



The Florida Senate

Local Funding Initiative Request - Fiscal Year 2018-2019

1. **Title of Project:** Hospital Inpatient & Outpatient Services Cancer Center Prospective Payment System Exemption
2. **Senate Sponsor:** Rene Garcia
3. **Date of Submission:** 01/30/2018

4. **Project/Program Description:**

Provides an exemption from the prospective payment system for cancer hospitals which have the exemption pursuant to Section 1833(t)(21)(B) of the Social Security Act. The state share of funding will be provided by an Intergovernmental transfer from the local government and will be deposited into the Agency's Grants and Donations Trust Fund to be used to draw the federal match.

5. **State Agency Contacted?** Yes

a. If yes, which state agency? Agency for Health Care Administration

b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested?

6. **Amount of Non-recurring Requested for fiscal year 2018-19:**

Amount Requested for Operations	Amount Requested for Fixed Capital Outlay	Total Amount of Requested State Funds
31,238,919		31,238,919

7. **Type, amount and percent of matching funds available for this project for fiscal year 2018-19:**

Type	Amount	Percent
Federal	50,239,743	61.7%
State (excluding the amount of this request)	0	0.0%
Local	0	0.0%
Other	0	0.0%
TOTAL	50,239,743	61.7 %

8. **Total Project Cost for fiscal year 2018-19 (including the Total Amount of Requested State Funds):** 81,478,662

9. **Previous Year Funding Details:**

- a. Has funding been provided in a previous state budget for this activity? Yes
- b. In the previous 5 fiscal years, how many years was funding provided? (Optional) 1
- c. What is the most recent fiscal year the project was funded? 2017-18
- d. Were the funds provided in the most recent fiscal year subsequently vetoed? Yes
- e. Complete the following Worksheet.



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FY:	Input Prior FY Appropriation for this project for FY 2017-18 (If appropriated in FY 2017-18 enter the appropriated amount, even if vetoed.)		
Column:	A	B	C
Funds Description:	Prior Year Recurring Funds *	Prior Year Nonrecurring Funds *	Total Funds Appropriated (Column A + Column B)
Input Amounts:		10,647,912	10,647,912

10. Is future-year funding likely to be requested?

Yes

a. If yes, indicate non-recurring amount per year.

\$7,184,014

11. Program Performance:

a. What is the specific purpose or goal that will be achieved by the funds requested?

Support for the provision of cancer care and treatment for charity and unfunded care patients.

b. What are the activities and services that will be provided to meet the intended purpose of these funds?

Cancer care and treatment.

c. How will the funds be expended?

Spending Category	Description	Amount
Administrative Costs		
<input type="checkbox"/> Executive Director/Project Head Salary and Benefits		
<input type="checkbox"/> Other Salary and Benefits		
<input type="checkbox"/> Expense/Equipment/Travel/Supplies/Other		
<input type="checkbox"/> Consultants/Contracted Services/Study		
Operational Costs		
<input type="checkbox"/> Salary and Benefits		



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<input checked="" type="checkbox"/> Expense/Equipment/Travel/Supplies/Other	Provide funding for charities and unfunded care provided by these cancer hospitals for inpatient and outpatient services.	81,478,662
<input type="checkbox"/> Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation		
<input type="checkbox"/> Construction/Renovation/Land/Planning Engineering		
TOTAL		81,478,662

d. What are the direct services to be provided to citizens by the appropriations project?

Inpatient & outpatient cancer care and treatment.

e. Who is the target population served by this project? How many individuals are expected to be served?

Over 800 cancer patients

f. What is the expected benefit or outcome of this project? What is the methodology by which this outcome will be measured?

Greater access to quality cancer care, AHCA reporting, FHURS

g. What are the suggested penalties that the contracting agency may consider in addition to its standard penalties for failing to meet deliverables or performance measures provided for in the contract?

None

12. The owner(s) of the facility to receive, directly or indirectly, any fixed capital outlay funding. Include the relationship between the owner(s) of the facility and the entity.

Not Available

13. Requestor Contact Information:

- a. **Name:** Raena Wright
- b. **Organization:** University of Miami
- c. **Email:** raenawright@miami.edu
- d. **Phone Number:** (786)574-0777

14. Recipient Contact Information:

- a. **Organization:** University of Miami & H. Lee Moffitt Cancer Center
- b. **County:** Hillsborough, Miami-Dade
- c. **Organization Type:**



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- ☐ For Profit
- ☐ Non Profit 501(c) (3)
- ☐ Non Profit 501(c) (4)
- ☒ Local Entity
- ☐ University or College
- ☐ Other (Please specify)

d. Contact Name: Raena Wright

e. E-mail Address: raenawright@miami.edu

f. Phone Number: (786)574-0777

15. If there is a registered lobbyist, fill out the lobbyist information below.

a. Name: Raena Wright

b. Firm: University of Miami

c. Email: raenawright@miami.edu

d. Phone Number: (786)574-0777