The Florida Senate

Local Funding Initiative Request - Fiscal Year 2018-2019

1. **Title of Project:** Neonatal and Pediactric Intensive and Critical Services Rate Increase
2. **Senate Sponsor:** Rene Garcia
3. **Date of Submission:** 12/14/2017
4. **Project/Program Description:**

   Medicaid rate increase for Neonatal and Pediatric Intensive Care physicians

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
2,756,980		2,756,980

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

Type	Amount	Percent
Federal	4,135,470	60.0%
State (excluding the amount of this request)	0	0.0%
Local	0	0.0%
Other	0	0.0%
TOTAL	4,135,470	60.0 %

8. **Total Project Cost for fiscal year 2018-19 (including the Total Amount of Requested State Funds):** 6,892,450

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? 2016-17
   d. Were the funds provided in the most recent fiscal year subsequently vetoed? No
   e. Complete the following Worksheet.

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. Is future-year funding likely to be requested?

No

11. Program Performance:

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

Increase access and quality of care for infants and children suffering from critical medical conditions who are in the Medicaid program.

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

Increase access and quality of care for infants and children suffering from critical medical conditions who are in the Medicaid program.

c. How will the funds be expended?

Spending Category	Description	Amount
Administrative Costs		
☐Executive Director/Project Head Salary and Benefits		
☐Other Salary and Benefits		
☐Expense/Equipment/Travel/Supplies/Other		
☐Consultants/Contracted Services/Study		
Operational Costs		
☑Salary and Benefits	The increased Medicaid rate will be allocated to AHCA who will then use the money to increase the medicaid rate for	2,756,980

	all neonatal and pediatric intensive care unit physicians	
☐Expense/Equipment/Travel/Supplies/Other		
☐Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation		
☐Construction/Renovation/Land/Planning Engineering		
TOTAL		2,756,980

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

Increase access and quality of care for infants and children suffering from critical medical conditions who are in the Medicaid program.

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

Infants and children on Medicaid

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

Increase access and quality of care for infants and children suffering from critical medical conditions who are in the Medicaid program.

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?

No other suggestions.

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 Applicable

13. Requestor Contact Information:

a. Name: Darren Patz
b. Organization: Mednax
c. Email: Darren_Patz@mednax.com
d. Phone Number: (786)473-4431

14. Recipient Contact Information:

a. Organization: Mednax
b. County: Statewide

c. Organization Type:

- ○ For Profit
- ○ Non Profit 501(c) (3)
- ○ Non Profit 501(c) (4)
- ○ Local Entity
- ○ University or College
- ⦿ Other (Please specify) Any NICU and PICU physicians that provide medical care to Medicaid recpients

d. Contact Name: Darren Patz

e. E-mail Address: Darren_Patz@mednax.com

f. Phone Number: (786)473-4431

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

a. Name: Joel Overton

b. Firm: Larry J. Overton and Associates

c. Email: joverton@loverton.net

d. Phone Number: (850)224-2859