Florida Agency for Health Care Administration

Legislative Budget Request
Fiscal Year 2023-2024

Ron DeSantis, Governor
Simone Marstiller, Secretary

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

LEGISLATIVE BUDGET REQUEST

Agency for Health Care Administration

Tallahassee, Florida 32308

October 14, 2022

Chris Spencer, Policy Director
Office of Policy and Budget
Executive Office of the Governor
1702 Capitol
Tallahassee, Florida 32399-0001

Eric Pridgeon, Staff Director
House Appropriations Committee
221 Capitol
Tallahassee, Florida 32399-1300

John Shettle, Interim 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 accurate presentation of our proposed needs for the 2023-2024 Fiscal Year. I have approved this submission.

Sincerely,

Simone Marstiller
Secretary

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

Temporary Special Duty – General Pay Additives Implementation Plan for Fiscal Year 2023-2024

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, the AHCA has used existing rate and salary appropriations to grant pay additives when warranted based on the duties and responsibilities of the position.

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

Temporary Special Duties – General Pay Additive

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

1. Justification and Description:

   a) Out-of-Title - When an employee is temporarily assigned to act in a vacant higher level position and actually performs a major portion of the duties of the higher level position.
   b) Vacant – When an employee is temporarily assigned to act in a position and perform a major portion of the duties of the vacant position.
   c) Extended Leave – When an employee is temporarily assigned to act in a position and perform a major portion of the duties of an employee who is on extended leave other than 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: The AHCA will need to determine this additive on a case-by-case basis, assessing the proper alignment of the specifications and the reason for the additive being placed. For employees filling any vacant positions, the additive would be placed upon approval and assignment of the additional duties. However, employees who are identified as working "out-of-title" for a period of time that exceeds 22 workdays within any six (6) 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 will be applied accordingly after proper evaluation. Any pay additive over 10 percent is subject to the review and approval of the Agency Head or their delegate. These additives will be provided to positions that have been deemed "mission critical" and that fall into one of the justifications/descriptions stated above. In order to arrive at the total additive to be applied AHCA will use the below formula:

Based on 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 = $43,151.19, hourly rate
$20.75 With 10% additive - $43,151.19 X .10 = $4,315.12
Anticipated Salary - $43,151.19 + $4,315.12 = $47,466.31
New Hourly Rate - $22.82, difference in hourly rate - $22.82 - $20.75 = $2.07
Projected Additive Total – 720 hours X $2.07 = $1,490.40 is the 90-day difference

5. Classes and number of positions affected: This pay additive could potentially affect any of our current 1147 Career Service position incumbents statewide.

6. Historical Data: Last fiscal year, a total of seven (7) full time equivalent (FTE) career service positions received general pay additives for performing the duties of a vacant position. Each position was considered "mission critical" and played a key role in carrying out the AHCA's day-to-day operations. All additives were in effect for the allotted 90 days with one (1) being extended to 180 days due to the circumstances of the vacant position and absent co-worker and required duties.

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

Average Min. Annual Salaries	X 10% of Min. Annual Salaries	# of FTEs
$40,748.17	$4,074.82	7

Based on the average estimated salaries stated above, the estimated calculation is as follows: $1,567.24 X 7 = $10,970.68. **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 2021-2022 General Appropriations Act." See Article 25, Section 1 (B) of the AFSCME Agreement. We would anticipate similar language in future agreements. The AHCA has a past practice of providing these pay additives to bargaining unit employees.

Florida Agency for Health Care Administration

Department Level Exhibits and Schedules

Ron DeSantis, Governor

Simone Marstiller, Secretary

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:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration v. Baker County Medical Services, Inc., d/b/a Ed Fraser Memorial Hospital	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	DSH-1006	
Summary of the Complaint:	Agency seeks reimbursement of overpayment pursuant to Disproportionate Share Hospital (DSH) audit.	
Amount of the Claim:	$658,492	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on August 31, 2022, at which time the parties must notify the Clerk of the status of the case.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	x	Agency Counsel (Joseph Hern)
		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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Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration v. North Broward Hospital District, d/b/a Broward Health Medical Center, Broward Health North, Broward Health Imperial Point, and Broward Health Coral Springs	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	DSH-1002, 1005, 1007, and 1010	
Summary of the Complaint:	N/A	
Amount of the Claim:	$2,201,313.00	
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:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on September 19, 2022, at which time the parties must notify the Clerk of the status of the case.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	x	Agency Counsel (Joe Hern)
		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. The Public Health Trust of Miami-Dade County	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	DSH-1009	
Summary of the Complaint:	Agency seeks reimbursement of overpayment pursuant to Disproportionate Share Hospital (DSH) audit.	
Amount of the Claim:	$56,949,051.00	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	A Final Order was issued on August 11, 2022, closing the file.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	x	Agency Counsel (Joe Hern)
		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. Alfred Ivan Murciano	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	18-2699MPI – now 19-3662MPI	
Summary of the Complaint:	Agency claims overpayment based upon coding errors, level of service issues, and medical necessity.	
Amount of the Claim:	$1,834,138.10 plus fines and costs	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	A Final Hearing was held on April 13, 2022, and Proposed Recommended Orders were filed on July 13, 2022. The Agency is awaiting the Recommended Order to be issued by the Administrative Law Judge.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel (Joe Hern)
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel

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Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	St. Joseph's Hospital (100978) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA Case No. 20170004078	
Summary of the Complaint:	Hospital challenging the Medicaid Inpatient and Outpatient Hospital Reimbursement Rates.	
Amount of the Claim:	$457,054 plus reprocessed amount for several years	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 9, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Peace River Regional Medical Center (100285) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-025MPF (DOAH Case #15-1547)	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates on or after July1, 2001 pursuant to AHCA's February 13, 2015, letter of determination.	
Amount of the Claim:	Provider owes AHCA $158,906.24	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Venice Regional Medical Center v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-201MPF (DOAH Case #15-1579)	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from January 1, 1985 through June 30, 2014, pursuant to AHCA's February 13, 2015, letter of determination.	
Amount of the Claim:	AHCA owes Provider $829,477.66	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Wuesthoff Health System (Rockledge) (CHS) (100111) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-019MPF (DOAH Case #15-1604) and 2018010066	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from January 1, 1985 through June 30, 2014, pursuant to AHCA's February 13, 2015, letter of determination.	
Amount of the Claim:	Provider owes AHCA $164,126.91 and undetermined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)

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Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Halifax Medical Center v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-109MPF (DOAH 15-1429)	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from January 1, 1985 through June 30, 2014, pursuant to AHCA's February 13, 2015, letter of determination.	
Amount of the Claim:	Allegedly $2,649,986.16	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Martin Memorial Hospital v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-071MPF (DOAH 15-1543)	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from January 1, 1985 through June 30, 2014, pursuant to AHCA's February 13, 2015, letter of determination.	
Amount of the Claim:	Provider owes AHCA $1,864,509.10	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
f 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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669
Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	North Broward Hospital District (Broward Health North) (100218) (15) v. Agency for Health Care Administration		
Court with Jurisdiction:	Agency for Health Care Administration		
Case Number:	AHCA 15-024MP/DOAH 15-1544		
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 1984 to 2014.		
Amount of the Claim:	AHCA owes $2,109,752.36		
Specific Statutes or Laws (including GAA) Challenged:	N/A		
Status of the Case:	AHCA and the provider are currently negotiating a settlement as the case is placed in abeyance.		
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 (Joe Goldstein, Shutts)	
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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Agency:	Agency for Health Care Administration		
Contact Person:	Josefina M. Tamayo, General Counsel	Phone Number:	850-412-3669
Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	North Broward Hospital District, Mount Sinai Medical Center of Florida, Inc., and Naples Community Hospital, Inc., on behalf of themselves and all others similarly situated, v. State of Florida, Agency for Health Care Administration		
Court with Jurisdiction:	State of Florida First District Court of Appeals		
Case Number:	DCA No.: 1D21-2485; L.T. No. 2019-CA-002677		
Summary of the Complaint:	This Appeal is from an Order from the Second Judicial Circuit for Leon County entering Final Judgment in favor of Defendant/Counter-Plaintiffs, AHCA. Plaintiff hospitals filed this breach of contract action claiming that AHCA's recoupment of Medicaid funds as part of its audits related to emergency services for undocumented aliens was unlawful in light of Lee Memorial Health System Gulf Coast Med. Ctr. V. State of Florida, Agency for Health Care Administration, 272 So. 3d 431 (Fla. 1st DCA 2019), in which the First DCA held that AHCA lacked statutory authority to conduct retrospective reviews of hospital claims. Plaintiffs claim that AHCA breached its Medicaid provider agreements by failing to refund the Medicaid funds it recouped pursuant to these audits. This is a putative class action, brought on behalf of all hospitals from whom AHCA recouped Medicaid funds pursuant to these audits during the five years prior to the filing of the complaint. On December 12, 2019, AHCA was served with an Amended Class Action Complaint, adding Mount Sinai Medical Center as a Plaintiff. AHCA is the Appellee in this case.		
Amount of the Claim:	An estimated $4 million for the 3 named plaintiffs; and An estimated additional $49 million for "all others similarly situated" during the time period of 5 years prior to the civil case being filed		
Specific Statutes or Laws (including GAA) Challenged:	§§ 409.905(5)(a), 409.913, Fla. Stat.		

<table>
<tr><td>Status of the Case:</td><td colspan="2">Briefing is complete and oral argument has not been ordered. The case now awaits a final decision by the Court.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td>X</td><td>Agency Counsel – Tracy George tracking purposes only</td></tr>
<tr><td></td><td>Office of the Attorney General or Division of Risk Management</td></tr>
<tr><td>X</td><td>Outside Contract Counsel – Joseph Goldstein</td></tr>
<tr><td>If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).</td><td colspan="2">Brannock Humphries & Berman

and

Duane Morris LLP</td></tr>
</table>

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Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	South Broward Hospital District, d/b/a Memorial Hospital Miramar (103454) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 15-163MPF/DOAH 15-1575 and AHCA Case No. 2018012735	
Summary of the Complaint:	Challenging reimbursement rates for January 2005 through June 30, 2014, and January 2011 through July 2016	
Amount of the Claim:	Not determined	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on September 13, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	South Broward Hospital District, d/b/a Memorial Hospital West (102521) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 15-141MPF/DOAH 15-1609, AHCA 2016-6618, and AHCA 2018-012736	
Summary of the Complaint:	Challenging inpatient and outpatient reimbursement rates	
Amount of the Claim:	Not determined	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 19, 2022, at which time the parties must notify the Clerk of the status of the case.	
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
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Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	South Broward Hospital District, d/b/a Memorial Regional Hospital (100200) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 15-023-MPF/DOAH 15-1603, AHCA 2018012739, and AHCA 2018017099	
Summary of the Complaint:	Challenging reimbursement rates	
Amount of the Claim:	Not determined	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 9, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	South Broward Hospital District, d/b/a Memorial Hospital Pembroke (102229) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 15-132MPF/DOAH 15-1608 and 2018009454	
Summary of the Complaint:	Challenging reimbursement rates	
Amount of the Claim:	Not determined	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on August 24, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Sebastian River Medical Center (CHS) (120014) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-215-MPF (DOAH 15-1551) and 2018-005114	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2003 to 2015	
Amount of the Claim:	AHCA owes Provider $268,703.76 plus an undetermined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 11, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory

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

Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Lake Wales Hospital Association (CHS) (101664) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-096-MPF (DOAH 15-1519)	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2006 to 2017	
Amount of the Claim:	Provider owes AHCA $17,844.03	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 9, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Seven Rivers Regional Medical (CHS) (119989) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-213-MPF (DOAH 15-1552) and AHCA Case No. 2018004778	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2006 to 2013	
Amount of the Claim:	Provider owes $1142,636.20 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 9, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Highlands Regional Medical Center (CHS) (100897) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-107-MPF (DOAH 15-1521) and AHCA 2018003844	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2004 to 2015	
Amount of the Claim:	Provider owes $51,423 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Pasco Regional Medical Center (Bayfront Health Dade City) (CHS) (109592) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-082MPF / DOAH 15-1546 and AHCA 2018004944	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2007 to 2014	
Amount of the Claim:	AHCA owes provider $82,817.62 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 19, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Starke HMA, LLC., d/b/a Shands Starke Medical Center (CHS) (100072) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-015-MPF (DOAH 15-1582) and AHCA 2018005895	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2009 to 2015	
Amount of the Claim:	Provider owes AHCA $699,826.37 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 11, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Santa Rosa Hospital (CHS) (101745) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-101-MPF (DOAH 15-1549) and AHCA 2018006936	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2006 to 2015 and July 1, 2015 through June 30, 2017	
Amount of the Claim:	AHCA working on update but initially owed an estimated $(304,567.51) plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)

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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Lehigh Regional Medical Center (CHS) (101117) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-065-MPF/DOAH 15-1518 and 2018004778	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2003 to 2015	
Amount of the Claim:	Provider owes $228,717.51 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 11, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Live Oak HMA, LLC., d/b/a Shands Live Oak Regional Medical Center (CHS) (101796) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-105-MPF (DOAH 15-1573) and 2018005042	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2007 to 2016	
Amount of the Claim:	Provider owes $522,952.94 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 19, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Wuesthoff Health System (Steward Melbourne Hospital) (CHS) (103209 v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-155MPF (DOAH Case #15-1605) and 2018007990	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from January 1, 1985 through June 30, 2014, pursuant to AHCA's February 13, 2015, letter of determination.	
Amount of the Claim:	AHCA owes $863,572.38 and undetermined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 11, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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).		

<table>
<tr><td colspan="4">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.</td></tr>
<tr><td>Agency:</td><td colspan="3">Agency for Health Care Administration</td></tr>
<tr><td>Contact Person:</td><td>Josefina Tamayo, General Counsel</td><td>Phone Number:</td><td>(850) 412-3669</td></tr>
</table>

<table>
<tr><td>Names of the Case: (If no case name, list the names of the plaintiff and defendant.)</td><td colspan="2">Heart of Florida Regional Medical Center (CHS) (102288) v. Agency for Health Care Administration</td></tr>
<tr><td>Court with Jurisdiction:</td><td colspan="2">Agency for Health Care Administration</td></tr>
<tr><td>Case Number:</td><td colspan="2">15-134-MPF / DOAH 15-1607 and AHCA 2018003840</td></tr>
<tr><td>Summary of the Complaint:</td><td colspan="2">Request for recalculation of Provider's inpatient and outpatient rates from 2005 to 2014</td></tr>
<tr><td>Amount of the Claim:</td><td colspan="2">Provider owes AHCA $8,494,660.36 plus to be determined amount</td></tr>
<tr><td>Specific Statutes or Laws (including GAA) Challenged:</td><td colspan="2">N/A</td></tr>
<tr><td>Status of the Case:</td><td colspan="2">The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on September 13, 2022, at which time the parties must notify the Clerk of the status of the case.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td></td><td>Agency Counsel</td></tr>
<tr><td></td><td>Office of the Attorney General or Division of Risk Management</td></tr>
<tr><td>X</td><td>Outside Contract Counsel (Joe Goldstein, Shutts)</td></tr>
<tr><td>If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).</td><td colspan="2"></td></tr>
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Schedule VII: Agency Litigation Inventory

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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Hernando HMA, LLC., d/b/a Bayfront Health Brooksville Medical Center (CHS) (100871) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	15-050-MPF (DOAH 15-1433)	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2007 to 2016	
Amount of the Claim:	Provider owes $845,920.12 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 11, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Key West HMA LLC., d/b/a Lower Keys Medical Center (CHS) (101192) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 15-072MPF (DOAH 15-1517) and AHCA 201707712	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2007 to 2016.	
Amount of the Claim:	AHCA owes $1,177,236 plus to be determined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on September 5, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Baptist Hospital Pensacola (100749) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 2018012484	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2011 to 2017	
Amount of the Claim:	Provider owes AHCA $19,397.50	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 19, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Morton Plant Hospital (101583) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 20167217	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2006 to 2008	
Amount of the Claim:	AHCA owes provider $2,000,723.68	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 19, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	UF Shands Hospital (Gainesville) (100030) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA NO.: 15-1574 / 2018017101	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from 2011-2013	
Amount of the Claim:	Undetermined	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on August 24, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Citrus Memorial Hospital (102199) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	2016013781	
Summary of the Complaint:	Request for recalculation of Provider's inpatient and outpatient rates from various years	
Amount of the Claim:	Undetermined	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 21, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Florida Baptist Medical Center (100609) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 15-042MPF/DOAH 15-1576, AHCA 2018016319, and AHCA Case No. 2019003948	
Summary of the Complaint:	Provider contends that Request for recalculation of Provider's inpatient and outpatient rates for 1985 to 2014, July 1, 2012, and July 1, 2013 to July 1, 2016	
Amount of the Claim:	Undetermined	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 19, 2022, at which time the parties must notify the Clerk of the status of the case.	
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
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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Naples HMA, LLC., d/b/a Physicians Regional Medical Center – Pine Ridge (103144) (112) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA 15-153MPF/DOAH 15-1548 and AHCA 2018007988	
Summary of the Complaint:	Provider contends that Request for recalculation of Provider's inpatient and outpatient rates for 2005 to 2016	
Amount of the Claim:	Provider owes AHCA $818,124 plus unprocessed amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on August 30, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Osceola SC, LLC., d/b/a St. Cloud Regional Medical Center (103462) (114) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA MPF 15-164/DOAH 15-1577 and AHCA 2018004982	
Summary of the Complaint:	Provider contends that Request for recalculation of Provider's inpatient and outpatient rates	
Amount of the Claim:	$275,955.10 plus lump sum for years to be re-processed	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 11, 2022, at which time the parties must notify the Clerk of the status of the case.	
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Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Larkin Community Hospital (120057) (103) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	AHCA Case No. 2018005246	
Summary of the Complaint:	Provider contends that request for recalculation of Provider's inpatient and outpatient rates	
Amount of the Claim:	Provider owes AHCA $16,197.78 plus and undetermined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 5, 2022, at which time the parties must notify the Clerk of the status of the case.	
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
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Contact Person:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	North Okaloosa Medical Center (101265) (110) v. Agency for Health Care Administration	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	MPF 15-077 / (DOAH 15-1522) and AHCA 2018007734	
Summary of the Complaint:	Provider contends that Request for recalculation of Provider's inpatient and outpatient rates for July 2011 rates	
Amount of the Claim:	AHCA owes provider $2,890,626.86 plus an undetermined amount	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The case has been placed in abeyance via an Order issued by the Agency Clerk. The abatement expires on October 11, 2022, at which time the parties must notify the Clerk of the status of the case.	
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 (Joe Goldstein, Shutts)
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:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Variety Children's Hospital (Nicklaus) (100609) v. Agency for Health Care Administration	
Court with Jurisdiction:	3rd District Court of Appeal	
Case Number:	DCA Case No. 3D21-1441 (Lower Case No. 21-112PH, AHCA Case No. 15-04OM)	
Summary of the Complaint:	Provider contends that AHCA cannot revise unaudited rates after entry of a Final Order that included audited and unaudited rates as to years 2007-2009	
Amount of the Claim:	$2,510,765	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	A Final Order was entered on April 5, 2022, closing the case.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	x	Agency Counsel (Tracy George)
		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:	Josefina Tamayo, General Counsel	Phone Number:	850/412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration v. Care Around the Clock Health and Human Services, Inc., dba Wright Choices	
Court with Jurisdiction:	Division of Administrative Hearings	
Case Number:	MPI No. 2020-0019545 / DOAH No. 22-2343MPI	
Summary of the Complaint:	Overpayment amount, including fines and costs	
Amount of the Claim:	$636,258.90	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	This case has been referred to the Division of Administrative Hearings for a final hearing.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel (Susan Sapoznikoff)
		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:	Josefina Tamayo, Esquire General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Florida Agency for Health Care Administration, Plaintiff, and Jackson Health System, Intervenor Plaintiff, v. United States Department of Health and Human Services and Xavier Becerra, Secretary of the United States Department of Health and Human Services, in his official capacity, Defendants
Court with Jurisdiction:	U.S. District Court for the Southern District of Florida; HHS Departmental Appeals Board
Case Numbers:	21-cv-21616-BB; FL/16/002/MAP; FL/2022/001/MAP; FL/2022/002/MAP (all inter-related)
Summary of the Complaints:	**21-cv-21616-BB:** Appeal of the final administrative decision of U.S. Department of HHS Departmental Appeals Board disallowing federal reimbursement for certain Medicaid payments (Low-Income Pool) made by the State to hospitals and medical providers from 7/1/06 – 6/30/13. In particular, the State is challenging HHS's methodology for calculating and including uncompensated costs. **FL/16/002/MAP:** CMS alleged unallowable payments of $63,233,036 for state fiscal years ended July 1, 2006, through June 30, 2009. AHCA appealed. HHS Department Appeals Board (DAB) rendered Decision No. 3032 upholding the disallowance except as related to Jackson Memorial costs, but otherwise remanding. **FL/2022/001/MAP**: In follow-up to OIG Audit A-04-17-04058, CMS issued a disallowance letter asserting a $270,896,331 overpayment (down from $411,932,576, based on AHCA's challenge) for alleged unallowable payments to Jackson Memorial Hospital under its LIP program for July 1, 2009, through June 30, 2014 (SFY 2010 through SFY 2014). **FL/2022/002/MAP**: On June 10, 2022, CMS issued a disallowance letter asserting an overpayment of $150,325,421 FFP for alleged unallowable payment to hospital and non-hospital [federal qualified health center (FQHC) and county health department (DHC) providers] under its LIP program for June 30, 2014, through June 30, 2018 (DY 8-12). CMS had previously contacted the Agency and advised it was going to skip the demand letter for DY 8-12 and go straight to the disallowance. This would allow settlement discussions to begin.
Amount of the Claim:	**21-cv-21616-BB:** $97,570,183.00

	FL/16/002/MAP: $63,233,036.00 **FL/2022/001/MAP**: $270,896,331.00 **FL/2022/002/MAP**: $150,325,421.00
Specific Statutes or Laws (including GAA) Challenged:	Special terms and conditions of Florida's "demonstration project" or "waiver,", effective 2006, pursuant to Section 1115 of the Social Security Act, 42 U.S.C. § 1316; Section 1905(a) of the Social Security Act, 42 U.S.C. § 1316; 42 U.S.C. § 1396a-b; 42 C.F.R. § 400.203; 42 C.F.R. § 447.299(c)(16)
Status of the Case:	**21-cv-21616-BB:** The case has been stayed until November 15, 2022. AHCA has repaid the $97M to CMS and recorded it on the FFY Q3 2021 CMS 64. A payment of $3,551,532 for interest (CVFR) was recorded on the FFY Q4 2021 CMS 64. AHCA is currently attempting to negotiate a settlement. **FL/16/002/MAP:** The Agency is awaiting an updated demand and disallowance letters from CMS. The amount is currently unspecified and remains to be determined but is not expected to exceed the original disallowance of $63,233,036 FFP (plus interest). **FL/2022/001/MAP**: AHCA sought reconsideration of the disallowance on August 9, 2022. **FL/2022/002/MAP**: AHCA sought reconsideration of the disallowance on August 9, 2022.
Who is representing (of record) the state in this lawsuit? Check all that apply.	X — Agency Counsel: = Shena Grantham, Esq. Office of the Attorney General or Division of Risk Management X — Outside Contract Counsel: Caroline M. Brown, Esq.
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 Florida Fiscal Portal.

Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, Esquire General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration vs. New Life Medical Institute, Inc.	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	2016-0006604	
Summary of the Complaint:	Medicaid Program Integrity audit resulted in an overpayment and sanctions to the Provider for a total amount of $2,791,236.83 which the Agency seeks to recover.	
Amount of the Claim:	$2,791,236.83	
Specific Statutes or Laws (including GAA) Challenged:	409.913	
Status of the Case:	A settlement agreement was executed by the parties and adopted via Final Agency Order on October 8, 2019.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel (Timothy Sparks)
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Florida Fiscal Portal.

Agency:	**Agency for Health Care Administration**		
Contact Person:	Josefina Tamayo, Esquire General Counsel	Phone Number:	(850) 412-3669

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Agency for Health Care Administration vs. Community Connections for Life, Inc.	
Court with Jurisdiction:	Agency for Health Care Administration	
Case Number:	2021-0021615	
Summary of the Complaint:	Provider billed the Medicaid FFS program for Statewide Medicaid Managed Care recipients resulting in an overpayment to the Provider of $13,256,883.20 which the Agency seeks to recover.	
Amount of the Claim:	$13,256,883.29	
Specific Statutes or Laws (including GAA) Challenged:	409.913	
Status of the Case:	A settlement agreement was executed by the parties and adopted via Final Agency Order May 16, 2022.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel (Timothy Sparks)
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel
If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).		

Schedule VII: Agency Litigation Inventory		
For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Governor's website.		
Agency for Health Care Administration		
Josefina M. Tamayo, General Counsel	Phone Number:	(850) 412-3664

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Senior Care Group Chapter 11 bankruptcy cases (7 related entities): • Senior Care Group, Inc. • SCG Baywood, LLC • SCG Gracewood, LLC • SCG Habourwood, LLC • SCG Laurellwood Nursing, LLC • The Bridges Nursing and Rehabilitation, LLC • Key West Health and Rehabilitation Center, LLC
Court with Jurisdiction:	Bankruptcy Court for the Middle District of Florida, Tampa Division
Case Number:	8:17-bk-06562 (Senior Care Group, Inc.) 8:17-bk-06563 (SCG Baywood, LLC) 8:17-bk-06564 (SCG Gracewood, LLC) 8:17-bk-06572 (SCG Harbourwood, LLC) 8:17-bk-06576 (SCG Laurellwood Nursing, LLC) 8:17-bk-06579 (The Bridges Nursing and Rehabilitation, LLC) 8:17-bk-06580 (Key West Health and Rehabilitation Center, LLC)
Summary of the Complaint:	These are bankruptcy cases in which AHCA has filed proofs of claim
Amount of the Claim:	$12,855,858.53 as of July 12, 2017 (it would have increased between that date and the filing of the bankruptcy petitions on July 27, 2017).
Specific Statutes or Laws (including GAA) Challenged:	Bankruptcy Code (Title 11 of the U.S. Code)
Status of the Case:	AHCA filed proofs of claim. The debtors sold four of the bankrupt facilities (Baywood, Gracewood, Harbourwood, and Laurellwood). AHCA received $2,535,154 in this sale as settlement of its claims against these four debtors.

<table>
<tr><td></td><td colspan="2">Chapter 11 Plan was confirmed in 2020, AHCA settled its remaining claims, and this matter is now closed.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td>x</td><td>Agency Counsel</td></tr>
<tr><td></td><td>Office of the Attorney General or Division of Risk Management</td></tr>
<tr><td></td><td>Outside Contract Counsel</td></tr>
<tr><td>If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).</td><td colspan="2">N/A</td></tr>
</table>

Schedule VII: Agency Litigation Inventory			
For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Florida Fiscal Portal.			
Agency:	**Agency for Health Care Administration**		
Contact Person:	Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	850-412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	FAMILY HEALTH CENTERS OF SOUTHWEST FLORIDA, INC., a Florida non-profit corporation, Plaintiff, v. SIMONE MARSTILLER, Secretary, Florida Agency for Health Care Administration, in her official capacity, Defendant.
Court with Jurisdiction:	U.S. District Court for the Middle District of Florida
Case Number:	2:21-cv-00278-SPC-NPM
Summary of the Complaint:	On April 1, 2021, Plaintiff, a federally qualified health center ("FQHC"), filed its Complaint for Injunctive and Declaratory Relief. AHCA was served on April 5, 2021. Plaintiff alleges that AHCA's reimbursement plan for FQHCs is inconsistent with the requirements of 42 U.S.C. § 1396a(bb)(3). This provision requires that the amount paid to a FQHC be "adjusted to take into account any increase or decrease in the scope of services furnished by the center or clinic during that fiscal year." 42 U.S.C. § 1396a(bb)(3)(B). Plaintiff contends that guidance issued by the federal Centers for Medicare and Medicaid Services ("CMS") in 2001 and 2010 constitute binding interpretations of this provision which define a change in the "scope of services" to mean "a change in the type, intensity, duration and/or amount of services." Plaintiff alleges that AHCA's reimbursement plan for FQHCs, contained in State Plan Amendment ("SPA") 2014-012, defines a "change in scope of services"[1] too narrowly, failing to take into account changes Plaintiff has made – changes which, Plaintiff alleges, would qualify as changes "in the type, intensity, duration and/or amount of services" under CMS guidance. Plaintiff contends that CMS's approval of SPA 2014-012 violates the federal Administrative Procedure Act ("APA") and that AHCA's application of SPA 2014-012 violates the Medicaid Act. Plaintiff alleges that it has been harmed because its costs

[1] SPA 2014-012 defines "a change in scope of service(s)" as either [t]he addition of a new service not previously provided by the FQHC" or [t]he elimination of an existing service provided by the FQHC."

<table>
<tr><td></td><td colspan="2">have significantly increased while its Medicaid reimbursements have not.

Plaintiff seeks an order declaring SPA 2014-012 invalid under the APA and the Medicaid Act and enjoining AHCA from implementing SPA 2014-012 with respect to payment adjustments related to changes in scope of services. Plaintiff further seeks an order requiring AHCA to submit a new state plan amendment that aligns with its preferred definition of changes in scope of services.</td></tr>
<tr><td>Amount of the Claim:</td><td colspan="2">Plaintiff seeks declaratory and injunctive relief</td></tr>
<tr><td>Specific Statutes or Laws (including GAA) Challenged:</td><td colspan="2">Plaintiff challenges a provision of Florida's Medicaid State Plan defining change in scope of services.</td></tr>
<tr><td>Status of the Case:</td><td colspan="2">The parties filed cross-motions for summary judgment. Responses (and replies) are pending.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td>X</td><td>Agency Counsel</td></tr>
<tr><td></td><td>Office of the Attorney General or Division of Risk Management</td></tr>
<tr><td></td><td>Outside Contract Counsel</td></tr>
<tr><td>If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).</td><td colspan="2"></td></tr>
</table>

Schedule VII: Agency Litigation Inventory			
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Agency:	**Agency for Health Care Administration**		
Contact Person:	Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	850-412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	BLANCA MEZA, by and through her Guardian, Aide Hernandez; DESTINY BELANGER, by and through her Guardian, Julie Belanger; on behalf of themselves and all others similarly situated; and DISABILITY RIGHTS FLORIDA, Plaintiffs, v. SIMONE MARSTILLER, in her official capacity as Secretary for the FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, Defendant.
Court with Jurisdiction:	U.S. District Court for the Middle District of Florida
Case Number:	3:22-cv-00783-MMH-LLL
Summary of the Complaint:	According to the Complaint, Plaintiffs are medically fragile adult Medicaid recipients with bladder and bowel incontinence. Plaintiffs allege that they have been prescribed incontinence supplies, including briefs and underpads, but that Florida's Medicaid program does not cover such supplies for adults unless the individual (1) has been diagnosed with AIDS and has a history of AIDS-related infection; (2) resides in a nursing facility; or (3) is enrolled in a home and community-based services Medicaid waiver program. Plaintiffs contend that the coverage of adult incontinence supplies is required by the federal Medicaid Act and that AHCA's coverage policy violates the Medicaid Act, Title II of the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act. Plaintiffs seek declaratory and injunctive relief requiring coverage of adult incontinence supplies for themselves and all similarly situated Medicaid recipients. Plaintiffs seek certification of the following class: All Florida Medicaid recipients whose prescription for incontinence supplies has been or will be denied Medicaid coverage based on Defendant's exclusion of those supplies for recipients aged 21 and older.
Amount of the Claim:	Plaintiffs seek declaratory and injunctive relief
Specific Statutes or Laws (including GAA) Challenged:	

<table>
<tr><td>Status of the Case:</td><td colspan="2">In addition to the Complaint, Plaintiffs filed a motion for preliminary injunction on behalf of Plaintiff Meza and motion for class certification. Plaintiff Meza withdrew her motion for preliminary injunction after AHCA agreed to provide Plaintiff’s incontinence supplies on an interim basis.

AHCA’s responses to the Complaint and Motion for Class Certification are currently due on September 8, 2022.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td>X</td><td>Agency Counsel – Andrew Sheeran monitoring</td></tr>
<tr><td></td><td>Office of the Attorney General or Division of Risk Management</td></tr>
<tr><td>X</td><td>Outside Contract Counsel – Rick Figlio and Alexandra Akre of Ausley McMullen</td></tr>
<tr><td>If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).</td><td colspan="2">Katy DeBriere of the Florida Health Justice Project

Alison DeBelder and Liam Joseph McGivern of Disability Rights Florida

Lewis Golinker</td></tr>
</table>

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Florida Fiscal Portal.

Agency:	**Agency for Health Care Administration**		
Contact Person:	Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	850-412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	MHB CONSULTANTS, INC., a dissolved Florida Corporation, Plaintiff, v. FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, Defendant.	
Court with Jurisdiction:	Circuit Court of the Second Judicial Circuit in and for Leon County, Florida	
Case Number:	2021 CA 001923	
Summary of the Complaint:	On November 9, 2021, Plaintiff MHB Consultants, Inc., Inc., filed its Complaint against AHCA alleging breach of contract. The Complaint was served on AHCA on December 8, 2021. Plaintiff alleges that AHCA wrongfully either denied or otherwise failed to pay $2,052,135.85 worth of Medicaid claims for services provided between March and May 2018. Plaintiff seeks general compensatory damages ("including consequential damages"), "special damages equivalent to the going marked value of Plaintiff's entire business at the time AHCA destroyed it," costs of suit, and prejudgment and post-judgment interest.	
Amount of the Claim:	$2,052,135.85	
Specific Statutes or Laws (including GAA) Challenged:	Plaintiff is not challenging any statute or law.	
Status of the Case:	Discovery is ongoing.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	X	Agency Counsel – Andrew Sheeran
		Office of the Attorney General or Division of Risk Management
		Outside Contract Counsel

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

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Florida Fiscal Portal.

Agency for Health Care Administration		
Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	850-412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	PLANNED PARENTHOOD OF SOUTHWEST AND CENTRAL FLORIDA, *et al.*, Plaintiffs, v. STATE OF FLORIDA, *et al.*, Defendants.
Court with Jurisdiction:	Circuit Court of the Second Judicial Circuit in and for Leon County; First District Court of Appeal
Case Number:	Circuit Court: 2022-CA-912 1st DCA: 1D22-2034
Summary of the Complaint:	Plaintiffs challenge HB 5's prohibition of abortions after 15 weeks of gestation (and related definitions) as violative of the right to privacy in Art. I, § 23 of the Florida Constitution.
Amount of the Claim:	Plaintiffs seek declaratory and injunctive relief.
Specific Statutes or Laws (including GAA) Challenged:	HB 5 amends chapter 390, Florida Statutes.
Status of the Case:	On July 5, 2022, the Circuit Court entered a preliminary injunction enjoining the enforcement of HB 5. On the same day, Defendants filed their notice of appeal of the court's order. Pursuant to Florida Rule of Appellate Procedure 9.310, this resulted in an automatic stay of the court's order. Plaintiffs filed an emergency motion to vacate the automatic stay in the circuit court, which the circuit court denied on July 12, 2022. Defendants filed their answer to the Complaint on July 18, 2022. On July 5, 2022, Defendants filed a motion with the 1st DCA to certify to the Florida Supreme Court. On July 13, 2022, Plaintiffs filed an emergency motion to vacate the automatic stay with the district court of appeal. On July 21, 2022, the 1st DCA issued its Order denying Plaintiffs' motion to vacate the automatic stay and rejecting Defendants' suggestions for certification to the Florida Supreme Court.

<table>
<tr><td></td><td colspan="2"></td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td></td><td>Agency Counsel</td></tr>
<tr><td>X</td><td>Office of the Attorney General or Division of Risk Management – James Percival</td></tr>
<tr><td></td><td>Outside Contract Counsel</td></tr>
<tr><td>If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).</td><td colspan="2"></td></tr>
</table>

<table>
<tr><td colspan="4">Schedule VII: Agency Litigation Inventory
For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Florida Fiscal Portal.</td></tr>
<tr><td colspan="4">Agency for Health Care Administration</td></tr>
<tr><td colspan="2">Andrew T. Sheeran, Acting Deputy General Counsel</td><td>Phone Number:</td><td>850-412-3670</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Names of the Case: (If no case name, list the names of the plaintiff and defendant.)</td><td colspan="3">United States v. State of Florida</td></tr>
<tr><td>Court with Jurisdiction:</td><td colspan="3">U.S. District Court for the Southern District of Florida</td></tr>
<tr><td>Case Number:</td><td colspan="3">0:12-cv-60460-DMM</td></tr>
<tr><td>Summary of the Complaint:</td><td colspan="3">In the Amended Complaint (Docket Entry 700, filed June 15, 2022), the United States alleges that the State of Florida discriminates against children under the age of twenty-one in violation of Title II of the Americans with Disabilities Act by failing to administer its services in the most integrated setting appropriate to their needs.</td></tr>
<tr><td>Amount of the Claim:</td><td colspan="3">The United States seeks declaratory and injunctive relief.</td></tr>
<tr><td>Specific Statutes or Laws (including GAA) Challenged:</td><td colspan="3">This action does not challenge specific statutes or laws. It is brought under Title II of the Americans with Disabilities Act.</td></tr>
<tr><td>Status of the Case:</td><td colspan="3">The United States' original complaint (filed in 2013) was dismissed for lack of standing in 2016. The United States filed its notice of appeal on August 7, 2017. Oral argument was held at the Eleventh Circuit in October 2018. On September 17, 2019, the Eleventh Circuit issued an Opinion reversing and remanding the District Court's dismissal. The State petitioned for rehearing en banc, and the petition was denied on December 22, 2021. The State filed a petition for writ of certiorari to the U.S. Supreme Court, which remains pending.

On remand, The United States filed an Amended Complaint. The State filed a motion to dismiss, which remains pending. Discovery is ongoing.</td></tr>
<tr><td></td><td>X</td><td colspan="2">Agency Counsel – Andrew Sheeran</td></tr>
</table>

Who is representing (of record) the state in this lawsuit? Check all that apply.		Office of the Attorney General or Division of Risk Management
	X	Outside Contract Counsel – Andy Bardos, Ashley Lukis, and Tim Moore of Gray Robinson

Schedule VII: Agency Litigation Inventory

For directions on completing this schedule, please see the "Legislative Budget Request (LBR) Instructions" located on the Florida Fiscal Portal.

Agency for Health Care Administration

Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	850-412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	W.B., by and through his father and legal guardian, David B., and A.W., by and through her mother and legal guardian, Brittany C. on behalf of themselves and all others similarly situated, Plaintiffs, v. Simone Marstiller, in her official capacity as Secretary for the Florida Agency for Health Care Administration, Defendant.
Court with Jurisdiction:	U.S. District Court for the Middle District of Florida
Case Number:	3:21-cv-00771-MMH-PDB
Summary of the Complaint:	Plaintiffs generally allege that AHCA's definition of "medical necessity," as set forth in Rule 59G-1.010, Florida Administrative Code, is more restrictive than what is permitted by federal law for Medicaid recipients under the age of 21. Specifically, Plaintiffs allege that the "early and periodic screening, diagnostic, and treatment services" ("EPSDT") provisions of the federal Medicaid Act require the coverage of all Medicaid services necessary "to correct or ameliorate" the physical or mental conditions of Medicaid recipients under the age of 21. 42 U.S.C. § 1396d(r)(5). Plaintiffs further allege that AHCA's medical necessity standard, by imposing requirements that services be, among other things, "necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain," and "[b]e furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider," results in the denial of services that must be covered under federal law. *See* Rule 59G-1.010, Florida Administrative Code. Plaintiffs contend that, as a result of the application of these allegedly unlawful requirements, W.B. was wrongfully denied coverage of services at a specialty treatment center in Cincinnati, Ohio, by the Children's Medical Services Health Plan, and A.W. was denied authorization of a specialty hospital bed by EQ Health.
Amount of the Claim:	Plaintiffs seek declaratory and injunctive relief.
Specific Statutes or Laws (including GAA) Challenged:	Rule 59G-1.010, Florida Administrative Code

<table>
<tr><td>Status of the Case:</td><td colspan="2">AHCA filed a motion to dismiss and response in opposition to Plaintiffs' motion for class certification. Both AHCA's motion to dismiss and Plaintiffs' motion for class certification remain pending.</td></tr>
<tr><td rowspan="3">Who is representing (of record) the state in this lawsuit? Check all that apply.</td><td>X</td><td>Agency Counsel – Andrew Sheeran</td></tr>
<tr><td>N/A</td><td>Office of the Attorney General or Division of Risk Management</td></tr>
<tr><td>X</td><td>Outside Contract Counsel – Rick Figlio and Alexandra Akre of Ausley McMullen</td></tr>
<tr><td>If the lawsuit is a class action (whether the class is certified or not), provide the name of the firm or firms representing the plaintiff(s).</td><td colspan="2">Plaintiffs are represented by Katy DeBriere of the Florida Health Justice Project, Joshua H. Norris of the Law Office of Joshua H. Norris, and Sarah Somers and Miriam D. Heard of the National Health Law Program.</td></tr>
</table>

Schedule VII: Agency Litigation Inventory

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

Agency for Health Care Administration

Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	(850) 412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Campbellton-Graceville Hospital Corporation Bankruptcy (Chapter 11)	
Court with Jurisdiction:	U.S. Bankruptcy Court for the Northern District of Florida	
Case Number:	Case No. 17-40185-KKS	
Summary of the Complaint:	This is a Chapter 11 bankruptcy in which AHCA will prepare and file a proof of claim.	
Amount of the Claim:	Unknown. Estimated between $3,000,000 and $6,000,000.	
Specific Statutes or Laws (including GAA) Challenged:	Bankruptcy Code (Title 11 of the U.S. Code)	
Status of the Case:	AHCA filed a proof of claim. Debtor's plan of liquidation was confirmed.	
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:	Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	(850) 412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Victor Manuel Triggiano Hernandez and Daniela Villamizar, Plaintiffs, v. Jackson Memorial Hospital Public Health Trust / Jackson Health System, a Florida entity, and Florida Agency for Health Care Administration, Defendants.	
Court with Jurisdiction:	In the Circuit Court of the Eleventh Judicial Circuit, in and for Miami-Dade County, Florida	
Case Number:	Case No. 2019-011599-CA-01	
Summary of the Complaint:	Plaintiffs bring a breach of contract claim and equitable estoppel claim against the hospital. The breach of contract claim includes an "in the alternative" claim that AHCA has a contractual duty (though it does not allege a breach by AHCA).	
Amount of the Claim:	$500,000	
Specific Statutes or Laws (including GAA) Challenged:	None.	
Status of the Case:	AHCA filed a motion to dismiss. Plaintiff filed an amended complaint which did not name AHCA as a defendant. This matter is closed with respect to AHCA.	
Who is representing (of record) the state in this lawsuit? Check all that apply.	x	Agency Counsel
		Office of the Attorney General or Division of Risk Management
		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 for Health Care Administration

Andrew T. Sheeran, Acting Deputy General Counsel	Phone Number:	(850) 412-3670

Names of the Case: (If no case name, list the names of the plaintiff and defendant.)	Children First Consultants, Inc., v. AHCA	
Court(s) with Jurisdiction:	Second Judicial Circuit in and for Leon County, Florida	
Case Number:	2020 CA 001774	
Summary of the Complaint:	Plaintiff claims that AHCA's denial of approximately $770,000 of claims and suspension of an additional approximate $831,000 of claims constituted breach of the Medicaid provider agreement	
Amount of the Claim:	Approximately $1.5 million	
Specific Statutes or Laws (including GAA) Challenged:	N/A	
Status of the Case:	The parties entered into a settlement agreement. This case is now 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

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Secretary's Office

Agency Total FTE's: 1,539.50
Agency Total # Positions: 1,544

Division Total FTE's: 105
Division Total # Positions: 106

Effective Date: July 01, 2022
Org. Level: 68-10-00-00-000
FTE's: 2 Positions: 2

037 MARSTILLER 9041
SEC OF HEALTH CARE ADMINISTRATION-AHCA
061394
025 CHIEF EXECUTIVES 1.0
10-1011-03

037 HUNTER 2236
OPERATIONS & MGMT CONSULTANT II - SES
063612
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 FARRILL 8289
CHIEF OF STAFF
053299
024 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-02

037 SMOAK 9043
DEPUTY SEC FOR HEALTH QUALITY ASSURANCE
061409
024 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
10-9111-02

037 HUDSON 9071
CHIEF OF HEALTH FACILITY REGULATION
000616
021 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-03

037 WALTZ 9072
CHIEF OF PLANS AND CONSTRUCTION-AHCA
046544
021 ARCHITECTURAL AND ENGINEERING MANAGERS 1.0
11-9041-03

052 REID 9065
CHIEF OF FIELD OPERATIONS-AHCA
026175
021 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-03

037 BENNETT 9046
CHIEF OF MEDICAID PROGRAM INTEGRITY-AHCA
039490
021 FINANCIAL MANAGERS 1.0
11-3031-03

037 HADDOCK 9078
ASST DEP SEC FOR HLTH QUALITY ASSURANCE
064910
023 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-01

037 FITCH 7264
CHIEF OF CENTRAL SERVICES
058980
021 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-03

037 BUSTOS 6822
CHIEF, HLTH INFO & POLICY ANALYSIS-AHCA
063541
021 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-03

037 LANGSTON 9049
INSPECTOR GENERAL-AHCA
053323
024 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-02

037 PREACHER 1665
AUDIT DIRECTOR - SES
019527
020 FINANCIAL MANAGERS 1.0
11-3031-02

037 BAKER 9471
CHIEF OF INVESTIGATION
064152
021 MANAGERS, ALL OTHER 1.0
11-9199-03

037 MADDEN 9029
DEP SECRETARY OF OPERATIONS - AHCA
061390
024 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-02

037 MAGNUSON 9073
FX PROGRAM DIRECTOR
019644
023 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-01

037 WARD 9204
DIRECTOR OF INFORMATION TECHNOLOGY
063449
023 COMPUTER & INFORMATION SYSTEMS MANAGERS 1.0
10-3021-01

037 ARMSTRONG 2133
DATA PROCESSING MANAGER - SES
080582
020 COMPUTER & INFORMATION SYSTEMS MANAGERS 1.0
11-3021-02

037 FREEMAN 8751
CHIEF OF STRATEGIC INFO TECHNOLOGIES
064169
021 COMPUTER & INFORMATION SYSTEMS MANAGERS 1.0
11-3021-03

037 EDWARDS 9535
CHIEF OF DISTRIBUTED INFRASTRUCTURE
064278
021 COMPUTER & INFORMATION SYSTEMS MANAGERS 1.0
11-3021-03

037 VACANT 9773
DIRECTOR OF ADMINISTRATION
063596
023 ADMINISTRATIVE SERVICES MANAGERS 1.0
10-3011-01

037 SKIPPER 9058
CHIEF OF HUMAN RESOURCES-AHCA
055058
021 HUMAN RESOURCE MANAGERS 1.0
11-3121-03

037 COLLINS 0670
CHIEF OF CONTRACT MANAGEMENT
017054
021 PURCHASING MANAGERS 1.0
11-3061-03

037 SMITH 9768
CHIEF OF FINANCE AND ACCOUNTING
064898
021 FINANCIAL MANAGERS 1.0
11-3031-03

037 KENYON 9430
CHIEF OF GENERAL SERVICES
056679
021 ADMINISTRATIVE SERVICES MANAGERS 1.0
11-3011-03

037 TAMAYO 8538
GENERAL COUNSEL-AHCA
032187
024 MANAGERS, ALL OTHER 1.0
10-9199-02

037 WALLACE 9075
DEPUTY SECRETARY FOR MEDICAID-AHCA
063629
024 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-02

037 WEIDA 9047
ASST DEP SEC FOR MEDICAID POLICY & QUAL
046476
023 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-01

037 VERGESON 8951
CHIEF OF MEDICAID QUALITY
064589
021 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-03

037 DALTON 8863
CHIEF OF MEDICAID POLICY
019298
021 FINANCIAL MANAGERS 1.0
11-3031-03

037 VACANT 9048
ASST DEP SEC FOR MEDICAID FIN & ANALYTIC
019253
023 FINANCIAL MANAGERS 1.0
10-3031-01

037 RING 8861
CHIEF OF MEDICAID DATA ANALYTICS
039495
021 FINANCIAL MANAGERS 1.0
11-3031-03

037 NOBLES 8506
CHIEF OF MEDICAID PROGRAM FINANCE
019502
021 FINANCIAL MANAGERS 1.0
11-3031-03

037 MEYER 9079
ASST DEP SEC FOR MEDICAID OPERATIONS
061961
023 GENERAL AND OPERATIONS MANAGERS 1.0
10-1021-01

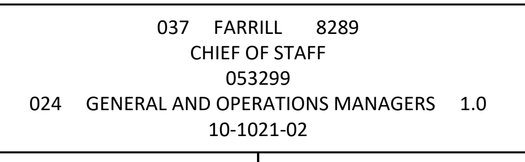
037 HULL 8859
CHIEF OF MEDICAID PLAN MGT OPERATIONS
019526
021 FINANCIAL MANAGERS 1.0
11-3031-03

036 COLE 8881
CHIEF OF MEDICAID RECIPIENT & PROV ASSIS
039753
021 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-03

037 TRAVIS 9394
CHIEF OF MEDICAID FISCAL AGENT OPERATION
064292
021 FINANCIAL MANAGERS 1.0
11-3031-03

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief of Staff

Effective Date: July 01, 2022
Org. Level: 68-10-10-00-000
FTE's: 3 Positions: 3



037 VACANT 6137
FEDERAL PROGRAMS COORDINATOR-AHCA
064901
021 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-03

037 ZANDER 9051
LEGISLATIVE AFFAIRS DIRECTOR-AHCA
053319
021 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-03

037 JUAREZ 9063
COMMUNICATIONS DIRECTOR-AHCA
063429
021 PUBLIC RELATIONS & FUNDRAISING MANAGERS 1.0
11-2031-03

VACANT
OPS
900199

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Deputy Chief of Staff

Effective Date: July 01, 2022
Org. Level: 68-10-10-00-001
FTE's: 3 Positions: 3

037 ZANDER 9051
LEGISLATIVE AFFAIRS DIRECTOR-AHCA
053319
021 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-03

037 STEELE 2225
SENIOR MANAGEMENT ANALYST II - SES
063430
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 GOULD 2234
OPERATIONS & MGMT CONSULTANT I - SES
024144
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Communications Office

Effective Date: July 01, 2022
Org. Level: 68-10-10-60-000
FTE's: 4 Positions: 4

Org. Level: 68-10-10-60-100
FTE's: 5 Positions: 5

037 JUAREZ 9063
COMMUNICATIONS DIRECTOR-AHCA
063429
021 PUBLIC RELATIONS & FUNDRAISING MANAGERS 1.0
11-2031-03

037 COLEMAN 2225
SENIOR MANAGEMENT ANALYST II - SES
056678
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 MCLAUGHLIN 2224
SENIOR MANAGEMENT ANALYST I - SES
064902
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

037 FENSKE 2224
SENIOR MANAGEMENT ANALYST I - SES
063446
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

ROMIMORA
OPS
900363

Multimedia Design
68-10-10-60-100

037 GOODSON 2250
AGENCY FOR HEALTH CARE ADMINISTRATOR-SES
000610
020 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-02

037 VACANT 0709
ADMINISTRATIVE ASSISTANT I
059710
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 DEROSE 2107
SYSTEMS PROJECT ANALYST
000580
008 COMPUTER SYSTEMS ANALYST 1.0
15-1121-03

037 MARKY 2107
SYSTEMS PROJECT ANALYST
064335
008 COMPUTER SYSTEMS ANALYST 1.0
15-1121-03

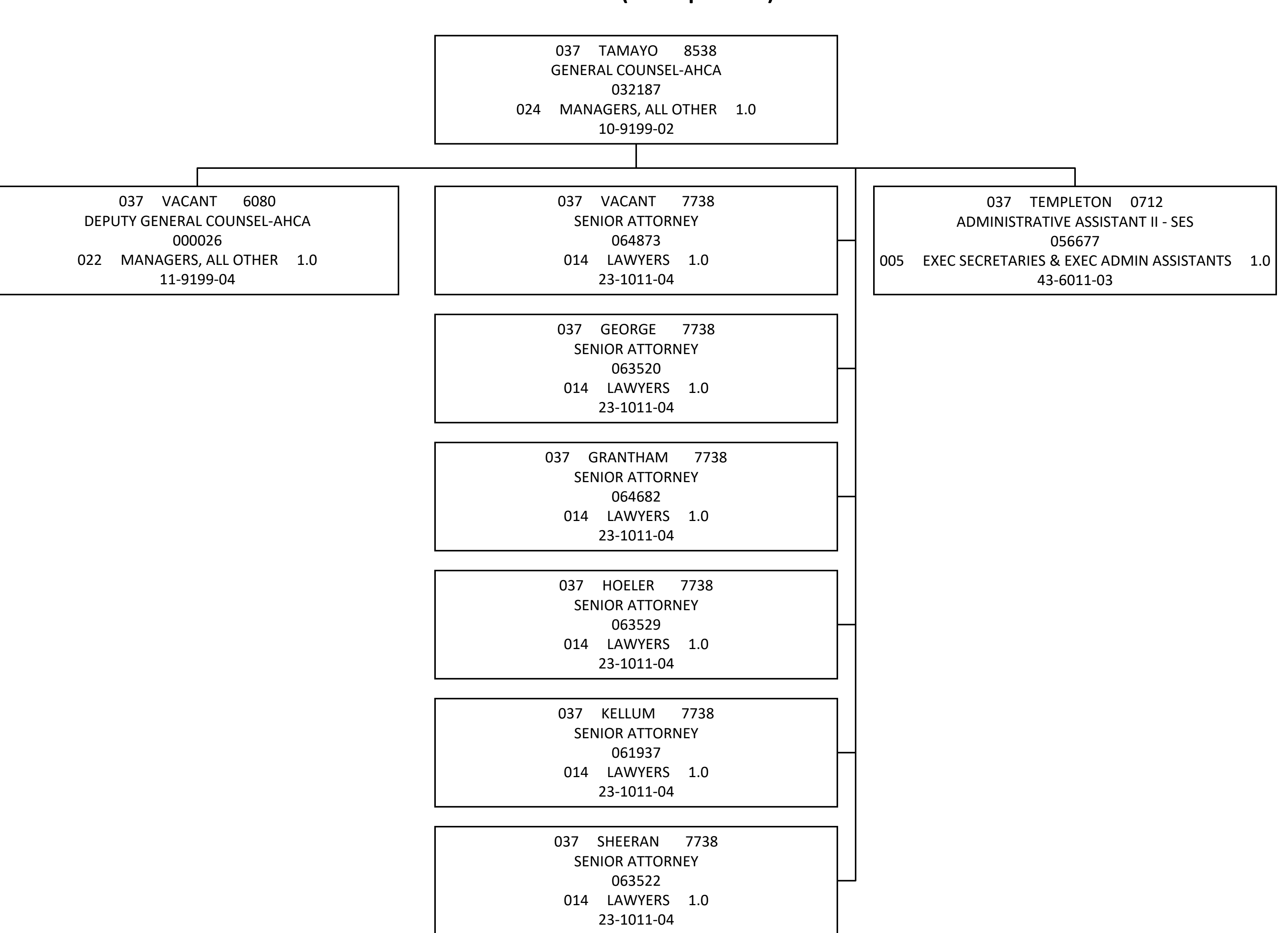
CEDENO-SANCHEZ
OPS
900224

037 CARROCCINO 3718
GRAPHICS CONSULTANT
063471
007 ARTISTS AND RELATED WORKERS, ALL OTHER 1.0
27-1019-03

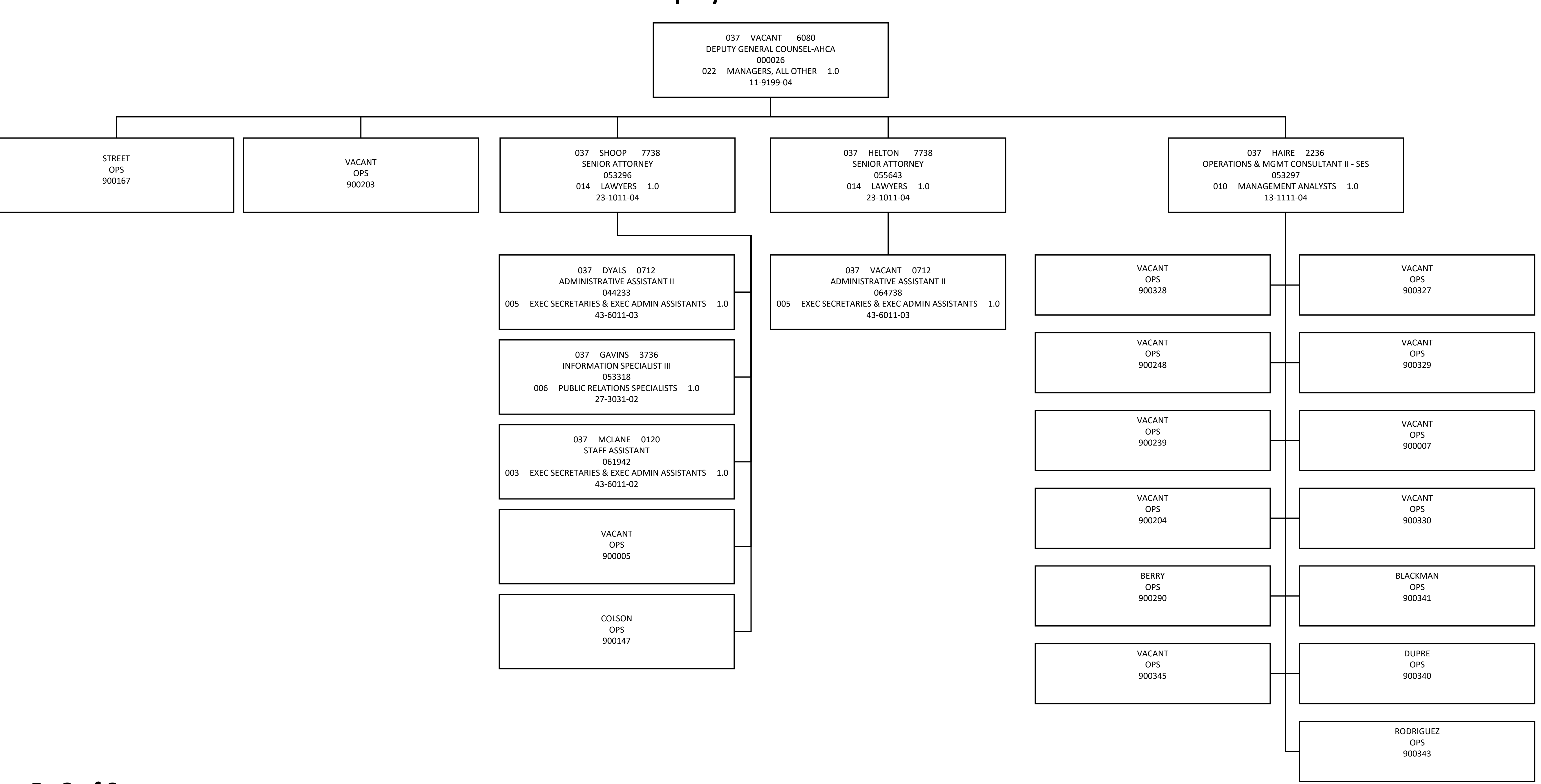
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
General Counsel

Effective Date: July 01, 2022
Org. Level: 68-10-20-00-000
FTE's: 59.5 Positions: 60

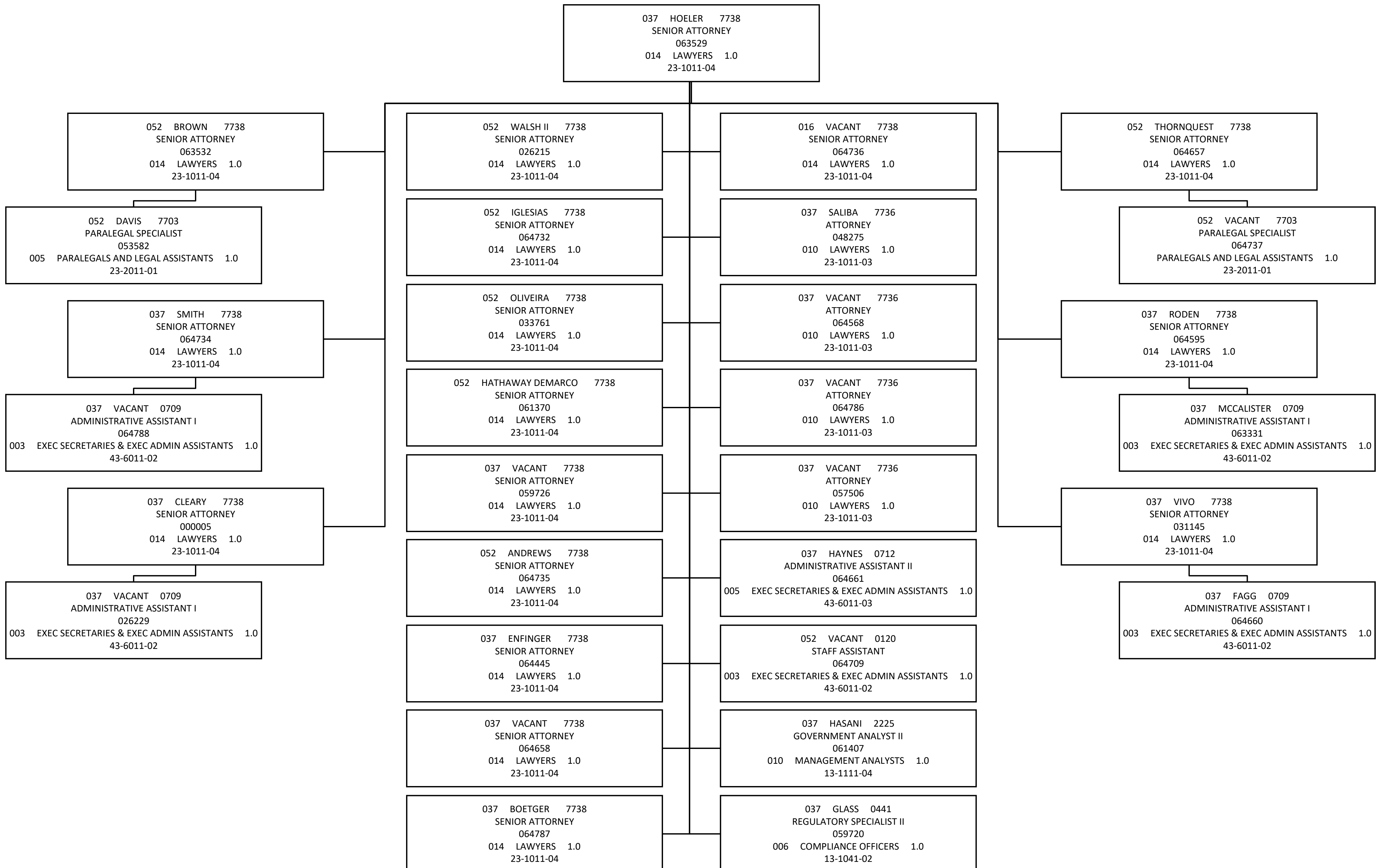
Tallahassee (Headquarters)



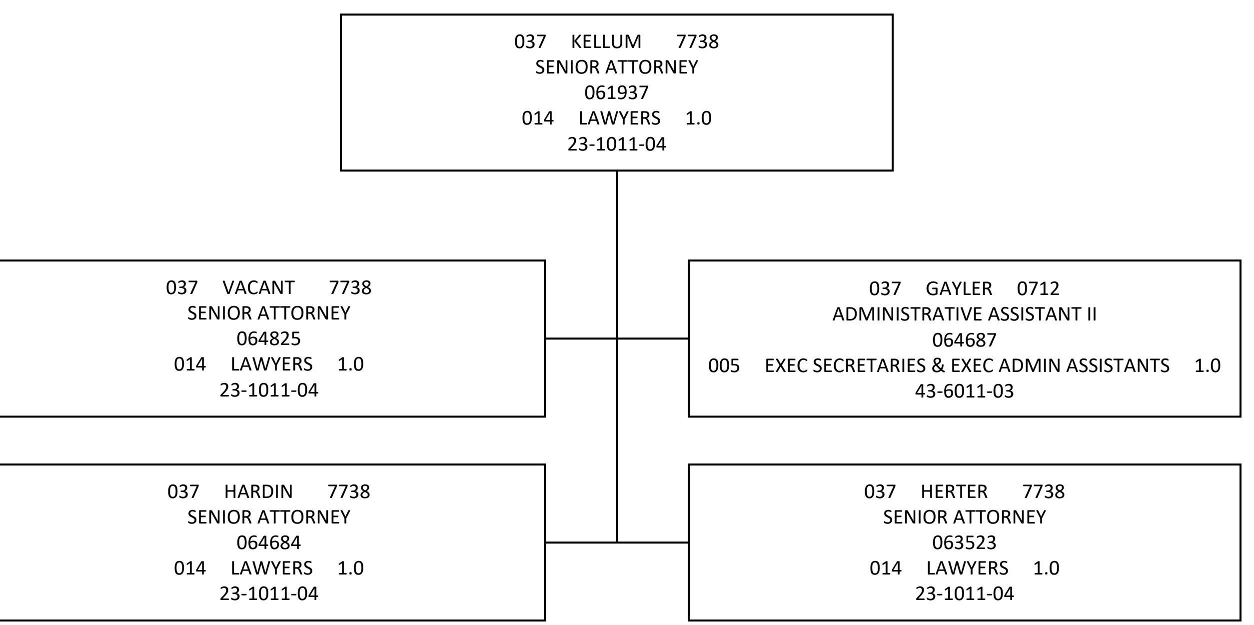
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Deputy General Counsel



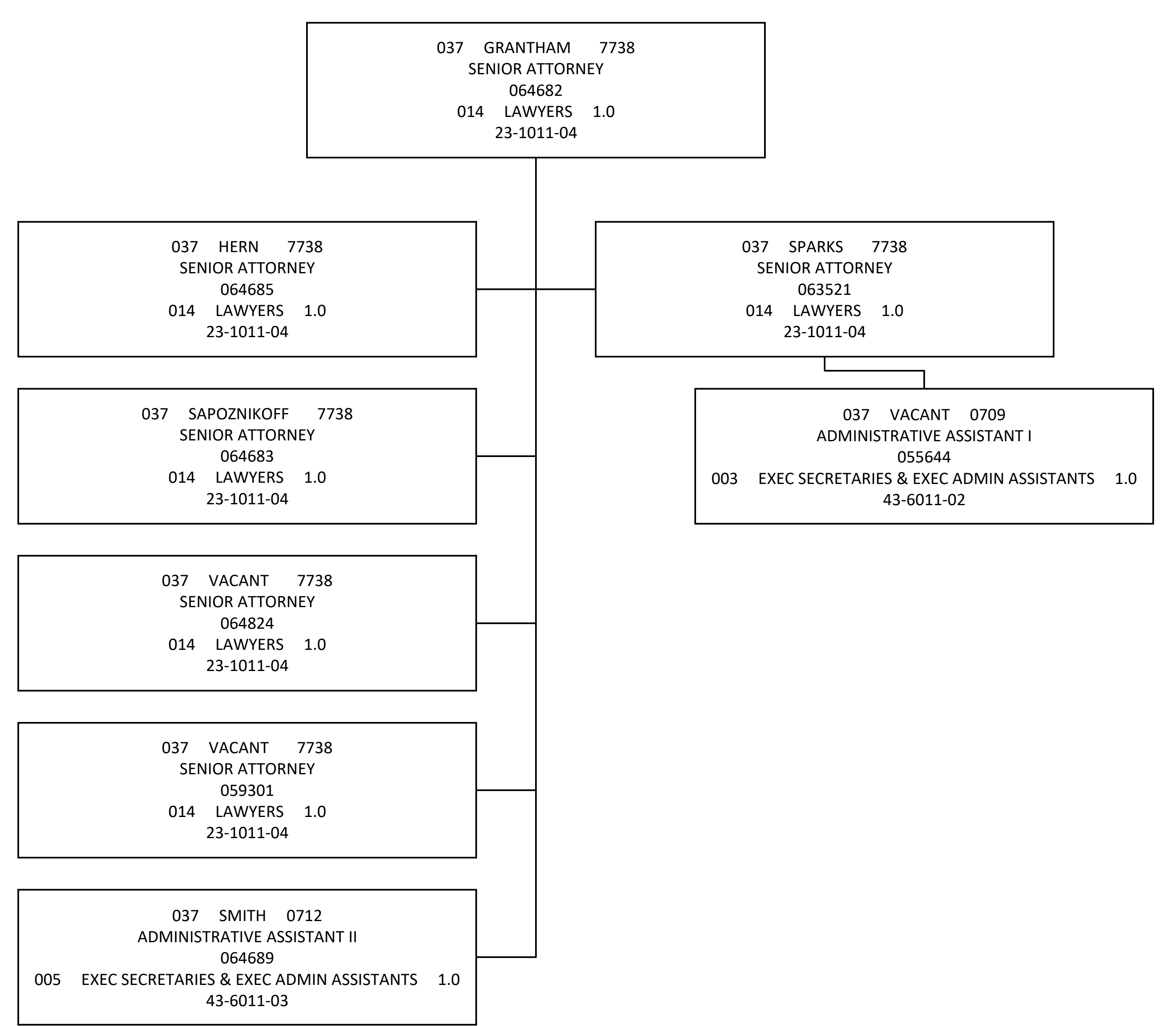
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief Facilities Counsel



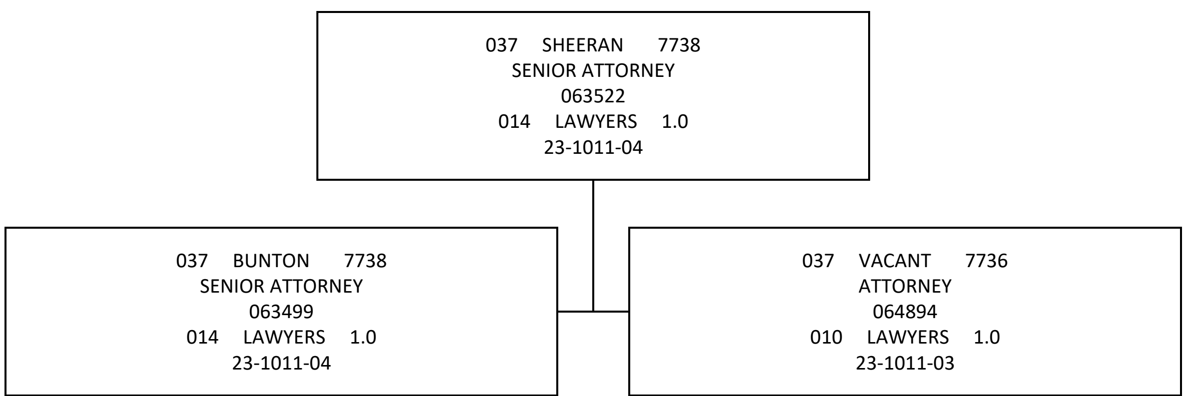
AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief Medicaid Policy Counsel



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief Medicaid Litigation/Rules Counsel



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief of State/Federal Litigation Counsel



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Chief Appellate Counsel

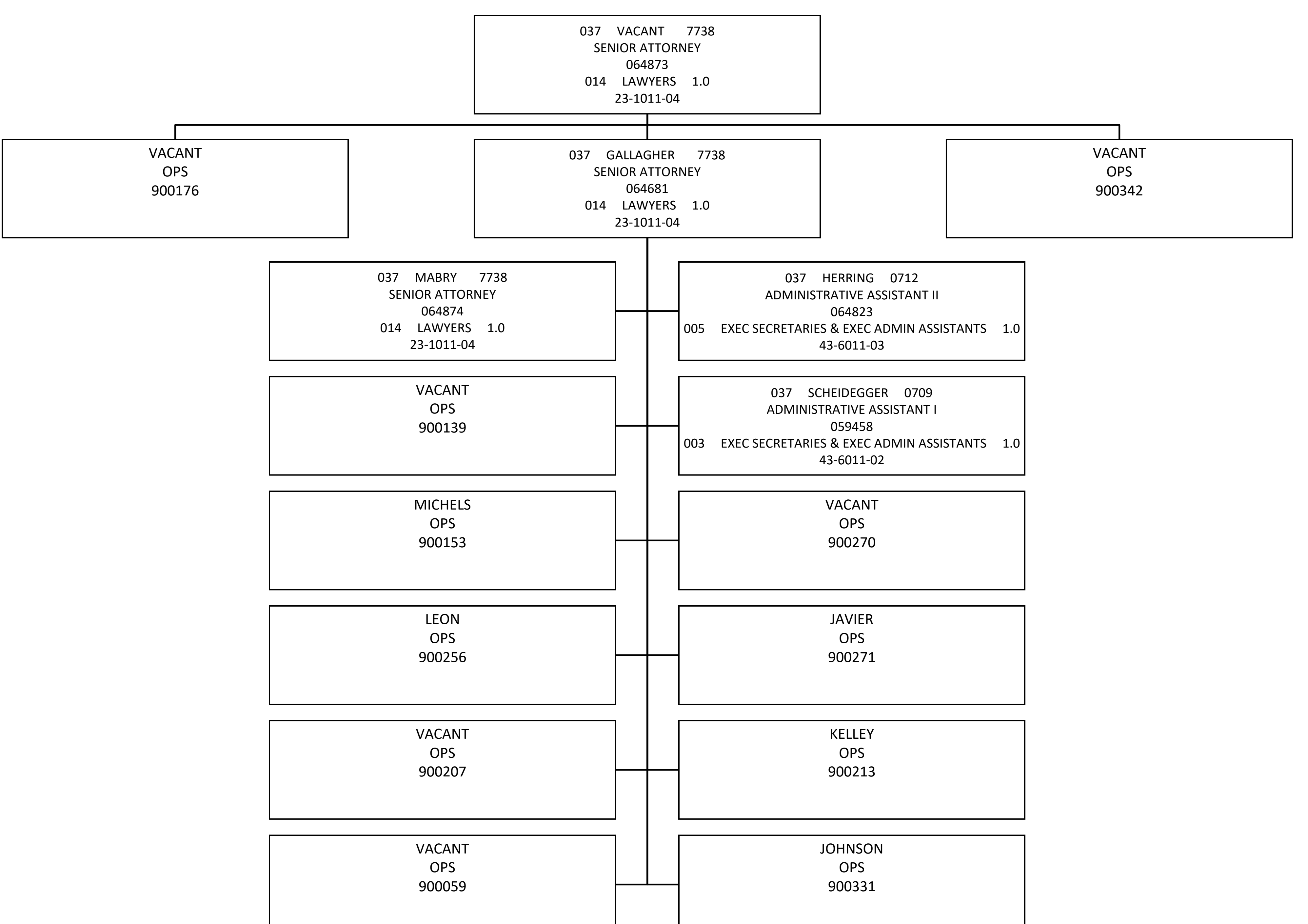
037 GEORGE 7738
SENIOR ATTORNEY
063520
014 LAWYERS 1.0
23-1011-04

037 KEOUGH-RAINS 7738
SENIOR ATTORNEY
059457
014 LAWYERS 1.0
23-1011-04

037 BELMONT 0712
ADMINISTRATIVE ASSISTANT II
064688
005 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-03

AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
General Counsel Fair Hearings

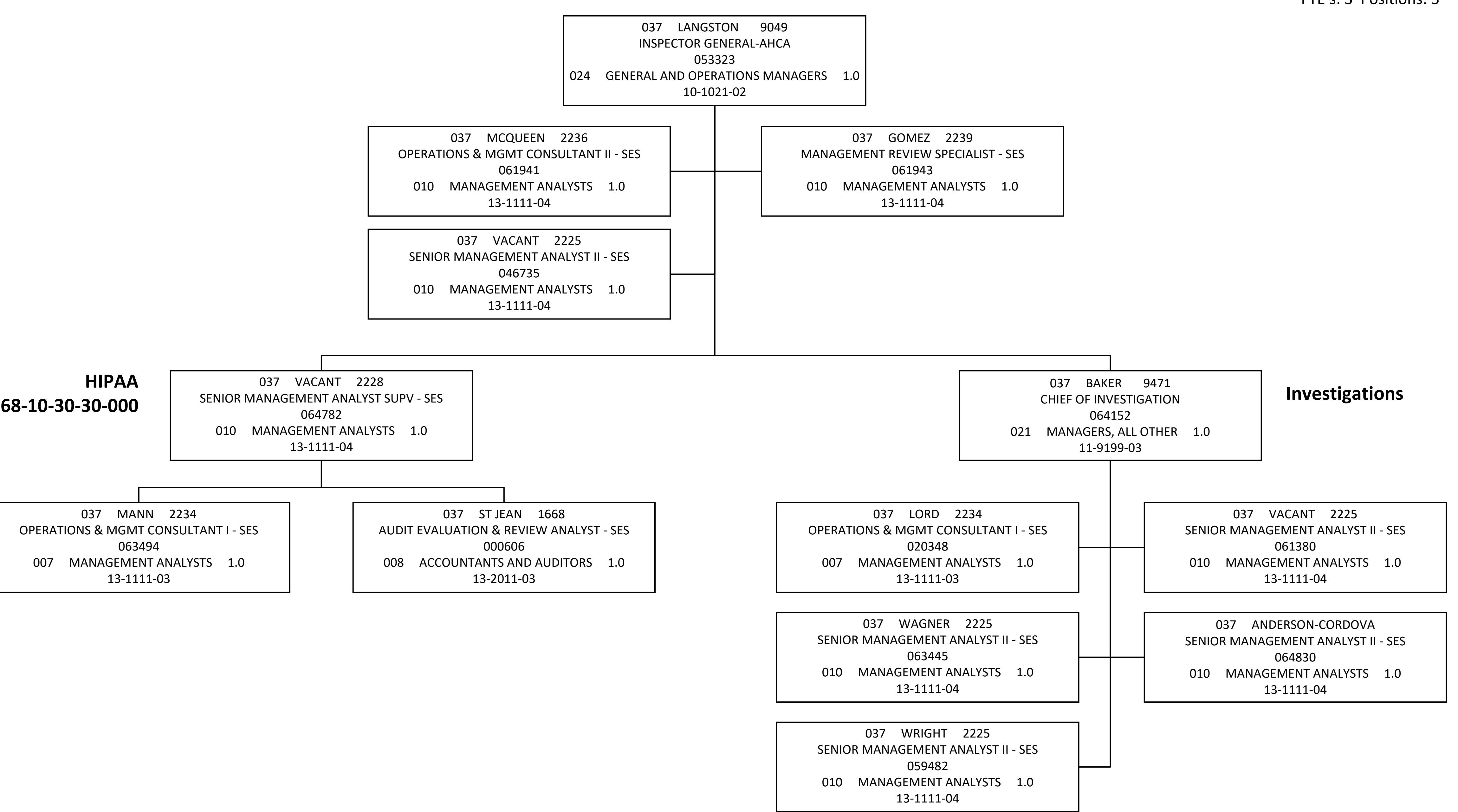
Effective Date: July 01, 2022
Org. Level: 68-10-20-10-000
FTE's: 5 Positions: 5



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Inspector General

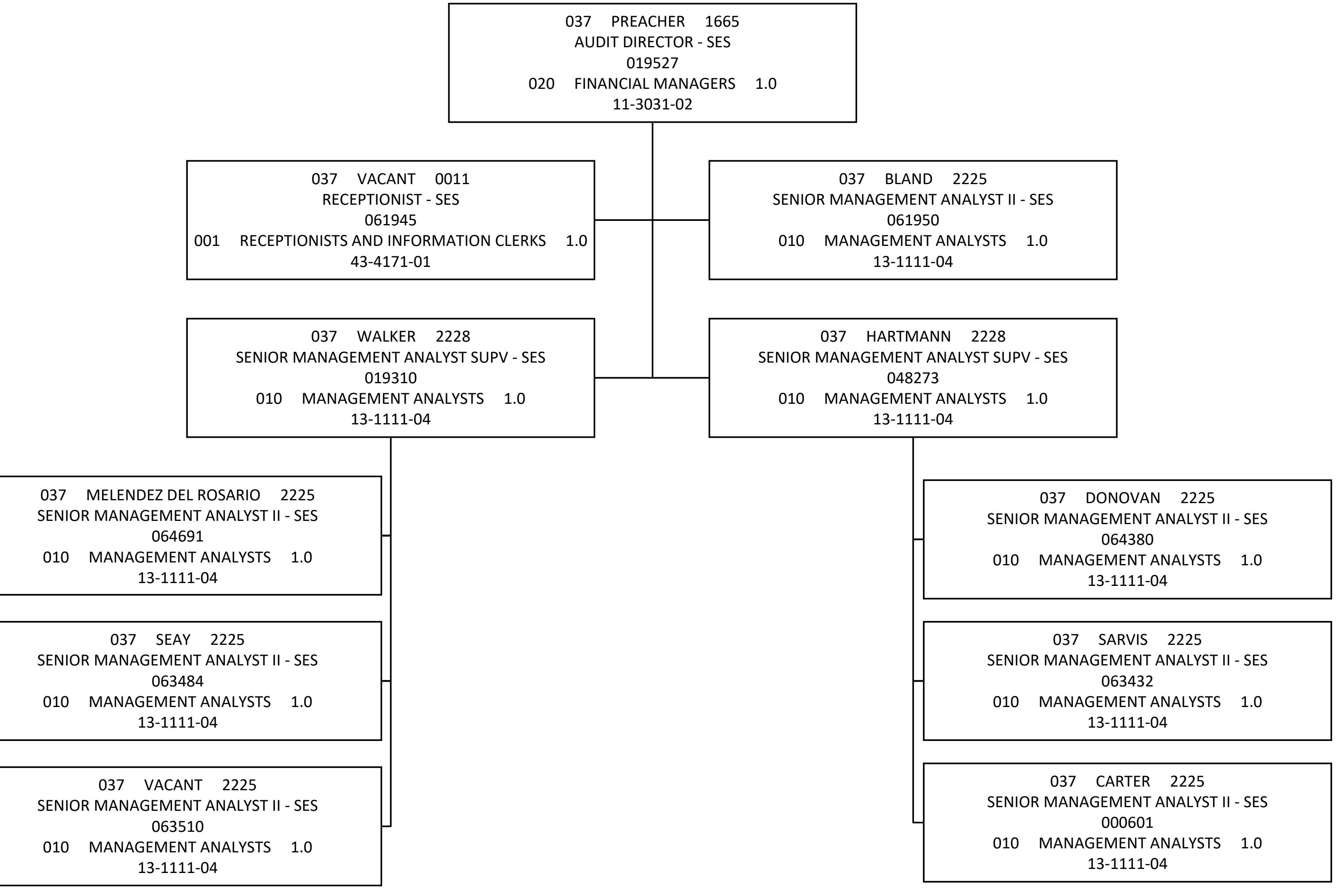
Effective Date: July 01, 2022
Org. Level: 68-10-30-00-000
FTE's: 10 Positions: 10

Org. Level: 68-10-30-30-000
FTE's: 3 Positions: 3



AGENCY FOR HEALTH CARE ADMINISTRATION
Executive Direction
Inspector General – Internal Audit

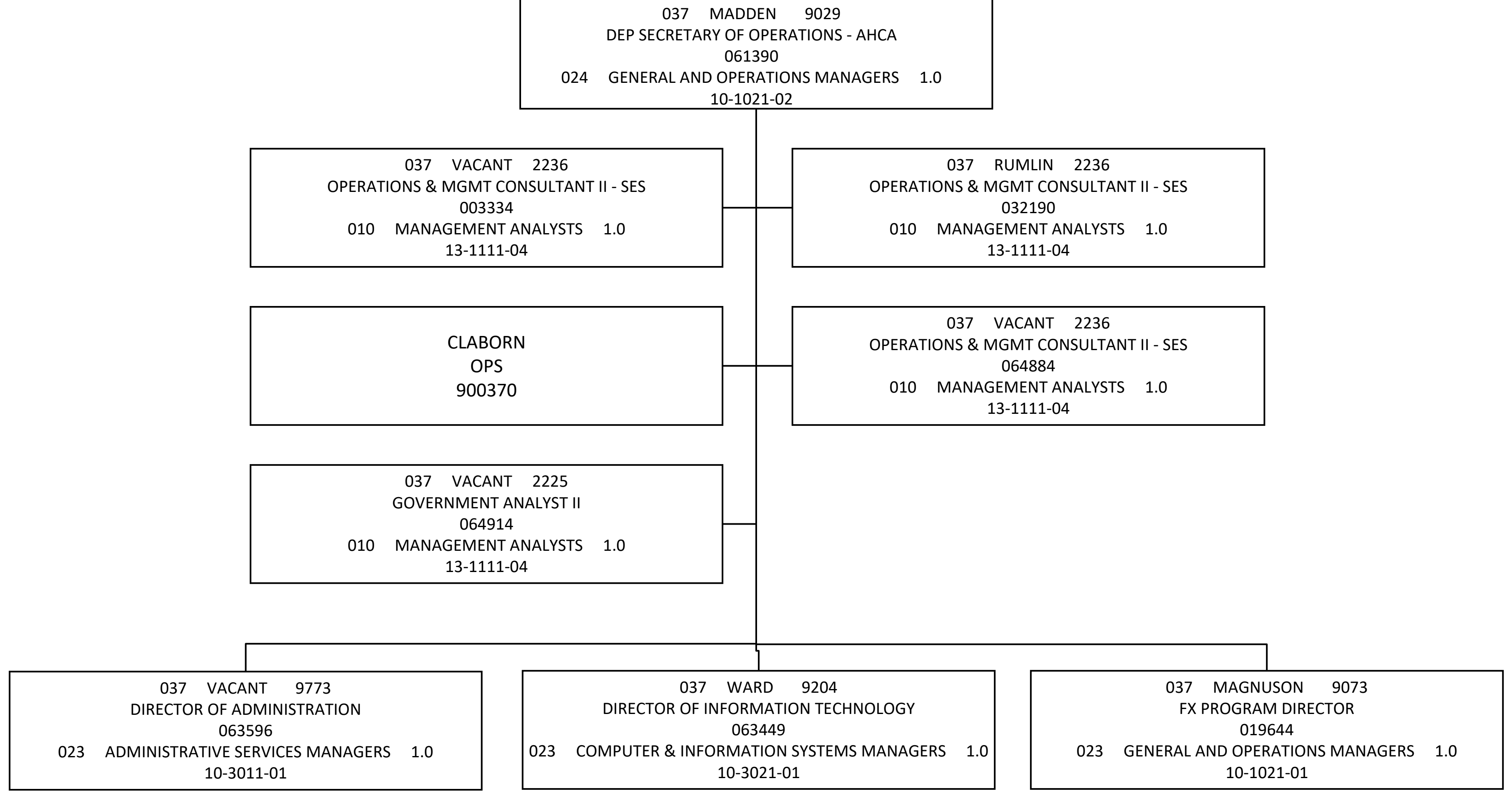
Effective Date: July 01, 2022
Org. Level: 68-10-30-20-000
FTE's: 10.5 Positions: 11



Division of Operations FTE's: 171.5
Division of Operations # of Positions: 172

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

Effective Date: July 01, 2022
Org. Level: 68-20-00-00-000
FTE's: 3 Positions: 3



AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Administration

Effective Date: July 01, 2022
Org. Level: 68-20-10-00-000
FTE's: 1 Positions: 1

037 VACANT 9773
DIRECTOR OF ADMINISTRATION
063596
023 ADMINISTRATIVE SERVICES MANAGERS 1.0
10-3011-01

037 SMITH 9768
CHIEF OF FINANCE AND ACCOUNTING
064898
021 FINANCIAL MANAGERS 1.0
11-3031-03

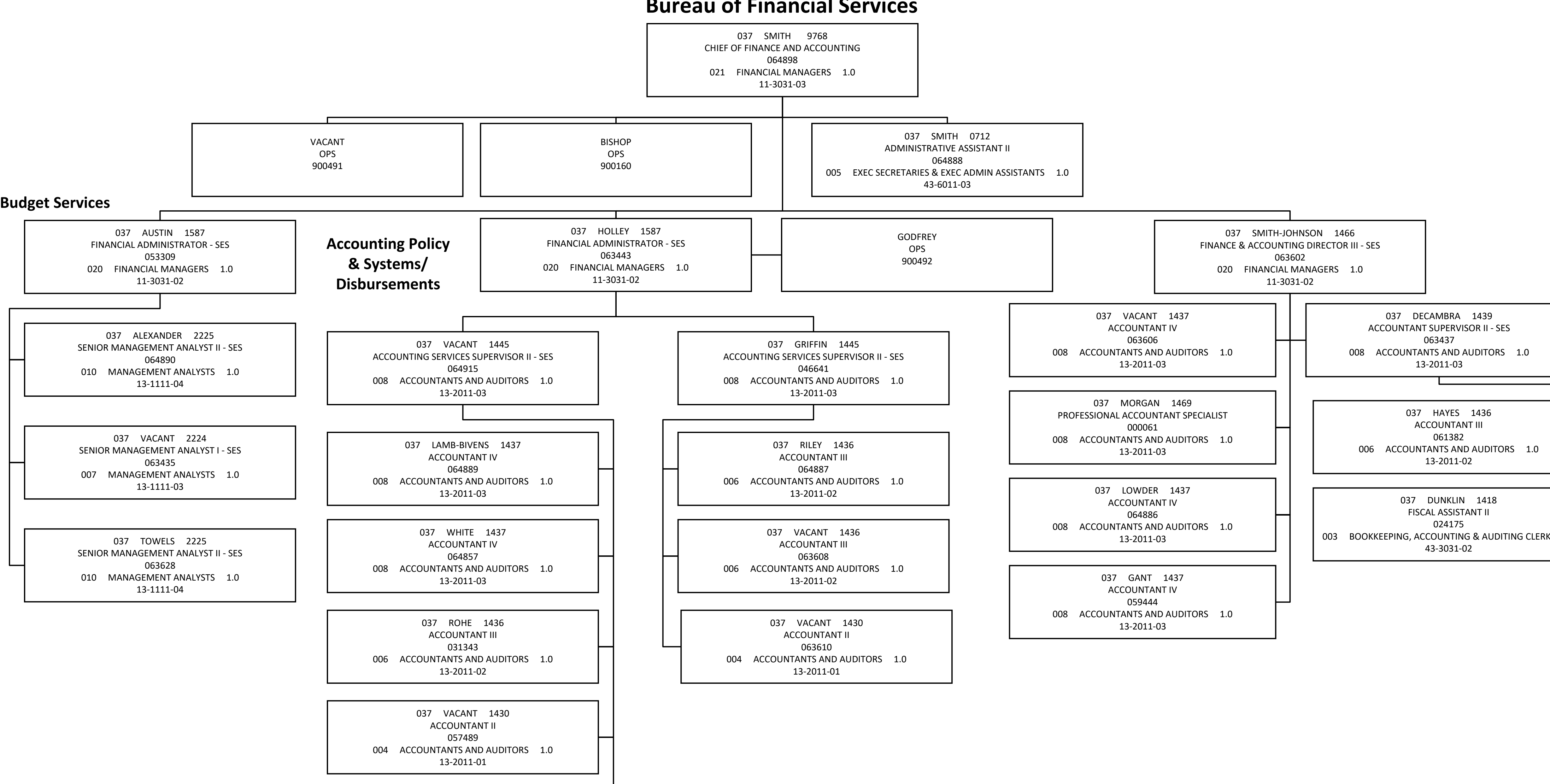
037 COLLINS 0670
CHIEF OF CONTRACT MANAGEMENT
017054
021 PURCHASING MANAGERS 1.0
11-3061-03

037 SKIPPER 9058
CHIEF OF HUMAN RESOURCES-AHCA
055058
021 HUMAN RESOURCE MANAGERS 1.0
11-3121-03

037 KENYON 9430
CHIEF OF GENERAL SERVICES
056679
021 ADMINISTRATIVE SERVICES MANAGERS 1.0
11-3011-03

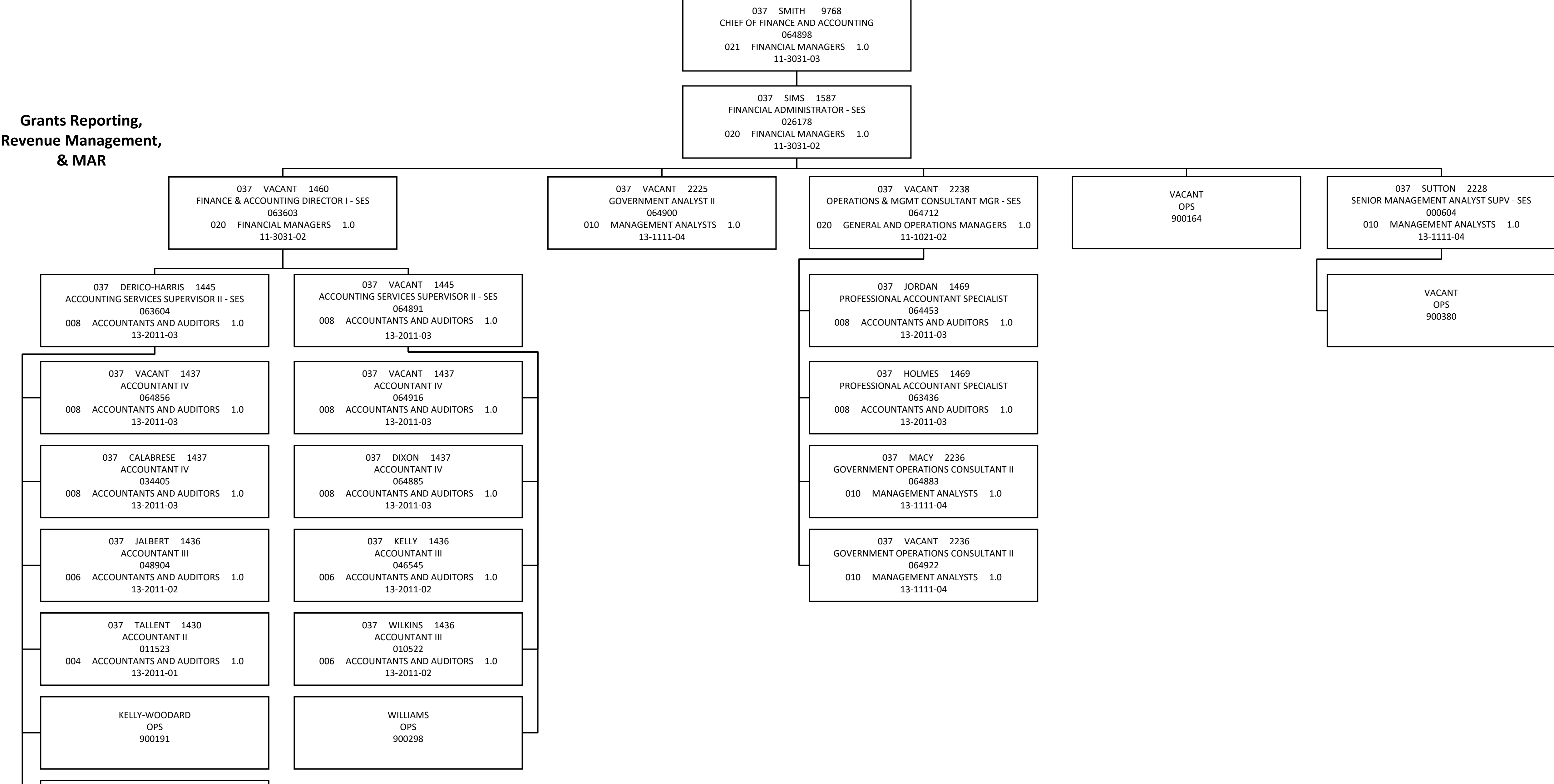
AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Administration
Bureau of Financial Services

Effective Date: July 01, 2022
Org. Level: 68-20-15-00-000
FTE's: 45 Positions: 45



AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Administration
Bureau of Financial Services

Effective Date: July 01, 2022
Org. Level: 68-20-15-00-000
FTE's: 45 Positions: 45

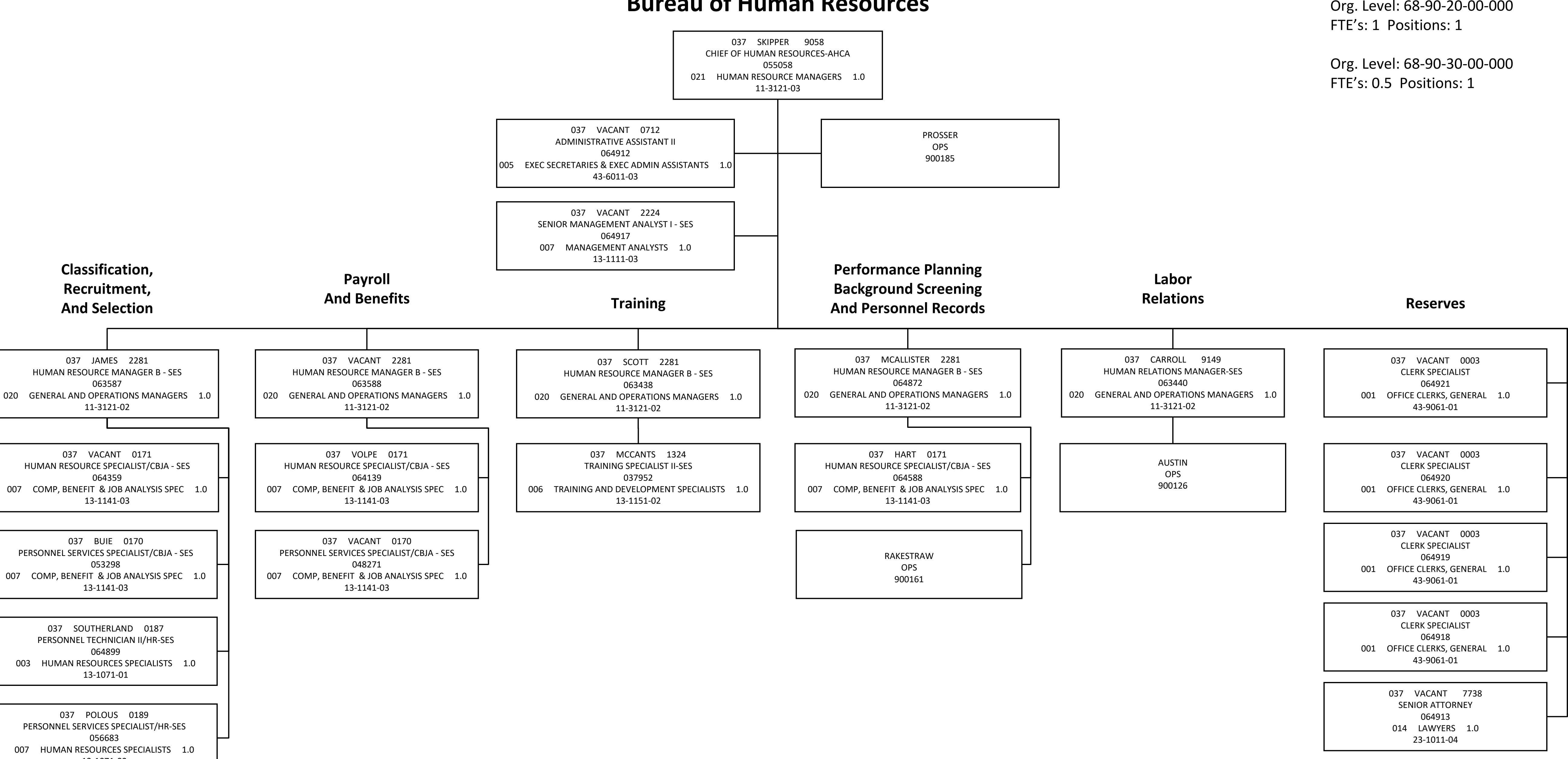


AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Administration
Bureau of Human Resources

Effective Date: July 01, 2022
Org. Level: 68-20-20-00-000
FTE's: 16 Positions: 16

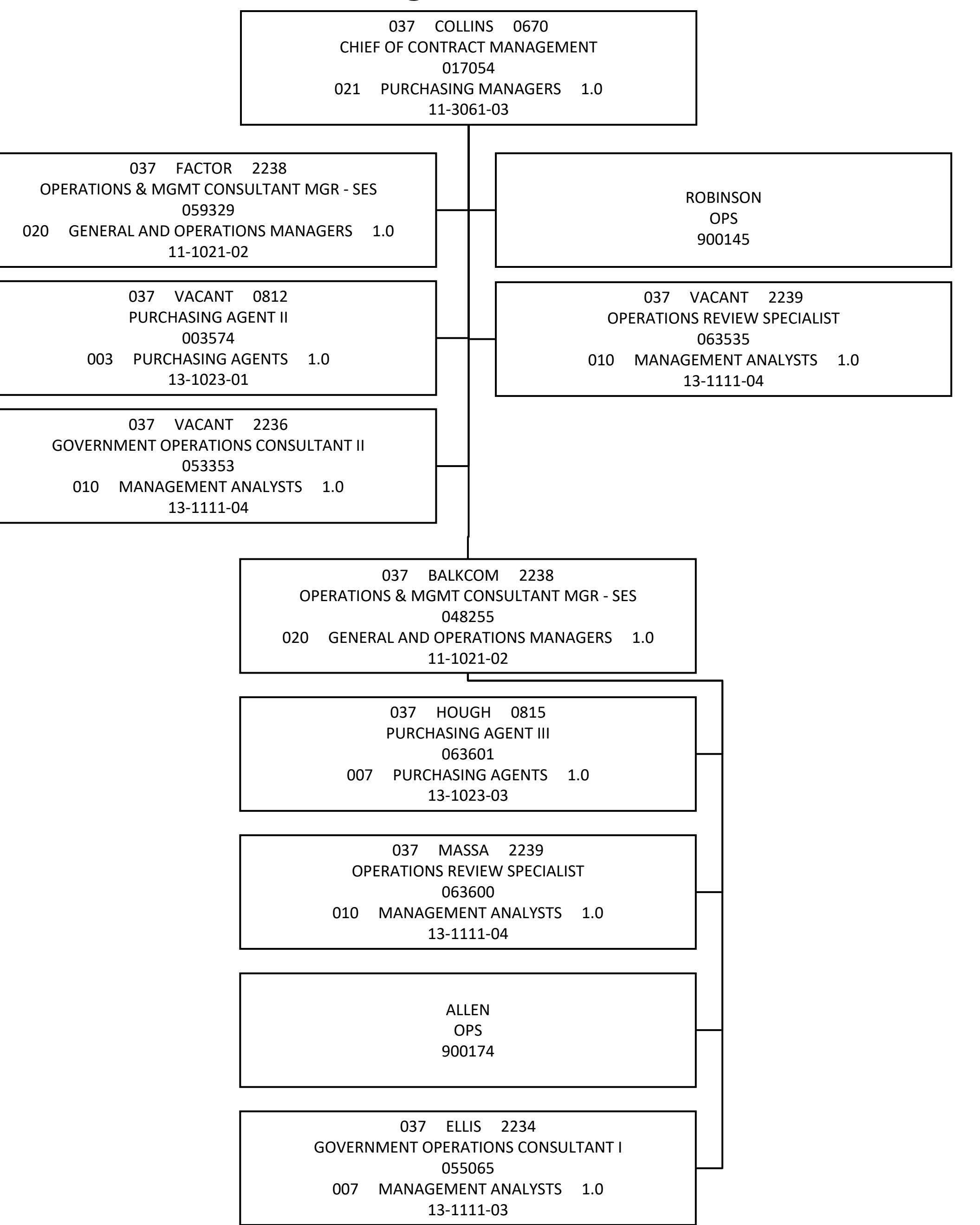
Org. Level: 68-90-20-00-000
FTE's: 1 Positions: 1

Org. Level: 68-90-30-00-000
FTE's: 0.5 Positions: 1



AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Administration
Bureau of Purchasing & Contract Administration

Effective Date: July 01, 2022
Org. Level: 68-20-30-00-000
FTE's: 9 Positions: 9



AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Administration
Bureau of General Services

Effective Date: July 01, 2022
Org. Level: 68-20-40-00-000
FTE's: 7 Positions: 7

037 KENYON 9430
CHIEF OF GENERAL SERVICES
056679
021 ADMINISTRATIVE SERVICES MANAGERS 1.0
11-3011-03

037 MERCK JR 2236
OPERATIONS & MGMT CONSULTANT II - SES
063597
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 0120
STAFF ASSISTANT
063599
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 TRUEBLOOD 0120
STAFF ASSISTANT
064458
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 WALKER 0120
STAFF ASSISTANT
061406
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

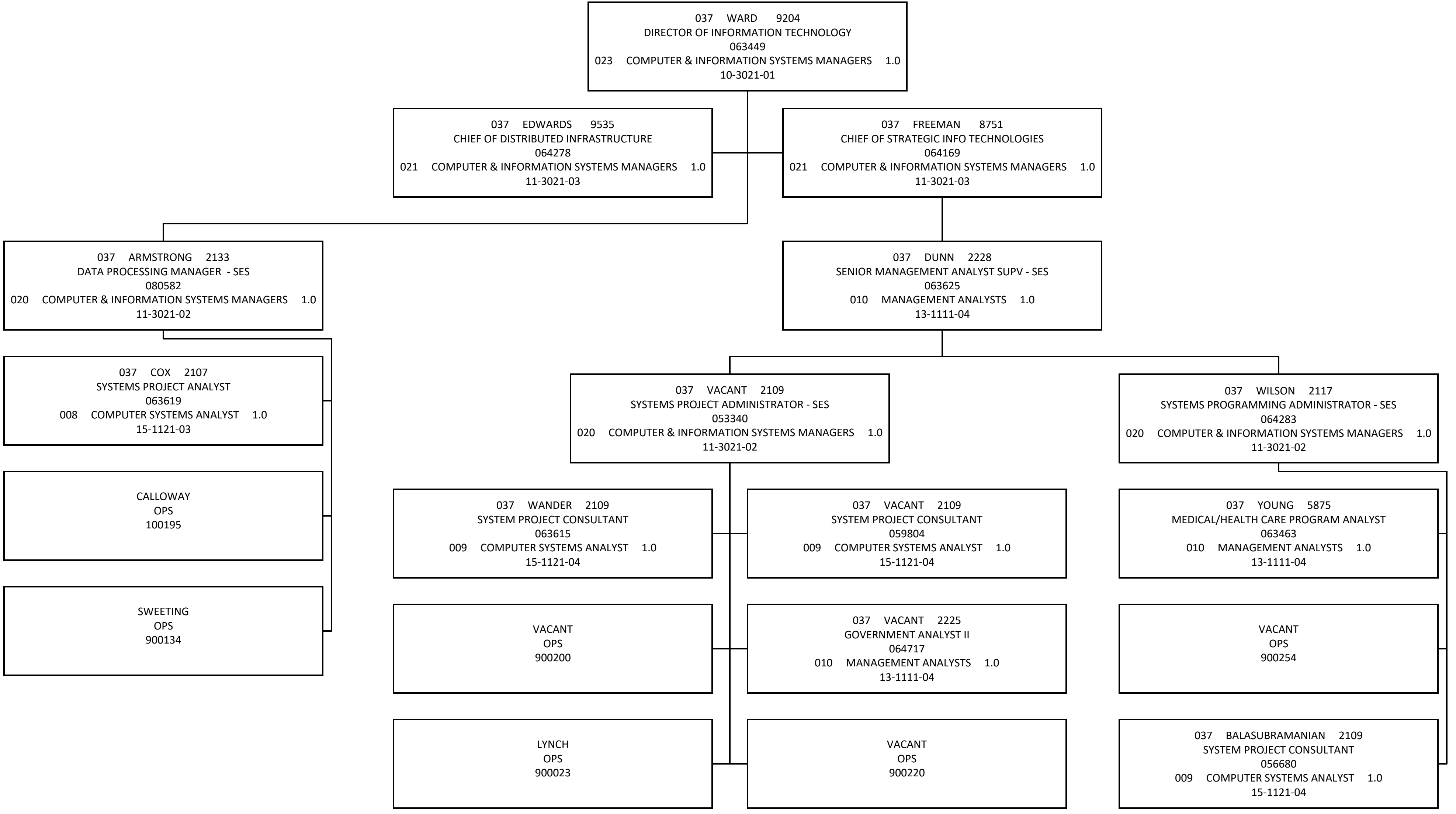
037 DONALDSON 0836
FACILITIES SERVICES MANAGER II - SES
063598
019 ADMINISTRATIVE SERVICES MANAGERS 1.0
11-3011-01

037 EARLE 0120
STAFF ASSISTANT
064909
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

THOMAS
OPS
900300

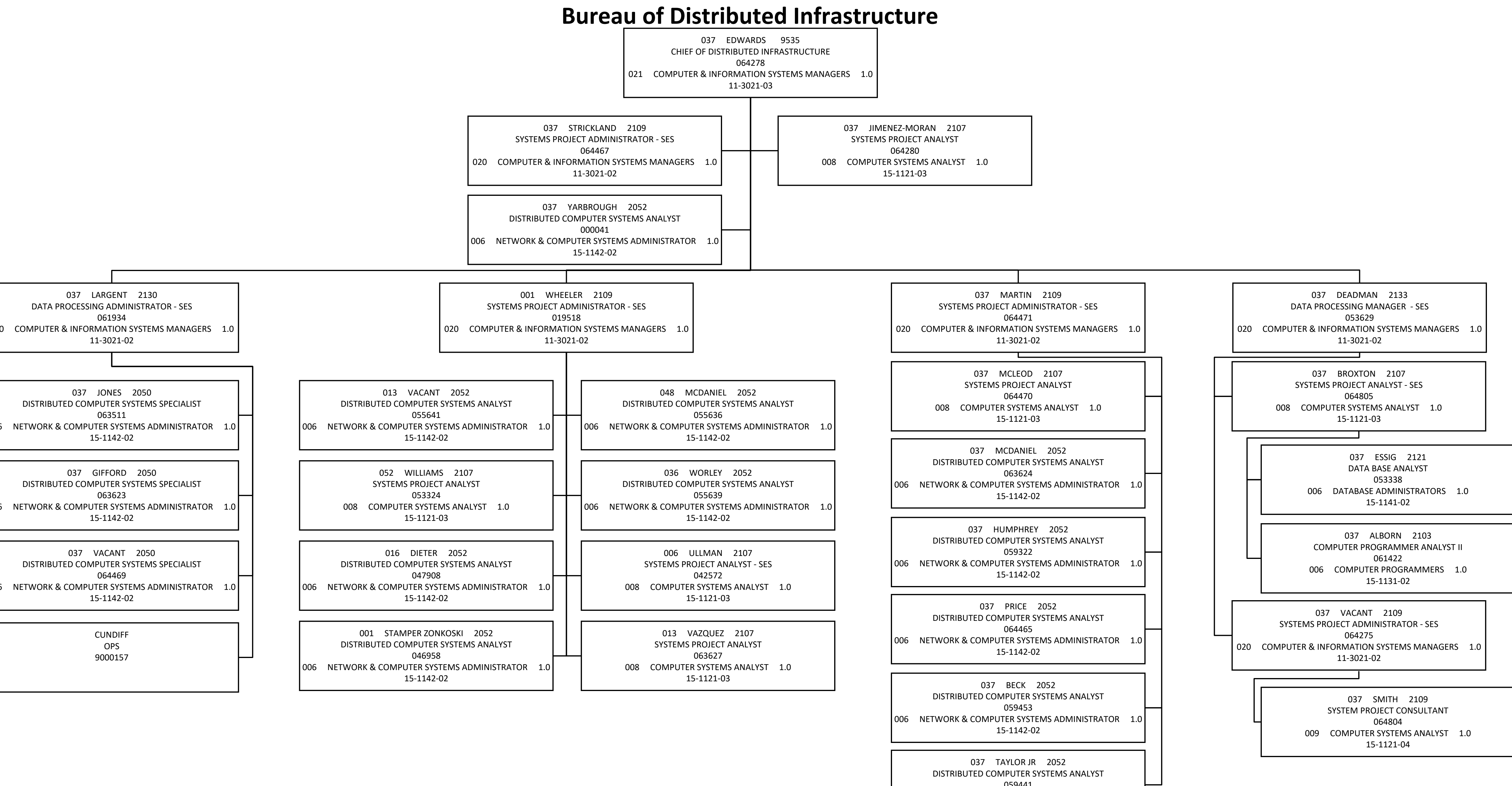
AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Information Technology
Director's Office

Effective Date: July 01, 2022
Org. Level: 68-20-60-00-000
FTE's: 13 Positions: 13



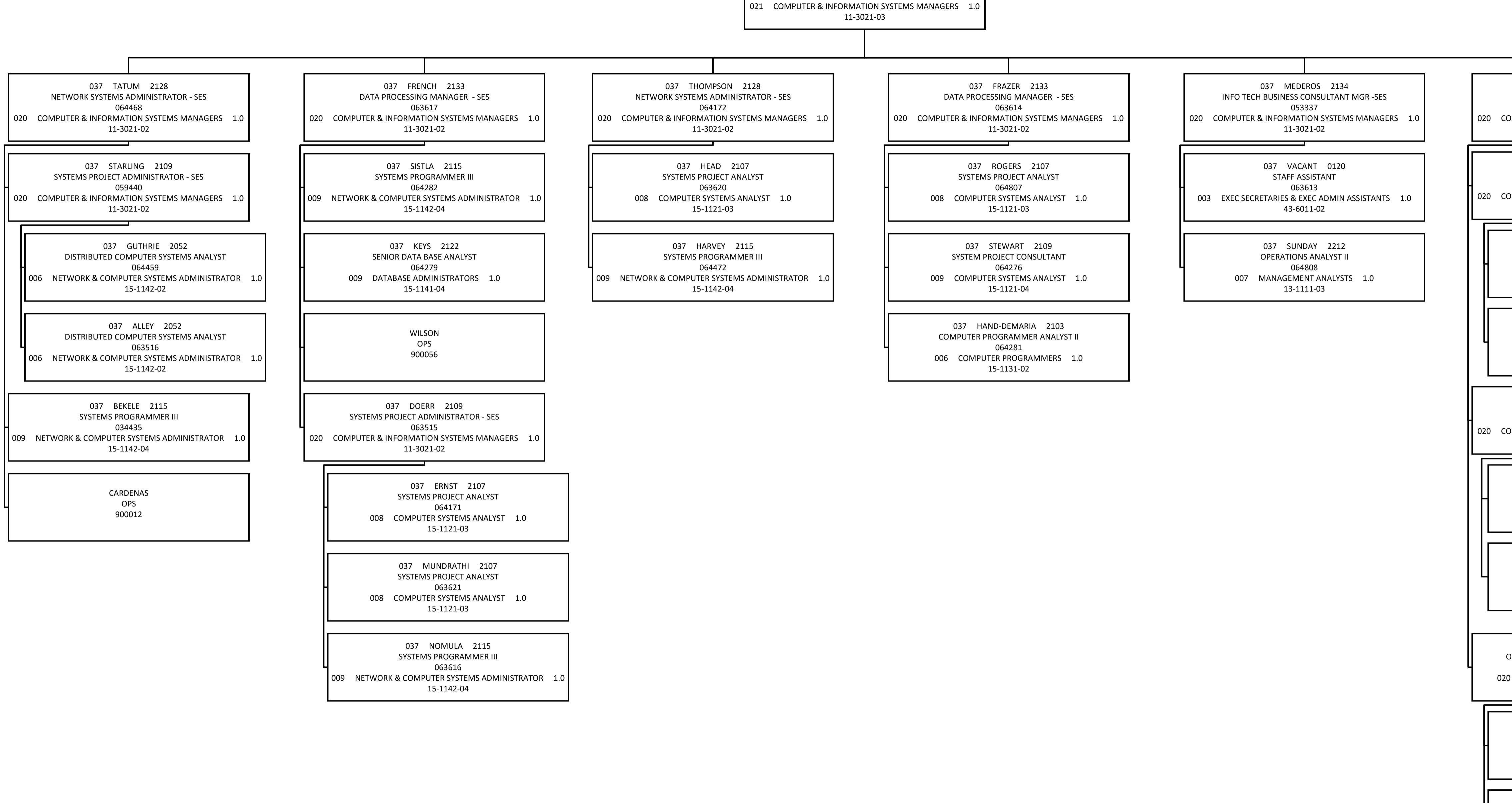
AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Information Technology
Bureau of Distributed Infrastructure

Effective Date: July 01, 2022
Org. Level: 68-20-60-00-100
FTE's: 31 Positions: 31



AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of Information Technology
Bureau of Strategic Info Technologies

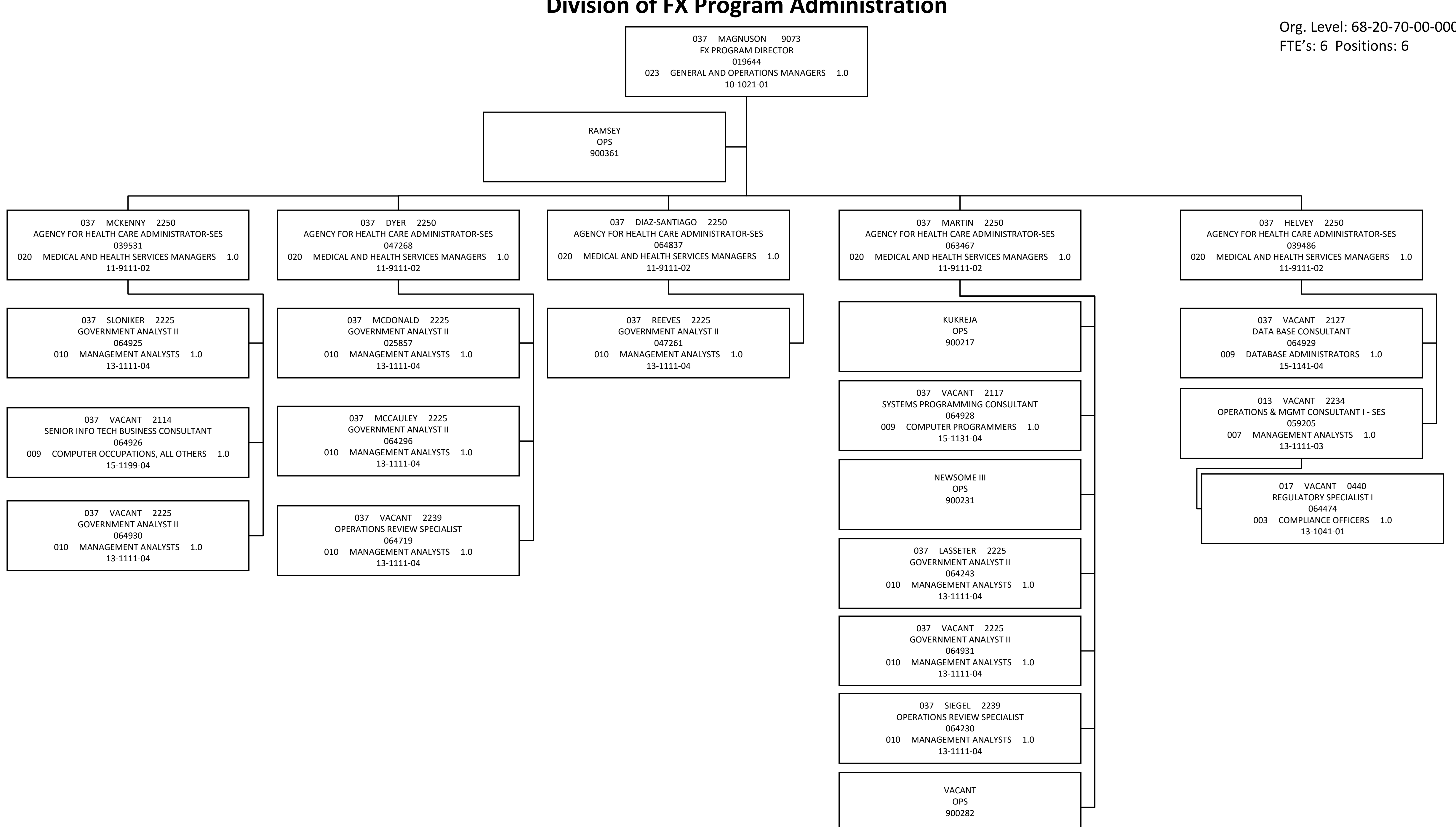
Effective Date: July 01, 2022
Org. Level: 68-20-60-00-200
FTE's: 26 Positions: 26



AGENCY FOR HEALTH CARE ADMINISTRATION
Deputy Secretary of Operations
Division of FX Program Administration

Effective Date: July 01, 2022
Org. Level: 68-40-70-00-000
FTE's: 13 Positions: 13

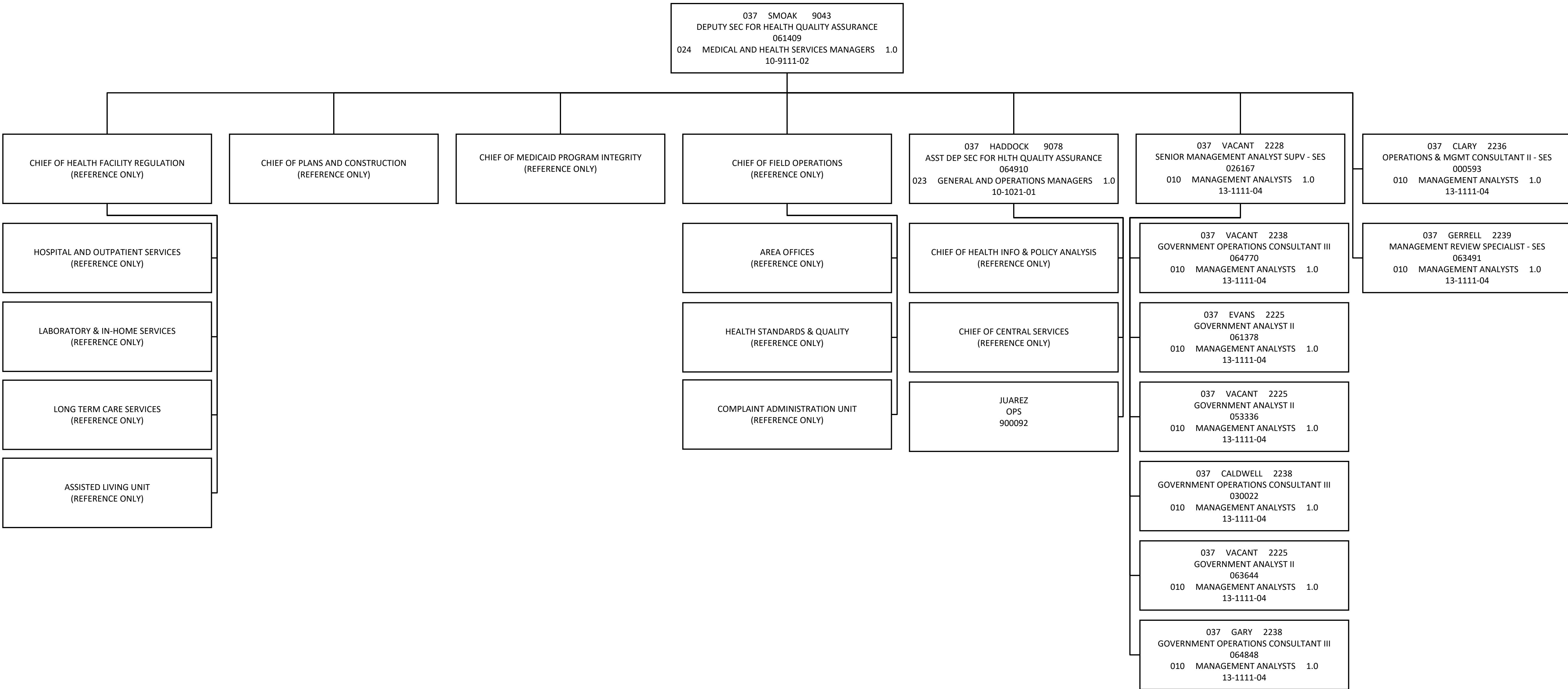
Org. Level: 68-20-70-00-000
FTE's: 6 Positions: 6



Division of HQA FTE's: 736.5
Division of HQA # of Positions: 738

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

Effective Date: July 01, 2022
Org. Level: 68-30-00-00-000
FTE's: 7 Positions: 7



AGENCY FOR HEALTH CARE ADMINISTRATION

Division of Health Quality Assurance
Bureau of Plans and Construction

Effective Date: July 01, 2022
Org. Level: 68-30-10-00-000
FTE's: 42 Positions: 42

037 WALTZ 9072
CHIEF OF PLANS AND CONSTRUCTION-AHCA
046544
021 ARCHITECTURAL AND ENGINEERING MANAGERS 1.0
11-9041-03

048 YOUNG 4519
SENIOR ARCHITECT - SES
057493
011 ARCHITECTS, EXCEPT LANDSCAPE 1.0
17-1011-04

037 GADSEN 0712
ADMINISTRATIVE ASSISTANT II
064181
005 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-03

013 PADIN 8639
PROFESSIONAL ENGINEERING ADMINISTRATOR
057494
020 ARCHITECTURAL AND ENGINEERING MANAGERS 1.0
11-9041-02

037 BIVINS 4633
ENGINEERING SPECIALIST III
057499
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

029 VACANT 4660
PROFESSIONAL ENGINEER II
057502
011 ENGINEERING, ALL OTHER 1.0
17-2199-04

013 DIAZ TEJERA 4660
PROFESSIONAL ENGINEER II
046549
011 ENGINEERING, ALL OTHER 1.0
17-2199-04

037 SOKAYEV 4633
ENGINEERING SPECIALIST III
064185
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

013 MENDOZA 4633
ENGINEERING SPECIALIST III
057510
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

013 SALIM 4633
ENGINEERING SPECIALIST III
057509
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

048 CARCADOR DIAZ 4633
ENGINEERING SPECIALIST III
064184
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

048 LOUPE 4633
ENGINEERING SPECIALIST III
061419
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

029 SYED 4633
ENGINEERING SPECIALIST III
064765
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

048 OCQUE QUINTERO 4633
ENGINEERING SPECIALIST III
057498
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

037 JIANG 8639
PROFESSIONAL ENGINEERING ADMINISTRATOR
059723
020 ARCHITECTURAL AND ENGINEERING MANAGERS 1.0
11-9041-02

048 WASSMAN 4660
PROFESSIONAL ENGINEER II
057495
011 ENGINEERING, ALL OTHER 1.0
17-2199-04

029 PHAM 4660
PROFESSIONAL ENGINEER II
057503
011 ENGINEERING, ALL OTHER 1.0
17-2199-04

013 ZARIFI-DIZAJI 4633
ENGINEERING SPECIALIST III
057507
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

037 AGGABAO 4633
ENGINEERING SPECIALIST III
064183
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

013 DABIRI 4633
ENGINEERING SPECIALIST III
064187
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

029 IPPOLITO 4660
PROFESSIONAL ENGINEER II
064182
011 ENGINEERING, ALL OTHER 1.0
17-2199-04

048 ALSTON 4633
ENGINEERING SPECIALIST III
057497
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

013 SANTANA 4660
PROFESSIONAL ENGINEER II
057496
011 ENGINEERING, ALL OTHER 1.0
17-2199-04

037 DIAZ 4660
PROFESSIONAL ENGINEER II
048256
011 ENGINEERING, ALL OTHER 1.0
17-2199-04

048 VACANT 4633
ENGINEERING SPECIALIST III
057500
009 ENGINEERING, ALL OTHER 1.0
17-2199-03

037 SIDHOM 2234
OPERATIONS & MGMT CONSULTANT I - SES
064360
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

029 SHARP 0108
ADMINISTRATIVE SECRETARY
026190
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 GEE 0709
ADMINISTRATIVE ASSISTANT I
064177
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

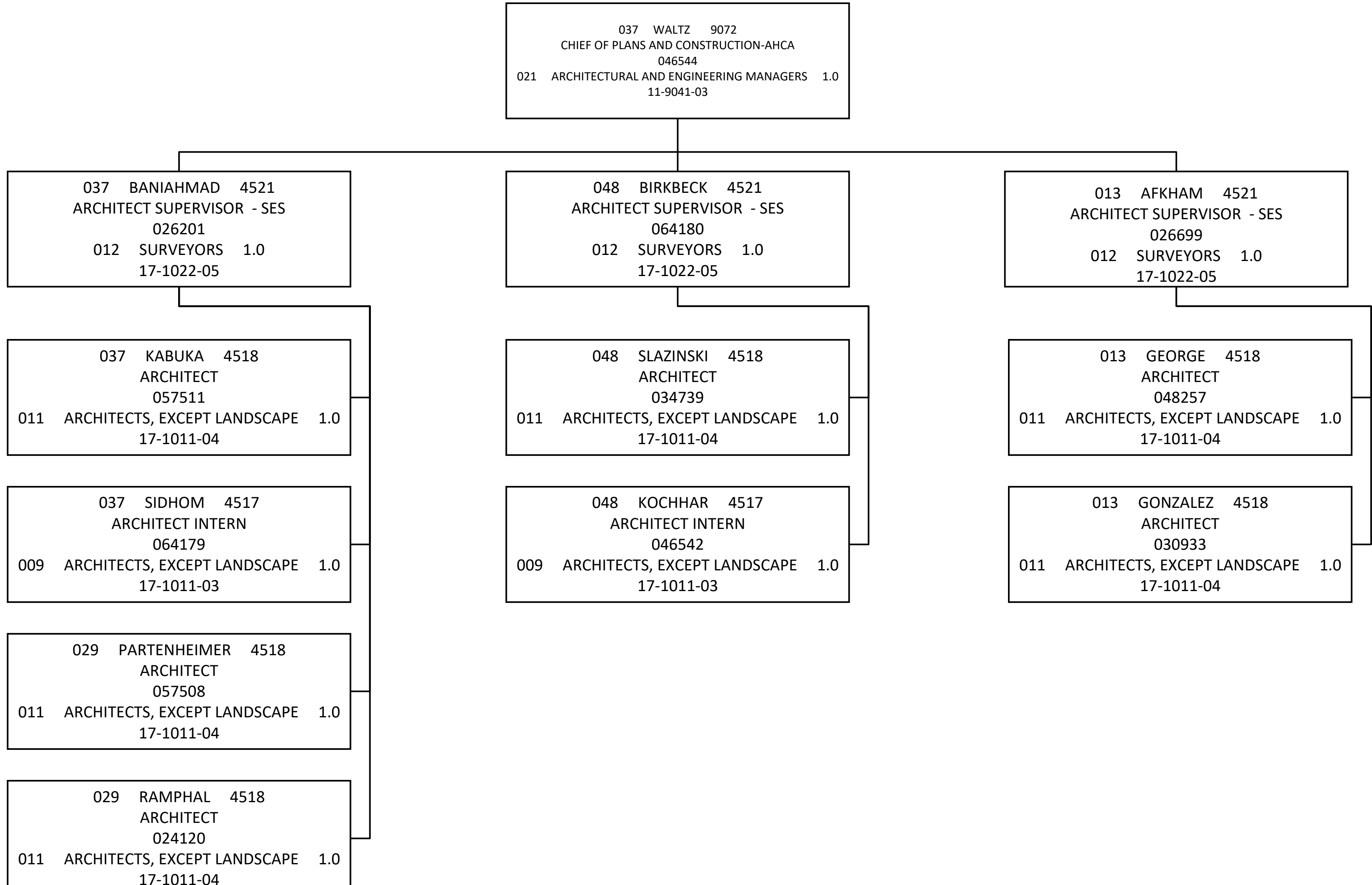
048 AGUAYO 0108
ADMINISTRATIVE SECRETARY
064178
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 ARTECHI 0108
ADMINISTRATIVE SECRETARY
031654
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

013 YANES 0108
ADMINISTRATIVE SECRETARY
057492
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

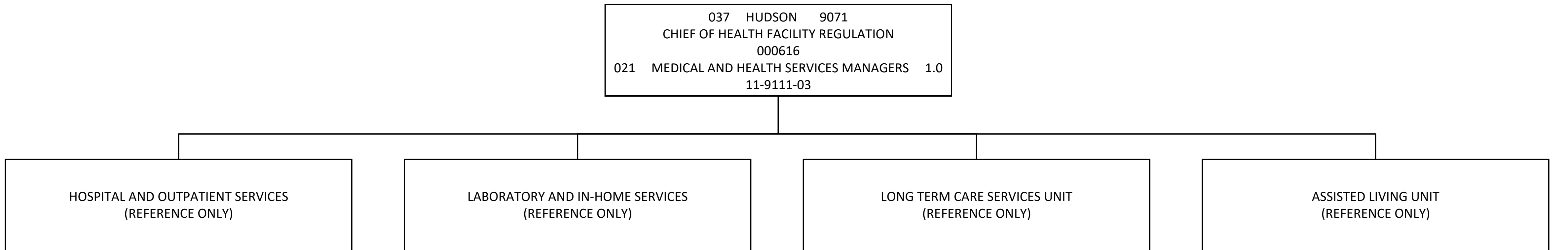
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Plans and Construction

Effective Date: July 01, 2022
Org. Level: 68-30-10-00-000
FTE's: 42 Positions: 42



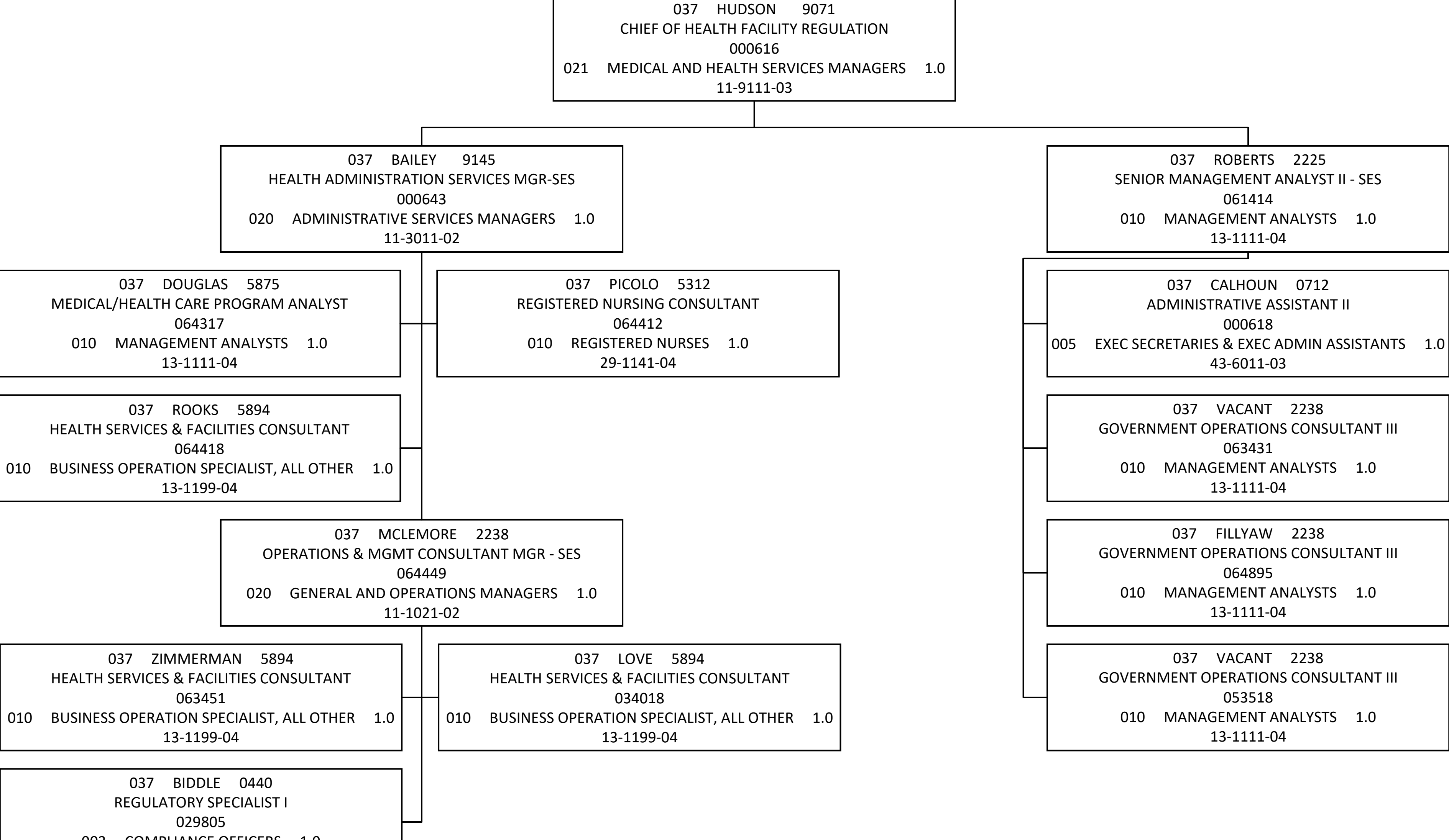
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Health Facility Regulation

Effective Date: July 01, 2022
Org. Level: 68-30-20-00-000
FTE's: 94.5 Positions: 95



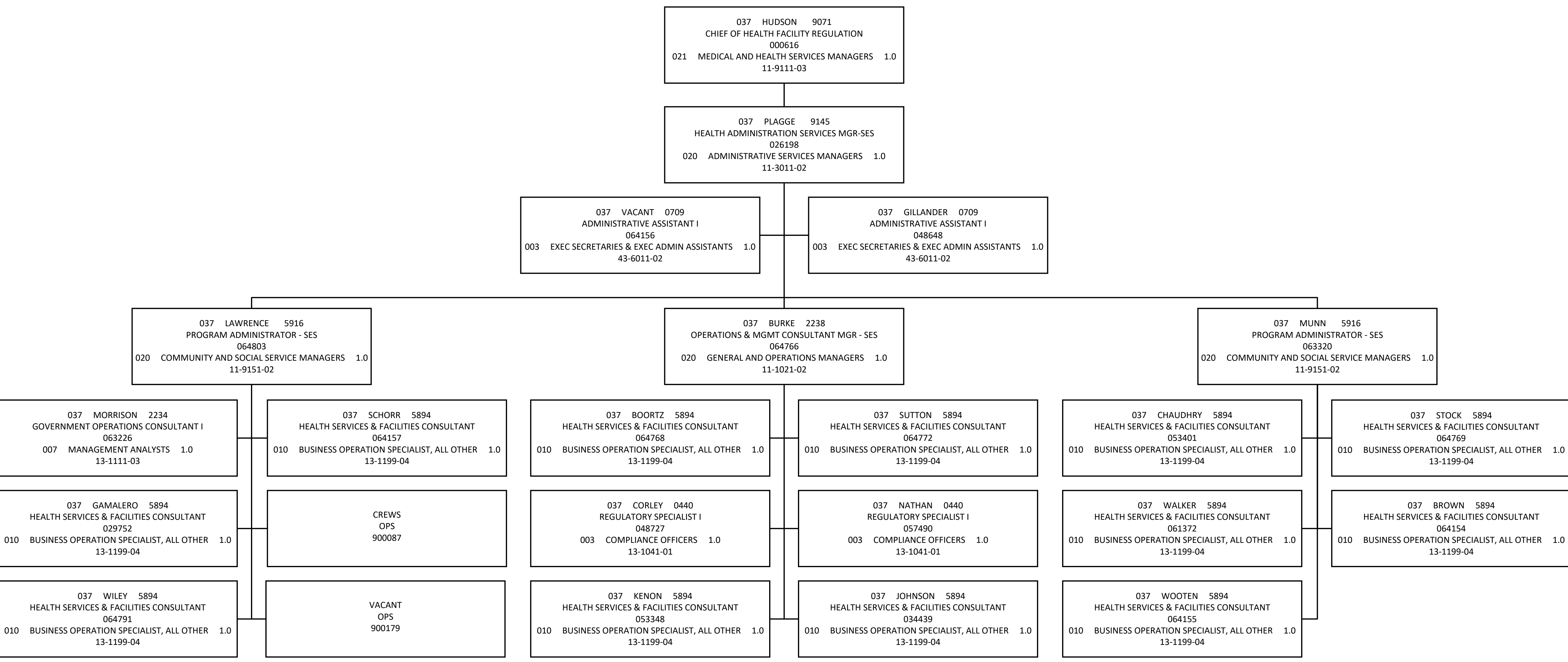
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Health Facility Regulation

Effective Date: July 01, 2022
Org. Level: 68-30-20-00-000
FTE's: 14 Positions: 14



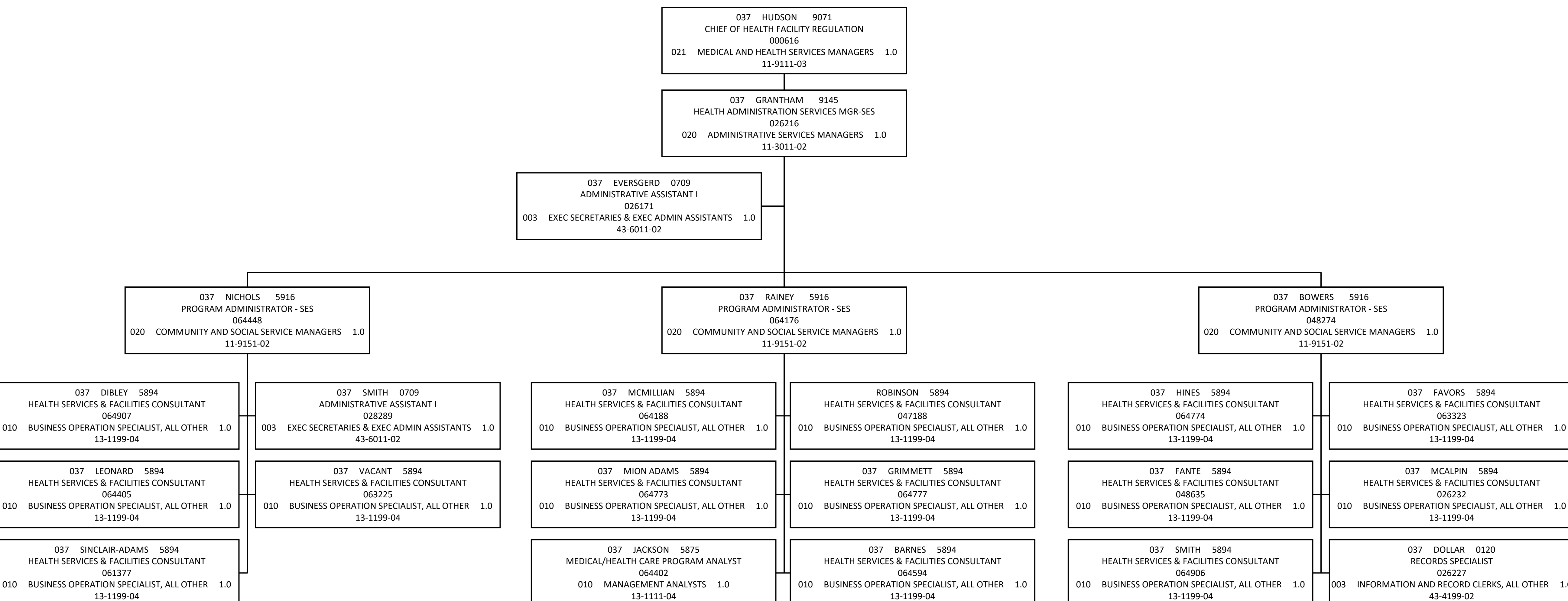
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Health Facility Regulation
Hospital & Outpatient Services

Effective Date: July 01, 2022
Org. Level: 68-30-20-20-000
FTE's: 21 Positions: 21



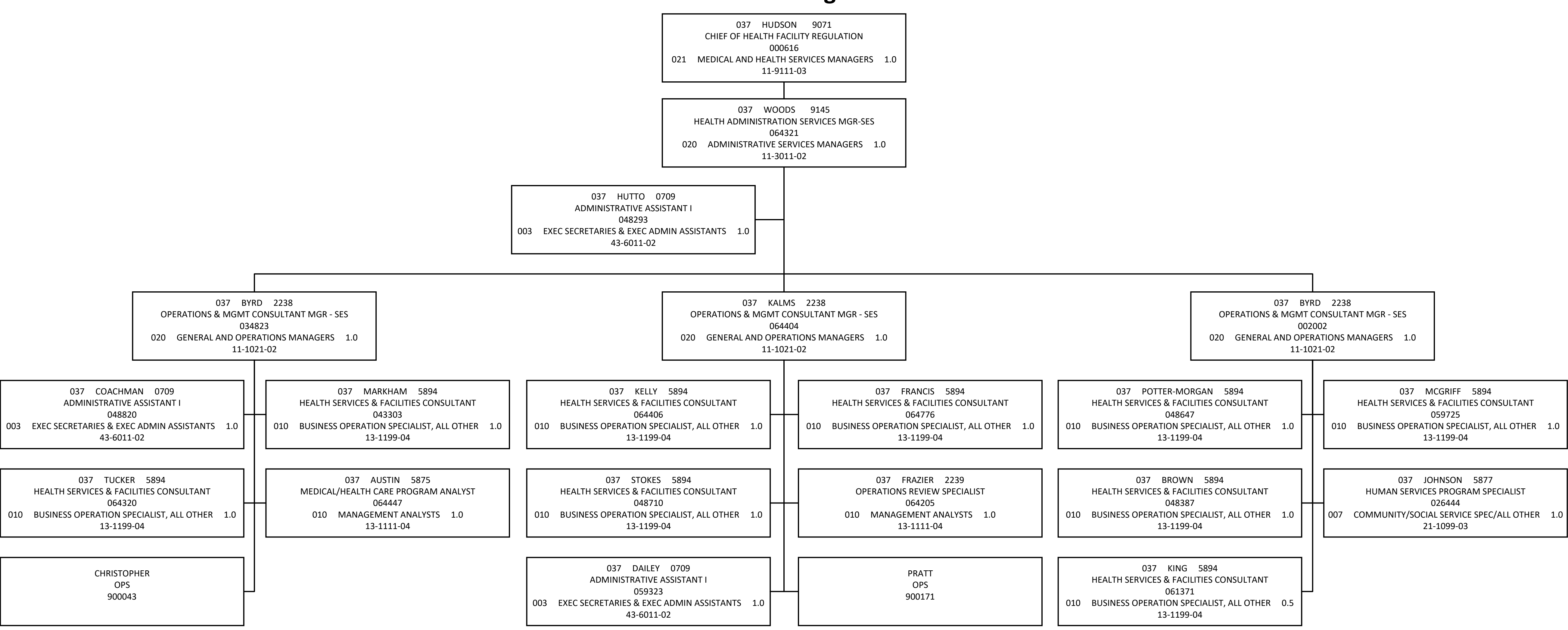
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Health Facility Regulation
Laboratory & In-Home Services

Effective Date: July 01, 2022
Org. Level: 68-30-20-35-000
FTE's: 22 Positions: 22



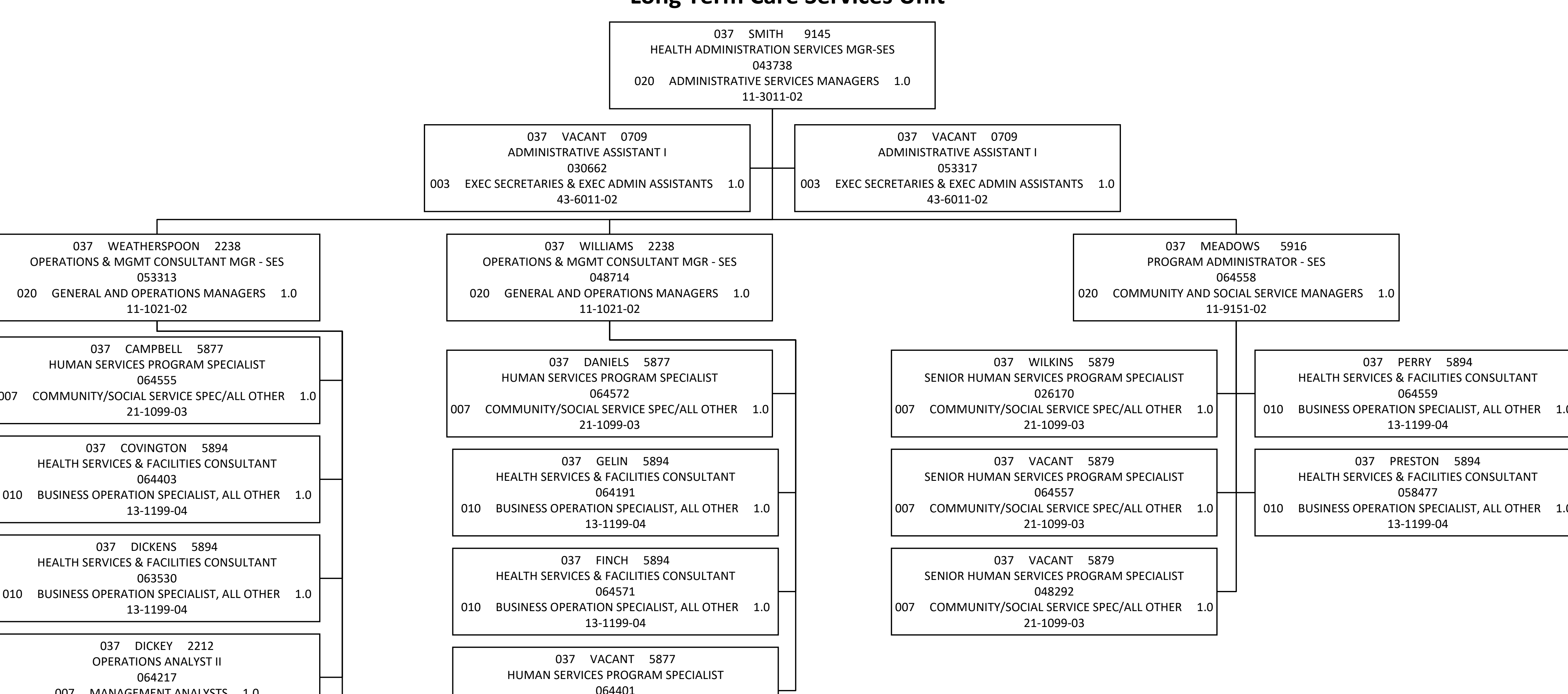
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Health Facility Regulation
Assisted Living Unit

Effective Date: July 01, 2022
Org. Level: 68-30-20-40-000
FTE's: 18.5 Positions: 19



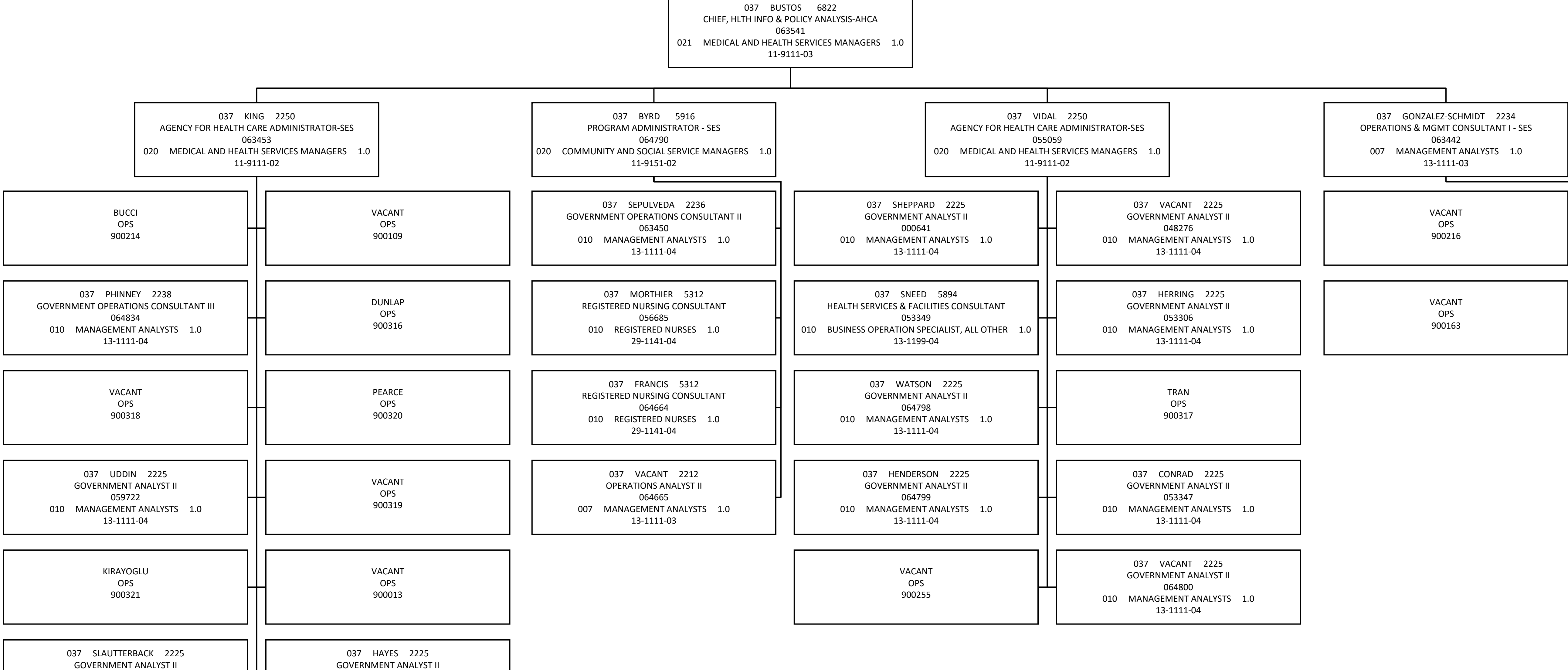
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Health Facility Regulation
Long Term Care Services Unit

Effective Date: July 01, 2022
Org. Level: 68-30-20-65-000
FTE's: 19 Positions: 19



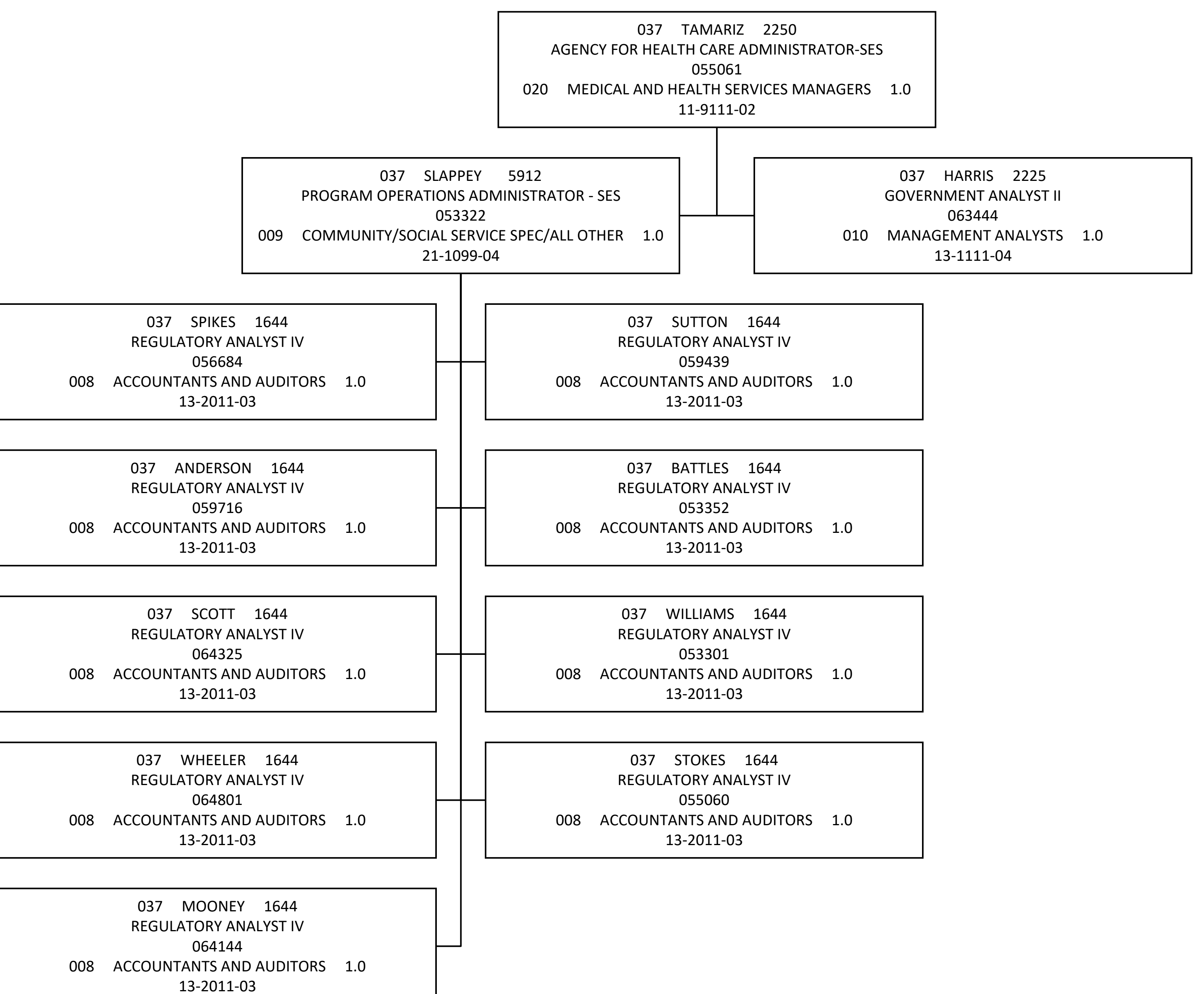
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of FL Center for Health Information & Transparency

Effective Date: July 01, 2022
Org. Level: 68-30-70-00-000
FTE's: 38 Positions: 38



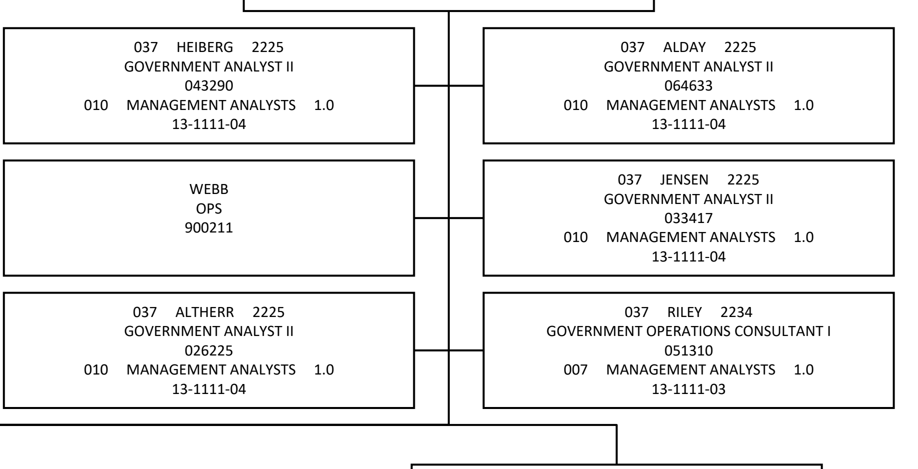
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of FL Center for Health Information & Transparency

Effective Date: July 01, 2022
Org. Level: 68-30-70-00-000
FTE's: 38 Positions: 38



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations

Effective Date: July 01, 2022
Org. Level: 68-30-30-00-000
FTE's: 26 Positions: 26



AREA OFFICE 2 (28 FTES) (REFERENCE ONLY)

AREA OFFICE 3 (29 FTES) (REFERENCE ONLY)

AREA OFFICE 4 (34 FTES) (REFERENCE ONLY)

AREA OFFICE 5 (80 FTES) (REFERENCE ONLY)

AREA OFFICE 7 (38 FTES) (REFERENCE ONLY)

AREA OFFICE 8 (36 FTES) (REFERENCE ONLY)

AREA OFFICE 9 (61 FTES) (REFERENCE ONLY)

AREA OFFICE 11 (56 FTES) (REFERENCE ONLY)

037 HART 2228
SENIOR MANAGEMENT ANALYST SUPV - SES
064652
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

THOMPSON
OPS
900347

037 VACANT 5312
REGISTERED NURSING CONSULTANT
064569
010 REGISTERED NURSES 1.0
29-1141-04

EDWARDS
OPS
900091

037 STRAIT 2236
GOVERNMENT OPERATIONS CONSULTANT II
064640
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 MORRISON 5312
REGISTERED NURSING CONSULTANT
064639
010 REGISTERED NURSES 1.0
29-1141-04

037 GREEN 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064648
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 KELLY 5312
REGISTERED NURSING CONSULTANT
064643
010 REGISTERED NURSES 1.0
29-1141-04

037 PHINAZEE 0108
ADMINISTRATIVE SECRETARY
061388
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 ELLSWORTH 5312
REGISTERED NURSING CONSULTANT
037433
010 REGISTERED NURSES 1.0
29-1141-04

OGORZALY
OPS
900124

037 ALEXANDER 5312
REGISTERED NURSING CONSULTANT
064793
010 REGISTERED NURSES 1.0
29-1141-04

037 KNERR 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064585
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 BLAIR 0441
REGULATORY SPECIALIST II
029751
006 COMPLIANCE OFFICERS 1.0
13-1041-02

037 ARNOLD 0440
REGULATORY SPECIALIST I
064645
003 COMPLIANCE OFFICERS 1.0
13-1041-01

037 LEWIS 0444
REGULATORY SPECIALIST III
064644
007 COMPLIANCE OFFICERS 1.0
13-1041-03

037 POLLOCK 5916
PROGRAM ADMINISTRATOR - SES
064214
020 COMMUNITY AND SOCIAL SERVICE MANAGERS 1.0
11-9151-02

037 ADAMS 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064225
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

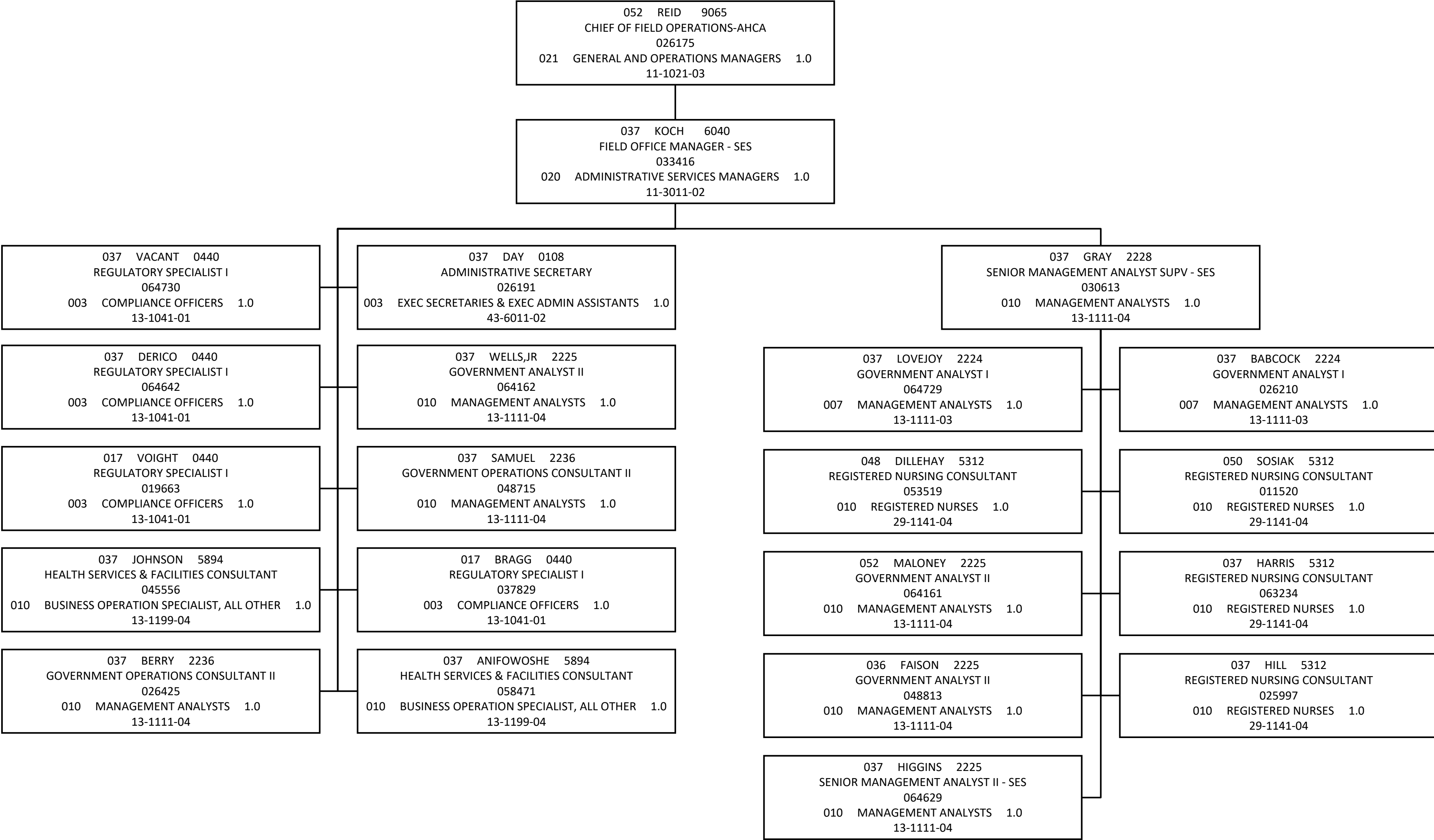
037 MURRAY 5894
HEALTH SERVICES & FACILITIES CONSULTANT
061379
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 FOSTER 5894
HEALTH SERVICES & FACILITIES CONSULTANT
048473
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 REED 5894
HEALTH SERVICES & FACILITIES CONSULTANT
046547
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

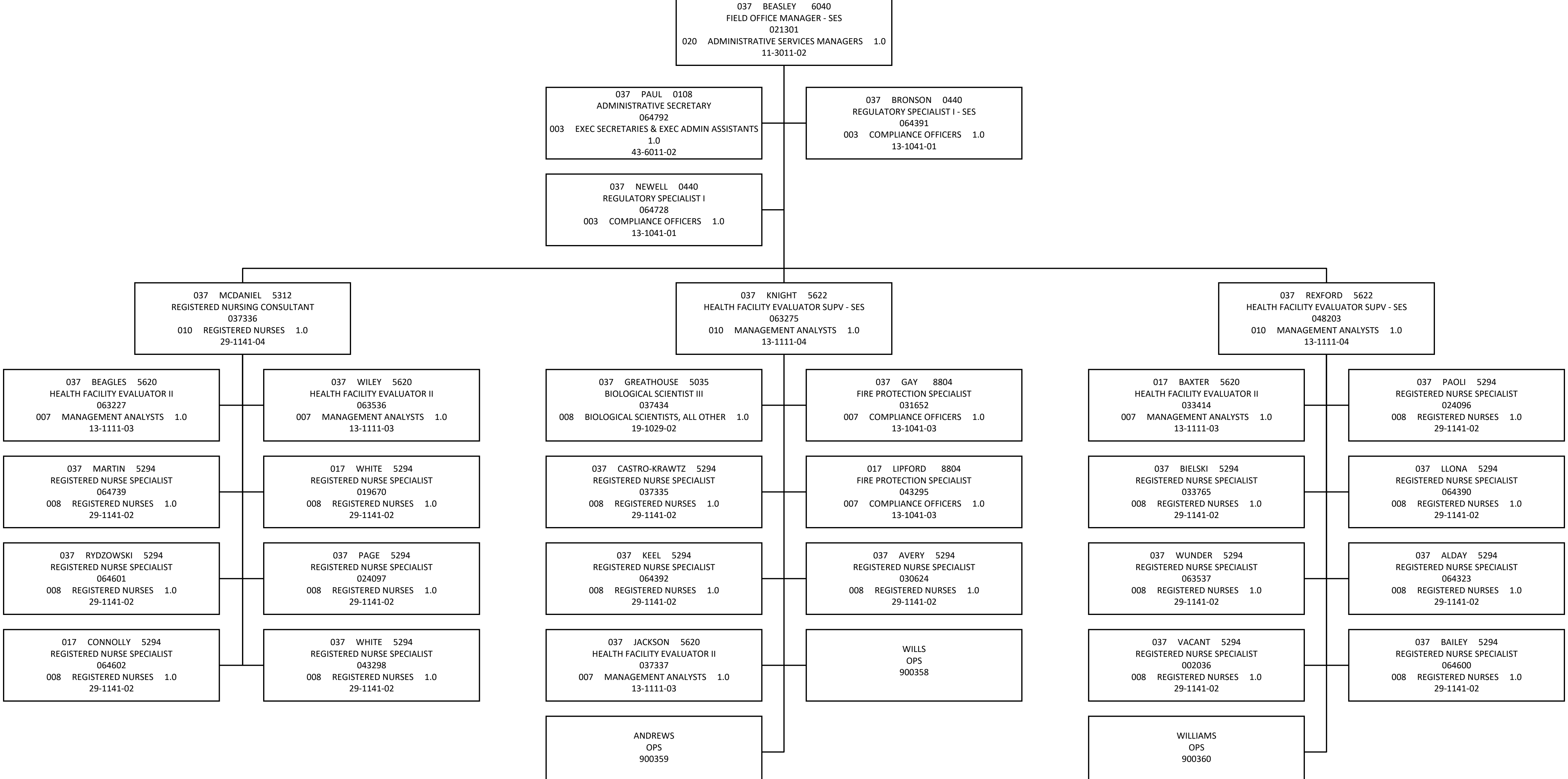
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Health Standards & Quality
Survey & Certification Support Branch

Effective Date: July 01, 2022
Org. Level: 68-30-30-30-000
FTE's: 18.5 Positions: 19



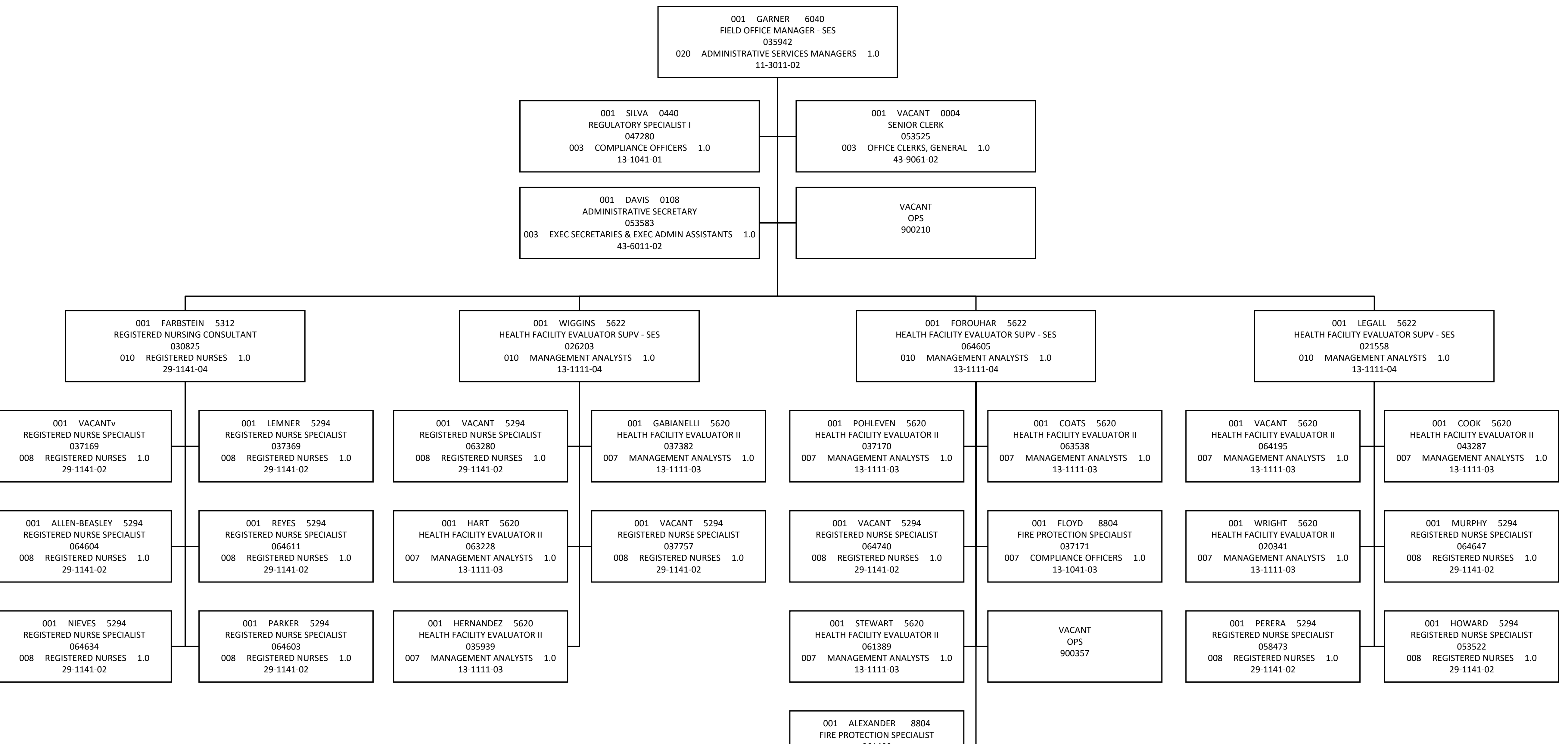
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 2 - Tallahassee

Effective Date: July 01, 2022
Org. Level: 68-30-30-02-000
FTE's: 30 Positions: 30

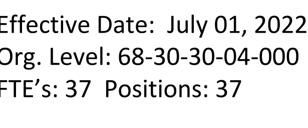


AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 3 - Alachua

Effective Date: July 01, 2022
Org. Level: 68-30-30-03-000
FTE's: 31 Positions: 31



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 4 - Jacksonville



016 DICKSON, JR. 6040
FIELD OFFICE MANAGER - SES
026197
020 ADMINISTRATIVE SERVICES MANAGERS 1.0
11-3011-02

016 MARTELLY WALCOTT 0440
REGULATORY SPECIALIST I
026211
003 COMPLIANCE OFFICERS 1.0
13-1041-01

016 MINYARD 0441
REGULATORY SPECIALIST II
031144
006 COMPLIANCE OFFICERS 1.0
13-1041-02

016 BASS 0108
ADMINISTRATIVE SECRETARY
043307
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

016 YORK 0108
ADMINISTRATIVE SECRETARY
026187
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

VACANT
OPS
900366

016 WISEHART 5622
HEALTH FACILITY EVALUATOR SUPV - SES
048821
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

016 WATSON 5620
HEALTH FACILITY EVALUATOR II
039472
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

016 JONES 5620
HEALTH FACILITY EVALUATOR II
034825
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

016 VACANT 5294
REGISTERED NURSE SPECIALIST
040043
008 REGISTERED NURSES 1.0
29-1141-02

016 VACANT 5620
HEALTH FACILITY EVALUATOR II
030707
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

016 DORCEY 5620
HEALTH FACILITY EVALUATOR II
026172
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

016 PASTORELLO 5620
HEALTH FACILITY EVALUATOR II
026224
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

016 STANLEY 5294
REGISTERED NURSE SPECIALIST
043291
008 REGISTERED NURSES 1.0
29-1141-02

HARDY
OPS
900292

016 GOODIN 5312
REGISTERED NURSING CONSULTANT
026233
010 REGISTERED NURSES 1.0
29-1141-04

016 CHIRA 5294
REGISTERED NURSE SPECIALIST
048817
008 REGISTERED NURSES 1.0
29-1141-02

016 MUNIU 5294
REGISTERED NURSE SPECIALIST
058474
008 REGISTERED NURSES 1.0
29-1141-02

016 HUNTONE 5294
REGISTERED NURSE SPECIALIST
063229
008 REGISTERED NURSES 1.0
29-1141-02

004 SHERRILL 5035
BIOLOGICAL SCIENTIST III
063328
008 BIOLOGICAL SCIENTISTS, ALL OTHER 1.0
19-1029-02

016 SALZER 5224
PUBLIC HEALTH NUTRITION CONSULTANT
048722
010 DIETITIANS AND NUTRITIONISTS 1.0
29-1031-04

016 VACANT 5294
REGISTERED NURSE SPECIALIST
024099
008 REGISTERED NURSES 1.0
29-1141-02

016 MCCOY 5224
PUBLIC HEALTH NUTRITION CONSULTANT
030840
010 DIETITIANS AND NUTRITIONISTS 1.0
29-1031-04

016 VACANT 5620
HEALTH FACILITY EVALUATOR II
024300
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

016 VACANT 5312
REGISTERED NURSING CONSULTANT
026207
010 REGISTERED NURSES 1.0
29-1141-04

016 VACANT 5294
REGISTERED NURSE SPECIALIST
064159
008 REGISTERED NURSES 1.0
29-1141-02

016 VACANT 5294
REGISTERED NURSE SPECIALIST
064741
008 REGISTERED NURSES 1.0
29-1141-02

016 BOSWELL 5294
REGISTERED NURSE SPECIALIST
064612
008 REGISTERED NURSES 1.0
29-1141-02

016 GOLDSBERRY 5294
REGISTERED NURSE SPECIALIST
034821
008 REGISTERED NURSES 1.0
29-1141-02

016 HENDRICKS 5294
REGISTERED NURSE SPECIALIST
026223
008 REGISTERED NURSES 1.0
29-1141-02

016 KORYSHEVA 5294
REGISTERED NURSE SPECIALIST
064614
008 REGISTERED NURSES 1.0
29-1141-02

016 VACANT 5294
REGISTERED NURSE SPECIALIST
030836
008 REGISTERED NURSES 1.0
29-1141-02

016 BADGER 5622
HEALTH FACILITY EVALUATOR SUPV - SES
064871
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

016 CARVALHO 5294
REGISTERED NURSE SPECIALIST
030623
008 REGISTERED NURSES 1.0
29-1141-02

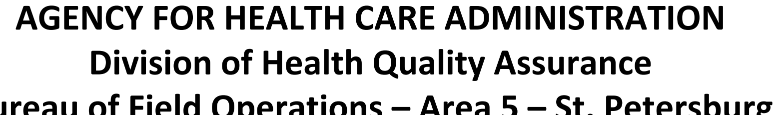
016 LEE 5294
REGISTERED NURSE SPECIALIST
061393
008 REGISTERED NURSES 1.0
29-1141-02

016 VACANT 8804
FIRE PROTECTION SPECIALIST
064635
007 COMPLIANCE OFFICERS 1.0
13-1041-03

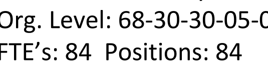
016 VACANT 5620
HEALTH FACILITY EVALUATOR II
048812
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

016 LAIRD 8804
FIRE PROTECTION SPECIALIST
031653
007 COMPLIANCE OFFICERS 1.0
13-1041-03

016 LINDNER 5879
SENIOR HUMAN SERVICES PROGRAM SPECIALIST
053581
007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0
21-1099-03



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 5 – St. Petersburg



Effective Date: July 01, 2022
Org. Level: 68-30-30-05-000
FTE's: 84 Positions: 84

052 LIMA 6040
FIELD OFFICE MANAGER - SES
026231
020 ADMINISTRATIVE SERVICES MANAGERS 1.0
11-3011-02

- 052 WALERSKI 0440 — REGULATORY SPECIALIST I — 061417 — 003 COMPLIANCE OFFICERS 1.0 — 13-1041-01
- 052 MCCURDY 0441 — REGULATORY SPECIALIST II — 064743 — 006 COMPLIANCE OFFICERS 1.0 — 13-1041-02
- 052 GARCIA 0441 — REGULATORY SPECIALIST II — 031655 — 006 COMPLIANCE OFFICERS 1.0 — 13-1041-02

052 SUTTER 5622 — HEALTH FACILITY EVALUATOR SUPV - SES — 026206 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04

- 052 CATEMBUNG 0108 — ADMINISTRATIVE SECRETARY — 026236 — 003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0 — 43-6011-02
- 052 WILLIAMS 0004 — SENIOR CLERK — 037230 — 003 OFFICE CLERKS, GENERAL 1.0 — 43-9061-02
- 052 ROGERS 5035 — BIOLOGICAL SCIENTIST III — 063330 — 008 BIOLOGICAL SCIENTISTS, ALL OTHER 1.0 — 19-1029-02
- 052 MARKOW 5035 — BIOLOGICAL SCIENTIST III — 026559 — 008 BIOLOGICAL SCIENTISTS, ALL OTHER 1.0 — 19-1029-02
- 052 SAUNDERS 0108 — ADMINISTRATIVE SECRETARY — 026226 — 003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0 — 43-6011-02
- 052 GARCIA 5620 — HEALTH FACILITY EVALUATOR II — 043296 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 BROOKS 0108 — ADMINISTRATIVE SECRETARY — 021078 — 003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0 — 43-6011-02

052 SZPILA 5312 — REGISTERED NURSING CONSULTANT — 053520 — 010 REGISTERED NURSES 1.0 — 29-1141-04

- 052 ROSS 5294 — REGISTERED NURSE SPECIALIST — 048816 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 VACANT 5294 — REGISTERED NURSE SPECIALIST — 064615 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 RIPOSIO 5294 — REGISTERED NURSE SPECIALIST — 053578 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 VACANT 5294 — REGISTERED NURSE SPECIALIST — 037201 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 REDMAN 5294 — REGISTERED NURSE SPECIALIST — 064622 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 FERRAI 5294 — REGISTERED NURSE SPECIALIST — 061397 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 BOCALBOS 5294 — REGISTERED NURSE SPECIALIST — 061404 — 008 REGISTERED NURSES 0.5 — 29-1141-02
- AROMOLA — OPS — 900184

052 HARDIE 5622 — HEALTH FACILITY EVALUATOR SUPV - SES — 048819 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04

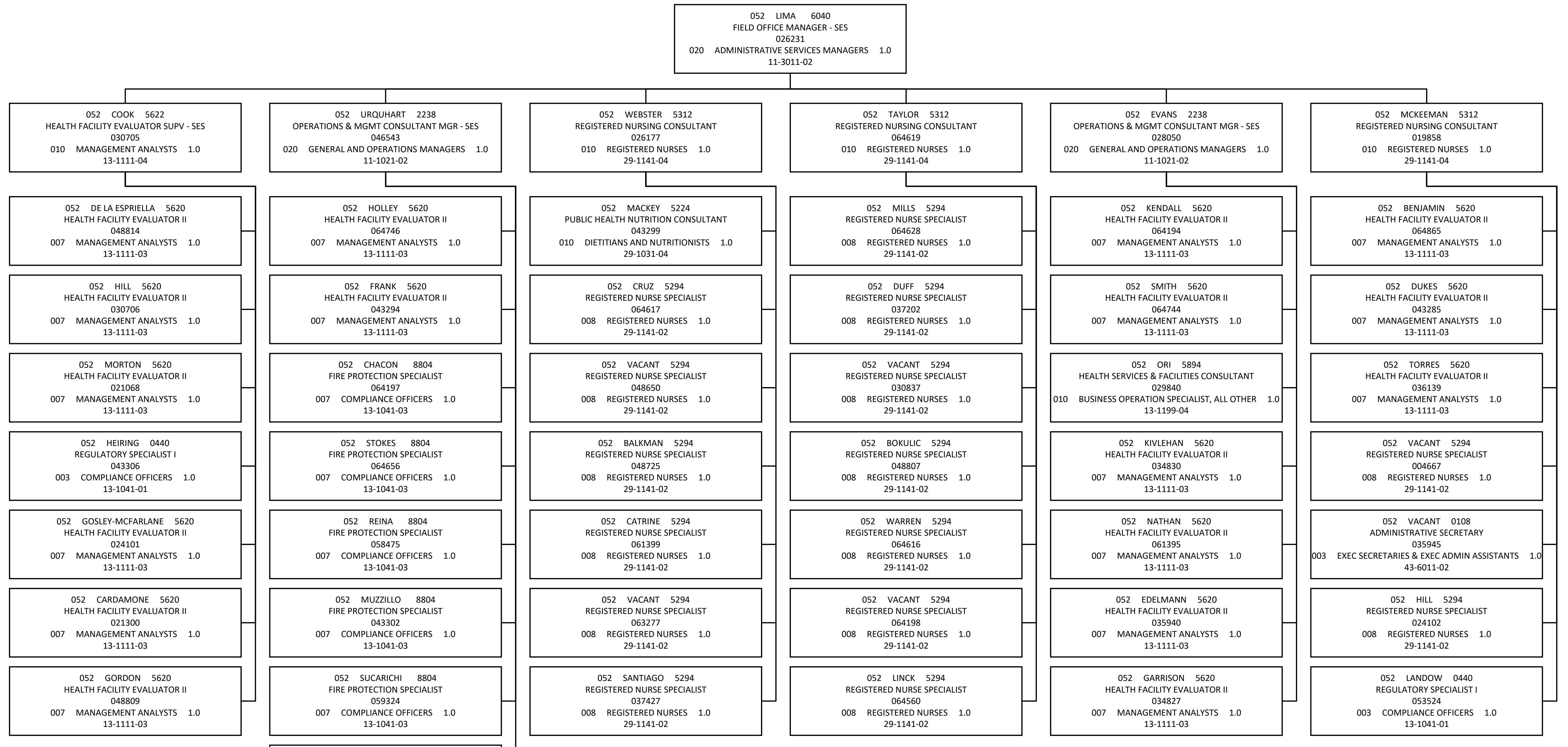
- VACANT — OPS — 900245
- 052 BATTLE 5620 — HEALTH FACILITY EVALUATOR II — 034826 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 COLLINS 5620 — HEALTH FACILITY EVALUATOR II — 048235 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 GRECO 5620 — HEALTH FACILITY EVALUATOR II — 021075 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 WILSON 5294 — REGISTERED NURSE SPECIALIST — 061403 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 ROBERTS 5620 — HEALTH FACILITY EVALUATOR II — 064745 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 VACANT 5620 — HEALTH FACILITY EVALUATOR II — 063231 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 VACANT 5294 — REGISTERED NURSE SPECIALIST — 030838 — 008 REGISTERED NURSES 1.0 — 29-1141-02

052 EARLE 5622 — HEALTH FACILITY EVALUATOR SUPV - SES — 064794 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04

- 052 MORIARTY 5294 — REGISTERED NURSE SPECIALIST — 064637 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 VACANT 5294 — REGISTERED NURSE SPECIALIST — 064606 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 PATTERSON 5620 — HEALTH FACILITY EVALUATOR II — 027627 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 VACANT 5294 — REGISTERED NURSE SPECIALIST — 061398 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 HOBBS 5294 — REGISTERED NURSE SPECIALIST — 031649 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- 052 BROWNLIE 5620 — HEALTH FACILITY EVALUATOR II — 024903 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
- 052 VACANT 5294 — REGISTERED NURSE SPECIALIST — 064742 — 008 REGISTERED NURSES 1.0 — 29-1141-02
- HOLMES — OPS — 900362

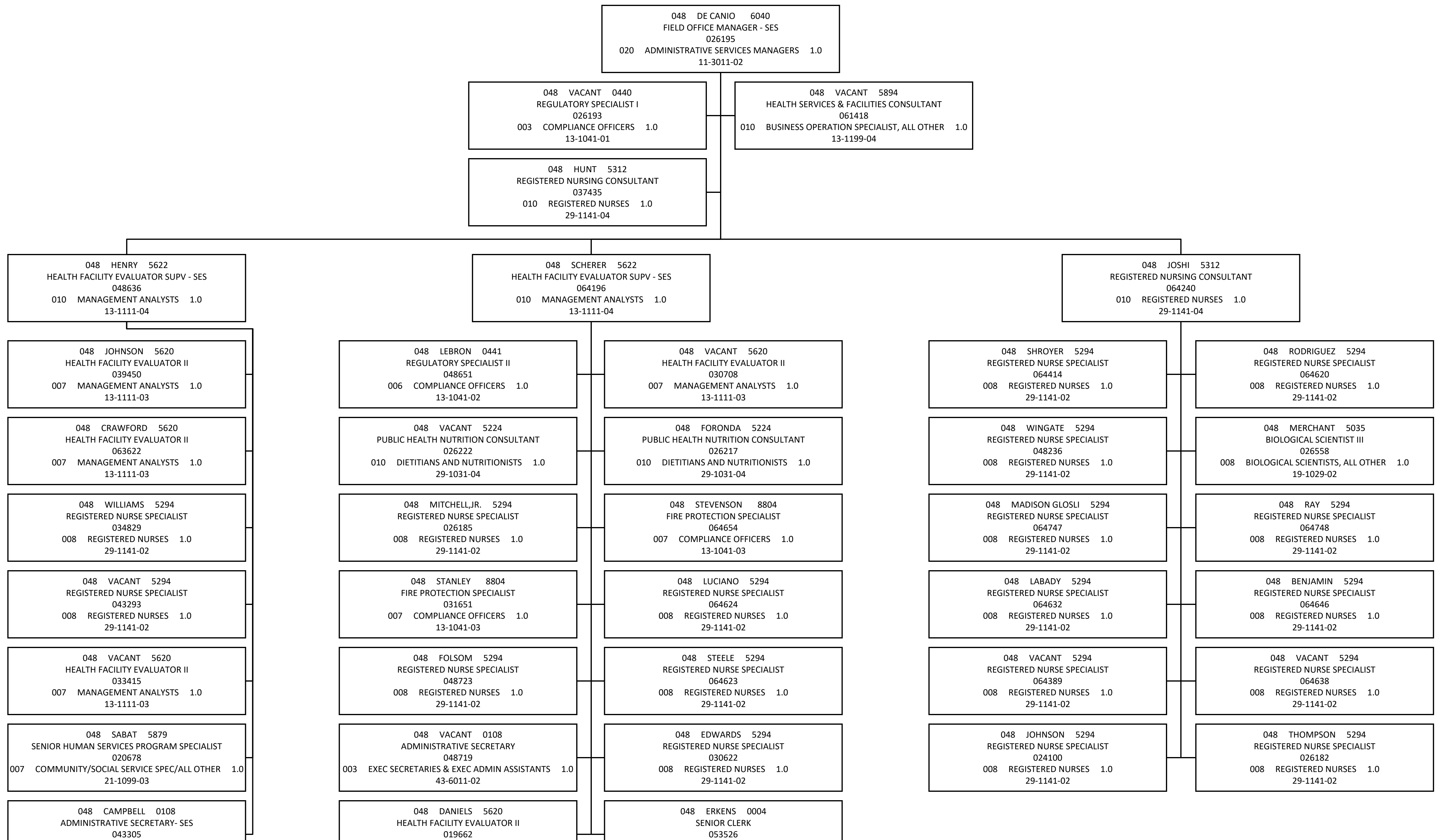
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 5 – St. Petersburg

Effective Date: July 01, 2022
Org. Level: 68-30-30-05-000
FTE's: 84 Positions: 84



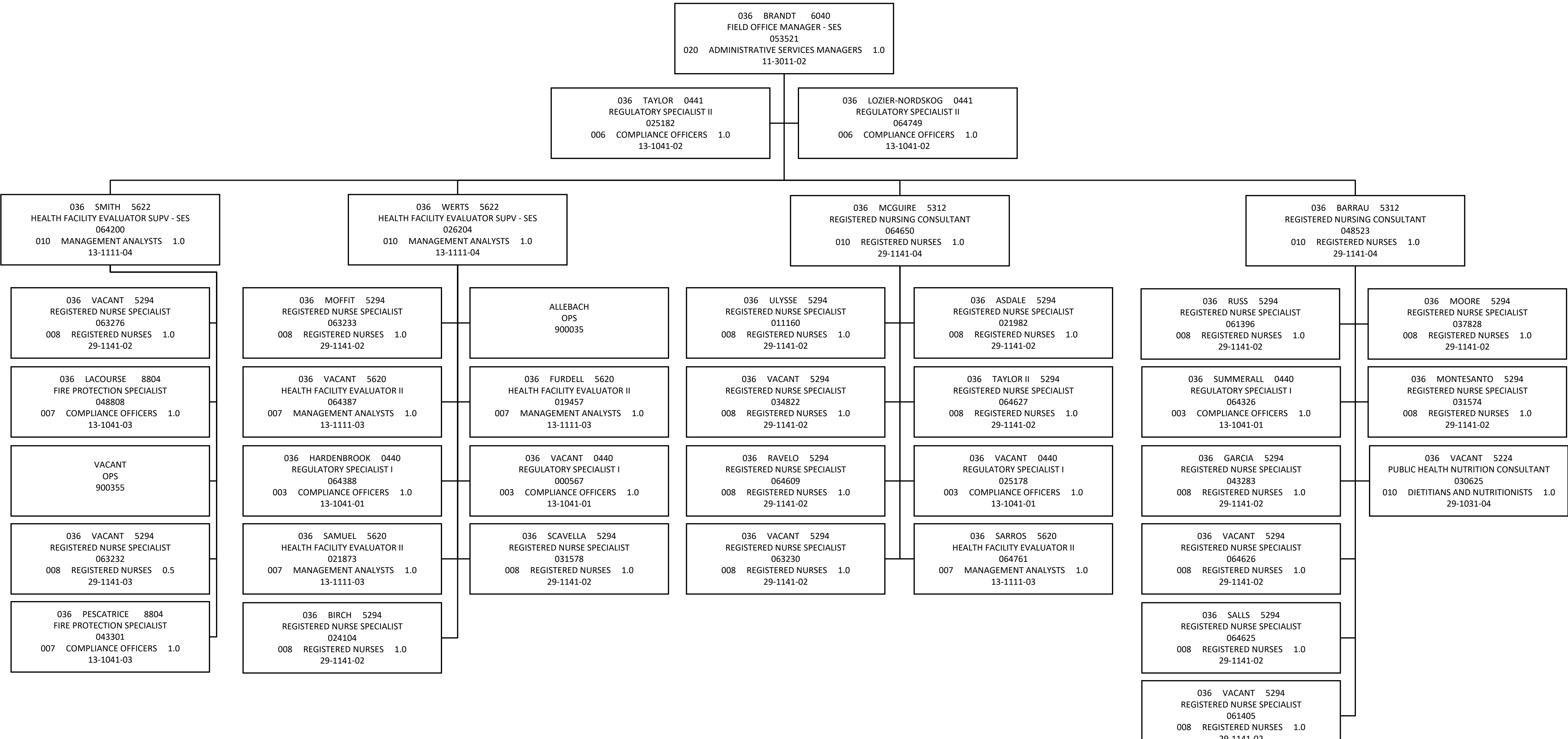
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 7 – Orlando

Effective Date: July 01, 2022
Org. Level: 68-30-30-07-000
FTE's: 40 Positions: 40



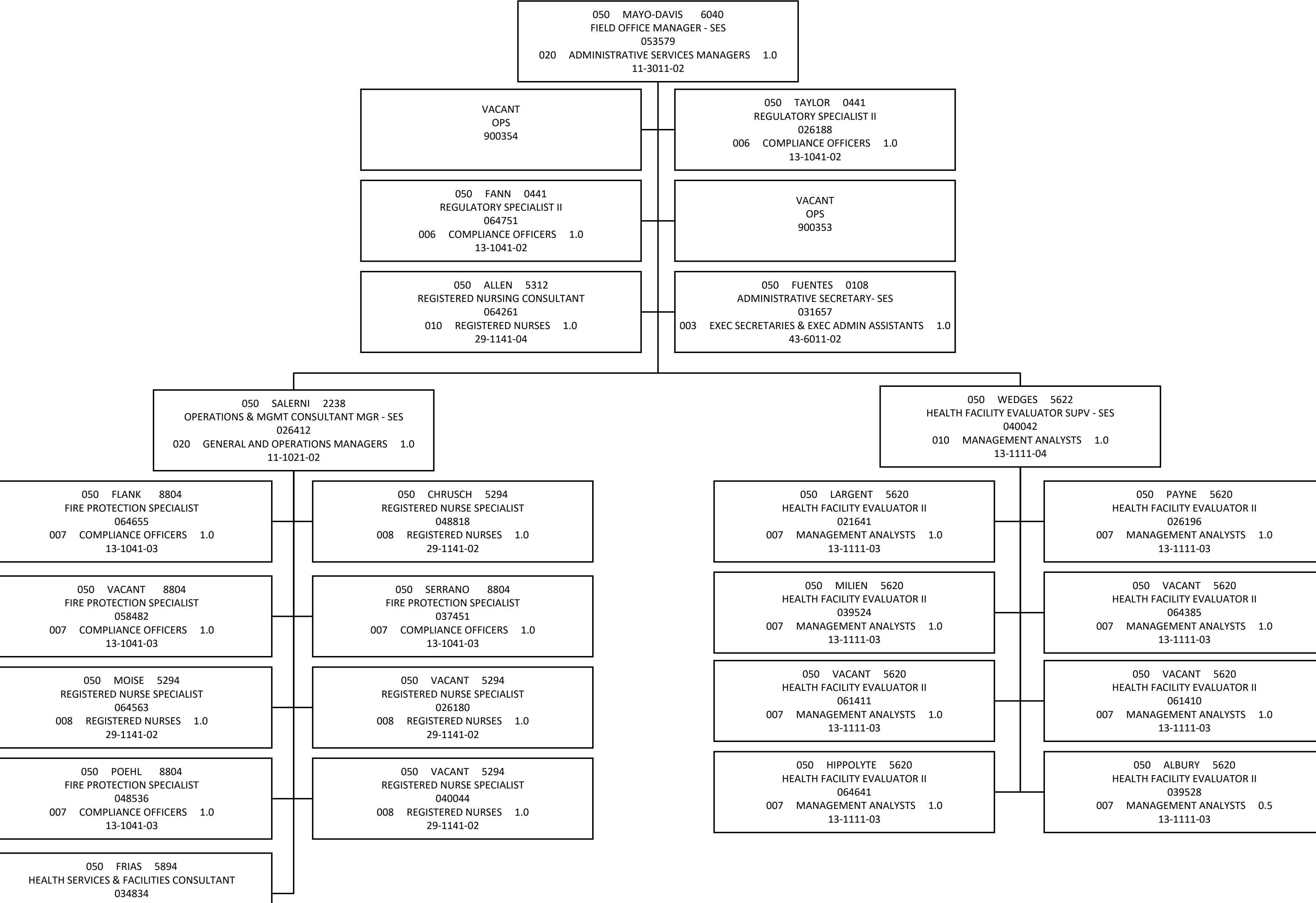
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 8 – Ft. Myers

Effective Date: July 01, 2022
Org. Level: 68-30-30-08-000
FTE's: 36 Positions: 36



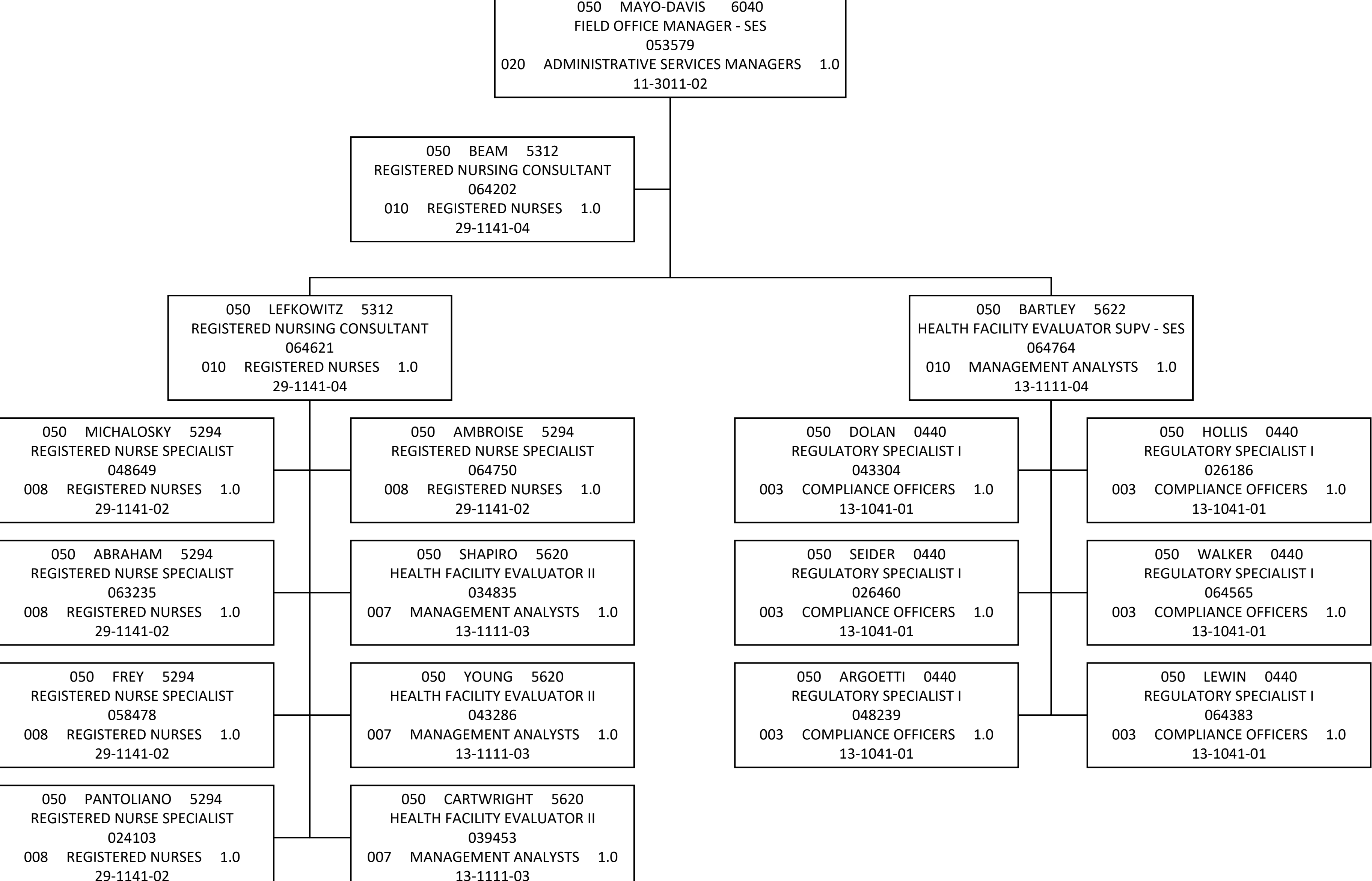
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 9 – Delray Beach

Effective Date: July 01, 2022
Org. Level: 68-30-30-09-000
FTE's:65 Positions: 65



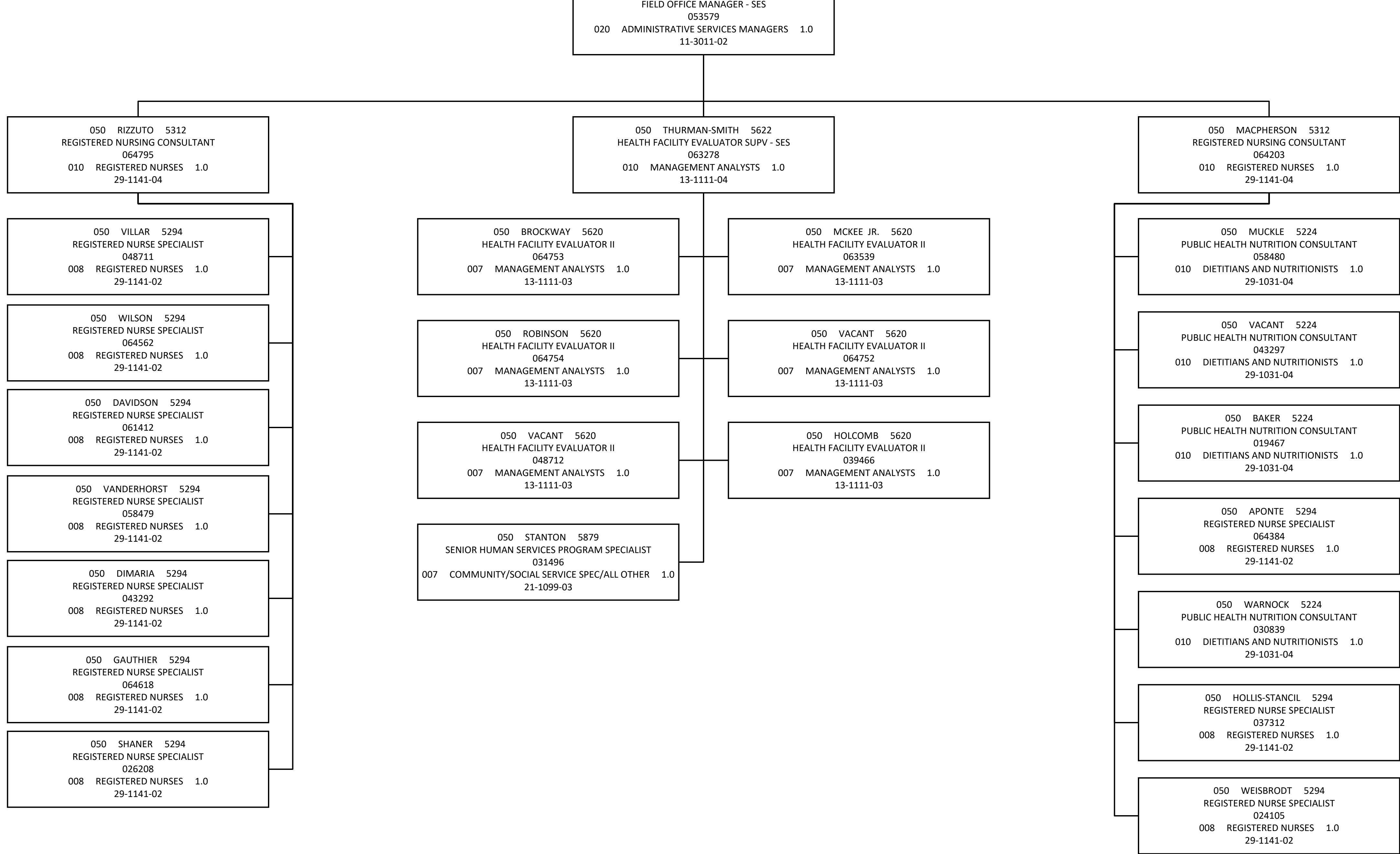
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 9 – Delray Beach

Effective Date: July 01, 2022
Org. Level: 68-30-30-09-000
FTE's:65 Positions: 65



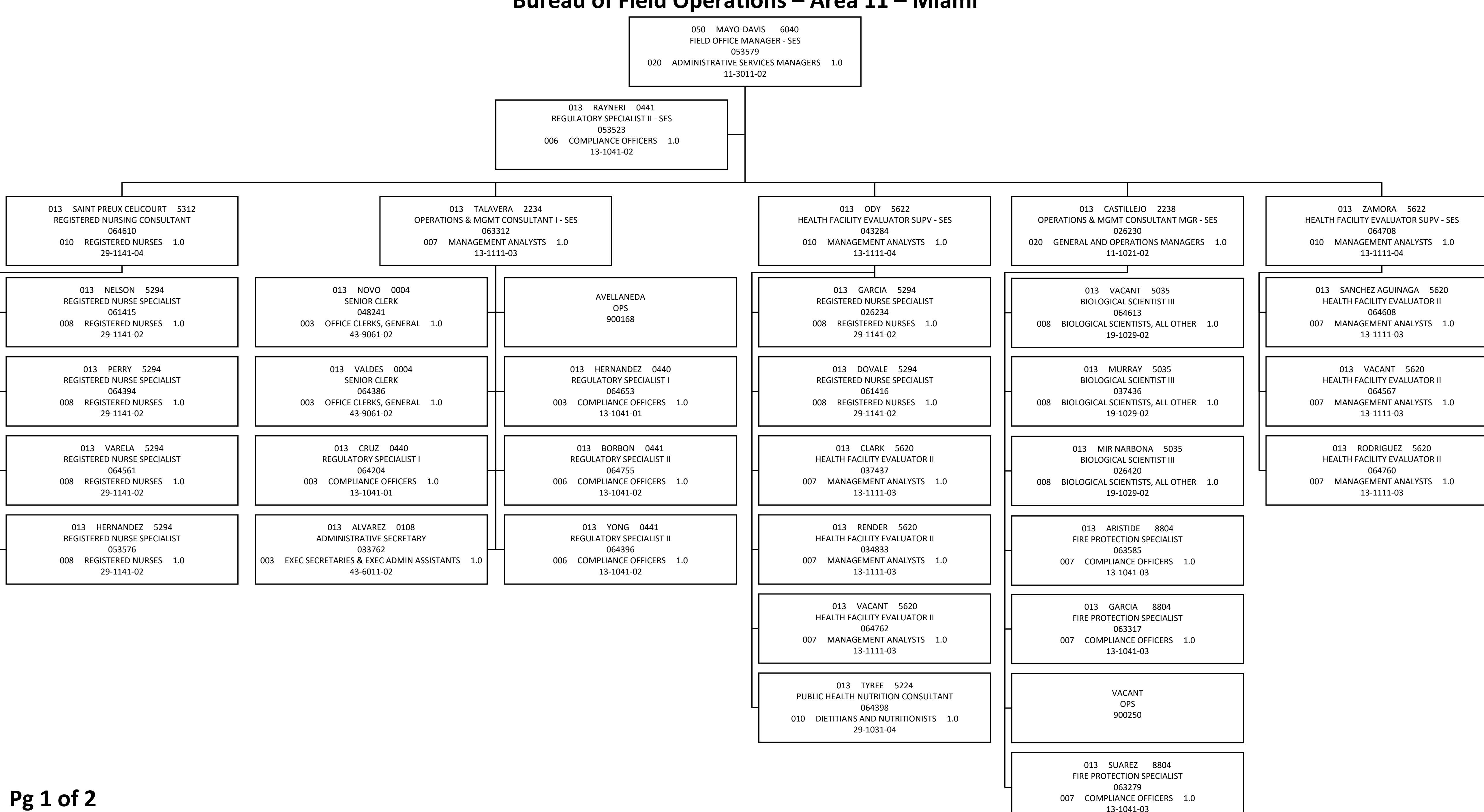
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 9 – Delray Beach

Effective Date: July 01, 2022
Org. Level: 68-30-30-09-000
FTE's:65 Positions: 65



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 11 – Miami

Effective Date: July 01, 2022
Org. Level: 68-30-30-11-000
FTE's: 59 Positions: 59

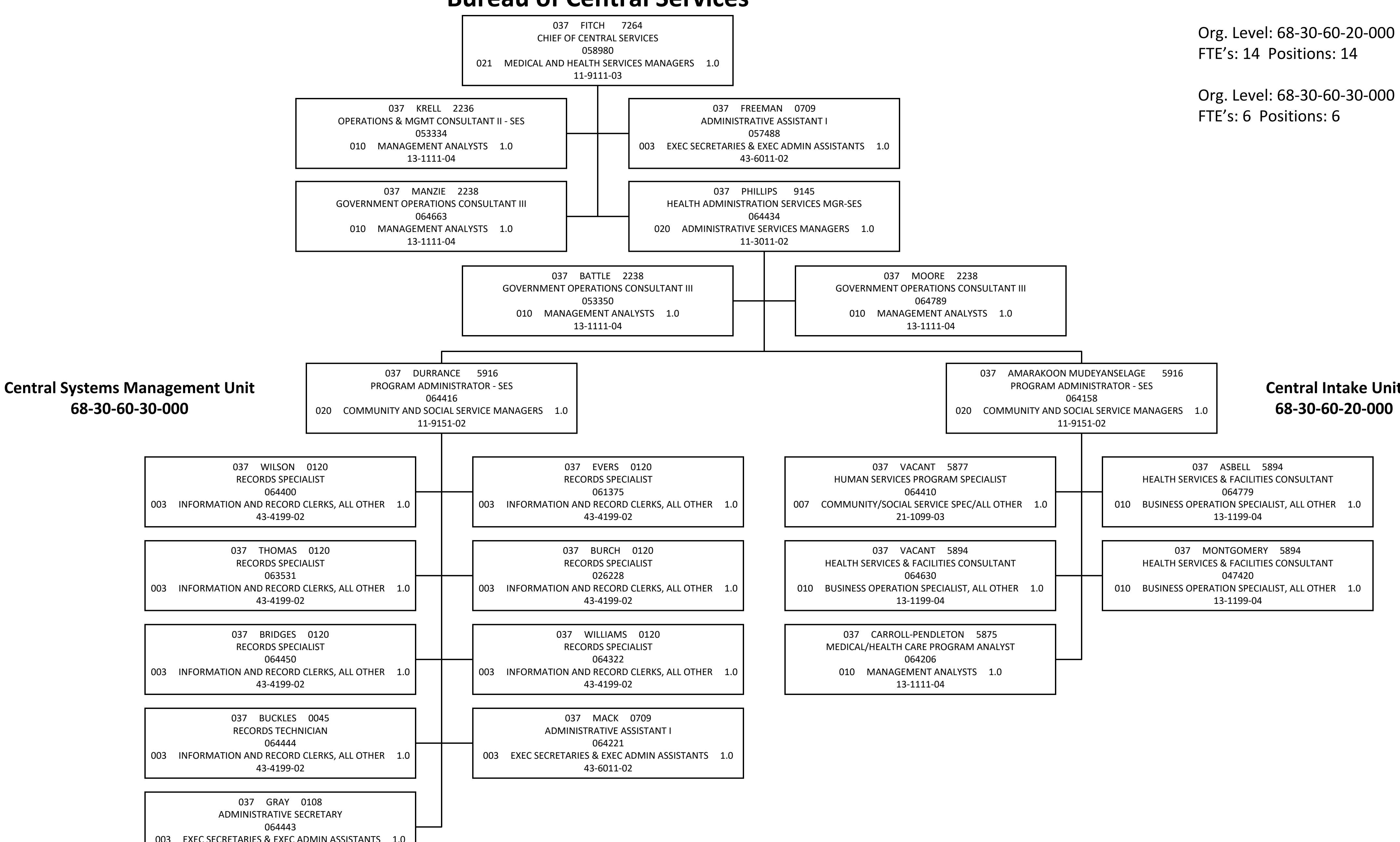


AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Field Operations – Area 11 – Miami

Effective Date: July 01, 2022
Org. Level: 68-30-30-11-000
FTE's: 59 Positions: 59

- 050 MAYO-DAVIS 6040 — FIELD OFFICE MANAGER - SES — 053579 — 020 ADMINISTRATIVE SERVICES MANAGERS 1.0 — 11-3011-02
  - 013 BAILEY 5622 — HEALTH FACILITY EVALUATOR SUPV - SES — 026194 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04
    - 013 GRAY 5620 — HEALTH FACILITY EVALUATOR II — 064564 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 VACANT 5620 — HEALTH FACILITY EVALUATOR II — 064866 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 QUINTYN 5620 — HEALTH FACILITY EVALUATOR II — 064324 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 VERDERA 5620 — HEALTH FACILITY EVALUATOR II — 035941 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 SAINVAL 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 058472 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
    - 013 PICADO 5620 — HEALTH FACILITY EVALUATOR II — 064757 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 RIVAS MURILLO 5620 — HEALTH FACILITY EVALUATOR II — 064758 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
  - 013 ROBINSON 5622 — HEALTH FACILITY EVALUATOR SUPV - SES — 037908 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04
    - 013 CALIXTE 5620 — HEALTH FACILITY EVALUATOR II — 064756 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 MONTERROSO 5620 — HEALTH FACILITY EVALUATOR II — 043289 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 ST JACQUES 5620 — HEALTH FACILITY EVALUATOR II — 064763 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 GONZALEZ 5620 — HEALTH FACILITY EVALUATOR II — 063236 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 GUELCE 5620 — HEALTH FACILITY EVALUATOR II — 064759 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 CHANTEZ 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048234 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
  - 013 WILLIAMS 5312 — REGISTERED NURSING CONSULTANT — 064796 — 010 REGISTERED NURSES 1.0 — 29-1141-04
    - 013 VACANT 5294 — REGISTERED NURSE SPECIALIST — 064631 — 008 REGISTERED NURSES 1.0 — 29-1141-02
    - 013 VACANT 5294 — REGISTERED NURSE SPECIALIST — 048726 — 008 REGISTERED NURSES 1.0 — 29-1141-02
    - 013 MANTILLA YANEZ 5620 — HEALTH FACILITY EVALUATOR II — 037428 — 007 MANAGEMENT ANALYSTS 1.0 — 13-1111-03
    - 013 BAILEY-DOWLING 5224 — PUBLIC HEALTH NUTRITION CONSULTANT — 048806 — 010 DIETITIANS AND NUTRITIONISTS 1.0 — 29-1031-04
    - 013 VACANT 5224 — PUBLIC HEALTH NUTRITION CONSULTANT — 026184 — 010 DIETITIANS AND NUTRITIONISTS 1.0 — 29-1031-04
    - 013 TOMLIN 5294 — REGISTERED NURSE SPECIALIST — 064393 — 008 REGISTERED NURSES 1.0 — 29-1141-02
    - 013 VACANT 5294 — REGISTERED NURSE SPECIALIST — 064607 — 008 REGISTERED NURSES 1.0 — 29-1141-02
  - 013 BROWN-WALKER 5312 — REGISTERED NURSING CONSULTANT — 061413 — 010 REGISTERED NURSES 1.0 — 29-1141-04
    - 013 LUENGO RODRIGUEZ 5294 — REGISTERED NURSE SPECIALIST — 064399 — 008 REGISTERED NURSES 1.0 — 29-1141-02
    - 013 STARKE 5294 — REGISTERED NURSE SPECIALIST — 048724 — 008 REGISTERED NURSES 1.0 — 29-1141-02
    - 013 MCMAHON 5294 — REGISTERED NURSE SPECIALIST — 064199 — 008 REGISTERED NURSES 1.0 — 29-1141-02

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



AGENCY FOR HEALTH CARE ADMINISTRATION

Division of Health Quality Assurance

Bureau of Central Services

Effective Date: July 01, 2022
Org. Level: 68-30-60-10-000
FTE's: 16 Positions: 16

037 FITCH 7264
CHIEF OF CENTRAL SERVICES
058980
021 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-03

037 HEYN 2228
SENIOR MANAGEMENT ANALYST SUPV - SES
048811
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

VACANT
OPS
900346

Background Screening Unit
68-30-60-10-000

ROBINSON 2238
OPERATIONS & MGMT CONSULTANT MGR - SES
064662
020 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-02

037 JORDAN 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064382
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 LOVETT 5894
HEALTH SERVICES & FACILITIES CONSULTANT
061383
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 BURKE 5877
HUMAN SERVICES PROGRAM SPECIALIST
064781
007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0
21-1099-03

037 VACANT 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064570
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 VEIRA 5894
HEALTH SERVICES & FACILITIES CONSULTANT
037815
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 VACANT 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064780
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 VACANT 2238
OPERATIONS & MGMT CONSULTANT MGR - SES
064201
020 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-02

037 LE CONTE 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064411
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

JOHNSON
OPS
900084

VACANT
OPS
900236

037 OWENS 5894
HEALTH SERVICES & FACILITIES CONSULTANT
064140
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

WARD
OPS
900159

037 MAY 0120
RECORDS SPECIALIST
043739
003 INFORMATION AND RECORD CLERKS, ALL OTHER 1.0
43-4199-02

HILL
OPS
900229

037 FLOUNORY 0108
ADMINISTRATIVE SECRETARY
064556
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 GOFF 5894
HEALTH SERVICES & FACILITIES CONSULTANT
061956
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

VACANT
OPS
900208

037 BRYANT 5894
HEALTH SERVICES & FACILITIES CONSULTANT
063533
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

VACANT
OPS
900235

VACANT
OPS
900090

RICHARDSON
OPS
900010

VACANT
OPS
900028

037 CEPHUS 0442
REGULATORY SUPERVISOR/CONSULTANT - SES
053304
007 COMPLIANCE OFFICERS 1.0
13-1041-03

VACANT
OPS
900154

037 VACANT 0120
STAFF ASSISTANT - SES
063448
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 SLOAN 0108
ADMINISTRATIVE SECRETARY
064190
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 CLARKE 0108
ADMINISTRATIVE SECRETARY
064189
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 HORN 0108
ADMINISTRATIVE SECRETARY
064897
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

Financial Analysis Unit
68-30-60-20-000

037 SMITH 1645
REGULATORY ANALYST SUPERVISOR - SES
053310
010 COMPLIANCE OFFICERS 1.0
13-1041-04

037 BROUSSARD 5894
HEALTH SERVICES & FACILITIES CONSULTANT
000614
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

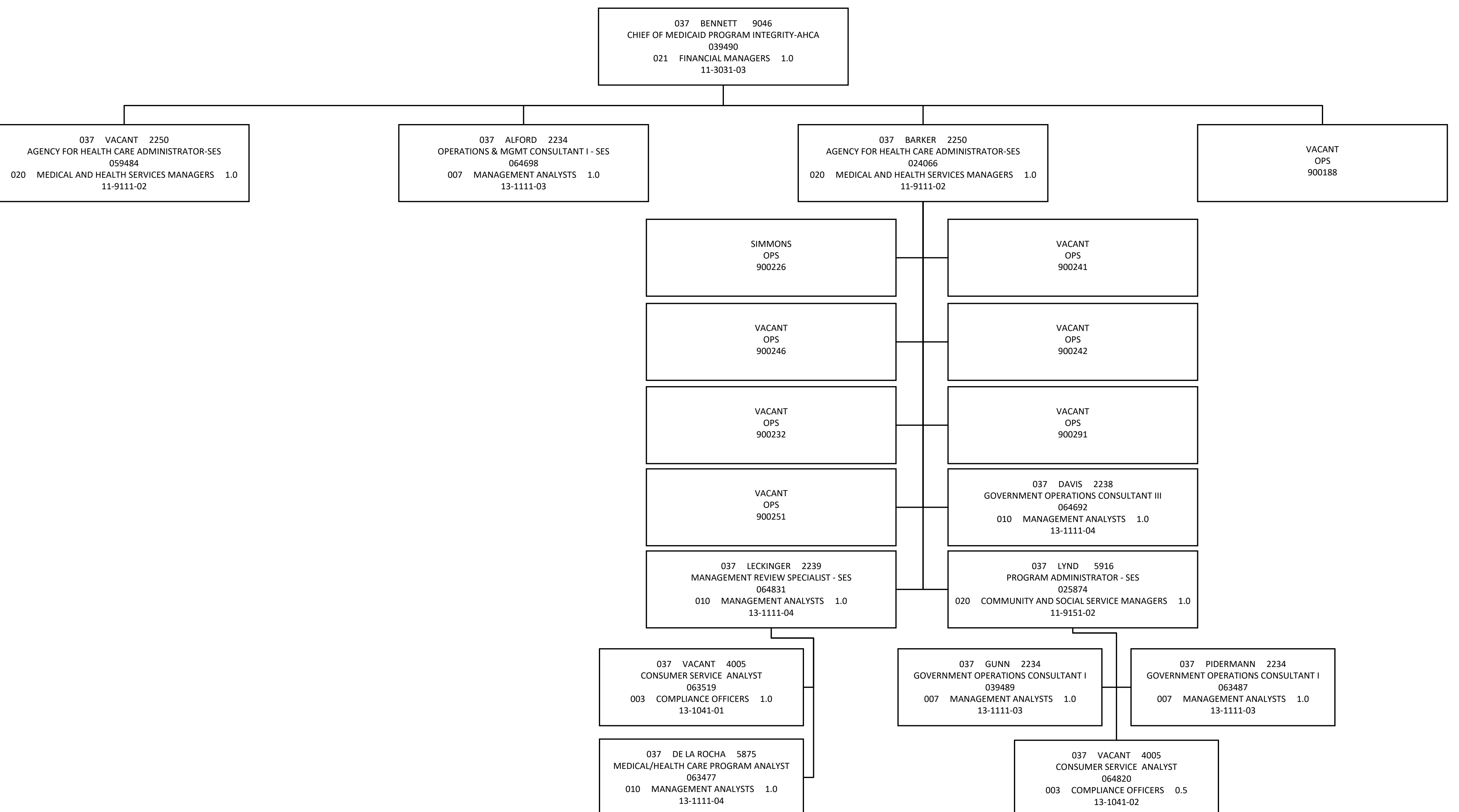
037 NOBLE 5894
HEALTH SERVICES & FACILITIES CONSULTANT
053326
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 WEST 5894
HEALTH SERVICES & FACILITIES CONSULTANT
055063
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

037 HILLMAN 5894
HEALTH SERVICES & FACILITIES CONSULTANT
053312
010 BUSINESS OPERATION SPECIALIST, ALL OTHER 1.0
13-1199-04

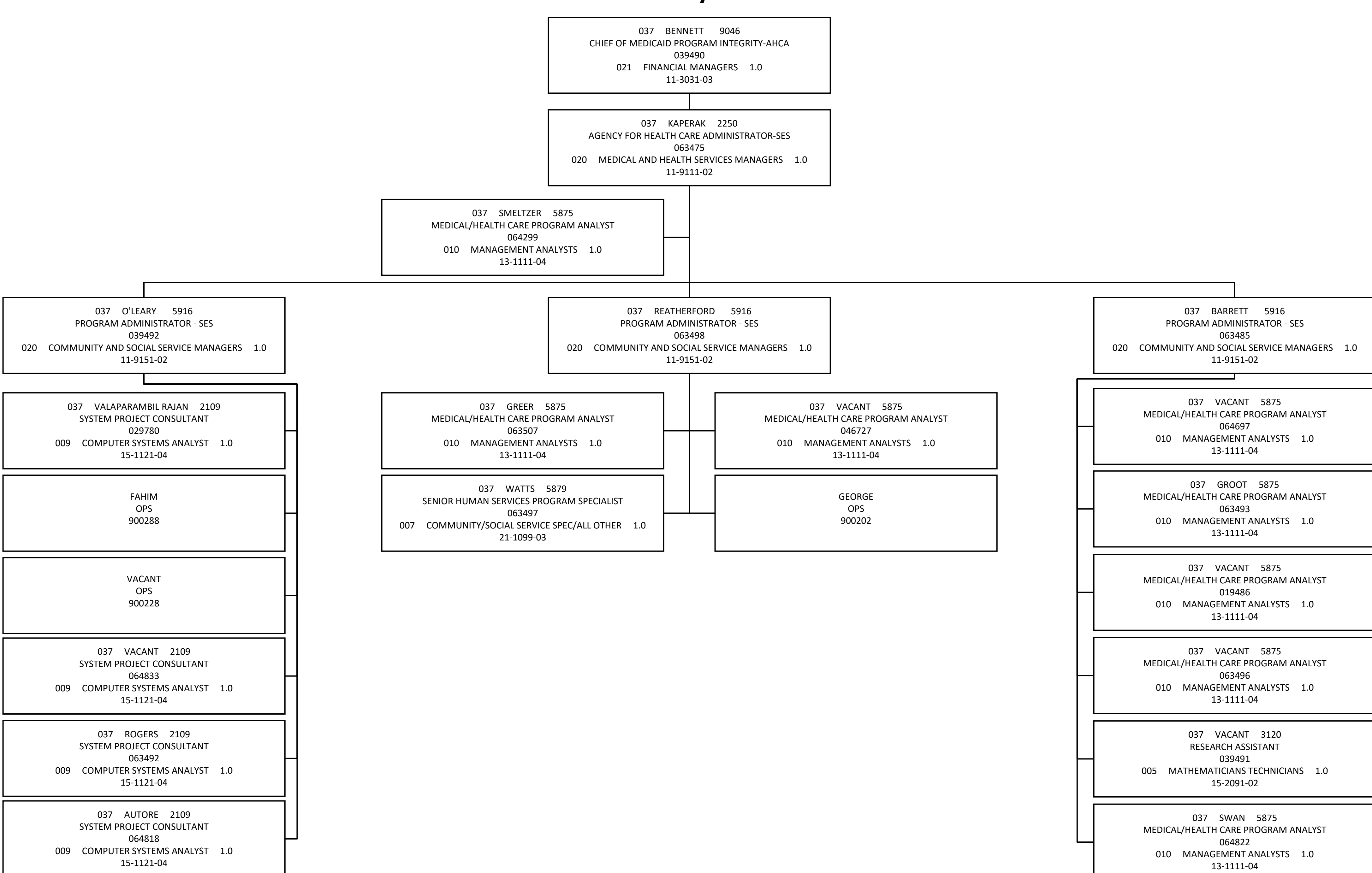
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Medicaid Program Integrity

Effective Date: July 01, 2022
Org. Level: 68-10-30-10-000
FTE's: 73.5 Positions: 74



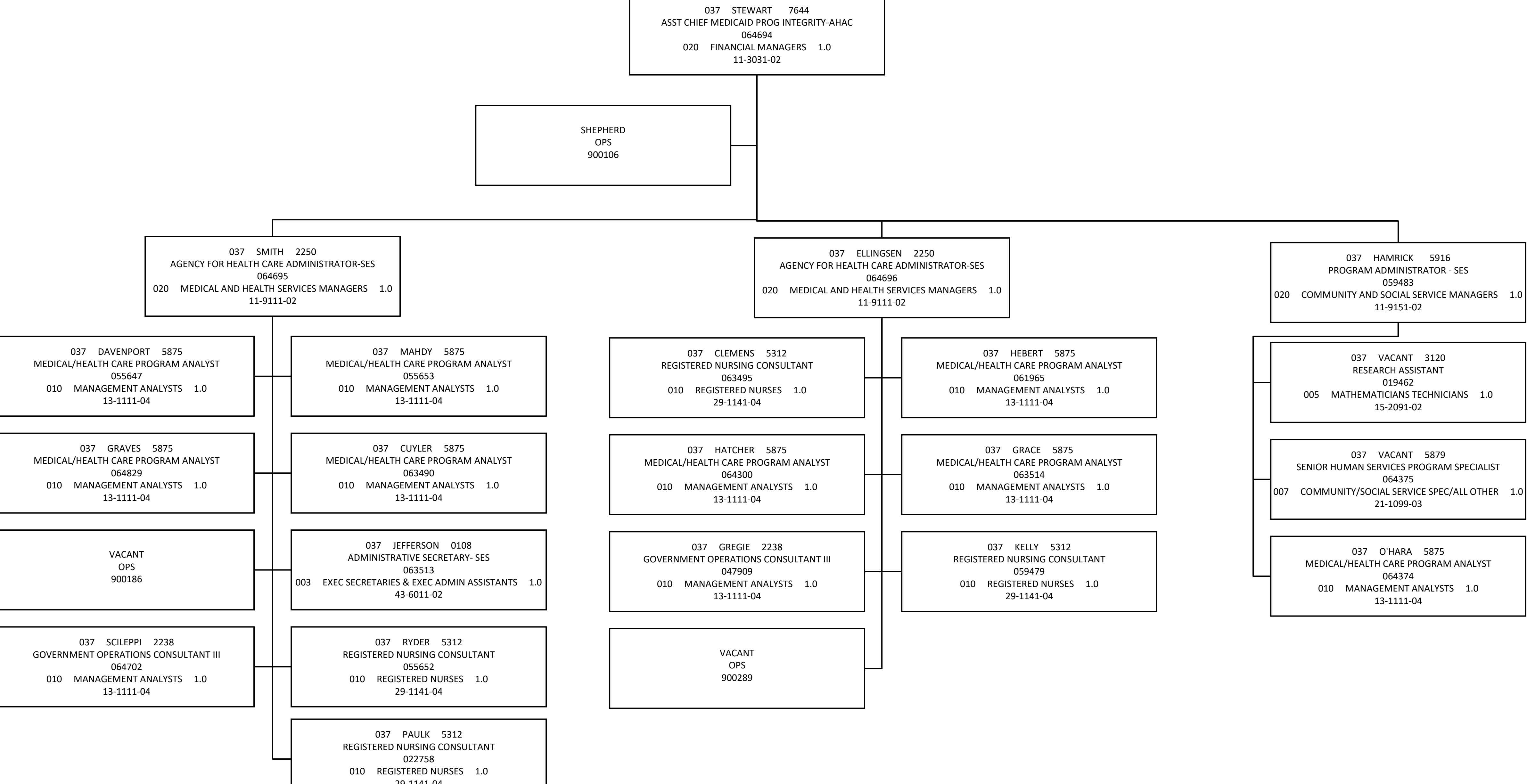
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Medicaid Program Integrity
Data Analysis Unit

Effective Date: July 01, 2022
Org. Level: 68-10-30-10-000
FTE's: 73.5 Positions: 74



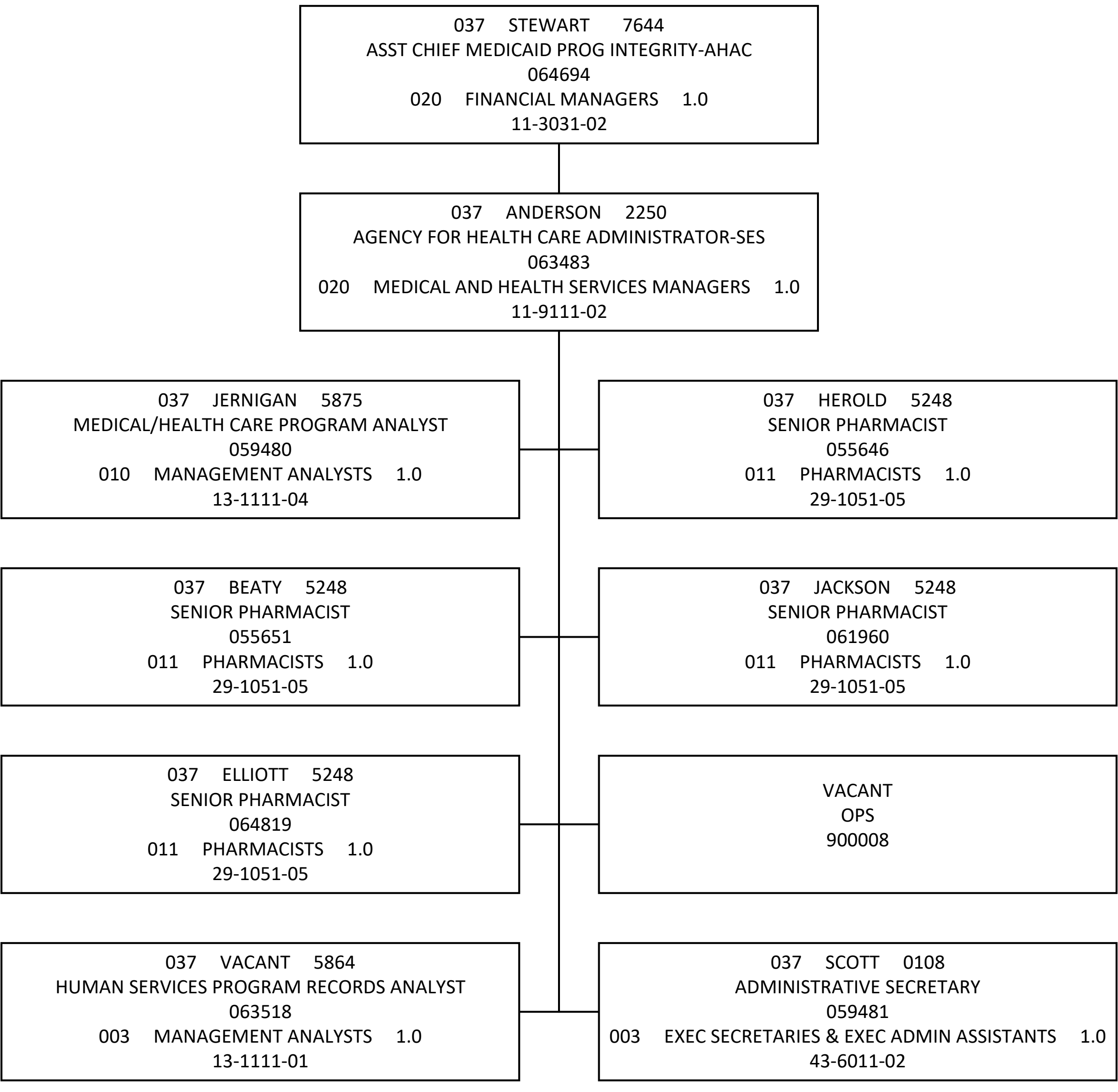
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Medicaid Program Integrity

Effective Date: July 01, 2022
Org. Level: 68-10-30-10-000
FTE's: 73.5 Positions: 74



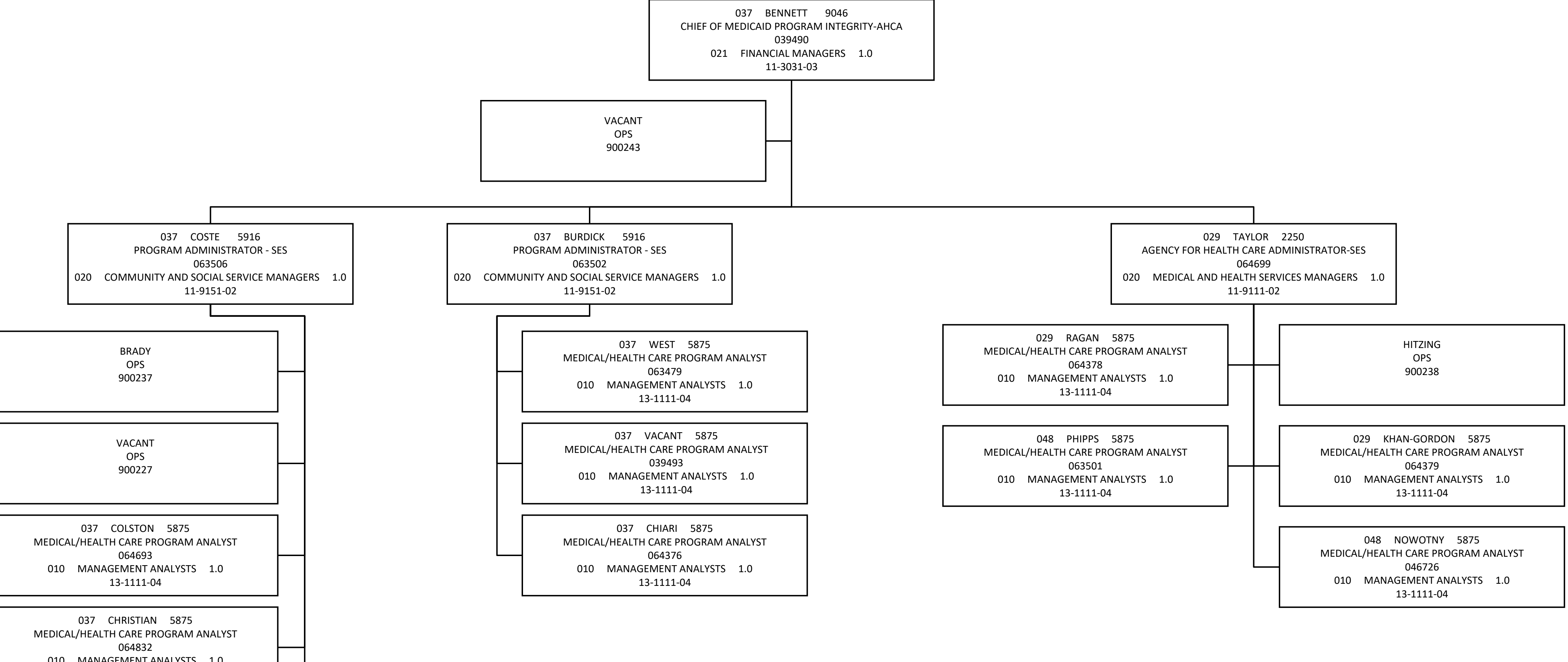
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Medicaid Program Integrity

Effective Date: July 01, 2022
Org. Level: 68-10-30-10-000
FTE's: 73.5 Positions: 74



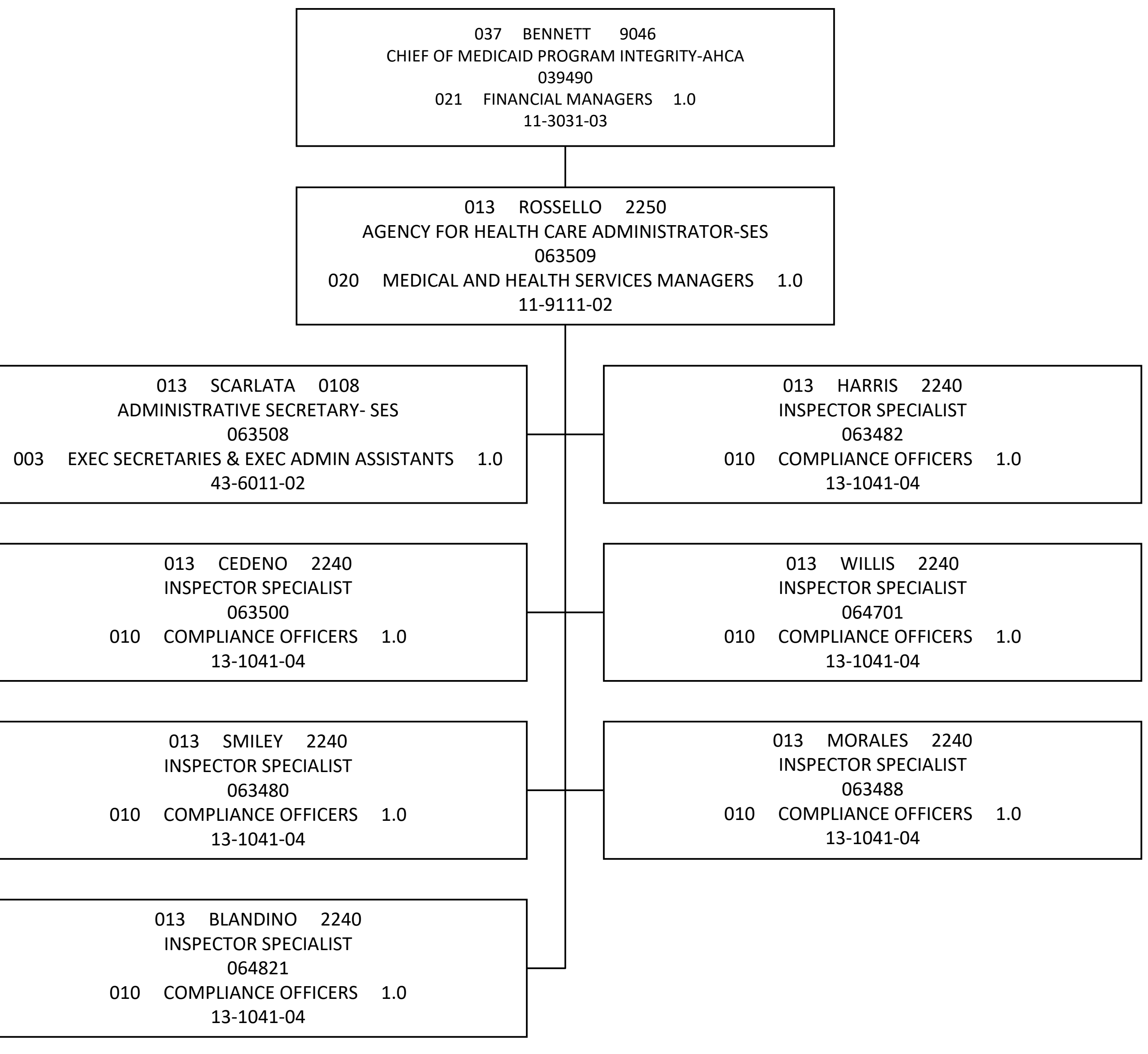
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Medicaid Program Integrity

Effective Date: July 01, 2022
Org. Level: 68-10-30-10-000
FTE's: 73.5 Positions: 74



AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Health Quality Assurance
Bureau of Medicaid Program Integrity
Field Operations Miami

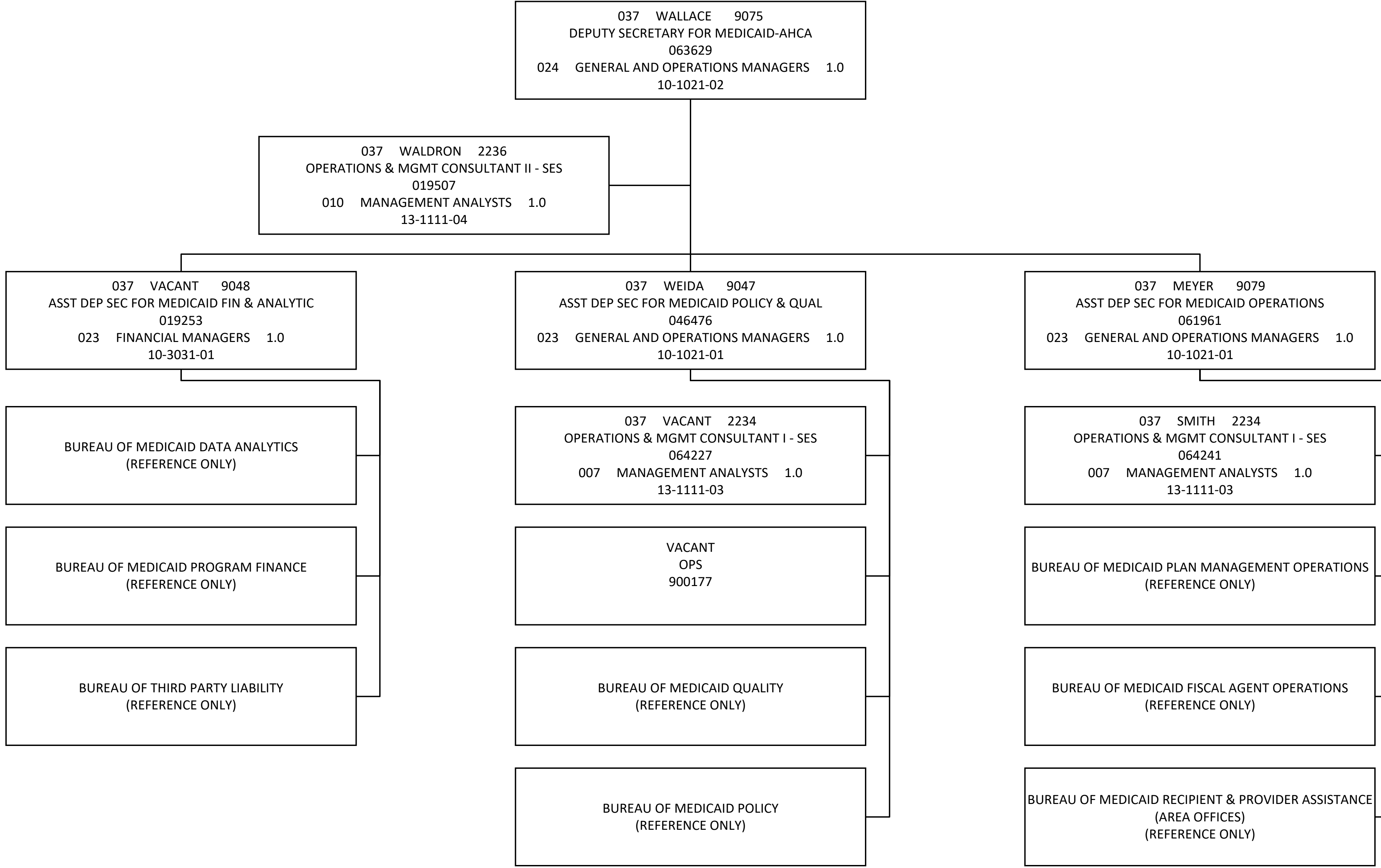
Effective Date: July 01, 2022
Org. Level: 68-10-30-10-011
FTE's: 8 Positions: 8



Division of Medicaid FTE's: 526.5
Division of Medicaid # of Positions: 528

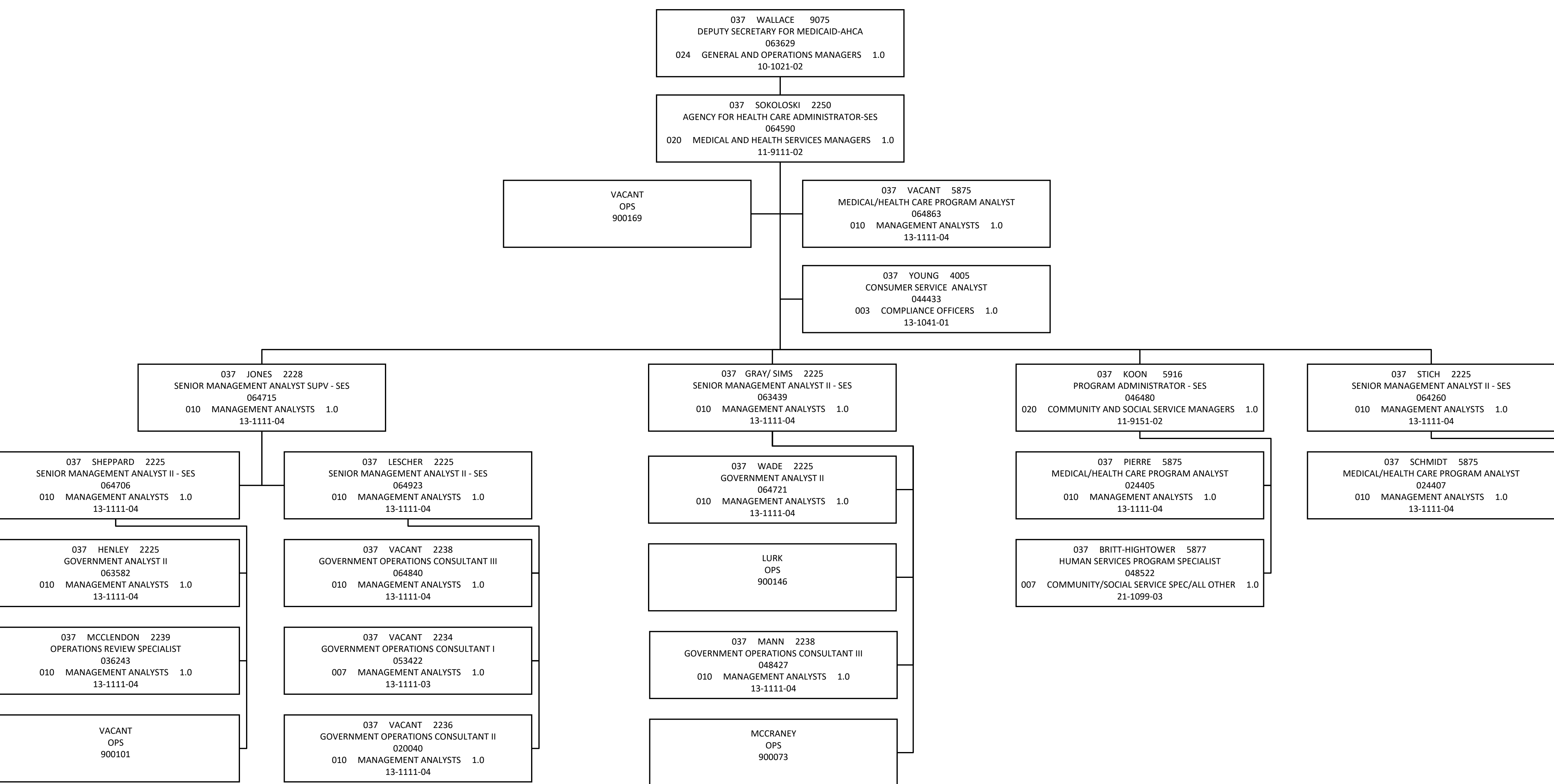
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Deputy Secretary's Office

Effective Date: July 01, 2022
Org. Level: 68-40-00-00-000
FTE's: 27 Positions: 27



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

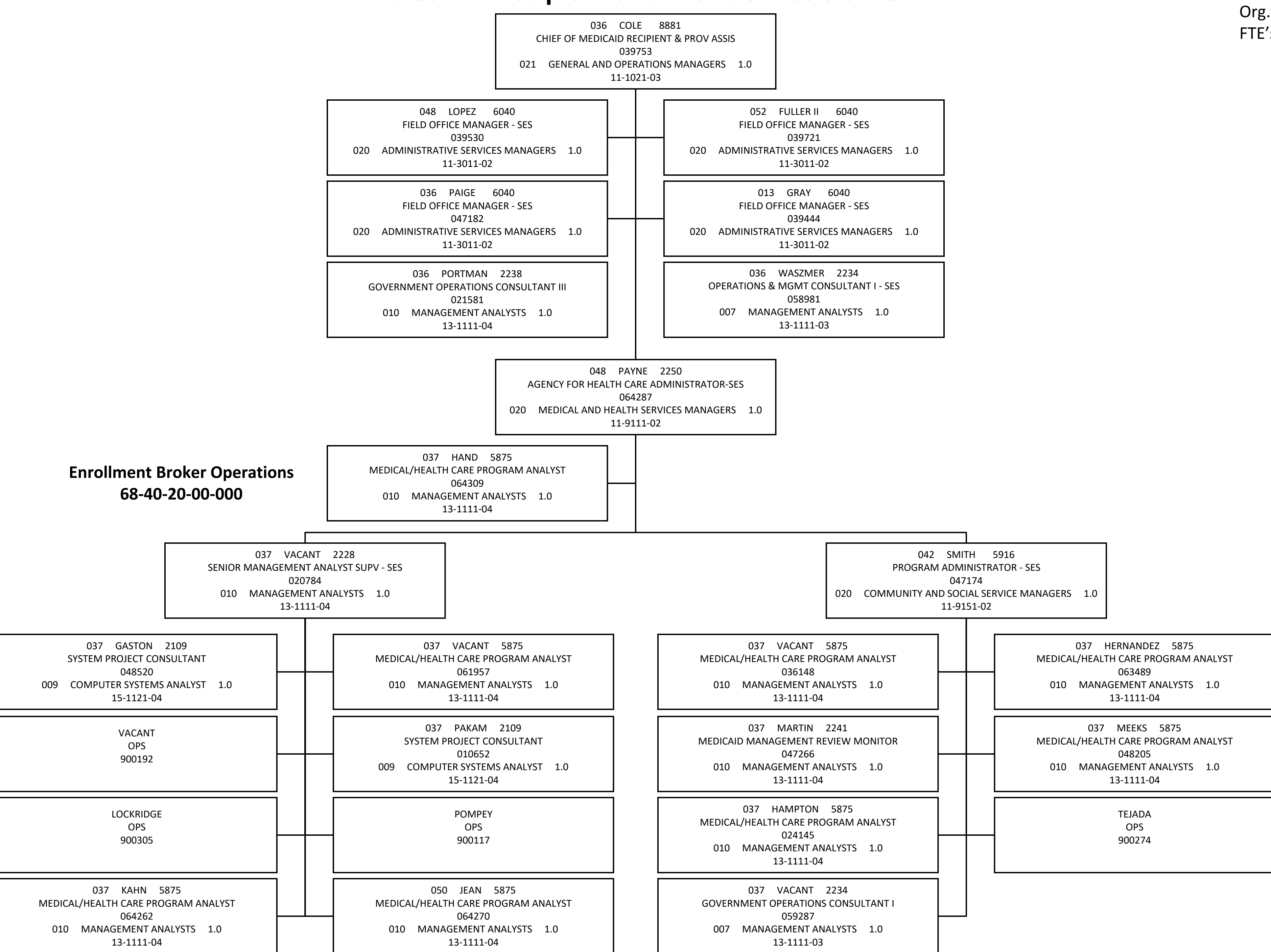
Effective Date: July 01, 2022
Org. Level: 68-40-00-00-000
FTE's: 27 Positions: 27



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

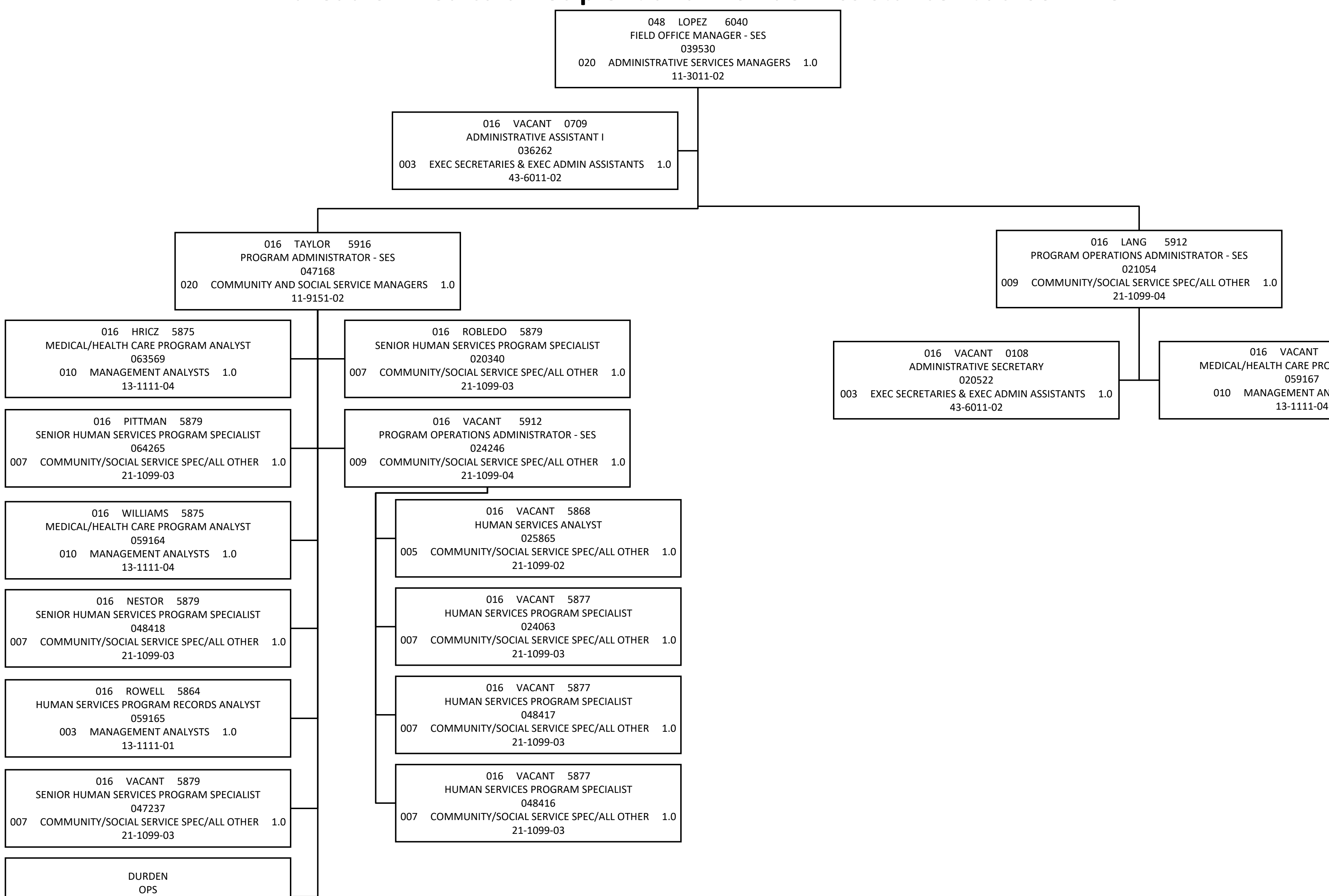
Effective Date: July 01, 2022
Org. Level: 68-40-10-00-000
FTE's: 4 Positions:4

Org. Level: 68-40-20-00-000
FTE's: 18 Positions:18



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

Effective Date: July 01, 2022
Org. Level: 68-40-10-04-000
FTE's: 22 Positions: 22



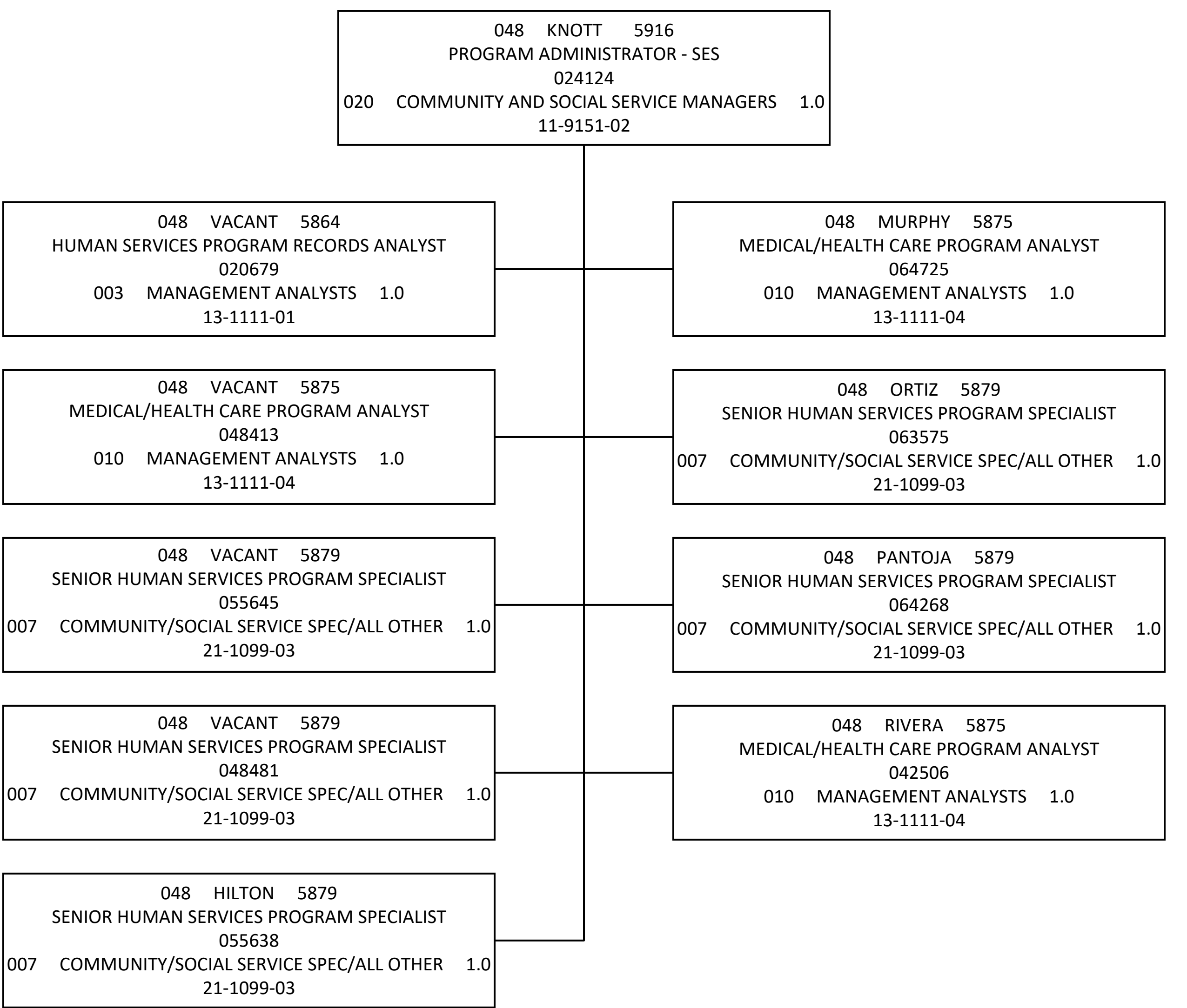
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance – St. Petersburg

Effective Date: July 01, 2022
Org. Level: 68-40-10-05-000
FTE's: 36 Positions: 36

- 036 COLE 8881 — CHIEF OF MEDICAID RECIPIENT & PROV ASSIS — 039753 — 021 GENERAL AND OPERATIONS MANAGERS 1.0 — 11-1021-03
  - 052 FULLER II 6040 — FIELD OFFICE MANAGER - SES — 039721 — 020 ADMINISTRATIVE SERVICES MANAGERS 1.0 — 11-3011-02
    - 052 SCHWEIKERT 0440 — REGULATORY SPECIALIST I — 036282 — 003 COMPLIANCE OFFICERS 1.0 — 13-1041-01
    - 052 THOMPSON 5875 — MEDICAL/HEALTH CARE PROGRAM ANALYST — 036255 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04
    - 052 MULLIGAN 5916 — PROGRAM ADMINISTRATOR - SES — 059398 — 020 COMMUNITY AND SOCIAL SERVICE MANAGERS 1.0 — 11-9151-02
      - 052 VACANT 0108 — ADMINISTRATIVE SECRETARY — 024301 — 003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0 — 43-6011-02
      - 017 SPRING 5875 — MEDICAL/HEALTH CARE PROGRAM ANALYST — 059328 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04
      - 052 GREEN 5864 — HUMAN SERVICES PROGRAM RECORDS ANALYST — 021186 — 003 MANAGEMENT ANALYSTS 1.0 — 13-1111-01
      - 052 LOUNSBERRY 5912 — PROGRAM OPERATIONS ADMINISTRATOR - SES — 048488 — 009 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-04
        - 052 FERNANDEZ 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 020163 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 052 HEAROD 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048485 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 052 NUGENT BELNAVIS 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048486 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 052 TAVAREZ 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048484 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 052 THOMPSON 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048483 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 052 COLQUITT 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 058971 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 052 MARTIN 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 021131 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 036 STAHLER 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048527 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 017 WHITESIDE 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 053446 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 052 HUGHART 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 053506 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 017 VINSKI III 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048474 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 052 VACANT 5875 — MEDICAL/HEALTH CARE PROGRAM ANALYST — 021065 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04
    - 052 NINIS 5916 — PROGRAM ADMINISTRATOR - SES — 047177 — 020 COMMUNITY AND SOCIAL SERVICE MANAGERS 1.0 — 11-9151-02
      - 029 FULLER 5912 — PROGRAM OPERATIONS ADMINISTRATOR - SES — 021401 — 009 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-04
        - 029 FITZGERALD 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048525 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 029 POMALES HERNANDEZ 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 064724 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 029 PETERSON 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048530 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 029 BENAVIDES 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 047183 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 029 VACANT 0108 — ADMINISTRATIVE SECRETARY — 043636 — 003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0 — 43-6011-02
        - 029 DAVIS 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 053461 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
        - 029 COTERA 5864 — HUMAN SERVICES PROGRAM RECORDS ANALYST — 047262 — 003 MANAGEMENT ANALYSTS 1.0 — 13-1111-01
      - 052 NEWSOME 5875 — MEDICAL/HEALTH CARE PROGRAM ANALYST — 019096 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04
      - 052 WESSEL 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 021191 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 052 BARNARD 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 064266 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 052 ARMISTEAD 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 048519 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 052 MOORE 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 024294 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
    - 048 SMITH 5916 — PROGRAM ADMINISTRATOR - SES — 047158 — 020 COMMUNITY AND SOCIAL SERVICE MANAGERS 1.0 — 11-9151-02
      - 048 PEREZ 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 053474 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 048 HERNANDEZ 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 024649 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 048 ANDERSON 5875 — MEDICAL/HEALTH CARE PROGRAM ANALYST — 064229 — 010 MANAGEMENT ANALYSTS 1.0 — 13-1111-04
      - 016 HAGLEY 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 020614 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03
      - 016 HARRIS 5879 — SENIOR HUMAN SERVICES PROGRAM SPECIALIST — 053421 — 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 — 21-1099-03

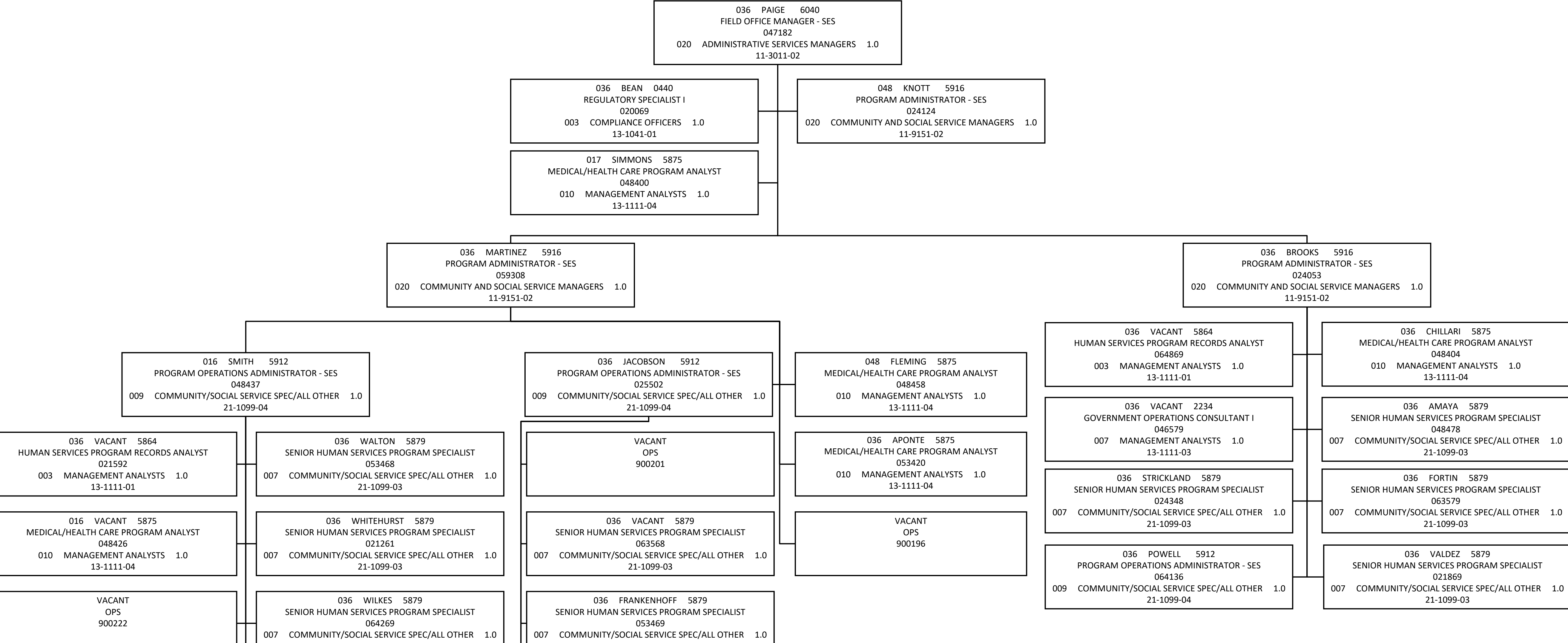
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance – Orlando

Effective Date: July 01, 2022
Org. Level: 68-40-10-07-000
FTE's: 11 Positions: 11



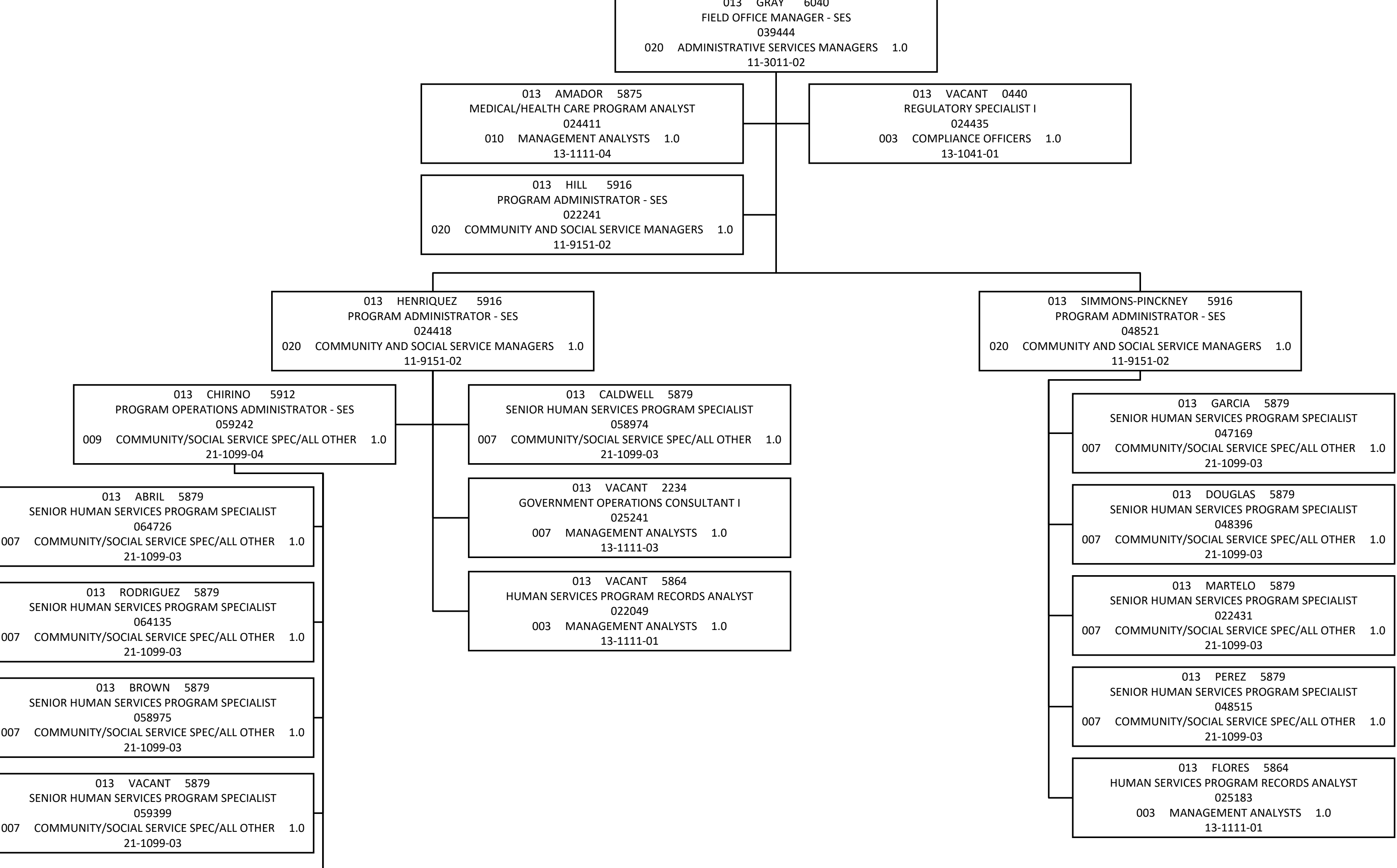
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance – Ft. Myers

Effective Date: July 01, 2022
Org. Level: 68-40-10-08-000
FTE's: 29 Positions: 29



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

Effective Date: July 01, 2022
Org. Level: 68-40-10-11-000
FTE's: 26 Positions: 26



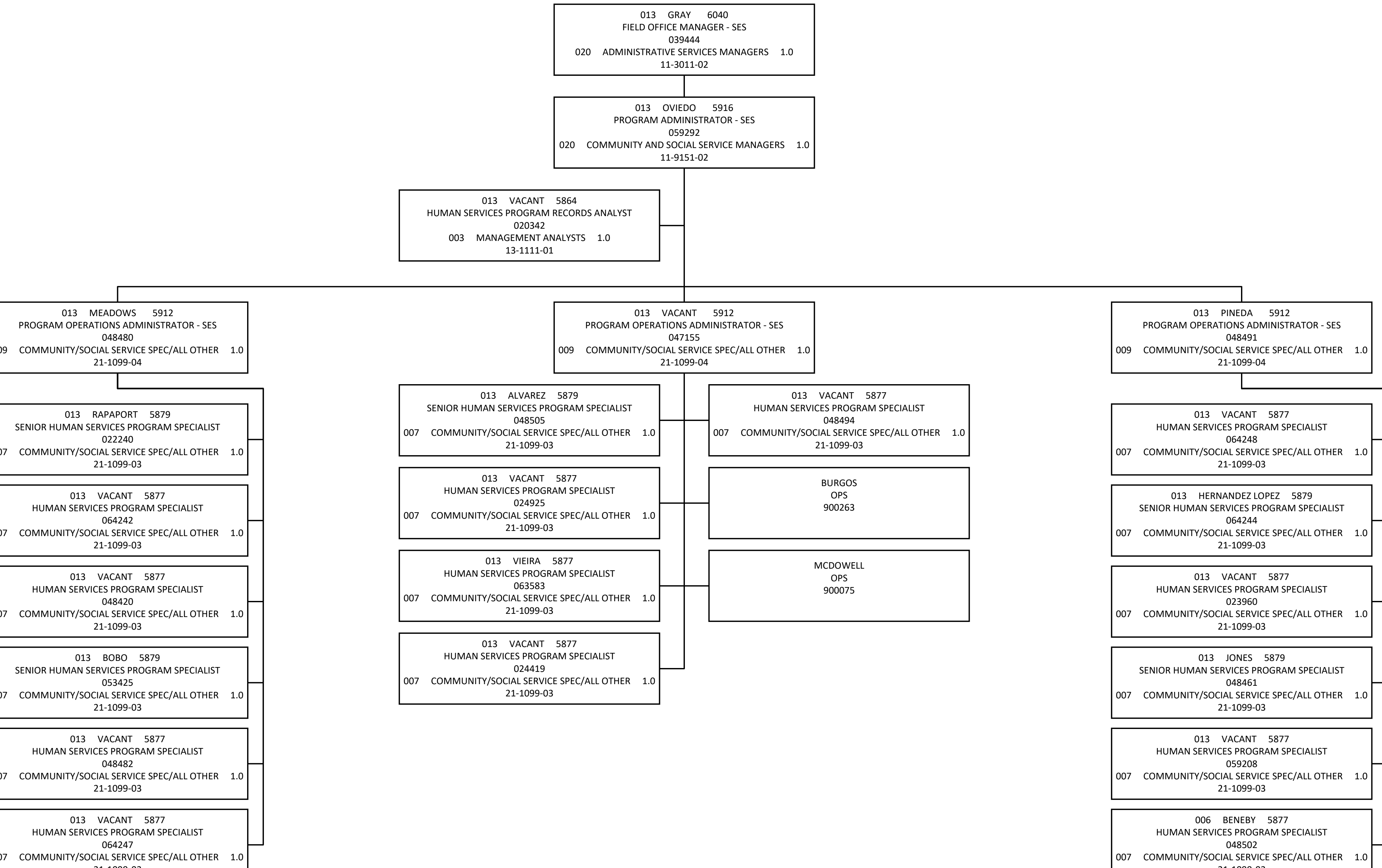
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance
Enrollment Broker Operations – Contact Center Orlando

Effective Date: July 01, 2022
Org. Level: 68-40-20-07-000
FTE's: 22 Positions: 22

- 048 LOPEZ 6040 – FIELD OFFICE MANAGER - SES – 039530 – 020 ADMINISTRATIVE SERVICES MANAGERS 1.0 – 11-3011-02
  - 048 WOOD 5875 – MEDICAL/HEALTH CARE PROGRAM ANALYST – 053447 – 010 MANAGEMENT ANALYSTS 1.0 – 13-1111-04
  - 048 SHAW 0440 – REGULATORY SPECIALIST I – 063584 – 003 COMPLIANCE OFFICERS 1.0 – 13-1041-01
  - 048 YOUNG 5875 – MEDICAL/HEALTH CARE PROGRAM ANALYST – 063570 – 010 MANAGEMENT ANALYSTS 1.0 – 13-1111-04
  - 017 JACKSON 5916 – PROGRAM ADMINISTRATOR - SES – 024372 – 020 COMMUNITY AND SOCIAL SERVICE MANAGERS 1.0 – 11-9151-02
    - 048 REYES 5864 – HUMAN SERVICES PROGRAM RECORDS ANALYST – 058976 – 003 MANAGEMENT ANALYSTS 1.0 – 13-1111-01
    - 048 DODOLL 5912 – PROGRAM OPERATIONS ADMINISTRATOR - SES – 020090 – 009 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-04
      - 048 SCOTT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 063577 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 048415 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 CHIN 5879 – SENIOR HUMAN SERVICES PROGRAM SPECIALIST – 045555 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 THURSTON 5879 – SENIOR HUMAN SERVICES PROGRAM SPECIALIST – 053473 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 SANTIAGO 5879 – SENIOR HUMAN SERVICES PROGRAM SPECIALIST – 048470 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 048556 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 019763 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - AYALA SANTIAGO – OPS – 900181
    - 048 GARCIA 5912 – PROGRAM OPERATIONS ADMINISTRATOR - SES – 063562 – 009 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-04
      - 048 AUGUSTIN-LEOW 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 063574 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 058972 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 DECEMBRE 5879 – SENIOR HUMAN SERVICES PROGRAM SPECIALIST – 022984 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 063571 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 SCOTT 5879 – SENIOR HUMAN SERVICES PROGRAM SPECIALIST – 048535 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 WILLIAMS 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 020609 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VELEZ 5879 – SENIOR HUMAN SERVICES PROGRAM SPECIALIST – 048487 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
    - 017 HENDERSON 5912 – PROGRAM OPERATIONS ADMINISTRATOR - SES – 061964 – 009 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-04
      - VOLTA – OPS – 900281
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 047562 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 CRUZ 5879 – SENIOR HUMAN SERVICES PROGRAM SPECIALIST – 024858 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 017 MCGINNIS 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 025964 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 RUIZ 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 063576 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 058973 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03
      - 048 VACANT 5877 – HUMAN SERVICES PROGRAM SPECIALIST – 021587 – 007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0 – 21-1099-03

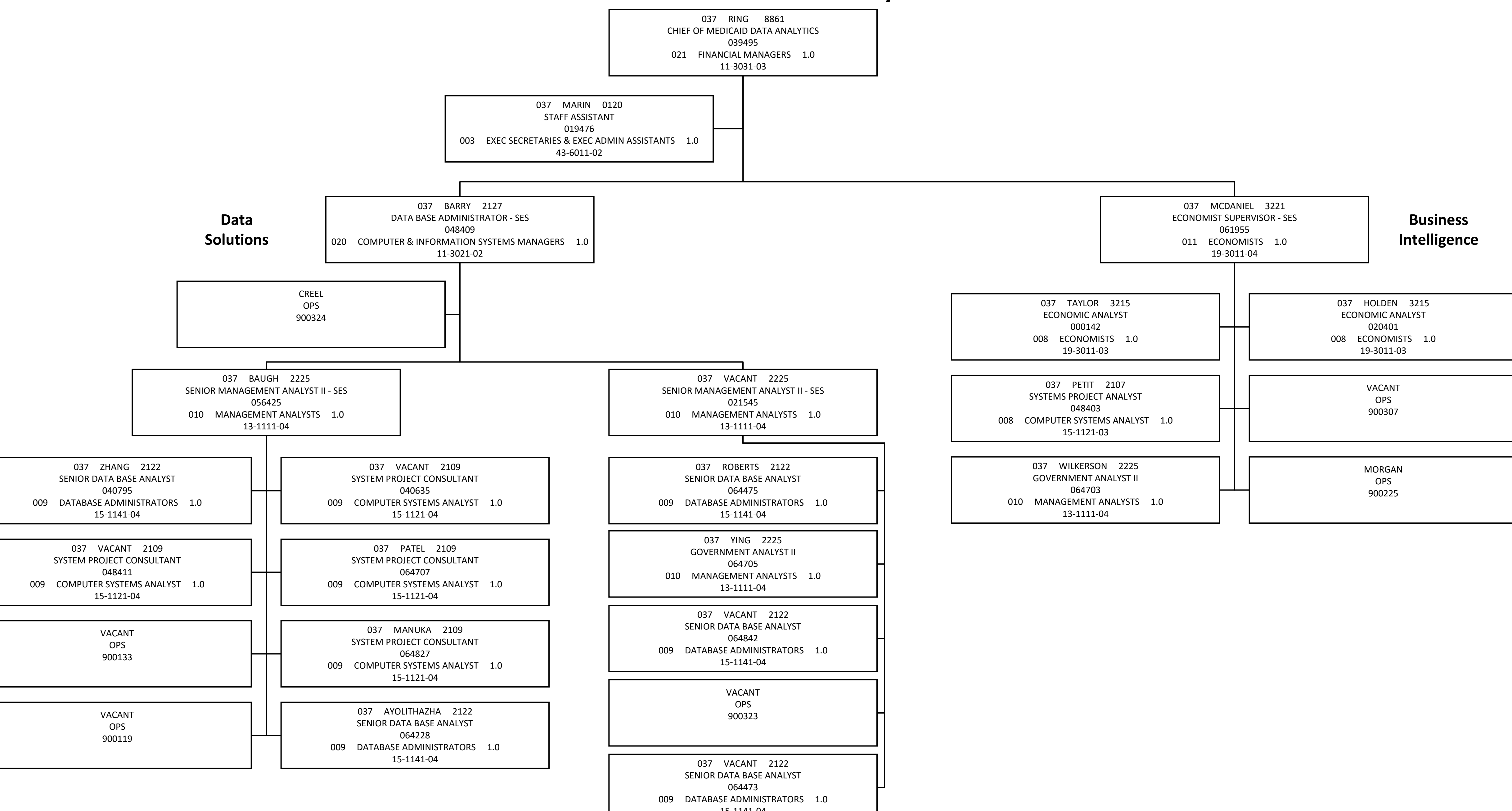
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Recipient and Provider Assistance
Enrollment Broker Operations – Contact Center Miami

Effective Date: July 01, 2022
Org. Level: 68-40-20-11-000
FTE's: 22 Positions: 22



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

Effective Date: July 01, 2022
Org. Level: 68-40-40-00-000
FTE's: 30 Positions: 30



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

Effective Date: July 01, 2022
Org. Level: 68-40-40-00-000
FTE's: 30 Positions: 30

037 RING 8861
CHIEF OF MEDICAID DATA ANALYTICS
039495
021 FINANCIAL MANAGERS 1.0
11-3031-03

Federal Reporting & Focused Studies

037 BOSQUE 2228
SENIOR MANAGEMENT ANALYST SUPV - SES
064151
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 PATE 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
024095
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 HU 3215
ECONOMIC ANALYST
064841
008 ECONOMISTS 1.0
19-3011-03

037 HOLTON 2225
GOVERNMENT ANALYST II
064813
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 RHODES 2122
SENIOR DATA BASE ANALYST
064256
009 DATABASE ADMINISTRATORS 1.0
15-1141-04

037 VACANT 2109
SYSTEM PROJECT CONSULTANT
061963
009 COMPUTER SYSTEMS ANALYST 1.0
15-1121-04

Actuarial Services

037 CROWE 3221
ECONOMIST SUPERVISOR - SES
046114
011 ECONOMISTS 1.0
19-3011-04

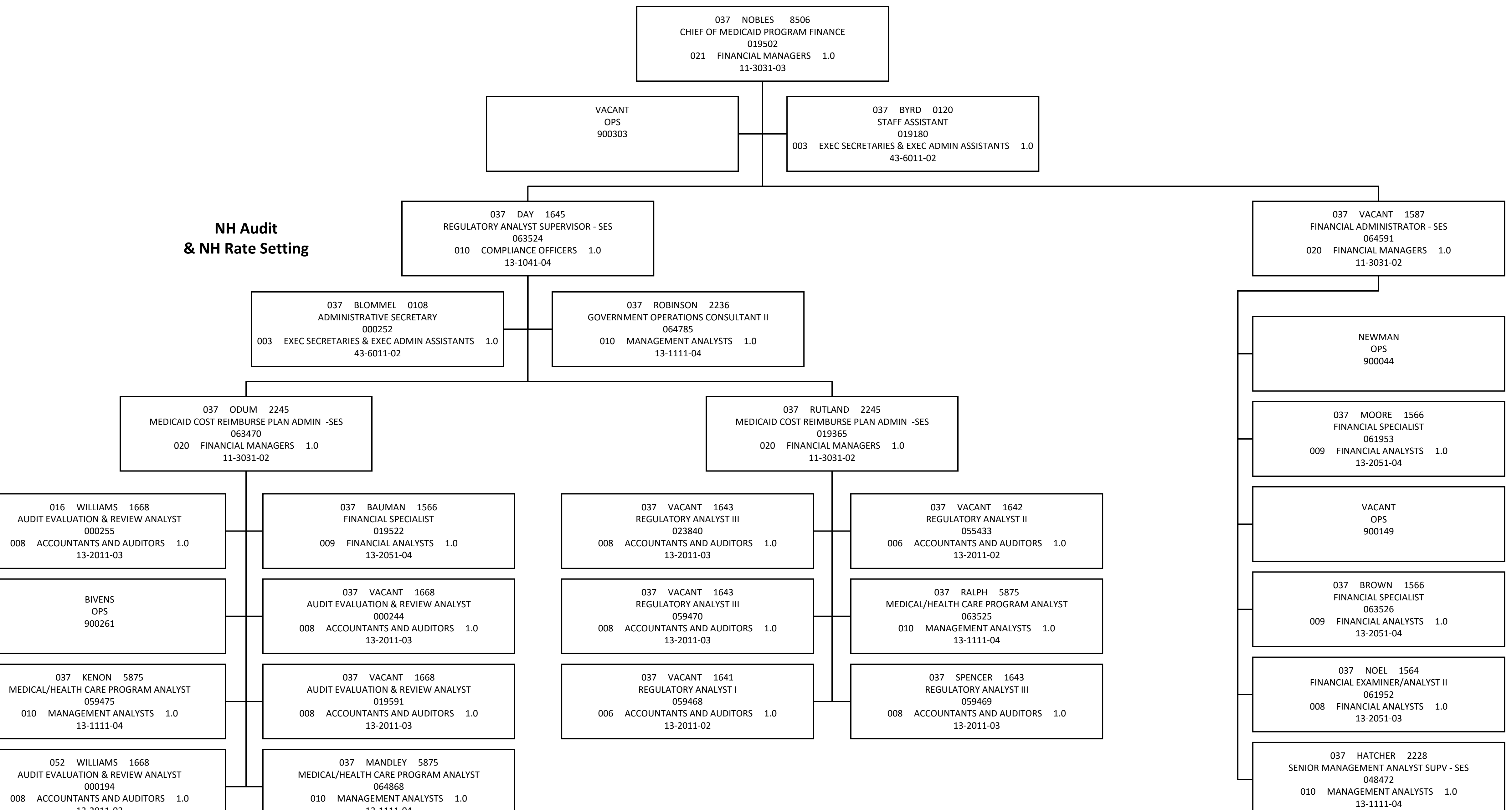
037 GARDY 8701
SENIOR ACTUARIAL ANALYST
064716
012 ACTUARIES 1.0
15-2011-04

037 JONES 3142
RESEARCH & STATISTICS CONSULTANT
019523
008 STATISTICIANS 1.0
15-2041-03

037 CAI 8701
SENIOR ACTUARIAL ANALYST
064839
012 ACTUARIES 1.0
15-2011-04

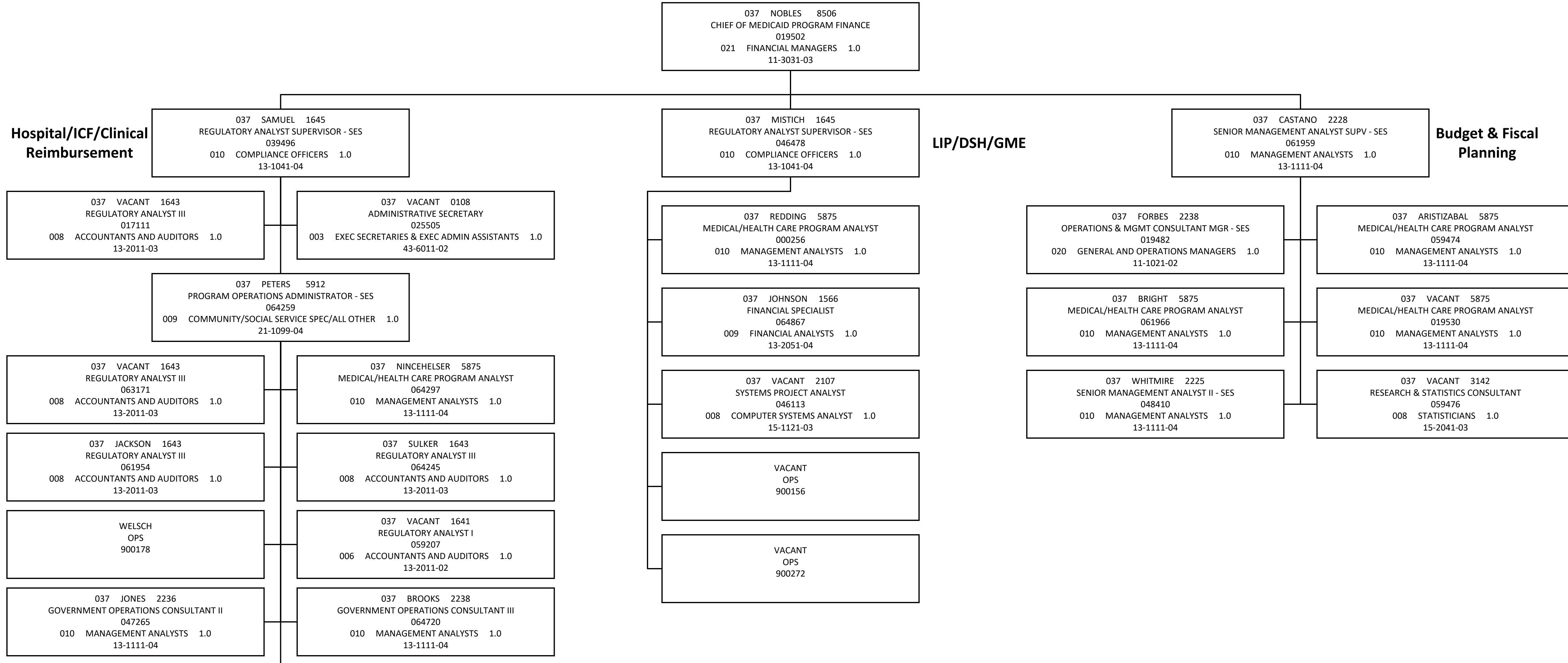
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Program Finance

Effective Date: July 01, 2022
Org. Level: 68-40-50-00-000
FTE's: 49 Positions: 49



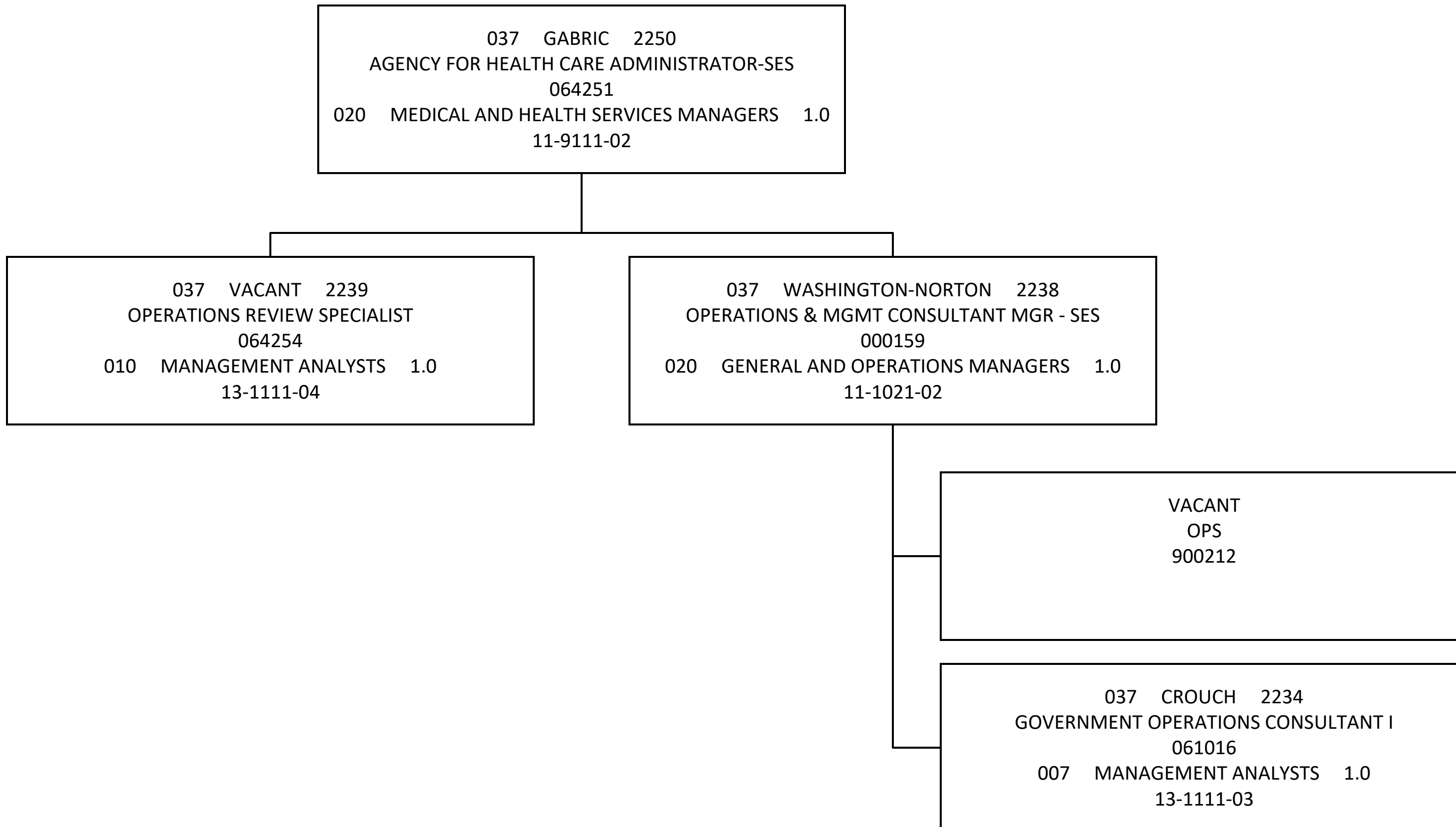
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Program Finance

Effective Date: July 01, 2022
Org. Level: 68-40-50-00-000
FTE's: 49 Positions: 49



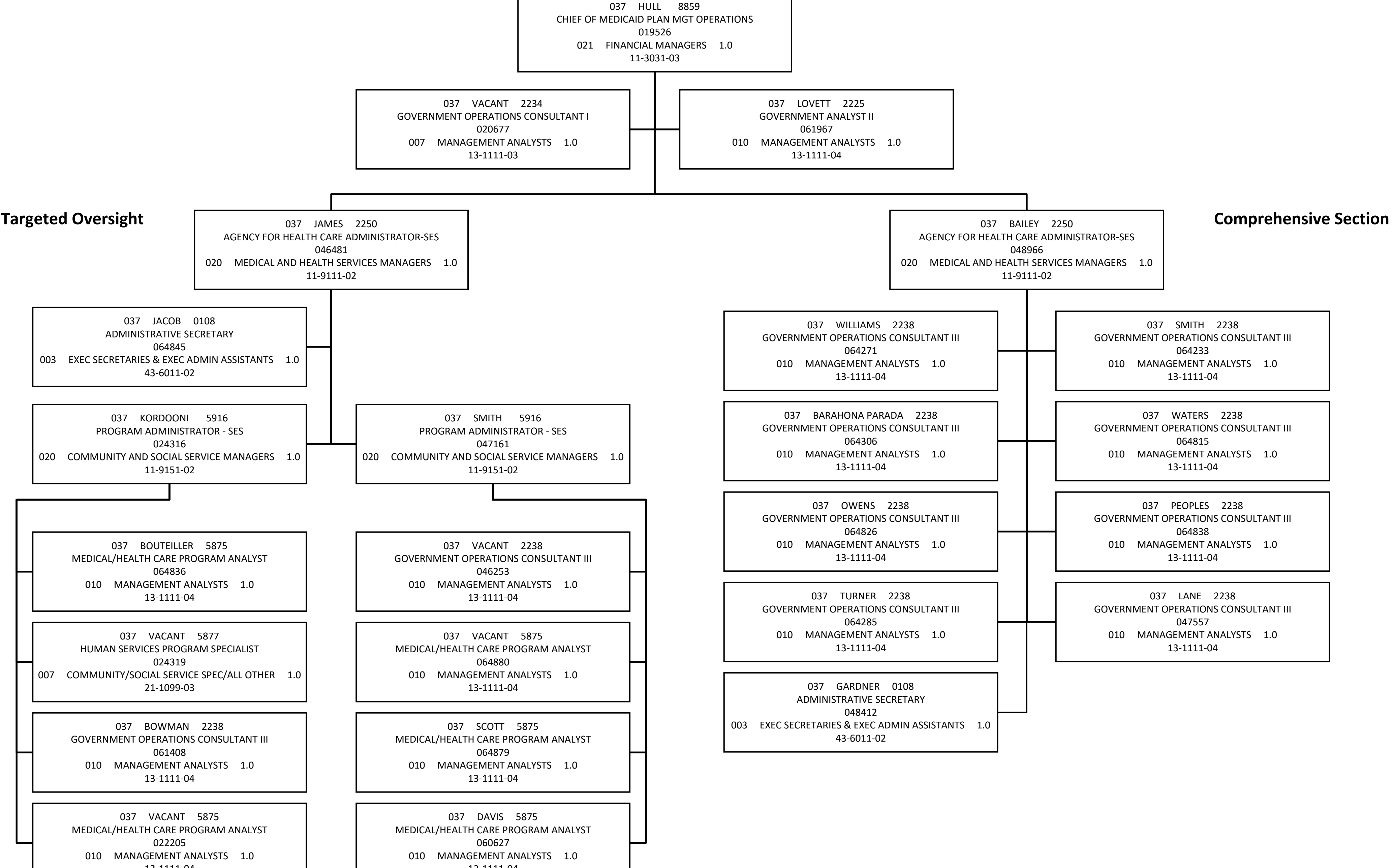
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Third Party Liability

Effective Date: July 01, 2022
Org. Level: 68-40-00-00-001
FTE's: 4 Positions: 4



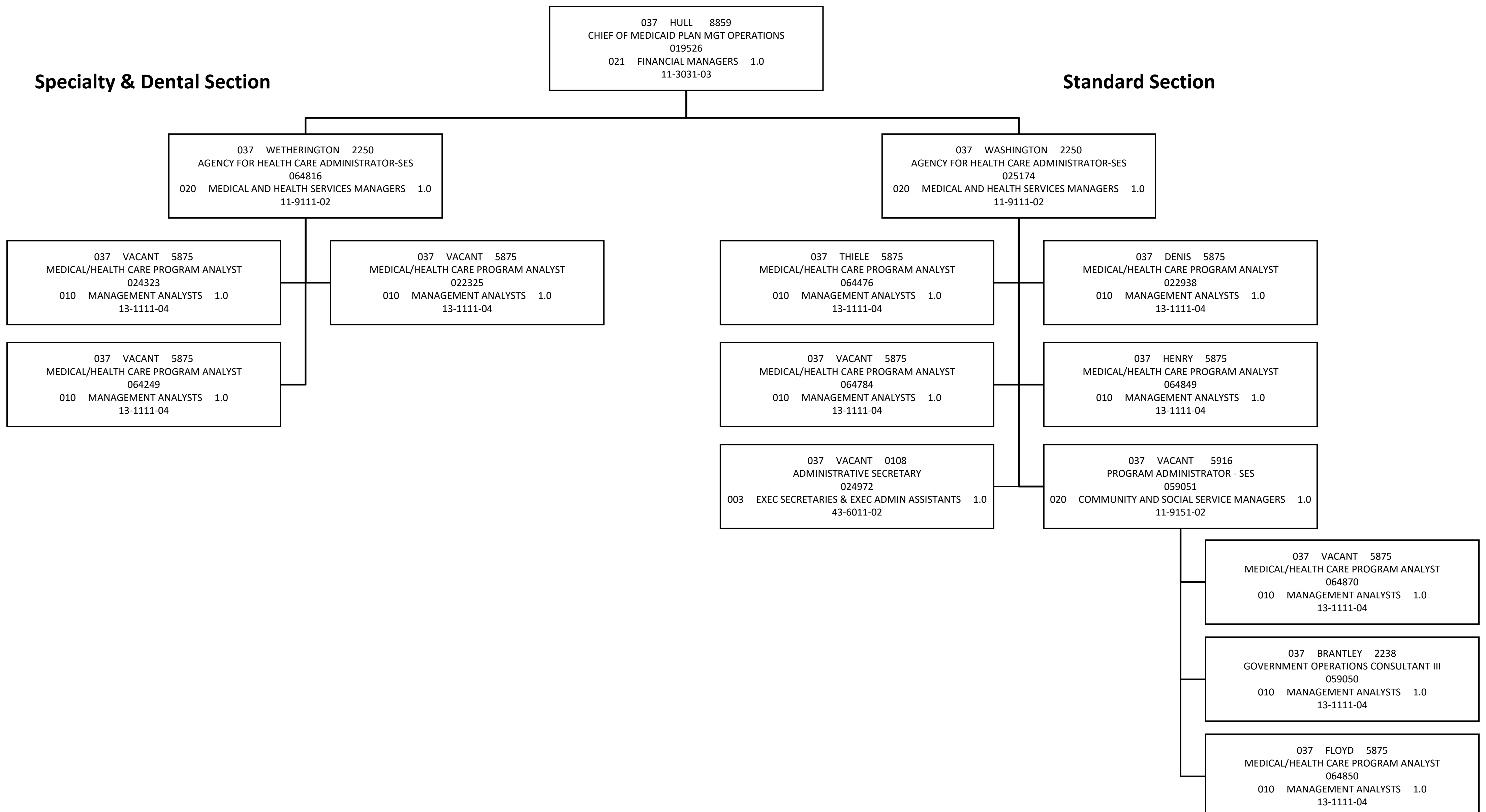
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Plan Management Operations

Effective Date: July 01, 2022
Org. Level: 68-40-30-00-000
FTE's: 44 Positions: 45



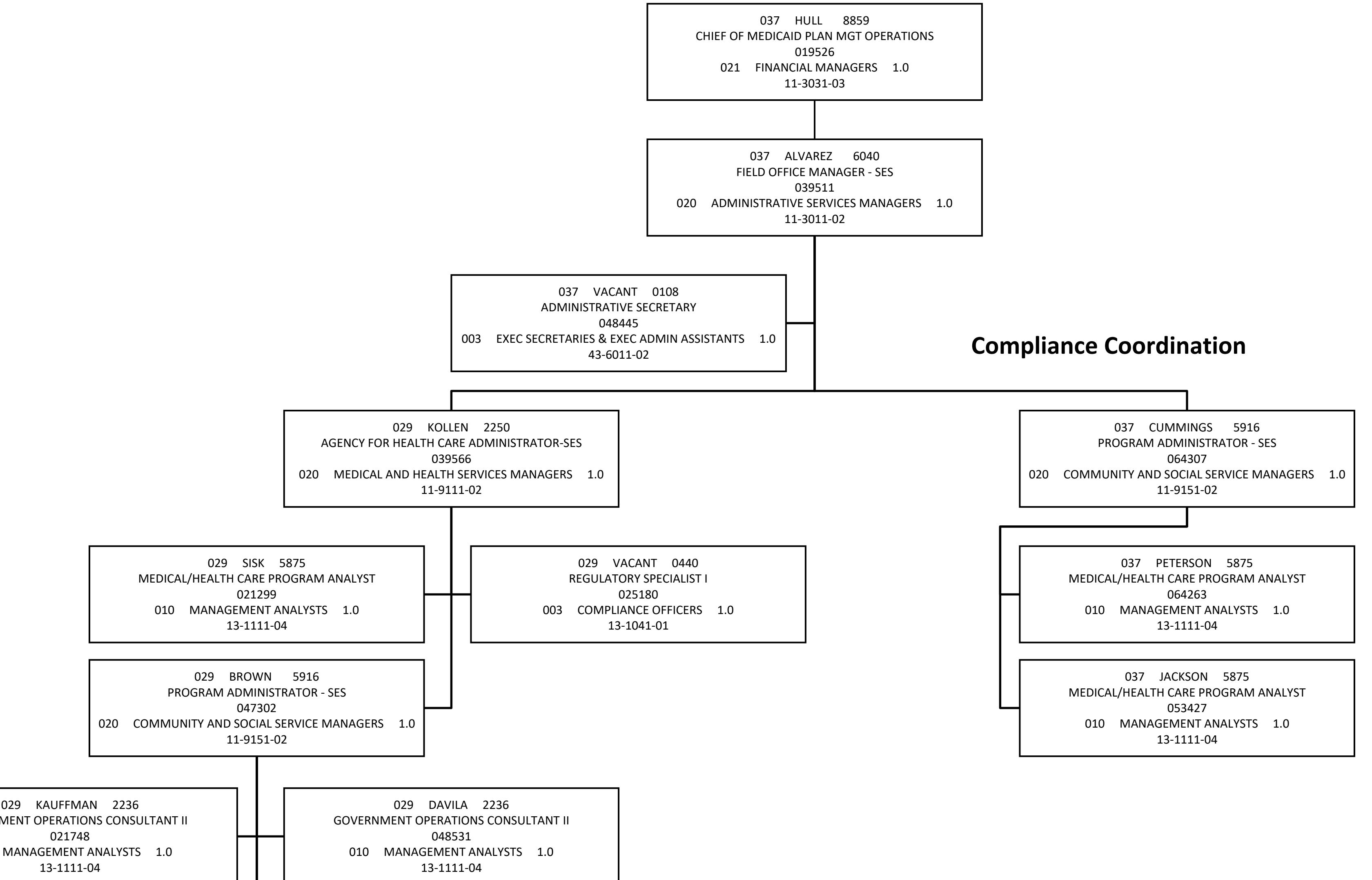
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Plan Management Operations

Effective Date: July 01, 2022
Org. Level: 68-40-30-00-000
FTE's: 44 Positions: 45



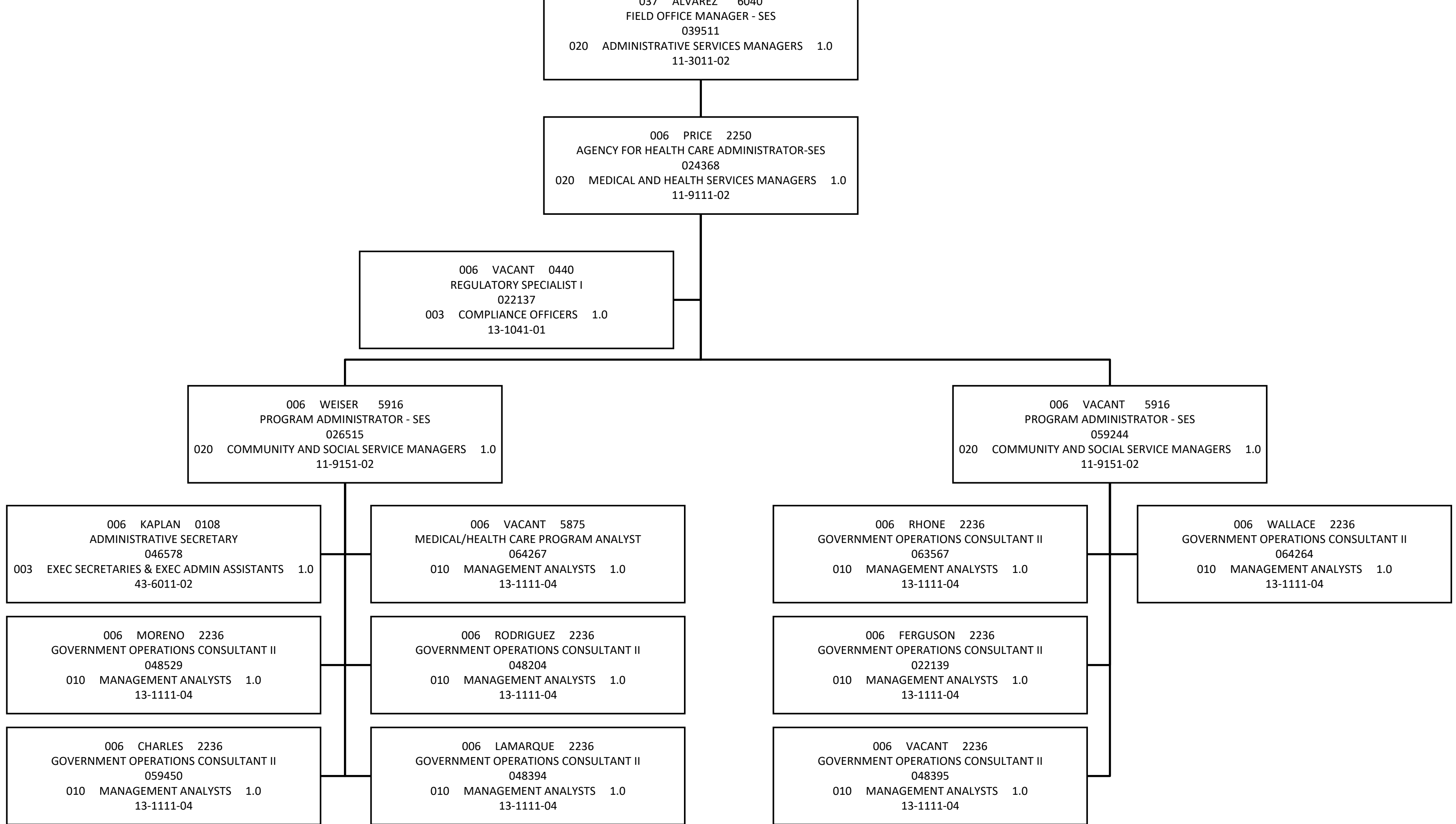
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Plan Management Operations - Tampa

Effective Date: July 01, 2022
Org. Level: 68-40-30-06-000
FTE's: 9 Positions: 9



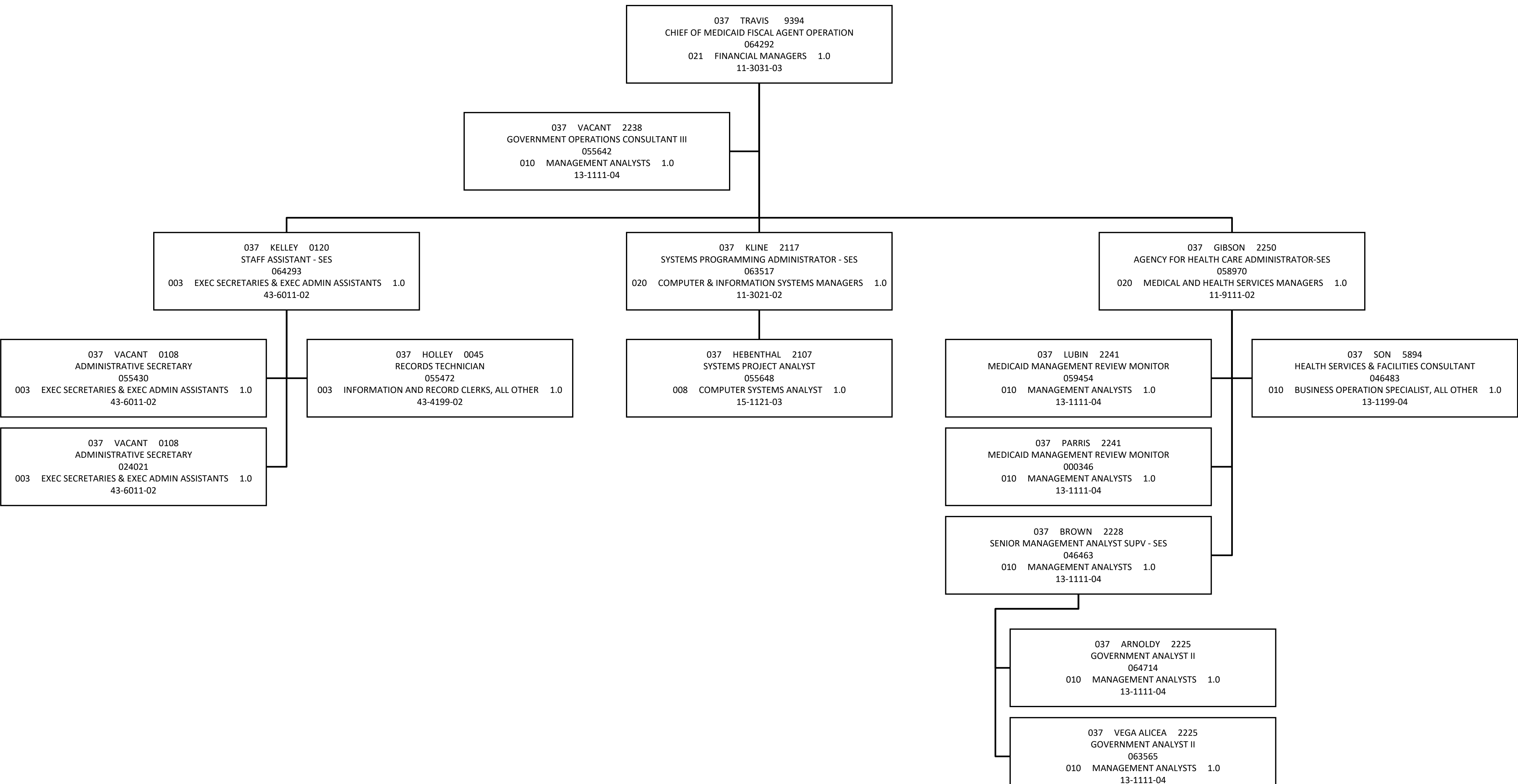
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Plan Management Operations – Ft. Lauderdale

Effective Date: July 01, 2022
Org. Level: 68-40-30-10-000
FTE's: 14 Positions: 14



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

Effective Date: July 01, 2022
Org. Level: 68-40-70-00-000
FTE's: 64 Positions:64



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

Effective Date: July 01, 2022
Org. Level: 68-40-70-00-000
FTE's: 64 Positions:64

037 TRAVIS 9394
CHIEF OF MEDICAID FISCAL AGENT OPERATION
064292
021 FINANCIAL MANAGERS 1.0
11-3031-03

037 GIDDENS 2250
AGENCY FOR HEALTH CARE ADMINISTRATOR-SES
039482
020 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-02

037 GIBSON 2238
OPERATIONS & MGMT CONSULTANT MGR - SES
055471
020 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-02

037 WILLIAMS 2241
MEDICAID MANAGEMENT REVIEW MONITOR
063473
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 TABB 2234
GOVERNMENT OPERATIONS CONSULTANT I
064290
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

MILLER
OPS
900198

VACANT
OPS
900259

VACANT
OPS
900265

ANDERSON
OPS
900215

037 HARDEN 2238
OPERATIONS & MGMT CONSULTANT MGR - SES
064455
020 GENERAL AND OPERATIONS MANAGERS 1.0
11-1021-02

FIELDS
OPS
900069

037 YEOMANS 2241
MEDICAID MANAGEMENT REVIEW MONITOR
048503
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 WATFORD 2241
MEDICAID MANAGEMENT REVIEW MONITOR
019302
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

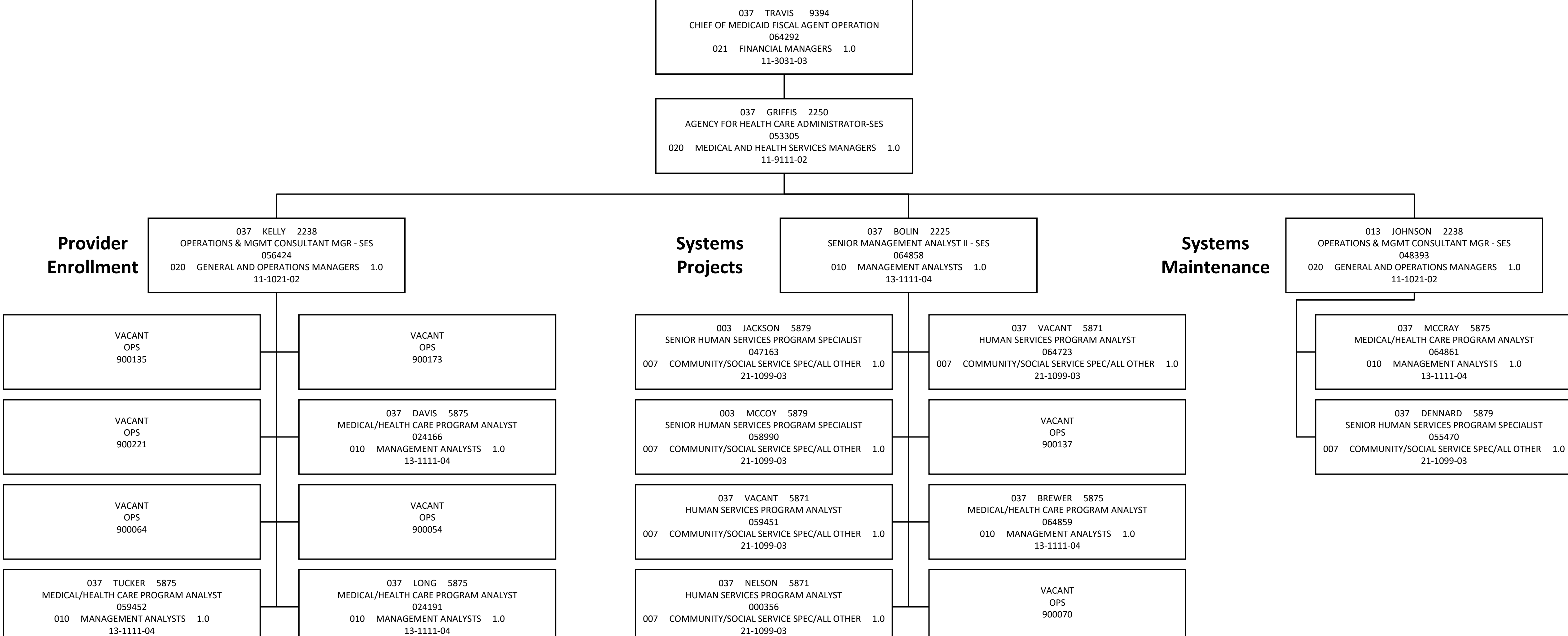
037 FRAZIER 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
064451
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
064452
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

VACANT
OPS
900260

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

Effective Date: July 01, 2022
Org. Level: 68-40-70-00-000
FTE's: 64 Positions: 64



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

Effective Date: July 01, 2022
Org. Level: 68-40-60-00-000
FTE's: 65 Positions: 65

037 DALTON 8863
CHIEF OF MEDICAID POLICY
019298
021 FINANCIAL MANAGERS 1.0
11-3031-03

037 VACANT 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
064935
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
064934
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 0709
ADMINISTRATIVE ASSISTANT I
064456
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

VACANT
OPS
900233

VACANT
OPS
900209

VACANT
OPS
900287

VACANT
OPS
900142

Federal Authorities

037 BOTTCHER 2250
AGENCY FOR HEALTH CARE ADMINISTRATOR-SES
020476
020 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-02

037 ENGLISH 2225
GOVERNMENT ANALYST II
039485
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
059460
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 HALL 2225
GOVERNMENT ANALYST II
064592
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 2225
GOVERNMENT ANALYST II
064783
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 PICKLE 2250
AGENCY FOR HEALTH CARE ADMINISTRATOR-SES
064903
020 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-02

037 CHEN 5248
SENIOR PHARMACIST
064904
011 PHARMACISTS 1.0
29-1051-05

037 BRACKETT 5916
PROGRAM CONSULTANT
064905
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

Canadian Prescription Drug Importation Program

037 MCGRATH 2250
AGENCY FOR HEALTH CARE ADMINISTRATOR-SES
059049
020 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-02

037 VACANT 2238
GOVERNMENT OPERATIONS CONSULTANT III
025870
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 2238
GOVERNMENT OPERATIONS CONSULTANT III
064846
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 2238
GOVERNMENT OPERATIONS CONSULTANT III
064878
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 2225
GOVERNMENT ANALYST II
056423
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
046957
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 2238
GOVERNMENT OPERATIONS CONSULTANT III
019512
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

VACANT
OPS
900285

037 VACANT 2225
GOVERNMENT ANALYST II
057052
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

VACANT
OPS
900311

037 VACANT 5879
SENIOR HUMAN SERVICES PROGRAM SPECIALIST
059466
007 COMMUNITY/SOCIAL SERVICE SPEC/ALL OTHER 1.0
21-1099-03

037 FULLINGTON 2238
GOVERNMENT OPERATIONS CONSULTANT III
019532
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

VACANT
OPS
900193

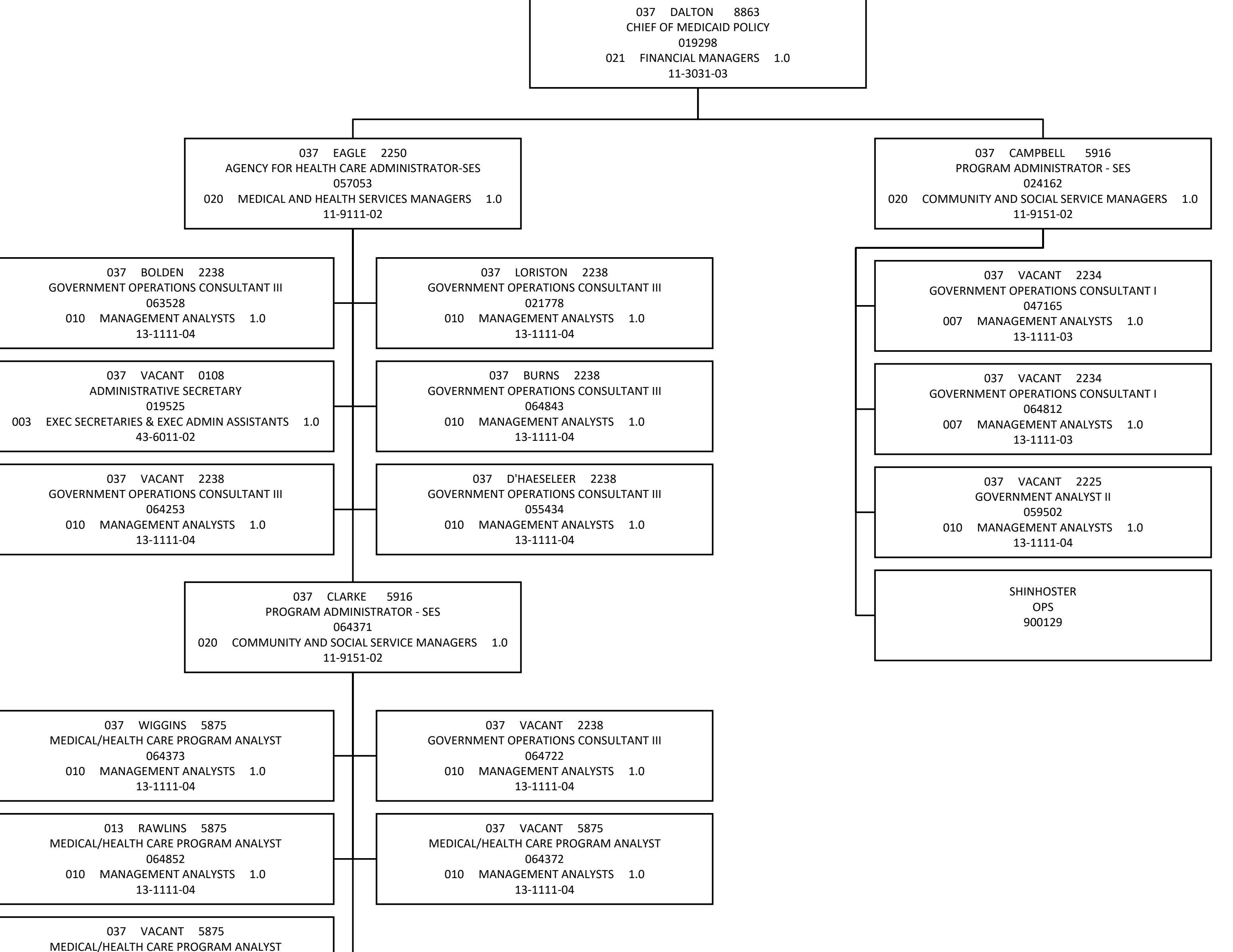
037 GIERING 5916
PROGRAM ADMINISTRATOR - SES
064277
020 COMMUNITY AND SOCIAL SERVICE MANAGERS 1.0
11-9151-02

037 VACANT 2225
GOVERNMENT ANALYST II
064810
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

VACANT
OPS
900283

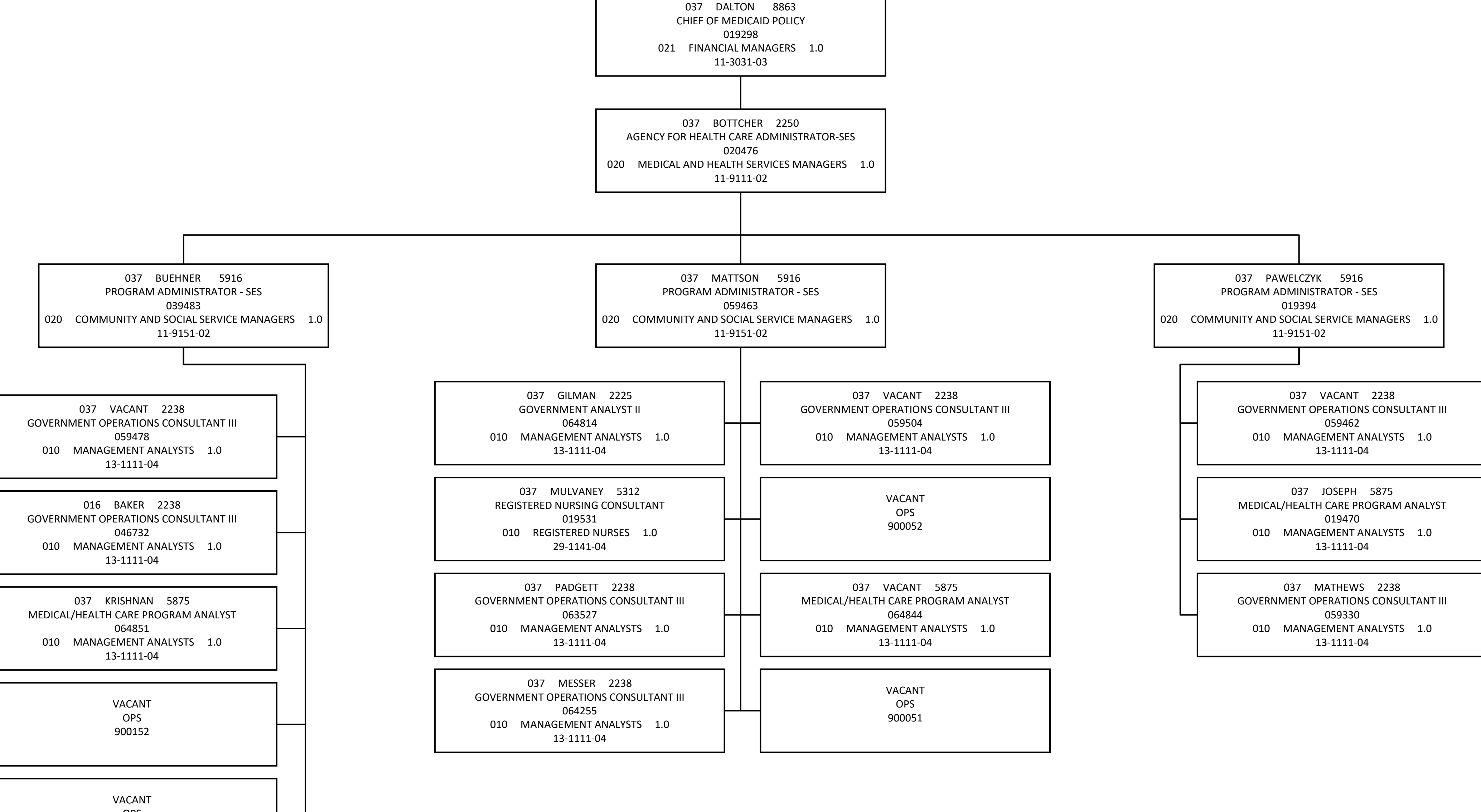
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Policy
Managed Care and Policy Contracts

Effective Date: July 01, 2022
Org. Level: 68-40-60-00-000
FTE's: 65 Positions: 65



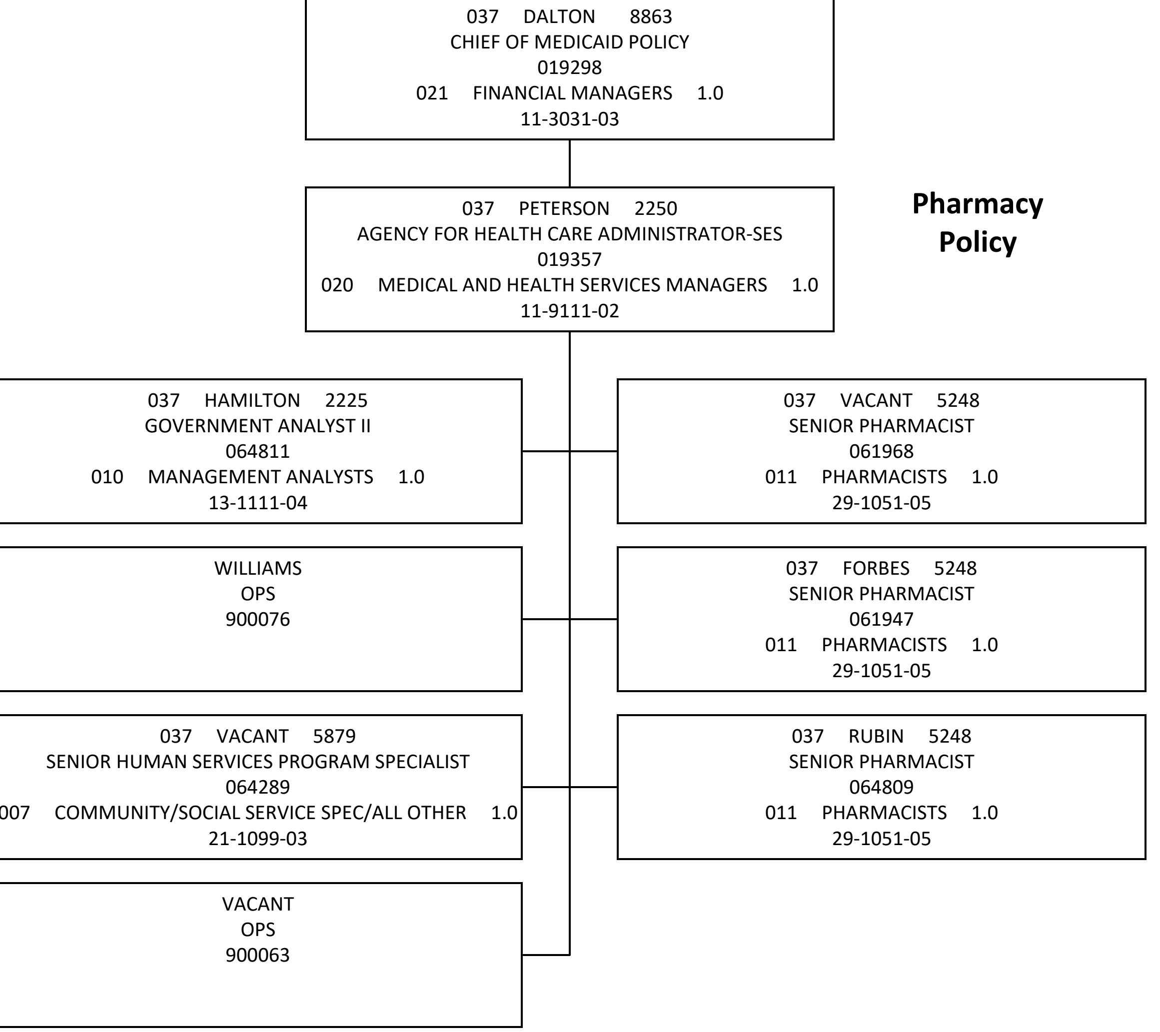
AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Policy
Medical and Behavioral Health Care Policy

Effective Date: July 01, 2022
Org. Level: 68-40-60-00-000
FTE's: 65 Positions: 65

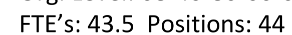


AGENCY FOR HEALTH CARE ADMINISTRATION
Division of Medicaid
Bureau of Medicaid Policy

Effective Date: July 01, 2022
Org. Level: 68-40-60-00-000
FTE's: 65 Positions: 65



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


Effective Date: July 01, 2022
Org. Level: 68-40-80-00-000
FTE's: 43.5 Positions: 44

037 VERGESON 8951
CHIEF OF MEDICAID QUALITY
064589
021 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-03

VACANT
OPS
900325

037 VACANT 0709
ADMINISTRATIVE ASSISTANT I
059325
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 PAULK 2234
GOVERNMENT OPERATIONS CONSULTANT I
048500
007 MANAGEMENT ANALYSTS 1.0
13-1111-03

037 VACANT 2238
GOVERNMENT OPERATIONS CONSULTANT III
064933
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

Quality Improvement & Evaluation Contracts

037 CROSS 2250
AGENCY FOR HEALTH CARE ADMINISTRATOR-SES
064212
020 MEDICAL AND HEALTH SERVICES MANAGERS 1.0
11-9111-02

037 LEWIS 2238
GOVERNMENT OPERATIONS CONSULTANT III
025875
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 CLARK 2238
GOVERNMENT OPERATIONS CONSULTANT III
059467
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 KEMP 5875
MEDICAL/HEALTH CARE PROGRAM ANALYST
064319
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 0108
ADMINISTRATIVE SECRETARY
048467
003 EXEC SECRETARIES & EXEC ADMIN ASSISTANTS 1.0
43-6011-02

037 HOLLAND 5916
PROGRAM ADMINISTRATOR - SES
061948
020 COMMUNITY AND SOCIAL SERVICE MANAGERS 1.0
11-9151-02

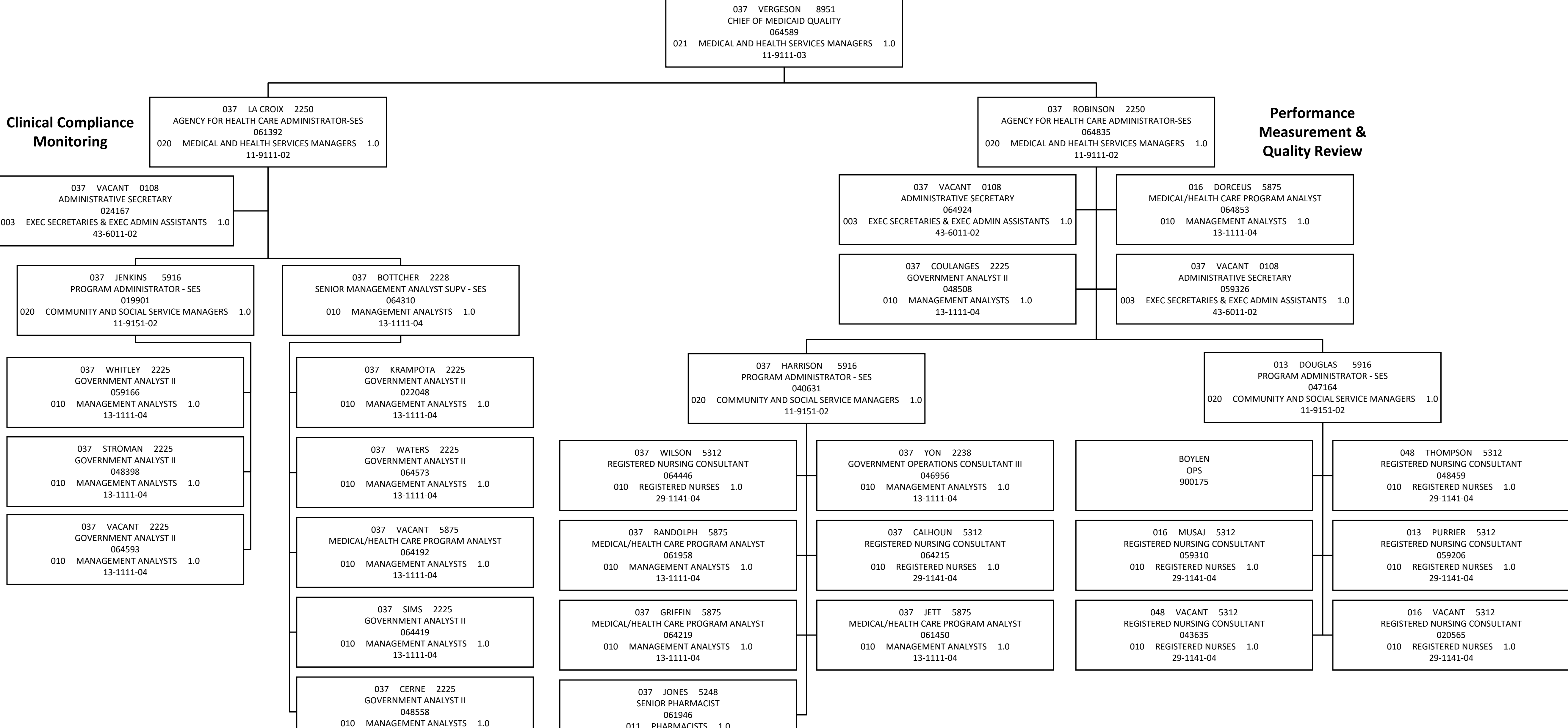
037 SMITH 2225
GOVERNMENT ANALYST II
064294
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 GONZALEZ 2225
GOVERNMENT ANALYST II
064713
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

037 VACANT 2225
GOVERNMENT ANALYST II
064704
010 MANAGEMENT ANALYSTS 1.0
13-1111-04

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

Effective Date: July 01, 2022
Org. Level: 68-40-80-00-000
FTE's: 43.5 Positions: 44



AGENCY FOR HEALTH CARE ADMINISTRATION	FISCAL YEAR 2021-22		
SECTION I: BUDGET	OPERATING		FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT		35,441,169,181	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)		1,513,613,002	0
FINAL BUDGET FOR AGENCY		36,954,782,183	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
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	26,351	48,443.76	1,276,541,613	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	103,438	6,853.58	708,920,681	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * **Number of case months Medicaid program services purchased**	170,647	4,681.85	798,943,442	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	170,647	1,460.21	249,180,085	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * **Number of case months Medicaid Program services purchased**	1,930,642	3,809.93	7,355,616,027	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months Medicaid program services purchased**	950,332	0.32	302,192	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case months Medicaid program services purchased**	151,277	68.06	10,296,351	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid program services purchased**	90,724	75,210.23	6,823,373,157	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	292,540	7,900.07	2,311,086,598	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	500,264	1,028.22	514,382,429	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	927,252	892.16	827,257,501	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of case months Medicaid Program services purchased**	8,308,508	302.08	2,509,841,695	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months Medicaid Program services purchased**	4,131,355	0.02	90,196	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid Program services purchased**	1,007,175	1,876.42	1,889,884,255	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid Program services purchased**	102,710	666.56	68,462,070	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid Program services purchased**	141,068	236.70	33,390,717	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid Program services purchased**	141,068	123.08	17,362,012	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid Program services purchased**	282,136	44.65	12,598,225	
Medically Needy - Case Management * **Number of case months Medicaid Program services purchased**	141,068	0.01	1,967	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	141,068	10,617.69	1,497,815,699	
Refugees - Hospital Inpatient * **Number of case months Medicaid Program services purchased**	12,530	101.56	1,272,599	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services purchased**	12,530	57,649.32	722,345,956	
Refugees - Hospital Outpatient * **Number of case months Medicaid Program services purchased**	12,530	55.65	697,357	
Nursing Home Care * **Number of case months Medicaid Program services purchased**	45,967	101,611.83	4,670,791,165	
Home And Community Based Services * **Number of case months Medicaid Program services purchased**	76,897	35,168.31	2,704,337,618	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * **Number of case months Medicaid Program services purchased**	464	835,072.30	387,473,549	
Long Term Care - Other * **Number of case months Medicaid Program services purchased**	122,863	4,304.97	528,921,366	
Purchase Medikids Program Services * **Number of case months Medicaid Program services purchased**	15,007	2,749.61	41,263,359	
Purchase Children's Medical Services Network Services * **Number of case months**	9,168	14,340.44	131,473,153	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	132,694	1,521.33	201,871,238	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial reviews conducted**	3,257	1,145.17	3,729,817	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of licensure/certification applications**	28,881	873.29	25,221,585	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys and complaint investigations**	16,688	5,210.23	86,948,392	
Health Standards And Quality * **Number of transactions**	2,816,170	3.31	9,333,353	
Plans And Construction * **Number of reviews performed**	3,360	3,024.15	10,161,135	
Background Screening * **Number of requests for screenings**	484,838	2.22	1,077,433	
TOTAL			36,432,265,987	

SECTION III: RECONCILIATION TO BUDGET		
PASS THROUGHS		
TRANSFER - STATE AGENCIES		
AID TO LOCAL GOVERNMENTS		
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS		
OTHER	223,357,521	
REVERSIONS	299,208,616	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	36,954,832,124	

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.

Note: A difference of 49,896.46 is the difference between the final reversion amount reflected in Section III and the carry/ certified reversion report amount, resulting in an adjusted difference of 44.54. This difference is due to rounding.

Schedule XIV
Variance from Long Range Financial Outlook

Agency: Agency for Health Care Administration **Contact: Sonya Smith, Chief, Financial Services**

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 2022 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 2023-2024 and list the amount projected in the long range financial outlook and the amounts projected in your Schedule I or budget request.

	Issue (Revenue or Budget Driver)	R/B*	FY 2023-2024 Estimate/Request Amount: Long Range Financial Outlook	FY 2023-2024 Estimate/Request Amount: Legislative Budget Request
a	Medicaid Price Level / Workload		-1054.6	-1054.5
b	KidCare		166.3	166.3
c	Medicaid Waivers		150.9	0
d				
j				

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. Variance is due to Medicaid waivers being included in the base budget.

* R/B = Revenue or Budget Driver

Office of Policy and Budget - June 2022

Florida Agency for Health Care Administration

Budget Entity Level Exhibits and Schedules

Ron DeSantis, Governor

Simone Marstiller, Secretary

Florida Agency for Health Care Administration

AGENCY FOR HEALTH CARE ADMINISTRATION
STATE OF FLORIDA

Schedule I Series

Ron DeSantis, Governor
Simone Marstiller, Secretary

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2023 - 2024

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

	Balance as of 6/30/2022		**SWFS* Adjustments**	**Adjusted Balance**
Chief Financial Officer's (CFO) Cash Balance	152,196,465.46	(A)	0.00	152,196,465.46
ADD: Other Cash (See Instructions)	242,529.03	(B)	0.00	242,529.03
ADD: Investments	0.00	(C)	0.00	0.00
ADD: Outstanding Accounts Receivable	63,699,913.43	(D)	(2,287,108.78)	61,412,804.65
ADD: ______________________________	0.00	(E)	0.00	0.00
Total Cash plus Accounts Receivable	**216,138,907.92**	(F)	**(2,287,108.78)**	**213,851,799.14**
LESS Allowances for Uncollectibles	4,688,332.23	(G)	0.00	4,688,332.23
LESS Approved "A" Certified Forwards	64,726,870.99	(H)	0.00	64,726,870.99
Approved "B" Certified Forwards	181,657.67	(H)	0.00	181,657.67
Approved "FCO" Certified Forwards	0.00	(H)	0.00	0.00
LESS: Other Accounts Payable (Nonoperatin	2,010,413.94	(I)	0.00	2,010,413.94
LESS: Deferred Inflows-Unavailable Revenu	4,663,065.71	(J)	(1,509,491.79)	3,153,573.92
Unreserved Fund Balance, 07/01/22	**139,868,567.38**	(K)	**(777,616.99)**	**139,090,950.39** **

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2023 - 2024

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/22 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**139,887,952.64**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	(1,932.83)	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment #B6800019 Receivable due from Federal Government for Title XVIII	(777,616.99)	(C)
SWFS Adjustment #C6800012 COVID -19 Receivable	0.00	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	(181,657.67)	(D)
Approved FCO Certified Forward per LAS/PBS	0.00	(D)
Advances to Other Funds (25700)	(15,000.00)	(D)
A/P not C/F-Operating Categories	0.00	(D)
Budget Entity to Budget Entity Cash Transfer	0.00	(D)
A/P not C/F-Operating Categories (38600) Salaries and Benefits	178,980.43	(D)
A/P not C/F-Operating Categories (35300) Expenses	224.81	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**139,090,950.39**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**139,090,950.39**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2023 - 2024

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

	Balance as of 6/30/2022		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	2,007,979.94	(A)	0.00	2,007,979.94	
ADD: Other Cash (See Instructions)	0.00	(B)	0.00	0.00	
ADD: Investments	0.00	(C)	0.00	0.00	
ADD: Outstanding Accounts Receivable	4,471,061.78	(D)	(207.32)	4,470,854.46	
ADD: ______________________	0.00	(E)	0.00	0.00	
Total Cash plus Accounts Receivable	**6,479,041.72**	(F)	**(207.32)**	**6,478,834.40**	
LESS Allowances for Uncollectibles	0.00	(G)	0.00	0.00	
LESS Approved "A" Certified Forwards	1,604,534.19	(H)	0.00	1,604,534.19	
Approved "B" Certified Forwards	0.00	(H)	0.00	0.00	
Approved "FCO" Certified Forwards	0.00	(H)	0.00	0.00	
LESS: Other Accounts Payable (Nonoperatin	0.00	(I)	0.00	0.00	
LESS: Deferred Inflows-Unavailable Revenu	0.00	(J)	0.00	0.00	
Unreserved Fund Balance, 07/01/22	**4,874,507.53**	(K)	**(207.32)**	**4,874,300.21**	**

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2023 - 2024

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/22		
Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**4,871,713.57**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	40,354.37	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
Receivable Adj #B6800002, B6800008, B6800011	207.32	(C)
SWFS Adjustment # and Description	0.00	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0.00	(D)
Approved FCO Certified Forward per LAS/PBS	0.00	(D)
A/P not C/F-Operating Categories - Expenses (GLC35300)	(23,768.03)	(D)
A/P not C/F-Operating Categories - Contracted Services (GLC 3530(	2,103.09	(D)
A/P not C/F-Operating Categories - Salaries and Benefits (GLC 386(	(21,483.39)	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**4,874,300.21**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**4,874,300.21**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2023 - 2024

Department Title: Agency for Health Care Administration
Trust Fund Title: Tobacco Settlement Trust Fund
Budget Entity: Departmental and Medicaid Services to Individuals (68501400)
LAS/PBS Fund Number: 2122

	Balance as of 6/30/2022		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	6,957,435.56	(A)	0.00	6,957,435.56	
ADD: Other Cash (See Instructions)	0.00	(B)	0.00	0.00	
ADD: Investments	0.00	(C)	0.00	0.00	
ADD: Outstanding Accounts Receivable	0.00	(D)	0.00	0.00	
ADD: ______________________________	0.00	(E)	0.00	0.00	
Total Cash plus Accounts Receivable	**6,957,435.56**	(F)	**0.00**	**6,957,435.56**	
LESS Allowances for Uncollectibles	0.00	(G)	0.00	0.00	
LESS Approved "A" Certified Forwards	3,030,147.85	(H)	0.00	3,030,147.85	
Approved "B" Certified Forwards	0.00	(H)	0.00	0.00	
Approved "FCO" Certified Forwards	0.00	(H)	0.00	0.00	
LESS: Other Accounts Payable (Nonoperating)	0.00	(I)	0.00	0.00	
LESS: Deferred Inflows-Unavailable Revenue	0.00	(J)	0.00	0.00	
Unreserved Fund Balance, 07/01/22	**3,927,287.71**	(K)	**0.00**	**3,927,287.71**	**

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2023 - 2024

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/22 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**3,927,287.71**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	0.00	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	0.00	(C)
SWFS Adjustment # and Description	0.00	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0.00	(D)
Approved FCO Certified Forward per LAS/PBS	0.00	(D)
A/P not C/F-Operating Categories	0.00	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**3,927,287.71**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**3,927,287.71**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2023 - 2024

Department Title:	Agency for Health Care Administration
Trust Fund Title:	Quality of Long-Term Care Facility Improvement Trust Fund
Budget Entity:	Departmental and Health Care Regulation (68700700)
LAS/PBS Fund Number:	2126

	Balance as of 6/30/2022		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	34,037,896.63	(A)	0.00	34,037,896.63	
ADD: Other Cash (See Instructions)	0.00	(B)	0.00	0.00	
ADD: Investments	0.00	(C)	0.00	0.00	
ADD: Outstanding Accounts Receivable	0.00	(D)	0.00	0.00	
ADD: COVID RECEIVABLE (FY20-21)	0.00	(E)	0.00	0.00	
Total Cash plus Accounts Receivable	**34,037,896.63**	(F)	**0.00**	**34,037,896.63**	
LESS Allowances for Uncollectibles	0.00	(G)	0.00	0.00	
LESS Approved "A" Certified Forwards	1,308,661.94	(H)	0.00	1,308,661.94	
Approved "B" Certified Forwards	0.00	(H)	0.00	0.00	
Approved "FCO" Certified Forwards	0.00	(H)	0.00	0.00	
LESS: Other Accounts Payable (Nonoperatin	0.00	(I)	0.00	0.00	
LESS:	0.00	(J)	0.00	0.00	
Unreserved Fund Balance, 07/01/22	**32,729,234.69**	(K)	**0.00**	**32,729,234.69**	**

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2023 - 2024

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/22		
Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**32,729,234.69**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	0.00	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	0.00	(C)
SWFS Adjustment # and Description	0.00	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0.00	(D)
Approved FCO Certified Forward per LAS/PBS	0.00	(D)
A/P not C/F-Operating Categories	0.00	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**32,729,234.69**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**32,729,234.69**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2023 - 2024

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

	Balance as of 6/30/2022		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	668,374,005.01	(A)	0.00	668,374,005.01	
ADD: Other Cash (See Instructions)	144,135,028.17	(B)	0.00	144,135,028.17	
ADD: Investments	0.00	(C)	0.00	0.00	
ADD: Outstanding Accounts Receivable	281,662,265.72	(D)	0.00	0.00	
ADD: ______________________________	0.00	(E)	0.00	0.00	
Total Cash plus Accounts Receivable	**1,094,171,298.90**	(F)	**0.00**	**1,094,171,298.90**	
LESS Allowances for Uncollectibles	5,695,307.73	(G)	0.00	5,695,307.73	
LESS Approved "A" Certified Forwards	214,606,944.04	(H)	0.00	214,606,944.04	
Approved "B" Certified Forwards	0.00	(H)	0.00	0.00	
Approved "FCO" Certified Forwards	0.00	(H)	0.00	0.00	
LESS: Other Accounts Payable (Deferred Inflo	5,714,151.35	(I)	0.00	5,714,151.35	
LESS: Other Accounts Payable (Nonoperating)	181,234,642.16	(I)	5,239,070.00	186,473,712.16	
LESS: Deferred Inflows-Unavailable Revenue	0.00	(J)	0.00	0.00	
Unreserved Fund Balance, 07/01/22	**686,920,253.62**	(K)	**(5,239,070.00)**	**681,681,183.62**	**

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2023 - 2024

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

BEGINNING TRIAL BALANCE:

	Amount	
Total Fund Balance Per FLAIR Trial Balance, 07/01/22 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**687,229,558.26**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	0.00	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
	0.00	(C)
Due to DOH - setup payable #B6800003	5,239,070.00	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0.00	(D)
Approved FCO Certified Forward per LAS/PBS	0.00	(D)
Budget Entity to Budget Entity Cash Transfer	0.00	(D)
Other Loans and Notes Receivable (GLC 25400)	343,671.82	(D)
Allowance for Uncollectibles (GLC 25900)	(34,367.18)	(D)
		(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**681,681,183.62**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**681,681,183.62**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2023 - 2024

Department Title:	Agency for Health Care Administration
Trust Fund Title:	Public Medical Assistance Trust Fund
Budget Entity:	Departmental and Medicaid Services to Individuals (68501400)
LAS/PBS Fund Number:	2565

	Balance as of 6/30/2022		SWFS* Adjustments	Adjusted Balance	
Chief Financial Officer's (CFO) Cash Balance	211,268,467.92	(A)		211,268,467.92	
ADD: Other Cash (See Instructions)	9,751,402.00	(B)		9,751,402.00	
ADD: Investments		(C)		0.00	
ADD: Outstanding Accounts Receivable	110,797,697.73	(D)		110,797,697.73	
ADD: ______________________________		(E)		0.00	
Total Cash plus Accounts Receivable	**331,817,567.65**	(F)	**0.00**	**331,817,567.65**	
LESS Allowances for Uncollectibles	34,433,026.92	(G)		34,433,026.92	
LESS Approved "A" Certified Forwards	132,144,472.03	(H)		132,144,472.03	
Approved "B" Certified Forwards		(H)		0.00	
Approved "FCO" Certified Forwards		(H)		0.00	
LESS: Other Accounts Payable (Nonoperating)		(I)		0.00	
LESS: Deferred Inflows-Unavailable Revenu	71,664,388.67	(J)		71,664,388.67	
Unreserved Fund Balance, 07/01/22	**93,575,680.03**	(K)	**0.00**	**93,575,680.03**	**

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2023 - 2024

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/22 Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**93,575,680.03**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	0.00	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	0.00	(C)
SWFS Adjustment # and Description	0.00	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0.00	(D)
Approved FCO Certified Forward per LAS/PBS	0.00	(D)
A/P not C/F-Operating Categories	0.00	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**93,575,680.03**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**93,575,680.03**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IC: RECONCILIATION OF UNRESERVED FUND BALANCE

Budget Period: 2023 - 2024

Department Title:	Agency for Health Care Administration
Trust Fund Title:	Refugee Assistance Trust Fund
Budget Entity:	Departmental and Medicaid Services to Indviduals (68501400)
LAS/PBS Fund Number:	2579

	Balance as of 6/30/2022		SWFS* Adjustments	Adjusted Balance
Chief Financial Officer's (CFO) Cash Balance	24,619,678.33	(A)		24,619,678.33
ADD: Other Cash (See Instructions)	0.00	(B)		0.00
ADD: Investments		(C)		0.00
ADD: Outstanding Accounts Receivable	14,917,575.68	(D)		14,917,575.68
ADD: ______________________________		(E)		0.00
Total Cash plus Accounts Receivable	**39,537,254.01**	(F)	**0.00**	**39,537,254.01**
LESS Allowances for Uncollectibles	0.00	(G)		0.00
LESS Approved "A" Certified Forwards	31,455,110.92	(H)		31,455,110.92
Approved "B" Certified Forwards		(H)		0.00
Approved "FCO" Certified Forwards		(H)		0.00
LESS: Other Accounts Payable (Nonoperating)		(I)		0.00
LESS: Deferred Inflows-Unavailable Revenu	0.00	(J)		0.00
Unreserved Fund Balance, 07/01/22	**8,082,143.09**	(K)	**0.00**	**8,082,143.09** **

Notes:

***SWFS = Statewide Financial Statement**

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

RECONCILIATION: BEGINNING TRIAL BALANCE TO SCHEDULE I and IC

Budget Period: 2023 - 2024

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

BEGINNING TRIAL BALANCE:

Total Fund Balance Per FLAIR Trial Balance, 07/01/22		
Total all GLC's 5XXXX for governmental funds; GLC 539XX for proprietary and fiduciary funds	**8,082,143.09**	(A)
Subtract Nonspendable Fund Balance (GLC 56XXX)	0.00	(B)
Add/Subtract Statewide Financial Statement (SWFS)Adjustments :		
SWFS Adjustment # and Description	0.00	(C)
SWFS Adjustment # and Description	0.00	(C)
Add/Subtract Other Adjustment(s):		
Approved "B" Carry Forward (Encumbrances) per LAS/PBS	0.00	(D)
Approved FCO Certified Forward per LAS/PBS	0.00	(D)
A/P not C/F-Operating Categories	0.00	(D)
ADJUSTED BEGINNING TRIAL BALANCE:	**8,082,143.09**	(E)
UNRESERVED FUND BALANCE, SCHEDULE IC (Line K)	**8,082,143.09**	(F)
DIFFERENCE:	**0.00**	(G)*

***SHOULD EQUAL ZERO.**

SCHEDULE IV-B FOR FLORIDA HEALTH CARE CONNECTIONS (FX)

For Fiscal Year 2023-24

Revision History

Date	**Version**	**Description**	**Author(s)**
8/31/2022	Draft 001	Updates and additions to the 21/22 Schedule IV-B	FXPA Team, Vendors, A. Ramsey, S. Stacknik
9/16/2022	Draft 002	Resolved Comments and edits accepted	A. Ramsey and S. Stacknik, SMEs
10/6/2022	Final Draft	Review of Final Draft of the 23/24 Schedule IV-B	FXPA Team, A. Ramsey, S. Stacknik, IV&V, SEAS, Finance and Accounting
10/14/2022	Final 100		

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FX 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: 09/15/2022
Project Name: Florida Health Care Connections (FX)	Is this project included in the Agency's LRPP? X Yes _No
FY 2022-23 LBR Issue Code:	FY 2022-23 LBR Issue Title: FMMIS/Florida Health Care Connections (FX)
Agency Contact for Schedule IV-B (Name, Phone #, and E-mail address): Michael Magnuson, 850-412-4791, Michael.Magnuson@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: Simone Marstiller Printed Name: Simone Marstiller, Secretary	Date: 10/14/2022
Agency Chief Information Officer (or equivalent): [signature] Printed Name: Scott Ward, Chief Information Officer	Date: 10/14/2022
Budget Officer: La-Shonna Austin Printed Name: La-Shonna Austin, Budget Administrator	Date: 10/14/2022

Planning Officer: Angela McKenny Printed Name: Angela McKenny, Office of Florida Health Connections	Date: 10/14/2022
Project Sponsor: Julie S. Madden Printed Name: Julie Madden, Deputy Secretary of Operations	Date: 10/14/2022

Schedule IV-B Preparers (Name, Phone #, and E-mail address):	
Business Need:	Michael Magnuson, 850-412-4791 Michael.Magnuson@ahca.myflorida.com
Cost Benefit Analysis:	Same as above
Risk Analysis:	Same as above
Technology Planning:	Same as above
Project Planning:	Same as above

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

Florida Health Care Connections (FX) is a multi-year program to modernize the current Medicaid technology using a modular approach while simultaneously improving overall Agency functionality and building better connections to other data sources and programs, resulting in the ability to provide better healthcare – all this leading to a world-class health care experience for all Floridians.

The FX vision and guiding principles were described in detail in the Agency's FY 2022-2023 – Schedule IV-B Florida Health Care Connection (including Attachment A Cost Benefit Analysis and Attachment B - Project Risk Assessment and the MITA Concept of Operations, which may be accessed by following the links provided. Although the guiding principles have not changed, Exhibit 1 highlights the key focus areas for the FX Program and the overarching goals that FX will achieve.

FX ROADMAP GUIDELINES

- Resolve fiscal agent contract by December 2024
- Ensure continuity of operations
- Prioritize items required to resolve the fiscal agent contract
- Pursue transformational improvements to the extent they do not negatively impact fiscal agent contract resolution

TOP 5 FX STRATEGIC PRIORITIES

1. Reduce risk of integration and cost to fiscal agent by accelerating contract resolution
2. Provider Experience: Streamline credentialing, licensing, Master Person Index, and Master Organization Index
3. Prioritize ability to have high-quality, accessible data, analytics, and reporting
4. Prioritize joint efficiencies with interoperability within the Agency
5. Strategically leverage efficient procurement vehicles where possible

TO REPLACE THE FISCAL AGENT, THE FOLLOWING BUSINESS AREAS MUST BE ADDRESSED:

IS/IP
EDW
Provider
Unified Operations Center
Core
Pharmacy Benefits Management
Recipient/Enrollment Broker

Exhibit 1: FX Strategic Mandate

To address the business needs for the State Fiscal Year (SFY) 2023-2024, FX includes projects in-progress and planned for the year. In this SFY the Agency intends to continue efforts by operating requirements in the Phase I vendor contracts, operating the services in Phase II: FX Infrastructure, and completing any outstanding procurement activities and operating the services in the Phase III: FX Modules to further the FMMIS/DSS/Fiscal Agent Contract Resolution.

2. Summary of the FX Vision, Guiding Principles, and Strategic Priorities

Agency executives developed the FX Vision by tying the FX strategy to the overall Mission, Vision, and Goals of the Agency.

The Agency's Mission is Better Health Care for all Floridians.

The Agency's Vision and long-range goals support the Agency's Mission. According to the FYs 2021-22 through 2025-26 Long-Range Program Plan, the Agency's Vision 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.* The Agency's long-range goals, as laid out in its Long-Range Program Plan, also support the Agency's Mission and are as follows:

a. To operate an efficient and effective government
b. To reduce or eliminate waste, fraud, and abuse
c. To ensure a stronger health care delivery system by getting the incentives in Medicaid right: allowing Florida Medicaid enrollees to choose a health plan based on quality and customer service to ensure Florida enrollees receive the care they need and deserve

The Agency's FX Vision is to Transform the Medicaid Enterprise to provide the best value, highest quality health care to Floridians. The Agency's FX Guiding Principles must be adhered to if the FX Vision is to be achieved. These Principles support the FX Vision and are as follows:

a. Enable high-quality and accessible data
b. Improve healthcare outcomes
c. Reduce complexity
d. Use evidenced-based decision-making
e. Improve integration with partners
f. Improve provider and recipient experiences
g. Enable good stewardship of Medicaid funds
h. Enable holistic decision-making rather than short-term focus

The FX Guiding Principles also support CMS' Medicaid Information Technology Architecture (MITA) Goals and Objectives.

The FX Guiding Principles are supported by Strategic Priorities, which define the areas of practical importance to achieve the FX Vision. The twelve FX Strategic Priorities are covered below. The first five are the highest priority and most influential in terms of influencing FX decision-making.

a. Reduce risk of integration and cost associated with legacy FMMIS by accelerating contract resolution.
b. Improve provider experience by streamlining credentialing and licensing, improve provider data, and overall experience
c. Prioritize ability to have high-quality accessible data, analytics, and reporting
d. Prioritize joint interoperability opportunities between agencies and within AHCA
e. Strategically leverage efficient procurement vehicles where possible.
f. Maximize staff efficiency

g. Prioritize renegotiating and improving both functionality and technology for large (non-FMMIS) system contracts
h. Minimize impacts of procurements on AHCA staff
i. Improve recipient visibility and experience through consolidated portal and contact center functionality where possible
j. Maximize accountability for vendor performance
k. Align to the CMS modularity to streamline system transformation and modernization
l. Reduce impacts on Agency and staff

B. State of the Program

1. FX Strategy

The Florida Medicaid Enterprise Strategic Plan lays the groundwork for a focused transformation guided by CMS standards and conditions and the Agency's guiding principles to improve service and outcomes. The strategic plan is a living document that will be refreshed as needed over the course of the FX program. This will allow the Agency to take advantage of new innovations as they became commercially available and to include this new knowledge in the FX Program as it evolves, while maintaining the long-term FX Vision to *Transform the Medicaid Enterprise to provide the greatest quality, the best experience, and the highest value in healthcare.*

The MMIS market has evolved since CMS issued its modularity guidance to states in 2015. The Agency's intent is to take advantage of these ongoing innovations, while implementing components and modules of FX. The Agency learned a great deal in the first two years of this transformation and experienced some internal change as well. For example, interoperability with other HHS agencies is more complex to achieve than initially anticipated but still represents enormous potential efficiencies for the state.

Several procurements are underway, which will ultimately require adjustments to the master schedule and planned activities.

The revised FX roadmap:

a. Aligns the FX roadmap to the FX Master Program Schedule.

b. Moves up the Core negotiation to allow more time for Core design, development, and implementation, and therefore reduce risk.

c. Delays the Provider Service Module (PSM) implementation start date by 6 months to prioritize the Core module procurement.

d. Starts the Unified Operations Center (UOC) implementation in Quarter 2 of SFY 2022-23 and prioritize recipient design, development, and implementation which supports approximately two-thirds of total contract volume.

e. Combines the planning and procurement phases for Pharmacy Benefits Management (PBM) and align with Core go-live.

f. Adds the IS/IP Module Integration (MI) Project for connecting new modules to the FX Enterprise as well as establishes prioritization to interface with legacy systems.

g. Communicates the uncertainty of future years due to dependency on module vendor selection and schedule.

2. FX Governance and Executive Steering Committee (ESC)

The Agency implemented the FX Governance Plan to include a 15-member Executive Steering Committee (ESC) in February 2021. The FX Governance structure has since been refined to better support the governance needs of a maturing multi-vendor implementation program. The FX Governance framework is divided into three discrete tiers.

a. Tier 1 is the FX Program Execution level and includes the FX Program and Portfolio, chartered FX Projects, and the FX Domains, as follows: FX Enterprise Program Management Office (EPMO), Architecture Review Board (ARB), and Program Design and Operations (PDO).

b. Tier 2 is the FX Program Strategy level and is solely comprised of a cross-vendor FX Program Governance Group. The FX Program Governance Group provides strategic leadership and has decision authority over high priority/impact items; maintains enterprise-level view of FX and Agency priorities, the FX Strategic Roadmap, and overall Agency business needs; and ensures strategic alignment between vendors, program, project, and IT priorities. The FX Deputy Executive Sponsor is the decision-maker on the FX Program Governance Group. The FX Director leads the FX Program Administration (FXPA) team members. FXPA acts as cross-project support and provides subject matter expertise for all FX projects and operates within each of the FX Domains and levels of FX Governance.

c. Tier 3 is the Executive Oversight level and includes either the Agency Secretary or designee, or the FX ESC. The Agency Secretary provides executive-level oversight and decision-making for the decisions escalated beyond the designee(s) at Tier 2, has responsibility over the Agency mission, and is accountable to the Legislature and external stakeholders. The FX ESC consults with the Executive Office of the Governor interagency working group, promotes and coordinates interoperability across state healthcare entities, and addresses project resources needs.

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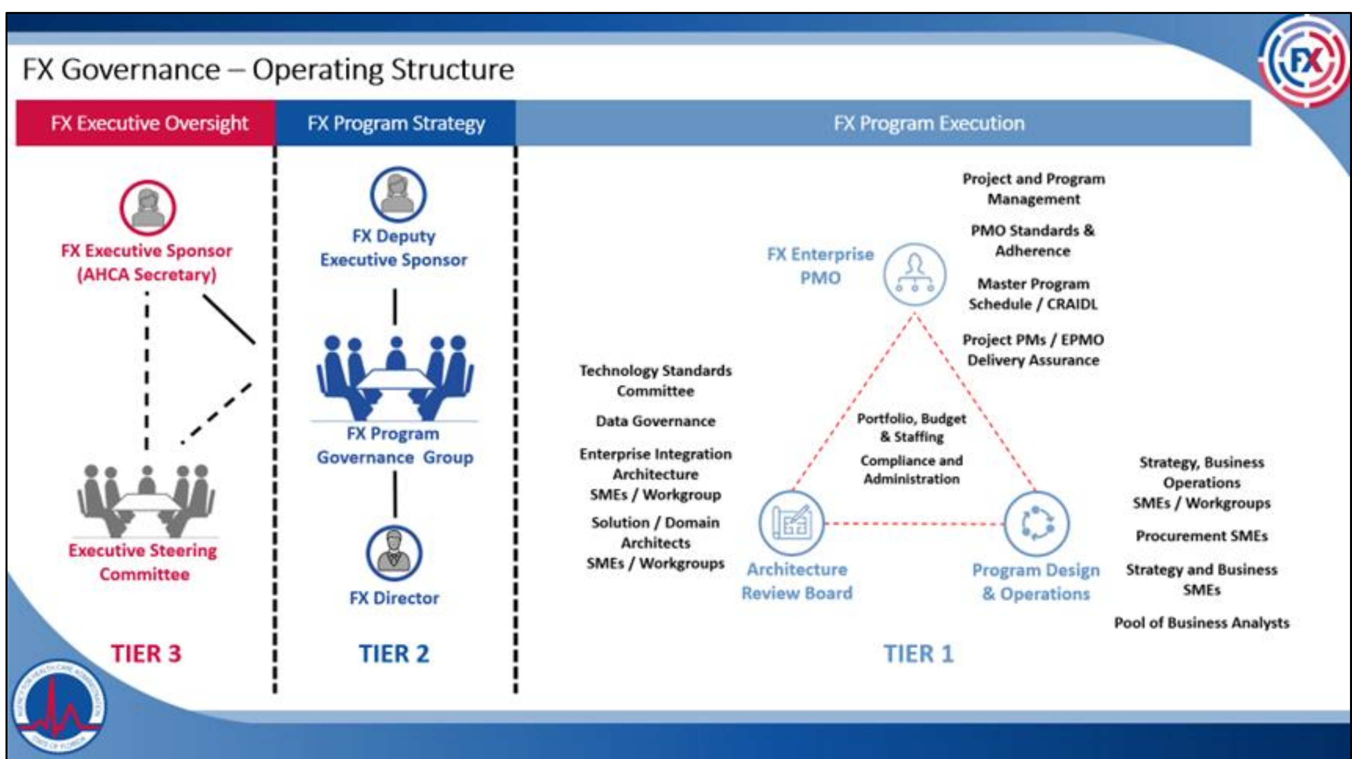

Exhibit 2: FX Governance-Operating Structure

The tiered process enables effective decision-making based on two separate paths:

a. Project-Based Governance Needs – occurs when a project decision need is defined within a project and by one or more of the FX Domains, and recommendations have been developed.

b. Program Governance Needs, Projects and Other Decisions – occurs when a decision is needed related to a new FX Project, new work, or to an FX standard or strategy. These decisions may include work proposed for existing resources, or other work that has a potential impact for the FX Program.

The ESC addresses the resources needs to provide better integration with sub-systems supporting Florida's Medicaid program. The ESC is comprised of seven representatives from the Agency, two representatives from the Department of Children and Families, and one representative each from the Department of Health, Department of Financial Services, Agency for Persons with Disabilities, Department of Elder Affairs, Department of Management Services, and Florida Healthy Kids Corporation.

The FX Program Governance Group, with approval by the FX Executive Sponsor, revised the FX roadmap in September 2022. The FX Governance framework supports the three phases of the FX Program.

Each of the three phases of the FX Program includes modules with specific objectives tied to

business benefits of a more technologically advanced solution to support improved health care. The components of each phase are outlined below:

#	Phase	Component / Module
I	Professional Ongoing Services	• Strategic Enterprise Advisory Services (SEAS) • Independent Verification and Validation (IV&V)
II	FX Infrastructure	• Integration Services and Integration Platform (IS/IP) Ongoing Services • Enterprise Data Warehouse (EDW)
III	FX Modules to further the FMMIS/DSS/Fiscal Agent Contract Resolution	• Unified Operations Center (UOC), including Recipient Management / Enrollment Broker functionality • Core (Claims / Encounter / Financial / Reference Management / Recipient Data /Necessary TPL Data) • Provider Services Module (PSM) • Pharmacy Benefits Management (PBM) and Pharmacy Services

3. Phase I: Professional Services

In Phase I, the Agency procured a Strategic Enterprise Advisory Services (SEAS) Vendor and an Independent Verification and Validation (IV&V) Vendor. Although the procurement activities of Phase I are completed, the professional services provided through these contracts will continue for this SFY and beyond.

a. Strategic Enterprise Advisory Services (SEAS) Executed contract with North Highland was renewed by Amendment through April 3, 2027.

The SEAS Vendor provides strategic, programmatic, and technical advisory services to the Agency and is considered an extension of the Agency in the management and oversight of the FX Program and portfolio. The SEAS Vendor operates the FX Enterprise Program Management Office (EPMO), and maintains FX standards, plans, and technical architecture documentation to promote consistency across FX's many vendors and projects. Operating the EPMO entails managing the Master Program Schedule (MPS), facilitating portfolio management, and managing the FX Program Change, Risks, Action Items, Issues, Decisions, and Lessons Learned (CRAIDL) log. The SEAS Vendor brings the relevant experience to guide the Agency toward meeting program objectives.

Details regarding previous SEAS task orders are available for review along with the approved task order for SFY 2022-2023.

b. Independent Verification and Validation (IV&V) (Purchase Requisition-- Reprocured July 2022 through June 2023—NTT Data continues in the IV&V role).

The IV&V vendor provides a rigorous independent evaluation and review that evaluates adherence to the standards, correctness, and quality of FX Program and projects' solutions to help the Agency ensure that projects are being developed and managed in accordance with Federal, State, and Agency requirements. IV&V services are required by federal regulation 45 CFR 95.626 to represent the interests of the CMS and pursuant to the Florida Information Technology Project Management and Oversight Standards in Florida Administrative Code (F.A.C) 60GG-1.001 through 60GG-1.009.

4. Phase II – FX Infrastructure

Phase II established the initial infrastructure to ensure standards of reuse and interoperability throughout FX with two foundational platforms. These foundational platforms are an Integration Services and Integration Platform (IS/IP) and an Enterprise Data Warehouse (EDW). During this phase the Fiscal Agent contract was extended by contract amendment to ensure the continued fiscal agent services throughout the transition. After the design and develop of the foundational platforms, the IS/IP and EDW vendors will continue to operate and maintain each under separate contracts.

a. Integration Services and Integration Platform (IS/IP) Operations

The IS/IP Vendor is responsible for the Operations and Maintenance (O&M) of the Integration Platform. The ongoing O&M of the Integration Platform is paid at a monthly fixed price and includes upgrading and maintaining software to the most recent versions, performing critical patch updates to systems, implementing new configuration settings and service modifications, maintaining audit logs, programs, and documentation, performing activities necessary to meet performance requirements, and Performing Annual Disaster Recovery activities. O&M also includes maintenance of the FX Enterprise Application Lifecyle (ALM) Management suite of tools and administration activities, such as provisioning access and creating new projects. The IS/IP scope also involves consistent cross-vendor coordination between SEAS, the Agency, EDW, and other vendors as they are added to the FX solution.

In July 2021, the Agency procured a cloud interconnection network, called FXNet, from Equinix to support interconnectivity between the FMMIS, IS/IP, EDW, and future FX modules. FXNet will also allow access to FX solutions via the internet, which enables work to be done via disaster recovery periods, allow Multi-Factor Authorization for external users and internal federated users who are logging in from a new location, and provide Security information and Event management. The IS/IP vendor has been tasked with creating a network architecture design to allow the FX modules to communicate with each other via the FXNet.

The Agency will work with the IS/IP vendor through Task Orders for activities required in SFY 2022-2023 with specific deliverables and milestones to include, but not limited to:

1) Integrate the ForgeRock platform into the FX Enterprise Portal to provide the single sign-on solution.

2) Develop and implement CMS interoperability patient access, formulary, and provider directory APIs for public access.

3) Develop and implement APIs to request and acquire patient access data, formulary data, and provider directory data from EDW.

4) Develop and implement the supporting technical, infrastructure, and security architecture to support the patient access API, formulary API, and provider directory API on the IS/IP platform.

5) Develop and implement substitutable medical applications and reusable technologies launching sequence of the public access API.

6) Develop and implement file transfer interface for other external source data providers for EDW.

In operations and maintenance, the Integration Platform (IP) serves as the centralized communication hub for all FX module communications. The Integration Services (IS) function orchestrates and coordinates the connections by integrating into the platform. The IS/IP Vendor is the systems integrator to plan, schedule, test, and validate connections to the platform for all future module vendors.

With the Integration Platform build complete, the IS/IP Vendor serves as the Systems Integrator to orchestrate the FX Integration ensuring the execution of the FX vision across all future module vendors and AHCA partners. Within architecture planning and standards set for the FX program, the IS/IP Vendor will contribute to architecture planning, and interoperability across the FX modules/module components, including the integration of health care data (e.g., member, provider, and claims data) from modules, as well as other enterprise system health care programs.

As a part of Module Integration activities, the IS/IP Vendor is working with partner State of Florida Agencies to analyze and classify existing FMMIS interfaces and develop approaches for modernizing the interfaces with real-time data, automation, improved data quality, and modern technology.

b. Enterprise Data Warehouse (EDW) Implementation

The Agency procured and is in the process of implementing an EDW solution, operational services, and analytical capabilities to meet the Agency's data requirements. The EDW go-live date is planned for March 2023. The EDW solution will allow the Agency to conduct complex analysis of program data for many aspects of Medicaid. The Agency and EDW vendor successfully launched the Operational Data Store (ODS), a component of the EDW, in the previous fiscal year.

c. CMSI Patient Access Rule (CPAR)

The CMS strives to improve the efficiency and effectiveness of the Medicaid Program nationwide. An example of this is the promulgation of the Interoperability and Patient Access Rule CMS-9115-F, which gives patients access to their health information. The creation of this rule required the Agency to decide whether to invest resources into the

legacy FMMIS or build compliance into the implementation of the FX Phase II foundation. The effort is not on the strategic roadmap but has been chartered as an FX project and will be monitored in the monthly status reports. The FX program scope also involves consistent cross-vendor coordination involving Deloitte, Accenture, and other vendors as they are added to the FX solution.

The project includes providing recipient claim, encounter, and formulary data to third party applications for presentation to the recipient population. Providing a provider directory to recipients is also in scope for the project. The implementation is scheduled for completion by the end of SFY 2022-2023.

d. Data Governance Framework Initiated

A Data Governance framework was initiated in SFY 2019-2020 that establishes data standards including data quality, metadata management, and data architecture and provides new efficiencies for managing data across the program and new opportunities for interoperability across the state. The Agency established a data governance organizational structure (known as the Data Governance Working Group) that is responsible for defining the standards and processes for making business-wide decisions from information assets. The group's current focus is providing the guidance needed for successful completion of the EDWI project.

5. Phase III: FX FMMIS Resolution

The objective of Phase III is to resolve the current Fiscal Agent (FA) contract. Phase III also includes activities to procure modules to transform and improve the FMMIS business processes, replacing this functionality with solutions that will be interoperable with other systems within FX, and the larger Florida HHS Agency ecosystem. The Agency will require open-source solutions, configurable commercial off-the-shelf (COTS) products, or other modular approaches to reduce reliance on custom development.

The FA vendor completed a Master Turnover Plan in August 2022. The Master Turnover Plan is an iterative approach for each FX module that is replacing FMMIS functionality. The FA vendor will coordinate with the Agency, IS/IP vendor, and FX vendors for planning activities. Turnover and transition activities will be facilitated by the IS/IP vendor in their System Integrator role. The FA vendor will provide a project plan for each turnover iteration and provide a supplemental turnover plan specific to the FX module that is replacing the FMMIS functionality in advance of the FX module go-live date, or upon notification from the Agency to begin planning activities.

1) **Unified Operations Center** (Contract with Automated Health Systems (AHS) was executed on October 13, 2022)

   Current major Agency systems (such as FMMIS and HealthTrack) and operational activities (all of which support the Medicaid Enterprise) includes multiple contact centers, vendors, and supporting software platforms. The UOC Module will include

the systems and infrastructure to support inbound and outbound multi-channel communications between the Agency and its stakeholders across the breadth of FX. This enables the Agency to consolidate communications and operational processing tasks beginning with the modules replacing the FMMIS, current FA contract, and HealthTrack. The UOC Procurement concluded with the posting of the Notice of Intent to award on June 14, 2022. The contract with the awarded vendor was executed on October 13, 2022. Services that will be provided by the UOC vendor include:

a. UOC Platform/Infrastructure- Customer management infrastructure to support all interactions between the Agency and its stakeholders. This includes the network, telephony, customer service, and business operations management technology. The UOC platform will support users across the FX enterprise including the Agency, UOC vendor, and FX module vendors.
b. Customer Service Operations- Skilled resources that support stakeholder needs across a range of customer service activities.
c. Business Area Operations- Skilled resources to support business operations or production tasks that results in the delivery of provider and recipient business services.
d. Communications Management- Management and tracking of outbound communications from the Agency to recipients and providers. This includes coordination of the release of information and ensures consistency of message and format.
e. Centralized Mail and Fulfillment- Management of printing, fulfilling, and mailing information of any type as approved by the Agency on a scheduled and an ad-hoc basis.
f. Customer Contact Analysis and Reporting- Historic and real-time analytic capabilities to understand issues, trends, and opportunities to inform decision-making and improve the interaction with Agency stakeholders.

2) **Core Systems Module** (Claims / Encounters / Enterprise Financial Management)
Core System Procurement (Vendor Award Pending)

The current Core FMMIS functions include claims/encounters transaction processing, banking, and financial processing (including capitation payments for Statewide Medicaid Managed Care (SMMC) health plans), claims payments, and pharmacy claims payments. Core FMMIS functions also include reference file management for edits and audits, benefit plans, coverage rules, reimbursement rules, diagnosis codes, procedure codes, modifiers, diagnosis related groups, revenue codes, and error codes. As the name “Core” suggests, this module represents the most essential functionality required for Medicaid processing and involves the longest combined timeframe for planning, procurement, and implementation. The completion of the Core procurement is planned for the second quarter of SFY 2022-2023.

The Core Systems module, a component of the FX Enterprise, will adjudicate fee-for-service claims for Medicaid reimbursement, process managed care encounter claims,

and support all Medicaid financial activity, including capitation payments. This approach enables the Agency to advance its goals of enabling high quality and accessible data, interoperability, improving healthcare outcomes for Floridians, reducing complexity, improving customer experience, and transforming to an enterprise, modular and flexible solution. As the name suggests, this module represents the most fundamental functionality required for Medicaid processing and the most complex functionality within FMMIS. A comprehensive analysis of the existing Core FMMIS functions was recently completed, including Electronic Data Interchange (EDI), claims and encounters transaction processing, banking, and financial processing (including capitation payments for health plans), claims payments, and pharmacy claims payments. Core FMMIS functions also include reference file management for edits and audits, third-party liability, recipient coverage dates, benefit plans and coverage rules, reimbursement rules, diagnosis codes, procedure codes, modifiers, diagnosis-related groupings, revenue codes, and error codes. These functions are interconnected and are planned to be transitioned from the current FMMIS into a Core module with multiple components integrated with FX. Most of the business operations service functions that support Core will be executed by the UOC.

3) **Provider Services Module (PSM)** Module (provider enrollment and maintenance) **PSM Procurement** (Vendor negotiations pending)

The business case for this project emphasized the need for a comprehensive requirement review to improve the provider experience and reduce the administrative burden for enrollment, licensure, and credentialing.

Currently, Medicaid enrolled providers are credentialed by the one or more health plans under which they provide services. As part of the Provider Services Module (PSM), the Agency will implement a single-source credentialing model designed to reduce duplication and improve the overall provider experience by minimizing the administrative burden.

The new FX Provider Services Module solution will have the ability to process provider enrollments with data from other systems that use provider data, such as the Florida Department of Health practitioner licensure system and the Care Provider Background Screening Clearinghouse. Active participation in the FX Executive Steering Committee (ESC) and the Executive Office of the Governor (EOG) Interoperability Workgroup is vital to the success of the Provider Services Module. The completion of the Provider Services Module procurement is planned for January 2023.

The PSM primarily includes provider Medicaid enrollment, credentialing, and maintenance. The Agency envisions a phased and flexible approach where additional functionality and responsibility can be added or defined in future-state operations, and where Agency staff can be supported by PSM Vendor staffing services during times of peak demand.

The PSM system also addresses issues of quality, integration, and interoperability. The Agency intends to leverage the National Committee for Quality Assurance standards for credentialing activities, and the Council for Affordable Quality Healthcare electronic data set. The PSM will also use the Master Person Index and Master Organization Index developed in the Phase II IS/IP implementation to improve provider identity reconciliation. Customer experience documentation, as well as business operations and support service functions, will be provided by the UOC Vendor to integrate provider touchpoints. Future opportunities exist to expand interoperability with partner agencies and systems that use or collect provider data.

4) **Pharmacy Benefits Management (PBM) Module** (procurement to begin SFY 2022-2023)

The Pharmacy Benefits Management (PBM) planning will begin SFY 2022-2023 with the required planning and analysis to prepare for the procurement. The PBM Module functions are included in the current FMMIS/FA contract. This module (which is currently subcontracted through the Fiscal Agent contract to Magellan) performs financial and clinical services for the fee-for-service (FFS) Medicaid population including drug price negotiation with manufacturers. The PBM processes pharmacy claims and e-prescribing and integrates with pharmacy point of sale systems. The PBM scope also contains prior authorization for certain required drugs and pharmacy fee collection. The future PBM scope may include monitoring prospective and retrospective drug utilization and overseeing preferred drug lists. The PBM Vendor may also provide operational staff to deliver information to providers, pharmacists, and recipients through the UOC platform.

The PBM module will perform designated financial and clinical services for the fee-for-service (FFS) Medicaid population and services that are used in both FFS and managed care (i.e., drug rebate negotiation with manufacturers and maintenance of the preferred drug list). The PBM solution includes a system to process pharmacy claims, e-prescribing functionality, integration with pharmacy point-of-sale systems, pharmacy fee collection, and pharmacy rate negotiation and rebate processing. Prior authorization for specified required drugs is also included in the PBM solution. The PBM Vendor is required to monitor prospective and retrospective drug utilization and oversee preferred drug lists. The PBM Vendor will also provide operational staff to deliver information to providers, pharmacists, and recipients. The PBM module functions are currently included in the FMMIS/fiscal agent contract and are fulfilled through a sub-contract.

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C. 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.

1. Operational Strategy for Long-Term Resources and Support

The services provided by the SEAS vendor up to this point in the project have been realigned so that some responsibilities will be moved from the vendor to the Agency or to the module vendors.

The Agency and FX implementation vendors will manage implementation and task order-based projects. The SEAS Vendor will not manage implementation or task order-based projects. SEAS' scope will continue to include but is not limited by these tasks. More details of the SEAS responsibilities are found in Task Order 008:

- Advisory Services in which SEAS provides recommendations to the Agency for consideration. SEAS does not have the authority to make decisions or act on those recommendations unless authorized by the Agency.
- The SEAS Vendor is no longer required to maintain P-1: MITA SS-A.
- SEAS technical support will shift from "develop or establish" to "update and maintain" for many artifacts and planning.
- SEAS technical support will shift from "perform" a role or task to "advise and consult" on many roles or tasks.

The Office of FX, under the Division of Operations, supports the FX vendors with complimenting state staff. The Office of FX manages the FX contracts through the implementation and certification periods which includes the oversight of the Enterprise Program Management Office.

The Office of FX works with the divisions of IT and Medicaid to manage the portfolio and change requests working with the SEAS Vendor and other contracted vendors.

Also included in this transition will be to build capacity within the Division of IT to support FX for systems integration and interoperability and support the Agency's Application Lifecycle Management (ALM) platform as well as the enterprise network, disaster recovery coordination, cyber security, and job scheduling.

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Modular Transition Approach

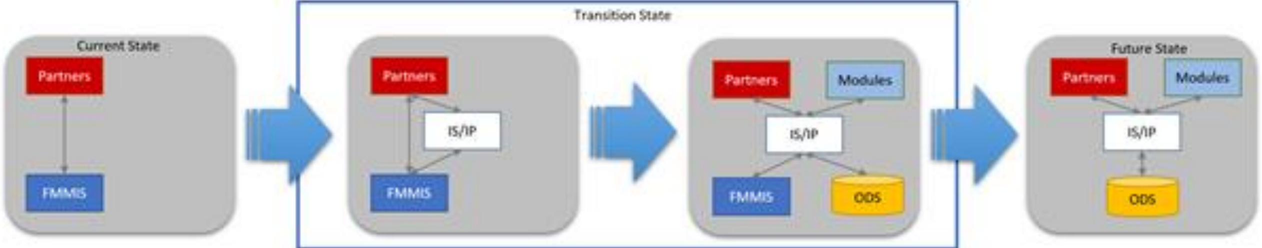

Exhibit 3: Modular Transition Approach

2. 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.

a. Current Business Process(es)

The current FX enterprise includes services, business processes, data management processes, and technical processes within the Agency, and interconnections and touchpoints with systems that reside outside the Agency necessary for administration of Agency programs, including Medicaid. The MITA Framework's Business Architecture defines ten generalized business areas, which are further broken down into a total of 80 business processes that articulate the complete inventory of business processes carried out by Florida Medicaid (and common to all states). Business Relationship Management

1) Care Management
2) Contractor Management
3) Eligibility and Enrollment Management
4) Financial Management
5) Member Management
6) Operations Management
7) Performance Management
8) Plan Management
9) Provider Management

b. Assumptions and Constraints

The FX Strategic Plan addresses the unique business requirements of FX, including

standards that affect the range of reasonable technical alternatives. On an enterprise-level, as well as on an individual project-by-project-level, successful implementation of the technical, policy, and process alternatives identified through the project is contingent on assumptions and subject to constraints.

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

1) The Agency, FX vendor staff, and other project stakeholders will be available, will actively participate in project activities, and will respond to requests in a timely manner.
2) Solicitations will result in the timely onboarding of the planned FX vendor teams with little to no impact to the master project schedule critical path items.
3) The FX 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 Agency initiatives currently in progress, and for any new initiatives over the life of the project.
4) Cooperation from stakeholders outside the Agency will be received in a timely manner.
5) The Agency and its vendors will provide proper testing environments in all existing systems and future systems to ensure continuity.
6) The Agency will evaluate and determine if non-emergency changes to existing system are critical to the program during the transition projects.
7) FX module solicitations will attract a sufficient pool of qualified vendors.
8) Agency will continue to evaluate and enforce the FX IT solutions and module vendors to adhere to the standards and guidelines published by the Department of Management Services (DMS).

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.

1) Resolution of the current FMMIS contract by December 31, 2024.
2) Changes to the existing FMMIS system will require Agency resources to focus on FMMIS changes, rather than FX development creating delays in FX system completion.
3) Agency resources are limited for review of deliverables produced by FX vendors as the same Agency resources are engaged across multiple aspects of the project.
4) Enhanced Federal Financial Participation (FFP) for FX modules and components is contingent upon approval of advanced planning documentation and module certifications by the CMS.

5) The lengthy Florida procurement process is a constraint relative to the overall project schedule. The Agency will evaluate the use of alternative source contracting and other methods to shorten procurement timelines where appropriate.

6) FX includes business processes and data transfers that rely on the cooperation and integration of outside agencies to maximize the potential benefit of FX.

These assumptions and constraints are documented and managed as part of the FX EPMO Charter and Program Management Plan (PMP) over the life of the program. Any changes to the program constraints will be updated as part of the process of updating the PMP.

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 Florida Medicaid Enterprise requires a comprehensive transformation to fulfill its mission of Better Health Care for all Floridians, while meeting evolving federal requirements and standards and responding to a changing healthcare landscape. FX is not only transformative for the Agency, but will improve how business processes are conducted, thereby affecting Agency staff, other agencies, providers, plans, and recipients.

The as-is and to-be capabilities for Medicaid business processes are aligned to the overall FX Strategic Plan. Using the MITA framework, Requirements Analysis and Development sessions have been conducted and will be iteratively updated to completely describe the business processes. This process has driven progress toward the Agency's goals of improving data quality, promoting modularity, and enhancing the provider experience.

Procurement requirements have been developed for the UOC, Provider Services Module, and Core Systems modules.

In terms of performance measures, CMS issued Standards and Conditions that must be met by states to be eligible for enhanced federal funding. These Standards and Conditions include the following:

a) CMS determines the system is likely to provide more efficient, economical, and effective administration of the State Plan.

b) The system meets the system requirements, standards and conditions, and performance standards in Part 11 of the State Medicaid Manual, as periodically amended.

c) The system is compatible with the claims processing and information retrieval systems used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs.

d) The system supports the data requirements of quality improvement organizations established under Part B of title XI of the Act.

e) The State owns any software that is designed, developed, installed or improved with 90 percent FFP.

f) The Department has a royalty free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use, for Federal Government purposes, software, modifications to software, and documentation that is designed, developed, installed or enhanced with 90 percent FFP.

g) The costs of the system are determined in accordance with 45 CFR 75, subpart E.

h) The Medicaid agency agrees in writing to use the system for the period of time specified in the advance planning document approved by CMS or for any shorter period of time that CMS determines justifies the Federal funds invested.

i) The agency agrees in writing that the information in the system will be safeguarded in accordance with subpart F, part 431 of this subchapter.

j) Use a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming, available in both human and machine readable formats.

k) Align to, and advance increasingly, in maturity for business, architecture, and data.

l) The agency ensures alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 45 CFR part 170, subpart B: The HIPAA privacy, security and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.

m) Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.

n) Support accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public.

o) Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

p) The system supports seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allows interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services as applicable.

q) For E&E systems, the State must have delivered acceptable MAGI-based system functionality, demonstrated by performance testing and results based on critical success factors, with limited mitigations and workarounds.

r) The State must submit plans that contain strategies for reducing the operational consequences of failure to meet applicable requirements for all major milestones and functionality. This should include, but not be limited to, the Disaster Recovery Plan and related Disaster Recovery Test results.

s) The agency, in writing through the APD, must identify key state personnel by name, type and time commitment assigned to each project.

t) Systems and modules developed, installed or improved with 90 percent match must include documentation of components and procedures such that the systems could be operated by a variety of contractors or other users.

u) For software systems and modules developed, installed or improved with 90 percent match, the State must consider strategies to minimize the costs and difficulty of operating the software on alternate hardware or operating systems.

v) Other conditions for compliance with existing statutory and regulatory requirements, issued through formal guidance procedures, determined by the Secretary to be necessary to update and ensure proper implementation of those existing requirements.

2) Business Solution Alternatives

The Agency’s strategy is to meet the goals of FX in a timely and cost-effective manner with a focus on minimizing risk to the project and continuing operations. As part of that effort, business process alternatives for FX were evaluated.

The “to-be” FX solution is an integrated collection of systems built from modular components that perform defined business functions allowing improved business agility, reduced dependence on a single vendor, and enablement of improved business outcomes. The “to-be” FX solution includes the scope to eventually modernize all Agency processes and applications by leveraging the Medicaid infrastructure to improve overall Agency functionality. While the characteristics of this “to-be” FX solution are consistent with all alternatives, there are multiple approach alternatives available to reach the FX solution.

A thorough research effort and market-scan of other states’ (with a bias toward those states further along on their modularity journey than Florida) strategies to modernize their Medicaid program delivery capability identified the following potential alternatives:

Modular Incremental Cutover– To replace FMMIS with multiple modules and integrate pieces as they are developed.

This alternative selects system(s) and operational processing performed for each business area and integrates the replacement modules (systems and operational processing) through incremental implementations or cut overs for business areas or bundles of business areas. With this approach the modular components of the existing system are replaced incrementally as you go until all components of all business areas are modernized. The Medicaid agencies in South Carolina, Tennessee, and Wyoming are pursuing this approach.

Modular Single-Cutover – To build a complete stand-alone modular solution before cutover.

This alternative selects, develops, integrates, and tests modular components and operational processing for all business areas and replaces the current processing through one single end-point implementation or cut-over to the new systems that are made from modular components. The Medicaid agencies in Georgia, Ohio, and Virginia are pursuing this approach.

Takeover to Modular – To have vendor(s) takeover the current FMMIS, then modularize over time.

This alternative has a vendor takeover operations of the existing fiscal agent systems and operational processing responsibilities and requires the takeover vendor to cooperate with replacing this existing solution with multi-vendor modular components over time after completion of the takeover. The Medicaid Agency in Wisconsin is pursuing this approach.

Modular Cohort Procurements – To combine business areas into fewer procurements, forcing possible vendor partnerships on larger modules.

This alternative is a variation of the modular incremental cutover approach that attempts to gain synergies by procuring and implementing modular solutions for business areas with significant interdependencies or synergies. The Medicaid Agency in New Mexico is pursuing this approach.

3) Rationale for Selection

The Agency considered the following pros and cons of each business solution alternative:

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Approach	Pros	Cons
Modular Incremental-Cutover	• Allows states to sunset elements of their current solution more quickly • Allows states to begin realizing the benefits of their transformation more quickly • Smaller integrations are less complex and less risky than larger ones • Less disruption occurs during incremental smaller implementations of each module or group of modules	• May lengthen the total transformation timeline • May result in some *throw-away* integration to the legacy MMIS solution
Modular Single-Cutover	• Decreases time and effort necessary to integrate with legacy system • Minimizes transformational-related changes to the legacy MMIS solution	• Full legacy solution remains live until cutover creating duplicate costs before legacy system resolution • Single large integration carries more complexity and risk
Takeover to Modular	• Allows ability to retain select elements of the legacy solution that may be functional • Minimizes disruption with current stakeholders • Provides a longer *runway* for modularity transition because it restarts the contract terms on the legacy system	• Reduces ability to leverage improved technology, especially in the short term • Delays realization of the benefits of modularity • Risk of limited vendor response to a takeover procurement • CMS has been less open to takeover procurements in recent years and these efforts may qualify for lower levels of Federal funding participation

Approach	Pros	Cons
Module Cohorts	• Fewer procurements could reduce the overall transformation timeline	• The vendor community has limited experience responding to these combined procurements • This strategy results in increased dependence on a small number of vendors • Potential for increased risk from complex sub/prime vendor relationships necessitated by the cohorts of business functionality

Exhibit 4: High-Level Rational

4) Agency Selection: Modular Incremental-Cutover Approach

The selection of the *modular incremental* cutover approach for FX is based on alignment to the vision and strategic priorities of the transformation.

The *modular incremental-cutover* approach achieves the right balance across these transformation priorities. Leveraging this option, we expect to achieve the transformation objectives at the lowest risk and realize transformation benefits more quickly, all while minimizing unnecessary staff impact and maximizing the efficiency of transformation resources.

At a broad level, the benefits of FX, that will be accelerated by the modular incremental cutover approach, are:

a) Integrated systems that can interoperate and communicate without relying on a common platform or technology
b) The ability to leverage technologies and systems for multiple functions in the FX Enterprise through procurement of modules and COTS technologies
c) Enhanced FFP for AHCA systems to maximize federal funding

The fundamental changes brought about by the near-term Phase II transformation activities of implementing the foundational EDW and IS/IP will support a single source of truth for data and will enable improvements to key business process areas through future project phases.

5) 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.

FX has leveraged the *modular incremental* cutover approach to replace the current functions of FMMIS/DSS/Fiscal Agent contract in phases. Planning has been based on the CMS Standards and Conditions to ultimately transition to an interoperable and unified FX where individual processes, modules, sub-systems, and systems work together to support Agency programs. FX will replace large, core aspects of the existing FMMIS and fundamentally improve business processes across multiple stakeholder groups encompassing recipients, providers, and Agency staff. A summary of the phases is included below.

a) *Phase I: Professional Services Procurements*. This phase focused on the procurement of professional service partners to support strategic planning and independent evaluation of the FX transformation.
b) *Phase II: FX Infrastructure* (which overlaps with the Phase III) includes procurement, implementation, and integration of the IS/IP and EDW components. Phase II also includes planning and development for additional FX modules.
c) *Phase III: FX FMMIS Resolution* is concurrently underway. Phase III of the FX transformation is focused on the procurement and implementation of the modules that will replace the FMMIS functionality. These modules include, the Unified Operations Center, the Core Systems, the Provider Services Module, and the Pharmacy Benefit Management Module.

6) Functional and Technical Requirements

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

Include through file insertion or attachment the functional and technical requirements analyses documentation developed and completed by the agency.

The functional and technical requirements for the FX modules define the processing requirements to accomplish the Agency mission and administration of the Medicaid program. These requirements align with the standard requirements of the healthcare insurance payer industry and include the unique aspects of administration of the Medicaid program. CMS historically has prescribed many functional requirements and provided direction through its documentation of MITA. MITA defines business, information, and technology architecture direction, standards, and processes. Functional and technical requirements are developed in accordance with MITA 3.0, and CMS Standards and Conditions (summarized in Section I. C. 1.). CMS has enforced adherence to defined requirements through the CMS certification process reviews to receive enhanced funding of ongoing operations. CMS actively promotes requirements reuse and interoperability between state system implementations.

The functional and technical requirements for each module use the following sources as input:

a. Requirements corresponding to each functional business area that were included in the requirements for State of Florida fiscal agent operations in previous fiscal agent replacement procurements
b. Module requirements included in procurements developed by other states
c. Leverage module requirements developed by the NASPO ValuePoint consortium of states
d. Standard healthcare industry payer requirements
e. Requirements included in other recent Florida agency procurements for similar functionality (e.g., licensing and enrollment systems)
f. Requirements established by the Florida Department of Management Services (DMS)

Requirements included in the scope of services of each module follow a standardized structure to promote consistency. The technical, security, information management, operations and maintenance, and project implementation methodology requirements are largely the same for most modules. The requirements also provide guidance on the desired degree of standardization and reuse of certain technology components used with module processing.

Requirements are defined and used through the phases of the FX Program Life Cycle. During planning, high-level requirements focused on process improvements are defined. During procurement, procurement level requirements that define the scope and expected services of vendors are defined. During project implementation, vendor(s) may validate and elaborate procurement requirements to a more detailed level that are comprehensive and discretely testable. In operations and maintenance, the detailed requirements are used to perform impact analysis and define what types of regression testing are needed when there are changes.

Exhibit 5 is a table of high-level requirements already defined for the IS/IP, EDW, Provider, Core, and UOC modules. These requirements informed the SFY2021-22 procurements.

Module Requirement	
IS/IP	
	Enterprise Service Bus
	Master Person Index/Master Organization Index
	Managed File Transfer
	Business Rules Engine
	Publish Subscribe Alerting
	Service Registry and Repository
	Single Sign-On
EDW	
	Security
	Reporting and Analytics

Module Requirement	
	Fraud and Abuse Reporting
	Quality Reporting
	Federal and Financial Reporting
	Operational and Analytical Data Stores
	Data Mart and Specialized Data Stores
	Enterprise Content Management
	Information Architecture
	Interfaces and Data Services
	Data Quality Control and Data Standardization
	Change Management
	Operations Testing
	Quality Management
	System and User Documentation
Provider Services Module	
	Provider Enrollment
	Enroll Provider
	Determine Provider Eligibility
	Disenroll Provider
	Inquire Provider Information
Provider Credentialing	
	Provider Information Management
	Terminate Provider
	Manage Provider Information
	Provider Support
	Manage Provider Grievance and Appeal
Core Systems (Claims/Encounters/Financial)	
	Edits, Processing, And Adjustments
	Pricing and Payment
	Benefit and Reference Data Management
	Claims Data and Reporting
	System Administration and Operations
	Service Authorizations
	Fiscal Management
	Federal Reporting
	Financial Reporting
	Capitation Payments
Unified Operations Center	
	Correspondence Management
	Customer Experience Strategy and Methodology
	Enterprise Customer Service Support
	Business Services – Provider Management
	Business Services – Recipient Management

Module Requirement	
	Enterprise Operations Management
	Workflow Management

Exhibit 5: High-Level Requirements

Exhibit 6 is an inventory that shows the business processes by module for which functional requirements will be defined.

Business Process Tables	
Module	**Business Process**
Pharmacy Benefit Management	
	Accounts Receivable Management
	Manage Drug Rebate
Plan Management	
	Compliance Management
	Prepare Recipient Explanation of Medical Benefits (REOMB)
	Identify Utilization Anomalies
	Establish Compliance Incident
	Manage Compliance Incident Information
	Determine Adverse Action Incident
	Health Benefit Administration
	Manage Rate Setting
	Manage Health Benefit Information
	Manage Reference Information
	Health Plan Administration
	Manage Health Plan Information
	Health Plan Management
	Manage Performance Measures
Third Party Liability (TPL)	
	Accounts Receivable Management
	Manage TPL Recovery
	Manage Estate Recovery
Enterprise Case Management	
	Case Management
	Manage Case Information
	Establish Case
Contractor Management	
	Contract Management
	Produce Solicitation
	Close Out Contract
	Award Contract
	Manage Contract
	Contractor Information Management

Business Process Tables	
Module	**Business Process**
	Manage Contractor Information
	Inquire Contractor Information
	Contractor Support
	Manage Contractor Communication
	Perform Contractor Outreach
	Manage Contractor Grievance and Appeal
	Standards Management
	Establish Business Relationship
	Manage Business Relationship Information
	Terminate Business Relationship
	Manage Business Relationship Communication

Exhibit 6: FX Module Business Processes

7) 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**	**Module**	**How will the Criteria be measured/assessed?**	**Who benefits?**	**Realization Date (MM/YY)**
1	Successful completion of MES Certification requirements and receipt of full CMS certification authorization back to day one of operations for each FX module.	N/A	Measured and assessed by CMS through the CMS-prescribed certification process	Medicaid Enterprise Florida State Government CMS	Ongoing as modules are operational
2	Successful completion of the design, development, and implementation (DDI) of the IS/IP Vendor’s solution.	IS/IP	Assessed by the Agency’s IS/IP Implementation team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Florida State Government CMS	03/21 Completed

Success Criteria Table					
#	**Description of Criteria**	**Module**	**How will the Criteria be measured/assessed?**	**Who benefits?**	**Realization Date (MM/YY)**
3	Successful completion of the design, development, and implementation (DDI) of the EDW Vendor's solution.	EDW	Assessed by the Agency's EDW Implementation team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise	3/23 In Process
4	Successful development of requirements for the UOC module procurement	UOC	Assessed by the Agency's Business Process Outsource team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Florida State Government CMS	06/21 Completed
5	Successful completion of the design, development, and implementation (DDI) of the UOC solution	UOC	Assessed by the Agency's Business Process Outsource team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Providers Recipients	06/25
6	Successful development of requirements for the Core (Claims/Encounters/Financial) Systems module procurement.	Core	Assessed by the Agency's Core team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Florida State Government CMS	07/21 Completed
7	Successful completion of the design, development, and implementation (DDI) of the Core Systems solution.	Core	Assessed by the Agency's Core team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Providers Recipients Florida State Government CMS	06/25

Success Criteria Table					
#	Description of Criteria	Module	How will the Criteria be measured/assessed?	Who benefits?	Realization Date (MM/YY)
8	Successful development of requirements for the Provider Services Module procurement.	Provider	Assessed by the Agency's Provider Management team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Florida State Government CMS	08/21 Completed
9	Successful completion of the design, development, and implementation (DDI) of the Provider Services Module solution.	Provider	Assessed by the Agency's Provider Management team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Providers	07/24
10	Successful development of requirements for the Pharmacy Benefit Management module procurement.	PBM	Assessed by the Agency's team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Florida State Government CMS	6/23
11	Successful completion of the design, development, and implementation (DDI) of the Pharmacy Benefit Management solution.	PBM	Assessed by the Agency's team comprised of Agency Subject Matter Experts and SEAS Support	Medicaid Enterprise Providers Recipients	06/25
12	Fully and successfully implement all Phase III modules.	Phase III	Assessed by the Agency's team comprised of Agency Management and SEAS Support	Medicaid Enterprise Florida State Government	06/25

Exhibit 7: Success Criteria

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.

The table below presents categories of tangible and intangible benefits anticipated through the FX life cycle. Detailed tangible benefit calculations are contained in the Cost Benefit Analysis, and those calculations are conservative estimates of the tangible benefit amounts. Through the ongoing strategic planning and planned updates of FX, additional tangible benefits will be identified and quantified. The Benefits Realization dates will be refined through the strategic project portfolio process and project management activities including project schedule development, requirements development, and project planning activities.

Benefits Realization Table					
#	**Description of Benefit**	**Who receives the benefit?**	**How is benefit realized?**	**How is the realization of the benefit measured?**	**Realization Start Date (MM/YY)**
1	Improved analytic staff productivity	State of Florida Medicaid Enterprise	Implementation of EDW	Reduced FTE time spent on analytical and data-related tasks	04/23
2	Improved operational staff productivity via automation of manual tasks	State of Florida Medicaid Enterprise	Implementation of EDW	Reduced FTE time spent on manual tasks	04/23
3	Improved analytic tools, processing speed, and persona-optimized data stores	State of Florida Medicaid Enterprise	Implementation of EDW	Improved fraud identification and recovery processing	04/23

Benefits Realization Table					
#	**Description of Benefit**	**Who receives the benefit?**	**How is benefit realized?**	**How is the realization of the benefit measured?**	**Realization Start Date (MM/YY)**
4	Reduced enrollment and licensure costs incurred by providers (first time and renewals)	Providers	Implementation of the Provider Services Module	Lower total provider administrative processing cost for Medicaid enrollment and licensure	07/24
5	Reduced enrollment and licensure support costs to AHCA (first time and renewals)	State of Florida Medicaid Enterprise	Implementation of the Provider Services Module	Lower total cost to the Agency for enrollment and licensure support	07/24
6	Reduced enrollment and licensure support costs to AHCA by fiscal agent	State of Florida Medicaid Enterprise	Implementation of the Provider Services Module	Lower fiscal agent cost to the Agency for enrollment and licensure support	07/24
7	Reduced contact and interaction management cost to Agency	State of Florida Medicaid Enterprise	Implementation of the UOC	Lower total cost to the Agency for public-facing contact and management	06/25
8	Reduced cost of contact center interaction - recipient time	Recipients State of Florida Medicaid Enterprise	Implementation of the UOC	Reduced recipient time spent per contact	06/25

Benefits Realization Table					
#	Description of Benefit	Who receives the benefit?	How is benefit realized?	How is the realization of the benefit measured?	Realization Start Date (MM/YY)
9	Reduced inaccurate payments (e.g., capitation payments through identity matching of duplicate recipients)	State of Florida Medicaid Enterprise	Implementation of EDW and the Core Systems module	Fewer inaccurate payments made to individual FFS Providers	04/23 and 06/25
10	Reduced Agency costs resulting from difference and latency in health plan policy implementation	State of Florida Medicaid Enterprise	Implementation of the Core Systems module	Lower Agency cost related to new and changed health plan policies	10/24
11	Reduced claim and encounter administration costs incurred by Agency operation management	State of Florida Medicaid Enterprise	Implementation of the Core Systems module	Lower percentage of encounters rejected and returned to the health plans (current benchmark is 30% returned)	10/24
12	Reduced claims administration costs incurred by providers	Providers	Implementation of the Core Systems module	Lower percentage of claims rejected and returned to providers (current benchmark is 35% returned)	10/24
13	Reduced encounter administration costs incurred by health plans	Health Plans	Implementation of the Core Systems module	Lower percentage of recipients utilizing a call center to make a plan selection	10/24

Benefits Realization Table					
#	**Description of Benefit**	**Who receives the benefit?**	**How is benefit realized?**	**How is the realization of the benefit measured?**	**Realization Start Date (MM/YY)**
14	Reduced encounter administration costs incurred by providers	Providers	Implementation of the Core Systems module	Lower total administration costs for providers	10/24
15	Reduced payment administration costs incurred by providers	Providers	Implementation of the Core Systems module	Lower total administration costs for providers	10/24
16	Reduced FFS pharmacy expenditures	State of Florida Medicaid Enterprise	Implementation of Pharmacy Benefit Management module	Lower total FFS pharmacy costs	06/25
17	Leverage and reuse technologies and systems through procurement of configurable COTS technologies and modules that require no custom development	State of Florida Medicaid Enterprise	Implementation of FX projects	Measured by the cost reduction in the acquisition of FMMIS replacement modules	TBD

Exhibit 8: Benefits Realization Table

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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.

1. The Cost Benefit Analysis (CBA) Forms

Exhibit 9 summarizes the required CBA Forms, which are included as Appendix A on the Florida Fiscal Portal, and must be completed and submitted with the Schedule IV-B.

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

Exhibit 9: Cost Benefit Analysis

- See the tab entitled "CBAForm1 NetTangibleBenefits" in the CBA file in Attachment A Cost Benefit Analysis.

- See the tab entitled "CBAForm2A BaselineProjectBudget" in the CBA file in Attachment A Cost Benefit Analysis.

CBAForm 2 - Project Cost Analysis

Agency	AHCA	Project	FX

PROJECT COST SUMMARY (from CBAForm 2A)							
PROJECT COST SUMMARY	Prior Years' Costs	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	TOTAL
TOTAL PROJECT COSTS (*)	$242,532,770	$160,272,360	$141,347,755	$49,428,823	$0	$0	$593,581,707
CUMULATIVE PROJECT COSTS (includes Current & Previous Years' Project-Related Costs)	$242,532,770	$402,805,129	$544,152,884	$593,581,707	$593,581,707	$593,581,707	
Total Costs are carried forward to CBAForm3 Project Investment Summary worksheet.							

PROJECT FUNDING SOURCES - CBAForm 2B							
PROJECT FUNDING SOURCES	Prior Years' Costs	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	TOTAL
General Revenue	$27,650,710	$18,821,417	$22,407,576	$4,984,084	$0	$0	$73,863,787
Trust Fund	$0	$0	$0	$0	$0	$0	$0
Federal Match	$214,882,060	$141,450,943	$118,940,180	$44,444,739	$0	$0	$519,717,921
Grants	$0	$0	$0	$0	$0	$0	$0
Other Specify	$0	$0	$0	$0	$0	$0	$0
TOTAL INVESTMENT	$242,532,770	$160,272,360	$141,347,755	$49,428,823	$0	$0	$593,581,707
CUMULATIVE INVESTMENT	$242,532,770	$402,805,129	$544,152,884	$593,581,707	$593,581,707	$593,581,707	

Characterization of Project Cost Estimate - CBAForm 2C			
Choose Type		Estimate Confidence	Enter % (+/-)
Detailed/Rigorous		Confidence Level	
Order of Magnitude	X	Confidence Level	15%
Placeholder		Confidence Level	

Exhibit 10: Project Cost Analysis

CBAForm 3 - Project Investment Summary

Agency	AHCA	Project	FX

	COST BENEFIT ANALYSIS -- CBAForm 3A						
	1	2	3	4	5	6	
	Prior Years' Costs	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	TOTAL FOR ALL YEARS
Project Cost	($242,532,770)	($160,272,360)	($141,347,755)	($49,428,823)	$0	$0	($593,581,707)
Net Tangible Benefits	$0	$9,703,239	$40,287,751	$150,570,522	$289,375,889	$289,640,291	$779,577,692
Return on Investment	($242,532,770)	($150,569,121)	($101,060,004)	$101,141,699	$289,375,889	$289,640,291	$185,995,984
						NPV =	$98,494,280

RETURN ON INVESTMENT ANALYSIS -- CBAForm 3B		
Payback Period (remaining years)	5.64	Payback Period is the time required to recover the investment costs of the project.
Breakeven Fiscal Year	2027-28	Fiscal Year during which the project's investment costs are recovered.
Net Present Value (NPV)	$98,494,280	NPV is the present-day value of the project's benefits less costs over the project's life cycle.
Internal Rate of Return (IRR)	9.37%	IRR is the project's rate of return.

	Investment Interest Earning Yield -- CBAForm 3C					
Fiscal Year	Prior Years	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28
Cost of Capital	3.50%	3.50%	3.50%	3.60%	3.60%	3.60%

Exhibit 11: Project Investment Summary

2. The Cost Benefit Analysis Results

FX is a multi-year program with costs and benefits estimated throughout the life of the program. The FX Program strategy and roadmap are assessed continually, with estimates being fine-tuned to incorporate new information. As such, cost and benefit amounts may change year-over-year as the FX strategy evolves and planned activities are conducted.

When examining costs for the entire period of FX program expenditures (i.e., through SFY 2025-2026), it is important to understand the treatment of M&O costs in the IV-B. M&O costs are treated as follows:

- The IV-B CBA only carries "transitional M&O". This is M&O that occurs in a fiscal year during which implementation is completed; i.e., DDI activity ends during the fiscal year in question. By contrast, NO M&O is present in a fiscal year that follows full implementation (there is no DDI in the year in question). Therefore, for all fiscal years following full implementation, no M&O is presented in the IV-B.

The reason for this treatment is that the IV-B is not a request for ongoing operating funds, which is what M&O is in a post-implementation fiscal year. The IV-B is a request for non-recurring funds, and only transitional M&O (M&O that supports transition to the newly implemented functionality) is therefore included.

The projected net benefits for FX are significant. Exhibit 12 presents an estimated NPV from the program of **$98,494,280**. The NPV calculation includes an estimate of **$779,577,692** in total program benefits and total program costs of **$593,581,707***. Because benefits continue after the analysis period, the calculated NPV is conservative, potentially understating benefits of the project to the Agency and Florida stakeholders.

*Of note is that $242,532,770 of the total program cost has been expended prior to SFY 2023-2024. This leaves a balance of $351,048,938 in program costs spread across the remaining program years. Additionally, $304,835,861 of this balance is to be paid through federal match dollars, leaving $46,213,077 to be paid with State of Florida funds.

a. Program Costs

The estimated total cost of implementing FX is $**593,581,707** over the life of the program.

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b. Project Financial Return Analysis

The Agency has computed the following values for FX.

Investment Term	Computed Value
Total Cost	$593,581,707
Benefits	$779,577,692 in total benefits
Payback Period	5.64 years
Payback Date	SFY 2027-2028
	Analysis
Net Tangible Benefits	$185,995,984 (total benefits minus total costs)
Net Present Value (NPV)	$98.5M
Internal Rate of Return (IRR)	9.37%

Exhibit 12: Project Financial Return Analysis

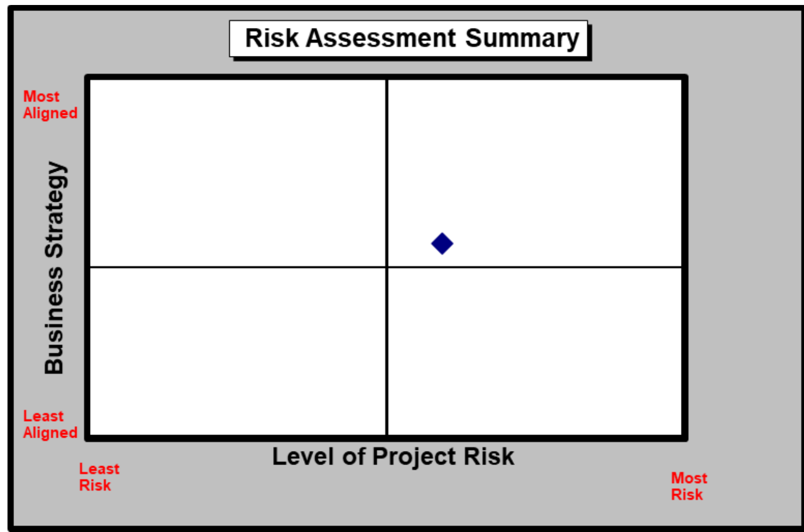
The breakeven year is SFY 2027-2028, meaning that benefits from FX will have fully “paid back” the investment costs of the program by that time. This breakeven indicates a strong program that pays for itself relatively quickly.

- The program NPV is $98.5 million. NPV is the present-day value of the program's benefits less costs over the program's life cycle. By this measure, the FX program is a sound investment.
- The IRR for FX is 9.37 percent. The IRR is an individual program's (such as FX’s) rate of return, and serves as a useful comparison when the Florida Legislature is making investment decisions. The Florida Legislature’s Office of Economic and Demographic Research (EDR) estimates the cost of capital for investment analysis purposes; for SFY 2023-2024, that rate is 3.50%. The FX program’s IRR far exceeds the projected cost of capital, and the program should produce considerable tangible benefits well-beyond the analysis period.

The Agency recommends that funding for continuation of the FX Program be requested by the Executive Office of the Governor and approved by the Legislature. The Agency is fully focused on successfully implementing the FX Program and has implemented an Outcomes Management Framework designed to help achieve identified benefit targets. The recommended next step is to secure the needed funding for SFY 2023-2024.

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.



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

Exhibit 13: Project Risk Assessment Summary

Exhibit 13 shows a snapshot of the RA Project Assessment Tool Summary Tab. The completed Risk Assessment Tool is Attachment B. FX is a program in the project management context. FX consists of many projects, which are evaluated, prioritized, and managed using portfolio and

program management processes to achieve intended outcomes and benefits. Standards and processes exist for project, program, and portfolio risk management. These can be found in the approved FX Project Management Standards, the FX EPMO Charter and Program Management Plan, and the FX Strategic Project Portfolio Management Plan.

The following questions in the Risk Assessment Tool were answered with these considerations:

- Question 1.02 – FX is a program in the project management context. FX consists of many projects, which are evaluated, prioritized, and managed using portfolio and program management processes to achieve intended outcomes and benefits. The FX objectives exist in the FX Strategic Plan. The objectives have been socialized with key stakeholder groups.
- Question 1.04 – The vision for how changes to the technology will improve business processes is documented and the approach has been approved by CMS.
- Question 1.07 – Some project phases and milestones are impacted by outside factors such as renewals of existing service contracts and state and federal funding. CMS understands the requirements of a program of this size and complexity.
- Question 1.08 – This answer refers to current awareness and knowledge of FX Program. This was previously answered as *Moderate external use or visibility* with the note visibility will increase as the program evolves and customers (providers, recipients, and other stakeholders) are introduced to new technologies. For FY 2022-23, this is increased to *Extensive external use or visibility* in anticipation of the implementation activities planned to start in FY 2022-23. Implementation will include Organizational Change Management activities, which will likely engage external stakeholders.
- Question 2.01 – The risk is mitigated by the SEAS Vendor and other FX vendors who have experience with the proposed solutions.
- Question 2.04 – All technology solutions must adhere to the standards and guidelines published by the DMS and CMS. All technology decisions must be approved by the FX Technology Standards Committee.
- Question 2.05 – Some minor legacy infrastructure components may be leveraged in the new solution, plus the integration platform was implemented in March 2021. Once the Enterprise Data Warehouse is implemented in FY 2022-23, only moderate infrastructure changes will remain.
- Question 3.03 – Process and policy changes are being documented as a task within each project schedule so they can be assessed at a project level.
- Question 3.04 – While the OCM Plan has been approved, it is updated as needed to reflect the evolving needs of FX. As the program progresses, new vendors are contracted, and new stakeholders get engaged.
- Question 3.06 – During the course of FX, more than 10% growth in the number of contractors is expected during design, development, and implementation activities. Once FX meets its objectives and transitions to operations, the change in the number of contractors is expected to decrease to 1% - 10%.
- Question 3.07 – It is expected that Medicaid providers will experience changes in the way they exchange data with the Agency. It is anticipated Medicaid recipients will experience moderate to low impact change that will improve their experience interacting with Medicaid.
- Question 3.09 – The vision for FX is far-reaching with many organizational change

requirements. The Agency has not recently undertaken a project with such a far-reaching vision and change requirements.

- Question 4.05 – Additional messages are developed to meet the needs of the evolving program.
- Question 4.06 – Key messages exist, and message outcomes or success measures are created as key messages are developed.
- Question 5.01 – FX spans multiple fiscal years and includes plans for many future projects, modules, and activities. A Spending Plan does not exist for the entire program. Spending Plans will be prepared for each fiscal year as work is prioritized and authorized through the portfolio management process. They will include spending needs to support contracts that are fully negotiated and signed. Order of Magnitude estimates have been developed for the FX module roadmap.
- Question 5.02 – Expenditures for the current fiscal year have been documented; planning and estimating have been done for future fiscal years.
- Question 5.09 – Extensive benefits validation has occurred but there may be additional benefits to identify and validate as the program evolves.
- Question 5.10 – The overall measurable payback for FX will be more than five years. Various sub-projects may realize payback within five years.
- Question 5.16 – Procurement selection criteria and outcomes have been clearly identified for current procurements. They have not yet been defined for future procurements.
- Question 5.18 – The procurements require *demos* of bidders' solutions; however, a demo isn't the same as a proof of concept or prototype.
- Question 6.03 – The Agency is responsible for integrating project deliverables into the final solution. The SEAS Vendor and the IS/IP Vendor support the Agency with the strategic, architectural, and technical elements of integration.
- Question 6.06 – This risk is mitigated in multiple ways. The Agency has assigned an experienced project manager to FX. The SEAS Vendor also has experience, and dedicated project managers assigned to the program and to the FX EPMO. Future FX vendors will also bring experienced, dedicated project managers to the program. IV&V is also contracted to oversee the program.
- Question 6.11 – Changes of a certain threshold are brought to FX Governance for consideration and authorization. All the Agency's functional areas are represented. by the FX Program Governance Group.
- Questions 7.04 and 7.05 – As of this writing, requirements and design specifications have been defined and documented for IS/IP and EDW. Requirements have been documented for the PSM, Core, and UOC modules. However, design specifications for those modules have not yet been documented. Additional modules will be elaborated and documented timely with their procurements.
- Question 7.08 –Major project deliverables are reviewed and approved by the FX Program Governance Group.
- Question 7.10 – A roadmap for the multi-year program including a high-level schedule has been approved.
- Question 7.11 – The FX Program is comprised of multiple projects, all of which have schedules that include all project tasks, milestones, dependencies, and resources. Anticipated projects have been identified in the FX Portfolio. Their tasks will be elaborated when FX Governance authorizes the project.

- Question 8.03 – It is expected team members will be dispersed across more than three locations during SFY 2022-2023: Agency staff are located at the Ft. Knox Office Complex. FX module vendors are located in multiple locations.

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

The Medicaid Enterprise System (MES) is a collection of many systems required to operate and maintain the Florida Medicaid program, each with its own platform, systems architecture, and proprietary data stores. The systems in the MES are islands of processing and information. Data exchange provides the bridge between these systems. The current Medicaid Enterprise includes the FMMIS and multiple systems and functions integrated or interfacing with the FMMIS, such as Automated Health Systems (AHS) HealthTrack system, the Health Information Exchange (HIE), and care management organization systems. **Exhibit 14** summarizes Florida's MMIS which encompasses mission critical business systems upon which the Medicaid Enterprise and Medicaid ecosystem depend.

This current state can be categorized as follows:

- Providers, health plans, and Agency systems primarily submit information to MMIS through Electronic Data Interchange (EDI) and Secure File Transfer Protocol (SFTP) batch transmissions
- Pharmacy Benefits is operated by an outside vendor, Magellan
- The enrollment broker vendor is Automated Health Systems. AHS operates both the Choice Counseling call center to enroll recipients in health plans and the Provider Network Verification (PNV) system to monitor health plan's provider network adequacy
- Other Florida agencies perform Medicaid processes using replicated Medicaid data; primarily using batch interfaces
- The Decision Support System (DSS) is the data warehouse that supports analytics, ad hoc inquiry and management, and administrative reporting
- The HIE system enables provider-to-provider exchange of information
- The system lacks a 360-degree view of recipient information or alerting of changes in social determinants of health data

MEDICAID ECOSYSTEM – Stakeholders and Other entities

Medicaid Enterprise

Medicaid Management Information System

Encounter Processing,
Fee-For-Service (FFS) Claims Processing,
DSS/Data Warehouse,
Prior Authorization (PA), Third Party Liability (TPL),
Pharmacy Benefits Management,
Member Services,
Financial Management,
Provider Eligibility and Enrollment Services

Recipient Eligibility & Enrollment
Managed Care Organizations
Federally Facilitated Marketplace (FFM)
Health Information Exchange
Medicaid Fiscal Agent Operations (MFAO)
SEAS Vendor

Facilities
Providers
Clearinghouses
Recipients
Other Payers
License Boards
State Legislature
Treasury
Other Florida State Agencies
CMS
Other Federal Agencies
Other States
Public
Researchers
Vendors
Standards Organizations

Exhibit 14: Medicaid Ecosystem

1. Current System

The information technology that supports the operation of the Medicaid program is distributed across many state agencies, health plans, and provider systems. There are hundreds of state agency computer systems and thousands of provider systems that must work together to deliver healthcare services to the people of Florida. In this highly distributed technology landscape, there is substantial duplication and inconsistencies of information and processing across systems.

Currently ten state agencies, including AHCA, have direct responsibilities for processing or supporting the operation of the Medicaid program. Within the Agency alone, there are more than 140 computer systems or applications in operation. More than 60 of these systems play a direct role supporting the operation of the Medicaid program. A complete list of FMMIS Inbound/Outbound Interfaces can be found in Appendix E.

The current Medicaid Enterprise contains several primary components including Electronic Data Interchange (EDI), the MMIS/DSS, interChange User Interface (UI), and the Pharmacy Benefit Management System (PBMS), all of which are built around Service Oriented Architecture (SOA) principles.

EDI manages the flow of the various X12 transactions into and out of the Medicaid Enterprise. EDI utililzes BizTalk and Simple Object Access Protocol (SOAP) servers, mapping X12 transactions into proprietary Extensible Markup Language (XML) file structures for processing in the FMMIS.

a. Description of Current System

The largest systems in the Medicaid Enterprise are the FMMIS and DSS-DW, currently

operated by the fiscal agent, Gainwell Technologies. The FMMIS components of the system are comprised primarily of a collection of custom-built software applications used for processing Medicaid claims and encounter transactions. This processing includes the adjudication of claims and encounter transactions via batch processes and online submissions, the processing of financial transactions, producing and distributing payments, the storing and utilization of provider and recipient enrollment and demographic data, and the implementation of business rules and supporting reference data.

The DSS components of the system are comprised of a collection of Extract, Transform, and Load (ETL) programs written in the C programming language, a set of Business Intelligence tools, and an Oracle database. The DSS provides the tools necessary for analytics and reporting.

The technologies utilized in the implementation of the FMMIS/DSS include Windows and HP-UX operating systems, Oracle and SQL Server databases; COTS products such as Business Objects, Crystal Reports, SPSS, and ArcView GIS; programming languages include C, C#, VB.NET, JavaScript, Perl, VBScript, R, and SAS. The FMMIS/DSS system is hosted at a commercial data center in Orlando, Florida.

The interChange User Interface (UI) is a web-based solution developed with Microsoft.NET technologies. The UI allows highly detailed access to all Claims, Provider, Recipient, Financial, and Reference data stored in the FMMIS. Authorized users also have update capabilities to relevant data.

The PBMS is a Point-of-Sale (POS) Pharmacy Claims processing system operated and maintained by Magellan Health Services. Currently the PBMS is comprised of proprietary software running on a UNIX platform with an Oracle Database from a data center in Maryland Heights, Missouri. This system receives and adjudicates Point-of-Sale NCPDP D.0 claims transactions which are subsequently transmitted via SFTP to the MMIS for payment. Users interact with pharmacy data via interChange or by means of FirstRx, a proprietary user interface operated by Magellan Health Services.

The number of agencies and systems that access and manage data used for healthcare delivery is likely to expand significantly. These agencies exert significant effort processing system-to-system interfaces to extract, load, and update information in one system with information from another system. Because of the many systems in operation, there is not a reliable *single source of truth* to make processing, reporting, policy analysis, investigation, or analytic decisions. Differences in data timeliness, data validation, data transformation, and application of policy within systems means reports and data analysis vary depending on which system performs the analysis.

Exhibit 15 provides a current state overview of the major components of the MMIS/DSS systems and interfaces with those systems.

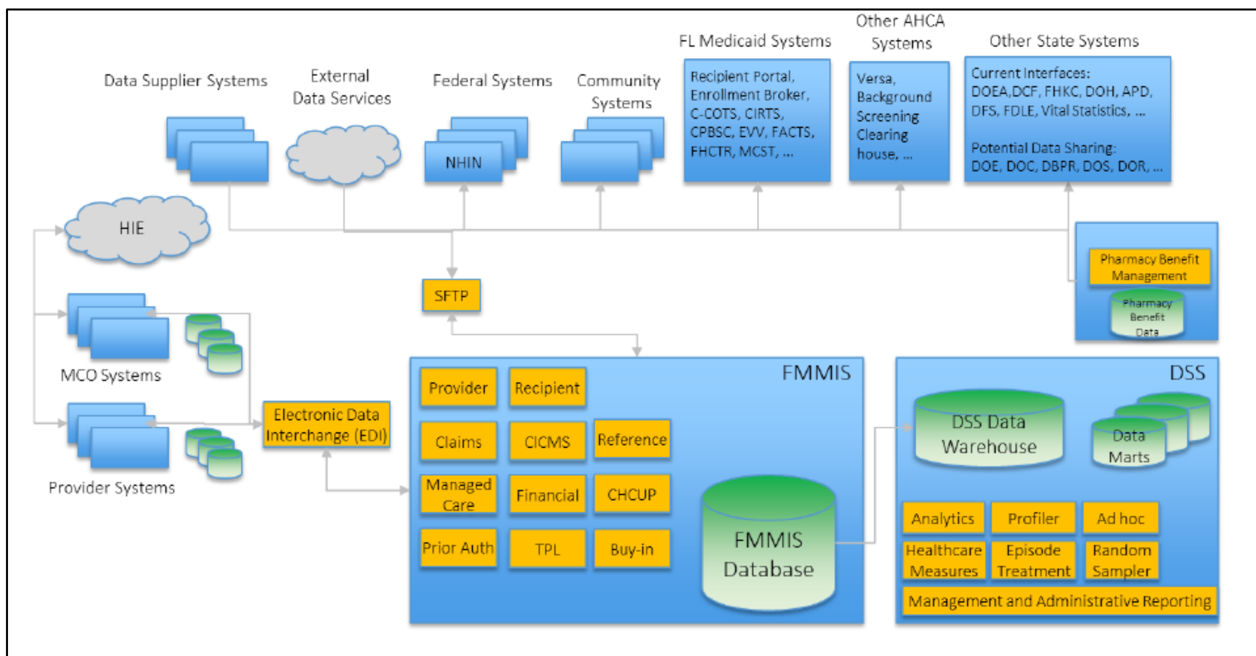


Exhibit 15: Current Conceptual Technical Architecture

As evidenced by the descriptions and visual above, Florida's health care delivery relies on highly distributed processing by many agencies and systems. Agency silos often operate with their own version of data, tools, business rules, software, and strategies. The current data architecture is causing many data challenges. There is no *single source of truth* since each agency and system have their own data. This duplication creates challenges in how agencies share data to perform their day-to-day functions. Likewise, there are over sixty (60) applications within the Agency that process Medicaid data—many of which have their own data stores. This is a challenge because the data from one application may not be consistent with the data from another application. As shown in **Exhibit 16** the main challenge is data stored across groups within the Agency, causing the following data integrity and availability issues:

- Multiple and often inconsistent versions of data
- Questions about the completeness, quality, and timeliness of data
- Poor analytic processing response times
- Inconsistent use of analytics, predictive modeling, and reporting capabilities

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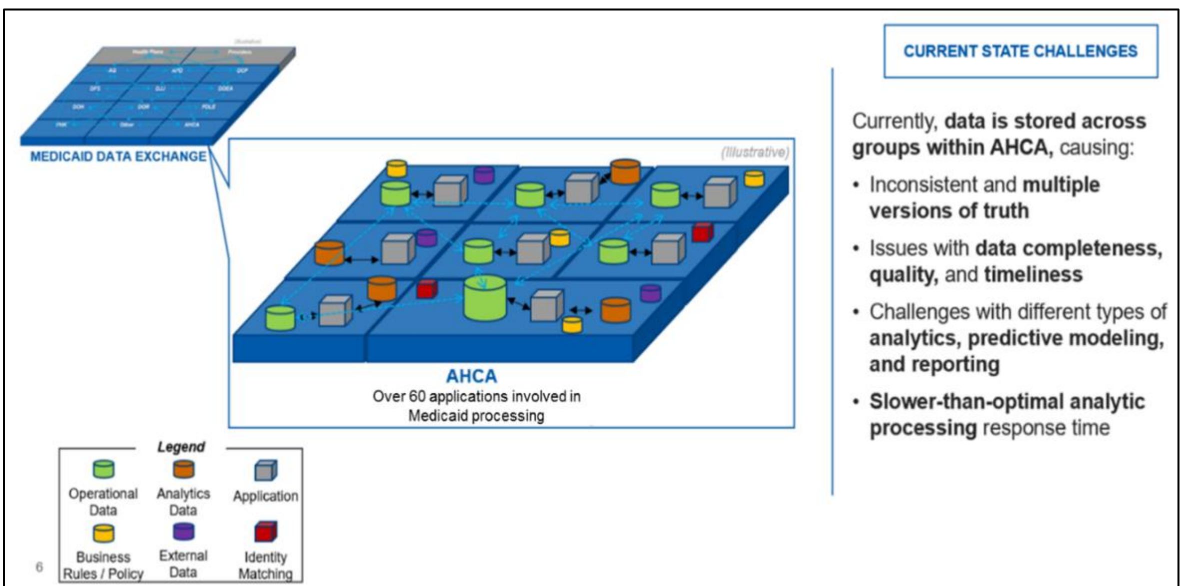


Exhibit 16: Current State

b. Current System Resource Requirements

To support the systems of the Medicaid Enterprise, the Agency includes an Information Technology Office that is responsible for overseeing the Agency's use of existing and emerging technologies in government operations, and its delivery of services to the public. They work to improve the Agency's efficiency through technology by aligning business and technology objectives to deliver effective solutions, and to make communication with the Agency straightforward and clear. Other Agency personnel may be required to provide additional support to the current Medicaid Enterprise systems.

To support the largest system in the Medicaid Enterprise, the fiscal agent, Gainwell Technologies, submits system staffing reports. In addition, the Bureau of Medicaid Fiscal Agent Operations within the Medicaid Division has oversight responsibilities for the fiscal agent provider enrollment, claims processing and payment, management of the FMMIS, and the DSS.

c. Current System Performance

The fiscal agent, Gainwell Technologies, submits a system performance report card for the largest system in the Medicaid Enterprise.

2. Information Technology Standards

FX IT solutions and module vendors must adhere to the standards and guidelines published by the Department of Management Services (DMS):

- Florida Information Technology Project Management and Oversight Standards described in Florida Administrative Rule 60GG-1.001 through 60GG-1.009, F.A.C.
- Florida Cybersecurity Standards described in Florida Administrative Rule 60GG-2.001 through 60GG-2.006, F.A.C.

- Florida Cloud Computing Standards described in Florida Administration Rule 60GG-4.001 through 60GG-2.006, F.A.C.
- Information Technology Architecture Standards described in Florida Administrative Rule 60GG-5, F.A.C.

All technology decisions must be approved by the FX Technology Standards Committee. FX IT solutions and module vendors must also adhere to the standards developed by the Agency's SEAS Vendor:

- T-3 FX Data Standards
- T-4 FX Technical Management Strategy
- T-6 FX Technology Standards
- T-8 FX Enterprise Data Security Plan

The Agency has adopted the FX Project Life Cycle to support consistent system development and project management methodologies. The FX Project Life Cycle is a system development life cycle based on the CMS eXpedited Life Cycle (XLC) customized to the Agency and Florida-specific project implementation processes. The XLC is a framework developed by CMS for defining tasks performed at each phase in the software implementation process.

The FX Project Life Cycle is shown in **Exhibit 17**. This image shows the phases of MES System Strategy and Execution activities. The FX Strategic Plan focuses on the first four phases, while phases five and six of execution are the primary focus of the FX Strategic Project Portfolio Management Plan. The FX Strategic Project Portfolio Management Plan provides inputs and monitoring for the remaining three phases seven, eight, and nine. The decision-making authority throughout the strategy and portfolio management is defined in the FX Governance Plan. The Portfolio Management Process enables the system strategy, defines activities in execution phases activities, and provides guidance on key decisions for each phase.

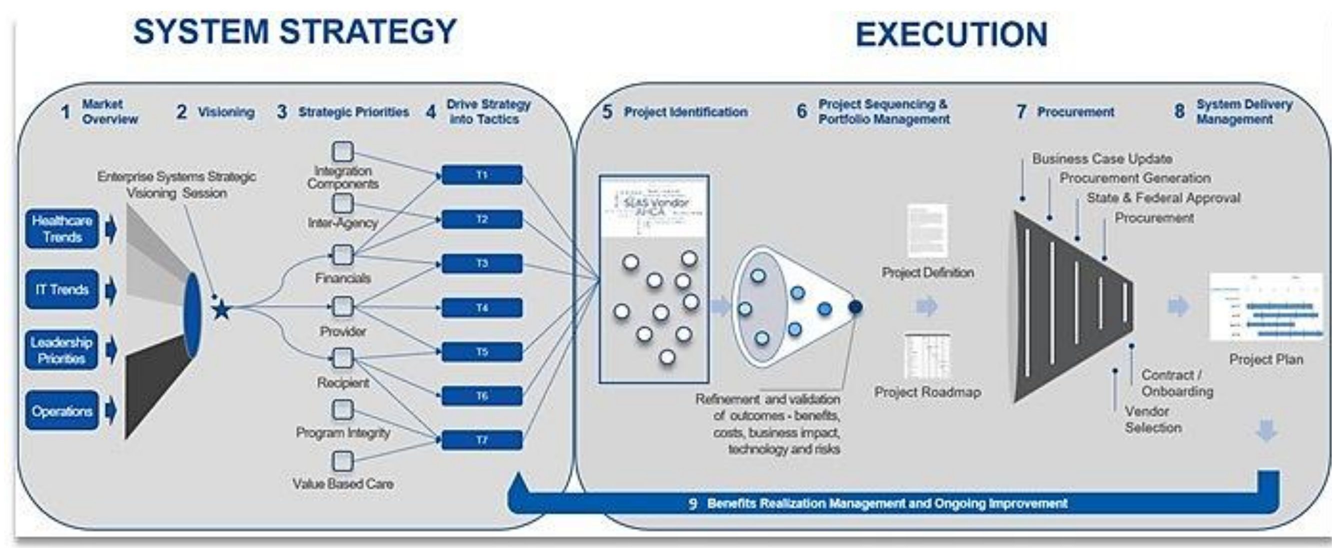


Exhibit 17: System Strategy and Portfolio Management Execution Process

B. Current Hardware and/or Software Inventory

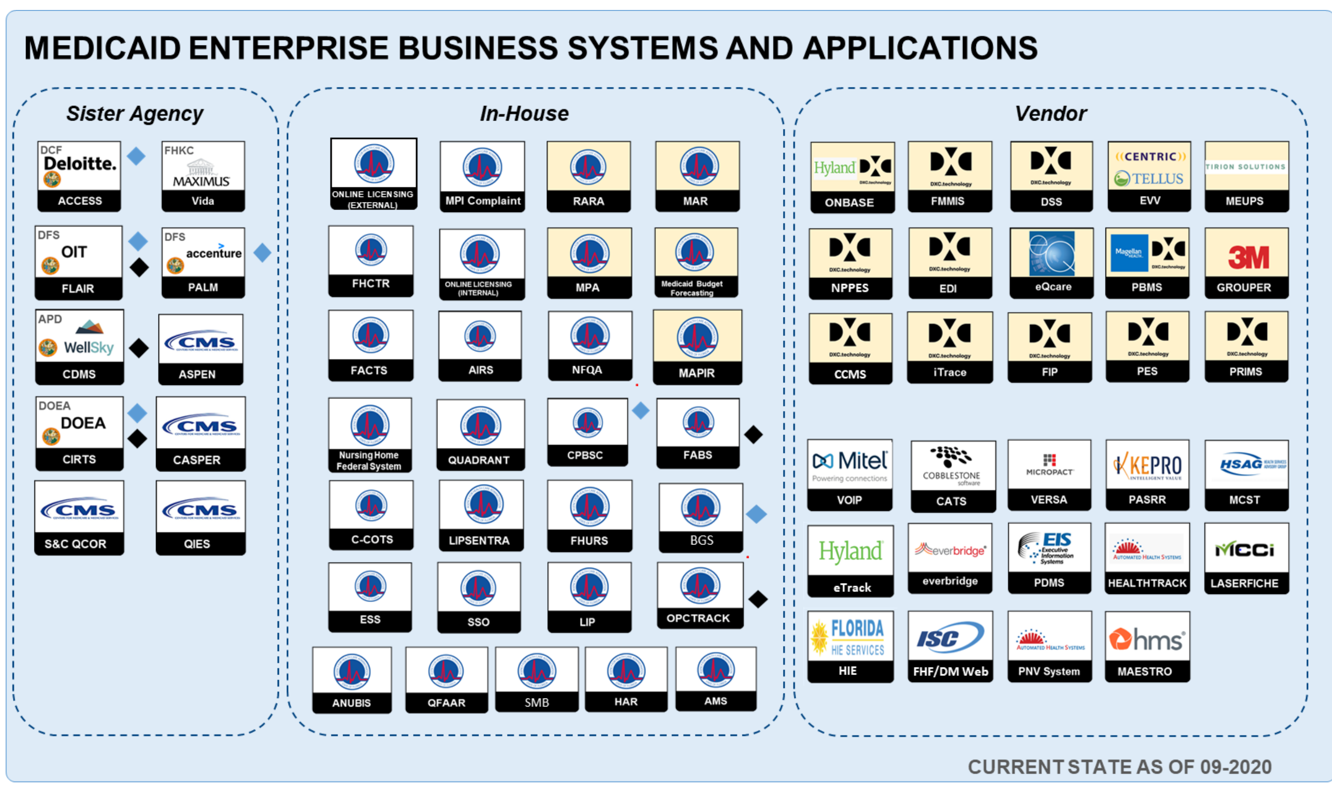
NOTE: Current customers of the state data center would obtain this information from the data center.

Applications/Software

The State of Florida Medicaid Enterprise is supported by a large, complex portfolio of systems and applications, totaling over sixty (60) systems and applications. Notably, the FMMIS includes thirteen (13) contracted business systems and five (5) internal applications, relying on two support applications for procurement and contract management services and forty-three (43) other business systems and applications that interact with or support FMMIS and Medicaid. These applications/systems are provided in **Exhibit 18** and **Exhibit 19.**

Application Owner	Description
AHCA (In-house)	At least 27 systems/applications
Partner/Sister Agency	At least 10 systems/applications
External Services (Vendor)	At least 26 systems/applications

Exhibit 18: System/Application Owner Table



Legend
• Icons used to represent vendor contracts and applications to clearly distinguish outsourced and insourced systems and applications • Systems managed by sister agencies noted by the Florida Seal ( ) and agency's initials • Systems developed and maintained by AHCA noted by the Agency logo ( ) • MMIS and Medicaid Enterprise framework used to array the icons • Subcontracts to DXC Technology marked with DXC Technology logo • Systems and applications scheduled for retirement marked with a black diamond (◆) • Systems and applications used beyond the ME marked with a blue diamond (◆)

Exhibit 19: AHCA (2020) Medicaid Business Systems and Applications Portfolio

Interfaces

The Agency has over two hundred (200) inbound/outbound interfaces between applications.

Storage

Exhibit 20 includes a summary of the high-level storage use by Agency applications.

Storage Location	Size
Fiscal Agent	▪ 30 Terabytes (TB) of 8 Online Transaction Processing (OLTP) databases (8 total) ▪ 16 TB Decision Support Systems (DSS) (3 total)

	▪ 41 TB of Content Management System (1 total) ▪ 4 Data Marts
Medicaid Data Analytics	▪ 60 TB of SQL Server
AHCA Information Technology (IT)	▪ Primarily SQL Server
IS/IP	▪ Oracle Exadata

Exhibit 20: Storage Use by Agency Applications

C. Proposed Technical Solution

To enable effective and responsive delivery of health-related services, the Agency is pursuing modular technology and processing solutions that work together seamlessly. Using modular solutions provides processing and operational agility to support the needs of organizations in Florida that deliver health services. A modular approach increases the opportunity to select the best technology and services from vendors while simultaneously avoiding vendor lock-in and the risks associated with a single solution.

To support this transformation, the Agency has developed the FX procurement strategy articulated in Section II A. 2, Business Objectives in this document. The FX transformation strategy proposes a phased approach to replace the current functions of the FMMIS and other Medicaid-related systems. These phases are based on the CMS Standards and Conditions (summarized in Section I. C. 1.) to ultimately transform Florida's Medicaid systems to an interoperable and unified enterprise where individual processes, modules, systems, and sub-systems work together to operate the Medicaid program. As mentioned before, the CMS Standards and Conditions must be met for states to qualify for enhanced federal funding. This approach is intended to provide the most efficient and cost-effective long-term solution for the system while complying with federal regulations, achieving federal certification, and obtaining enhanced federal funding. The phases of the FX strategy are as follows:

#	Phase	Component/Module
1	Professional Services Procurements	Strategic Enterprise Advisory Services Independent Verification and Validation
2	FX Infrastructure	Integration Services and Integration Platform Enterprise Data Warehouse
3	FX FMMIS Resolution	Unified Operations Center Core Systems (Claims/Encounter/Financial/Reference

		Management) Provider Services Module Pharmacy Benefit Management

Exhibit 21: FX Strategy

The modules of the proposed to-be technical solution include sunsetting current Medicaid Enterprise business systems, starting with the FMMIS. A visual of the Medicaid Enterprise systems mapped by module is provided in **Exhibit 22**.

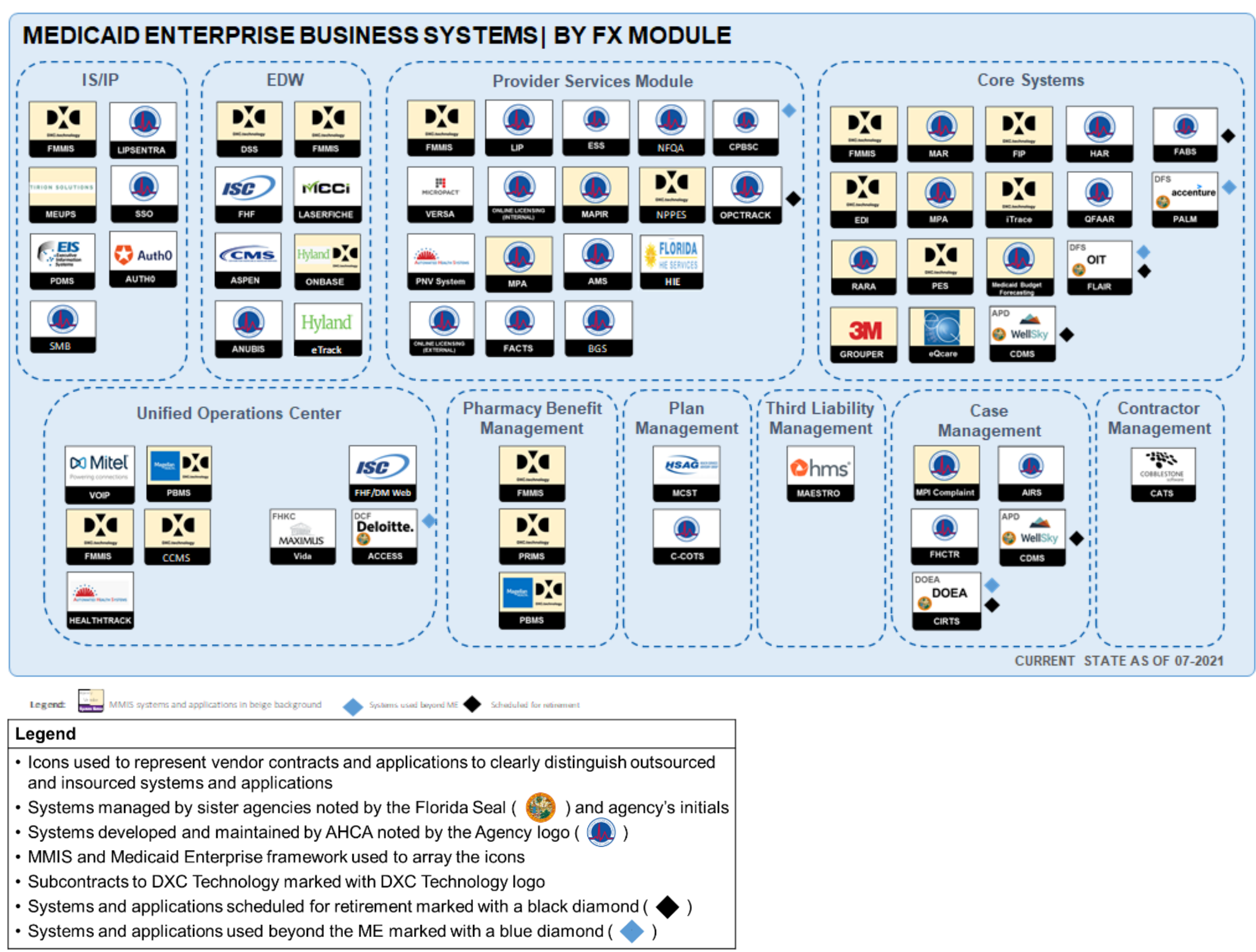


Exhibit 22: Medicaid Enterprise Business Systems by FX Module.

The SEAS Vendor worked with the Agency to produce technical deliverables that defined the data management, technology, system design and implementation, and enterprise security management strategy and standards for the program. FX module vendors will be required to adhere to the strategies and standards in their proposed technical solutions in response to competitive solicitations.

a) T-1 FX Data Management Strategy
b) T-2 FX Information Architecture
c) T-3 FX Data Standards
d) T-4 FX Technical Management Strategy
e) T-5 FX Technical Architecture Documentation
f) T-6 FX Technology Standards
g) T-7 FX Design and Implementation Management Standards
h) T-8 FX Enterprise Data Security Plan

1. Technical Solution Alternatives

The Agency, with the assistance of the SEAS Vendor has conducted, and will continue to conduct, alternatives analyses, cost-benefit analyses, and healthcare IT industry scans for emerging technologies to identify opportunities to leverage COTS technologies, cloud platforms, Software-as-a-Service, and open application programming interfaces. As solutions are identified, the Agency will request enhanced FFP through the APD process and CMS certification of Medicaid IT systems. Procurement of system modules in Phase III of FX will replace functionality in the current FMMIS, providing an opportunity for cost reduction in the fiscal agent contract. The SEAS Vendor will also identify opportunities to reuse technologies and systems across the FX Enterprise, in accordance with the CMS Standards and Conditions (summarized in Section I. C. 1.).

The Agency will consider using open-competitive solicitations or other alternative contract sources to procure future FX modules and components. The Agency will adopt the procurement method that best meets the needs of the Agency. The Agency will leverage the work of the NASPO ValuePoint solutions for Medicaid Systems in the development of procurements when available.

All FX modules encompass business processes contracted under the current fiscal agent contract and those that relate to important Medicaid business processes performed by the Agency or contracted by vendors other than the current fiscal agent. All procured modules are to be:

a) Interoperable with other systems within FX
b) Open-source solutions
c) Configurable COTS products, or other modular approaches that reduce the need for custom development

2. Rationale for Selection

FX module solutions will be selected based on the specific technical requirements and evaluation criteria described in each solicitation, utilizing the IS/IP and EDW as the foundational solutions to meet the Agency's strategic priorities. The Agency's strategy includes a plan to assimilate modular solutions to replace current functional systems or sub-systems quickly and efficiently as technology evolves. At a high-level, the following criteria are applicable to technical solution selection:

a) Return on investment and business process improvement impact

b) Adherence to the Agency's data management and technology strategies

c) Aligns with expected market evolution in data management

d) Enables a higher level of business agility and reduces costs to convert proprietary vendor data

3. Recommended Technical Solution

The recommended technical solution for the future of FX is a modular collection of systems enabled by the critical infrastructure elements of IS/IP, EDW and UOC. Any future module must align to the FX Vision, FX Guiding Principles, and FX Strategic Priorities and adhere to the FX Data Management vision and primary strategies. These six strategies are provided below and can be referenced in the FX Data Management Strategy for more detail:

a) Improve data quality by operating from a single source of policy truth

b) Evolve core processing with data validation at the point of business event data collection

c) Provide seamless access to a real-time, 360-degree (360˚) view of recipient and provider information

d) Decouple data from proprietary systems and application stores

e) Operate with business area and persona optimized data marts and data analysis tools

f) Prepare to collect and manage recipient and provider experience and outcome data

D. Proposed Solution Description

1. Summary Description of Proposed System

The proposed solution supporting the six primary strategies mentioned above, is the Data Management Strategy Vision To-Be diagram shown in **Exhibit 23**.

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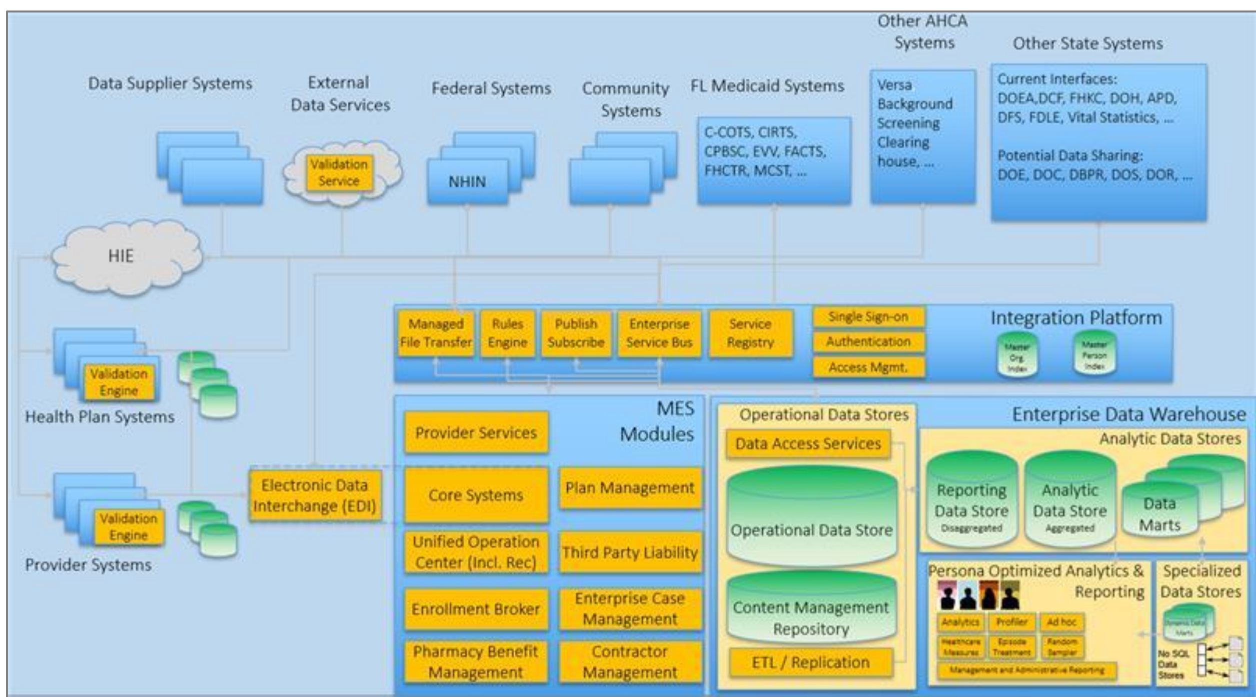

Exhibit 23: FX Conceptual Architecture Diagram.

The *T-1: Data Management Strategy* provides guidance for future data systems and modernization of current enterprise data management systems. The strategy includes modernizing the Agency's data infrastructure to support the transformation of Agency business and application systems. Over the course of FX, the *T-1: Data Management Strategy* will incrementally evolve to refine and provide additional guidance on data management strategic topics that benefit FX.

The *T-1: Data Management Strategy* describes an approach to the overall management of the availability, usability, integrity, and security of the Agency data assets. The overall purpose of the strategy is to:

a) Make data integration efforts within and across agencies more efficient
b) Support MITA's guidance for modularized implementation of various healthcare components and easier sharing of data
c) Provide a common set of processes, tools, and data standards for the Agency's data solutions
d) Improve data quality, reduce duplication, and associated frustration and overhead
e) Comply with state and federal requirements
f) Reduce technology support and maintenance cost
g) Manage structured and unstructured, operational, transactional, reporting, and analytic data across the Agency

The first two information systems to leverage the modernized enterprise data platform and processes for the Agency are IS/IP, that includes an Enterprise Service Bus (ESB),

and the EDW, both of which are part of the in-process *Phase II: FX Infrastructure* in the FX roadmap. These platforms provide the foundation for transforming the Agency into a data-driven organization and improving data quality, performance, and information accessibility.

Future State: Integration Services and Integration Platform (IS/IP)

The enterprise integration capabilities of the IS/IP solution allow Agency systems to be much more efficient in sharing data and services between systems within the Agency, with other agencies, and with partners. Two major goals of the integration platform are (1) reduced duplication of data across systems, and (2) improved data consistency and communication of data changes between systems when there is a business need for data to be duplicated.

The IS/IP solution, as depicted below in **Exhibit 24** enables:

a) Near real-time data processing access and sharing between different organizations and systems, reducing the propagation of duplicated and inconsistent data
b) A 360-degree (360˚) view of information by linking data about recipients and providers
c) Application of consistent business rules and policy
d) Single sign-on and securing data in transit

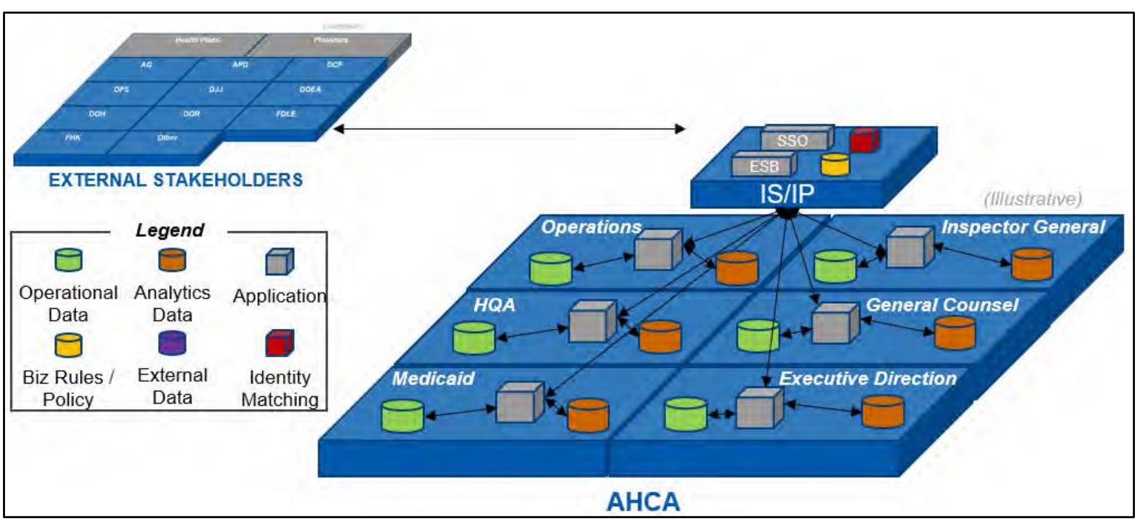

Exhibit 24: IS/IP Future State

The IS/IP Vendor has architected the system to be flexible and capable of supporting future technology integration approaches (e.g., microservices) as well as traditional (legacy) interfaces and protocols. IS/IP will enable the Agency to exchange information with external systems easily and securely to obtain, validate, and manage information

Exhibit 25 shows how the IS/IP platform will serve as the connection point between the FX modules (the grey boxes on the right and the blue boxes on the left). The IS/IP platform consists of three key components. At the high-level system, there is an Enterprise Service Bus platform at the top which includes business rules management.

The second platform in the lower half is the Master Data Management platform, where the Master Organization Index and Master Person Index (MOI/MPI) will be built. The third platform is the Single Sign-On (SSO) platform built on the Identity and Access management in the yellow color in the middle.

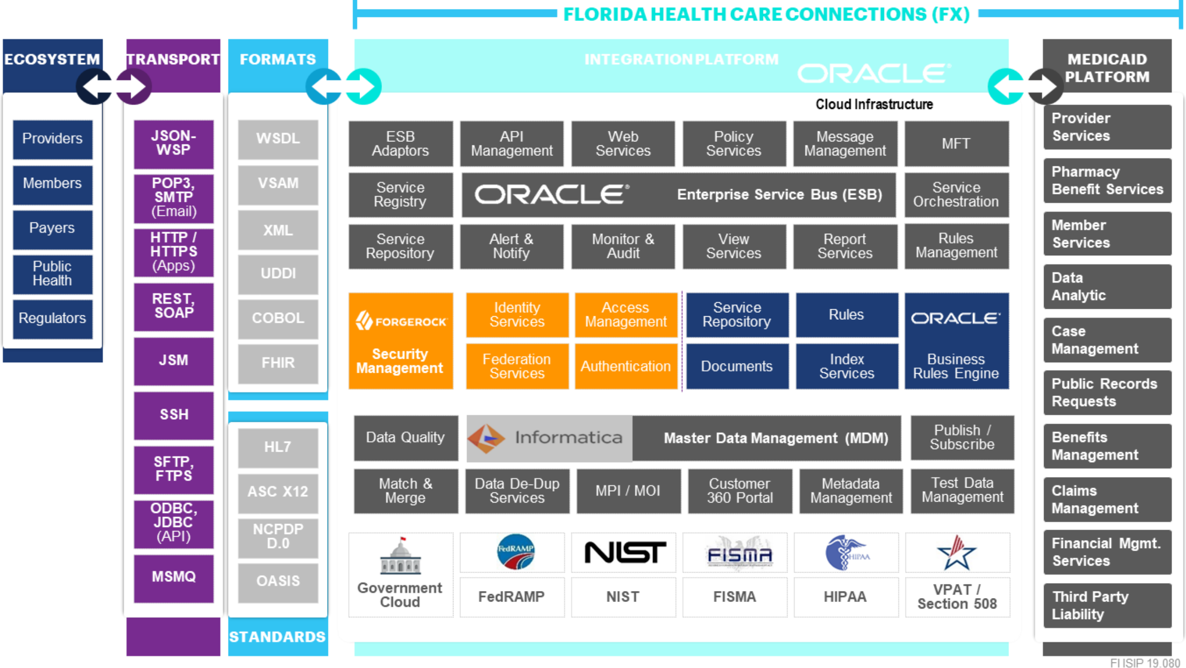

Exhibit 25: IS/IP Connections

2. Future State: Enterprise Data Service (EDW)

The enterprise data service and analytic capabilities of the EDW Solution will provide Agency stakeholders with enhanced data management and analytics capabilities. The EDW creates a model that promotes having a *single source of truth* for applications to access data from this central source (rather than keeping data within each application). The implementation of the EDW project will facilitate the decoupling of systems and data to make data available and consistent throughout the ecosystem, which will improve data quality, consistency, and tools for operational data use and analytic processing. The EDW Solution shown in **Exhibit 26** will enable:

a) Single source of truth to improve data quality, accuracy, and accessibility

b) Improved timeliness and consistency of data

c) Improved analytic data processing with holistic business unit and persona optimized Data Marts and tools

d) System innovation and simplified system implementation

e) Elimination of inconsistent data and processing

f) Reduction in duplicated data

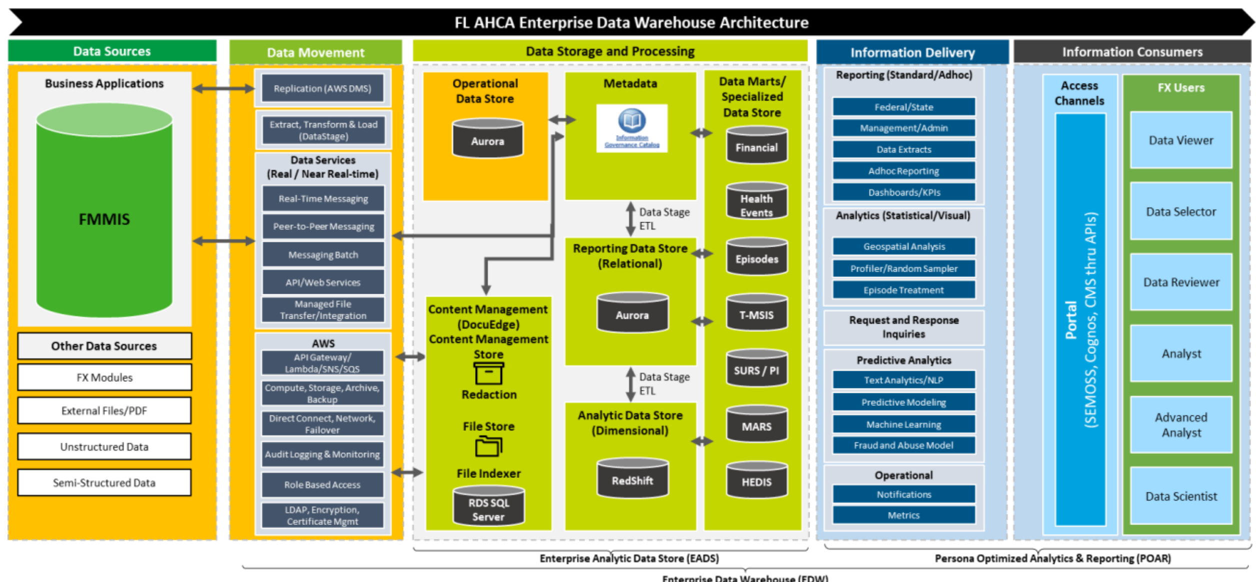

Exhibit 26 Project Future State

3. Future State: Modular Processing Systems and Services

The use of modular processing systems and service capabilities using the real or near real-time data provided by the EDW Solution and applying consistent business rules, will reshape the application landscape, reducing duplicated applications and inconsistent processing. The implementation of Modular Systems shown in **Exhibit 27** will:

a) Identify and propose improvements to mature operational business processing capabilities

b) Standardize business processing (e.g., enrollment, case management) to improve recipient and provider experience

c) Add new processing power and capabilities without the capacity constraints of a single vendor

d) Enable use of processing services by external organizations and systems

e) Enable high-quality and accessible data

f) Improve integration with external partners

g) Reduce complexity

h) Improve focus on and measurement of health care outcomes

i) Enable holistic decision-making

j) Use evidence-based processing

k) Improve analytics

l) Reduce fraud, waste, and abuse

m) Improve the ease and accuracy of Provider claims payments

n) Improve the effectiveness of federal cost reporting to maintain federal funding eligibility

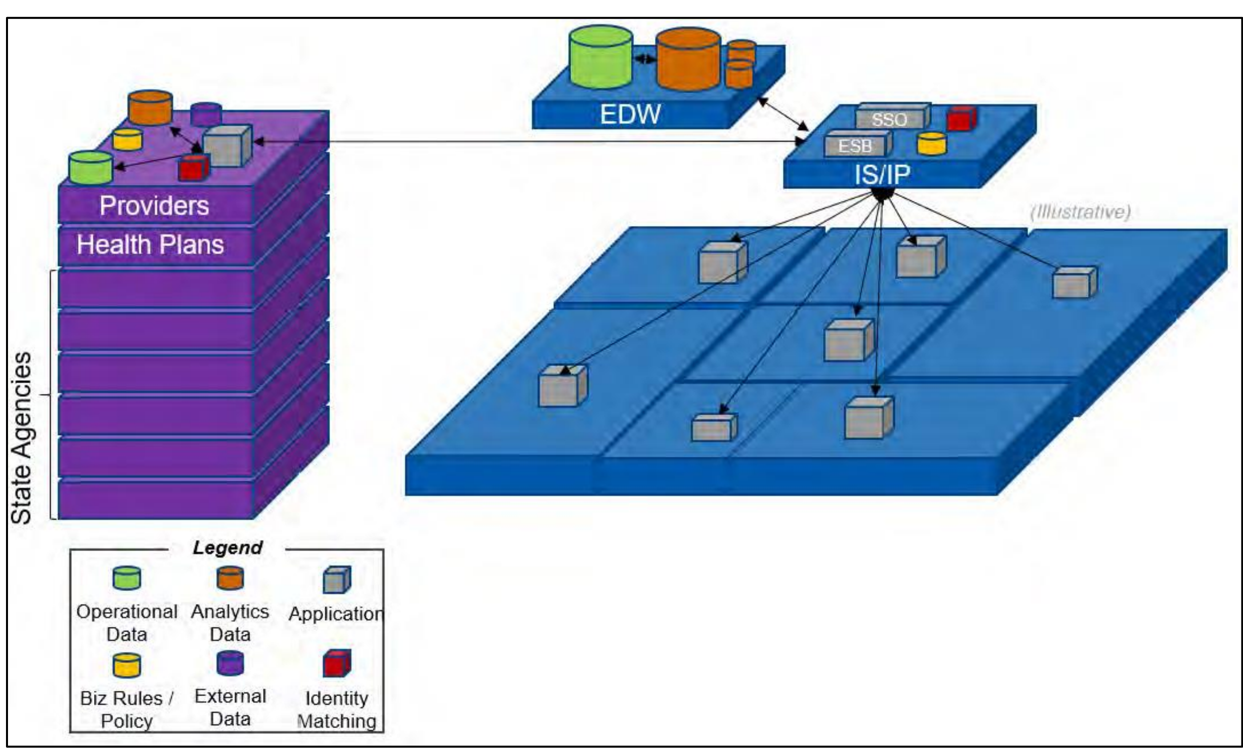

Exhibit 27: Modular Future State

Exhibit 28 provides a brief description of each Data Management Strategy enabling capability provided through the combined services of the Phase II Infrastructure platform (IS/IP and EDW).

Enabling Capability	Description
Managed File Transfer (MFT)	Enables fast and secure transmission of files between systems, audit trail, and archival of files.
Rules Engine	Provides decisions based on edit rules, policy, and datasets.
Validation Service	Public or third-party service that validates pre-authorizations, claims, and encounter transactions.
Validation Engine	Processing engine within distributed plan and provider systems that validates and makes pre-authorization, claims, and encounter acceptance decisions using rules and policy distributed by the Agency.
Publish Subscribe	Notifies subscribers/designated systems of information updates about a recipient or provider.

Enabling Capability	Description
Enterprise Service Bus	Connects any approved request for data or processing to the data or processing service provider in real or near real-time. Real-time processing is continuous and typically happens in seconds. Near real-time processing may not be continuous and typically happens in minutes rather than seconds. In addition, real-time processing is synchronous, which simplifies the request response process. Near real-time processing implies asynchronous processing, which adds the complexity of input queuing and accepting asynchronous responses.
Service Registry/Repository	Tracks web services and usage information.
Single Sign-on	Allows users to authenticate to multiple systems using the same user ID across multiple systems.
Authentication	Common framework that authenticates user access with modules and applications.
Access Management	Common framework that manages role-based access control within modules and applications.
Master Person Index	Processing that identifies records about the same person within a system or found in other systems
Master Organization Index	Processing that identifies records about the same organization within a system or found in other systems.
Data Access Services	Provides decoupled access to data at varying levels of granularity. Data access services will span from elemental data services to module specific data services to composite cross module data services.
Operational Data Store	The data store of transactional data. Access to operational data is through data access services and APIs.
Extract Transform Load (ETL)/Data Replication	Software that transfers information between data stores.
Reporting Data Store	A data store optimized for use by dashboards and reporting and is continuously updated with data from the operational data store.
Analytic Data Store	The data store optimized for analytic analysis. Also referred to as the data warehouse.

Enabling Capability	Description
Data Marts	Specialized data stores that are structured and optimized for specific types of analysis or used by specific business units.
Dynamic Data Marts	Data stores that are created upon request in an optimized structure for a specific analysis or type of analysis.
Not Only SQL (NoSQL) Analytic Data Stores	Analytic data store that is optimized for unstructured data sources and big data analytics.

Exhibit 28: Data Management Strategy Enabling Capability

Exhibit 29 maps each data management enabling capability to the pillars of the Data Management Strategy Vision.

Enabling Capability	Single Source of Truth Policy and Edit Rules	Data Validate at Point of Data Collection	Secure Real-time 360˚ View of Information	Decouple Data from Applications	Business and Persona Optimized Data / Tools	Recipient and Provider Experience / Outcome
Managed File Transfer (MFT)			□			
Rules Engine	□	□				
Validation Engine	□	□				
Validation Service	□	□				
Publish Subscribe			□			
Enterprise Service Bus			□			
Service Registry/Repository			□			
Single Sign-on			□			

Enabling capability	Single Source of Truth Policy and Edit Rules	Data Validate at Point of Data Collection	Secure Real-Time 360˚ View of Information	Decouple Data from Applications	Business and Persona Optimized Data / Tools	Recipient and Provider Experience / Outcome
Authentication			□			
Access Management			□			
Master Person Index			□			□
Master Organization Index			□			□
Data Access Services		□	□	□		
Operational Data Store				□		
ETL/Data Replication				□	□	
Reporting Data Store			□	□	□	
Analytic Data Store					□	□
Data Marts					□	□
Dynamic Data Marts					□	□
NoSQL Analytic Data Stores					□	□

Exhibit 29: Data Management Strategy Vision Matrix

4. Resource and Summary Level Funding Requirements

The resource and summary funding level requirements for the proposed solution are unknown currently. The program is using outcome based and net present value (NPV) business cases to define, select, and approve specific projects. The impact of specific projects on resources and funding levels will be documented in the project definition, selection, and approval process. Because the number of recipients, providers, claims, and encounters and other transactions is very large, even small changes in processing that improve data quality, improve data timeliness, reduce errors, reduce fraud, improper

payments, reduce manual processing, and prevent avoidable costs can have large net benefits even if processing resources and processing costs increase.

E. Capacity Planning

(historical and current trends versus projected requirements)

Modernizing system solutions and infrastructure to support large state processing and data volumes is critical. Historically, processing constraints and performance issues have undermined the Agency's attempts to reuse solutions from smaller states when those solutions were unable to process the large transaction and data volumes of Florida.

Capacity requirements are based on historical data and new system design specifications and performance requirements. Technology planning has identified the factors that will drive relative changes from the current state processing, storage, and network capacity to support the business of the Agency.

Operational Data Processing Capacity – Operational data processing is the transaction processing performed with Agency systems. Operational data processing examples include interactive systems, e.g., interChange, provider enrollments, batch fee-for-service transactions, and batch encounter transactions.

Processing Changes **–** The processing to support operational data processing will change driven by:

a) Growth in recipient population

b) Ecosystem wide use of real-time information

c) Reduction in system-to-system interface data replication and interface processing

d) Increased information used in processing

e) Real-time business rules and decision-making

Storage Changes **–** The storage to support operational data processing will change driven by:

a) Growth in recipient population

b) Increased information used in processing

c) Reduction in duplication of data across systems

Network Changes **–** The network to support operational data processing will change driven by:

a) Growth in recipient population

b) Ecosystem wide use of real-time information

c) Increased information used in processing

d) Real-time business rules and decision-making

e) Physical location of systems and users

Analytic Data Processing Capacity **–** Analytic data processing includes reporting, dashboard, ad hoc inquiries, data analysis for investigation and policy setting, and predictive modeling.

Processing Changes **–** The processing to support analytic data processing will change driven by:

a) Increased information used in processing

b) Growth in recipient population

c) Increased sophistication of analysis

Storage Changes **–** The storage to support analytic data processing will change driven by:

a) Growth in recipient population

b) Increased information used in processing

Network Changes **–** The network to support analytic data processing will change driven by:

a) Reduced data replication loading and interface processing of bureau specific analytic data stores

b) Increased information used in processing

c) The net effect of the projected changes in capacity is:

d) Processing – very large accelerating increase in cumulative processing capacity needs from current

e) Storage – very large accelerating increase in cumulative storage capacity needs from current

f) Network – increase in cumulative network capacity needs from current

g) To minimize the risk of processing, storage, and network capacity affecting business operations new systems will:

h) Encourage use of cloud infrastructure that can be dynamically provisioned quickly at low cost

i) Require proof of ability to scale horizontally allowing transactions processing to occur in parallel

j) Provide services that allow processing to occur in the health plan, provider, and external systems

k) Monitor impacts on bandwidth capacity and make adjustments for endpoints

External Systems Capacity – External systems that are the *source of truth* for information external to the Agency systems will experience a change in processing, storage, and network usage profile and capacity needs. The new Agency systems will use integration technologies that allow transactional near real-time access to information in

external systems. This change will shift processing from high-volume batch processes and files replication to use of direct access by small real-time web services and APIs. External systems should use less storage for interface files and interface file archives. The external systems would likely experience increased processing use and change in processing usage patterns to service requests from external systems.

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.

During SFYs 2017-2020, the SEAS Vendor developed 17 standards-setting deliverables and established an Enterprise Program Management Office (EPMO). The deliverables, outlined in the table below, establishes plans and standards for projects within FX and are kept pertinent through, at a minimum, annual reviews, and refreshes.

The FX Program uses a portfolio management process through which projects are evaluated and prioritized for their ability to achieve the strategic objectives of FX. The *S-3: FX Strategic Plan* identifies the strategy for the Medicaid Enterprise System transformation. The FX Governance structure facilitates portfolio and escalated project decision-making at the most appropriate level of management. As FX Governance approves projects identified to achieve the FX strategy, they are managed and/or monitored by the FX EPMO at the project-level, integrated at the program-level, and monitored through project close out. Each project within the FX Portfolio follows the standards and processes documented in the Agency-approved deliverables, which are listed in the table below and can be found on the Agency's FX Projects Repository.

The FX EPMO is considered a controlling style PMO: it provides direction and oversight for approved FX projects and is staffed by a team of experienced project and program managers who establish, maintain, and uphold standards for the management of FX projects and sub-programs. The standards are complemented by process definitions, tools, templates, and mentoring. The monitoring duties of the FX EPMO include program-wide status reporting; schedule management; change, risk, action item, issue, decision, and lessons learned management; and quality management.

Organization, Strategic, Programmatic, and Technical Domains	
Deliverable	**Description**
O-1: SEAS Management Plan	Outlines how the SEAS Vendor will perform its contractually required duties.
S-1: FX Governance Plan	Defines the governance structure and processes to enable effective and efficient advancement of FX.

Organization, Strategic, Programmatic, and Technical Domains	
Deliverable	**Description**
S-3: FX Strategic Plan	Serves as an iterative strategy and concept of operations that will continually guide the Agency's transition to a modular technical environment.
S-4: Strategic Project Portfolio Management Plan	Develops a documented plan for the identification, categorization, evaluation, selection, and prioritization of projects to accomplish the Agency's FX Program strategies, while balancing conflicting demands by allocating resources based on the Agency's priorities and capacity.
P-2: FX Project Management Standards	Establishes the standards for management of FX projects, leveraging the existing Agency, state, and industry standard project management standards and tools.
P-3: FX Project Management Toolkit	Complements the *P-2: FX Project Management Standards* by providing project management training materials and corresponding tools and templates.
P-4: Medicaid Enterprise Certification Management Plan	Provides an overall plan to manage the MES Certification life cycle for each applicable FX module outlining the steps for the Agency to conduct and comply with the Streamlined Modular Certification process.
T-1: Data Management Strategy	Develops and establishes the Data Management Strategy that aligns with the approach defined in the MITA 3.0 Part II Information Architecture – Chapter 2 Data Management Strategy. The *T-1: Data Management Strategy* is the product of discovery, stakeholder input, strategic analysis, program strategy, and direction about techniques and priorities to support overall improvement of FX outcomes.
T-2: Information Architecture Documentation	Provides the iterative documentation through the implementation of the modularized solution. Its primary purpose is to serve as the guiding principles of the overall data strategy for the system and the assessment of the business areas level of maturity within that data strategy.

Organization, Strategic, Programmatic, and Technical Domains	
Deliverable	**Description**
T-3: Data Standards	Develops and establishes the Data Standards as per MITA 3.0 Part II Information Architecture – Chapter 5 Data Standards. The *T-3: Data Standards* are the product of discovery, stakeholder input, strategic analysis, program strategy and direction about techniques and priorities to support overall improvement of FX outcomes.
T,-4: Technical Management Strategy	Develops and establishes the Technical Management Strategy that aligns with the approach defined in the MITA 3.0 Part III Technical Architecture – Chapter 2 Technical Management Strategy. The *T-4: Technical Management Strategy* is the product of discovery, stakeholder input, strategic analysis, program strategy and direction about techniques and priorities to support overall improvement of FX outcomes.
T-5: Technical Architecture Documentation	Establishes the framework for the Business Services, Technical Services, Application Architecture, and Technical Capability Matrix (TCM) for the enterprise per the MITA 3.0 standards.
T-6: Technology Standards	Establishes the Technology Standards Reference Model (TSRM) and the Technology Standards Reference Guide (TSRG) for the enterprise per MITA 3.0 standards. The Technology Standards Reference Model (TSRM) is the common technology vocabulary that organizes, and groups related technology components standardizing the names and descriptions of those components. The Technology Standards Reference Guide (TSRG) isa repository of standards relevant to technology components that identifies and prioritizes the relevance of specific technology standards in the enterprise
T-7: Design and Implementation Management Standards	Establishes guidance and management procedures to establish a uniform, enterprise approach based on industry standards for Requirements Development, Design, Development and Integration, Testing, Change Management and Implementation activities.

Organization, Strategic, Programmatic, and Technical Domains	
Deliverable	**Description**
T-8: Enterprise Data Security Plan	Provides the iterative documentation through the implementation of the modularized solution. The primary purpose is to serve as the guiding principles of the enterprise data security for the systems and vendors that are involved in the procurement, implementation, and operation of the FX.
O-2: FX EPMO Charter and Program Management Plan	Charters the FX EPMO and establishes the guidelines and operational processes by which the FX EPMO shall manage and/or monitor FX projects assigned by FX Portfolio Management.

Exhibit 30: FX Deliverables

SCHEDULE IX: MAJOR AUDIT FINDINGS AND RECOMMENDATIONS

Budget Period: 2023-20244

Department: Agency for Health Care Administration

Acting Chief Internal Auditor: Karen Preacher

Budget Entity: Administration and Support (68200000)

Phone Number: (850) 412-3968

(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 2021-22					
AG 2022-200 AG 20-21 Operational Audit - Multi Agency	*March to August 2020*	*COVID-19 Data Collection and Reporting at Selected State Entities*	**Finding#5** Monitoring of Health Facility Data Reporting. Agency records did not evidence the evaluation of the accuracy of COVID-19 data reported by hospitals, nursing homes, and assisted living facilities and such facilities did not always report required information. **Recommendations** We recommend that Agency management take steps to promote the accurate reporting by health facilities of all data required by Agency guidelines.	**Management Response** The Emergency Status System (ESS) was initially built to collect a limited amount of data during hurricanes and severe weather events. It was not intended to be used for emergencies outside of this scope, having been built for a specific purpose that provided an avenue for licensed health care facilities to provide information regarding the impact of a tropical weather event to their physical facility and/or individuals under their care. When presented with the complexities of the data required for the pandemic, the Agency utilized the existing resources to modify the system to aid in accurate and timely reporting by health systems within a week's time. While items such as bed availability and resource needs were already built into ESS data fields, data related to COVID positive patients was not. It should be noted the data needed fluctuated during the timeframe of the audit which requires an agile system. ESS was not designed to be agile in nature and all modifications had to be made manually. As data requirements changed, the Agency worked alongside state and local partners to update these fields and communicate these changes. It should be noted the specific example given in finding 5 to compare census to licensed beds may be misleading. Pursuant to s. 408.821(2), Florida Statutes (F.S.) a provider may temporarily exceed their licensed capacity to act as a receiving provider in accordance with an approved emergency operations plan for up to 15 days. Given this, the auditor may not have a full understanding of the health facility licensing process in Florida. The Agency consistently worked alongside licensed health care providers in reporting accurate data. However, data is only as accurate as the person who is submitting it into the system. Throughout the pandemic, the Agency worked with providers who may have inaccurately reported information through direct contact around the clock. The finding is extremely general in nature and does not account for the level of effort and work public servants and health care providers did to ensure this information was collected timely and accurately. Regarding the portion of Finding 5 which states, "such facilities did not always report required information." Please note that in any ESS event, the Agency uses all available outreach mechanisms to ensure timely and accurate responses, including working trade associations, and other state and local partners to communicate needs. Agency Employees worked well outside their job descriptions to serve their state, and this should be commended. During the 2022 Legislative Session, the Agency received $340,000 in funding to support the continued modernization of ESS into a more agile Health Facility Reporting Tool that will be a better resource for future events. Additionally, the funds will allow the Agency to make modifications to provide better workflow management, conduct routine drills and exercises, provide notification to users, and better manage access controls.	

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				Although the Agency maintains that it collected high quality data that was instrumental in the COVID response, it will continue to work to address opportunities for improvements that sync with the finding and recommendation including: -Standardize the reporting naming convention so that reports can be easily reviewed to determine their purpose. -Develop a Quality Assurance (QA) process for data which would include QA reports and system modifications to reduce data entry errors. -Determine measures to ensure compliance with reporting requirements.	
			Finding#7 ESS Access Controls. Agency user access privilege controls for the Emergency Status System (ESS) need enhancement to better prevent and detect inappropriate access to the ESS.		
			Recommendations We recommend that Agency management strengthen IT access controls to ensure that ESS user access privileges are limited to the minimum necessary for a user to perform their current job duties and deactivated immediately upon separation from Agency employment. We also recommend that Agency management perform and document periodic reviews of ESS user access privileges.	**Management Response** The Agency takes information and data security seriously pursuant to Chapter 282.318, F.S. This includes having established standards for both internal and external users accessing Agency IT systems and applications, such as the Emergency Status System (ESS). While the audit provides a broad level overview of ESS, it does not consider that user access privileges are established for both internal and external users regarding the level of information that may be viewed, the ability to input data into fields, and export data (internal). As referenced in Finding 5, ESS was initially built using internal resources to respond to severe weather events with a limited duration, such as a hurricane. Given the sporadic use based on hurricane season, external user access was extremely limited. Additionally, the level of information health care facilities were asked to provide during hurricane season was minute in comparison to the level of data points needed during the pandemic. To ensure that information was provided timely and accurately, health care facilities did have more individuals using the system than in prior events. However, the level of access was unchanged. Regarding Finding 7, it should be noted the finding related to strengthening, "IT access controls to ensure that ESS user access privileges are limited to the minimum necessary for a user to perform their current job duties and deactivated immediately upon separation from Agency employment." This was and continues to be established Agency process as outlined below: Agency Account Deactivation: Access to the ESS for members of the Agency's workforce requires an active Agency Active Directory (AD) account. These accounts are required to be terminated on the last day of employment. To ensure accounts are disabled timely, IT Security monitors an active report which compares employment status to AD status so that outliers can be corrected immediately. Staff that authorize ESS access retires all ESS specialized users from AD annually and validates appropriate access privileges. This review is documented by authorizing staff. ESS User Privileges: Regarding ESS access controls, readers should note that while internal users have a level of access based on their job function, external users only have access to a specific event and may only provide information at the request of the Agency. When a specific weather and/or emergency related event is closed within ESS, access to such event is no longer accessible to all external users and internal users who are not classified as an administrator.	
AG 2022-189 AG 20-21 Federal Awards & Financial Statement Audit	***FYE 6/30/21***	***State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards***	**Finding#2021-077**		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Agency records did not evidence that Florida Medicaid Management Information System (FMMIS) user access privileges were timely deactivated when access was no longer needed.		
			Recommendations We recommend that Agency management enhance employment separation notification controls to ensure that FMMIS user access privileges are deactivated immediately upon a user's separation from Agency employment.	**Management Response** The Agency concurs. The Agency will implement employment separation notification controls to ensure the immediate deactivation of FMMIS user access privileges upon separation from Agency employment.	
			Finding#2021-078 Certain security controls related to user authentication for the Florida Medicaid Management Information System (FMMIS) need improvement to ensure the confidentiality, integrity, and availability of FMMIS data and related information technology (IT) resources.		
			Recommendations We recommend that Agency management improve certain security controls related to FMMIS user authentication to ensure the confidentiality, integrity, and availability of FMMIS data and related IT resources.	**Management Response** The recommended functionality is not supported by the current FMMIS provisioning system. However, in order to access the FMMIS, State users must access the State's network, which does contain the recommended security controls. Current State procurements include the recommended functionality requirements.	
			Finding#2021-080 The Agency did not always ensure that an independent audit of the accuracy, truthfulness, and completeness of encounter data for each health plan was conducted at least once every 3 years nor post the results of financial audits to its Web site.		
			Recommendations We recommend that Agency management establish policies and procedures requiring an EDV study for each health plan at least every 3 years to ensure the accuracy, truthfulness, and completeness of encounter data and post the results of financial audits on its Web site.	**Management Response** The Agency will work in collaboration with its EQRO to develop policies and procedures to ensure that the accuracy, truthfulness, and completeness of encounter data is validated at least once every three years for each plan, during the next three-year cycle (SFY 22/23 – SFY 24/25). The Agency currently contracts with two independent CPA firms that conduct audits on the Achieved Savings Rebate financial reports on an annual basis. Audits are conducted after the Annual financial statements are received in May. The CPA firms must submit the Final Audit Reports to the Agency by September 1st.	
			Finding#2021-081 The Agency did not obtain from health plans a report that included all MLR information required by Federal regulations.		
			Recommendations We recommend that the Agency ensure that the ASR Financial Report obtained from each MCO, PIHP, and PAHP includes all the MLR information required by Federal regulations.	**Management Response** The Agency will update the Achieved Saving Rebate Financial Report, specifically the Medical Loss Ratio (MLR) Exhibit, by adding a line for the Credibility Adjustment in order to maintain compliance with that Federal requirement. The Agency will also make amendments to the Instructions tab, as well as the MLR Exhibit, to comply with the regulation requiring Health Plans to provide a comparison of MLR information per 42 CFR 438.8(k).	
			Finding#2021-082 The Agency's confidentiality agreement with its fiscal agent did not include required elements in accordance with the NCCI Technical Guidance Manual for Medicaid Services.		
			Recommendations	**Management Response**	

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			We recommend that the Agency amend its fiscal agent contract confidentiality agreement to include the elements required by the NCCI Technical Guidance Manual for Medicaid Services.	The Agency is currently involved in an active procurement of the Florida Health Care Connections (FX) Core which will process Medicaid Fee-For-Service Claims and Managed Care Encounters, and will contain reference file information such as NCCI Edits. The recommendations will be included in the new FX Core contract, which is expected to be awarded by the end of 2022, and will go live by the end of 2024.	
			Finding#2021-083 The Agency did not ensure that all external quality review activities were performed in accordance with Federal requirements.		
			Recommendations We recommend that the Agency ensure that EQR activities, including compliance reviews, are conducted in accordance with Federal regulations.	**Management Response** The Agency is on track to complete the three-year compliance review by the end of the review period. The three-year compliance review period began in January 2022 and will end in December 2024. The EQRO will begin conducting the review of the state's compliance review activities in January 2025 (i.e., SFY 24/25); therefore, this item cannot be fully corrected until the EQRO reports findings in the Annual Technical Report that is due to the Centers for Medicare & Medicaid Services (CMS) in April 2026.	
			Finding#2021-084 Internal controls related to the Pharmaceutical Claims Processing System (PCPS) were not always appropriately designed and operating effectively.		
			Recommendations We recommend that the Agency ensure that the service organization takes timely and appropriate corrective action to resolve the deficiencies noted in the independent service auditor's report.	**Management Response** The Agency received the Magellan (Pharmaceutical Claims Processing System) SOC 1 report in October 2021. The Agency met with Magellan and Gainwell (Magellan is a sub-contractor to Gainwell, the Florida Medicaid Fiscal Agent) in December 2021. CAPs were due on January 31, 2022, and were delivered to Agency on January 20, 2022. The Agency is currently monitoring the completion of the three Magellan Corrective Action Plans.	
			Finding#2021-085 The Agency did not ensure that the subservice organization's internal controls related to the Pharmaceutical Rebate Information Management System (PRIMS) were appropriately designed and operating effectively.		
			Recommendations We recommend that, as applicable, Agency management make or obtain independent and periodic assessments of the effectiveness of subservice organization controls relevant to PRIMS, such as through the timely and documented review of service auditor reports.	**Management Response** For the first part of the audit period, PRIMS was housed at the New Mexico Data Center (NMDC). Gainwell, the fiscal agent, moved their hosting services from the NMDC to Amazon Web Service (AWS). Since Gainwell canceled their contract with NMDC, NMDC did not perform a SOC audit for PRIMS, which would provide evidence of the effectiveness of relevant service organization controls. The AWS SOC report was submitted to the auditors, which covered the last three months of the audit period.	
			Finding#2021-086 The list used by the Agency to conduct periodic Fraud and Abuse Case Tracking System (FACTS) system user access privilege reviews did not promote an effective review of the appropriateness of all user accounts.		
			Recommendations We recommend that Agency management complete periodic reviews of the appropriateness of FACTS user access privileges using system-generated lists of user accounts.	**Management Response** The Agency concurs. The Agency has transitioned to using system-generated conduct periodic reviews of FACTS user access privileges, effective March 9, 2022.	
			Finding#AM 2021-05 Agency 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, prior to audit adjustment, amounts reported on the State's SEFA were incorrect.		

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			Recommendations We recommend that the Agency enhance procedures to ensure that the data used to prepare the SEFA is correct and the information reported on the SEFA data form is reviewed by management for accuracy and completeness prior to submission to the FDFS.	**Management Response** To ensure the accuracy and completeness of Agency's SEFA submission, Agency will modify its SEFA reporting procedures. These revised procedures will include steps for pulling data for the closeout period; the types of data, including accruals, that should be pulled; and verification of the FMAP percentage for reported expenditures. If COVID-19 funding is received, procedures will also include steps to separately identify COVID-19 costs on the SEFA reporting form. Management reviews and approves the SEFA prior to its submission to FDFS; however, Agency agrees with the recommendation to include management review for accuracy and completeness to its SEFA reporting procedures.	
AHCA-2122-03-A	***FY 2018 -19 through FY 2020-21***	***Enterprise Audit for House Bill 1079***	**Finding#1** Agency contracts were not always entered timely (within 30-days) or accurately into the Florida Accountability Contract Tracking System (FACTS), as required by Section 215.985(14)(a), F.S.		
			Recommendations Our Office recommends the Agency ensure contract data and documents are accurately entered into FACTS within the statutory 30-day deadline.	**Management Response** We concur and will follow current procedures to ensure all applicable contracts are automatically entered into FACTS within the statutory 30-day deadline.	
			We also recommend that the Agency ensure that contracts/grant disbursements with inactive vendors and past end dates are identified in FACTS and corrected.	We concur and will ensure inactive vendors are notified to update their MFMP registrations or take related measures. We will also update any contracts in FACTS that no longer need to remain open for invoicing/payment purposes	
			Finding#2 Agency procurement policies, procedures, and quality assurance processes need to be updated and revised.		
			Recommendations Our Office recommends the Agency revise and update relevant internal procurement policies and procedures.	**Management Response** We concur and will update policy and procedures to reflect new statutory requirements that resulted from HB 1079 and other processes that have changed since the current policy was updated in 2015.	
			We also recommend the Agency institute additional quality assurance processes over the entry of contracts into FACTS to ensure greater accuracy of the data in FACTS.	We concur and will update quality assurance review processes to verify the timeliness and accuracy of the contract data and documents entered in FACTS.	
			Finding#3 Agency procurement processes relevant to conflict-of-interest documentation need improvement.		
			Recommendations Our Office recommends the AHCA Procurement Office implement relevant quality assurance processes to ensure that conflict-of-interest questionnaire forms are completed and included for all executed contracts.	**Management Response** We concur and will revise quality assurance review processes to ensure conflict of interest questionnaire forms are completed before executing a contract.	
			We also recommend the internal conflict-of-interest questionnaire form be updated to specifically note the five-year previous vendor employment prohibition for Agency contract managers.	We concur and are in the process of updating our conflict-of-interest form to address the new statutory requirement.	
AHCA-2122-04-A		***Enterprise Audit of Cybersecurity Continuous Monitoring***	This information technology audit was released as a **confidential** report pursuant to Section 282.318, Florida Statutes, and is therefore not available for public distribution.		
AUDITS FOR FISCAL YEAR 2020-21					
AG 2020-013	***7/1/18 to 1/31/19***	***Analysis of Selected Medicaid Claims Data***			

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AG 18-19 Operational Audit - AHCA			**Finding** Our audit found that Agency controls could be enhanced to better prevent or detect potential improper Medicaid claims payments. As part of our audit, we analyzed selected FFS claims adjudicated during the period July 2017 through March 2019 and the encounter data for selected SMMC program claims billed during the period July 2017 through March 2019. The selected claim types included, but were not limited to, those for controlled substances prescriptions, human immunodeficiency virus (HIV) prescriptions, home health care visits, and dental services. Our analysis of the selected Medicaid claim types identified numerous claims, summarized in Table 1, that appeared to be contrary to State or Federal law, Agency rules or policies, or other guidelines, and, in some instances, indicative of potential fraud or abuse.		
			Recommendations We recommend that Agency management enhance FMMIS and MCO oversight controls to better prevent or detect potential improper Medicaid claims payments.	**Management Response** *(See final report and six-month status report for complete response)* Controlled Substances Florida Medicaid maintains a number of safeguards through the utilization management process which includes automated and manual prior authorizations, step-edit criteria, and other system edits (quantity limits, age limits, etc.) to ensure appropriate prescribing practices or use of medication. Regarding the management of controlled substances, refills of OxyContin or any other control II substance is federally prohibited. Federal law requires a new prescription from the physician for OxyContin or oxycodone to be filled. Consultation with the prescriber is required in these instances. Additionally, statutory exemptions to prescriber enrollment requirements are applied by Florida Medicaid to ensure reimbursement for only medically necessary services. HIV Prescriptions Prior to the 2014 implementation of Statewide Medicaid Managed Care, the Agency implemented an automatic prior authorization (auto-PA) process to ensure Medicaid recipients obtaining HIV medications have an HIV medical claims diagnosis in their history. If the policy rules established by the automatic prior authorization criteria are not met, the submitted claim will deny and trigger a manual prior authorization review process for verification of consultation with a prescriber. Home Health Visits Health plans provided justification on their system edits related to the specific claim samples in question and are conducting audits to identify any home health paid claims during an inpatient admission. The Agency also reviewed claim samples identified by the auditors and does not recommend system changes in the fee-for-service delivery system nor through the health plans. Encounter Claims: Twenty of the claims were encounter claims from a recipient enrolled in a managed care plan. The plans' coverage may be more expansive than the coverage policy. Seven health plans were contacted about the 20 encounter claims. Because prior authorization was in place for the home health services, clean claims did pay. Identifying home health claims that were paid for dates of service when a member was inpatient must be done as retro-payment review. For the claims identified by the AG, the plans will be reaching out to the home health providers to request documentation and then take appropriate action. These claims were encounter claims and as such health plans may exceed the limits of the coverage policy. Additionally, it is likely the home health visit claim was made prior to the hospital or nursing facility claim was filed with the health plan. Fee-for-Service Claims: Ten claims are fee-for-service claims. Prior authorization is required for home health visits. This is one of the mechanisms the state uses to apply utilization management of home health services. Providers obtain authorization every 60 days. However, when the prior authorization is approved it is not possible to predict health emergencies or natural disasters that may result in an inpatient stay.	

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				Dental Services Florida Medicaid dental services are provided through three Statewide Medicaid Managed Care Dental plans. Each plan has the flexibility and responsibility to apply medically appropriate utilization criteria for dental services. Root canal procedures require a prior authorization in fee-for-service Medicaid. The Agency disagrees with the finding that the number of root canals performed in one date of service and the average length of time to perform a root canal are automatically grounds to identify overpayment by Medicaid. Such determinations require clinical review, and the Agency requested an expert analysis of these situations with licensed and practicing dentists within the Department of Health and the Medicaid dental plans. The AG references the American Association of Endodontists as their source for the expected procedural time for a root canal appointment (90 minutes). However, this reference does not detail the various factors that may affect the overall root canal procedure time. These include primary versus permanent teeth, the location of a tooth, root structure, level of decay, compliance of the patient, level of anesthesia, etc. Therefore, the Agency does not find the AG's reference for root canal procedure time to be adequate or accurate, thus system updates are not necessary.	
AG 2021-028 AG 19-20 IT Operational Audit	***September 25, 2020***	***Surplus Computer Hard Drive Disposal Processes***			
			Finding#2 Periodic Review of Physical Access Privileges. AHCA and DCF physical access policies and procedures need enhancement to ensure that periodic reviews of physical access privileges to secure IT areas are conducted and the results of such reviews are maintained in agency records.		
			Recommendations We recommend that AHCA and DCF management improve physical access policies and procedures to require periodic physical access privilege reviews of secure IT areas and ensure that documentation of such reviews is maintained in agency records.	**Management Response** Corrected. AHCA's written Administrative Policy & Procedure (AP&P) #4029 Security and ID Badges (physical access policy) has been revised with a workable form for tracking purposes. This revised policy is awaiting approval from the new AHCA Deputy Secretary of Operations who started employment on March 15, 2021. Process implemented: In addition to termination procedures, AHCA's Support Services section monitors secure IT areas access rights which are granted through AHCA badges. The AHCA Division of IT security team receives monthly logs of access to the Computer Resource Center (CRC) for validation of access privileges.	
			Finding#3 Surplus Computer Hard Drive Sanitization and Disposition Procedures and Documentation. AHCA, DCF, and DOE procedures for tracking and maintaining records related to the sanitization and disposition of surplus computer hard drives need improvement.		
			Recommendations We recommend that AHCA, DCF, and DOE management establish comprehensive policies and procedures for the surplus computer hard drive sanitization and disposition process and ensure that agency records appropriately account for and evidence the sanitization and disposition of all surplus computer hard drives.	**Management Response** Corrected. AHCA's written Administrative Policy & Procedure (AP&P) #4029 Security and ID Badges (physical access policy) has been revised with a workable form for tracking purposes. This revised policy is awaiting approval from the new AHCA Deputy Secretary of Operations who started employment on March 15, 2021. The tracking form is now in use by the Division of IT and Support Services Office although no items have been surplused since the conclusion of this audit.	
AG 2021-182 AG 19-20 Federal Awards & Financial Statement Audit	***FYE 6/30/20***	***State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards***			
			Finding#2020-040		

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			Agency records did not evidence that periodic reviews of the appropriateness of Florida Medicaid Management Information System (FMMIS) user access privileges were always completed or that access privileges were timely deactivated when access was no longer needed.		
			Recommendations We recommend that Agency management strengthen controls to ensure that periodic reviews of FMMIS access privileges are adequately performed and documented in Agency records. We also recommend that Agency management enhance controls to ensure that FMMIS user access privileges are deactivated immediately upon a user's separation from Agency employment.	**Management Response** To ensure timely deactivation of Agency internal MEUPS user access, the following actions will be taken: 1. Agency will create a 'New Org/Department Owners' Tip Sheet providing an overview of the provisioning process, links to MEUPS documents and requirements for transfers and access terminations. • Tip sheet completed and posted to the MFAO Systems SharePoint site May 3, 2021 2. A Agency IT Help Desk ticket-based task will be assigned to MFAO during the Agency workforce member termination process. • The Agency IT Help Desk ticket-based task process was implemented May 3, 2021. 3. Agency procedures will be modified to: a) Terminate applicable MEUPS access upon receipt of ticket. • Procedures updated in the MFAO Operations and Maintenance (O&M) Security Procedures Guide (Section 2 Daily AHCA Termination Reviews) and posted the MFAO Systems SharePoint site May 20, 2021. b) Follow Agency IT Help Desk Ticket task resolution procedures. • Procedures implemented May 11, 2021. The CAP was completed and fully implemented on May 20, 2021.	
			Finding#2020-041 Agency records did not evidence that site visits of Medicaid program providers were conducted in accordance with Federal regulations.		
			Recommendations We recommend that the Agency enhance controls to ensure that providers seeking enrollment in the Florida Medicaid program receive site visits in accordance with Federal regulations. In addition, we recommend that the Agency revalidate the enrollment of providers in all service locations at least every 5 years in accordance with Federal regulations.	**Management Response** 1. Make Prior Year Adjustment: Prior Period Adjustment (PPA) for the federal share (FS) of $32,358.85 was reported on the Q1-2021 CMS-64 Line 10A. • Completed and verified May 19, 2021 2. Mitigate Human errors in processing • Provide re-training to staff. • Completed June 20, 2021 • Modify user interface (UI) to not allow application approval without a Site visit when required. • Implemented August 27, 2021 3. Correct/Modify Risk level for Provider Types not aligned with CMS • Agency workgroup tasked with re-evaluating RBS categories. • Completed March 30, 2021 • Modify Risk Levels according to workgroup recommendations. • Implemented August 27, 2021. 4. Evaluate State's protocol for site visit requirement at revalidation for providers with multiple locations. • Per CMS' direction, this was not required. "At revalidation, for the base provider and its 99 branches, the State Medicaid Agency has the discretion to determine the location at which the state (or state's contractor) will perform the site visit. They are not required to perform 99 site visits."	
			Finding#2020-042 The Agency did not ensure that all external quality review activities were performed in accordance with Federal requirements.		
			Recommendations	**Management Response**	

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			We recommend that the Agency ensure that EQR activities, including compliance reviews, are conducted in accordance with Federal regulations.	As previously indicated, during the timeframe in question, numerous required EQR activities were reviewed. However, despite this intensive and comprehensive monitoring, we previously concurred that, in the period prior to 2019, we had not monitored some of the aspects required by the federal Centers for Medicare and Medicaid Services. We have since studied the requirements and have taken steps to ensure our EQR vendor has all the data needed to perform activities in accordance with Federal requirements. We have also created a plan to complete all mandatory monitoring. Based on discussion with the auditors, we understand that the three-year period will always be a "rolling" three-year look-back, and thus our comprehensive monitoring plan will not yield full compliance until the audit that encompasses 2020-2021. Despite this, we are confident that a close review of the Agency oversight of the managed care plans will show that it is not only comprehensive but that the approach to targeted monitoring yields far higher health plan performance and member outcomes than a monitoring approach that simply adheres to the minimum federal requirements.	
			Finding#2020-043 The Agency did not ensure that cost report audits were conducted in accordance with the approved Florida Medicaid State Plan and Federal regulations.		
			Recommendations To ensure compliance with Federal regulations and the approved Medicaid State Plan, we recommend that Agency management ensure that cost reports audits are conducted in accordance with GAAS.	**Management Response** Agency has removed all references to the GAAS from the State Plan Amendment which will be effective July 1, 2021. This State Plan Amendment will be submitted to CMS by September 30, 2021.	
			Finding#2020-047 Internal controls related to the Pharmaceutical Claims Processing System (PCPS) were not always appropriately designed and operating effectively.		
			Recommendations We recommend that the Agency ensure that the service organization takes timely and appropriate corrective action to resolve the deficiencies noted in the independent service auditor's report.	**Management Response** Agency will develop a process to ensure the timely review of the independent service auditor's report; and identify and oversee any required corrective action plans. Agency will: 1. Develop a schedule of expected delivery dates of the independent service auditor's reports. • Completed March 3, 2021 2. Post schedule to a new SharePoint Calendar. • Completed March 3, 2021 3. Create procedures and processes to send notifications, and follow up notifications, to the Agency's report reviewers until verification of the review is complete. • Procedure guide updated and posted to MFAO Systems SharePoint site (Systems Operations and Maintenance (O&M) Team Procedure Guide V7.0, MFAO Sections 24.3 Schedule Initial e-mail; 24.4 Schedule future delivery; 24.5 Set up follow up reminder; and 24.6 Post Monthly Review. • Completed May 3, 2021 Fully Completed May 3, 2021	
AG 2021-198 AG 19-20 Operational Audit - AHCA	*7/1/18 to 1/31/20*	***MediKids Program Funding and Selected Administrative Activities***			
			Finding#1 MediKids Funding. Contrary to State law, amounts collected from families whose children participated in the full-pay portion of the MediKids program were not sufficient to pay for the full cost of the MediKids program.		
			Recommendations	**Management Response**	

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			We recommend that Agency management take steps to ensure that families enrolled in the full-pay portion of Medikids pay the full cost of the premium in accordance with State law.	The Agency has worked with our actuarial firm and determined there is a need for an increase in the full-pay family premium. The Agency is currently working with the Florida Healthy Kids Corporation to notify the MediKids full-pay recipients of the premium increase. It is anticipated that the increase will be effective January 1, 2022. The Agency will continue to monitor the program in the future to determine if there is a need for further increases or decreases in the full-pay premium.	
			Finding#2 Accounting and Budgeting Policies and Procedures and Staff Training The Bureau of Financial Services (BFS) had not established sufficiently comprehensive policies and procedures or developed a BFS-specific training program to ensure that staff received sufficient training related to the Agency's complex accounting and budgeting tasks. A similar finding was noted in prior audit reports, most recently in our report No. 2018-172.		
			Recommendations We recommend that BFS management update policies and procedures to ensure that BFS responsibilities and unique operations are sufficiently addressed. The updated policies and procedures should promote compliance with applicable laws, rules, regulations, and accounting standards, and provide sufficient guidance to ensure consistency in the event of staff turnover. In addition, we again recommend that BFS management develop a staff training program that is specifically tailored to address the complexity of the Agency's financial operations and maintain appropriate documentation demonstrating BFS staff attendance at training activities or why formal training activities were not required.	**Management Response** BFS has established the Agency standard for policies and procedures and completed several draft procedures, which are in final review at this time. Completion of the remaining procedures is underway. A training plan for the Revenue Section has been implemented. BFS is working on the remaining staff training plans, which will meet the operational needs of each section.	
			Finding#3 Accounting Transactions BFS controls continue to need enhancement to ensure that accounting transactions are properly reviewed and approved.		
			Recommendations We recommend that BFS management update review and approval processes to encompass the accounting transactions noted on audit and ensure that Agency records evidence the review and approval of all Agency accounting transactions.	**Management Response** BFS is still reviewing and updating policy and procedures that will improve the review controls for different accounting cycles and maintain the review and approval evidence.	
			Finding#4 Prompt Payments BFS controls need enhancement to ensure that payments are accurately recorded in the Florida Accounting Information Resource Subsystem (FLAIR) and comply with statutory prompt payment requirements. A similar finding was noted in prior audit reports, most recently in our report No. 2018-172.		
			Recommendations We again recommend that BFS management strengthen invoice payment and processing controls to promote compliance with statutory prompt payment requirements.	**Management Response** BFS regularly communicates with all team members the importance of using the correct transaction dates, however, additional training will be given to all the Disbursement Unit team members on choosing the correct transaction date. We continue to use the report for the purpose of tracking prompt payment and update our measure on a bi-weekly basis. The team has also initiated a new weekly process for management to ensure invoices follow the prompt payment law.	
			Finding#5 Mobile Device Security Controls Security controls over mobile device utilization need improvement to ensure the confidentiality, integrity, and availability of Agency data and information technology (IT) resources.		
			Recommendations	**Management Response**	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			We recommend that Agency management enhance certain security controls related to employee use of mobile devices to ensure the confidentiality, integrity, and availability of Agency data and related IT resources.	Implemented Microsoft Azure Sentinel in May of 2021, with User Behavior Analytics functionality to identify all unknown access attempts. Devices that are not recognized are investigated by the Agency IT Security Team. Remote Desktop Protocol will continue to be phased-out as the COVID Pandemic emergency subsides. The Agency will turn to Virtual Private Network services on state issued devices for Agency use in the future outside any state-of-emergencies that require emergency IT needs.	
			Finding#6 Property Inventories Agency tangible personal property controls need enhancement to ensure that physical property inventories are timely conducted and the results submitted to the Agency Property Administrator in accordance with established time frames.		
			Recommendations We recommend that Agency management take steps to ensure that physical inventories of tangible personal property are timely performed and the results of the inventories are submitted to the Agency Property Administrator in accordance with established time frames.	**Management Response** The Agency performed the FY 2020-2021 physical inventory of tangible personal property and completed the entire process within the target of 90 days. No additional changes to the policies and procedures were needed.	
			Finding#7 Property Records Agency controls regarding the accuracy and completeness of the information needed to correctly report and maintain proper accountability over Agency property and demonstrate compliance with applicable Department of Financial Services rules need enhancement.		
			Recommendations We recommend that Agency management enhance controls to promote the complete and accurate recording of all required property information in Agency property records.	**Management Response** The Agency has revised the procedures for property recording. With the Agency's upcoming inventory, we will be continuing the process of reviewing data. Property recorded in FLAIR using the TR16 does not produce a voucher number. As of May 2021, the agency has begun to enter the requested voucher number associated with a recorded property entry into the Other Document Number (ODN) description field within FLAIR. Upon beginning this solution, it has been discovered that although the voucher number is entered in the ODN field when inputting the TR 16 it does not show on the Property Master File. However, it does show when the transaction history for the entry is pulled. Note: According to the DFS Asset Management FLAIR Procedure Manual (p 28) the voucher number is not an input requirement when creating a transaction on the Property Master File.	
			Finding#8 Property Acquisitions As similarly noted in prior audit reports, most recently in our report No. 2018-002, the Agency did not always timely or accurately record tangible personal property acquisitions in Agency property records.		
			Recommendations We again recommend that Agency management enhance tangible personal property controls to ensure that Agency property records are timely updated for tangible personal property acquisitions and accurately maintained in accordance with DFS rules. Such tangible personal property control enhancements should include a specified time frame for recording tangible personal property acquisitions to Agency property records and guidance addressing the recording of property items at the correct cost.	**Management Response** The Agency has implemented revised property management procedures. Submissions are being processed in a timely manner. The Agency will continue to educate and provide more guidance to ensure that proper procedures are followed.	
			Finding#9 Contract Information Reporting The Agency did not post information for all Agency contracts to the Florida Accountability Contract Tracking System (FACTS) as required by State law. A similar finding was noted in our report No. 2019-015.		

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			Recommendations We recommend that Agency management enhance controls to ensure that required contract information for all Agency contracts is timely posted to FACTS in accordance with State law.	**Management Response** As of October 8, 2021, the Bureau of Purchasing and Contract Administration has entered 44 Statewide Medicaid Managed Care (SMMC) and Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) contracts into FACTS.	
			Finding#10 VERSA Regulation System and Clearinghouse Access Controls As similarly noted in our report No. 2018-172, IT user access controls for the Versa Regulation system and Care Provider Background Screening Clearinghouse need improvement to ensure that periodic reviews of user access privileges are adequately performed and documented and Agency records demonstrate that user access privileges are timely deactivated when access is no longer needed.		
			Recommendations We again recommend that Agency management strengthen controls to ensure that periodic reviews of VERSA Regulation system and Clearinghouse user access privileges are adequately performed and documented in Agency records. We also recommend that Agency management enhance controls to ensure that VERSA Regulation system user access privileges are deactivated immediately upon a user's separation from Agency employment.	**Management Response** The Transfer, Promotion and Separation (TPS) process for Versa and the Clearinghouse has been enhanced by increasing the IT Help Desk surveillance of tasks assigned to ensure user access privileges are deactivated. The Background Screening Clearinghouse will be using a new single-sign-on (SSO) application within the next six months to assist with the management of Clearinghouse external user accounts including periodic reviews.	
			Finding#11 FLAIR Access Controls Agency controls over employee access to FLAIR continue to need improvement to help prevent and detect any improper or unauthorized use of FLAIR access privileges.		
			Recommendations We recommend that Agency management enhance FLAIR access controls to ensure the appropriate assignment and timely removal of FLAIR user access privileges. Such enhancements should include: •Conducting complete periodic FLAIR access reviews and maintaining appropriate documentation for changes in FLAIR user access privileges necessitated by the reviews. •Limiting FLAIR user access privileges to promote an appropriate separation of duties and requiring that, where incompatible access privileges are necessary, establishing and documenting compensating controls. •Removing FLAIR user access privileges immediately upon a user's separation from Department employment.	**Management Response** BFS: BFS has implemented revised procedures for FLAIR access. Requests are being documented in a timely manner. All policies and procedures have been updated. IT: Division of IT System Access Review process has been enhanced.	
AHCA-1718-02-A	**1/1/18 to 12/31/18**	**HQA Tracking of Final Orders**	**Finding#1** HQA Tracking and Monitoring of Non-Monetary Compliance Penalties. HQA staff did not consistently monitor and track nonmonetary final orders as required.		
			Recommendations 1. We recommend that HQA follow the provisions set forth in the Protocol in which the Enforcement Unit runs the Open Case Compliance Report monthly and quarterly to effectively monitor all non-monetary compliance items more than 30 or 90 calendar days past due. We further recommend that monitoring be documented.	**Management Response** HQA Response: *Complete as of 12/27/21* 1. Concur. Significant progress has been made to track and monitor non-monetary compliance. As of the monthly report on 6/1/2021, only 11 past-due non-monetary compliance items were outstanding. Currently, there is no SQL rule for non-monetary items, but one is being created as of 6/16/2021. The SQL rule will mirror the one in place for monetary compliance and will force the licensure units to use their leverage over the facility's need to comply with these penalties as well.	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			2. We recommend that HFR and Field Operations follow the provisions set forth in the Protocol requiring staff to reach out to facilities with open non-monetary compliance penalties under their purview. Staff should also enter any notations needed, enter a completion date in VERSA for applicable non-monetary compliance penalties, and save documentation of compliance with these penalties in accordance with the Protocol.	2. *Complete as of 12/27/21* Concur. HFR and Field Operations agree with the recommendation to follow the provisions set forth in the Protocol. HFR and Field Operations staff currently review the Open Case Compliance Report for necessary action and update VERSA and as necessary.	
			Finding#2 Financial Services Intake of Final Orders and Collection of Monetary Penalties. Financial Services manual process for the intake of final orders and the collection of final order monetary penalties did not always properly identify final order monetary penalties.		
			Recommendations 1. We recommend that Financial Services use the system generated Open Case Compliance Report derived from VERSA to identify any new HQA final orders filed and monitor final orders with outstanding monetary penalties due to the Agency in accordance with the Protocol.	**Management Response** Financial Services Response: *Complete as of 12/27/21* 1. Concur: Financial Services will use the Open Case Compliance Report to aide in identifying new HQA Final orders and monitor outstanding monetary penalties due on a bi-weekly basis.	
			2. We recommend that Financial Services follow the provisions in the Administrative Final Orders Processing/Recording procedures which note that CAMS can generate a "Current Delinquencies" aging report for outstanding HQA final order penalties that have not been paid and use CAMS to generate collection letters for past due final order monetary penalties.	Financial Services Response: *Status as of 6/27/22* 2. Paul's Consulting Firm is in the process of working on the sprint to complete the CAMS enhancements to generate past due collection notices. In Progress. HQA Response: *Status as of 6/27/22* 2. Complete on our end. We recommend using both CAMS and HQA report data to ensure no missing data exists. We have and will continue to do so.	
			Finding#3 Efficiency of Updating Final Order VERSA Payment Information. Different entry points in processing final order monetary penalties in Financial Services and HQA resulted in some delays in posting payment information into VERSA.		
			Recommendations 1. We recommend that Financial Services work with HQA to process final order monetary penalty payments more efficiently. In general, payments received should arrive and be processed by HQA Central Intake as the single point of entry for monetary final order payments. Collection letters should be revised to be consistent with the payment address in the initial final order.	**Management Response** Financial Services Response: *Complete as of 12/27/21* 1. Concur: Financial Services will update the past due collection letters address referenced in the final orders. HQA Response: Concur. HQA Enforcement Unit agrees with Recommendations 1 and 2. The Cash Receipts Report does seem to come more frequently (approximately bi-weekly) from Financial Services, but some errors sometimes do appear in the data.	
			2. For any payments received by Financial Services, we recommend that Financial Services provide a bi-weekly report to HQA Enforcement, rather than the monthly report contemplated by the Protocol. This report should include relevant supporting documentation to update VERSA, as required by the Protocol.	Financial Services Response: *Status as of 11/15/21* 2. Financial Services has implemented additional procedures to reconcile HQA Cash Receipts Reports to CAMS to ensure accuracy. HQA Response: *Status as of 11/15/21* The Cash Receipts Report is sent by Financial Services approximately bi-weekly, but there are still concerns with errors appearing in the data and HQA continues to work on addressing the errors.	
			Finding#4 VERSA Updates of Monetary Compliance Penalties. Final order monetary compliance penalties were not always updated or closed appropriately in VERSA.		
			Recommendations	**Management Response**	

REPORT NUMBER	PERIOD ENDING	UNIT/AREA	SUMMARY OF FINDINGS AND RECOMMENDATIONS	SUMMARY OF CORRECTIVE ACTION TAKEN	ISSUE CODE
			1. We recommend that, as contemplated by the Protocol, the Final Order Process Workgroup meet monthly to discuss appropriate data entry of final orders in VERSA to include monetary compliance items. The Workgroup should include not only staff referenced in the Protocol - the Office of the Deputy Secretary of HQA, the Enforcement Unit, and OGC, but also include a member of Financial Services.	HQA Response: *Status as of 6/27/22* Ongoing tweaks to the Protocol. Progress has been made but the draft update has not yet been implemented. In Progress.	
			2. We also recommend HQA update the provisions set forth in the Protocol in which the Workgroup facilitator distribute follow-up action items as needed on any identified issues to include representation from the Bureau of Financial Services and monetary compliance items.	HQA Response: *Status as of 6/27/22* *Ongoing tweaks to the Protocol. Progress has been made but the draft update has not yet been implemented. In Progress.*	
			Finding#5 Misidentified Final Order Payments. Financial Services staff sometimes misidentified and misclassified HQA final order payments.		
			Recommendations We recommend that HQA and OGC work together to create a unique HQA and MPI identifier on the final order that would help distinguish between the various final orders. For example, using the acronyms HQA and MPI as part of the final order number will allow for easier identification of such orders by Cash Room staff.	**Management Response** Financial Services and HQA Response: *Complete as of 12/27/21* Financial Services and HQA have worked together and confirmed there is a unique identifier in place between HQA and MPI final orders. A dash after the first four numbers is present in MPI final orders and not present in HQA final orders. Financial Services has already provided training to staff to identify the differences and we believe the issue has been successfully resolved.	
			Finding#6 Obsolete Compliance Requirements. HQA final orders with certain obsolete compliance requirements were issued by OGC.		
			Recommendations 1. We recommend that both HFR and OGC ensure the “Return License" non-monetary compliance penalty is no longer used in HQA final orders and that final order language is updated to note that the license is null and void and can no longer be used.	**Management Response** HQA Response: *Complete as of 12/27/21* HFR agrees that the return license compliance penalty is obsolete and will work with OGC to ensure it is no longer used. The return license compliance penalty will be closed in VERSA as it is identified on the monthly report as it is no longer applicable. OGC recommends a statutory change in 408.81, F.S. to clarify a provider should notify the Agency of discontinuance of operations instead of surrendering the physical license.	
			2. We also recommend that any current "Return License" compliance penalties be closed in VERSA by HQA staff.	*Complete as of 12/27/21*	

END OF DOCUMENT

Fiscal Year 2023-24 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Administration
Agency Budget Officer/OPB Analyst Name: La-Shonna K. Austin / Shenita White

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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
1. GENERAL							
1.1	Are Columns A01, A04, A05, A91, A92, A93, A94, A95, A96, A36, A10, IA1, IA4, 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)? Is Column A02 set to TRANSFER CONTROL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for the Trust Fund Files (the Budget Files should already be on TRANSFER CONTROL for DISPLAY and MANAGEMENT CONTROL for UPDATE)? 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 or Web LBR Column Security)**	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	Have Column A03 budget files been copied to Column A12? Run the Exhibit B Audit Comparison Report to verify. **(EXBR, EXBA)**	Y	Y	Y	Y	Y	Y
1.4	Have Column A03 trust fund files been copied to Column A12? Run Schedule I **(SC1R, SC1 or SC1R, SC1D adding column A12**) to verify.	Y	Y	Y	Y	Y	Y
1.5	Has Column A12 security been set correctly to ALL for DISPLAY status and MANAGEMENT CONTROL for UPDATE status for Budget and Trust Fund files? **(CSDR, CSA)**	Y	Y	Y	Y	Y	Y
TIP	The agency should prepare the budget request for submission in this order: 1) Copy Column A03 to Column A12, and 2) Lock columns as described above. A security control feature included in the LAS/PBS Web upload process requires columns to be in the proper status before uploading to the portal.						
2. EXHIBIT A (EADR, EXA)							
2.1	Is the budget entity authority and description consistent with the agency's LRPP and does it conform to the directives provided on page 56 of the LBR Instructions?	Y	Y	Y	Y	Y	Y
2.2	Are the statewide issues generated systematically (estimated expenditures, nonrecurring expenditures, etc.) included?	Y	Y	Y	Y	Y	Y
2.3	Are the issue codes and titles consistent with *Section 3* of the LBR Instructions (pages 14 through 27)? 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.	N/A	N/A	N/A	N/A	N/A	N/A

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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
AUDITS:							
3.2	Negative Appropriation Category Audit for Agency Request (Columns A03 and A04): Are all appropriation categories positive by budget entity and program component at the FSI level? Are all nonrecurring amounts less than requested amounts? **(NACR, NAC - Report should print "No Negative Appropriation Categories Found")**	Y	Y	Y	Y	Y	Y
3.3	Current Year Estimated Verification Comparison Report: Is Column A02 equal to Column B07? **(EXBR, EXBC - Report should print "Records Selected Net To Zero")**	Y	Y	Y	Y	Y	Y
TIP	Generally look for and be able to fully explain significant differences between A02 and A03.						
TIP	Exhibit B - A02 equal to B07: Compares Current Year Estimated column to a backup of A02. This audit is necessary to ensure that the historical detail records have not been adjusted. Records selected should net to zero.						
TIP	Requests for appropriations which require advance payment authority must use the sub-title "Grants and Aids". For advance payment authority to local units of government, the Aid to Local Government appropriation category (05XXXX) should be used. For advance payment authority to non-profit organizations or other units of state government, 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 59 of the LBR Instructions?	Y	Y	Y	Y	Y	Y
4.2	Is the program component code and title used correct?	Y	Y	Y	Y	Y	Y
TIP	Fund shifts or transfers of services or activities between program components will be displayed on an Exhibit D whereas it may not be visible on an Exhibit A.						
5. EXHIBIT D-1 (ED1R, EXD1)							
5.1	Are all object of expenditures positive amounts? (This is a manual check.)	Y	Y	Y	Y	Y	Y
AUDITS:							
5.2	Do the fund totals agree with the object category totals within each appropriation category? **(ED1R, XD1A - Report should print "No Differences Found For This Report")**	Y	Y	Y	Y	Y	Y
5.3	FLAIR Expenditure/Appropriation Ledger Comparison Report: Is Column A01 less than Column B04? **(EXBR, EXBB - Negative differences [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

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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
TIP	If objects are negative amounts, the agency must make adjustments to Column A01 to correct the object amounts. In addition, the fund totals must be adjusted to reflect the adjustment made to the object data.						
TIP	If fund totals and object totals do not agree or negative object amounts exist, the agency must adjust Column A01.						
TIP	Exhibit B - A01 less than B04: This audit is to ensure that the disbursements and carry/certifications forward in A01 are less than FY 2021-22 approved budget. Amounts should be positive. The $5,000 allowance is necessary for rounding.						
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. Note that there is a $5,000 allowance at the department level.						
6. EXHIBIT D-3 (ED3R, ED3) (Not required in the LBR - for analytical purposes only.)							
6.1	Are issues appropriately aligned with appropriation categories?	Y	Y	Y	Y	Y	Y
TIP	Exhibit D-3 is not 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) (Required to be posted to the Florida Fiscal Portal)							
7.1	Are the issue titles correct and do they clearly identify the issue? (See pages 15 through 27 of the LBR Instructions.)	Y	Y	Y	Y	Y	Y
7.2	Does the issue narrative adequately explain the agency's request and is the explanation consistent with the LRPP? (See pages 64 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 66 through 69 of the LBR Instructions?	Y	N/A	Y	N/A	N/A	N/A
7.4	Are all issues with an IT component identified with a "Y" in the "IT COMPONENT?" field? If the issue contains an IT component, has that component been identified and documented?	Y	N/A	Y	N/A	N/A	N/A
7.5	Does the issue narrative explain any variances from the Standard Expense and Human Resource Services Assessments package? Is the nonrecurring portion in the nonrecurring column? (See pages E.4 through E.5 of the LBR Instructions.)	N/A	N/A	N/A	N/A	N/A	N/A
7.6	Does the salary rate request amount accurately reflect any new requests and are the amounts proportionate to the Salaries and Benefits request? Note: Salary rate should always be annualized.	Y	N/A	Y	N/A	N/A	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. (See pages 93 through 92 of the LBR Instructions.)	Y	N/A	Y	N/A	N/A	Y
7.8	Does the issue narrative include the Consensus Estimating Conference forecast, where appropriate?	N/A	N/A	N/A	Y	Y	N/A

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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
7.9	Does the issue narrative reference the specific county(ies) where applicable?	N/A	N/A	N/A	N/A	Y	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 #23-003?	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 LAS/PBS 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.	N/A	N/A	N/A	Y	Y	N/A
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 26 and 88 of the LBR Instructions.)	Y	N/A	Y	N/A	N/A	Y
7.17	Do the issues relating to *Information Technology (IT)* have a "C" in the sixth position of the issue code (36XXXCX) and are the correct issue codes used (361XXC0, 362XXC0, 363XXC0, 24010C0, 30010C0, 33011C0, 160E470, or 160E480)?	Y	N/A	Y	N/A	N/A	N/A
7.18	Are the issues relating to *major audit findings and recommendations* properly coded (4A0XXX0, 4B0XXX0)?	N/A	N/A	N/A	N/A	N/A	N/A
7.19	Does the issue narrative identify the strategy or strategies in the Five Year Statewide Strategic Plan for Economic Development?	Y	Y	Y	Y	Y	Y
AUDIT:							
7.20	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
7.21	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
7.22	Does the General Revenue for 200XXXX (Estimated Expenditures Realignment) issues net to zero? **(GENR, LBR3)**	N/A	N/A	N/A	N/A	N/A	N/A
7.23	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

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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
7.24	Has narrative been entered for all issues requested by the agency? Agencies do not need to include narrative for startup issues (1001000, 2103XXX, etc.) that were not input by the agency. **(NAAR, BSNR)**	Y	Y	Y	Y	Y	Y
7.25	Has the agency entered annualization issues (260XXX0) for any issue that was partially funded in Fiscal Year 2022-23? Review Column G66 to determine whether any incremental amounts are needed to fully fund an issue that was initially appropriated in Fiscal Year 2022-23. Do not add annualization issues for pay and benefit distribution issues, as those annualization issues (26AXXXX) have already been added to A03.	N/A	N/A	N/A	Y	Y	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 64 through 69 of the LBR Instructions.						
TIP	Check BAPS to verify status of budget amendments. Check for reapprovals not picked up in the General Appropriations Act. Verify that Lump Sum appropriations in Column A02 do not appear in Column A03. Review budget amendments to verify that 160XXX0 issue amounts correspond accurately and net to zero for General Revenue funds.						
TIP	If an agency is receiving federal funds from another agency the FSI should = 9 (Transfer - Recipient of Federal Funds). The agency that originally receives the funds directly from the federal agency should use FSI = 3 (Federal Funds).						
TIP	If an appropriation made in the FY 2022-23 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) (Required to be posted to the Florida Fiscal Portal)							
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)? *Note: The Schedule IA for the Health Care Trust Fund (2003) and Schedule IC for the Medical Care Trust Fund (2474) will be provided on a later date.*	Y	N	N	N	N	N

Fiscal Year 2023-24 LBR Technical Review Checklist

Department/Budget Entity (Service): Agency for Health Care Administration
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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
8.4	Have the Examination of Regulatory Fees Part I and Part II forms been included for the applicable regulatory programs? *Note: The forms for the Health Care Trust Fund (2003) will be provided on a later date.*	N/A	N/A	N/A	N/A	N/A	N
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)? *Note: The narrative for the following trust funds will be provided on a later date.* *- Health Care Trust Fund (2003)* *- Administrative Trust Fund (2021)* *- Grants and Donations Trust Fund (2339)* *- Medical Care Trust Fund (2474)*	N	N	N	N	N	N
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

Fiscal Year 2023-24 LBR Technical Review Checklist

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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
8.16	Are the Schedule I revenues consistent with the FSI's reported in the Exhibit D-3A?	Y	Y	Y	Y	Y	Y
8.17	If applicable, are nonrecurring revenues entered into Column A04?	Y	Y	Y	Y	Y	Y
8.18	Has the agency certified the revenue estimates in columns A02 and A03 to be the latest and most accurate available? Does the certification include a statement that the agency will notify OPB of any significant changes in revenue estimates that occur prior to the Governor's Budget Recommendations being issued?	Y	Y	Y	Y	Y	Y
8.19	Is a 5% trust fund reserve reflected in Section II? If not, is sufficient justification provided for exemption? Are the additional narrative requirements provided? *Note: The narrative for the following trust funds will be provided on a later date.* *- Health Care Trust Fund (2003)* *- Administrative Trust Fund (2021)* *- Grants and Donations Trust Fund (2339)* *- Medical Care Trust Fund (2474)*	N	N	N	N	N	N
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, Section III?	Y	Y	Y	Y	Y	Y
8.25	Are current year September operating reversions (if available) appropriately shown in column A02, Section III?	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? *Note: The Schedule IC for the Medical Care Trust Fund (2474) will be provided on a later date.*	Y	N	N	N	N	Y
8.27	Has the agency analyzed for continuing appropriations (category 13XXXX) and properly accounted for in the appropriate column(s) in Section III?	N/A	N/A	N/A	N/A	N/A	N/A
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

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	Action	Program or Service (Budget Entity Codes)					
		68200000	68500100	68500200	68501400	68501500	68700700
8.29	Does Line I of Column A01 (Schedule I) equal Line K of the Schedule IC? *Note: The Schedule IC for the Medical Care Trust Fund (2474) will be provided on a later date.*	Y	N	N	N	N	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 of the Schedule 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 pages 124 through 126 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 155 of the LBR Instructions.)	Y	N/A	Y	N/A	N/A	Y
10. SCHEDULE III (PSCR, SC3)							
10.1	Is the appropriate lapse amount applied? (See page 90 of the LBR Instructions.)	N/A	N/A	N/A	N/A	N/A	N/A
10.2	Are amounts in *Other Salary Amount* appropriate and fully justified? (See pages 93 through 94 of the LBR Instructions for appropriate use of the OAD transaction.) Use **OADI** or **OADR** to identify agency other salary amounts requested.	Y	N/A	Y	N/A	N/A	Y

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		68200000	68500100	68500200	68501400	68501500	68700700
11. SCHEDULE IV (EADR, SC4)							
11.1	Are the correct Information Technology (IT) issue codes used?	Y	N/A	Y	N/A	N/A	N/A
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 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**						
TIP	If all or a portion of an issue is intended to be reduced on a nonrecurring basis, include the total reduction amount in Column A91 and the nonrecurring portion in Column A92.						
14. SCHEDULE VIIIB-2 (EADR, S8B2) (Required to be posted to the Florida Fiscal Portal)							
14.1	Do the reductions comply with the instructions provided on pages 99 through 102 of the LBR Instructions regarding a 10% reduction in General Revenue and Trust Funds, including the verification that the 33BXXX0 issue has NOT been used? Verify that excluded appropriation categories and funds were not used (e.g. funds with FSI 3 and 9, etc.)	N/A	N/A	N/A	Y	Y	N/A
TIP	Compare the debt service amount requested (IOE N or other IOE used for debt service) with the debt service need included in the Schedule VI: Detail of Debt Service, to determine whether any debt has been retired and may be reduced.						
TIP	If all or a portion of an issue is intended to be reduced on a nonrecurring basis, in the absence of a nonrecurring column, include that intent in narrative.						
15. SCHEDULE VIIIC (EADR, S8C) (NO LONGER REQUIRED)							
16. SCHEDULE XI (UCSR,SCXI) (LAS/PBS Web - see pages 104-108 of the LBR Instructions for detailed instructions) (Required to be posted to the Florida Fiscal Portal in Manual Documents)							
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 2021-22 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	N/A	Y	N/A	N/A	Y

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	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: The activities listed in **Audit #3** do not have an associated output standard. In addition, the activities were not identified as a Transfer to a State Agency, as Aid to Local Government, or a Payment of Pensions, Benefits and Claims. Activities listed here should represent transfers/pass-throughs that are not represented by those above or administrative costs that are unique to the agency and are not appropriate to be allocated to all other activities.)	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")** *Note: There is a total difference of ($49,941.00) when comparing the sections. ($49,896.46) is the difference between the final reversion amount reflected in Section III and the carry/certified forward reversion report amount. The remaining amount of ($44.54) is due to rounding.*	N/J	N/J	N/J	N/J	N/J	N/J
TIP	If Section I and Section III have a small difference, it may be due to rounding and therefore will be acceptable.						
17. MANUALLY PREPARED EXHIBITS & SCHEDULES (Required to be posted to the Florida Fiscal Portal)							
17.1	Do exhibits and schedules comply with LBR Instructions (pages 52 through 109 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 128 of the LBR instructions for exceptions to this rule)? Have all IV-Bs been emailed to: **IT@LASPBS.STATE.FL.US?**	N/A	N/A	Y	N/A	N/A	N/A
17.5	Are all forms relating to Fixed Capital Outlay (FCO) funding requests submitted in the proper form, including a Truth in Bonding statement (if applicable) ?	N/A	N/A	N/A	N/A	N/A	N/A
AUDITS - GENERAL INFORMATION							
TIP	Review *Section 6: Audits* of the LBR Instructions (pages 154 through 156) 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) (Required to be posted to the Florida Fiscal Portal)							
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)?	N/A	N/A	N/A	N/A	N/A	N/A
18.3	Do all CIP forms comply with CIP Instructions where applicable (see CIP Instructions)?	Y	Y	Y	Y	Y	Y
18.4	Does the agency request include 5 year projections (Columns A03, A06, A07, A08 and A09)?	N/A	N/A	N/A	N/A	N/A	N/A

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18.5	Are the appropriate counties identified in the narrative?	N/A	N/A	N/A	N/A	N/A	N/A
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?	N/A	N/A	N/A	N/A	N/A	N/A
TIP	Requests for Fixed Capital Outlay appropriations which are Grants and Aids to Local Governments and Non-Profit Organizations must use the Grants and Aids to Local Governments and Non-Profit Organizations - Fixed Capital Outlay major appropriation category (140XXX) and include the sub-title "Grants and Aids". These appropriations utilize a CIP-B form as justification.						
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