1. **Title of Project:** Cancer Hospital Prospective Payment System Exempt

2. **Senate Sponsor:** Manny Diaz

3. **Date of Submission:** 02/07/2019

4. **Project/Program Description:**
   
   Provides an exemption to the prospective payment system for the Medical Reimbursement to qualifying cancer hospitals that meet the criteria under 42 USC Section 1395 ww (d) (I) (B) (v).

5. **State Agency to receive requested funds:** Agency for Health Care Administration

6. **Amount of the Nonrecurring Request for Fiscal Year 2019-2020**

<table>
<thead>
<tr>
<th>Type of Funding</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations</td>
<td>31,393,728</td>
</tr>
<tr>
<td>Fixed Capital Outlay</td>
<td></td>
</tr>
<tr>
<td><strong>Total State Funds Requested</strong></td>
<td>31,393,728</td>
</tr>
</tbody>
</table>

7. **Total Project Cost for Fiscal Year 2019-2020 (including matching funds available for this project)**

<table>
<thead>
<tr>
<th>Type of Funding</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total State Funds Requested (from question #6)</td>
<td>31,393,728</td>
<td>38.53%</td>
</tr>
<tr>
<td>Federal</td>
<td>50,084,933</td>
<td>61.47%</td>
</tr>
<tr>
<td>State (excluding the amount of this request)</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Local</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Project Costs for Fiscal Year 2019-2020</strong></td>
<td><strong>81,478,661</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

8. **Has this project previously received state funding?** Yes

<table>
<thead>
<tr>
<th>Fiscal Year (yyyy-yy)</th>
<th>Recurring Amount</th>
<th>NonRecurring Amount</th>
<th>Specific Appropriation #</th>
<th>Vetoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-19</td>
<td>31,695,199</td>
<td>199</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

9. **Is future-year funding likely to be requested?** Yes
   a. If yes, indicate non-recurring amount per year. 31,393,728

10. **Details on how the requested state funds will be expended**

    | Spending Category Administrative Costs: | Description | Amount |
    |-----------------------------------------|-------------|--------|
    | Executive Director/Project Head Salary and Benefits |             |        |
Other Salary and Benefits
Expense/Equipment/Travel/Supplies/Other
Consultants/Contracted Services/Study

**Operational Costs:**

<table>
<thead>
<tr>
<th>Salary and Benefits</th>
<th>Expense/Equipment/Travel/Supplies/Other</th>
<th>Consultants/Contracted Services/Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Cover the cost of providing Medicaid services</td>
</tr>
</tbody>
</table>

**Fixed Capital Construction/Major Renovation:**

<table>
<thead>
<tr>
<th>Construction/Renovation/Land/Planning Engineering</th>
<th></th>
</tr>
</thead>
</table>

**Total State Funds Requested (must equal total from question #6)**

31,393,728

11. Program Performance:

   a. **What is the specific purpose or goal that will be achieved by the funds requested?**
      Cost payment for care and treatment.
   
   b. **What are the activities and services that will be provided to meet the intended purpose of these funds?**
      Delivery of health care.
   
   c. **What are the direct services to be provided to citizens by the appropriations project?**
      Health care and treatment.
   
   d. **Who is the target population served by this project? How many individuals are expected to be served?**
      Approximately 25,000 Medicaid eligible persons will receive care.
   
   e. **What is the expected benefit or outcome of this project? What is the methodology by which this outcome will be measured?**
      Payments will only be made for services delivered; quality metrics will be developed.
   
   f. **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?**
      Payments will not be made for services not provided.

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.

   none

13. Requestor Contact Information:

   a. **Name:** Raena Wright
   
   b. **Organization:** University of Miami
   
   c. **E-mail Address:** raenawright@miami.edu
   
   d. **Phone Number:** (786)574-0777
14. **Recipient Contact Information:**
   a. **Organization:** University of Miami and H. Lee Moffitt Cancer Center
   b. **County:** Hillsborough, Miami-Dade
   c. **Organization Type:**
      - 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. **Lobbyist Contact Information**
   a. **Name:** Raena Wright
   b. **Firm Name:** raenawright@miami.edu
   c. **E-mail Address:** raenawright@miami.edu
   d. **Phone Number:** (786)574-0777