benefit realized?	How is the realization of the benefit measured?	Realization Date (MM/YY)
1	Consolidated Enterprise System with a single sign-on, increased accuracy, security, functionality, efficiency, reliability, compatibility and a well-documented system	Agency Staff; Management Team; Bureau Staff	Accurate monitoring and reporting of over 1 billion in annual transactions.	Time - In Bureau Staff time that is saved and applied to meet other goals and directives, which will be measured by comparing time log studies before and after full transition is completed for specific tasks. Efficiencies - In efficient reporting that is used for weekly, monthly, quarterly and annual reporting (State, Federal) which will be realized in the accuracy of reports and measured in comparison of manual reporting processes and the newly implemented web-based reporting process. As each process is documented, to include all manual processes, it will become the benchmark for which the Agency will measure against.	Project end date

2	Risk reduction due to the replacement of the unsupported legacy system in the AHCA enterprise.	AHCA	Once all the FoxPro 9.0 legacy systems are replaced, regular security and vulnerability patching can commence.	Measured by the reduction in risk as indicated on the periodic IT Risk Assessments.	As each module is rolled out there will be a reduction in risk.

B. See Attachment Cost Benefit Analysis

Please See Attached Appendix A – Cost Benefit Analysis

V. Major Project Risk Assessment

C. Risk Assessment Summary

Please See Attached Appendix B– Project Risk Assessment Summary

VI. Technology Planning

Purpose: To ensure there is close alignment with the business, functional requirements and the selected technology.

A. Current Information Technology Environment

1. Current System

a. Description of current system

The existing Visual FoxPro Enterprise System is an interactive, multi-user client-server relational database financial and budgeting system that utilizes a streamlined, step-by-step, end-user interface. The code and database structures are exclusively Microsoft Visual FoxPro 9.0.

The Enterprise System is currently:

- Stable;
- Contains features and major modules that align with the Bureau's current business processes;
- Integrates with SunCom, PeopleFirst, and FLAIR;
- Reconciles with FLAIR daily;
- Predicated upon 20 years of in-house Visual FoxPro programming;
- Contains limited security;
- Runs on the Agency's local area network (LAN); and
- Contains no outside/third party access to data or reports.

In addition:

The Enterprise System is currently:

- Within a mapped LAN environment.
- Each end-user executes an instance of the system from within the Bureau's LAN. Outside agencies, end-users or third parties cannot access the system. **This inability to selectively share data and reports with entities at all levels of government (and private entities) who could benefit from this information is considered to be a major limitation of the existing architecture.**
- Existing, bureau end-users have direct access to system databases. This capability is considered another security disadvantage of the existing system.
- From a network perspective, the existing system is not limited by disk space.

There are approximately 34 concurrent users; however, this number has remained somewhat limited due to the fact that updating the system can be difficult as concurrent users increase and by the fact that third party entities cannot gain access to the system. While there is not a maximum limit on the number of concurrent users, all users MUST have mapped access to the internal server on which the client-server system resides. As of the writing of this document, all users have access to all system features. End-user security profiles *(by module)* have not yet been implemented. To date, there are no known abuses of user's performing prohibited functions; however, there are long-term security concerns regarding end-users who have direct access to all client-server databases, especially in regards to HIPAA.

The existing, client-server Enterprise System is currently processing over one million annual transactions and nearly $1 billion in annual receivables. If left in an unsupported state, the potential for security risks is amplified and the systems processing these annual receivables could be compromised leaving the Agency with fiduciary responsibilities that are unable to be met. The emphasis is on the mission critical functions that these systems support and their requirement to function as intended in order to meet the needs of the Agency.

b. Current system resource requirements

The Visual FoxPro environment and architecture, while old, was very efficient in regards to compact code and streamlined database sizes. Visual FoxPro is a "compiled" language. End-users invoke a single

executable file. The current system *(including all data)* can fit on a single flash drive. The system is approximately 9 GB in size *(including all data)*. This total does NOT include spreadsheets, reports or other documents saved and sent via manual processes or other electronic forms. From a disk space perspective, the system utilizes minimal requirements.

The FLAIR daily download FTP files must be "manually" imported each morning. In a web-based environment, this process would be eliminated via an automated SQL Server stored procedure. To achieve a connection to PeopleFirst, an ODBC driver must be installed on select end-user workstations. The connection to SunCom utilizes an old non-secure DOS FTP connection.

The system needs 17 MB of RAM for a single user when starting up. Testing revealed a peak usage of 50 MB of usage for less than a minute, while stabilizing to 33 MB of RAM after executing complex tasks. Due to its intranet nature, the resources needed are relatively small. The system supports multiple users, and because the bulk of the system resides in each end-user's PC memory, the system isn't significantly affected by any increase in concurrent users. That said, the system is very slow due to the amount of I/O that Visual FoxPro performs across the LAN – especially when querying larger databases.

c. Current system performance

The Enterprise System is slow. The Visual FoxPro environment is very fast when databases remain under one-hundred thousand records. However, the TRHIST annual database contains over one million records. Queries against this large database, which occur multiple times daily, by multiple users, cause considerable delays in achieving desired reporting results. Reports are accurate, but slow.

Calculations are fast. Many of the system features *(Health Care Trust Fund, Time Validation, Automated Journal Transfers, Medicaid Accounts Receivable, etc.,)* contain extremely complex and lengthy calculations. Visual FoxPro performs these calculations very rapidly because it is a compiled environment working at a binary level.

A local information technology consulting vendor is responsible for maintaining the existing Enterprise System. Over the last two years, the vendor has consolidated almost all the disparate Visual FoxPro systems into one system - The Enterprise System. The vendor has two resources that are considered "experts" in the Visual FoxPro and financial and budgeting environments.

The system is currently stable and accurate - there are no immediate crises, but the outdated client-server system obviously cannot continue indefinitely. The system will have problems coping with growth.

2. Information Technology Standards

The standard for all software development is web-based technology. Conversely, the existing Enterprise System is "client-server" based. This is an aging technology.

As of the writing of this document, the Agency standard for web development is ASP.NET (4.5 Framework), SQL Server 2014.

From a security standards standpoint:

Password Requirements for a web-based solution:

- All users will be required to change their passwords in compliance with Rule 74-2, Florida Cybersecurity Standards..
- The system will automatically require password changes *(all users).*
- Passwords will be changed to a minimum of 8 characters and must include at least one of the following: capital letters, special characters and numbers.
- Users will not be able to set their password to their User ID.
- The last six passwords for each user will be stored in an encrypted table.
- All passwords stored in the system will be encrypted.
- Passwords will be masked as they are typed.
- Users will be prompted to change password *(immediately after login)* whenever a temporary password is emailed via the "Forgot Your Password" button.
- Only ***temporary*** passwords will be emailed to users who have forgotten their password.

- Temporary passwords will be generated using a random generator algorithm.

Other audit features for a web-based solution:

- All User Logins will be tracked and stored in a permanent log (table). The log will include successful ***and*** unsuccessful logins. As part of the log, the IP address from where the user accessed *(or attempted to access)* the system will be stored. The log will be available to Security Officers and Administrators only. At a minimum, it will be searchable by user ID and date range.
- Four Unsuccessful Login attempts will result in the "Active User" checkbox being disabled. This will effectively "lock-out" that user until the Security Officer User Role re-enables the checkbox. The Security Officer role will be notified, via email, that a user has been de-activated due to unsuccessful logins.
- A popup notification screen will be created, which will appear to the Security Officer role. This screen will show all Interim Manager temporary users. This feature is similar to the existing popup notification "Pending FSR" screen.

Activity Tracking

The following activities *(listed below)* will be permanently tracked by Username and IP Address and stored in a log *(table)*:

- Deletions (All), including Temporary Batch Table Payment deletions,
- Users Created and Deleted, and
- FSRs that are "Un-approved."

The log will be searchable by User ID or Date Range, and will only be accessible by Administrators. The Security Officer and Administrator roles will have access to this log.

B. Current Hardware and/or Software Inventory

The existing Enterprise System resides on an internal DOH/SSRC server. Because the technology is client-server based, the hardware requirements are limited. Within the Bureau, standard hardware is a Lenovo ThinkCentre M series with an Intel i5 CPU chip that runs up to 3.2 GHz. Additionally, some staff use state issued tablets which use a USB hub to connect. Most employees, including supervisors, have dual Dell flat panel monitors. Most, if not all of the computers are hardwired into the network via Ethernet cables. The main peripherals, including a mouse and keyboard, are connected using USB connections. The operating system on each computer is Windows 7 Enterprise, Service Pack 1. The tablets all utilize the Windows 10 operating system. As of the writing of this document, bureau computers run Windows 7 operating system, Internet Explorer version 10.0.9200.17566. Microsoft Office 2013 is available for all staff to draft, edit and produce their reports and other work.

Within the Enterprise System, most data are exported in spreadsheet form. These spreadsheets are either saved locally or to a common, shared, network drive. The existing Enterprise System has "pointers" to Microsoft Word files, but these files are not stored "within" the system. The system contains "links" to these external network files.

Given the current client-server technology, there are no foreseeable needs to upgrade Bureau hardware, or associated software.

Important:

Because Visual FoxPro technology is aging and is no longer supported by Microsoft, scheduled updates to servers and/or scheduled updates to end-users operating systems and/or scheduled updates to other network software applications could result in a fatal system shutdown. In fact, this scenario occurred in 2015 when a new, approved and vetted, anti-virus software package was placed into production throughout the Agency. That software caused many of the older FoxPro systems to "crash". The crises were avoided

when a local vendor upgraded the aging systems from older versions of FoxPro to Visual FoxPro 9.0., which is also old.

In summary, because Microsoft FoxPro is no longer supported by Microsoft, an upgrade to a new operating system *(i.e. Windows 10)* throughout the Agency could result in the entire Enterprise Financial System ceasing to function throughout the Bureau.

C. Proposed Solution Description

1. Summary description of proposed system

- The Bureau is seeking a custom, secure, web-based, relational database financial solution that replicates all features of the existing Enterprise System via the implementation of specific deliverables.
- All Enterprise System data *(including historical data)* must be accurately converted to SQL Server.
- The proposed solution will utilize a front-end graphical user interface that allows users to navigate, query, enter data, and perform their other relevant financial and budgeting duties.
- The proposed solution will interface with FLAIR, FACTS, SunCom and PeopleFirst.
- Whenever/wherever possible, the proposed solution will improve upon existing Enterprise user interface features without significantly changing those features.
- The proposed solution will have improved user-security profiles including a security matrix by user, by business module.
- The proposed solution, when applicable, will allow the Bureau and outside agencies to provide collaborative opportunities for information.
- The proposed solution will be scalable in regards to users and data.
- The proposed solution is expected to have, with ongoing maintenance, a shelf-life of eight to ten years.
- While some features in the proposed solution may be required for technology reasons or best practices for a web-based system, it is preferred that the new system is similar in functionality to the existing Enterprise system.
- The proposed solution will be properly documented (both within the source code and end-user documentation).

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

Agency will request a specific appropriation (non-recurring) for each year of this project. This project is expected to cost $4.5 million, distributed over a period of three years. This "not to exceed" amount will cover the costs of analysis, solution development, implementation and training of staff. Please see attached "Project Management Plan."

D. Capacity Planning
(historical and current trends versus projected requirements)

A capacity plan is outside of the scope of this document

VII. . Project Management Planning

Purpose: To require the agency to provide evidence of its thorough project planning and provide the tools the agency will use to carry out and manage the proposed project. These documents adhere to AST standards and best practices:

A. Cost Benefit Analysis

See Appendix A – Cost Benefit Analysis

B. Risk Management Plan

See Appendix B – Project Risk Assessment

C. Implementation Plan

See Appendix C – Implementation Plan

D. Change Management Plan

See Appendix D – Change Management Plan

E. Quality Management Plan

See Appendix E – Quality Management Plan

F. Project Log Workbook

See Appendix F – Project Log Workbook

G. Requirements Traceability Matrix

See Appendix G – Requirements Traceability Matrix

VIII. Appendices

A. Glossary of Terms

Agency	Agency of Health Care Administration
AHCA	Agency of Health Care Administration
AST	Agency for State Technology
AJT	Automated Journal Transfers - Allows for automatic allocation of funds to the correct funding account
ATF	Administrative Trust Fund
BE	Budget Entity
Bureau	AHCA's Bureau of Financial Services
Cat.dbf	A database file that contains category numbers
Client-Server	Network architecture in which each computer or process on the network is either a client (end user) or a server (where information lives, is accessed from, and saved to). Each of the clients directly connect to the server utilizing a number of connection protocols. In this document, the terminology refers to a centralized server, of which the clients (staff) must directly connect to the server (Enterprise).
CPU	Central Processing Unit - This is the part of the computer that does the thinking
CUR_MAS	Current_Master - An extremely important file in Enterprise and is where much of the data is copied from for further analysis and manipulation within Enterprise
Data	A piece of information
Database	An organized collection of data
.dbf	The file extension for database files
DFS	Department of Financial Services
Ethernet	A standard networking technology that allows the efficient and simple dispersion of wired internet on the local and wide area network levels. Certain flavors of Ethernet cords could deliver up to 400 Gb/s of internet speed.
Enterprise /E9	A custom built accounting platform for AHCA's Bureau of Financial Services written in Visual Fox Pro 9 and is a stable, reliable platform as of this writing

ENC	Encumbrance
EO	Expansion Options
ES	Expansion Set
EXT_PGM / EXT_PGM.dbf	External Programs database file
FA	Finance and Accounting
FACTS	Fraud and Abuse Case Tracking System is an Agency web-based system that MAR uploads data to.
FLAIR	The Florida Accounting Information Resource (FLAIR) is a double entry, computer-based, general ledger accounting system, which is utilized to perform the State's accounting and financial management functions. As provided in State law, FLAIR plays a major role in ensuring that State financial transactions are accurately and timely recorded. The accounts of all State agencies are coordinated through FLAIR, which processes expense, payroll, retirement, unemployment compensation, and public assistance payments. FLAIR also provides accounting control over assets, liabilities, revenues and expenditures, budgetary history, management and control.
Visual FoxPro	The original programming language that was used to code the Bureau's pre-Enterprise systems. The last service pack (SP2) was initially released in 2004. Visual FoxPro is an object oriented programming language, as well as a relational database management system.
F.S.	Florida Statutes
FTP	File Transfer Protocol. FTP is a standard computer process of transferring data over a Transmission Control Protocol (TCP) network, such as the Internet.
GB	GigaBytes - This is a unit of measure for computer memory that is equal to 1000^3 Byte
GL	General Ledger
HAR	Hospitals Accounts Receivable
HCTF	Health Care Trust Fund
HQA	Health Quality Assurance.
IE	Internet Explorer - the default web browser for many computers in the state
IntranetMachine Date	The date in the system that cannot be accessed by users; it must be changed in the programming, if at all.

MAR	Medicaid Accounts Receivable.
MB	MegaBytes - This is a unit of measure for computer memory that is roughly equivalent to 1000^2 Bytes
Medicaid	Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists the elderly and disabled with the costs of nursing facility care and other medical and long-term care expenses. In Florida, the Agency for Health Care Administration (Agency) is responsible for administrating the Medicaid program.
MHz	MegaHertz.
MySQL	A popular relational database management software utilizing SQL. Second in the 2015 market to Oracle Database.
Oracle	Oracle is a company that owns many commonly used large scale computer technologies. These include the Oracle Database, Oracle Database Connection, Oracle Fusion, and MySQL
OCA	Other Cost Accumulators
Object Code	A unique code associated with collections of expenditures and/or revenue types.
OFR	Overpayment & Fraud Recovery
Org Code	Organization Code - This is the agency-level unique identifier for programs, services, activities.
PeopleFirst	The State of Florida's self-service, secure, web-based Human Resource information system. PeopleFirst is used for various and important portions of Enterprise, including Payroll and Time Validation
Pos95.DBF	Original database where agency-wide personnel data has been saved to for the last 20 years. Is constantly updated and currently curated by staff.
RAM	Random Access Memory
Record(s)	A basic data structure. Can be as small as a single number, or text that is thousands of characters long.
SME	Subject Matter Expert
SQL	Structured Query Language. It is a programming language that is popularly used for database management. SQL is extremely popular for its simplicity and ease of use.
SSIS	SQL Server Information/Interface Service - collection of code that allows for database information transfers
SunCom	The state's phone network system

System	An interconnected group of hardware and software that produces, displays, creates, manages
Tables	An organizational grouping within a database. Can contain vast amounts of fields and rows. Data is held within records.
TR51UP.dbf	A database file uploaded to FLAIR from Overpayment & Fraud Recoupment.
TRHIST/TRHIST.dbf	Transaction History - the file containing a history of transactions
TransHist.dbf	Transaction History database file.
Web-Based	The architecture between the application and the end user. This relationship utilizes the internet to connect the application with the end user, as an extended client-server relationship.
Visual Fox Pro/VFP	Name for the next release of Visual FoxPro, *after* Microsoft had acquired rights to the language.
Visual Fox Pro 9/VFP9	Visual Fox Pro 9 is the final iteration of Visual FoxPro. Microsoft announced that there would be no support for Windows 7, 8, 8.1 or 10. Support for Vista is discontinued as of January 13, 2015.

CBAForm 1 - Net Tangible Benefits

Agency	AHCA	Project	Enterprise System

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	FY 2017-18			FY 2018-19			FY 2019-20			FY 2020-21			FY 2021-22		
(Recurring Costs 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) Cost Change 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 Costs -- Agency-Managed Staff	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A.b Total Staff	0.00	5.00	5.00	0.00	5.00	5.00	0.00	5.00	5.00	0.00	0.00	0.00	0.00	0.00	0.00
A-1.a. State FTEs (Salaries & Benefits)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-1.b. State 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 Staff (Salaries)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-2.b. OPS (#)	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 Contractors)	0.00	5.00	5.00	0.00	5.00	5.00	0.00	5.00	5.00	0.00	0.00	0.00	0.00	0.00	0.00
B. Application Maintenance Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-1. Managed Services (Staffing)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-2. Hardware	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-3. Software	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-4. Other Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C. Data Center Provider Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-1. Managed Services (Staffing)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-2. Infrastructure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-3. Network / Hosting Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-4. Disaster Recovery	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-5. Other Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D. Plant & Facility Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
E. Other Costs	$0	$1,536,000	$1,536,000	$0	$1,536,000	$1,536,000	$0	$1,536,000	$1,536,000	$0	$0	$0	$0	$0	$0
E-1. Training	$0	$67,500	$67,500	$0	$67,500	$67,500	$0	$67,500	$67,500	$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 Contracted Services	$0	$1,468,500	$1,468,500	$0	$1,468,500	$1,468,500	$0	$1,468,500	$1,468,500	$0	$0	$0	$0	$0	$0
Total of Recurring Operational Costs	$0	$1,536,000	$1,536,000	$0	$1,536,000	$1,536,000	$0	$1,536,000	$1,536,000	$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:		($1,536,000)			($1,536,000)			($1,536,000)			$0			$0	

CHARACTERIZATION OF PROJECT BENEFIT ESTIMATE -- CBAForm 1B			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous	☑	Confidence Level	100%
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	Enterprise System			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.***				FY2017-18			FY2018-19			FY2019-20			FY2020-21			FY2021-22			TOTAL
3				$ -		$ 1,536,000			$ 1,536,000			$ 1,536,000			$ -			$ -		$ 4,608,000
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	$ 135,000	$ -	0.00	$ 135,000	$ -	0.00	$ 135,000	$ -	0.00	$ -	$ -	0.00	$ -	$ -	$ 405,000
9	Project oversight to include Independent Verification & Validation (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	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	$ -
11	Separate requirements analysis and feasibility study procurements.	**Project Planning/Analysis**	Contracted Services	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ -
12	Hardware purchases not included in 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	$ -		$ 1,273,500	$ -		$ 1,273,500	$ -		$ 1,273,500	$ -		$ -	$ -		$ -	$ -	$ 3,820,500
15	All first-time training costs associated with the project.	**Training**	Contracted Services	$ -		$ 67,500	$ -		$ 67,500	$ -		$ 67,500	$ -		$ -	$ -		$ -	$ -	$ 202,500
16	Include the quote received from the data center provider 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	$ -		$ 60,000	$ -		$ 60,000	$ -		$ 60,000	$ -		$ -	$ -		$ -	$ -	$ 180,000
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	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ -
21		**Total**		**$ -**	**0.00**	**$ 1,536,000**	**$ -**	**0.00**	**$ 1,536,000**	**$ -**	**0.00**	**$ 1,536,000**	**$ -**	**0.00**	**$ -**	**$ -**	**0.00**	**$ -**	**$ -**	**$ 4,608,000**

CBAForm 2 - Project Cost Analysis

Agency	AHCA	Project	Enterprise System

PROJECT COST SUMMARY	*PROJECT COST SUMMARY (from CBAForm 2A)*					TOTAL
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	
TOTAL PROJECT COSTS (*)	$1,536,000	$1,536,000	$1,536,000	$0	$0	$4,608,000
CUMULATIVE PROJECT COSTS *(includes Current & Previous Years' Project-Related Costs)*	$1,536,000	$3,072,000	$4,608,000	$4,608,000	$4,608,000	
Total Costs are carried forward to CBAForm3 Project Investment Summary worksheet.						

PROJECT FUNDING SOURCES	*PROJECT FUNDING SOURCES - CBAForm 2B*					TOTAL
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	
General Revenue	$0	$0	$0	$0	$0	$0
Trust Fund	$1,536,000	$1,536,000	$1,536,000	$0	$0	$4,608,000
Federal Match ☐	$0	$0	$0	$0	$0	$0
Grants ☐	$0	$0	$0	$0	$0	$0
Other ☐ Specify	$0	$0	$0	$0	$0	$0
TOTAL INVESTMENT	$1,536,000	$1,536,000	$1,536,000	$0	$0	$4,608,000
CUMULATIVE INVESTMENT	$1,536,000	$3,072,000	$4,608,000	$4,608,000	$4,608,000	

Characterization of Project Cost Estimate - CBAForm 2C			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous	x	Confidence Level	100%
Order of Magnitude	x	Confidence Level	100%
Placeholder		Confidence Level	

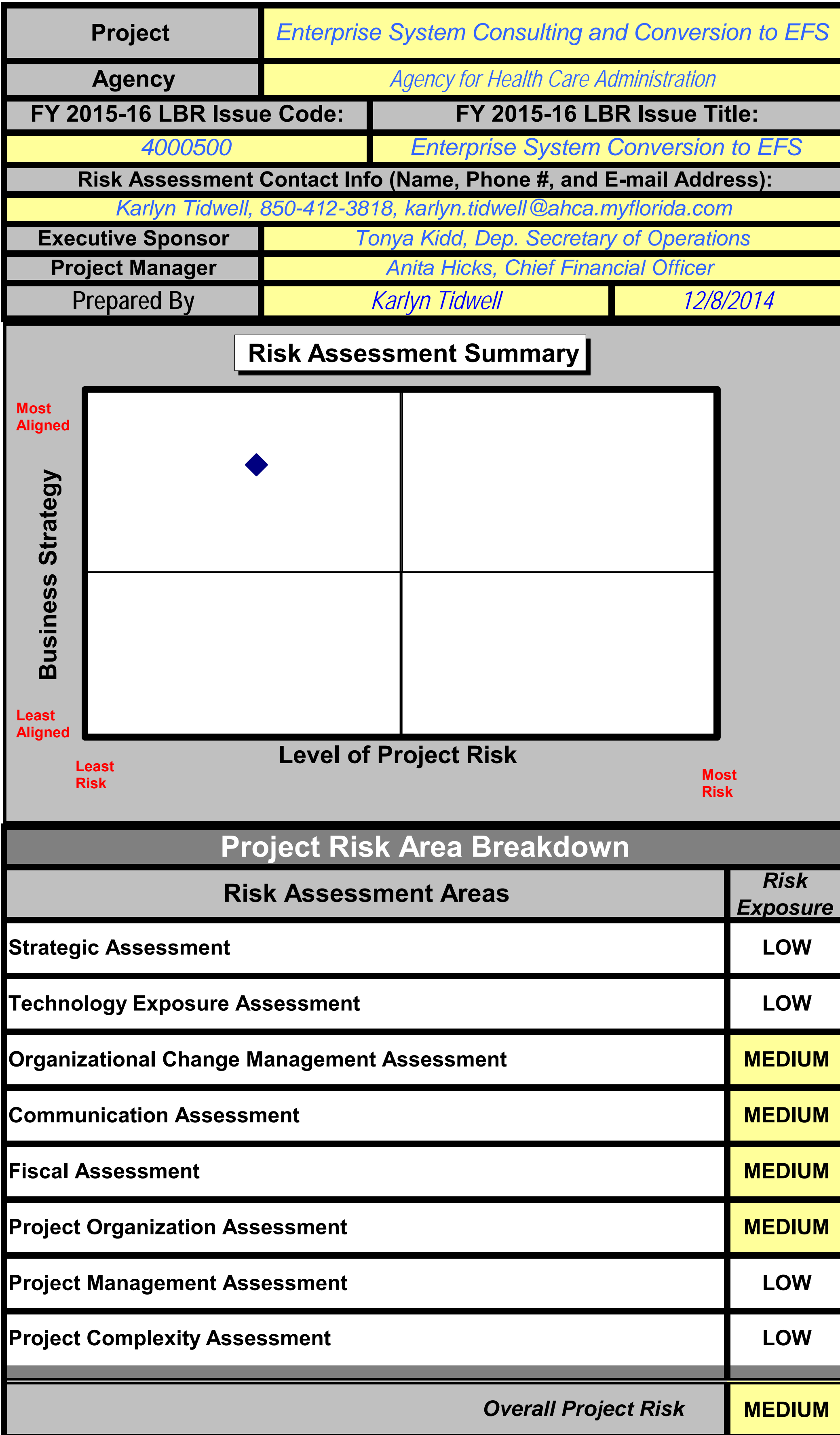
CBAForm 3 - Project Investment Summary

Agency	AHCA	Project	Enterprise System

COST BENEFIT ANALYSIS -- CBAForm 3A						
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	TOTAL FOR ALL YEARS
Project Cost	$1,536,000	$1,536,000	$1,536,000	$0	$0	$4,608,000
Net Tangible Benefits	($1,536,000)	($1,536,000)	($1,536,000)	$0	$0	($4,608,000)
Return on Investment	($3,072,000)	($3,072,000)	($3,072,000)	$0	$0	($9,216,000)
Year to Year Change in Program Staffing	5	5	5	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)	($8,758,827)	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 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Cost of Capital	1.94%	2.07%	3.18%	4.32%	4.85%



Project	Enterprise System Consulting and Conversion to EFS	
Agency	Agency for Health Care Administration	
FY 2015-16 LBR Issue Code:	FY 2015-16 LBR Issue Title:	
4000500	Enterprise System Conversion to EFS	
Risk Assessment Contact Info (Name, Phone #, and E-mail Address):		
Karlyn Tidwell, 850-412-3818, karlyn.tidwell@ahca.myflorida.com		
Executive Sponsor	Tonya Kidd, Dep. Secretary of Operations	
Project Manager	Anita Hicks, Chief Financial Officer	
Prepared By	Karlyn Tidwell	12/8/2014

Risk Assessment Summary

Project Risk Area Breakdown

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

Agency: Agency for Health Care Administration Project: Enterprise System Consulting and Conversion to EFS

Section 1 -- Strategic Area			
#	Criteria	Values	Answer
1.01	Are project objectives clearly aligned with the agency's legal mission?	0% to 40% -- Few or no objectives aligned	81% to 100% -- All or nearly all objectives aligned
		41% to 80% -- Some objectives aligned	
		81% to 100% -- All or nearly all objectives aligned	
1.02	Are project objectives clearly documented and understood by all stakeholder groups?	Not documented or agreed to by stakeholders	Documented with sign-off by stakeholders
		Informal agreement by stakeholders	
		Documented with sign-off by stakeholders	
1.03	Are the project sponsor, senior management, and other executive stakeholders actively involved in meetings for the review and success of the project?	Not or rarely involved	Project charter signed by executive sponsor and executive team actively engaged in steering committee meetings
		Most regularly attend executive steering committee meetings	
		Project charter signed by executive sponsor and executive team actively engaged in steering committee meetings	
1.04	Has the agency documented its vision for how changes to the proposed technology will improve its business processes?	Vision is not documented	Vision is completely documented
		Vision is partially documented	
		Vision is completely documented	
1.05	Have all project business/program area requirements, assumptions, constraints, and priorities been defined and documented?	0% to 40% -- Few or none defined and documented	81% to 100% -- All or nearly all defined and documented
		41% to 80% -- Some defined and documented	
		81% to 100% -- All or nearly all defined and documented	
1.06	Are all needed changes in law, rule, or policy identified and documented?	No changes needed	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	Single agency-wide use or visibility
		Single agency-wide use or visibility	
		Use or visibility at division and/or bureau level only	
1.10	Is this a multi-year project?	Greater than 5 years	Between 1 and 3 years
		Between 3 and 5 years	
		Between 1 and 3 years	
		1 year or less	

Agency: Agency for Health Care Administration Project: Enterprise System Consulting and Conversion to EFS

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

Agency: Agency for Health Care Administration Project: Enterprise System Consulting and Conversion to EFS

#	Criteria	Values	Answer
Section 3 -- Organizational Change Management Area			
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	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	Less than 1% contractor count change
		1 to 10% contractor count change	
		Less than 1% contractor count change	
3.07	What is the expected level of change impact on the citizens of the State of Florida if the project is successfully implemented?	Extensive change or new way of providing/receiving services or information)	Minor or no changes
		Moderate changes	
		Minor or no changes	
3.08	What is the expected change impact on other state or local government agencies as a result of implementing the project?	Extensive change or new way of providing/receiving services or information	Minor or no changes
		Moderate changes	
		Minor or no changes	
3.09	Has the agency successfully completed a project with similar organizational change requirements?	No experience/Not recently (>5 Years)	Recently completed project with similar change requirements
		Recently completed project with fewer change requirements	
		Recently completed project with similar change requirements	
		Recently completed project with greater change requirements	

Agency: Agency Name Project: Project Name

#	Criteria	Value Options	Answer
Section 4 -- Communication Area			
4.01	Has a documented Communication Plan been approved for this project?	Yes No	No
4.02	Does the project Communication Plan promote the collection and use of feedback from management, project team, and business stakeholders (including end users)?	Negligible or no feedback in Plan Routine feedback in Plan Proactive use of feedback in Plan	Routine 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	All or nearly all messages have 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: Enterprise System Consulting and Conversion to EFS

Section 5 -- Fiscal Area			
#	Criteria	Values	Answer
5.01	Has a documented Spending Plan been approved for the entire project lifecycle?	Yes	No
		No	
5.02	Have all project expenditures been identified in the Spending Plan?	0% to 40% -- None or few defined and documented	81% to 100% -- All or nearly all defined and documented
		41% to 80% -- Some defined and documented	
		81% to 100% -- All or nearly all defined and documented	
5.03	What is the estimated total cost of this project over its entire lifecycle?	Unknown	Between $2 M and $10 M
		Greater than $10 M	
		Between $2 M and $10 M	
		Between $500K and $1,999,999	
		Less than $500 K	
5.04	Is the cost estimate for this project based on quantitative analysis using a standards-based estimation model?	Yes	Yes
		No	
5.05	What is the character of the cost estimates for this project?	Detailed and rigorous (accurate within ±10%)	Detailed and rigorous (accurate within ±10%)
		Order of magnitude – estimate could vary between 10-100%	
		Placeholder – actual cost may exceed estimate by more than 100%	
5.06	Are funds available within existing agency resources to complete this project?	Yes	Yes
		No	
5.07	Will/should multiple state or local agencies help fund this project or system?	Funding from single agency	Funding from single agency
		Funding from local government agencies	
		Funding from other state agencies	
5.08	If federal financial participation is anticipated as a source of funding, has federal approval been requested and received?	Neither requested nor received	Neither requested nor received
		Requested but not received	
		Requested and received	
		Not applicable	
5.09	Have all tangible and intangible benefits been identified and validated as reliable and achievable?	Project benefits have not been identified or validated	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	Within 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: Enterprise System Consulting and Conversion to EFS

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	Yes
		No	
5.16	Have all procurement selection criteria and outcomes been clearly identified?	No selection criteria or outcomes have been identified	All or nearly all selection criteria and expected outcomes have been defined and documented
		Some selection criteria and outcomes have been defined and documented	
		All or nearly all selection criteria and expected outcomes have been defined and documented	
5.17	Does the procurement strategy use a multi-stage evaluation process to progressively narrow the field of prospective vendors to the single, best qualified candidate?	Procurement strategy has not been developed	Multi-stage evaluation not planned/used for procurement
		Multi-stage evaluation not planned/used for procurement	
		Multi-stage evaluation and proof of concept or prototype planned/used to select best qualified vendor	
5.18	For projects with total cost exceeding $10 million, did/will the procurement strategy require a proof of concept or prototype as part of the bid response?	Procurement strategy has not been developed	Not applicable
		No, bid response did/will not require proof of concept or prototype	
		Yes, bid response did/will include proof of concept or prototype	
		Not applicable	

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Section 6 -- Project Organization Area			
#	Criteria	Values	Answer
6.01	Is the project organization and governance structure clearly defined and documented within an approved project plan?	Yes 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	Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented
6.06	Is an experienced project manager dedicated fulltime to the project?	No experienced project manager assigned No, 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	No, project manager assigned more than half-time, but less than full-time 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	No, business, functional or technical experts dedicated more than half-time but less than full-time 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 board has been established

Agency: Agency for Health Care Administration Project: Enterprise System Consulting and Conversion to EFS

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

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

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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	Single location
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	Single location
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	5 to 8
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	None
8.07	What is the impact of the project on state operations?	Business process change in single division or bureau Agency-wide business process change Statewide or multiple agency business process change	Business process change in single division or bureau
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	Infrastructure upgrade
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	Greater size and complexity

SCHEDULE IV-B FOR MEDICAID ENTERPRISE SYSTEMS PROCUREMENT PROJECT

For Fiscal Year 2017-18

September 2016

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 Medicaid Enterprise Systems (MES) Procurement Project	Is this project included in the Agency's LRPP? ____ Yes __X__ No
FY 2017-18 LBR Issue Code: 68500200160200000041001600000000	FY 2017-18 LBR Issue Title: Florida Medicaid Management Information System (FMMIS)
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Angela Ramsey, 850-412-3440, 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: [signature] Printed Name: Justin Senior, Interim Secretary	Date: 10/12/16
Agency Chief Information Officer (or equivalent): [signature] Printed Name: Scott Ward, Chief Information Officer	Date: 10/13/16
Budget Officer: [signature] Printed Name: Anita Hicks, Chief Financial Officer	Date: 10/12/16
Planning Officer: Printed Name:	Date:
Project Sponsor: [signature] Printed Name: Gay Munyon	Date: 10/14/2016
Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Suzanne Stacknik, 850-412-4064, Suzanne.Stacknik@ahca.myflorida.com
Cost Benefit Analysis:	Terri Fuller, 850-412-3457, Terresa.Fuller@ahca.myflorida.com
Risk Analysis:	Terri Fuller, 850-412-3457, Terresa.Fuller@ahca.myflorida.com
Technology Planning:	Angela Ramsey, 850-412-3440, Angela.Ramsey@ahca.myflorida.com
Project Planning:	Angela Ramsey, 850-412-3440, 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 that are similar to the service level agreements currently in use, 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 Technical Solution
- 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 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

Purpose: To clearly articulate the business-related need(s) for the proposed project.

1. Business Need

This project was initiated as the Florida Medicaid Management Information System (FMMIS) re-procurement project. This project was to span several years starting with planning in 2014 through implementation of the replacement fiscal agent contract in 2018. Hewlett-Packard Enterprise (HPE) 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, including Statewide Medicaid Managed Care (SMMC), the Agency secured assistance from multiple planning vendors to establish a Project Management Office (PMO), conduct research and planning, and perform independent verification and validation services for the project.

After considerable research, the Agency's Project Governance team approved the takeover of the current FMMIS in the next fiscal agent contract with a proposed "go-live" date of July 1, 2018. After receiving Centers for Medicare and Medicaid Services (CMS) concurrence with this strategy in July 2015, the Agency proposed to incorporate systems integrator requirements into the project. By including system integrator requirements into the solicitation, the Agency sought to promote Medicaid Information Technology Architecture (MITA) maturity through the FMMIS and to truly become the "central information nervous system," supporting the Medicaid Enterprise through the development of data and interoperability standards for technical services and move to a more modular set of services and systems needed to meet all of the functional needs of the Medicaid program.

Just prior to the proposed solicitation release in December 2015, CMS issued a Request for Additional Information (RAI) letter requiring the Agency to solicit a separate vendor for systems integration as a requirement for Florida to obtain enhanced Federal Financial Participation (FFP). This letter is provided as Attachment A. This new direction from CMS was a departure from the approved Planning Advance Planning Document (PAPD), Implementation Advance Planning Document (IAPD), and previously held discussions with CMS. CMS issued a conditional approval of Florida's IAPD update consistent with the changes required in the RAI letter.

In light of the emerging guidance from CMS, the Agency revised its original procurement strategy and released the Florida Medicaid Enterprise Systems (MES) Procurement Strategy on May 2, 2016, and version 2 on June 6, 2016, provided as Attachment B to this document. In addition, the FMMIS re-procurement project has been re-purposed as the Florida MES procurement project. The Florida MES includes the business, data, services, technical processes, and systems with the Agency necessary for the administration of the Florida Medicaid program, as well as interconnections and touch points with systems that reside outside the Agency. The FMMIS has historically been the central system within the Florida Medicaid Enterprise as the single, integrated system of claims processing and information retrieval. As the Medicaid program has grown more complex, the systems needed to support the Florida Medicaid Enterprise have grown in number and complexity. The current Florida MES includes the FMMIS as well as separate systems that function to support Florida Medicaid and the Agency. One of the CMS goals is to transition from a monolithic MMIS to a group of modular systems that provide the services and system functions required for the Medicaid program. The objectives of the Florida MES procurement project are to develop the infrastructure for the Florida MES and transition to Service-Oriented Architecture (SOA) to increase the interoperability within the MES for sharing information and services utilizing a common platform.

The Agency has been in regular communication with CMS representatives regarding the Agency's strategy and planning to develop the best solution for Florida and to comply with the new federal directives contained in recently released rule and sub-regulatory guidance. CMS has released three of the four State Medicaid Directors Letters (SMDLs) sub-regulatory guidance and the Agency is waiting for further clarification from CMS in the final SMDL. The SMDLs are provided as Attachments C, D and E.

In accordance with the Florida MES Procurement Strategy, the Agency proposes to extend the current HPE fiscal agent contract beyond the current end date of June 30, 2018, for up to two years, and not pursue an FMMIS takeover procurement at this time. Florida must ensure a fully functional FMMIS, Fiscal Agent (FA), and Decision Support Services (DSS) to support Medicaid operations during the interim planning and development periods for the future state of the MES. Extending the current HPE fiscal agent contract will allow for continued operations without a takeover procurement. Additionally, the Agency amended the PMO contract and Independent Validation and Verification (IV&V) contract to end earlier than as originally procured since the services relate to the FMMIS re-procurement project.

The first phase of the Florida MES procurement project is to procure a Strategic Enterprise Advisory Services (SEAS) Vendor. The SEAS Vendor shall provide the consulting expertise needed to develop the strategy for the Florida MES in accordance with the MITA Framework 3.0 and the CMS Conditions and Standards and provide the technical advisory expertise to identify solutions that meet current and future business needs of the MES in an incremental and efficient way. The SEAS vendor shall serve as an effective advisor and partner to the Agency and provide ongoing strategic, technical advisory, and programmatic services.

Subsequent to the initiation of the SEAS contract, the Agency will procure the services of a Systems Integrator (SI). The SI will provide the technical expertise to ensure the integrity and interoperability of the MES by performing technical systems integration in coordination with multiple vendors providing the technology solutions.

The Agency also plans to issue a new Request for Quote (RFQ) under the new State Term Contract to procure an IV&V vendor to begin at the time the SEAS Vendor contract begins. The IV&V vendor will provide an independent and unbiased perspective on the progress of MES development and the integrity and functionality of Medicaid systems. IV&V services are required by Federal regulation 45 CFR § 95.626 in order to represent the interests of CMS, and are also required pursuant to the Florida Information Technology Project Management and Oversight Standards found in Florida Administrative Rule 74-1.001 through 74-1.009, Florida Administrative Code.

2. Business Objectives

NOTE: For IT projects with total cost in excess of $10 million, the business objectives described in this section must be consistent with existing or proposed substantive policy required in s. 216.023(4)(a)10, F.S.

The business objectives of the MES Procurement Project include the following:

- Issue an Invitation to Negotiate (ITN) for Strategic Enterprise Advisory Services (SEAS);
- Develop an enterprise systems governance and reporting structure in advance of the SEAS vendor;
- Operate the interim PMO using existing Agency resources in the Bureau of Medicaid Fiscal Agent Operations in advance of the SEAS vendor;
- Negotiate and award the SEAS vendor contract;
- Issue an RFQ for IV&V services and award a contract with the selected vendor;
- Issue a solicitation for Systems Integrator (SI) services;
- Extend the current HPE contract beyond the current end date of June 30, 2018 to ensure the continued operation of the FMMIS/FA/DSS during the transition period of the MES.

The long-range strategic objectives of the Medicaid Enterprise currently include the following:

- Promote the use of the current MITA Framework;
- Integrate care and improve outcomes;
- Leverage data across the Medicaid Enterprise;
- Enhance agility in processes, organization and systems;
- Optimize budget including Federal Financial Participation (FFP);
- Achieve Federal certification for Medicaid enterprise systems;

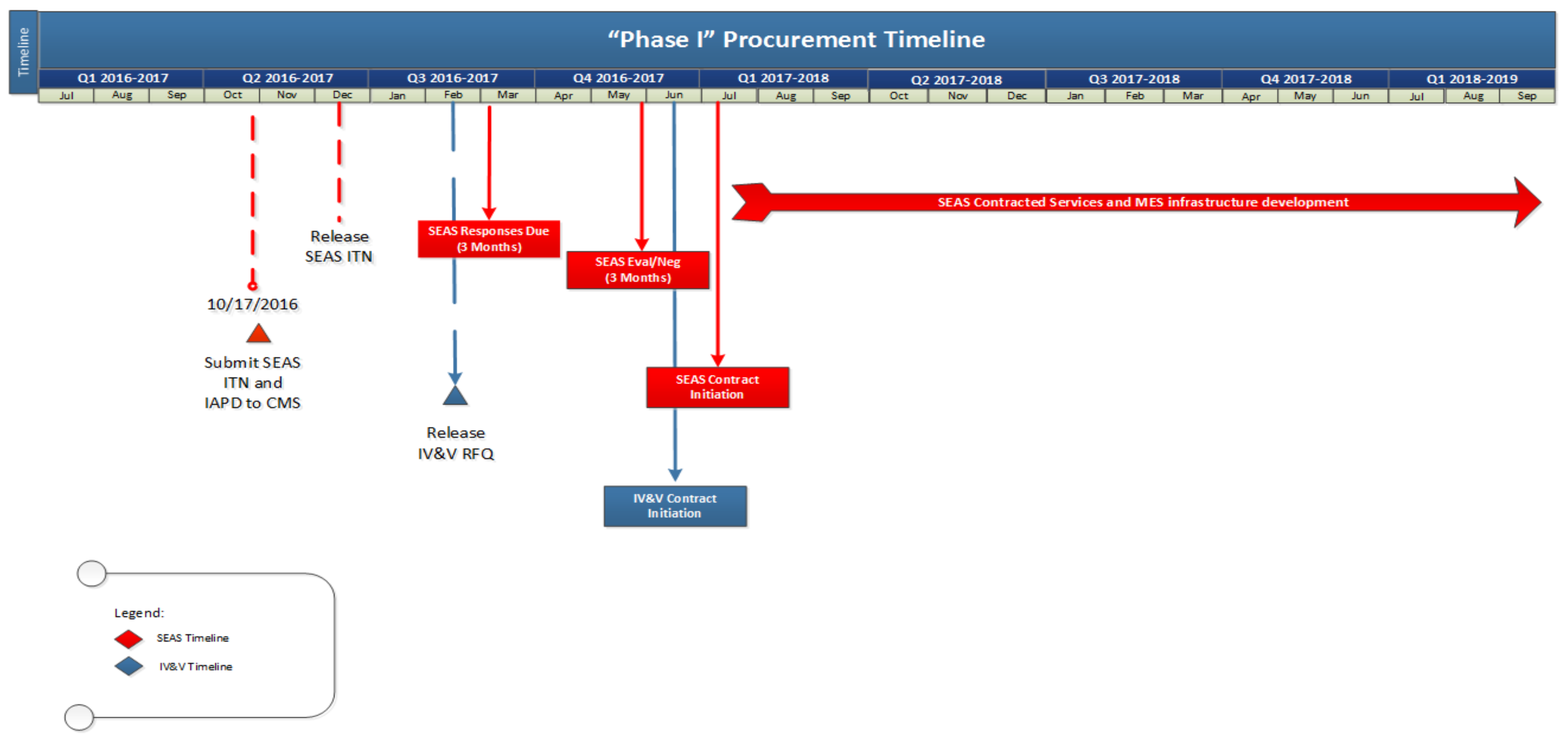
- Enable business continuity and disaster recovery;
- Advance MITA maturity;
- Comply with Federal standards, guidance and mandates;
- Enable consistent, predictable, and repeatable data storage and use;
- Consolidate functionality and data within the Medicaid Enterprise;
- Expand automated processes with a focus on communications and workflow;
- Support managed care;
- Support innovations in program operations.

Several critical Federal initiatives that impact Florida must be considered as decisions are made for the MES. Some of the more high-profile initiatives 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;
- New requirements for Medicaid as a result of ACA, including the concept of the health insurance exchange and increased provider enrollment and screening capability.

The Agency, in coordination with the SEAS vendor and the Governance structure, will develop the end-to-end solution for business processes within the Medicaid Enterprise through the use of strategic planning, needs assessment, requirements analysis, and thorough research. The Agency plans to procure an Enterprise Data Warehouse (EDW) to replace the current DSS, procure an Enterprise Service Bus (ESB) platform to develop an integrated software architecture model, integrate functionality and technology infrastructure in the Medicaid Enterprise, and procure commercial off-the-shelf (COTS), cloud based, Software as a Services (SaaS), and/or open application programming interfaces (APIs) products to replace functionality currently provided under the FMMIS.

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



Timeline
"Phase I" Procurement Timeline
Q1 2016-2017
Q2 2016-2017
Q3 2016-2017
Q4 2016-2017
Q1 2017-2018
Q2 2017-2018
Q3 2017-2018
Q4 2017-2018
Q1 2018-2019
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
SEAS Contracted Services and MES infrastructure development
Release SEAS ITN
SEAS Responses Due (3 Months)
SEAS Eval/Neg (3 Months)
10/17/2016
Submit SEAS ITN and IAPD to CMS
SEAS Contract Initiation
Release IV&V RFQ
IV&V Contract Initiation
Legend:
SEAS Timeline
IV&V Timeline

B. Baseline Analysis

Purpose: To establish a basis for understanding the business processes, stakeholder groups, and current technologies that will be affected by the project and the level of business transformation that will be required for the project to be successful.

1. Current Business Process(es)

NOTE: If an agency has completed a workflow analysis, include through file insertion or attachment the analyses documentation developed and completed by the agency.

In August 2014 Florida Medicaid hired a research and planning consultant, CSG Government Solutions, Inc., to assist the Agency in business needs analysis through a Medicaid Information Technology Architecture State Self-Assessment (MITA SS-A) developed by 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. Key tasks completed by the research and planning consultant include:

- Research of available technologies including national innovative models and collaborative options with other states;
- Research of DSS and data analytics products and services;
- Assessment of the current MMIS and DSS functionality and operations;
- Planned and conducted business requirements gathering sessions organized by the MITA Framework 3.0 structure in order to update the current Florida MITA SS-A;
- Developed a gap analysis of the current MMIS/DSS environment/MITA maturity level and the updated "To Be" maturity level;
- Planned and conducted technical and operations requirements gathering sessions for the prior FMMIS re-procurement project;
- Research documenting other state procurement strategies.

In collaboration with stakeholders, Florida Medicaid staff led 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 Agency's business needs and support the Florida MITA SS-A. For functions and capabilities that do not currently exist in the Medicaid Enterprise, the capability will be designed, developed and implemented through a standard System Life Cycle Development methodology in coordination with the SEAS vendor. All potential solutions will be analyzed to determine the most effective and efficient implementation of the required functions.

In coordination with consultants, the Agency completed Requirement Analysis and Development (RAD) sessions in order to completely describe the business needs for the MMIS and DSS. These business needs serve as the baseline analysis of the prior FMMIS re-procurement project.

After the SEAS vendor contract has been executed, the SEAS vendor will document an analysis of the MES using the components of the current MITA SS-A which includes the MITA Business, Information and Technical Capability Matrices Assessment, the Conditions and Standards Assessment, and update the Agency's 2014 MITA SS-A and MITA Roadmap. The SEAS vendor will also conduct sessions with Agency staff in order to develop business process models, business process maps, obtain input for MITA "To Be" capabilities, develop MITA-related performance measures for the MES for MITA maturity advancement. Upon completion, the resulting artifacts will serve as the baseline analysis for the MES procurement project. These artifacts will be used to identify improvement recommendations and solutions for the Medicaid Enterprise in alignment with strategic objectives.

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:

- Agency 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.
- Agency leadership and CMS will provide timely review and response to the draft SEAS solicitation documents.
- The Agency governance structure will provide timely decision making and project guidance to facilitate an integrated approach to the prioritization of time, resources and budget across all of the Agency 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.

- Federal funding for the MES Procurement project is contingent upon the timely completion, submission and approval of the required advanced planning documentation by CMS.
- The continued operations of the FMMIS/DSS and Fiscal Agent operations are contingent upon execution of a contract extension beyond the current expiration date of July 31, 2018.
- Agency resources are limited for management of the SEAS vendor, SI vendor, IV&V vendor, and related MES procurement projects.
- SEAS vendor contract execution and start date and related contracts are subject to change based on any solicitation protest(s).

This list of constraints will serve to inform the initial list of project risks and be documented and managed as part of the MES Procurement Project Management (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.

C. Proposed Business Process Requirements

Purpose: To establish a basis for understanding what business process requirements the proposed solution must meet in order to select an appropriate solution for the project.

1. Proposed Business Process Requirements

The Agency, along with the consultants procured to assist with the process, conducted Requirement Analysis and Development sessions in order to completely describe the business needs for the MMIS and DSS under the prior FMMIS re-procurement project. The following preparation work was completed in order to arrive at a description the business needs of the Agency, 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 its 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, enables the Agency as the State Medicaid Agency (SMA) to enhance Florida's Medicaid technical infrastructure and help

shape the future vision of the Florida Medicaid Enterprise.

The SS-A is part of the Agency's strategic plan for the transformation of the Medicaid Enterprise. The centerpiece of the strategic plan is a modernization roadmap that identifies the activities and timelines for maturing the Medicaid Enterprise Systems. An annual 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 its business needs.

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 include:

- 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. Each of these architectures is discussed in detail in separate sections of this document.

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 and must be taken into account in an SS-A. These 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
- 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 F 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, Inc., 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 G - Report on Research Tasks.

3. Rationale for Selection

The Agency's Project Governance team approved the takeover of the current FMMIS in the next fiscal agent contract with enhancements, and proposed to incorporate systems integrator requirements. As described above, CMS issued a RAI letter requiring a separate solicitation for a systems integrator in order for Florida to obtain FFP. As a result, the Agency revised its original procurement strategy and released the Florida Medicaid Enterprise Systems (MES) Procurement Strategy on May 2, 2016, and version 2 on June 6, 2016. This MES Procurement Strategy seeks to promote MITA and the CMS required conditions and standards while meeting the business needs of the Medicaid Enterprise. Specifically, the future Florida Medicaid Enterprise will connect services and infrastructures regardless of the underlying platforms, software architectures and network protocols. Integration offers greater functionality and capability over the current data file exchange process.

4. Recommended Business Solution

> ***NOTE: For IT projects with total cost in excess of $10 million, the project scope described in this section must be consistent with existing or proposed substantive policy required in s. 216.023(4) (a) 10, F.S.***

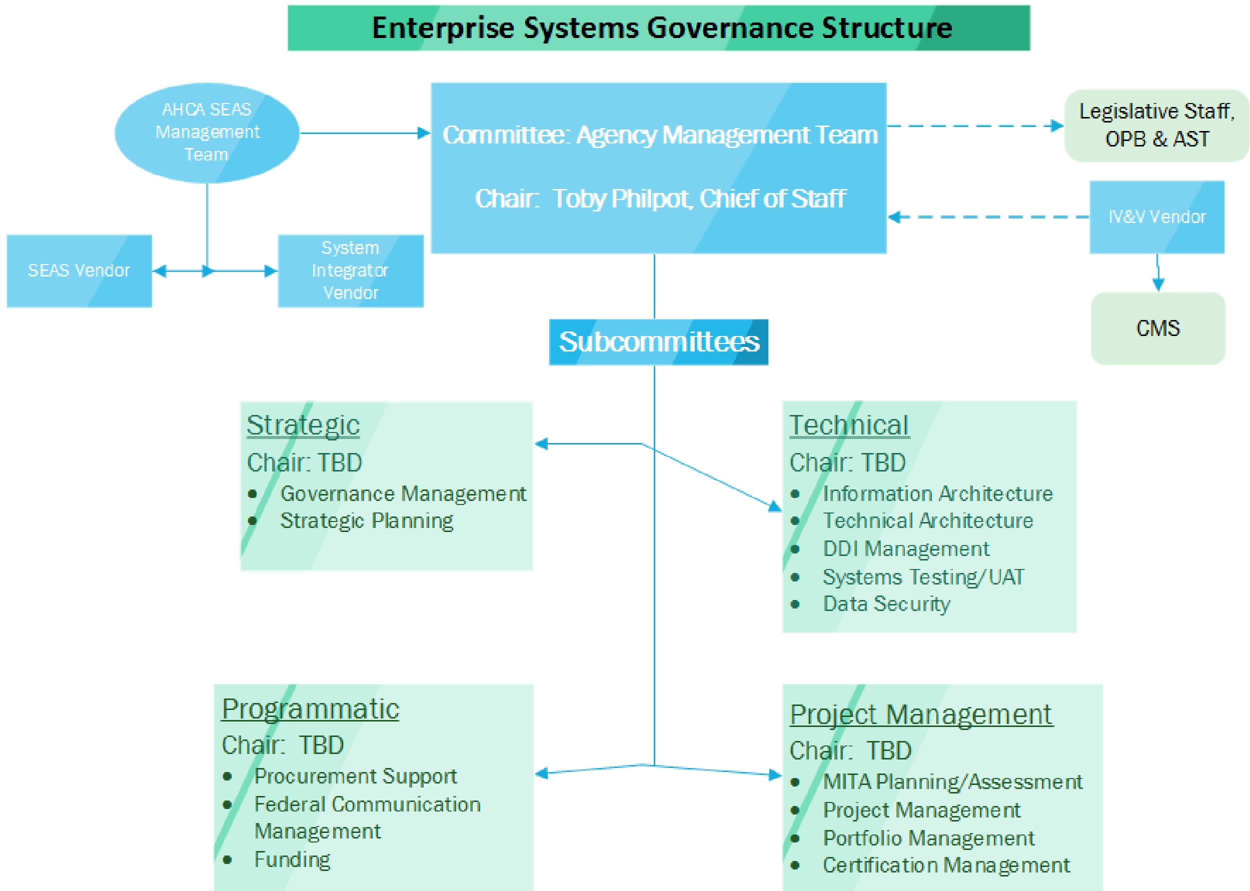
In the first phase of the MES Procurement Project, the recommended business solution is to procure a Strategic Enterprise Advisory Services (SEAS) vendor in order to obtain the expertise needed to develop the framework for the MES in accordance with the CMS Conditions and Standards, including MITA 3.0, and facilitate the interoperability of business and technical services across the MES.

The recommended scope of work for the SEAS vendor includes strategic, programmatic, and technical advisory services. Strategic and programmatic activities include the development and facilitation of an MES governance strategy, establishing and managing a project management office, and developing procurement strategies to build the MES technical infrastructure.

Technical activities include developing and documenting the MES information architecture plan inclusive of a master data management plan and data sharing architecture. The vendor will develop an integration framework, and technical architecture to include requirements for system monitoring. The vendor shall identify the specific MES data standards that apply to each applicable MES project, communicate with MES vendors regarding technical standards and document MES vendor compliance with the Agency-approved data standards and architecture requirement. In addition, the SEAS vendor shall provide oversight and management for MES projects to assure compliance with systems architecture and standards for interoperability.

The SEAS vendor will work in coordination with the Systems Integrator (SI) vendor. The Agency will procure the services of an SI vendor in order to ensure the integrity and interoperability of the MES by performing technical systems integration in coordination with multiple vendors providing the technology solutions.

Additional solutions for the MES will be developed by the Agency in coordination with the SEAS vendor and through the enterprise systems governance decision procedures. The Agency's enterprise systems governance structure will be developed in order to make coordinated IT decisions at the Agency enterprise level and align business decisions with strategic objectives. Below is the proposed organizational structure.


Enterprise Systems Governance Structure
AHCA SEAS Management Team
Committee: Agency Management Team
Chair: Toby Philpot, Chief of Staff
Legislative Staff, OPB & AST
IV&V Vendor
CMS
SEAS Vendor
System Integrator Vendor
Subcommittees
Strategic
Chair: TBD
Governance Management
Strategic Planning
Technical
Chair: TBD
Information Architecture
Technical Architecture
DDI Management
Systems Testing/UAT
Data Security
Programmatic
Chair: TBD
Procurement Support
Federal Communication Management
Funding
Project Management
Chair: TBD
MITA Planning/Assessment
Project Management
Portfolio Management
Certification Management

D. Functional and Technical Requirements

Purpose: To identify the functional and technical system requirements that must be met by the project.

The discussion of MITA is inclusive of Information (data) and Technical (functional) Architectures, as well as the expectations for adhering to the conditions and standards set by Federal regulation. Profiles for these requirements are attached to this document for reference in Attachment F. 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 were identified for the prior FMMIS re-procurement project. Functional and technical requirements have not been identified at this point of the planning phase of the MES procurement project. As solution(s) are procured, this section can be updated.

III. Success Criteria

Purpose: To identify the critical results, both outputs and outcomes, that must be realized for the project to be considered a success.

SUCCESS CRITERIA TABLE				
#	Description of Criteria	How will the Criteria be measured/assessed?	Who benefits?	Realization Date (MM/YY)
1	Establish and maintain a PMO provided by the SEAS vendor over the life of the project to ensure the standardization of the project management processes and the visibility of project performance across the project teams, external stakeholders and project and Agency governance committees.	Assessed through project management documentation	• The Agency, • Medicaid Providers, • Medicaid Recipients, • Potential Vendors.	07/17
2	Develop and implement a procurement strategy and plan to conduct the MES project solicitations in a manner that maximizes opportunities to achieve system integration and flexibility as well as provide business value across the Agency Medicaid Enterprise and programs.	Assessed through project management documentation and the IV&V vendor	• The Agency, • Medicaid Providers, • Medicaid Recipients, • Potential Vendors	08/18
3	Alignment of the MES vendor and Agency staff roles, responsibilities, and relationships to establish a cohesive, collaborative, and harmonious team mutually focused on strategic goals and objectives	Assessed through project management documentation and the IV&V vendor	• The Agency, • Medicaid Providers, • Medicaid Recipients, • Contracted MES Vendor(s)	08/18

SUCCESS CRITERIA TABLE				
4	Completion of CMS milestone reviews throughout the Medicaid Enterprise Certification Life Cycle using the current Medicaid Enterprise Certification Toolkit (MECT), and achievement of CMS certification for Medicaid Enterprise Systems.	Measured and assessed by CMS through the CMS-prescribed certification process	• The Agency, • Florida State government	TBD

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

A. Benefits Realization Table

Purpose: To calculate and declare the tangible benefits compared to the total investment of resources needed to support the proposed IT project.

Initial tangible benefits are identified at this point of the planning phase of the project. After a solution is procured, this section can be updated.

For each tangible benefit, identify the recipient of the benefit, how and when it is realized, how the realization will be measured, and how the benefit will be measured to include estimates of tangible benefit amounts.

BENEFITS REALIZATION TABLE					
#	**Description of Benefit**	**Who receives the benefit?**	**How is benefit realized?**	**How is the realization of the benefit measured?**	**Realization Date (MM/YY)**
1	Develop integrated systems that communicate effectively to achieve Medicaid goals through interoperability and common standards.	Medicaid recipients and providers.	Procurement of modular systems that replace functionality currently provided under the FMMIS.	Measured through project management documentation and the CMS-prescribed certification process	2019 through 2022
2	Optimize Federal Financial Participation (FFP) to maximize impact of State of Florida funding through Federal match.	State of Florida	Achievement of CMS certification for modular systems.	Measured by CMS through the CMS-prescribed certification process.	2019 through 2022

B. Cost Benefit Analysis (CBA)

Purpose: To provide a comprehensive financial prospectus specifying the project's tangible benefits, funding requirements, and proposed source(s) of funding.

A cost benefit analysis of the MES procurement project is identified at this point of the planning phase of the project as a placeholder amount. After solution(s) are procured, this section can be updated. Preliminary versions of the CBA forms have been completed and will be updated as the project progresses.

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	The expected changes in operational costs are for MES infrastructure due to procurement of modular systems that replace functionality currently provided under the FMMIS.
CBA Form 2 - Project Cost Analysis	Baseline Project Budget: The estimated project costs for fiscal year 2017-2018 are $7,496,308. This includes $1,646,308 for IV&V services, $5,000,000 for the SEAS vendor, $600,000 for MES infrastructure development, and $250,000 contingency funds for any legal challenges that may arise during the procurement processes. Project Funding Sources: The planned sources of project funds are General Revenue, and the Medical Care Trust Fund in the Executive Direction and Support Services budget entity in the Contracted Services category.
CBA Form 3 - Project Investment Summary	Investment Summary Calculations: Summarizes total project costs and net tangible benefits and automatically calculates: • Return on Investment – ($7,496,308) for FY 2017-18, total for all years is ($33,036,900) • Payback Period – no payback period indicated • Breakeven Fiscal Year – no payback indicated • Net Present Value ($29,918,787) • Internal Rate of Return - no IRR is indicated

V. Schedule IV-B Major Project Risk Assessment

Purpose: To provide an initial high-level assessment of overall risk incurred by the project to enable appropriate risk mitigation and oversight and to improve the likelihood of project success. The risk assessment summary identifies the overall level of risk associated with the project and provides an assessment of the project's alignment with business objectives.

> ***NOTE: All multi-year projects must update the Risk Assessment Component of the Schedule IV-B along with any other components that have been changed from the original Feasibility Study.***

The attached Appendix B includes risks related to the SEAS vendor solicitation and the IV&V pending RFQ which have well developed requirements. The risks related to infrastructure development including the Enterprise Data Warehouse (EDW) and Enterprise Service Bus (ESB) procurement(s) pertain to early project initiation; the technical

solutions, and design and development are unknown at this time. The preliminary version of Appendix B form has been completed and will be updated as the project progresses.

The Agency's Risk Management Plan is provided as Attachment H. An interim PMO managed by existing Agency staff in the Bureau of Medicaid Fiscal Agent Operations is in the process of identifying potential events in the MES procurement project planning activities that could become threats or opportunities. PMO responsibilities will be transitioned to the selected SEAS vendor, and a complete risk assessment summary of the project will be conducted at that point.

Schedule IV-B Technology Planning

Purpose: To ensure there is close alignment with the business and functional requirements and the selected technology.

This section cannot be completed in September 2016 at this point of the planning phase of the project. After the planning phase has been completed in coordination with the SEAS vendor and MES solution(s) are 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 I 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 J to this schedule.

b. Current System Resource Requirements

The HPE organizational chart for August 2016 is Attachment K.

c. Current System Performance

The System Performance Report Card for May 2016 is Attachment L.

2. Information Technology Standards

Medicaid systems are bound by Federal regulations found in 42 CFR § 433.112(b) 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 Conditions and Standards are described in detail in Attachment M and Attachment N.

B. Current Hardware and/or Software Inventory

NOTE: Current customers of the state data center would obtain this information from the data center.

The current hardware and software inventory of the Florida MES will be documented in coordination with the SEAS vendor. An update to this section will be submitted when the inventory has been documented.

C. Proposed Technical Solution

The proposed technical solution cannot be described in September 2016 at this point of the planning phase of the project. After the SEAS vendor is procured, this section can be updated with the recommended technical solution(s). The SEAS vendor will provide their recommended solution(s) for review and approval through the Agency's Governance procedures.

1. Technical Solution Alternatives

2. Rationale for Selection

3. Recommended Technical Solution

D. Proposed Solution Description

The proposed solution cannot be described in September 2016 at this point of the planning phase of the project. After the SEAS vendor is procured, this section can be updated with the recommended proposed solution(s). The SEAS vendor will provide their recommended solution(s) for review and approval through the Agency's Governance procedures.

1. Summary Description of Proposed System

2. Resource and Summary Level Funding Requirements for Proposed Solution (if known)

E. Capacity Planning *(historical and current trends versus projected requirements)*

Capacity planning for the recommended solution(s) proposed by the SEAS vendor cannot be described in September 2016 at this point of the planning phase of the project. After the SEAS vendor is procured, this section can be updated with capacity planning.

VI. Schedule IV-B Project Management Planning

***Purpose:** To require the agency to provide evidence of its thorough project planning and provide the tools the agency will use to carry out and manage the proposed project. The level of detail must be appropriate for the project's scope and complexity.*

NOTE: For IT projects with total cost in excess of $10 million, the project scope, business objectives, and timelines described in this section must be consistent with existing or proposed substantive policy required in s. 216.023(4)(a)10, F.S.

The Agency contracted with The North Highland Company for establishing a Project Management Office (PMO) for

the term of the prior FMMIS re-procurement project. The PMO plans developed by North Highland will be maintained by the Agency's interim PMO. The documentation developed by North Highland will be revised and expanded upon by the SEAS vendor in order to establish an enterprise PMO for the Medicaid Enterprise. The following documentation is attached:

- Project Charter – Attachment O
- Project Management Plan – Attachment P
- Stakeholder Analysis – Attachment Q
- Communications Management Plan – Attachment R
- Work Breakdown Structure (WBS) – Attachment S
- Risk Management Plan – Attachment H
- Change Management Plan – Attachment T
- Project Schedule – Attachment U
- Cost Management Plan – Attachment V
- Procurement Management Plan – Attachment W

VII. Appendices

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

Attachment A CMS Request for Additional Information (RAI) Letter

Attachment B Florida MES Procurement Strategy version 2, June 6, 2016

Attachment C State Medicaid Director Letter No. 1

Attachment D State Medicaid Director Letter No. 2

Attachment E State Medicaid Director Letter No. 3

Attachment F MITA SS-A Profiles

Attachment G Report on Research Tasks

Attachment H Risk Management Plan

Attachment I MITA SS-A Report Update – 2014

Attachment J Gap Analysis Report

Attachment K HPE Organizational Chart

Attachment L System Performance Report Card

Attachment M CMS Conditions and Standards

Attachment N 42 CFR § 433.112

Attachment O Project Charter

Attachment P Project Management Plan

Attachment Q Stakeholder Analysis

Attachment R Communications Management Plan

Attachment S Work Breakdown Structure (WBS)

Attachment T Change Management Plan

Attachment U Project Schedule

Attachment V Cost Management Plan

Attachment W Procurement Management Plan

CBAForm 1 - Net Tangible Benefits

Agency ency for Health Care Administra   Project MES Procurement Project

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	FY 2017-18			FY 2018-19			FY 2019-20			FY 2020-21			FY 2021-22		
(Recurring Costs 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) Cost Change 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 Costs -- Agency-Managed Staff	$3,784,000	$0	$3,784,000	$3,784,000	$0	$3,784,000	$3,784,000	$0	$3,784,000	$3,784,000	$0	$3,784,000	$3,784,000	$0	$3,784,000
A.b Total Staff	64.00	0.00	64.00	64.00	0.00	64.00	64.00	0.00	64.00	64.00	0.00	64.00	64.00	0.00	64.00
A-1.a. State FTEs (Salaries & Benefits)	$3,117,375	$0	$3,117,375	$3,117,375	$0	$3,117,375	$3,117,375	$0	$3,117,375	$3,117,375	$0	$3,117,375	$3,117,375	$0	$3,117,375
A-1.b. State FTEs (#)	48.00	0.00	48.00	48.00	0.00	48.00	48.00	0.00	48.00	48.00	0.00	48.00	48.00	0.00	48.00
A-2.a. OPS Staff (Salaries)	$666,625	$0	$666,625	$666,625	$0	$666,625	$666,625	$0	$666,625	$666,625	$0	$666,625	$666,625	$0	$666,625
A-2.b. OPS (#)	16.00	0.00	16.00	16.00	0.00	16.00	16.00	0.00	16.00	16.00	0.00	16.00	16.00	0.00	16.00
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 Contractors)	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. Application Maintenance Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-1. Managed Services (Staffing)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-2. Hardware	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-3. Software	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-4. Other Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C. Data Center Provider Costs	$56,558,092	$0	$56,558,092	$56,558,092	$0	$56,558,092	$56,558,092	-$2,617,130	$53,940,962	$53,940,962	-$2,486,274	$51,454,688	$51,454,688	-$2,361,960	$49,092,728
C-1. Managed Services (Staffing)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-2. Infrastructure	$52,342,616	$0	$52,342,616	$52,342,616	$0	$52,342,616	$52,342,616	-$2,617,130	$49,725,486	$49,725,486	-$2,486,274	$47,239,212	$47,239,212	-$2,361,960	$44,877,252
C-3. Network / Hosting Services	$2,115,476	$0	$2,115,476	$2,115,476	$0	$2,115,476	$2,115,476	$0	$2,115,476	$2,115,476	$0	$2,115,476	$2,115,476	$0	$2,115,476
C-4. Disaster Recovery	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-5. Other Pass Through Printing, Postage, State	$2,100,000	$0	$2,100,000	$2,100,000	$0	$2,100,000	$2,100,000	$0	$2,100,000	$2,100,000	$0	$2,100,000	$2,100,000	$0	$2,100,000
D. Plant & Facility Costs	$2,041,046	$0	$2,041,046	$2,041,046	$0	$2,041,046	$2,041,046	$0	$2,041,046	$2,041,046	$0	$2,041,046	$2,041,046	$0	$2,041,046
E. Other Costs	$743,911	$0	$743,911	$743,911	$0	$743,911	$743,911	$0	$743,911	$743,911	$0	$743,911	$743,911	$0	$743,911
E-1. Training	$564,928	$0	$564,928	$564,928	$0	$564,928	$564,928	$0	$564,928	$564,928	$0	$564,928	$564,928	$0	$564,928
E-2. Travel	$132,990	$0	$132,990	$132,990	$0	$132,990	$132,990	$0	$132,990	$132,990	$0	$132,990	$132,990	$0	$132,990
E-3. Other Performance Bond	$45,993	$0	$45,993	$45,993	$0	$45,993	$45,993	$0	$45,993	$45,993	$0	$45,993	$45,993	$0	$45,993
Total of Recurring Operational Costs	$63,127,049	$0	$63,127,049	$63,127,049	$0	$63,127,049	$63,127,049	-$2,617,130	$60,509,919	$60,509,919	-$2,486,274	$58,023,645	$58,023,645	-$2,361,960	$55,661,685
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			$2,617,130			$2,486,274			$2,361,960	

CHARACTERIZATION OF PROJECT BENEFIT ESTIMATE -- CBAForm 1B			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous	☐	Confidence Level	
Order of Magnitude	☐	Confidence Level	
Placeholder	☑	Confidence Level	200%

	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	MES Procurement Project			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.***				**FY2017-18**			**FY2018-19**			**FY2019-20**			**FY2020-21**			**FY2021-22**			**TOTAL**
3				$ -		$ 7,496,308			$ 8,251,489			$ 8,251,489			$ 8,251,489			$ 8,251,489		$ 40,502,264
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 to include Independent Verification & Validation (IV&V) personnel and related deliverables.	**Project Oversight: IV&V**	Contracted Services	$ -	0.00	$ 1,646,308	$ -	0.00	$ 2,051,489	$ -	0.00	$ 2,051,489	$ -	0.00	$ 2,051,489	$ -	0.00	$ 2,051,489	$ -	$ 9,852,264
10	Staffing costs for all professional services not included in other categories.	**Consultants/Contractors: SEAS Vendor**	Contracted Services	$ -	0.00	$ 5,000,000	$ -	0.00	$ 5,000,000	$ -	0.00	$ 5,000,000	$ -	0.00	$ 5,000,000	$ -	0.00	$ 5,000,000	$ -	$ 25,000,000
11	Separate requirements analysis and feasibility study procurements.	**Project Planning/Analysis: Systems Integrator and modular procurements**	Contracted Services	$ -		$ 600,000	$ -		$ 950,000	$ -		$ 950,000	$ -		$ 950,000	$ -		$ 950,000	$ -	$ 4,400,000
12	Hardware purchases not included in 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 data center provider 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: Legal**	Contracted Services	$ -		$ 250,000	$ -		$ 250,000	$ -		$ 250,000	$ -		$ 250,000	$ -		$ 250,000	$ -	$ 1,250,000
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	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ -
21		**Total**		**$ -**	**0.00**	**$ 7,496,308**	**$ -**	**0.00**	**$ 8,251,489**	**$ -**	**0.00**	**$ 8,251,489**	**$ -**	**0.00**	**$ 8,251,489**	**$ -**	**0.00**	**$ 8,251,489**	**$ -**	**$ 40,502,264**

CBAForm 2 - Project Cost Analysis

Agency ncy for Health Care Administra Project MES Procurement Project

PROJECT COST SUMMARY	PROJECT COST SUMMARY (from CBAForm 2A)					TOTAL
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	
TOTAL PROJECT COSTS (*)	$7,496,308	$8,251,489	$8,251,489	$8,251,489	$8,251,489	$40,502,264
CUMULATIVE PROJECT COSTS *(includes Current & Previous Years' Project-Related Costs)*	$7,496,308	$15,747,797	$23,999,286	$32,250,775	$40,502,264	
Total Costs are carried forward to CBAForm3 Project Investment Summary worksheet.						

PROJECT FUNDING SOURCES	PROJECT FUNDING SOURCES - CBAForm 2B					TOTAL
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	
General Revenue	$0	$0	$0	$0	$0	$0
Trust Fund	$0	$0	$0	$0	$0	$0
Federal Match ☐	$0	$0	$0	$0	$0	$0
Grants ☐	$0	$0	$0	$0	$0	$0
Other ☐ Specify	$0	$0	$0	$0	$0	$0
TOTAL INVESTMENT	$0	$0	$0	$0	$0	$0
CUMULATIVE INVESTMENT	$0	$0	$0	$0	$0	

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

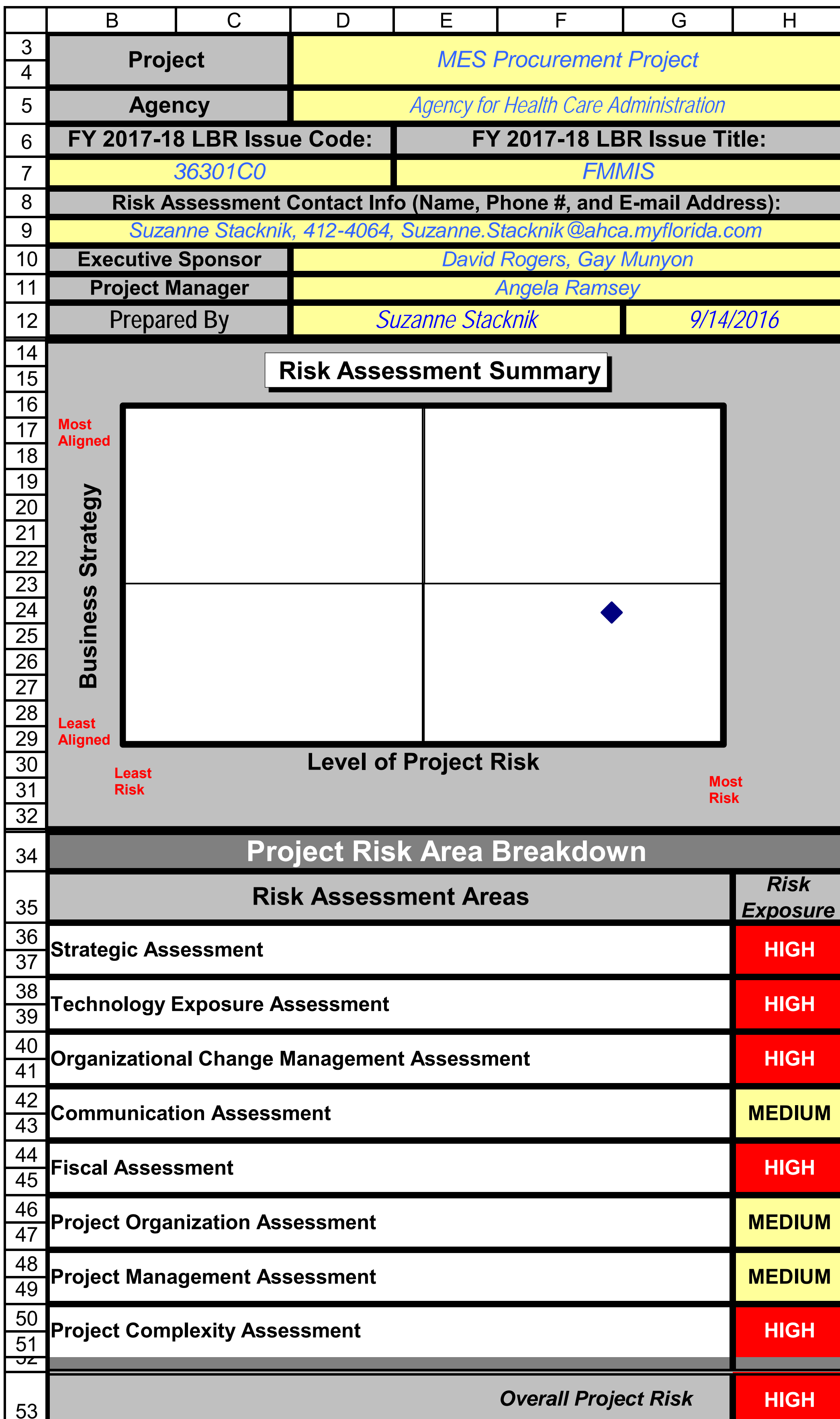
CBAForm 3 - Project Investment Summary

Agency: ȷency for Health Care Administratiı
Project: MES Procurement Project

COST BENEFIT ANALYSIS -- CBAForm 3A						
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	TOTAL FOR ALL YEARS
Project Cost	$7,496,308	$8,251,489	$8,251,489	$8,251,489	$8,251,489	$40,502,264
Net Tangible Benefits	$0	$0	$2,617,130	$2,486,274	$2,361,960	$7,465,364
Return on Investment	($7,496,308)	($8,251,489)	($5,634,359)	($5,765,215)	($5,889,529)	($33,036,900)
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)	($29,918,787)	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 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Cost of Capital	1.94%	2.07%	3.18%	4.32%	4.85%



Field	Value
Project	MES Procurement Project
Agency	Agency for Health Care Administration
FY 2017-18 LBR Issue Code:	36301C0
FY 2017-18 LBR Issue Title:	FMMIS
Risk Assessment Contact Info (Name, Phone #, and E-mail Address):	Suzanne Stacknik, 412-4064, Suzanne.Stacknik@ahca.myflorida.com
Executive Sponsor	David Rogers, Gay Munyon
Project Manager	Angela Ramsey
Prepared By	Suzanne Stacknik — 9/14/2016

Risk Assessment Summary

Project Risk Area Breakdown

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

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 1 -- Strategic Area			
4	#	Criteria	Values	Answer
5	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
6			41% to 80% -- Some objectives aligned	
7			81% to 100% -- All or nearly all objectives aligned	
8	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
9			Informal agreement by stakeholders	
10			Documented with sign-off by stakeholders	
11	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
12			Most regularly attend executive steering committee meetings	
13			Project charter signed by executive sponsor and executive team actively engaged in steering committee meetings	
14	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 partially documented
15			Vision is partially documented	
16			Vision is completely documented	
17	1.05	Have all project business/program area requirements, assumptions, constraints, and priorities been defined and documented?	0% to 40% -- Few or none defined and documented	41% to 80% -- Some defined and documented
18			41% to 80% -- Some defined and documented	
19			81% to 100% -- All or nearly all defined and documented	
20	1.06	Are all needed changes in law, rule, or policy identified and documented?	No changes needed	Changes are identified in concept only
21			Changes unknown	
22			Changes are identified in concept only	
23			Changes are identified and documented	
24			Legislation or proposed rule change is drafted	
25	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
26			Some	
27			All or nearly all	
28	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
29			Moderate external use or visibility	
30			Extensive external use or visibility	
31	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
32			Single agency-wide use or visibility	
33			Use or visibility at division and/or bureau level only	
34	1.10	Is this a multi-year project?	Greater than 5 years	Between 3 and 5 years
35			Between 3 and 5 years	
36			Between 1 and 3 years	
37			1 year or less	

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 2 -- Technology Area			
4	#	Criteria	Values	Answer
5	2.01	Does the agency have experience working with, operating, and supporting the proposed technical solution in a production environment?	Read about only or attended conference and/or vendor presentation	Read about only or attended conference and/or vendor presentation
6			Supported prototype or production system less than 6 months	
7			Supported production system 6 months to 12 months	
8			Supported production system 1 year to 3 years	
9			Installed and supported production system more than 3 years	
10	2.02	Does the agency's internal staff have sufficient knowledge of the proposed technical solution 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
11			External technical resources will be needed through implementation only	
12			Internal resources have sufficient knowledge for implementation and operations	
13	2.03	Have all relevant technical alternatives/ solution options been researched, documented and considered?	No technology alternatives researched	Some alternatives documented and considered
14			Some alternatives documented and considered	
15			All or nearly all alternatives documented and considered	
16	2.04	Does the proposed technical solution 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
17			Some relevant standards have been incorporated into the proposed technology	
18			Proposed technology solution is fully compliant with all relevant agency, statewide, or industry standards	
19	2.05	Does the proposed technical solution require significant change to the agency's existing technology infrastructure?	Minor or no infrastructure change required	Extensive infrastructure change required
20			Moderate infrastructure change required	
21			Extensive infrastructure change required	
22			Complete infrastructure replacement	
23	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
24			Capacity requirements are defined only at a conceptual level	
25			Capacity requirements are based on historical data and new system design specifications and performance requirements	

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 3 -- Organizational Change Management Area			
4	#	Criteria	Values	Answer
5	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
6			Moderate changes to organization structure, staff or business processes	
7			Minimal changes to organization structure, staff or business processes structure	
8	3.02	Will this project impact essential business processes?	Yes	Yes
9			No	
10	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	0% to 40% -- Few or no process changes defined and documented
11			41% to 80% -- Some process changes defined and documented	
12			81% to 100% -- All or nearly all processes defiined and documented	
13	3.04	Has an Organizational Change Management Plan been approved for this project?	Yes	Yes
14			No	
15	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
16			1% to 10% FTE count change	
17			Less than 1% FTE count change	
18	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
19			1 to 10% contractor count change	
20			Less than 1% contractor count change	
21	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
22			Moderate changes	
23			Minor or no changes	
24	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
25			Moderate changes	
26			Minor or no changes	
27	3.09	Has the agency successfully completed a project with similar organizational change requirements?	No experience/Not recently (>5 Years)	Recently completed project with fewer change requirements
28			Recently completed project with fewer change requirements	
29			Recently completed project with similar change requirements	
30			Recently completed project with greater change requirements	

	B	C	D	E
1	Agency: Agency Name			Project: Project Name
3	Section 4 -- Communication Area			
4	#	Criteria	Value Options	Answer
5	4.01	Has a documented Communication Plan been approved for this project?	Yes	Yes
6			No	
7	4.02	Does the project Communication Plan promote the collection and use of feedback from management, project team, and business stakeholders (including end users)?	Negligible or no feedback in Plan	Proactive use of feedback in Plan
8			Routine feedback in Plan	
9			Proactive use of feedback in Plan	
10	4.03	Have all required communication channels been identified and documented in the Communication Plan?	Yes	Yes
11			No	
12	4.04	Are all affected stakeholders included in the Communication Plan?	Yes	Yes
13			No	
14	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
15			Some key messages have been developed	
16			All or nearly all messages are documented	
17	4.06	Have desired message outcomes and success measures been identified in the Communication Plan?	Plan does not include desired messages outcomes and success measures	Plan does not include desired messages outcomes and success measures
18			Success measures have been developed for some messages	
19			All or nearly all messages have success measures	
20	4.07	Does the project Communication Plan identify and assign needed staff and resources?	Yes	Yes
21			No	

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 5 -- Fiscal Area			
4	#	Criteria	Values	Answer
5	5.01	Has a documented Spending Plan been approved for the entire project lifecycle?	Yes	No
6			No	
7	5.02	Have all project expenditures been identified in the Spending Plan?	0% to 40% -- None or few defined and documented	0% to 40% -- None or few defined and documented
8			41% to 80% -- Some defined and documented	
9			81% to 100% -- All or nearly all defined and documented	
10	5.03	What is the estimated total cost of this project over its entire lifecycle?	Unknown	Greater than $10 M
11			Greater than $10 M	
12			Between $2 M and $10 M	
13			Between $500K and $1,999,999	
14			Less than $500 K	
15	5.04	Is the cost estimate for this project based on quantitative analysis using a standards-based estimation model?	Yes	No
16			No	
17	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%
18			Order of magnitude – estimate could vary between 10-100%	
19			Placeholder – actual cost may exceed estimate by more than 100%	
20	5.06	Are funds available within existing agency resources to complete this project?	Yes	No
21			No	
22	5.07	Will/should multiple state or local agencies help fund this project or system?	Funding from single agency	Funding from single agency
23			Funding from local government agencies	
24			Funding from other state agencies	
25	5.08	If federal financial participation is anticipated as a source of funding, has federal approval been requested and received?	Neither requested nor received	Requested and received
26			Requested but not received	
27			Requested and received	
28			Not applicable	
29	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
30			Some project benefits have been identified but not validated	
31			Most project benefits have been identified but not validated	
32			All or nearly all project benefits have been identified and validated	
33	5.10	What is the benefit payback period that is defined and documented?	Within 1 year	More than 5 years
34			Within 3 years	
35			Within 5 years	
36			More than 5 years	
37			No payback	
38	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
39			Stakeholders have not been consulted re: procurement strategy	
40			Stakeholders have reviewed and approved the proposed procurement strategy	
41	5.12	What is the planned approach for acquiring necessary products and solution services to successfully complete the project?	Time and Expense (T&E)	Combination FFP and T&E
42			Firm Fixed Price (FFP)	
43			Combination FFP and T&E	
44	5.13	What is the planned approach for procuring hardware and software for the project?	Timing of major hardware and software purchases has not yet been determined	Timing of major hardware

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 5 -- Fiscal Area			
4	#	Criteria	Values	Answer
45			Purchase all hardware and software at start of project to take advantage of one-time discounts	and software purchases has not yet been determined
46			Just-in-time purchasing of hardware and software is documented in the project schedule	
47	5.14	Has a contract manager been assigned to this project?	No contract manager assigned	No contract manager assigned
48			Contract manager is the procurement manager	
49			Contract manager is the project manager	
50			Contract manager assigned is not the procurement manager or the project manager	
51	5.15	Has equipment leasing been considered for the project's large-scale computing purchases?	Yes	No
52			No	
53	5.16	Have all procurement selection criteria and outcomes been clearly identified?	No selection criteria or outcomes have been identified	Some selection criteria and outcomes have been defined and documented
54			Some selection criteria and outcomes have been defined and documented	
55			All or nearly all selection criteria and expected outcomes have been defined and documented	
56	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
57			Multi-stage evaluation not planned/used for procurement	
58			Multi-stage evaluation and proof of concept or prototype planned/used to select best qualified vendor	
59	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
60			No, bid response did/will not require proof of concept or prototype	
61			Yes, bid response did/will include proof of concept or prototype	
62			Not applicable	
63				
64				
65				
66				

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 6 -- Project Organization Area			
4	#	Criteria	Values	Answer
5	6.01	Is the project organization and governance structure clearly defined and documented within an approved project plan?	Yes	Yes
6			No	
7	6.02	Have all roles and responsibilities for the executive steering committee been clearly identified?	None or few have been defined and documented	All or nearly all have been defined and documented
8			Some have been defined and documented	
9			All or nearly all have been defined and documented	
10	6.03	Who is responsible for integrating project deliverables into the final solution?	Not yet determined	System Integrator (contractor)
11			Agency	
12			System Integrator (contractor)	
13	6.04	How many project managers and project directors will be responsible for managing the project?	3 or more	3 or more
14			2	
15			1	
16	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
17			Some or most staff roles and responsibilities and needed skills have been identified	
18			Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented	
19	6.06	Is an experienced project manager dedicated fulltime to the project?	No experienced project manager assigned	Yes, experienced project manager dedicated full-time, 100% to project
20			No, project manager is assigned 50% or less to project	
21			No, project manager assigned more than half-time, but less than full-time to project	
22			Yes, experienced project manager dedicated full-time, 100% to project	
23	6.07	Are qualified project management team members dedicated full-time to the project	None	Yes, business, functional or technical experts dedicated full-time, 100% to project
24			No, business, functional or technical experts dedicated 50% or less to project	
25			No, business, functional or technical experts dedicated more than half-time but less than full-time to project	
26			Yes, business, functional or technical experts dedicated full-time, 100% to project	
27	6.08	Does the agency have the necessary knowledge, skills, and abilities to staff the project team with in-house resources?	Few or no staff from in-house resources	Few or no staff from in-house resources
28			Half of staff from in-house resources	
29			Mostly staffed from in-house resources	
30			Completely staffed from in-house resources	
31	6.09	Is agency IT personnel turnover expected to significantly impact this project?	Minimal or no impact	Minimal or no impact
32			Moderate impact	
33			Extensive impact	
34	6.10	Does the project governance structure establish a formal change review and control board to address proposed changes in project scope, schedule, or cost?	Yes	Yes
35			No	
36	6.11	Are all affected stakeholders represented by functional manager on the change review and control board?	No board has been established	No, all stakeholders are not represented on the board
37			No, only IT staff are on change review and control board	
38			No, all stakeholders are not represented on the board	
39			Yes, all stakeholders are represented by functional manager	

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 7 -- Project Management Area			
4	#	Criteria	Values	Answer
5	7.01	Does the project management team use a standard commercially available project management methodology to plan, implement, and control the project?	No	Yes
6			Project Management team will use the methodology selected by the systems integrator	
7			Yes	
8	7.02	For how many projects has the agency successfully used the selected project management methodology?	None	More than 3
9			1-3	
10			More than 3	
11	7.03	How many members of the project team are proficient in the use of the selected project management methodology?	None	All or nearly all
12			Some	
13			All or nearly all	
14	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
15			41 to 80% -- Some have been defined and documented	
16			81% to 100% -- All or nearly all have been defined and documented	
17	7.05	Have all design specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented	0% to 40% -- None or few have been defined and documented
18			41 to 80% -- Some have been defined and documented	
19			81% to 100% -- All or nearly all have been defined and documented	
20	7.06	Are all requirements and design specifications traceable to specific business rules?	0% to 40% -- None or few are traceable	0% to 40% -- None or few are traceable
21			41 to 80% -- Some are traceable	
22			81% to 100% -- All or nearly all requirements and specifications are traceable	
23	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
24			Some deliverables and acceptance criteria have been defined and documented	
25			All or nearly all deliverables and acceptance criteria have been defined and documented	
26	7.08	Is written approval required from executive sponsor, business stakeholders, and project manager for review and sign-off of major project deliverables?	No sign-off required	Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables
27			Only project manager signs-off	
28			Review and sign-off from the executive sponsor, business stakeholder, and project manager are required on all major project deliverables	
29	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	0% to 40% -- None or few have been defined to the work package level
30			41 to 80% -- Some have been defined to the work package level	
31			81% to 100% -- All or nearly all have been defined to the work package level	
32	7.10	Has a documented project schedule been approved for the entire project lifecycle?	Yes	No
33			No	
34	7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints),	Yes	No

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
3	Section 7 -- Project Management Area			
4	#	Criteria	Values	Answer
35		critical milestones, and resources?	No	No
36	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
37			Project team uses formal processes	
38			Project team and executive steering committee use formal status reporting processes	
39	7.13	Are all necessary planning and reporting templates, e.g., work plans, status reports, issues and risk management, available?	No templates are available	All planning and reporting templates are available
40			Some templates are available	
41			All planning and reporting templates are available	
42	7.14	Has a documented Risk Management Plan been approved for this project?	Yes	Yes
43			No	
44	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
45			Some have been defined and documented	
46			All known risks and mitigation strategies have been defined	
47	7.16	Are standard change request, review and approval processes documented and in place for this project?	Yes	Yes
48			No	
49	7.17	Are issue reporting and management processes documented and in place for this project?	Yes	Yes
50			No	

	B	C	D	E
1	Agency: Agency for Health Care Administration			Project: MES Procurement Project
2				
3	Section 8 -- Project Complexity Area			
4	#	Criteria	Values	Answer
5	8.01	How complex is the proposed solution compared to the current agency systems?	Unknown at this time	More complex
6			More complex	
7			Similar complexity	
8			Less complex	
9	8.02	Are the business users or end users dispersed across multiple cities, counties, districts, or regions?	Single location	More than 3 sites
10			3 sites or fewer	
11			More than 3 sites	
12	8.03	Are the project team members dispersed across multiple cities, counties, districts, or regions?	Single location	Single location
13			3 sites or fewer	
14			More than 3 sites	
15	8.04	How many external contracting or consulting organizations will this project require?	No external organizations	1 to 3 external organizations
16			1 to 3 external organizations	
17			More than 3 external organizations	
18	8.05	What is the expected project team size?	Greater than 15	Greater than 15
19			9 to 15	
20			5 to 8	
21			Less than 5	
22	8.06	How many external entities (e.g., other agencies, community service providers, or local government entities) will be impacted by this project or system?	More than 4	More than 4
23			2 to 4	
24			1	
25			None	
26	8.07	What is the impact of the project on state operations?	Business process change in single division or bureau	Statewide or multiple agency business process change
27			Agency-wide business process change	
28			Statewide or multiple agency business process change	
29	8.08	Has the agency successfully completed a similarly-sized project when acting as Systems Integrator?	Yes	Yes
30			No	
31	8.09	What type of project is this?	Infrastructure upgrade	Combination of the above
32			Implementation requiring software development or purchasing commercial off the shelf (COTS) software	
33			Business Process Reengineering	
34			Combination of the above	
35	8.10	Has the project manager successfully managed similar projects to completion?	No recent experience	Greater size and complexity
36			Lesser size and complexity	
37			Similar size and complexity	
38			Greater size and complexity	
39	8.11	Does the agency management have experience governing projects of equal or similar size and complexity to successful completion?	No recent experience	Greater size and complexity
40			Lesser size and complexity	
41			Similar size and complexity	
42			Greater size and complexity	

SCHEDULE IV-B FOR PROVIDER DATA MANAGEMENT SYSTEM

For Fiscal Year 2017-18

August 25, 2016

THE FLORIDA 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: Provider Data Management System	Is this project included in the Agency's LRPP? X Yes ____ No
FY 2017-18 LBR Issue Code:	FY 2017-18 LBR Issue Title:
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Molly McKinstry, Deputy Secretary, Health Quality Assurance	
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: Justin M. Senior, Interim Secretary	Date: 10/12/16
Agency Chief Information Officer (or equivalent): [signature] Printed Name: Scott Ward, CIO	Date: 10/13/16
Budget Officer: [signature] Printed Name: Anita B. Hicks, CFO	Date: 10/12/16
Planning Officer: [signature] Printed Name: Michael Magnuson	Date: 10/13/2016
Project Sponsor: [signature] Printed Name: Molly McKinstry	Date: 10/13/16
Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Ryan Fitch
Cost Benefit Analysis:	Ryan Fitch
Risk Analysis:	Mike Magnuson
Technology Planning:	Mike Magnuson
Project Planning:	Mike Magnuson

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 that are similar to the service level agreements currently in use, 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 Technical Solution
- 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 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

Purpose: To clearly articulate the business-related need(s) for the proposed project.

1. Business Need

The Florida Agency for Health Care Administration (AHCA) Provider Data Management System (PDMS) initiative is intended to move the Agency toward its strategic goal of master data management (MDM) for health care practitioner and facility information. The system was originally funded during the FY 2014-15 Legislative session starting with two sources of AHCA data, Medicaid Providers (businesses and individuals enrolled/contracted to provide Medicaid services) and the Health Quality Assurance (HQA) facility licensees. The first phase of PDMS resulted in the successful integration of these sources into single records and the subsequent ability to monitor change in either system so that other systems can be alerted. The intent of this Legislative Budget Request (LBR) is to further system integration by including records received by the FL Department of Health Medical Quality Assurance (DOH) and enhance automation between AHCA's mission essential IT systems: Florida Medicaid Management Information Services (FMMIS) and the health facility licensing system, Versa Regulation (VERSA).

As the Agency for Health Care Administration has already established a successful model for background screening across multiple programs, it is well positioned to integrate health care provider information. The benefits of this integration, like those observed in the implementation of the Background Screening Clearinghouse, are a reduction in the administrative burdens across the state enterprise as well as within the provider community. Much like the savings achieved through efficiencies of the Background Screening Clearinghouse, savings of time and cost will be observed on behalf of the facilities and individuals when self-reported activities need only go to one system and shared by multiple systems. Savings are achieved both internally and externally (both public and private business entities) when we share information between these systems and eliminate the need for updates to be made manually in each system. This efficiency is the result of both MDM principles and streamlined business processes that require each program area to consider the long-term benefits on an enterprise level as well as the needs of the individual program.

The Florida Agency for State Technology (AST) has taken interest in the AHCA PDMS solution in an effort to promote MDM. AST staffs have been meeting with the Agency to learn more about the successes of integration the PDMS has achieved.

2. Business Objectives

The following strategic objectives are sought for the Agency:

- Agency's efficiency, data quality, ability to provide exceptional customer service, financial accuracy and effective stewardship of state resources:
    - By introducing an automated master record management solution for Agency licensed provider and, now, healthcare practitioner data in the current software-as-a-service solution model.
- Standardize, Validate, & Enrich Agency Data
    - To further improve the accuracy of data in the PDMS, the current data would be enhanced and enriched with the health care practitioner information received daily from the DOH. This will require the new set of data to be analyzed and put through the three phases of

integration, which are Standardize, Validate and Enrich. Standardization occurred on text fields which naturally differ such as; addresses, individual names, business names, and phone numbers. Other fields like codes and identifiers were validated and standardized so the resulting data would be consistent and reliable. The team then used a blend of existing technology, experience, and feedback from business users to enrich data, adding cluster information to support better entity matching results.

- DOH integrated data results will be reviewed incrementally with stakeholders and subject matter experts to collect feedback.
    - Using processes developed in the initial creation of the PDMS, multiple iterations of review assure that the team and stakeholders are comfortable with the cluster strength. Our approach for the first phase was to over-cluster and assign each cluster member a relative confidence metric that indicates how well an entity record fits with other entity records in its assigned cluster. This phase will require coordination between both DOH MQA staff and AHCA HQA staff. We have reached out to DOH to introduce this concept and the benefits to the agencies and provider community. The PDMS will be made available to DOH to either set up alerts or make updates directly to their records as needed.
    - Survivorship algorithms that identify the most valid source of truth for a data element have been used in the current system to make the best attempt at reconciling discrepancies between data sets. When decisions cannot be made through the system, data stewards must be engaged. Additional stakeholders and data stewards at DOH with the ability and authority to make data decisions will be engaged as a result of this project.
- Make the Provider “Single Source of Truth” Available to the State-Enterprise
    - After processing data to define entity clusters, master records, and relationships; the next logical step is to make the provider directory available to end users and systems within the agency (and eventually other agencies starting with DOH). An extensible database and web application was deployed to support entity searching within the agency for the first phase. This will be leveraged for the next phase of integration. Systems (with appropriate access rights) are able to make Simple Object Access Protocol (SOAP) Web Service calls to search for providers or standardize names and addresses. The web services are a key to enabling proactive data quality checks on enrollment and licensing systems. Each participating agency will be granted secure access to these web services and then be able to set up alerts or make changes in the source system if desired. *For example, DOH requires licensed physicians to self-report if they are Medicaid Providers. The PDMS will allow real-time access to that information for DOH to update the profile record without waiting for the bi-annual renewal cycle.*
- Enable Feedback Loop and Matching Metrics
    - While the matching algorithms we deployed were powerful, business users typically have additional institutional knowledge of specific providers that may not be apparent in data or can be masked by irreconcilable data quality issues. A match override feature was provided to allow business users to merge and split entity clusters based on business knowledge. This feedback feature allows the end users to address minor inconsistencies and the project team to identify if there are any emerging trends that could be incorporated back into the matching logic.
    - Additionally, the agency will have the capability to update configurations using a data exchange protocol. Examples include the ability to edit/add to stem word logic and keep crosswalk/lookup tables up to date. Stem words, such as “Pharma” to also mean “Pharmacy” allow the system to standardize non-conventional words and industry terms

to enhance the matching and deduplication. The system also outputs match metrics allowing metrics like median cluster size and cluster count to be monitored and assessed for changes after significant events.

B. Baseline Analysis

Purpose: To establish a basis for understanding the business processes, stakeholder groups, and current technologies that will be affected by the project and the level of business transformation that will be required for the project to be successful.

1. Current Business Process(es)

Predominantly, manual or static business processes are currently used by AHCA to reconcile healthcare practitioner and facility information within the Division of Medicaid, the Division of Health Quality Assurance and the FL Department of Health's Medicaid Quality Assurance Division. Each system could potentially house conflicting data on the same individual. For example, an individual with an address, date of birth and tax ID could be in the HQA system as a Medical Director of a licensed facility. She will have a record in the DOH system as a licensed physician and may also be enrolled as a Medicaid Provider to bill for physician services. We have found many instances where this occurs and the DOH record conflicts with the other records due to a name change.

The figure below shows how the information between these systems can intersect. Most records exist in either the HQA system or the DOH system and the Medicaid system. However, like in the example above, there are instances where one might exist in all three. In the current model, a name change would need to be reported to all three program areas.

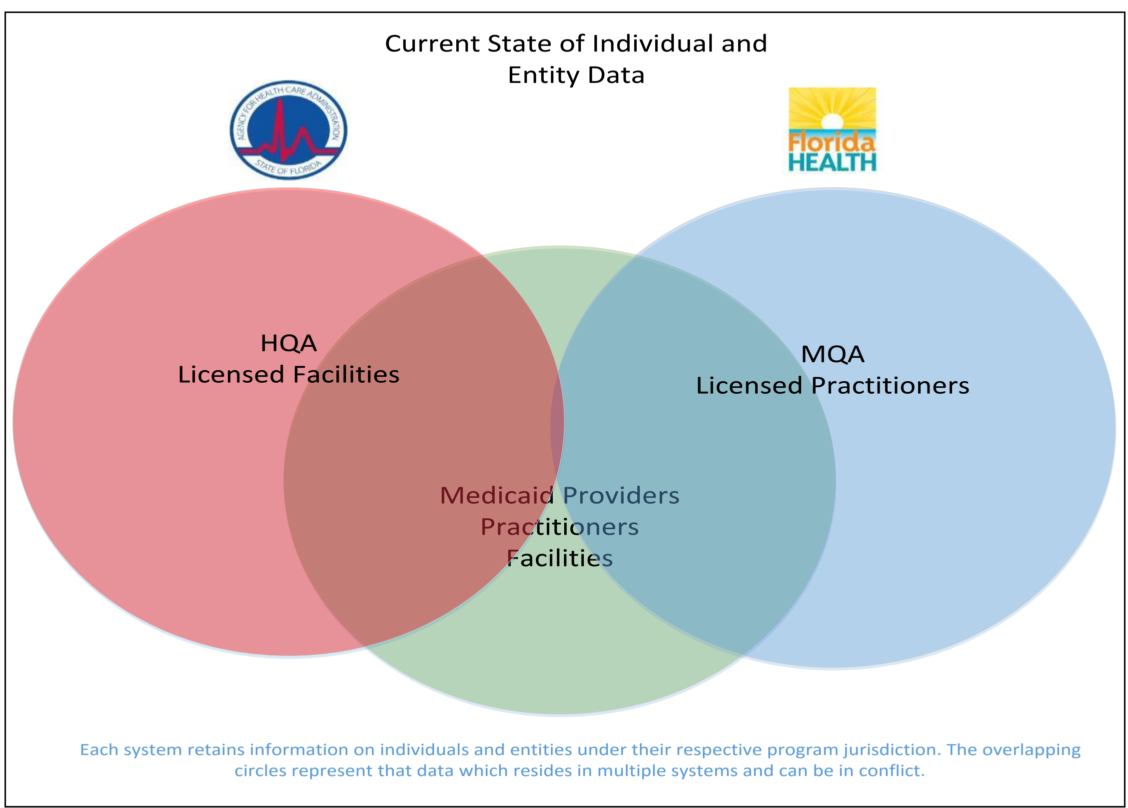


Figure 1: Data records between systems

Before the current PDMS was implemented, the Agency had issues with the consistency, reliability, and quality of provider data across systems like FMMIS enrollment, licensing, and business registries. For example; a provider's address, license information, name, tax identifiers, ownership/related entities, or other critical information may be updated in a single system, and not reflected elsewhere. The result is licensees spending valuable time navigating between multiple disparate systems to be sure all information is updated or agency employees needing to identify providers across systems building one-off crosswalks to assist where there aren't enough consistent data elements to match data.

Provider data are used to drive many critical business functions at the AHCA like provider enrollment, licensing, background screenings, accounts receivable, fraud/waste/abuse, etc. These data should be reconciled and made available and surfaced across the enterprise.

The PDMS Nightly Reconciliation Process (Figure 2) illustrates the nightly processing of the PDMS in the cloud, which results in two products for end-user consumption, a web service and a full set of data. Using this system, the Agency established an internal initiative to reconcile all records in a provider type, in order to pilot the use and benefits of the system as a tool to clean up data. The team chose Ambulatory Surgical Centers as there is a high number of licensed centers that are also enrolled as Medicaid Providers.

There are 434 actively licensed Ambulatory Surgical Centers in the HQA system. Of these, 31 facilities did not match in the Medicaid system that should have. These match issues were reconciled by fixing data in the two systems as well as refining the matching algorithm in the PDMS. A number of lessons were learned from this activity. For example, Medicaid names did not always match the licensure name. Some provider types on the Medicaid file are incorrect, and the licensure file does not always have the correct Medicaid ID or a valid National Provider Identifier (NPI). Skilled Nursing Facilities are currently being reviewed.

Some of the practical and immediate uses of PDMS include notifying the licensure unit of correct Medicaid IDs and NPIs; notifying the Medicaid program of a change in ownership for a facility, and identifying related entities for accounts receivable.

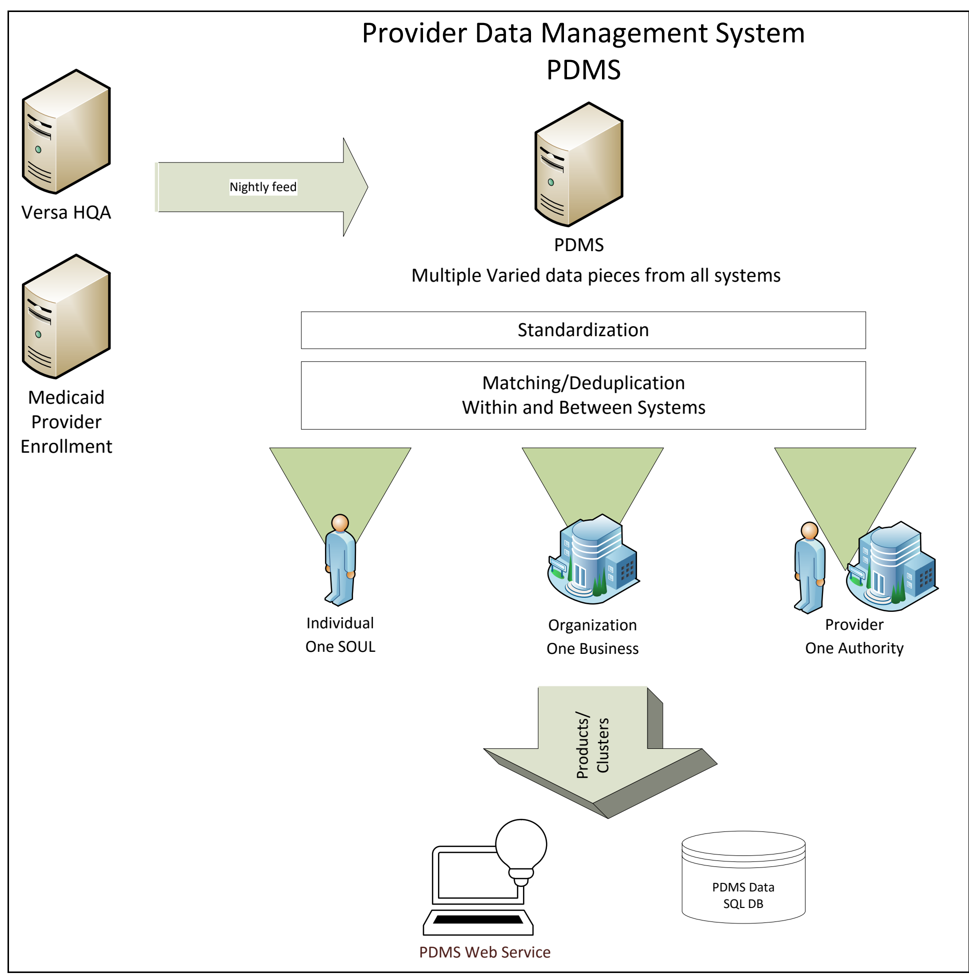


Figure 2: PDMS Nightly Reconciliation Process, Standardize, Validate, Enrich

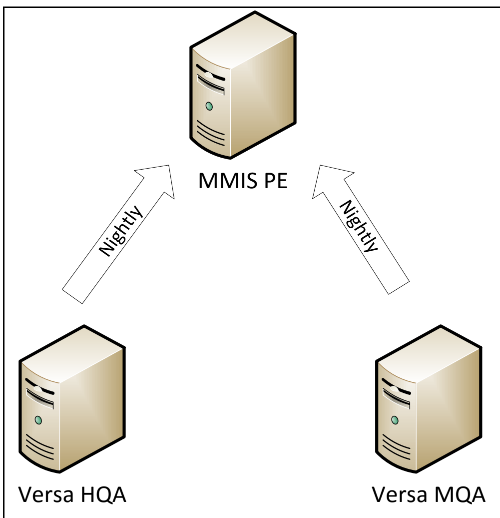


Figure 3: Current One-Way Interface

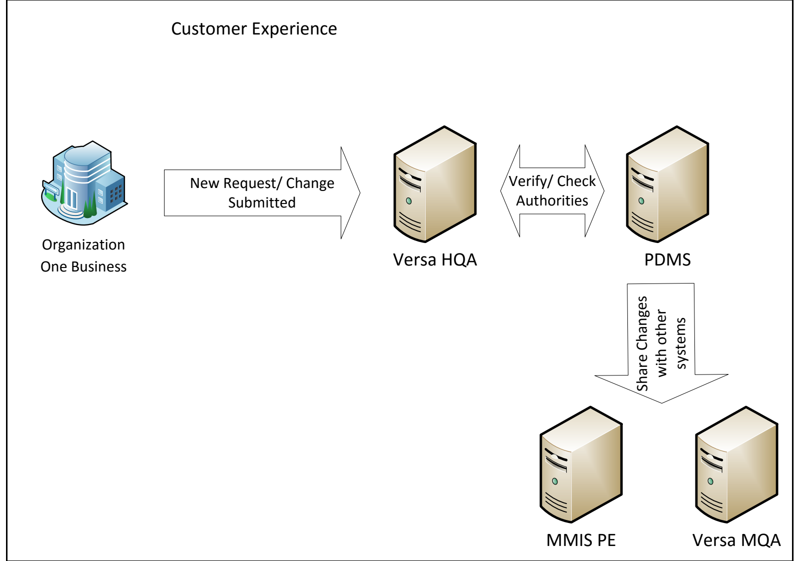


Figure 4: Customer Experience (Note that this project will make the data available from PDMS to the source systems. The source systems will be modified in separate projects to consider the change through alerts or changes to the source record.)

2. Assumptions and Constraints

Because the first phase of the AHCA PDMS is currently implemented, the following assumptions are made:

- DOH / Versa /FMMIS diagrams with "join" criteria will be, or are created.
- Examples of questionable data will be provided back to the AHCA and DOH data stewards for review and remediation .

- Validated data dictionaries are current for FMMIS & Versa (HQA and MQA)
- Most of the information required to translate codes are in a data dictionary
- An Entity Diagram is available for the DOH System
    - An Entity Diagram will help describe the data base table relationships
- Standard data intake and data entry process are known since AHCA uses the same licensure software platform (Versa) as DOH
- The system will serve providers who enter data by performing proactive validation
- Current Memorandums of Understanding and Data Use Agreements between AHCA and DOH would apply for this interoperability effort

The following constraints are noted:

- The current PDMS is maintained as a service. The algorithms used to standardize, validate and enrich the data as well as the weighting formulas are configurable by request but proprietary to the vendor
- PDMS data will be available but the source system modification will need to be conducted separately

C. Proposed Business Process Requirements

Purpose: To establish a basis for understanding what business process requirements the proposed solution must meet in order to select an appropriate solution for the project.

1. Proposed Business Process Requirements

As the funding requested is mostly for the enhancement of the service, which reconciles entity data, business processes are not changed but rather enhanced by this project. As noticed in Figure 3 above, the customer would make a change to one of the source systems and the PDMS would have the links back to other source systems. It is the decision of the receiving system on how to process that information. For example, if a facility licensed under the HQA system makes change to their mailing address, the PDMS would notify the Medicaid Provider Enrollment system if that facility was also a Medicaid provider. The Medicaid Provider Enrollment system would be modified to automatically accept the change or to require a manual intervention depending on the business rules developed.

2. Business Solution Alternatives

3. Rationale for Selection

The current PDMS system design, which compares the two data sources would be enhanced by this funding. The current system was built under a competitively bid contract. Since the current contract allows for an unspecified number of data sources to establish a single source of truth, it could be amended to require the additional data source integration.

4. Recommended Business Solution

The Agency recommends adding the Florida Department of Health's Division of Medical Quality Assurance's provider data into the current AHCA PDMS.

The yellow box in the schematic below represents the new additional data to be integrated with AHCA's current Provider Data Management System (PDMS).

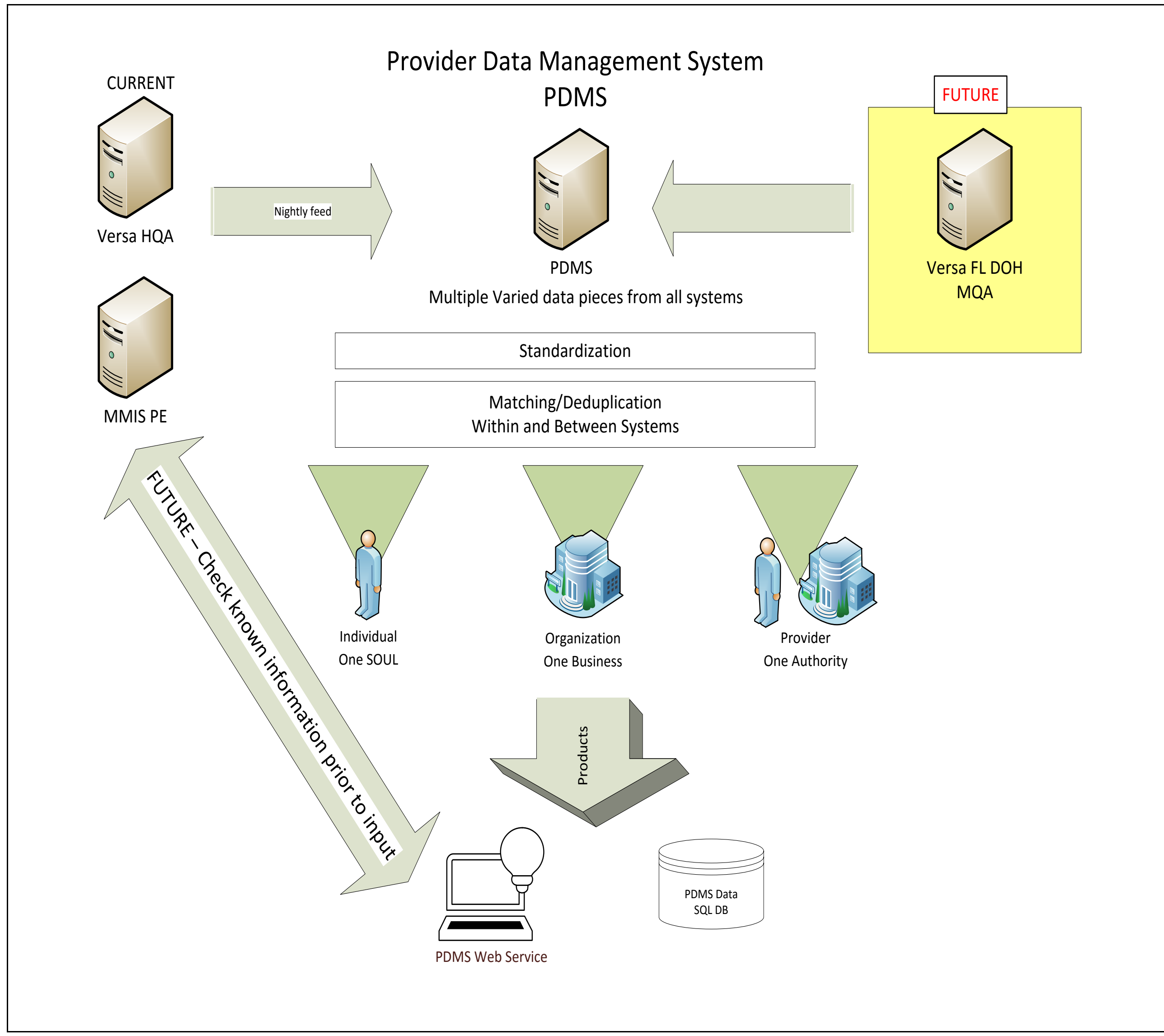


Figure 5: Future integration of DOH data into the Standardize, Validate, Enrich process. The added step of validating against PDMS for the source system will be brought in through changes to those systems.

D. Functional and Technical Requirements

Purpose: To identify the functional and technical system requirements that must be met by the project.

The vendor will be required to conduct the Joint Application Design (JAD) sessions and develop a Requirements Traceability Matrix (RTM) detailing the needs of the project to integrate the new data set. This will include:

- Analyzing the DOH data for accuracy
- Mapping all profile related fields to the existing PDMS
- Establishing new weighting and confidence standards for matching and deduplication
- Determining any and all relationship types between individuals and entities

- Establishing survivorship standards for conflicting data within and between the source systems and administrative tools for the modification of survivorship rules
- Modified secure web services for the inclusion of the new DOH data fields if needed
- Nightly processing within a 4-6 hour window for the availability of data no more than 18-24 hours out of date
- Monitoring records for changes and web services for alerting the source systems when a change is made elsewhere in the PDMS enterprise

III. Success Criteria

Purpose: To identify the critical results, both outputs and outcomes, that must be realized for the project to be considered a success.

SUCCESS CRITERIA TABLE				
#	**Description of Criteria**	**How will the Criteria be measured/assessed?**	**Who benefits?**	**Realization Date (MM/YY)**
1	Ability to search any individual or entity known to any combination of the source systems and identify a single source of truth on that individual or entity.	An application will be available to end users through an API interfaced to source systems to provide search ability	Both internal agencies and external customers will benefit from the enhanced matching and automations.	07/2018
2	Successful modification of survivorship rules through an administrative portal.	Through User Interfaces and UAT	Both internal agencies and external customers will benefit from the enhanced matching and automations.	07/2018
3	Ability to alert systems of interest when a change is made to a record in any source system.	Testing of web services	DOH and AHCA staff and licensees.	12/2018
4	Increased awareness of relationships between individuals and entities for the collection of accounts receivable.	By searching a single portal for individuals and entities who owe money prior to renewals	Florida tax payers	12/2018

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

A. Benefits Realization Table

Purpose: To calculate and declare the tangible benefits compared to the total investment of resources needed to support the proposed IT project.

For each tangible benefit, identify the recipient of the benefit, how and when it is realized, how the realization will be measured, and how the benefit will be measured to include estimates of tangible benefit amounts.

BENEFITS REALIZATION TABLE					
#	**Description of Benefit**	**Who receives the benefit?**	**How is benefit realized?**	**How is the realization of the benefit measured?**	**Realization Date (MM/YY)**
1	Accurate and current information exchange between programs and systems.	All internal stakeholders as well as external licensees.	Better entity resolution	Decrease in administrative burden on reporting changes to multiple agencies/sources. Reduction in time to process license and Medicaid enrollment applications. Real-time exchange of alerts between systems in the event of disciplinary action in any program.	Beginning 07/2018 and conditional on source system modification.
2	Increase in the recovery of accounts receivable across providers and provider types	AHCA and State of Florida	Accounts Receivable	More dollars recovered prior to renewal or licensure through better matching	12/2018
3	Decrease in fraud/abuse and inappropriate payments	AHCA and State of Florida	Fraud and Abuse detection	Increase in the number of denials for enrollment and/or licensure on individuals and entities with prior history of fraud/abuse	12/2018

B. Cost Benefit Analysis (CBA)

Purpose: To provide a comprehensive financial prospectus specifying the project's tangible benefits, funding requirements, and proposed source(s) of funding.

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	Please see Appendix A
CBA Form 2 - Project Cost Analysis	Please see Appendix A
CBA Form 3 - Project Investment Summary	Please see Appendix A

V. Schedule IV-B Major Project Risk Assessment

Purpose: To provide an initial high-level assessment of overall risk incurred by the project to enable appropriate risk mitigation and oversight and to improve the likelihood of project success. The risk assessment summary identifies the overall level of risk associated with the project and provides an assessment of the project's alignment with business objectives.

> ***NOTE: All multi-year projects must update the Risk Assessment Component of the Schedule IV-B along with any other components that have been changed from the original Feasibility Study.***

Please see attached Appendix B – Risk Assessment Tool

There are two major risks to the realization of the downstream benefits of the PDMS:

- Establishment of the data governance structure including data stewards to follow up on concerns and conflicts between data.
- Ability and willingness to modify source systems to use the PDMS as the single source of truth

The mitigation of these risks is essential to the project and will require some intervention by the Agency for State Technology (AST). As each agency lacks the authority to pull multiple agencies together for this Master Data Management initiative, having the support of the AST is essential to success.

Additional risks and mitigation strategies will be identified once the project is initiated.

VI. Schedule IV-B Technology Planning

Purpose: To ensure there is close alignment with the business and functional requirements and the selected technology.

A. Current Information Technology Environment

1. Current System

The two data sets are sent by Secure File Transfer Protocol (SFTP) each night to the vendor.

The Current PDMS is available in two forms, both of which are provided as a service to the Agency and 100% hosted by the vendor.

- Web Services – These are secure services to allow for the lookup of providers, individuals and entities and receive profile and relationship information.
- Complete Data Refresh (daily) – Received each morning through SFTP after the nightly run so AHCA has access to the full set in SQL format if needed.

a. Description of Current System

Figure 6: Current PDMS nightly data processing flow

b. Current System Resource Requirements

Bandwidth only. All other services performed by the vendor.

c. Current System Performance

Processing of data feeds in PDMS is approximately 6-7 hours nightly.

2. Information Technology Standards

B. Current Hardware and/or Software Inventory

All PDMS services outsourced to the vendor as Software as a Service (SaaS)

C. Proposed Technical Solution

1. Technical Solution Alternatives

The Agency has taken on several initiatives using existing resources in the past in order to clean up the data between the source systems. The challenge has always been in that the data discrepancies are inherent in the manual process of reporting and reconciliation. Much time is spent mining data in the source systems to find identities but it can only be done on a case by case basis. For example, if a final order is issued against a Medicaid Provider, then there is manual process to look up that provider in the HQA system to determine if administrative action should be taken on their facility license. These manual processes are time consuming but can be considered an alternative to reconciling the data between the systems.

2. Rationale for Selection

The current contract is a SaaS model, which could be leveraged for this additional source of data integration.

3. Recommended Technical Solution

The integration of the DOH into the PDMS to increase the accuracy of the data and the acceptance of the PDMS as a single source of truth.

D. Proposed Solution Description

1. **Summary Description of Proposed System** – See above Section C.4.

2. **Resource and Summary Level Funding Requirements for Proposed Solution (if known)**

E. Capacity Planning

To Be Determined

VII. Schedule IV-B Project Management Planning

This enhancement to the PDMS will come with project management from the vendor. The vendor is required, by contract, to comply with Rule 74-1, F.A.C. and the Agency's Information System Development Methodology.

NOTE: For IT projects with total cost in excess of $10 million, the project scope, business objectives, and timelines described in this section must be consistent with existing or proposed substantive policy required in s. 216.023(4)(a)10, F.S.

VIII. Appendices

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

Appendix A – Cost Benefit Analysis (CBA) Forms

Appendix B – Risk Assessment Tool

APPENDIX A

CBAForm 1 - Net Tangible Benefits

Agency AHCA   Project)ata Management System Enha

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	FY 2017-18			FY 2018-19			FY 2019-20			FY 2020-21			FY 2021-22		
(Recurring Costs 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) Cost Change 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 Costs -- Agency-Managed Staff	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207
A.b Total Staff	0.91	-0.90	0.01	0.91	-0.90	0.01	0.91	-0.90	0.01	0.91	-0.90	0.01	0.91	-0.90	0.01
A-1.a. State FTEs (Salaries & Benefits)	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207
A-1.b. State FTEs (#)	0.91	-0.90	0.01	0.91	-0.90	0.01	0.91	-0.90	0.01	0.91	-0.90	0.01	0.91	-0.90	0.01
A-2.a. OPS Staff (Salaries)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
A-2.b. OPS (#)	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 Contractors)	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. Application Maintenance Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-1. Managed Services (Staffing)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-2. Hardware	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-3. Software	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
B-4. Other Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C. Data Center Provider Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-1. Managed Services (Staffing)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-2. Infrastructure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-3. Network / Hosting Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-4. Disaster Recovery	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C-5. Other Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D. Plant & Facility Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
E. Other Costs	$0	$0	$0	$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 Specify	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total of Recurring Operational Costs	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207	$48,546	-$37,339	$11,207
F. Additional Tangible Benefits:		$0			$0			$0			$0			$0	
F-1. Increased ability to recover monies		$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:		$37,339			$37,339			$37,339			$37,339			$37,339	

CHARACTERIZATION OF PROJECT BENEFIT ESTIMATE -- CBAForm 1B			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous	☐	Confidence Level	
Order of Magnitude	☑	Confidence Level	80%
Placeholder	☐	Confidence Level	

	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	Provider Data Management System Enhancements			*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.***				FY2017-18			FY2018-19			FY2019-20			FY2020-21			FY2021-22			TOTAL
3				$ -		$ 750,000			$ 100,000			$ 100,000			$ 100,000			$ 100,000		$ 1,150,000
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 to include Independent Verification & Validation (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	$ -	0.00	$ 150,000	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	0.00	$ -	$ -	$ 150,000
11	Separate requirements analysis and feasibility study procurements.	**Project Planning/Analysis**	Contracted Services	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ -
12	Hardware purchases not included in data center services.	**Hardware**	OCO	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ -
13	Commercial software purchases and licensing costs.	**Commercial Software**	Contracted Services	$ -		$ -	$ -		$ 100,000	$ -		$ 100,000	$ -		$ 100,000	$ -		$ 100,000	$ -	$ 400,000
14	Professional services with fixed-price costs (i.e. software development, installation, project documentation)	**Project Deliverables**	Contracted Services	$ -		$ 600,000	$ -			$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ 600,000
15	All first-time training costs associated with the project.	**Training**	Contracted Services	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ -
16	Include the quote received from the data center provider 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	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	$ -
21		**Total**		**$ -**	**0.00**	**$ 750,000**	**$ -**	**0.00**	**$ 100,000**	**$ -**	**0.00**	**$ 100,000**	**$ -**	**0.00**	**$ 100,000**	**$ -**	**0.00**	**$ 100,000**	**$ -**	**$ 1,150,000**

CBAForm 2 - Project Cost Analysis

Agency AHCA

Project der Data Management System Enhancer

PROJECT COST SUMMARY	PROJECT COST SUMMARY (from CBAForm 2A)					TOTAL
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	
TOTAL PROJECT COSTS (*)	$750,000	$100,000	$100,000	$100,000	$100,000	$1,150,000
CUMULATIVE PROJECT COSTS *(includes Current & Previous Years' Project-Related Costs)*	$750,000	$850,000	$950,000	$1,050,000	$1,150,000	
Total Costs are carried forward to CBAForm3 Project Investment Summary worksheet.						

PROJECT FUNDING SOURCES	PROJECT FUNDING SOURCES - CBAForm 2B					TOTAL
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	
General Revenue	$0	$0	$0	$0	$0	$0
Trust Fund	$750,000	$100,000	$100,000	$100,000	$100,000	$1,150,000
Federal Match ☐	$0	$0	$0	$0	$0	$0
Grants ☐	$0	$0	$0	$0	$0	$0
Other ☐ Specify	$0	$0	$0	$0	$0	$0
TOTAL INVESTMENT	$750,000	$100,000	$100,000	$100,000	$100,000	$1,150,000
CUMULATIVE INVESTMENT	$750,000	$850,000	$950,000	$1,050,000	$1,150,000	

Characterization of Project Cost Estimate - CBAForm 2C			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous		Confidence Level	
Order of Magnitude	X - more savings are likely to o	Confidence Level	80%
Placeholder		Confidence Level	

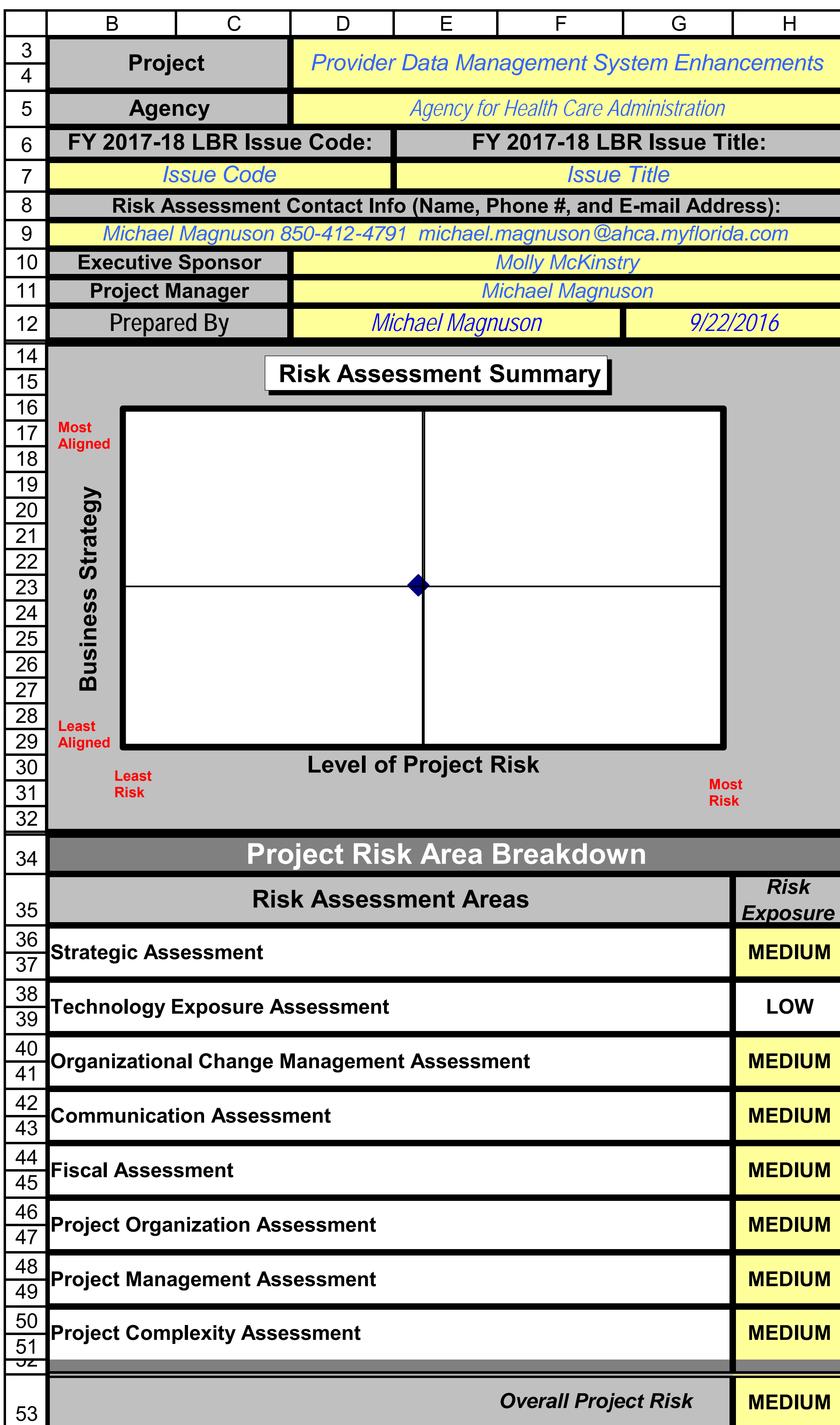
CBAForm 3 - Project Investment Summary

Agency	AHCA	Project	ta Management System En

COST BENEFIT ANALYSIS -- CBAForm 3A						
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	TOTAL FOR ALL YEARS
Project Cost	$750,000	$100,000	$100,000	$100,000	$100,000	$1,150,000
Net Tangible Benefits	$37,339	$37,339	$37,339	$37,339	$37,339	$186,695
Return on Investment	($712,661)	($62,661)	($62,661)	($62,661)	($62,661)	($963,305)
Year to Year Change in Program Staffing	(1)	(1)	(1)	(1)	(1)	

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)	($918,646)	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 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Cost of Capital	1.94%	2.07%	3.18%	4.32%	4.85%



Project	*Provider Data Management System Enhancements*	
Agency	*Agency for Health Care Administration*	
FY 2017-18 LBR Issue Code:	**FY 2017-18 LBR Issue Title:**	
Issue Code	*Issue Title*	
Risk Assessment Contact Info (Name, Phone #, and E-mail Address):		
Michael Magnuson 850-412-4791 michael.magnuson@ahca.myflorida.com		
Executive Sponsor	*Molly McKinstry*	
Project Manager	*Michael Magnuson*	
Prepared By	*Michael Magnuson*	*9/22/2016*

Risk Assessment Summary

Project Risk Area Breakdown

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

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
3	Section 1 -- Strategic Area			
4	#	Criteria	Values	Answer
5	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
6			41% to 80% -- Some objectives aligned	
7			81% to 100% -- All or nearly all objectives aligned	
8	1.02	Are project objectives clearly documented and understood by all stakeholder groups?	Not documented or agreed to by stakeholders	Informal agreement by stakeholders
9			Informal agreement by stakeholders	
10			Documented with sign-off by stakeholders	
11	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
12			Most regularly attend executive steering committee meetings	
13			Project charter signed by executive sponsor and executive team actively engaged in steering committee meetings	
14	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 partially documented
15			Vision is partially documented	
16			Vision is completely documented	
17	1.05	Have all project business/program area requirements, assumptions, constraints, and priorities been defined and documented?	0% to 40% -- Few or none defined and documented	41% to 80% -- Some defined and documented
18			41% to 80% -- Some defined and documented	
19			81% to 100% -- All or nearly all defined and documented	
20	1.06	Are all needed changes in law, rule, or policy identified and documented?	No changes needed	Changes are identified in concept only
21			Changes unknown	
22			Changes are identified in concept only	
23			Changes are identified and documented	
24			Legislation or proposed rule change is drafted	
25	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	Few or none
26			Some	
27			All or nearly all	
28	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
29			Moderate external use or visibility	
30			Extensive external use or visibility	
31	1.09	What is the internal (e.g. state agency) visibility of the proposed system or project?	Multiple agency or state enterprise visibility	Single agency-wide use or visibility
32			Single agency-wide use or visibility	
33			Use or visibility at division and/or bureau level only	
34	1.10	Is this a multi-year project?	Greater than 5 years	Between 1 and 3 years
35			Between 3 and 5 years	
36			Between 1 and 3 years	
37			1 year or less	

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
3	Section 2 -- Technology Area			
4	#	Criteria	Values	Answer
5	2.01	Does the agency have experience working with, operating, and supporting the proposed technical solution in a production environment?	Read about only or attended conference and/or vendor presentation	Supported production system 1 year to 3 years
6			Supported prototype or production system less than 6 months	
7			Supported production system 6 months to 12 months	
8			Supported production system 1 year to 3 years	
9			Installed and supported production system more than 3 years	
10	2.02	Does the agency's internal staff have sufficient knowledge of the proposed technical solution 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
11			External technical resources will be needed through implementation only	
12			Internal resources have sufficient knowledge for implementation and operations	
13	2.03	Have all relevant technical alternatives/ solution options been researched, documented and considered?	No technology alternatives researched	All or nearly all alternatives documented and considered
14			Some alternatives documented and considered	
15			All or nearly all alternatives documented and considered	
16	2.04	Does the proposed technical solution 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
17			Some relevant standards have been incorporated into the proposed technology	
18			Proposed technology solution is fully compliant with all relevant agency, statewide, or industry standards	
19	2.05	Does the proposed technical solution require significant change to the agency's existing technology infrastructure?	Minor or no infrastructure change required	Minor or no infrastructure change required
20			Moderate infrastructure change required	
21			Extensive infrastructure change required	
22			Complete infrastructure replacement	
23	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
24			Capacity requirements are defined only at a conceptual level	
25			Capacity requirements are based on historical data and new system design specifications and performance requirements	

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
3	Section 3 -- Organizational Change Management Area			
4	#	Criteria	Values	Answer
5	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
6			Moderate changes to organization structure, staff or business processes	
7			Minimal changes to organization structure, staff or business processes structure	
8	3.02	Will this project impact essential business processes?	Yes	Yes
9			No	
10	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
11			41% to 80% -- Some process changes defined and documented	
12			81% to 100% -- All or nearly all processes defiined and documented	
13	3.04	Has an Organizational Change Management Plan been approved for this project?	Yes	No
14			No	
15	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
16			1% to 10% FTE count change	
17			Less than 1% FTE count change	
18	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
19			1 to 10% contractor count change	
20			Less than 1% contractor count change	
21	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
22			Moderate changes	
23			Minor or no changes	
24	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
25			Moderate changes	
26			Minor or no changes	
27	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
28			Recently completed project with fewer change requirements	
29			Recently completed project with similar change requirements	
30			Recently completed project with greater change requirements	

	B	C	D	E
1	Agency: Agency Name			Project: Project Name
3	Section 4 -- Communication Area			
4	#	Criteria	Value Options	Answer
5	4.01	Has a documented Communication Plan been approved for this project?	Yes	Yes
6			No	
7	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
8			Routine feedback in Plan	
9			Proactive use of feedback in Plan	
10	4.03	Have all required communication channels been identified and documented in the Communication Plan?	Yes	Yes
11			No	
12	4.04	Are all affected stakeholders included in the Communication Plan?	Yes	No
13			No	
14	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
15			Some key messages have been developed	
16			All or nearly all messages are documented	
17	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
18			Success measures have been developed for some messages	
19			All or nearly all messages have success measures	
20	4.07	Does the project Communication Plan identify and assign needed staff and resources?	Yes	Yes
21			No	

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
3	Section 5 -- Fiscal Area			
4	#	Criteria	Values	Answer
5	5.01	Has a documented Spending Plan been approved for the entire project lifecycle?	Yes	Yes
6			No	
7	5.02	Have all project expenditures been identified in the Spending Plan?	0% to 40% -- None or few defined and documented	81% to 100% -- All or nearly all defined and documented
8			41% to 80% -- Some defined and documented	
9			81% to 100% -- All or nearly all defined and documented	
10	5.03	What is the estimated total cost of this project over its entire lifecycle?	Unknown	Between $500K and $1,999,999
11			Greater than $10 M	
12			Between $2 M and $10 M	
13			Between $500K and $1,999,999	
14			Less than $500 K	
15	5.04	Is the cost estimate for this project based on quantitative analysis using a standards-based estimation model?	Yes	Yes
16			No	
17	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%
18			Order of magnitude – estimate could vary between 10-100%	
19			Placeholder – actual cost may exceed estimate by more than 100%	
20	5.06	Are funds available within existing agency resources to complete this project?	Yes	No
21			No	
22	5.07	Will/should multiple state or local agencies help fund this project or system?	Funding from single agency	Funding from single agency
23			Funding from local government agencies	
24			Funding from other state agencies	
25	5.08	If federal financial participation is anticipated as a source of funding, has federal approval been requested and received?	Neither requested nor received	Neither requested nor received
26			Requested but not received	
27			Requested and received	
28			Not applicable	
29	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
30			Some project benefits have been identified but not validated	
31			Most project benefits have been identified but not validated	
32			All or nearly all project benefits have been identified and validated	
33	5.10	What is the benefit payback period that is defined and documented?	Within 1 year	Within 3 years
34			Within 3 years	
35			Within 5 years	
36			More than 5 years	
37			No payback	
38	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
39			Stakeholders have not been consulted re: procurement strategy	
40			Stakeholders have reviewed and approved the proposed procurement strategy	
41	5.12	What is the planned approach for acquiring necessary products and solution services to successfully complete the project?	Time and Expense (T&E)	Combination FFP and T&E
42			Firm Fixed Price (FFP)	
43			Combination FFP and T&E	
44	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

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
3	Section 5 -- Fiscal Area			
4	#	Criteria	Values	Answer
45			Purchase all hardware and software at start of project to take advantage of one-time discounts	hardware and software is documented in the project schedule
46			Just-in-time purchasing of hardware and software is documented in the project schedule	
47	5.14	Has a contract manager been assigned to this project?	No contract manager assigned	Contract manager is the project manager
48			Contract manager is the procurement manager	
49			Contract manager is the project manager	
50			Contract manager assigned is not the procurement manager or the project manager	
51	5.15	Has equipment leasing been considered for the project's large-scale computing purchases?	Yes	Yes
52			No	
53	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
54			Some selection criteria and outcomes have been defined and documented	
55			All or nearly all selection criteria and expected outcomes have been defined and documented	
56	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
57			Multi-stage evaluation not planned/used for procurement	
58			Multi-stage evaluation and proof of concept or prototype planned/used to select best qualified vendor	
59	5.18	For projects with total cost exceeding $10 million, did/will the procurement strategy require a proof of concept or prototype as part of the bid response?	Procurement strategy has not been developed	Not applicable
60			No, bid response did/will not require proof of concept or prototype	
61			Yes, bid response did/will include proof of concept or prototype	
62			Not applicable	
63				
64				
65				
66				

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
3	Section 6 -- Project Organization Area			
4	#	Criteria	Values	Answer
5	6.01	Is the project organization and governance structure clearly defined and documented within an approved project plan?	Yes	No
6			No	
7	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
8			Some have been defined and documented	
9			All or nearly all have been defined and documented	
10	6.03	Who is responsible for integrating project deliverables into the final solution?	Not yet determined	System Integrator (contractor)
11			Agency	
12			System Integrator (contractor)	
13	6.04	How many project managers and project directors will be responsible for managing the project?	3 or more	2
14			2	
15			1	
16	6.05	Has a project staffing plan specifying the number of required resources (including project team, program staff, and contractors) and their corresponding roles, responsibilities and needed skill levels been developed?	Needed staff and skills have not been identified	Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented
17			Some or most staff roles and responsibilities and needed skills have been identified	
18			Staffing plan identifying all staff roles, responsibilities, and skill levels have been documented	
19	6.06	Is an experienced project manager dedicated fulltime to the project?	No experienced project manager assigned	No, project manager assigned more than half-time, but less than full-time to project
20			No, project manager is assigned 50% or less to project	
21			No, project manager assigned more than half-time, but less than full-time to project	
22			Yes, experienced project manager dedicated full-time, 100% to project	
23	6.07	Are qualified project management team members dedicated full-time to the project	None	No, business, functional or technical experts dedicated more than half-time but less than full-time to project
24			No, business, functional or technical experts dedicated 50% or less to project	
25			No, business, functional or technical experts dedicated more than half-time but less than full-time to project	
26			Yes, business, functional or technical experts dedicated full-time, 100% to project	
27	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
28			Half of staff from in-house resources	
29			Mostly staffed from in-house resources	
30			Completely staffed from in-house resources	
31	6.09	Is agency IT personnel turnover expected to significantly impact this project?	Minimal or no impact	Minimal or no impact
32			Moderate impact	
33			Extensive impact	
34	6.10	Does the project governance structure establish a formal change review and control board to address proposed changes in project scope, schedule, or cost?	Yes	Yes
35			No	
36	6.11	Are all affected stakeholders represented by functional manager on the change review and control board?	No board has been established	Yes, all stakeholders are represented by functional manager
37			No, only IT staff are on change review and control board	
38			No, all stakeholders are not represented on the board	
39			Yes, all stakeholders are represented by functional manager	

Agency: Agency for Health Care Administration | Project: Provider Data Management System Enhancements

Section 7 -- Project Management Area

#	Criteria	Values	Answer
7.01	Does the project management team use a standard commercially available project management methodology to plan, implement, and control the project?	No Project Management team will use the methodology selected by the systems integrator Yes	Yes
7.02	For how many projects has the agency successfully used the selected project management methodology?	None 1-3 More than 3	More than 3
7.03	How many members of the project team are proficient in the use of the selected project management methodology?	None Some All or nearly all	All or nearly all
7.04	Have all requirements specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	41 to 80% -- Some have been defined and documented
7.05	Have all design specifications been unambiguously defined and documented?	0% to 40% -- None or few have been defined and documented 41 to 80% -- Some have been defined and documented 81% to 100% -- All or nearly all have been defined and documented	41 to 80% -- Some have been defined and documented
7.06	Are all requirements and design specifications traceable to specific business rules?	0% to 40% -- None or few are traceable 41 to 80% -- Some are traceable 81% to 100% -- All or nearly all requirements and specifications are traceable	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	No
7.11	Does the project schedule specify all project tasks, go/no-go decision points (checkpoints),	Yes	No

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
3	Section 7 -- Project Management Area			
4	#	Criteria	Values	Answer
35		critical milestones, and resources?	No	No
36	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
37			Project team uses formal processes	
38			Project team and executive steering committee use formal status reporting processes	
39	7.13	Are all necessary planning and reporting templates, e.g., work plans, status reports, issues and risk management, available?	No templates are available	All planning and reporting templates are available
40			Some templates are available	
41			All planning and reporting templates are available	
42	7.14	Has a documented Risk Management Plan been approved for this project?	Yes	No
43			No	
44	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
45			Some have been defined and documented	
46			All known risks and mitigation strategies have been defined	
47	7.16	Are standard change request, review and approval processes documented and in place for this project?	Yes	Yes
48			No	
49	7.17	Are issue reporting and management processes documented and in place for this project?	Yes	Yes
50			No	

	B	C	D	E
1	Agency: Agency for Health Care Administration		Project: Provider Data Management System Enhancements	
2				
3	Section 8 -- Project Complexity Area			
4	#	Criteria	Values	Answer
5	8.01	How complex is the proposed solution compared to the current agency systems?	Unknown at this time	Similar complexity
6			More complex	
7			Similar complexity	
8			Less complex	
9	8.02	Are the business users or end users dispersed across multiple cities, counties, districts, or regions?	Single location	More than 3 sites
10			3 sites or fewer	
11			More than 3 sites	
12	8.03	Are the project team members dispersed across multiple cities, counties, districts, or regions?	Single location	Single location
13			3 sites or fewer	
14			More than 3 sites	
15	8.04	How many external contracting or consulting organizations will this project require?	No external organizations	1 to 3 external organizations
16			1 to 3 external organizations	
17			More than 3 external organizations	
18	8.05	What is the expected project team size?	Greater than 15	5 to 8
19			9 to 15	
20			5 to 8	
21			Less than 5	
22	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	None
23			2 to 4	
24			1	
25			None	
26	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
27			Agency-wide business process change	
28			Statewide or multiple agency business process change	
29	8.08	Has the agency successfully completed a similarly-sized project when acting as Systems Integrator?	Yes	Yes
30			No	
31	8.09	What type of project is this?	Infrastructure upgrade	Implementation requiring software development or purchasing commercial off the shelf (COTS) software
32			Implementation requiring software development or purchasing commercial off the shelf (COTS) software	
33			Business Process Reengineering	
34			Combination of the above	
35	8.10	Has the project manager successfully managed similar projects to completion?	No recent experience	Greater size and complexity
36			Lesser size and complexity	
37			Similar size and complexity	
38			Greater size and complexity	
39	8.11	Does the agency management have experience governing projects of equal or similar size and complexity to successful completion?	No recent experience	Greater size and complexity
40			Lesser size and complexity	
41			Similar size and complexity	
42			Greater size and complexity	

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS Budget Period: 2017-18 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 2015-16					
AG 2016-159	FYE 6/30/15	State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards	**2015-019** General information technology (IT) controls for the Florida Medicaid Management Information System (FMMIS) need improvement. Additionally, the FAHCA did not fairly state the status of a similar finding on the Summary Schedule of Prior Audit Findings (SSPAF). **Recommendation** We recommend that the FAHCA ensure the State's fiscal agent takes timely and appropriate corrective action to resolve the deficiencies noted in the HPES SSAE 16 Type II report.	**Management Response** Issue #1 and #2: The FLXIX Security Policies and Procedures Manual was modified (version 1.1) to add security procedures for monitoring and auditing Switch User ID access to production. Section 7.1.4 of the Procedure Manual - Post implementation of corrective action states: The access is monitored on a daily basis by a HPES Solution Architect and a Systems Engineer who do not have the access to the super user ID. Therefore, two independent individuals are conducting the reviews. On a weekly basis, Switch User ID access is reviewed to verify if the level of access is appropriate for the individual's job responsibilities. This corrective action was applied to production level access and not applicable to test environments. Issue #3: The FLXIX Security Policies and Procedures Manual was modified (version 1.1) to add security procedures for monitoring and auditing Switch User ID access to production. The access reviews are conducted as follows (per Security Policies and Procedure Manual): o Switch User activity is recorded for each system and uploaded daily to the FLXIX SharePoint site. o The activity is reviewed by and signed off by the Leveraged Security Administrator (or FLXIX Security Officer (SO)). o Any questions about the activity are directed to the Solution Architect and the Systems individuals who performed the activities. o The review must verify that a valid Change Order (CO) or Florida Interactive Portal (FIP) was recorded for all the Switch User usage. Issue #4: Reviews are conducted each quarter and a report is delivered to Medicaid Fiscal Agent Operations (MFAO). The MFAO reviews the report as part of the HPES Report Card process. The HPE Report card assigns a score for measurable performance measures, and when the Fiscal Agent receives an unacceptable score, they are liable for liquidated damages under the current contract. Issue #5 and #6: HPES modified the system monitoring procedures to monitor Switch User Access for Unix Systems. Access and special privileges have been granted to a minimal number of HPES staff. UNIX produces a listing of the access group members. Issue #7: HPES has the system parameters appropriately configured. The result of the change is to call a verification function. Execution of this function results in the verification of the password length, as well as approximately a dozen other verifications.	
			2015-033 The FAHCA continued to record medical assistance related payments to incorrect appropriation categories in the State's accounting records. **Recommendation** We again recommend that the FAHCA strengthen procedures for the accurate recording of medical assistance related payments in the State's accounting records.	The FAHCA will continue to make every effort to ensure that medical assistance related payments are accurately recorded in the State's accounting records. The FAHCA implemented an Electronic Fund Transfer (EFT) process for the payment of the medical assistance related payments allowing payments to be posted against the correct category at the time of vouchering in the event release, budget, and cash are sufficient. In the event release and budget are not sufficient to record medical assistance related payments to the correct appropriation category, a budget amendment will be submitted to realign budget authority in accordance with actual expenditures.	

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS **Budget Period: 2017-18 FY**

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(1) REPORT NUMBER	(2) PERIOD ENDING	(3) UNIT/AREA	(4) SUMMARY OF FINDINGS AND RECOMMENDATIONS	(5) SUMMARY OF CORRECTIVE ACTION TAKEN	(6) ISSUE CODE
				Unable to give a specific corrective action date because the corrective action is dependent upon factors not within the control of the FAHCA such as when a Legislative Budget Commission meeting is held, timelines for the submission of year-end budget amendments, and year-end deadlines for submitting vouchers for payment.	
			2015-035 The FAHCA did not always calculate Federal funds draws or related expenditures correctly. Additionally, 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 and that the amounts of the draws and the corresponding payments are correct.	The FAHCA will continue to refine its process relating to federal funds draws and related expenditures through training, quality and management reviews, and collaboration with contract managers and other subject matter experts. Currently, the FAHCA maintains payment logs to ensure payments are processed timely, at the correct rate, and in the correct amount. These payment logs are reconciled quarterly with FLAIR data by the Disbursement accounting staff. In addition, contract managers' meetings are held quarterly to review contract activities and ensure payments have been properly recorded in accounting records. The FAHCA amended its process for federal funds draws to require the Disbursement accounting staff to submit a request to initiate the draw of federal funds for contract payments. This allows federal funds draws to be directly linked to specific payments. The FAHCA will enhance its process by providing another round of training to staff on the proper implementation of the process, developing a checklist for a self-review by the accounting staff to check for accuracy, adding a Disbursement unit management review for quality assurance purposes, and locking certain cells of the Draw/Payment template to prevent unwanted or inadvertent changes. With regard to federal funds draws not being limited to amounts needed for immediate cash needs, the FAHCA will continue to review this process. However, when the FAHCA is required to request federal funds using estimated expenditures (during holidays and office closures), there will always be a possibility of an overdraw of federal funds. This cannot be avoided entirely. The consequence of not having sufficient federal funds available to meet immediate cash needs for operations could result in hardship or adversity for Medicaid providers if funds are not available to make medical assistance related payments timely.	
			2015-036 Medical service claim payments made to providers of Medicaid services were sometimes made for services claimed to have been rendered subsequent to the recipient's date of death. ***Auditor's Remarks*** In its response, the FAHCA indicated that for the 13 claims for provider type 67 (home and community based providers), Medicaid Policy allowed a 30-day grace period subsequent to the recipient's date of death. Additionally, the FAHCA indicated that it appeared that the providers entered the billing dates as the dates of service instead of the actual dates of last service. However, the FAHCA was unable to provide the cited policy upon request and notwithstanding the policy, it is unclear from the FAHCA's response how claims with dates of service subsequent to a recipient's date of death are allowable. A review of the claims' data in FMMIS indicated that for 12 of the 13 claims, the dates of service preceded the billing dates and the dates were not equivalent. **Recommendation** We recommend that the FAHCA ensure that appropriate electronic and manual controls are in place and operating effectively to ensure that only appropriate Medicaid claims are processed.	The Florida Medicaid Management Information System updates its date of death field upon notification of death from outside sources (Vital Statistics, Department of Children and Families, etc.). Our contracted third party liability vendor performs, under a Medicaid Program Integrity (MPI) recovery project, the auditing and recovery of claims paid subsequent to the recipients' date of death when receiving notification of the actual date of death.	

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS **Budget Period: 2017-18 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
				"Follow-up Response to Original Audit: For 4 claims totaling $5,460.31, audits of the claims were ongoing. Update: Audits are complete. Medicaid has received recoupment payments on three audits with one yet to be received. For 13 claims totaling $3,484.72, the FAHCA allowed a 30-day grace period, subsequent to the recipient's date of death, for each provider to submit the claim. However, FMMIS records indicated that the claims' dates of service were also subsequent to the recipients' dates of death. Update: These 13 claims were for provider type 67 (home and community based providers). Medicaid Policy allows a 30-day grace period subsequent to the recipients' date of death. Although these 13 claims indicate a date of service subsequent to the recipients' date of death, all 13 fell within the 30-day grace period. No TPL recovery was initiated due to the grace period policy. The FAHCA will review the policy to determine if the policy needs clarification to take into account the date of death and the billing practices of the Home and Community Based Waiver Providers. If the policy needs to be revised, FAHCA will also see what revision needs to be made to the FMMIS." Additional Update: These providers typically bill once a month and do not enter the specific dates of service since they are typically in the clients' homes several days a month. It appears that these providers entered the billing date as the date of service as opposed to the actual date of last service. The FAHCA will provide training to these providers to ensure they submit correct service date information and a provider alert will be issued concerning procedures for reimbursement following a Medicaid recipient's death. For 16 claims totaling $1,800.76, the FAHCA indicated that the claims were audited, but that the moneys had not been recouped. Update: Of these claims, five audits showed FMMIS contained improper provider address information. The TPL vendor is researching to resend the findings to the provider. The remaining 11 audits were completed with no payments yet to be received, and the TPL vendor is continuing follow-up recoupment activities. For 11 claims totaling $556.65, the FAHCA indicated that the dollar amount of the claims did not meet the threshold to pursue recoupment. Update: Recoupment thresholds are set by Medicaid Program Integrity. The TPL vendor will continue to monitor these providers for potential future recoupments. The TPL Unit will continue to follow-up with our vendor to ensure recoupment/payment of the outstanding identified audits. The TPL unit will meet with MPI and our vendor to determine methods to improve post payment recoupment activities and timelines.	
			2015-037 The FAHCA did not adequately ensure that the service organization's internal controls related to the invoicing, collection, and reporting of drug rebates were appropriately designed and operating effectively. **Recommendation** We recommend that the FAHCA ensure that service organization internal controls related to the invoicing, collection, and reporting of drug rebates are appropriately designed and operating effectively.	This audit period was from July 1, 2014 - June 30, 2015. The contract was updated in May 2015 with additional Service Level Agreements (SLAs). These additional SLAs were added to the contract in lieu of requiring a Statement on Standards for Attestation Engagements (SSAE-16) audit. To mitigate this exclusion, the new contract manager received access to the Pharmaceutical Rebate Information Management System (PRIMS) to perform random reviews and confirm the following: invoices are mailed on time; collections are completely and accurately posted in the receivables system; and the system detail which supports the federal and state reporting is substantiated by the reconciled transaction activity and drills down to all claim level details supporting any rebate invoice. Additionally, the claim level detail can be compared to the Florida Medicaid Management Information System (FLMMIS) claims data, which ensures all information is being invoiced on behalf of the FAHCA accurately. Lastly, the FAHCA has the ability to sample any transaction at random through front-end system queries. In conclusion, internal controls such as performing random reviews for the monthly and quarterly reports and verifying data ensures that invoicing, collection, and reporting of drug rebates are entered timely allowing FAHCA to monitor the efficiency of the PRIMS system.	

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS

Budget Period: 2017-18 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
			2015-038 The FAHCA made payments to ineligible Medicaid Program providers.		
			Recommendation We recommend that the FAHCA ensure that Medicaid Program payments are made only to providers with Medicaid Provider Agreements in effect.	The FAHCA has opened a system change request to create a renewal process for out-of-state providers. Until such time as that is implemented, the FAHCA will monitor out-of-state provider agreement expiration dates, restrict the provider's claims when the agreement expires, and communicate with the provider regarding the need to renew their agreement.	
			2015-040 The FAHCA's established procedures did not provide for the timely monitoring of the vendor contracted to perform hospital cost report audits.		
			Recommendation We recommend that the FAHCA ensure that the performance of the hospital cost report audits be timely monitored.	Background Information on Issue - The cost report is a combination of Medicare Title XVIII, Title V and Medicaid Title XIX. The audit of the cost report for Medicare Title XVIII and Title V portion of the cost including total hospital cost and charges are done by the Medicare Intermediary. The Myers and Stauffer CPA firm is responsible only for auditing Medicaid costs and charges on the report. The Centers for Medicare and Medicaid Services (CMS) expects the Medicare Intermediary to settle all cost reports submitted by each hospital by issuing a Notice of Program Reimbursement (NPR). In short, typically the Medicaid portion of the audit process will not be completed until the Medicare audit is completed. The Medicaid Audit Program which is utilized by Myers and Stauffer was reviewed by FAHCA and approved to be used by Myers and Stauffer. FAHCA's contracted CPA firm, Myers and Stauffer, had provided notice to FAHCA regarding the 315 completed audits. FAHCA staff downloaded a few of the audit reports from the Myers and Stauffer website to ensure that all the necessary paperwork was provided and available for FAHCA to re-calculate the Medicaid rates based on the audited cost report. None of the 315 completed audits provided to FAHCA by Myers and Stauffer have been processed to re-calculate the Medicaid rates due to FAHCA having a backlog of audits to complete. In general, FAHCA processes audits in the order in which they are received from the contracted CPA firm. The 315 completed audits will be processed in accordance with FAHCA policy and this will ensure that FAHCA is in compliance with the contract monitoring plan. FAHCA is currently working on the backlog of audits from the prior and current vendors. For hospitals selected for revising the Medicaid rates, this process will include completing audits from the prior vendor as well as audits completed by Myers and Stauffer, our current vendor. FAHCA is currently utilizing other staff within the bureau to work on processing the backlog of hospital audits. FAHCA anticipates completing both backlogs around March 1, 2018.	
			2015-041 The FAHCA computer system used to store all Medicaid Program Integrity (MPI) complaints and cases, the Fraud and Abuse Case Tracking System (FACTS), did not appear to store all complaints and cases received and established during the 2014-15 fiscal year.		
			Recommendation We recommend that the FAHCA ensure that all complaints and cases received and established are appropriately documented in FACTS through sequential complaint and case numbers and that the reasons for missing complaint and case numbers, if any, are appropriately documented.	For the review period of July 1, 2014, through June 30, 2015, 6,481 files constituting both complaints and cases were established in the new Medicaid Program Integrity Fraud and Abuse Case Tracking System (FACTS). The creation of these cases and complaints in the new FACTS system was accomplished through a combination of: 1) migrating legacy data into the new FACTS system from the predecessor system in use since 2003; 2) test cases being created for the new FACTS system's testing and training: and 3) new cases and complaints being created to accommodate instant matters. The 305 FACTS-assigned complaint numbers and 392 FACTS-assigned case numbers that were identified in the audit as missing included an unknown quantity abandoned as duplicative before an investigation was actually initiated, test complaints and cases created for system testing and training, and possibly actual referrals related to reports of fraud, waste, and abuse.	

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Budget Period: 2017-18 FY

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				The new FACTS system and business processes were designed to ensure there was no duplication of investigative files, therefore new complaints or case file numbers duplicating legacy file numbers were abandoned by design. FAHCA recognizes this is not the optimum condition and is exploring a system remedy to ensure that a future audit log captures all system-generated complaint and case numbers along with a “reason code” if a complaint or case number is abandoned due to it being duplicative, inactivated, or closed. Because the missing numbers in FACTS do not specifically reflect evidence of missed opportunities to identify fraud, abuse, or waste and due to the likelihood that several of the missing numbers were attributed to the migration of legacy data and related system testing, further efforts to identify or reconstruct those complaints or cases will be suspended. If evidence surfaces to indicate that missing files are controlled by 42 CFR 455.14, which requires that the Medicaid agency (FAHCA) conduct a preliminary investigation upon identification of questionable practices or upon receipt of an actual complaint of Medicaid fraud or program abuse, MPI will re-establish those complaints or cases within the FACTS system and pursue them to a logical conclusion. As of February 2, 2016, the FAHCA has asked the FACTS contractor to provide a cost estimate to upgrade the new FACTS system to capture all complaint and case numbers issued for retention in an auditable log, along with a “reason code” if a complaint or case number is abandoned. If existing project funding is sufficient to accomplish this priority upgrade, the Agency will proceed with the corrective action in the current fiscal year to eliminate the likelihood of a recurrence of this finding.	
13-14	**10/2013 to 3/2014**	**Medicaid Recipient File Management Bureau of Fiscal Agent Operations**	**Finding 1** OnBase Error Correction Process Efficiency. RFU’s OnBase Error Correction Process needs improvement. The process does not prioritize correcting older errors in a systematic way. For errors noted in the October 2013 error reports, thirty-two percent of error code 1007, twenty-four percent of error code 1202, and ten percent of error code 2002 remained uncorrected at the end of six months.		
			Recommendation 1. Coordinate with DCF staff to systematically prioritize the correction of older recipient errors first (when applicable) to prevent continued reappearance in the error reports by developing an aging analysis report.	1. The joint Error Correction Process project task force between DCF and AHCA/MFAO continues. Locating missing SSNs and entering SSNs into the eligibility source system remains the responsibility of DCF. MFAO has provided technical assistance and training to DCF staff helping them to read and understand the error reports generated by the FMMIS to identify the recipients who are missing SSNs. DCF is making a system enhancement with an implementation date of September 2016, to increase the numbers of SSNs obtained by DCF eligibility processors. The DCF system change will alert and require eligibility processors to review the missing information (SSN) and perform a follow-up to obtain the SSN. DCF will ensure that the eligibility processors receive training on the system enhancement once it is ready for installation.	
			2. Finalize desk procedures to standardize the OnBase report error correction process including addressing the correction of older errors first.	2. Completed on March 2, 2016. MFAO reviewed and revised the desk level procedure guide. OnBase reports are worked daily but not all errors can be resolved by AHCA, so the error may reappear until the data is changed in the FLORIDA system. AHCA collaborated with DCF management to understand and focus on the OnBase error reporting process during this review period. With the increased focus, the issue of aging errors will be reduced because of DCF’s focused efforts to improve data and reduce the number of eligibility errors appearing and remaining on OnBase reports.	
			Finding 2 FMMIS does not end the Medicaid recipient benefit plans even when the FLORIDA system ends eligibility for recipient files due to missing SSNs. The fatal error caused by having a missing SSN prevents an update in FMMIS that includes ending a benefit plan.		

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			Recommendation Implement CSR 2888 to allow FMMIS to accept DCF's closure of recipient eligibility spans for recipient files with missing SSNs.	Completed on November 12, 2015. CSR 2888 and the associated change order 79784 was completed on November 12, 2015. FMMIS accepts a closure without an SSN on the file from DCF. Medicaid is ended appropriately in FMMIS.	
15-08	Calendar Years 2014 and 2015	Background Screening Clearinghouse Program	**Finding 1** The BGS unit has not established a quality assurance (QA) process to review analysts' eligibility determinations.		
			Recommendation We recommend BGS implement a QA process and develop a sampling program that includes reviewing high risk determinations, such as criminal offenses committed in other states, or the criminal history of an applicant with a large number of offenses.	We concur with a need to implement a QA process for eligibility determinations. We will implement a process for management review of a sample of eligibility determinations. We will pursue system enhancements to include the QA process as part of the application and create a work item for management (and staff/peer reviews) including the identification of "high risk" scenarios that would automatically result in a management or peer review.	
			Finding 2 The BGS unit does not effectively monitor analysts' turnaround time to review background screening results.		
			Recommendation We recommend management continue to work with IT to develop appropriate reports to monitor the number of days to make eligibility determinations.	The Unit is currently working with IT on developing a variety of reports using the Clearinghouse data including staff productivity measures. With limited resources, we have prioritized reports needed to ensure patient safety as the top priority. However, the Unit will continue to work towards completion of this reporting ability.	
			Finding 3 Staff in some other state agencies experienced delays in accessing the BGS Clearinghouse.		
			Recommendation We recommend that the BGS unit implement processes to help ensure that state agencies receive timely access to the BGS Clearinghouse.	The Bureau has shifted resources to help the Unit manage an increasing volume of work including issues related to other agency access. The Unit will pursue system changes of the application to streamline the process of onboarding staff of other agencies.	
			Finding 4 The BGS Clearinghouse does not contain complete information for exemption cases, and the electronic case documents archived in Laserfiche are not always complete.		
			Recommendation 1. We recommend the development of written guidelines and procedures outlining the documents and system fields that are required to be completed. 2. We recommend a system edit be created to prevent the closure of a case unless all items in the system checklist have been checked as completed.	We concur with the recommendations, and will add them to future Clearinghouse application development.	
			Finding 5 The BGS Exemption section lacks adequate written guidelines.		
			Recommendation We recommend management consider establishing written guidelines for processing exemption applications.	Completed. To dictate a consistent process would require promulgation of a rule and remove the ability to consider a case by case approach, however, all cases are reviewed by management in both the Unit and the Secretary's office.	
			Finding 6 The BGS Exemption section, at the time of our review, did not review sealed criminal history records on adults.		
			Recommendation We recommend that the BGS unit continue to review sealed adult criminal history records in determining eligibility.	Completed. The BGS unit is currently following the recommendation.	

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			Finding 7 The BGS unit has not finalized a process to identify employees that have been determined ineligible, but are still listed as employed on the provider's roster. **Recommendation** 1. We recommend that the BGS unit finalize their process to monitor employer's actions after notification of an employee's rapback. 2. We also recommend that HQA finalize their enforcement process to fine violators.	Completed. The recommendation is currently being followed. The process is: 1. Facility is notified when a potential employee eligibility status changed. 2. Staff runs a report to identify ineligible employees on an employee roster. 3. Facility is contacted by certified mail, and instructed to correct the employee issue. 4. If the issue is not corrected it is elevated to licensure unit for corrective action (including a fine). 5. If it is still not correct, field staff is sent out to investigate and depending on the field investigations findings may result in an action against the license.	
15-09	**6/1/14 - 11/30/14**	**Third Party Liability Review**	**Finding 1** The TPL Unit does not have written internal policies, procedures, or guidelines regarding monitoring of the TPL vendor contract. **Recommendation** We recommend that the TPL Unit develop written contract monitoring procedures.	The TPL unit will develop a written contract monitoring tool to coincide with Agency contract monitoring guidelines.	
			Finding 2 The TPL Unit does not adequately document monitoring of the TPL vendor's handling of casualty and estate recovery cases. **Recommendation** We recommend that the TPL Unit document and formalize monitoring of the TPL vendor's activities and communication with the vendor by: • Capturing the results of monitoring such as by utilizing contract monitoring case review checklists and/or issuing monitoring report letters similar to what was previously utilized to document and track the review of cases or other areas of concern identified by the TPL Unit. • Verifying the accuracy of the vendor's quality assurance report cards, on a sample basis, as part of the monitoring process and documenting the review of report card submissions and any discrepancies found to allow for tracking to gauge quality improvement or deficiencies. • Documenting any guidance or directives given by the Agency in cases requiring Agency input in the case file.	The TPL unit will develop protocols to document our monitoring activities, which will include but not be limited to reviewing submitted quality assurance report cards and randomly chosen sample of Estate, Trust & Annuity, and Casualty cases.	
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 Fraud Prevention and Control Unit 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.	

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			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.	
			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 (PASRR)**	**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.]		

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			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.	Completed. CAP was submitted to HHS/DCA and is pending 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.	Completed. The agreement was fully executed in August 2015.	
			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.	Completed. The comprehensive agreement was executed on 4/13/16.	
CIG 2014-01	**FY10-11 and FY11-12**	**Assessment of Managed Care Organizations' (MCO) 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. 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. 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.	

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				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.	
			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.)	Regarding the recommendation that MPI require MCOs to describe their efforts taken to recover identified overpayments and provide reasons for unrecovered overpayments, 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, found at page 36 of 119 of the following: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/SMMC_Report_Guide_Final_Effective_2015-01-01.pdf.	
			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. Since the audit's fieldwork was 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 3 Anti-fraud plans do not always provide the information necessary to assess investigations and the reporting structure within an MCO.		
			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.		

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			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. 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. Effective January 1, 2015, the MCO Contract "Report Guide" requires MCOs to report activities from the "prior state fiscal year." This can be found on page 33 of 119 in the Reporting Guide that will become effective January 2015, and reads as follows: *The purpose of this report is to provide the Agency a summarized annual report on the Managed Care Plan's experience in implementing an anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts for the prior State Fiscal Year (SFY).*	
			Finding 8 MPI does not have written policies and procedures for the review of the anti-fraud plans.		
			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.	Completed. The IOP was finalized in December of 2015. Routine review of MPI procedures dictates that the IOP be again reviewed. As such, a minor amendment resulted in an updated IOP in May 2016.	
			Finding 9 Not all Managed Care Unit (MCU) staff members have received external training related to Medicaid fraud prevention, detection, and investigation.		

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			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.	Completed. We have our protocol in place, training is ongoing, but we are not at 100% of our staff meeting our minimal standards. We probably never will be because all staff have 9 months from the date of hire (or nine months from the protocol adoption) to meet the standards. We are substantially complete, however. 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. (2) 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. (3) 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.	Completed. In 2015-2016 FY, the Managed Care Unit conducted the anti-fraud plan reviews for all health plans and initiated onsite reviews of all plans. The Unit work plan includes continuing to review every plan by onsite review each fiscal year. As the work plan allows each plan to be reviewed annually, it is not necessary to prioritize by perceived fraud risk. However, plan reviews are prioritized, in consultation with the Division of Medicaid and other organizational units within MPI to determine the Medicaid program needs and utilize those needs in prioritizing reviews.	

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS **Budget Period: 2017-18 FY**

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

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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.	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.)	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.		

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			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. 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.	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. 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.	Completed. 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.	Completed. 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.		

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			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.	
			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.	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.	
			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.	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. 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.		

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			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 Bureau has implemented its new policy for titling OCAs to better distinguish between OCAs used to capture state and federal share of expenditures and rolled out the new structure as part of its FY 2015-2016 approved operating budget on July 1, 2015. Implementation of the new OCAs has given the involved supervisors a better understanding of the OCA structure which will strengthen the review process. The Bureau can now update its OCA Matrix (data element table), which identifies critical data elements such as the federal participation rate (FFP), CFDA number, and source of the state share. Anticipated completion date for the data element table update is December 31, 2015. The Bureau is on target to start its quarterly reviews of the FLAIR data with the quarter ending September 2015.	
			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.	Fully Corrected. After 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 required financial statement adjustments forms were submitted. 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.	Fully Corrected. The Bureau held several meetings to discuss, review, and modify our procedures on Schedule of Expenditures of Federal Awards (SEFA). As a result, the Bureau utilized the Florida Department of Financial Services' (FDFS') SEFA template to identify and define the specific data required for this report as it relates to FAHCA. In addition, the Bureau has implemented its new policy for titling OCAs to better distinguish between OCAs used to capture state and federal share of expenditures and rolled out the new structure as part of its FY 2015-2016 approved operating budget on July 1, 2015. Implementation of the new OCAs has given the involved supervisors a better understanding of the OCA structure which will strengthen the review process.	
			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.	Fully Corrected. Proviso language in the SFY 2013-2014 legislative appropriations limited Healthy Kids dental payments to $12.57 per member per month. Florida Healthy Kids Corporation (FHKC) projected their dental plan rates would average $12.57 or less for the year based on 50,000 Healthy Kids enrollees transitioning to Medicaid in January 2014, to comply with the Affordable Care Act requirements. Most of the children transitioning were enrolled in dental plans with a higher rate, so when they transitioned to Medicaid the average rate would be reduced. The FAHCA delayed the transition to coincide with the implementation of the Medicaid Managed Medical Assistance Program. As a result of the enrollees remaining in the Healthy Kids dental plans longer than expected, the Healthy Kids average dental rate was $12.58; $0.01 higher than specified. FHKC repaid the overage by including an adjustment of $19,095.71 in their February 2015 total invoice, received by the FAHCA on February 11, 2015. This represents the questioned costs of $19,978.93 minus $883.22, an amount previously adjusted. Due to the uniqueness of events in SFY 2013-2014, this problem should not recur.	

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			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 Affordable Care Act (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 the 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 – CO #73223 was created to modify the FL MMIS to exclude the Qualified Medicare Beneficiaries (QMB) benefit plan from copay processing logic. CO #73223 was implemented on January 13, 2015. CO #74982 is currently in an "open" status and once implemented will identify the physician Medicare crossover claims that need to be reprocessed. CO #81184 was created, coded and implemented to exclude copay for crossover claims when the provider bills using an emergency diagnosis code. CO #81184 was implemented June 26, 2015. The affected claims are currently being identified and pulled for reprocessing. Date of Death Claims – CO #65743 was generated to synchronize the enrollment dates with the Date of Death (DOD). These modifications will cause capitation payments to be recouped and aligned with the DOD. The auto recoupment processing for DOD reasons will take place for all ongoing DOD updates. CO #65743 was implemented on March 5, 2015. CO # 77842 was generated to handle DOD recoupments for previous time periods. At present, the first quarter of 2015 has been processed. Additional modifications are needed after the first recoupment process to identify these recoupments as DOD type recoupments. The FAHCA Plan Managers are currently developing a recoupment plan for years prior to 2015. This plan is expected to be completed around September 2015. Durable Medical Equipment (DME) - CSR #2889 has been written to address this issue. It is currently in analysis and, due to the scope of this project, should be completed by December 2015. At that time, a project plan and timeline for the system updates will be created. 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.	
			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.	Fully Corrected. Updated response as of 1/8/16: MFAO has determined that the initial SSPAF Status for Finding 2014-037 is correct as reported and should remain in a Fully Corrected status. CO #65277 - 2014 SSAE16 Audit Support was implemented on November 6, 2014, and identifies when authorized software developers switched to an HP Global ID. However, due to an overlap in the SSAE16 reporting period and the date the FMMIS changes were implemented, the finding was flagged on the SSAE16 report. Documentation has been provided to the SSAE16 auditors.	
			2014-038 The FAHCA continued to record medical assistance related payments to incorrect appropriation categories in the State's accounting records.		

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			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 continues to make every effort to ensure that medical assistance related payments are accurately recorded in the State's accounting records. The FAHCA implemented an Electronic Fund Transfer (EFT) process for the payment of the medical assistance related payments allowing payments to be posted against the correct category at the time of vouchering if release, budget, and cash are sufficient. If release or budget is not available for the posting of expenditures, a budget amendment approved by the Legislative Budget Commission is required.	
			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.	New policy fully implemented: 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.	The Health Quality Assurance Licensure and Certification Procedures Manual was fully updated and implemented June 2015. Within this manual the Bureau of Field Operations has incorporated the timeframes for conducting the annual licensure Fire Life Safety Survey along with the revisit. The timeframes state that annual licensure surveys must be completed no later than 15.9 months from the previous annual licensure survey. Additionally, revisits must be conducted within 90-days from the date of exit, unless the facility has an approved State or Federal Waiver. Exception to the scheduling timeframes may be approved by the Chief of Field Operations and documentation of the approval maintained by the field office. The Bureau of Field Operations continues to monitor compliance with the survey timeframes. In February 2015, we developed a new report, which supplements existing Fire Life Safety scheduling reports to better capture re-licensure timeframes based on initial licensure completion. During the creation of this additional report, we discovered several instances in which some initial Fire Life Safety Surveys were conducted by staff in the Bureau of Plans and Construction, in conjunction with the 100% construction survey reviews, but were not entered into our survey database (ASPEN). Entry into the ASPEN system is required in order for the surveys to appear on scheduling reports. Although these outlier initial licensure surveys were conducted timely, since the initial survey dates were not entered into the ASPEN system, they were inadvertently excluded from scheduling reports. This report will assist in providing additional oversight to ensure all Fire Life Safety Surveys are completed within the required timeframes. Effective February 2015, the Bureau of Field Operations is now conducting all initial licensure Fire Life Safety Surveys. This will facilitate oversight of the data entry system since the initial Fire Life Safety Survey is now coupled with the health survey so that all requisite processes follow a consistent protocol as with other survey activities.	
			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.	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. This should lead to audits being settled in a timelier manner. Cost reports are also being selected for audit as timely as possible. Between July 1, 2014 and June 30, 2015, 157 audits were assigned to various CPA firms. During that time 121 final audits were issued to the providers. In addition, 170 audit appeal cases were closed by FAHCA and Attorney General Staff.	

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				Under the contract with Myers and Stauffer, LLC the on-line website allows FAHCA to review the on-going status of audit work for each hospital's cost report. This website allows a real time report. For the past SFY 2014-2015, the vendor completed 270 audits which are in accordance to the current contract requirement. We receive a monthly status report and have bi-weekly conference calls to review the current status of audits.	

1 A bill to be entitled
2
3 An act relating to Medicaid.
4
5 Be It Enacted by the Legislature of the State of Florida:
6
7 Section 1. Subsection (11) is added to Section 409.904,
8 Florida Statutes, to read:
9
10 409.904 Optional payments for eligible persons.—The agency
11 may make payments for medical assistance and related services on
12 behalf of the following persons who are determined to be
13 eligible subject to the income, assets, and categorical
14 eligibility tests set forth in federal and state law. Payment on
15 behalf of these Medicaid eligible persons is subject to the
16 availability of moneys and any limitations established by the
17 General Appropriations Act or chapter 216.
18 (11) Subject to federal waiver approval, a person diagnosed
19 with Acquired Immune Deficiency Syndrome (AIDS), who has an
20 AIDS-related opportunistic infection and is at risk of
21 hospitalization as determined by the Agency or its designee, and
22 whose income is at, or below, 300 percent of the Federal Benefit
23 Rate(FBR).
24
25 Section 2. Subsection (13)(b) of Section 409.906, Florida
26 Statutes is amended to read:
27 409.906 Optional Medicaid services.—Subject to specific
28 appropriations, the agency may make payments for services which

CODING: Words stricken are deletions; words underlined are additions.

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29 are optional to the state under Title XIX of the Social Security
30 Act and are furnished by Medicaid providers to recipients who
31 are determined to be eligible on the dates on which the services
32 were provided. Any optional service that is provided shall be
33 provided only when medically necessary and in accordance with
34 state and federal law. Optional services rendered by providers
35 in mobile units to Medicaid recipients may be restricted or
36 prohibited by the agency. Nothing in this section shall be
37 construed to prevent or limit the agency from adjusting fees,
38 reimbursement rates, lengths of stay, number of visits, or
39 number of services, or making any other adjustments necessary to
40 comply with the availability of moneys and any limitations or
41 directions provided for in the General Appropriations Act or
42 chapter 216. If necessary to safeguard the state's systems of
43 providing services to elderly and disabled persons and subject
44 to the notice and review provisions of s. 216.177, the Governor
45 may direct the Agency for Health Care Administration to amend
46 the Medicaid state plan to delete the optional Medicaid service
47 known as "Intermediate Care Facilities for the Developmentally
48 Disabled." Optional services may include:
49 (13) HOME AND COMMUNITY-BASED SERVICES.—
50 (a) The agency may pay for home-based or community-based
51 services that are rendered to a recipient in accordance with a
52 federally approved waiver program. The agency may limit or
53 eliminate coverage for certain services, preauthorize high-cost
54 or highly utilized services, or make any other adjustments
55 necessary to comply with any limitations or directions provided
56 for in the General Appropriations Act.

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57 ~~(b) The agency may consolidate types of services offered in~~
58 ~~the Aged and Disabled Waiver, the Channeling Waiver, the Project~~
59 ~~AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury~~
60 ~~Waiver programs in order to group similar services under a~~
61 ~~single service, or continue a service upon evidence of the need~~
62 ~~for including a particular service type in a particular waiver.~~
63 ~~The agency is authorized to seek a Medicaid state plan amendment~~
64 ~~or federal waiver approval to implement this policy.~~
65 ~~(c)~~ (b) The agency may implement a utilization management
66 program designed to prior-authorize home and community-based
67 service plans and includes, but is not limited to, assessing
68 proposed quantity and duration of services and monitoring
69 ongoing service use by participants in the program. The agency
70 is authorized to competitively procure a qualified organization
71 to provide utilization management of home and community-based
72 services. The agency is authorized to seek any federal waivers
73 to implement this initiative.
74 ~~(d)~~ (c) The agency shall request federal approval to develop
75 a system to require payment of premiums or other cost sharing by
76 the parents of a child who is being served by a waiver under
77 this subsection if the adjusted household income is greater than
78 100 percent of the federal poverty level. The amount of the
79 premium or cost sharing shall be calculated using a sliding
80 scale based on the size of the family, the amount of the
81 parent's adjusted gross income, and the federal poverty
82 guidelines. The premium and cost-sharing system developed by the
83 agency shall not adversely affect federal funding to the state.
84 After the agency receives federal approval, the Department of

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85 Children and Families may collect income information from
86 parents of children who will be affected by this paragraph.
87 ~~(c)~~ (d) The agency shall seek federal approval to pay for
88 flexible services for persons with severe mental illness or
89 substance use disorders, including, but not limited to,
90 temporary housing assistance. Payments may be made as enhanced
91 capitation rates or incentive payments to managed care plans
92 that meet the requirements of s. 409.968(4).
93
94 Section 3. Subsection (8)(a)11 of Section 409.912, Florida
95 Statute is amended to read:
96 409.912 Cost-effective purchasing of health care.—The
97 agency shall purchase goods and services for Medicaid recipients
98 in the most cost-effective manner consistent with the delivery
99 of quality medical care. To ensure that medical services are
100 effectively utilized, the agency may, in any case, require a
101 confirmation or second physician's opinion of the correct
102 diagnosis for purposes of authorizing future services under the
103 Medicaid program. This section does not restrict access to
104 emergency services or poststabilization care services as defined
105 in 42 C.F.R. s. 438.114. Such confirmation or second opinion
106 shall be rendered in a manner approved by the agency. The agency
107 shall maximize the use of prepaid per capita and prepaid
108 aggregate fixed-sum basis services when appropriate and other
109 alternative service delivery and reimbursement methodologies,
110 including competitive bidding pursuant to s. 287.057, designed
111 to facilitate the cost-effective purchase of a case-managed
112 continuum of care. The agency shall also require providers to

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113 minimize the exposure of recipients to the need for acute
114 inpatient, custodial, and other institutional care and the
115 inappropriate or unnecessary use of high-cost services. The
116 agency shall contract with a vendor to monitor and evaluate the
117 clinical practice patterns of providers in order to identify
118 trends that are outside the normal practice patterns of a
119 provider's professional peers or the national guidelines of a
120 provider's professional association. The vendor must be able to
121 provide information and counseling to a provider whose practice
122 patterns are outside the norms, in consultation with the agency,
123 to improve patient care and reduce inappropriate utilization.
124 The agency may mandate prior authorization, drug therapy
125 management, or disease management participation for certain
126 populations of Medicaid beneficiaries, certain drug classes, or
127 particular drugs to prevent fraud, abuse, overuse, and possible
128 dangerous drug interactions. The Pharmaceutical and Therapeutics
129 Committee shall make recommendations to the agency on drugs for
130 which prior authorization is required. The agency shall inform
131 the Pharmaceutical and Therapeutics Committee of its decisions
132 regarding drugs subject to prior authorization. The agency is
133 authorized to limit the entities it contracts with or enrolls as
134 Medicaid providers by developing a provider network through
135 provider credentialing. The agency may competitively bid single-
136 source-provider contracts if procurement of goods or services
137 results in demonstrated cost savings to the state without
138 limiting access to care. The agency may limit its network based
139 on the assessment of beneficiary access to care, provider
140 availability, provider quality standards, time and distance

141 standards for access to care, the cultural competence of the
142 provider network, demographic characteristics of Medicaid
143 beneficiaries, practice and provider-to-beneficiary standards,
144 appointment wait times, beneficiary use of services, provider
145 turnover, provider profiling, provider licensure history,
146 previous program integrity investigations and findings, peer
147 review, provider Medicaid policy and billing compliance records,
148 clinical and medical record audits, and other factors. Providers
149 are not entitled to enrollment in the Medicaid provider network.
150 The agency shall determine instances in which allowing Medicaid
151 beneficiaries to purchase durable medical equipment and other
152 goods is less expensive to the Medicaid program than long-term
153 rental of the equipment or goods. The agency may establish rules
154 to facilitate purchases in lieu of long-term rentals in order to
155 protect against fraud and abuse in the Medicaid program as
156 defined in s. 409.913. The agency may seek federal waivers
157 necessary to administer these policies.
158 (8)(a) The agency shall implement a Medicaid prescribed-
159 drug spending-control program that includes the following
160 components:
161 ~~11. The agency shall implement a Medicaid prescription drug~~
162 ~~management system.~~
163 ~~a. The agency may contract with a vendor that has~~
164 ~~experience in operating prescription drug management systems in~~
165 ~~order to implement this system. Any management system that is~~
166 ~~implemented in accordance with this subparagraph must rely on~~
167 ~~cooperation between physicians and pharmacists to determine~~
168 ~~appropriate practice patterns and clinical guidelines to improve~~

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169 ~~the prescribing, dispensing, and use of drugs in the Medicaid~~
170 ~~program. The agency may seek federal waivers to implement this~~
171 ~~program.~~
172 ~~b. The drug management system must be designed to improve~~
173 ~~the quality of care and prescribing practices based on best~~
174 ~~practice guidelines, improve patient adherence to medication~~
175 ~~plans, reduce clinical risk, and lower prescribed drug costs and~~
176 ~~the rate of inappropriate spending on Medicaid prescription~~
177 ~~drugs. The program must:~~
178 ~~(I) Provide for the adoption of best practice guidelines~~
179 ~~for the prescribing and use of drugs in the Medicaid program,~~
180 ~~including translating best practice guidelines into practice;~~
181 ~~reviewing prescriber patterns and comparing them to indicators~~
182 ~~that are based on national standards and practice patterns of~~
183 ~~clinical peers in their community, statewide, and nationally;~~
184 ~~and determine deviations from best practice guidelines.~~
185 ~~(II) Implement processes for providing feedback to and~~
186 ~~educating prescribers using best practice educational materials~~
187 ~~and peer-to-peer consultation.~~
188 ~~(III) Assess Medicaid recipients who are outliers in their~~
189 ~~use of a single or multiple prescription drugs with regard to~~
190 ~~the numbers and types of drugs taken, drug dosages, combination~~
191 ~~drug therapies, and other indicators of improper use of~~
192 ~~prescription drugs.~~
193 ~~(IV) Alert prescribers to recipients who fail to refill~~
194 ~~prescriptions in a timely fashion, are prescribed multiple drugs~~
195 ~~that may be redundant or contraindicated, or may have other~~
196 ~~potential medication problems.~~

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197
198 Section 4. Subsections (1)(b) and (2)(a) of Section
199 409.979, Florida Statutes are amended to read:
200 409.979 Eligibility.—
201 (1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid
202 recipients who meet all of the following criteria are eligible
203 to receive long-term care services and must receive long-term
204 care services by participating in the long-term care managed
205 care program. The recipient must be:
206 (a) Sixty-five years of age or older, or age 18 or older
207 and eligible for Medicaid by reason of a disability.
208 (b) Determined by the Comprehensive Assessment Review and
209 Evaluation for Long-Term Care Services (CARES) preadmission
210 screening program to require nursing facility care as defined in
211 s. 409.985(3), or in the case of individuals diagnosed with
212 cystic fibrosis, determined by the CARES to require hospital
213 level of care.
214 (2) ENROLLMENT OFFERS.—Subject to the availability of
215 funds, the Department of Elderly Affairs shall make offers for
216 enrollment to eligible individuals based on a wait-list
217 prioritization. Before making enrollment offers, the agency and
218 the Department of Elderly Affairs shall determine that
219 sufficient funds exist to support additional enrollment into
220 plans.
221 (a) Medicaid recipients enrolled in one of the following
222 home and community-based service Medicaid waivers are eligible
223 to participate in the long-term care managed care program when
224 all eligibility criteria requirements established in paragraph

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225 (1) of this subsection are met and shall be transitioned into
226 the long-term care managed care program, by October 1, 2017:
227 1. Traumatic Brain and Spinal Cord Injury Waiver.
228 2. Adult Cystic Fibrosis Waiver.
229 3. Project AIDS Care Waiver.
230 The agency shall seek federal approval to terminate the
231 Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic
232 Fibrosis Waiver, and the Project AIDS Care Waiver once all
233 eligible Medicaid recipients have transitioned into the long-
234 term care managed care program.
235 Section 5. This act shall take effect July 1, 2017.
236

Fiscal Year 2017-18 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 (no trust fund files for narrative columns)? Are Columns A06, A07, A08 and A09 for Fixed Capital Outlay (FCO) set to TRANSFER CONTROL for DISPLAY status only (UPDATE status remains on OWNER)? **(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 to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status? **(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
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.						

Action	Program or Service (Budget Entity Codes)					
	68200000	68500100	68500200	68501400	68501500	68700700
TIP Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.						
TIP Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, a Special Categories appropriation category (10XXXX) should be used.						
4. EXHIBIT D (EADR, EXD)						
4.1 Is the program component objective statement consistent with the agency LRPP, and does it conform to the directives provided on page 62 of the LBR Instructions?	Y	Y	Y	Y	Y	Y
4.2 Is the program component code and title used correct?	Y	Y	Y	Y	Y	Y
TIP Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.						
5. EXHIBIT D-1 (ED1R, EXD1)						
5.1 Are all object of expenditures positive amounts? (This is a manual check.)						
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 [with a $5,000 allowance] 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 [with a $5,000 allowance at the department level] 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 2015-16 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 29 of the LBR Instructions.)	Y	Y	Y	Y	Y	Y

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See pages 67 through 69 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 72 of the LBR Instructions?	Y	Y	Y	Y	Y	Y
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	Y	Y	Y	Y	Y	Y
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E.4 through E.6 of the LBR Instructions.)	Y	Y	Y	Y	Y	Y
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	Y	Y	Y	Y	Y	Y
7.7	Does the issue narrative thoroughly explain/justify all Salaries and Benefits amounts entered into the Other Salary Amounts transactions (OADA/C)? Amounts entered into OAD are reflected in the Position Detail of Salaries and Benefits section of the Exhibit D-3A.	Y	Y	Y	Y	Y	Y
7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	Y	Y	Y	Y	Y	Y
7.9	Does the issue narrative reference the specific county(ies) where applicable?	N/A	N/A	N/A	N/A	N/A	N/A
7.10	Do the 160XXX0 issues reflect budget amendments that have been approved (or in the process of being approved) and that have a recurring impact (including Lump Sums)? Have the approved budget amendments been entered in Column A18 as instructed in Memo #17-001?	N/A	N/A	N/A	N/A	N/A	N/A
7.11	When appropriate are there any 160XXX0 issues included to delete positions placed in reserve in the OPB Position and Rate Ledger (e.g. unfunded grants)? Note: Lump sum appropriations not yet allocated should not be deleted. **(PLRR, PLMO)**	N/A	N/A	N/A	N/A	N/A	N/A
7.12	Does the issue narrative include plans to satisfy additional space requirements when requesting additional positions?	N/A	N/A	N/A	N/A	N/A	N/A
7.13	Has the agency included a 160XXX0 issue and 210XXXX and 260XXX0 issues as required for lump sum distributions?	N/A	N/A	N/A	N/A	N/A	N/A
7.14	Do the amounts reflect appropriate FSI assignments?	Y	Y	Y	Y	Y	Y
7.15	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 issue codes relating to special *salary and benefits* issues (e.g., position reclassification, pay grade adjustment, overtime/on-call pay, etc.) have an "A" in the fifth position of the issue code (XXXXAXX) and are they self-contained (not combined with other issues)? (See pages 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, 30010C0, 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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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:		Y	Y	Y	Y	Y	Y
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
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 67 through 71 of the LBR Instructions.						
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.						
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).						
TIP	If 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 2017-18 data center costs, this can be completed by using the State Data Center data processing services category (210001).						
TIP	If an appropriation made in the FY 2016-17 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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
8.5	Have the required detailed narratives been provided (5% trust fund reserve narrative; method for computing the distribution of cost for general management and administrative services narrative; adjustments narrative; revenue estimating methodology narrative**;** fixed capital outlay adjustment narrative)?	Y	Y	Y	Y	Y	Y
8.6	Has the Inter-Agency Transfers Reported on Schedule I form been included as applicable for transfers totaling $100,000 or more for the fiscal year?	Y	Y	Y	Y	Y	Y
8.7	If the agency is scheduled for the annual trust fund review this year, have the Schedule ID and applicable draft legislation been included for recreation, modification or termination of existing trust funds?	N/A	N/A	N/A	N/A	N/A	N/A
8.8	If the agency is scheduled for the annual trust fund review this year, have the necessary trust funds been requested for creation pursuant to section 215.32(2)(b), Florida Statutes - including the Schedule ID and applicable legislation?	N/A	N/A	N/A	N/A	N/A	N/A
8.9	Are the revenue codes correct? In the case of federal revenues, has the agency appropriately identified direct versus indirect receipts (object codes 000700, 000750, 000799, 001510 and 001599)? For non-grant federal revenues, is the correct revenue code identified (codes 000504, 000119, 001270, 001870, 001970)?	Y	Y	Y	Y	Y	Y
8.10	Are the statutory authority references correct?	Y	Y	Y	Y	Y	Y
8.11	Are the General Revenue Service Charge percentage rates used for each revenue source correct? (Refer to 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

Action	Program or Service (Budget Entity Codes)					
	68200000	68500100	68500200	68501400	68501500	68700700
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
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 ALL trust funds having an unreserved fund balance in columns A01, A02 and/or A03, and if so, does each column's 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? (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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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 (with "C" in 6th position or within a program component of 1603000000), 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**	N/A	N/A	N/A	N/A	N/A	N/A
14. SCHEDULE VIIIB-2 (EADR, S8B2)							
14.1	Do the reductions comply with the instructions provided on pages 104 through 106 of the LBR Instructions regarding a 10% reduction in recurring General Revenue and Trust Funds, including the verification that the 33BXXX0 issue has NOT been used?	Y	Y	Y	Y	Y	Y
15. SCHEDULE VIIIC (EADR, S8C) (LAS/PBS Web - see page 107-109 of the LBR Instructions for detailed instructions)							
15.1	Agencies are required to generate this schedule via the LAS/PBS Web.	Y	Y	Y	Y	Y	Y
15.2	Does the schedule include at least three and no more than 10 unique reprioritization issues, in priority order? Manual Check.	Y	Y	Y	Y	Y	Y
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 2015-16 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

	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
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")**	N	N	N	N	N	N
TIP	If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.	For 16.7 - Please see Schedule XI, sub note (5)					
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	Does manual exhibits tie to LAS/PBS 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 Schedule IV-B for each IT project over $1 million (see page 134 of the LBR instructions for exceptions to this rule)? Have all IV-Bs 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
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