MEDICAID ENTERPRISE SYSTEMS (MES) IMPLEMENTATION
ADVANCE PLANNING DOCUMENT UPDATE (1)

Florida Health Care Connections (FX)/ Florida Medicaid Management Information System (FMMIS) Transition

State of Florida
Agency for Health Care Administration
Divisions of Medicaid and Operations

June 2022

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Name of State Medicaid Agency: Florida Agency for Health Care Administration

Name of Contacts at State Medicaid Agency: Angela Ramsey

E-Mail Addresses of Contacts at State Medicaid Agency: angela.ramsey@ahca.myflorida.com

Telephone Numbers of Contacts at State Medicaid Agency: 850-212-6244 (mobile)

Date of Submission to CMS Regional Point of Contact: May 19, 2022

CHANGE RECORD

Date	Coordinator	Version	Comments
July 2020	A. Ramsey		FX 2020 – Transition IAPD
5/9/2022	R. Lasseter	100	Quality Review
5/11/2022	A. Ramsey	100	FX 2022-1 – Transition IAPD Update New Requests: ➢ FXPA office space ➢ Additional State Staff ➢ IS/IP Module Systems Integration ➢ Pharmacy Benefits Management ➢ Organizational Change Management ➢ Testing Center of Excellence ➢ Third Party Liability

1. Executive Summary

This Implementation Advance Planning Document Update (IAPDU) provides the Centers for Medicare and Medicaid Services (CMS) with a request for additional funding for the continuation of activities of the Florida Health Care Connections (FX)/Florida Medicaid Management Information System (FMMIS) Transition Program. The first two years (FFY 2020—2022) of Enhanced Federal Financial Participation (FFP) was approved for the FX/FMMIS Transition Program in CMS approval letter number FL-2019-11-04-MMIS-IAPD-FX-FMMIS. IAPDU (1) describes plans for the program and funding requests for FFY 2022—2023. The Florida FX Program will continue to report progress, changes in planning/implementation activities, and FFP for the FX Program through the federal APD process and the regularly held monthly meetings with our State Officer. Florida also benefits from guidance received less formally from CMS through our State Officer to answer questions and to ensure compliance with federal expectations.

2. Statement of Need and Objectives

The Agency for Health Care Administration (Agency) plans to implement the components of FX by using a phased approach to replace the current functions of the Fiscal Agent services, FMMIS, Decision Support System (DSS), and other Medicaid Enterprise Systems (MES) based on CMS conditions and standards. Ultimately, the systems will transition to an interoperable and unified FX where individual processes, modules, sub-systems, and systems work together to support Florida Medicaid. This approach intends to provide the most efficient and cost-effective long-term solution for the Agency, while complying with federal regulations, achieving federal certification, and obtaining enhanced FFP.

The purpose of the FX FMMIS Transition Program is to prepare for the transition to the FX modules and to interface with the new modular enterprise system until all FMMIS functionalities are replaced. This IAPDU requests continued funding, through Federal Fiscal Year 2024, for the transition of the Fiscal Agent services, the FMMIS, the DSS and other functional services and systems currently used to operate Florida Medicaid. The Agency is requesting that this IAPDU also represent Florida's FX Annual APDU for the State Fiscal Year 2021 – 2022, as well. The program's comprehensive details contained the IAPDU would be repetitive in an Annual APDU, with a similar timing. FX/FMMIS transition activities are anticipated to continue as planned and will be updated an APD Update document, as needed.

3. Project Scope

The future-state transformation is a four-phased strategy that builds on work completed in Phases I and II of the original FX Procurement strategy, which was initiated in 2016. Phases II–IV have been updated to align with the refreshed FX Strategy. These phases are overlapping and will be executed concurrently. The current MES components may remain as part of MES or integrate with other MES components or an FX module. This

transition will be accomplished through the IS/IP Vendor. The following table is the general status of each phase as of the end of the state fiscal year 2021/2022.

#	PHASE	COMPONENT / MODULE	STATUS
I	Professional Services Support	1. Strategic Enterprise Advisory Services 2. Independent Verification and Validation	1. Initiated and ongoing 2. Initiated and ongoing
II	FX Infrastructure	1. Integration Services and Integration Platform 2. Enterprise Data Warehouse	1. Initiated and operational 2. In DDI
III	FX FMMIS Transition	1. Unified Operations Center 2. FX Core (Claims/Encounter/Financial/ Management) 3. Provider Management 4. Pharmacy Benefit Management	1. In procurement 2. In procurement 3. In procurement 4. In planning
#	PHASE	COMPONENT / MODULE	STATUS
IV	Remaining Functional Modules	1. Plan Management 2. Third Party Liability 3. Enterprise Case Management 4. Contractor Management	1. Future project 2. Future project 3. Future project 4. Future project

Exhibit 1: FX Program Phases

4. Project Management

4.1 FX – Program Administration Office Space

The Agency formed an FX Program Administrative (FXPA) organization to guide, direct, and oversee the activities required for the FX projects, with a focus on the Medicaid systems transition and fiscal agent activities that support the operation of the current MMIS. FXPA works closely with the SEAS vendor on these activities, which span the life cycle of the projects from planning, solicitation development, procurement, design and development, implementation, and in some cases, operations and maintenance of the procured systems and services. FXPA is staffed with Agency Full Time Equivalent (FTE), Other Personal Services (OPS), and contracted staff augmentation. The FX

program also calls on many Subject Matter Experts (SME) to complete the transition tasks. SMEs are not collocated with the FXPA staff.

The Agency is requesting in this IAPDU a new spending category of enhanced FFP for the office space occupied by the FXPA team. The office space is fully dedicated to the FXPA team on the campus of the Agency headquarters state office in Tallahassee.

AHCA Facility Lease Cost by Location

Location	Lease #	Square Footage	Yearly Cost SFY 21-22 (May 2022 through June 2022)	Yearly Cost SFY 22-23	Yearly Cost SFY 23-24
Headquarters	680:0076 - FXPA	4,999 sq.ft.			
Fiscal Year Cost Breakout					
SFY 21-22	2 months at $24.26 per sq.ft. = $10,106.31 per month		**$20,212.62**		
SFY 22-23	8 months at $24.26 per sq.ft. = $10,106.31 per month 4 months at $24.44 per sq.ft. = $10,181.30 per month			**$121,575.68**	
SFY 23-24	8 months at $24.44 per sq.ft. = $10,181.30 per month 4 months at $24.63 per sq.ft. = $10,260.45 per month				**$122,492.16**

Exhibit 2: FX Program Administration Office Space Costs

4.2 Project Management Standards

The Agency will continue to use professional project management standards for projects undertaken by the FX Program. These standards include:

Deliverable	Contents
Spend Plan	• Fiscal year planned and incurred expenditures by month and total • Fiscal year actual expenditures by month and total
Resource Plan	• Organizational charts • Resource capacity reports • Defined responsibilities of staff
Risk Management Plan	• Identification of risks • Process for tracking and monitoring risks • Assignment of risk management responsibility
Project Schedule	• Task start and end dates • Task sequences

Deliverable	Contents
Implementation Plan	• Readiness plan to implement the system changes • Operational readiness plan to support the changes after go-live, including post-implementation monitoring reporting
Updates to Initial PMO standards and plans	• Project Management Plan • Project Charter • Project Process Agreement • Quality Management Plan • Communication Management Plan • Schedule Management Plan • Scope Management Plan • Issue Management Plan
Project Status Reporting: Weekly Monthly Quarterly	• General status report • Completed and Planned activities • Project issues • Risk status • Cost variance report • Schedule variance report
Project Closeout Report and Lessons Learned	• Identification of the project's results, including performance metrics • Identification of lessons learned to improve future projects

Exhibit 3: Project Management Deliverables

The Risk Management Plan will include the mitigation plans required by 42 CFR 433.112(b)(18) to address strategies to reduce the consequences of failure for major milestones and functionality.

4.3 Program Key Dates

The Project includes Agency and vendor resources to coordinate with the FX program team, oversee the project management, analysis, coding, and testing activities. The SEAS Vendor is responsible for documenting a detailed master project work plan that outlines the work breakdown of the tasks necessary to complete the project scope. The Key Dates for the FX program are listed on the following table.

Task Name	Planned Finish
FX-Master-Program-Schedule	
FX Transformation	
Enterprise Data Warehouse - Implementation	March 2023
Provider Services Module - Implementation	October 2023
Unified Operations Center - Implementation	March 2024
Core Systems - Implementation	October 2024
Pharmacy - Implementation	October 2024
Other Tracking Items	
IS/IP Reprocurement	November 2022
CMS Interoperability - Implementation	May 2023
Managed Care Contract Modifications Executed	December 2023
Core Required Interfaces	June 2024

Exhibit 4: FX Program Key Dates

4.4 Project Organization

The following organizational chart represents the Agency leadership resources associated with the FX Program.

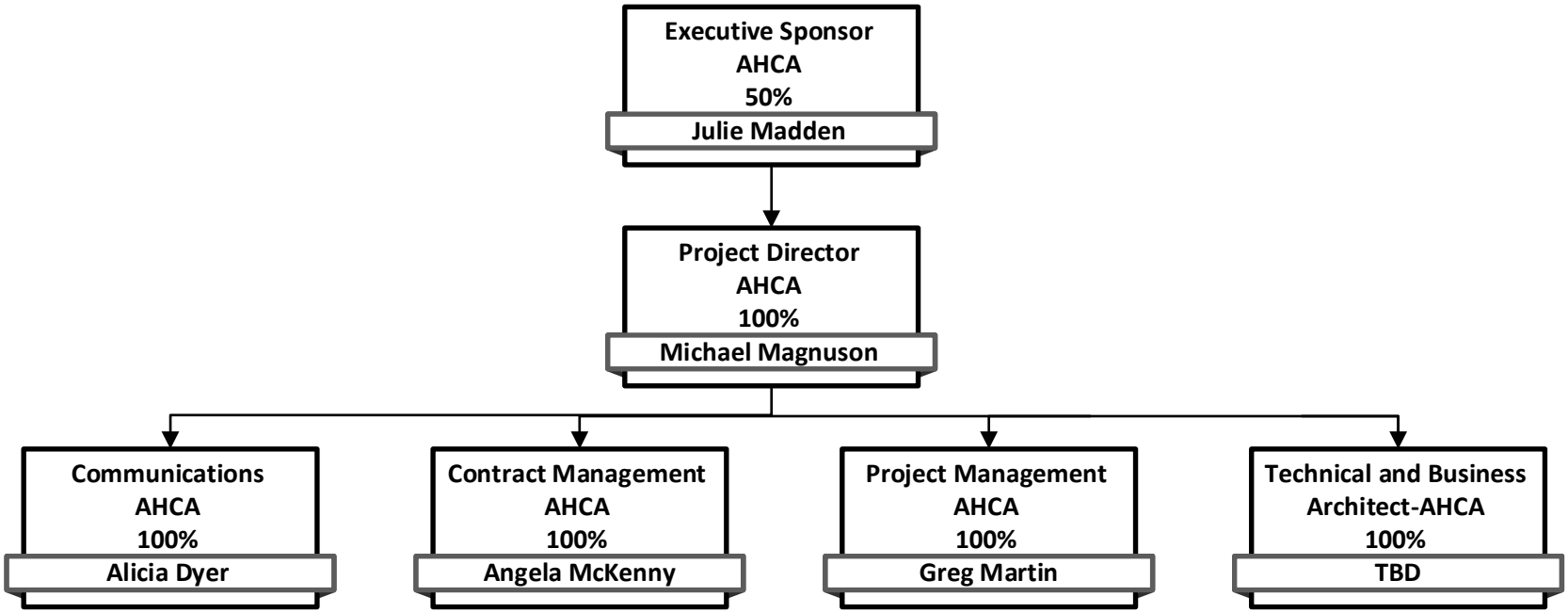

Exhibit 5: Project Organizational Chart

4.5 State Personnel Resources

Florida will dedicate the personnel and resources necessary to assure successful transition of the MMIS and DSS. Significant changes in the dedicated staff will be reported in an IAPD Update.

State Agency Staff Costs Starting SFY 2022--2023				12 Months		
Position	**No. FTE**	**Time Allocation to Project**	**Cost Per Month**	**Cost Per Year**	**90% FFP**	**10% State**
FX PA Project Sponsor	1	50%	$3,750	$45,000	$40,500	$4,500
FX PA Project Director	1	100%	$10,000	$120,000	$108,000	$12,000
FX PA Project Team Leads	4	100%	$30,000	$360,000	$324,000	$36,000
FX PA Senior Management Analyst	10	100%	$65,000	$780,000	$702,000	$78,000
Subtotals	**16**		**$108,750**	**$1,305,000**	**$1,174,500**	**$130,500**
Work Groups						
AHCA IS/IP Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA IS/IP Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
IS/IP Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
IS/IP Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
AHCA EDW Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA EDW Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
EDW Technical Analyst	4	25%	$6,500	$78,000	$70,200	$7,800
EDW Business Analyst	4	25%	$6,500	$78,000	$70,200	$7,800
AHCA UOC Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA UOC Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
UOC Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
UOC Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
AHCA Provider Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Provider Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
Provider Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Provider Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
AHCA Core Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Core Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
Core Technical Analyst	5	25%	$8,125	$97,500	$87,750	$9,750
Core Business Analyst	5	25%	$8,125	$97,500	$87,750	$9,750
AHCA Business Matrix Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Business Matrix Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
Business Matrix Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Business Matrix Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
AHCA Recipient Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Recipient Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600

State Agency Staff Costs Starting SFY 2022--2023				12 Months		
Position	**No. FTE**	**Time Allocation to Project**	**Cost Per Month**	**Cost Per Year**	**90% FFP**	**10% State**
Recipient Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Recipient Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
OCM Team Lead	1	100%	$10,000	$120,000	$108,000	$12,000
OCM Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
OCM Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
OCM Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Totals	**82**		**$300,500**	**$3,606,000**	**$3,245,400**	**$360,600**

Exhibit 6: State Personnel Resources

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4.6 Project Timeline

The following roadmap *(dated 2021)* represents the high-level timeline that the Agency anticipates for the FX Program activities.

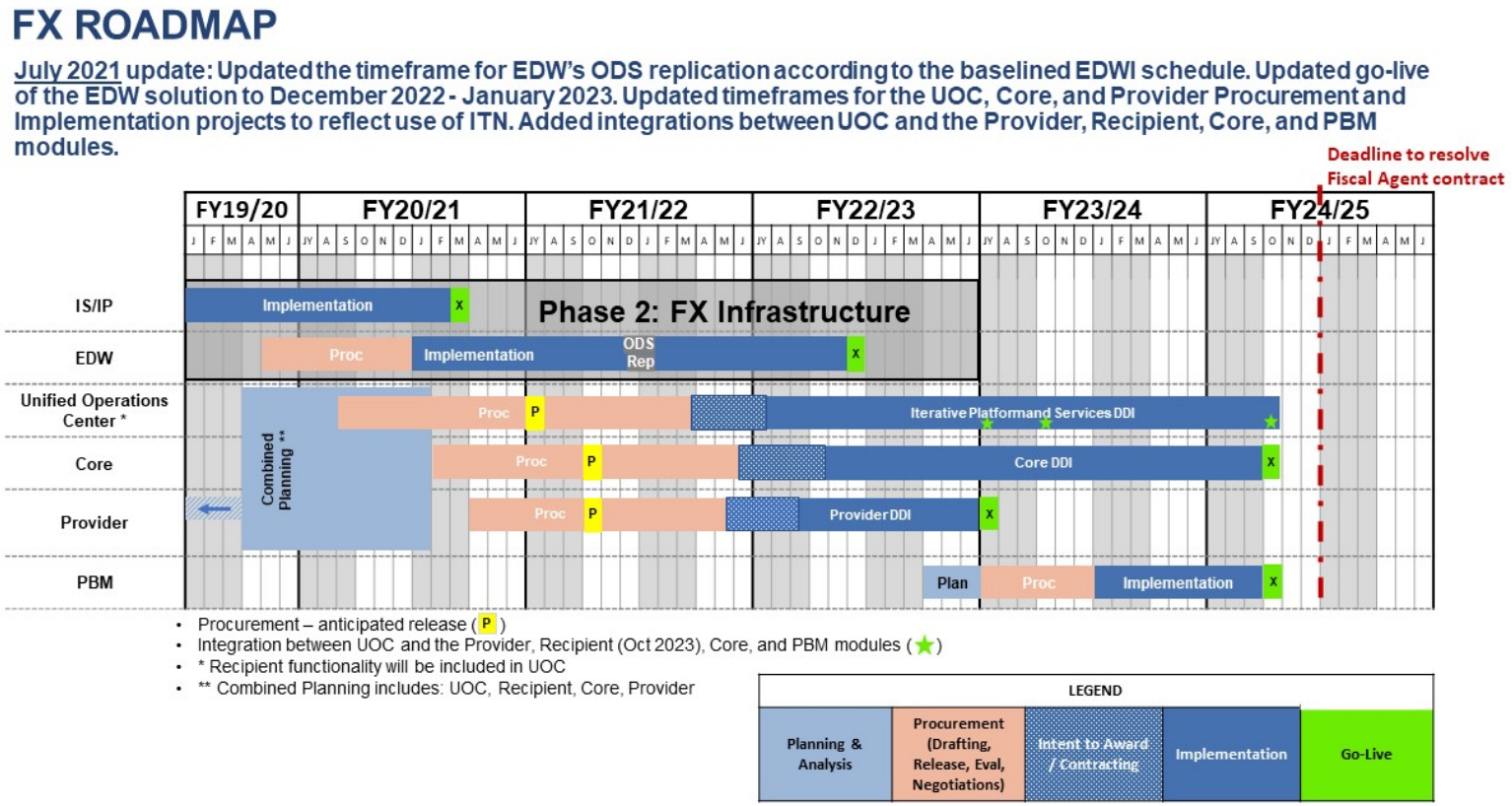

Exhibit 7: FX Road Map

5. Proposed FX Program Budget

5.1 Budget Summary

FX Program Component	SFY 2022-23	SFY 2023-24
SEAS	$9,746,661	$9,746,661
IV&V	$3,230,996	$3,230,996
FMMIS Transition Support	$6,107,060	$9,645,325
IS/IP		
Operations	$6,722,472	$6,897,951
Enhancements	$14,425,800	$15,000,000
EDW		
Implementation	$6,339,609	$3,656,946
Operations	$2,236,493	$8,437,897
Enhancements	$7,464,633	$15,000,000
CMS Interoperability	$5,848,252	0
Contract Services		
Implementation	$960,000	$960,000
Operations	$1,987,970	$1,949,000
Enhancements	$190,000	$190,000
Module Systems Integration	$763,957	$4,896,000
Provider		
Procurement	$131,328	$-
Implementation	$8,742,975	$1,948,414
Operations	$0	$3,290,015
Enhancements	$750,000	$2,611,200
CORE		
Procurement	$288,288	$-
Implementation	$21,383,458	$28,709,433
Operations	$0	$3,166,667
Enhancements	$0	$435,200
Unified Operations Center		
Procurement	$41,040	$-
Implementation	$13,686,615	$15,438,437
Operations	$0	$7,489,698
Enhancements	$0	$652,800
Pharmacy Benefit Management		
Procurement	$439,280	$-
Implementation	$0	$790,400
Operations	$0	$3,692,246
Enhancements	$0	$435,200
Third Party Liability		
Planning	$0	$280,800
Procurement	$0	$790,400
Outside Legal	$297,000	0
Software	$216,113	$183,351
State Staff Enhanced FFP	$3,606,000	$3,606,000
State Office Space Enhanced FFP	$121,576	$122,492
SFY TOTAL	**$115,727,576**	**$153,253,529**

Exhibit 8: Budget Summary

5.2 Budget Detail

FLORIDA MEDICAID ENTERPRISE SYSTEMS (MES) IMPLEMENTATION PLANNING BUDGET												
PLANNING TASKS	SFY 2022-2023						SFY 2023-2024					
	FFP 90%	State 10%	FFP 75%	State 25%	FFP 50%	State 50%	FFP 90%	State 10%	FFP 75%	State 25%	FFP 50%	State 50%
Strategic Enterprise Advisory Services (SEAS) Tasks												
SEAS Strategic Planning, Program and Project Management	$ 8,771,995	$ 974,666	$ -	$ -	$ -	$ -	$ 8,771,995	$ 974,666	$ -	$ -	$ -	$ -
IV&V Tasks												
Monitor activities and report to CMS and the Florida Department of Management Services	$ 2,907,896	$ 323,100	$ -	$ -	$ -	$ -	$ 2,907,896	$ 323,100	$ -	$ -	$ -	$ -
FMMIS Tranisiton Support												
FMMIS Tranisiton Support	$ 5,496,354	$ 610,706	$ -	$ -	$ -	$ -	$ 8,680,793	$ 964,533	$ -	$ -	$ -	$ -
Infrastructure Phase												
Integration Services/Integration Platform (IS/IP) - Operations	$ -	$ -	$5,041,854	$1,680,618	$ -	$ -	$ -	$ -	$ 5,173,463	$1,724,488	$ -	$ -
Integration Services/Integration Platform (IS/IP) - Task Orders	$12,983,220	$ 1,442,580	$ -	$ -	$ -	$ -	$ 13,500,000	$ 1,500,000	$ -	$ -	$ -	$ -
Enterprise Data Warehouse (EDW) - Implementation	$ 5,705,648	$ 633,961	$ -	$ -	$ -	$ -	$ 3,291,251	$ 365,695	$ -	$ -	$ -	$ -
Enterprise Data Warehouse (EDW) - Operations	$ -	$ -	$1,677,370	$ 559,123	$ -	$ -	$ -	$ -	$ 6,328,423	$2,109,474	$ -	$ -
Enterprise Data Warehouse (EDW) - Task Orders	$ 6,718,170	$ 746,463	$ -	$ -	$ -	$ -	$ 13,500,000	$ 1,500,000	$ -	$ -	$ -	$ -
CMS - Interoperability - Implementation	$ 5,263,427	$ 584,825	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contract Services - Operations	$ -	$ -	$1,490,978	$ 496,993	$ -	$ -	$ -	$ -	$ 1,461,750	$ 487,250	$ -	$ -
Contract Services - Task Orders	$ 171,000	$ 19,000	$ -	$ -	$ -	$ -	$ 171,000	$ 19,000	$ -	$ -	$ -	$ -
Software Support Licenses	$ -	$ -	$ 162,085	$ 54,028	$ -	$ -	$ -	$ -	$ 137,513	$ 45,838	$ -	$ -
Module Existing Systems Integrations	$ 687,561	$ 76,396	$ -	$ -	$ -	$ -	$ 4,406,400	$ 489,600	$ -	$ -	$ -	$ -
Module Acquisition Phase												
Provider - Procurement	$ 118,195	$ 13,133	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Provider - Implementation	$ 7,868,678	$ 874,298	$ -	$ -	$ -	$ -	$ 1,753,573	$ 194,841	$ -	$ -	$ -	$ -
Provider - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,467,511	$ 822,504	$ -	$ -
Provider - Task Orders	$ 675,000	$ 75,000	$ -	$ -	$ -	$ -	$ 2,350,080	$ 261,120	$ -	$ -	$ -	$ -
Core - Procurement	$ 259,459	$ 28,829	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Core - Implementation	$19,245,112	$ 2,138,346	$ -	$ -	$ -	$ -	$ 25,838,490	$ 2,870,943	$ -	$ -	$ -	$ -
Core - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,375,000	$ 791,667	$ -	$ -
Core - Task Orders	$ -	$ -	$ -	$ -	$ -	$ -	$ 391,680	$ 43,520	$ -	$ -	$ -	$ -
Unified Operations Center - Procurement	$ 36,936	$ 4,104	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Unified Operations Center - Implementation	$12,317,954	$ 1,368,662	$ -	$ -	$ -	$ -	$ 13,894,593	$ 1,543,844	$ -	$ -	$ -	$ -
Unified Operations Center - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,617,274	$1,872,425	$ -	$ -
Unified Operations Center - Task Orders	$ -	$ -	$ -	$ -	$ -	$ -	$ 587,520	$ 65,280	$ -	$ -	$ -	$ -
Pharmacy Benefits Management - Planning	$ 395,352	$ 43,928	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefits Management - Procurement	$ -	$ -	$ -	$ -	$ -	$ -	$ 711,360	$ 79,040	$ -	$ -	$ -	$ -
Pharmacy Benefits Management - Implementation	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,323,021	$ 369,225	$ -	$ -	$ -	$ -
Pharmacy Benefits Management - Task Orders	$ -	$ -	$ -	$ -	$ -	$ -	$ 391,680	$ 43,520	$ -	$ -	$ -	$ -
Third Party Liability - Planning	$ -	$ -	$ -	$ -	$ -	$ -	$ 252,720	$ 28,080	$ -	$ -	$ -	$ -
Third Party Liability - Procurement	$ -	$ -	$ -	$ -	$ -	$ -	$ 711,360	$ 79,040	$ -	$ -	$ -	$ -
Contract Services - Implementation	$ 864,000	$ 96,000	$ -	$ -	$ -	$ -	$ 864,000	$ 96,000	$ -	$ -	$ -	$ -
Outside Legal Counsel	$ -	$ -	$ -	$ -	$148,500	$148,500	$ -	$ -	$ -	$ -	$ -	$ -
State Agency Costs												
Additional FFP for existing FTEs	$ 3,245,400	$ 360,600	$ -	$ -	$ -	$ -	$ 3,245,400	$ 360,600	$ -	$ -	$ -	$ -
Additional FFP for facility costs	$ 109,418	$ 12,158	$ -	$ -	$ -	$ -	$ 110,243	$ 12,249	$ -	$ -	$ -	$ -
IAPD Total Request by FFP	**$93,840,775**	**$10,426,753**	**$8,372,286**	**$2,790,762**	**$148,500**	**$148,500**	**$ 109,655,055**	**$12,183,895**	**$23,560,934**	**$7,853,645**	**$ -**	**$ -**
IAPD Total Request by SFY	**$115,727,576**						**$153,253,529**					

Exhibit 9: FX State Budget Table

5.3 Cost Allocation Plan and/or Methodology

Cost allocation regulations as described in 2 CFR Part 200 do not apply to this project at this time. All activities and benefits described in this IAPDU are contained within the Medicaid Agency. As future endeavors include parts of the MES that are outside of or shared with Medicaid, cost allocations will become a part of the planning and implementation APDs as appropriate.

5.4 An Estimate of Prospective Cost Distribution

Please see Appendix A for the MMIS Detailed Budget Table as reflected in the Federal Fiscal Years covered by this IAPDU request.

6. Cost Benefit Analysis

There is a financial benefit in making the most appropriate decisions in the modernization of Medicaid's systems and operation of fiscal agent services. It is the intent of the FX program that the Agency, with the aid of consultants, identifies ways to reduce cost through project management, minimize manual processes, enhance data analytics to prevent fraud, improve programmatic decisions by utilizing advanced statistical analytics, incorporate the use of modular system components, and share systems with other state agencies.

7. CMS Required Assurances

This IAPDU provides evidence of declaration, indicated by the checked boxes below, that Florida FX will meet these requirements.

7.1 Security/Interface and Disaster Recovery/Business Continuity Requirements Statement

- ☑ The State Agency will implement and/or maintain an existing comprehensive Automated Data Processing (ADP) security and interface program for ADP systems and installations involved in the administration of the Medicaid program.
- ☑ The State Agency will have disaster recovery plans and procedures available.

Specifically, the Agency will comply with the following Federal Regulations:

- ☑ 42 CFR 431, Subpart F (Safeguarding Information on Applicants and Beneficiaries)
- ☑ 42 CFR 435.960 (Standardized formats for furnishing and obtaining information to verifying income and eligibility)
- ☑ 45 CFR 95.617 (Software and Ownership Rights in Specific Conditions for FFP)
- ☑ 45 CFR 95.601 (Scope and Applicability)
- ☑ 45 CFR 205.50 (Safeguarding Information for the Financial Assistance Programs)
- ☑ 45 CFR 303.21 (Safeguarding and disclosure of Confidential Information)

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7.2 Conditions Attestation

This section provides the required assurances of compliance with 42 CFR 433.112(b)(1) through (b)(22). These conditions must be met by states to be eligible for enhanced Federal matched funding for the design, development, installation, or enhancement, and operations of a mechanized claims processing and information retrieval system. The State of Florida, Agency for Health Care Administration (AHCA), attests that the project will comply with the CMS conditions described below.

#	Condition Name and Description	Compliance	
		Yes	No
1	The system will provide a more efficient, economical, and effective administration of the State plan.	X	
2	The system meets the system requirements, standards and conditions, and performance standards in Part 11 of the State Medicaid Manual, as periodically amended.	X	
3	The system is compatible with the claims processing and information retrieval system used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs.	X	
4	The system supports the data requirements of quality improvement organizations established under Part B of title XI of the Act.	X	
5	The State owns any software that is designed, developed, installed, or improved with 90 percent FFP.	X	
6	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.	X	
7	The costs of the system are determined in accordance with 45 CFR 75, subpart E.	X	
8	The Florida AHCA 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.	X	
9	The Florida AHCA agrees in writing that the information in the system will be safeguarded in accordance with 42 CFR 431 subpart F.	X	
10	The Florida AHCA will 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.	X	
11	Align to, and advance increasingly, in maturity for business, architecture, and data.	X	

#	Condition Name and Description	Compliance	
		Yes	No
12	The Florida AHCA 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.	X	
13	Promotes sharing, leverage, and reuse of Medicaid technologies and systems within and among States.	X	
14	Supports accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public.	X	
15	Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.	X	
16	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.	X	
17	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.		N/A
18	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.	X	
19	The Florida AHCA in writing through the APD, has identified key state personnel by name, type and time commitment assigned to each project.	X	
20	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.	X	
21	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.	X	
22	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.	X	

Exhibit 10: CMS Conditions and Standards Compliance Matrix

7.3 Procurement Assurances

The Agency plans to use open and competitive procurements for all contracted work related to the design, development, and implementation of enhancements to the FX. The procurement process will comply with all applicable federal regulations and provisions as indicated in Exhibit 4: Procurement Assurances.

Procurement Standards		**Compliance**	
		Yes	**No**
45 CFR Part 95.613	Procurement Standards	X	
45 CFR Part 75	Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments	X	
SMM Section 11267	Required Assurances	X	
SMD Letter of 12/04/1995	Letter to State Medicaid Directors regarding the policy on sole source procurements and prior approval requirements for certain procurements	X	
Access to Records		**Compliance**	
		Yes	**No**
45 CFR Part 95.615	Access to Systems and Records	X	
SMM Section 11267	Required Assurances	X	
Software & Ownership Rights, Federal Licenses, Information Safeguarding, HIPAA Compliance and Progress Reports		**Compliance**	
		Yes	**No**
42 CFR Part 431	Safeguarding Information on Applicants and Beneficiaries	X	
42 CFR Part 433.112 (b)(1-22)	FFP for Design, Development, Installation or Enhancement of Mechanized Claims Processing and Information Retrieval Systems	X	
45 CFR Part 95.617	Software and Ownership Rights	X	
45 CFR Part 164	Security and Privacy	X	
SMM Section 11267	Required Assurances	X	
IV&V		**Compliance**	
		Yes	**No**
45 CFR Part 95.626	Independent Verification and Validation	X	

Exhibit 11: Procurement Assurances

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APPENDIX A: MMIS DETAILED BUDGET TABLE

Federal Fiscal Years 2023 and 2024

MES/FX as of 4/2022	CMS Share (90% FFP)	State Share -10%	CMS Share (75% FFP)	State Share -25%	CMS Share (50% FFP)	State Share -50%	**FUNDING FFP Total**	**State Share Total**
	2B†		2B†		2B†		**2B**	
FFY 2022 ‡	$15,634,995	$1,737,222	$1,779,812	$593,271	$118,800	$118,800	**$17,533,607**	**$2,449,292**
FFY 2023	$101,082,000	$11,231,333	$10,386,904	$3,462,301	$29,700	$29,700	**$111,498,603**	**$14,723,335**
FFY 2024	$104,877,940	$11,653,104	$33,930,719	$11,310,240	$0	$0	**$138,808,659**	**$22,963,344**
Total	**$221,594,935**	**$24,621,659**	**$46,097,435**	**$15,365,812**	**$148,500**	**$148,500**	**$267,840,869**	**$40,135,971**

MES/FX as of 4/2022	CMS Share-- State Staff and Facility Costs (90% FFP)	CMS Share-- State Staff and Facility Costs -10%	CMS Share (75% FFP)	State Share -25%	CMS Share (50% FFP)	State Share -50%	**FUNDING FFP Total**	**State Share Total**
	2A†		--		**2A†**		**2A**	
FFY 2022 ‡	$838,705	$93,189	$0	$0	$0	$0	$838,705	$93,189
FFY 2023	$3,355,025	$372,781	$0	$0	$0	$0	$3,355,025	$372,781
FFY 2024	$3,355,853	$372,873	$0	$0	$0	$0	$3,355,853	$372,873
Total	**$7,549,582**	**$838,842**	**$0**	**$0**	**$0**	**$0**	**$7,549,582**	**$838,842**

MES/FX as of 4/2022	CMS Share	State Share	CMS Share	State Share	CMS Share	State Share	**TOTAL FFP**	**STATE SHARE TOTAL**	**APD TOTAL (TOTAL COMPUTABLE)**
	2A&B†	--	4A&B†	--	5A,B&C†	--			
FFY 2022 ‡	$18,372,311	$2,542,482					$18,372,311	$2,542,482	**$20,914,793**
FFY 2023	$114,853,628	$15,096,115					$114,853,628	$15,096,115	**$129,949,743**
FFY 2024	$142,164,511	$23,336,217					$142,164,511	$23,336,217	**$165,500,728**
Total	**$275,390,451**	**$40,974,813**	**$0**	**$0**	**$0**	**$0**	**$275,390,451**	**$40,974,813**	**$316,365,264**

‡ - *FFY 2022 includes only quarter 4*

ATTACHMENT A — PHASE I: PROFESSIONAL CONTRACTS

The objective of Phase I was to procure professional service partners to support strategic planning and independent evaluation of the FX transformation. During this phase, the existing fiscal agent contract was extended to December 31, 2024, to allow sufficient time for the MMIS transition.

A.1 Strategic Enterprise Advisory Services (SEAS) Vendor

The SEAS Vendor (currently North Highland) is tasked with providing the consulting expertise needed to develop the strategic plan for FX in accordance with the MITA Framework 3.0 and the CMS Standards and Conditions, manage an Enterprise Program Management Office (EPMO) and develop and maintain associated standards; develop and maintain data and technical standards; develop and maintain information and technical architecture documentation; and establish an enterprise data security plan. The SEAS Vendor is also tasked with providing strategic project portfolio management. The SEAS contract is currently being renewed for five years, starting July 1, 2022.

SEAS IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	Portfolio and program management; enterprise architecture; technical and business advisory services	2023-2024	Portfolio and program management; enterprise architecture; technical and business advisory services

SEAS IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$9,746,661	$9,746,661

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A.2 Independent Validation & Verification (IV&V) Vendor

The IV&V Vendor (currently NTT Data) is tasked with providing an objective, neutral, and independent assessment of deliverables produced by all FX vendors. The IV&V Vendor assesses and reports on the FX Programs' organization and planning, procurement, management, technical solution development and implementation, and provides analysis and support for the CMS certification. The IV&V contract expires 6/20/2022; Agency is in the process of procuring a new contract.

IV&V IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	Validation and verification services, certification analysis and support;	2023-2024	Validation and verification services, certification analysis and support;

IV&V IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$3,230,996	$3,230,996

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ATTACHMENT B — PHASE II: FX INFRASTRUCTURE

Phase II established the technical foundation of the modular transformation through the Agency's transition to modularity with a Systems Integrator that operates the Integration Services and Integration Platform (IS/IP) Solution. Data Governance framework is supported by the Enterprise Data Warehouse (EDW) and has established data standards for data quality, metadata management, and data architecture. The results promise to provide new efficiencies for managing data across the enterprise.

B.1 Integrated Services/Integrated Platform (IS/IP) Vendor

IS/IP, currently operated by Accenture, serves as the conduit, or interface, through which all FX data is requested and returned. IS/IP will focus on establishing and maintaining interoperability through the central integration platform.

The Integration Platform went live in March 2021, so ongoing Operations and Maintenance (O&M) activities are occurring, as well as activities to implement enhancements to the platform in the form of Task Orders. The contract with the IS/IP vendor expires November 2022. The Agency expects to renew the contract with Accenture for three years, as allowed by Florida procurement regulations.

IS/IP is required by contract to provide a single sign-on capability and administrative layer for all AHCA systems connected to IS/IP, simplifying password resets. Planning work for this started in the report year of SFY 2020/2021 and is expected to be complete in SFY 2021/2022.

IS/IP IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	1. O and M	2023-2024	1. O and M
	2. Enhancement Task Order 0004 - Integration Services & FX Enterprise Portal (ISEP) 3. Enhancement Task Orders as FX modules are developed		2. Enhancement Task Orders as FX modules are developed

IS/IP IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$21,148,272	$21,897,951

Streamlined Modular Certification (SMC)

IS/IP is not a certifiable component of the MMIS replacement on its own. The IS/IP Vendor is bound by contract to provide support to other FX modules as needed to achieve and maintain federal certification of the FX module.

IS/IP CPAR Interoperability

Included in the interoperability is the CMS requirements for interoperability of healthcare delivery systems, referred to in Florida's FX program as CPAR. On March 9, 2020, CMS released the Interoperability and Patient Access final rule (CMS-9115-F), which provides patients access to their health information when they need it most and in a way that they can best use it. The Interoperability and Patient Access final rule (CMS-9115-F) is a step towards this goal by regulating Medicare Advantage (MA), Medicaid, Children's Health Insurance Program (CHIP), and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs). There are seven policies in this ruling. Among them are the Patient Access API and Provider Directory API. Florida is committed to implementing the CMS Interoperability rule to ensure a more effective management of Florida Medicaid.

CPAR IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	1. Continue work on implementation activities started in SFU 2021-2022	2023-2024	Enhancement Task Orders as FX requires
	2. Enhancement Task Orders as FX requires		

CPAR IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$5,848,252	$0

Streamlined Modular Certification (SMC)
The Agency and SEAS are in the start-up of the implementation of the CMS Interoperability rule. The explanation of the desired outcomes and required metrics will be developed and reported to CMS in future IAPD Updates.

IS/IP Module Integration (MI)

MI is responsible for the connection of functional modules to the FX Enterprise. The Agency will work with vendors to determine what changes are necessary to interface with the new platform and services. This engagement will plan, prioritize, and implement the transition to the FX Enterprise. The team will leverage the FX Executive Steering Committee (ESC) to help communicate and prioritize those interfaces outside the Agency.

MI IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	1. Enhancement Task Order 0004 - Integration Services & FX Enterprise Portal (ISEP)	2023-2024	Enhancement Task Orders as FX modules are developed
	2. Enhancement Task Orders as FX modules are developed		

MI IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$763,957	$3,230,996

Streamlined Modular Certification (SMC)
Module Integration is not a certifiable component of the MMIS replacement on its own. The IS/IP Vendor is bound by contract to provide support to other FX modules as needed to achieve and maintain federal certification of the FX module.

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B.2 Enterprise Data Warehouse (EDW) Vendor

The EDW contract was awarded to Deloitte in December 2020. The EDW solution will allow the Agency to conduct complex analysis of program data for many aspects of Medicaid, from health outcome measurement to managed care rate setting. The Agency has procured an EDW solution, operational services, and analytical capabilities to meet the Agency's data requirements. The EDW will be a modern data management solution that will enable improved data integration across the entire Medicaid Enterprise.

EDW IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	1. Completion of Design, Development, and Implementation/ Transition to Operations and Management; 2. Integration with IS/IP	2023-2024	1. EDW Operations and Maintenance; 2. Modular Integrations

EDW IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$21,888,986	$27,094,843

Streamlined Modular Certification (SMC)

The Agency, EDW vendor, and SEAS are developing specific desired outcomes and required metrics that will be reported to CMS as the outcomes evolve, prior to go-live of the EDW. The following are EDW outcomes that form the baseline and that will be refined in the development efforts under way. Additional desired outcomes and required metrics will be reported to CMS in the future.

Enterprise Data Warehouse Outcomes

Reference	Outcome	Source(s)
EDW1	The system supports various business processes' reporting requirements	42 CFR 431.428
EDW2	The solution includes analytical and reporting capabilities to support key policy decision making	42 CFR 433.112
EDW3	The EDW solution supports understanding of patient health events.	Medicaid Best Practice

EDW4	The EDW solution supports understanding the delivery of healthcare services through a holistic view of data.	Medicaid Best Practice
EDW5	The EDW solution supports reduction of overpayments.	EDW Contract EXD091: SR-179; SR-213
EDW6	The EDW solution assists in the identification of service misutilization.	EDW Contract EXD091: SR-177; SR-179; PD-9; PD-17; WKP-5
EDW7	The EDW solution supports compliant T-MSIS reporting.	EDW Contract EXD091: FDRP-004, FDRP-012
EDW8	The EDW solution supports efficient CMS-64 reporting.	EDW Contract EXD091: FDRP0-003
EDW9	The EDW solution supports reliable data analytics in the Medicaid program.	EDW Contract EXD091: PD-6, PD-9, PD-15, WKP-5
EDW10	The EDW solution is well-positioned to support future business needs by being extensible, accurate, and highly available.	EDW Contract EXD091: PM-5, PM-6, PD-10, PM-11, PM-12

B.3 FMMIS Transition

In order to facilitate the FMMIS (operated by GainWell) transition to FX modules, the current Fiscal Agent vendor has been tasked to create a schedule mutually agreed upon by the Agency and Fiscal Agent vendor. The transition schedule will facilitate the planning, system analysis/design, testing, implementation, and post-implementation activities related to FMMIS transition. The Fiscal Agent vendor will coordinate with the successor FX module vendors, other contractors, and the Agency in the planning and transfer of system functionality and the related operational functions. The Fiscal Agent vendor will perform iterative phases of turnover activities for each FX module, including training, documentation transfer, and resource support.

FMMIS Transition IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022-2023	FMMIS EDWI Support	2023-2024	FMMIS UOC Support
	Support EDW Change Management		FMMIS Core Module Support

State Fiscal Year	Activities	State Fiscal Year	Activities
	Turnover to EDW		FMMIS PBM Support
	FMMIS Provider Module Support		Turnover Activities

FMMIS Transition IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$6,107,060	$9,645,325

Streamlined Modular Certification (SMC)

FMMIS Transition is not a certifiable component of the MMIS replacement.

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ATTACHMENT C — PHASE III: FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM (FMMIS) TRANSITION

Phase III leverages the infrastructure established in Phase II to transition from the Agency's current Fiscal Agent contract to enable the modular, integrated business and Information Technology (IT) transformation vision to be realized in the transition projects.

C.1 Unified Operations Center (UOC) Vendor

Current operations of the FMMIS and other Agency systems and operational activities (all of which support the Medicaid Enterprise) include multiple contact centers, vendors, and supporting software platforms. There is currently no unified record of Agency communications between platforms resulting in a siloed and confusing user experience. In addition, multi-vendor/platform environments create redundant costs that could be consolidated. 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 approach enables the Agency to consolidate communications and operational aspects beginning with the modules replacing the FMMIS/current fiscal agent contract. The UOC will include the network, on telephony, and systems used in contact management. It will support interactions by phone, email, chat, SMS text, social media, voice assistant, internal/external conference, print and mail operations, and customer contact analytics. Major components of the module include unified contact distribution and routing, self-service interaction capabilities (e.g., interactive voice response and chatbots), workforce management, quality assurance, contact recording and translation, multi-language support, and contact knowledge management.

The objectives of the UOC Module include:

a. Consolidate customer service, enterprise operations, and communications functions that are currently fragmented across several systems (FMMIS, Enrollment Broker, Pharmacy Benefits Management (PBM)) to provide a more consistent and cohesive user experience;

b. Increase efficiency of the Agency customer service and contact operations by leveraging a flexible staffing pool of knowledge agents cross-trained on the consolidated service array; and

c. Modernize best-practice customer service and contact technology and infrastructure that will support more customer self-service, better analytical functionality, and increase Agency data-driven decision-making.

As of the submission date of this IAPDU, the UOC solicitation is in negotiations.

UOC IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022-2023	1. Complete procurement of UOC Module 2. Prepare for design, development, and implementation	2023-2024	1. Continue design, development and implementation activities 2. Prepare for iterative Go-lives

UOC IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$13,727,655	$23,580,935

Streamlined Modular Certification (SMC)

UOC is not a certifiable component of the MMIS replacement on its own. The UOC Vendor will be bound by contract to provide support to other FX modules as needed to achieve and maintain federal certification of those modules.

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C.2 FX Core Module

The FX Core Module will adjudicate fee-for-service claims for Medicaid reimbursement, process managed care encounter transactions, maintain recipient system functionality, and support all Medicaid financial activity. The FX Core Module represents the most fundamental functionality required for Medicaid transition, and involves the longest combined timeframe for planning, procurement, and implementation. The Invitation to Negotiate (ITN) was issued and the proposals submitted by vendors have been evaluated. The Agency plans to conduct negotiations for the Core Module in the June to July 2022 time frame.

The Core Solution includes the following suite of services:

b. Claims Processing
    1. Claims Processing
    2. Electronic Data Interchange (EDI)
    3. Edits and Audits
    4. Explanation of Benefits
    5. Pricing
    6. Suspends
    7. Managing Reference Information (including coverage and limitations)
c. Encounters
    1. Encounters Processing
    2. EDI
    3. Edits and Audits
    4. Explanation of Benefits
    5. Shadow Pricing
d. Financial
    1. Remittance Advice
    2. Medicare, Claim, Premiums, and Other Financial Payments
    3. Program Integrity
    4. Financial and IRS 1099 Activity
    5. Reporting
e. Managed Care Capitation Payments
    1. Rate Setting Support
    2. Payment Processing
    3. Adjustments and Recoupments
    4. File Reconciliation
    5. Reporting
f. Recipient Data Management
    1. Eligibility
    2. Enrollment
    3. File Maintenance
g. Core Business Support Services
    1. Tier 2 / Tier 3 Customer Service Support (in collaboration with UOC and Agency teams
    2. Processing and Payment support
    3. EDI Help Desk

A comprehensive analysis of the existing FMMIS Core functions was conducted, including claims and encounters transaction processing, banking, and financial processing (including capitation payments for health plans), claims payments, and pharmacy claims payment. FMMIS Core 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 an FX Core Module.

The goal of the Core Solution is to provide scalable, reliable, streamlined, secure claims and encounters processing, financial management and managed care capitation payments, enabling more efficient and effective service delivery for the Medicaid program and improving healthcare outcomes for Floridians.

Objectives:

a. Transition claims, encounters, financial processing and management (including managed care capitation payments) from the current Fiscal Agent to a modern, modular Core solution by state legislative prescribed deadline of December 31, 2024.
b. Reduce the number of wrongly rejected claims and encounters, lessening the administrative burden and cost on the Agency, providers, and health plans.
c. Reduce the number of claim resubmissions by improving communications of claim status.
d. Improve the reliability of plan encounter data eliminating the need, cost, and duplicate submission of the ‘special feed’ from the plans.
e. Reduce claim validation processing costs in Agency systems.
f. Reduce Agency financial staff time on manual data re-entry and processing.
g. Separate business rules and edit/audit processing capabilities for claims and encounters.
h. Eliminate remaining paper claims and associated manual processes.
i. Implement an accessible and efficient UI with enhanced visibility to claim details.
j. Improve data quality and management and increased automation to reconcile and update recipient information.

Core IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022-2023	1. Complete procurement of Core Module	2023-2024	1. Continue design, development and implementation activities 2. Prepare for Go-live

	2. Prepare for design, development, and implementation		

Core IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$21,671,746	$32,311,300

Streamlined Modular Certification (SMC)

The Agency, Core vendor, and SEAS will develop specific desired outcomes and required metrics that will be reported to CMS as the outcomes evolve. The following are outcomes that form the baseline and that will be refined in the development efforts as a part of design, development, and implementation (DDI). Additional desired outcomes and required metrics will be reported to CMS in the future.

Core Module Outcomes

Claims	Outcome	Source(s)
Claims	The system receives, ingests, and retains claims, claims adjustments, and supporting documentation submitted both electronically and by paper in standard formats.	45 CFR 162.1102
Claims	The system performs comprehensive validation of claims and claims adjustments, including validity of services.	42 CFR 431.052 42 CFR 431.055 42 CFR 447.26 42 CFR 447.45(f) 45 CFR 162.1002 SMD Letter 10-017 SMM Part 11 Section 11300
Claims	The system confirms authorization for services that require prior approval to manage costs or ensure patient safety, and that the services provided are consistent with the authorization. The system accepts use of the authorization by multiple sequential providers during the period as allowed by state rules. Prior-authorization records stored by the system are correctly associated with the relevant claim(s).	SSA 1927(d)(5) 42 CFR 431.630 42 CFR 431.960 45 CFR 162.1302 SMM Part 4 SMM Part 11 Section 11325

Claims	The system correctly calculates payable amounts in accordance with the State Plan and logs accounts payable amounts for payment processing. The system accepts, adjusts, or denies claim line items and amounts and captures the applicable reason codes.	42 CFR 431.052
Claims	The state communicates claims status throughout the submission and payment processes and in response to inquiry. If there are correctable errors in a claims submission, the system suspends the claims, attaches pre-defined reason code(s) to suspended claims, and communicates those errors to the provider for correction. The system associates applicable error or reason code(s) for all statuses (e.g., rejected, suspended, denied, approved for payment, paid) and communicates those to the submitter. The system shows providers, case managers and members current submission status through one or more of the following: • Automatic notices as appropriate based on claims decision or suspension. • Explanation of Benefits (EOB). • Providing prompt response to inquiries regarding the status of any claim through a variety of appropriate technologies and tracking and monitoring responses to the inquiries. • Application programming interface (API)	45 CFR Part 162.1402 (c) 45 CFR Part 162.1403 (a) & (b) 42 CFR 431.60 (a) & (b) SMM Part 11 Section 11325
Claims	The system tracks each claim throughout the adjudication process (including logging edits made to the claim) and retains transaction history to support claims processing, reporting, appeals, audits, and other uses.	42 CFR 447.45 42 CFR 431.17 SMM Part 11 Section 11325
Encounter	**Outcome**	**Source(s)**
Encounter	The system ingests encounter data (submissions and re-submissions) from MCOs and sends quality transaction feedback back to the plans to ensure appropriate industry standard format. (Quality transaction checks include, but are not limited to completeness, missing information, formatting, and the TR3 implementation guide business rules validations).	42 CFR 438.242

Encounter	The system ingests encounter data (submissions and re-submissions) from managed care entities in compliance with HIPAA security and privacy standards and performing quality checks for completeness and accuracy before submitting to CMS using standardized formatting, such as ASC X12N 837, NCPDP and the ASC X12N 835, as appropriate. (Quality checks include, but are not limited to completeness, character types, missing information, formatting, duplicates, and business rules validations, such as payment to disenrolled providers, etc.).	42 CFR 438.604, 438.818, and 438.242
Encounter	The state includes submission requirements (timeliness, re-submissions, etc.), definitions, data specifications and standards, and consequences for non-compliance in its managed care contracts. The state enforces consequences for non-compliance.	42 CFR Part 438.3
Encounter	The state uses encounter data to calculate capitation rates and performs payment comparisons with FFS claims data.	42 CFR Part 438
Financial	**Outcome**	**Source(s)**
Financial Management	The system calculates FFS provider payment or recoupment amounts, as well as value-based and alternative payment models (APM), correctly and initiates payment or recoupment action as appropriate.	Section 1902(a)(37) of the Act 42 CFR 433.139 42 CFR 447.20 42 CFR 447.45 42 CFR 447.56 42 CFR 447.272
Financial Management	The system pays providers promptly via direct transfer and electronic remittance advice or by paper check and remittance advice if electronic means are not available.	42 CFR 447.45 42 CFR 447.46
Financial Management	The system supports the provider appeals by providing a financial history of the claim along with any adjustments to the provider's account resulting from an appeal.	42 CFR 431.152
Financial Management	The system accurately pays per member/per month capitation payments electronically in a timely fashion. Payments account for reconciliation of withholds, incentives, payment	42 CFR 438 42 CFR 447.56(d)

	errors, beneficiary cost sharing, and any other term laid out in an MCO contract.	
Financial Management	The system accurately tallies recoupments by tracking repayments and amounts outstanding for individual transactions and in aggregate for a provider.	42 CFR 447
Financial Management	The state recovers third party liability (TPL) payments by: • Tracking individual TPL transactions, repayments, outstanding amounts due, • Aggregating by member, member type, provider, third party, and time period, • Alerting state recovery units when appropriate, and • Electronically transferring payments to the state.	42 CFR 433.139
Financial Management	The system processes drug rebates accurately and quickly.	42 CFR 447.509
Financial Management	State and federal entities receive timely and accurate financial reports (cost reporting, financial monitoring, and regulatory reporting), and record of all transactions according to state and federal accounting, transaction retention, and audit standards.	42 CFR 431.428 42 CFR 433.32
Financial Management	The system tracks that Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household does not exceed an aggregate limit of five percent of the family's income. If the beneficiaries at risk of reaching the aggregate family limit, the system tracks each family's incurred premiums and cost sharing without relying on beneficiary documentation.	42 CFR 447.56(f)
Recipient	**Outcome**	**Source(s)**
Recipient	The system auto-assigns managed care enrollees to appropriate managed care organizations, per state and federal regulations.	CFR 42 438.54
Recipient	The system sends notice, or facilitates, to the enrolled member with an initial assignment, a reasonable period to change the selection, and appropriate information needed to make an	CFR 42 438.10, 438.54

	informed choice. If no selection is made, the system either confirms the original assignment, or assigns the member to FFS.	
Recipient	The system disenrolls members at the request of the plan and in accordance with state procedures.	42 CFR 438.56(b) (c), and (d)
Recipient	Disenrollments are effective in the system the first day of the second month following the request for disenrollment.	42 CFR 438.56(e)
Recipient	The system notifies enrollees of their disenrollment rights at least 60 days before the start of each enrollment period. This notification is in writing.	42 CFR 438.56(f)
Recipient	To prevent duplication of activities, enrollee's needs are captured by the system so that MCOs, PIHPs, and PAHPs can see and share the information (in accordance with privacy controls).	42 CFR 438.208(b)
Recipient	The system allows beneficiaries or their representative to receive information through multiple channels including phone, Internet, in-person, and via auxiliary aids and services.	42 CFR 438.71
Recipient	The state provides content required by 42 CFR 438.10, including but not limited to definitions for managed care and enrollee handbook, through a website maintained by the state.	42 CFR 438.10(c)
Recipient	Potential enrollees are provided information about the state's managed care program when the individual become eligible or is required to enroll in a managed care program. The information includes, but is not limited to the right to disenroll, basic features of managed care, service area coverage, covered benefits, and provider directory and formulary information.	42 CFR 438.10(e)
Recipient	The system maintains an up-to-date (updated at least annually) fee-for-service (FFS) or primary care case-management (PCCM) provider directory containing the following: • Physician/provider • Specialty • Address and telephone number • Whether the physician/provider is accepting new Medicaid patients (for PCCM providers), and	Section 1902(a)(83), 1902(mm), SMD # 18-007

	• The physician/provider's cultural capabilities and a list of languages supported (for PCCM providers).	
Recipient	The system captures enough information such that the state can evaluate whether members have access to adequate networks. (Adequacy is based on the state's plan and federal regulations).	42 CFR 438.68

C.3 Provider Services Module

The Provider Services Module (PSM) plans include provider credentialing, Medicaid enrollment, and file maintenance. The Provider Services vendor may offer a solution that will better integrate existing professional and facility licensure, Medicaid enrollment, and health plan credentialing processes into a single source to minimize errors and simplify the process for the provider community. The Provider solution will leverage the Master Person Index and Master Organization Index developed in the Phase II IS/IP implementation to improve provider identity reconciliation. Planned scope of the PSM will allow for concurrent processing of enrollment, and plan credentialing activities for both initial enrollment as well as renewals. The PSM will also eliminate siloed activities that act as predecessors for additional onboarding tasks. Furthermore, the need for providers to interact and react to requests from multiple entities will be alleviated. The Invitation to Negotiate (ITN) was issued and the proposals submitted by vendors have been evaluated. The Agency plans to conduct negotiations for the Provider Services Module in the July 2022 time frame.

In addition to provider enrollment and credentialing activities, the desired functions of the PSM include provider account management processes such as name change, address change, Change of Ownership (CHOW), and specialty addition or change.

The Agency desires a PSM with the following, minimum features:

a. A simple and seamless provider experience across all interactions and channels.
b. An overall provider enrollment and maintenance solution that will accept and process applications through a web-based provider self-service tool.
c. A workflow driven solution to allow both internal and external users to follow defined business processes that will ensure the user experience is optimized and established policies are followed.
d. An automated screening and monitoring component to complete required screening and monitoring activities for enrolling and actively enrolled providers compliant with the Code of Federal Regulations 42 CFR 455.436, in addition to State-specific requirements and policy.
e. The ability to coordinate with the EDW Vendor to develop and publish reports and dashboards on the EDW's Enterprise Reporting Solution.
f. A solution with a high degree of configurability.
g. A Self-Service Portal including the following minimum functionality:
    1. An inbox for providers to receive and respond to messages.
    2. A maintenance feature that allows active and inactive providers to update and validate their provider record through direct data entry via the web, based on selected criteria.
    3. A provider search feature for both authenticated users and public users to search for providers using a variety of search criteria.
    4. Account administration for users to add or remove provider account users and change user roles for all self-service functions.

5. Online resources (e.g., links to relevant websites and key contact information).

h. A recipient eligibility inquiry tool that performs real-time recipient eligibility verification (e.g., Benefit Plan enrollment, Care Management enrollment, Waiver Program information, program limits, service limits, and Third Party Liability (TPL) information).
i. A claim status inquiry function that performs in real-time to allow providers to check the status of their claims.
j. A remittance advice inquiry feature that provides authorized user access to provider remittance advice information.
k. An upload, download, and view function that provides the ability for authorized users to upload, download, and view Health Insurance Portability and Accountability Act (HIPAA) compliant healthcare transactions (e.g., 270/271 batch eligibility status inquiry and response).
l. Primary source verification based on Credentials Verification Organization (CVO) National Committee for Quality Assurance (NCQA) standards.
m. Combined Medicaid Enrollment, and Credentialing (initial and renewal).
n. Account Management.
o. Communications.
p. Performance Management, i.e., system performance, user performance, business process performance.
q. Workflow and Assignment Management.
r. Customer Care

PSM IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023		2023-2024	
	1. Complete procurement of Provider Module 2. Prepare for design, development, and implementation		1. Continue design, development and implementation activities 2. Prepare for Go-live

PSM IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$9,624,303	$7,849,629

Streamlined Modular Certification (SMC)

The Agency, Provider Services vendor, and SEAS will develop specific desired outcomes and required metrics that will be reported to CMS as the outcomes evolve. The following are outcomes that form the baseline and that will be refined

in the development efforts as a part of design, development, and implementation (DDI). Additional desired outcomes and required metrics will be reported to CMS in the future.

Provider Management Outcomes

Reference	Outcome	Source(s)
Provider Management	A provider can initiate, save, and apply to be a Medicaid provider.	42 CFR 455.410(a)
Provider Management	A state user can view screening results from other authorized agencies (Medicare, CHIP, other related agencies) to approve provider if applicable.	42 CFR 455.410(c)
Provider Management	A state user can verify that any provider purporting to be licensed in a state is licensed by such state and confirm that the provider's license has not expired and that there are no current limitations on the provider's license ensure valid licenses for a provider.	42 CFR 455.412
Provider Management	The system tracks the provider enrollment period to ensure that the state initiates provider revalidation at least every five years.	42 CFR 455.414
Provider Management	A state user (or the system, based on automated business rules) must terminate or deny a provider's enrollment upon certain conditions (refer to the specific regulatory requirements conditions in 42CFR455.416).	42 CFR 455.416
Provider Management	After deactivation, a provider seeking reactivation must be re-screened by the state and submit payment of associated application fees before their enrollment is reactivated.	42 CFR 455.420
Provider Management	A provider can appeal a termination or denial decision, and a state user can monitor the appeal process and resolution including nursing homes and ICFs/IID.	42 CFR 455.422
Provider Management	A state user can manage information for mandatory pre-enrollment and post-enrollment site visits conducted on a provider in a moderate or high-risk category.	42 CFR 455.432(a)
Provider Management	A state user can view the status of criminal background checks, fingerprinting, and site	42 CFR 455.434

Reference	Outcome	Source(s)
	visits for a provider as required based on their risk level and state law.	
Provider Management	The system checks appropriate databases to confirm a provider's identity and exclusion status for enrollment and reenrollment and conducts routine checks using federal databases including: Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), and the Excluded Parties List System (EPLS). Authorized users can view the results of the data matches as needed.	42 CFR 455.436
Provider Management	A state user can assign and screen all applications by a risk categorization of limited, moderate, or high for a provider at the time of new application, re-enrollment, or re-validation of enrollment. A state user can adjust a provider's risk level due to payment suspension or moratorium.	42 CFR 455.450
Provider Management	The system can collect application fees. A state user ensures any applicable application fee is collected before executing a provider agreement.	42 CFR 455.460
Provider Management	A state user can set CMS and state-imposed temporary moratoria-on new providers or provider types in six-month increments.	42 CFR 455.470
Provider Management	A state user can determine network adequacy based upon federal regulations and state plan.	42 CFR 438.68
Provider Management	A state user, and/or the system, can send and receive provider sanction and termination information shared from other states and Medicare to determine continued enrollment for providers.	42 CFR 455.416(c)
Provider Management	The system can generate relevant notices or communications to providers to include, but not limited to, application status, requests for additional information, re-enrollment termination, investigations of fraud, suspension of payment in cases of fraud.	42 CFR 455.23
Provider Management	A state user can report required information about fraud and abuse to the appropriate officials.	42 CFR 455.17

Reference	Outcome	Source(s)
Provider Management	The system, or a state user, can suspend payment to providers in cases of fraud.	42 CFR 455.23
Provider Management	A state user can view provider agreements and disclosures as required by federal and state regulations.	42 CFR 455.104 42 CFR 455.105 42 CFR 455.106 42 CFR 455.107
Provider Management	A state user can view information from a managed care plan describing changes in a network provider's circumstances that may affect the provider's eligibility to participate in Medicaid, including termination of the provider agreement.	42 CFR 438.608(a)
Provider Management	A beneficiary can view and search a provider directory.	42 CFR 438.10(h)

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C.4 Pharmacy Benefits Management

The Pharmacy Benefits Management (PBM) Module will perform designated financial and clinical prescribed drug services for the fee-for-service (FFS) Medicaid population, encounter data collection and other services that are used in managed care. A vendor, yet to be determined, will be responsible for drug manufacturer rebate negotiation, drug rebate collection, maintenance of the preferred drug list (PDL). The PBM vendor's solution will include a system to process pharmacy claims; allow for system updates; implementation of edits and change requests; and support e-prescribing functionality and integration with pharmacy point-of-sale systems. Prior authorizations, electronic or automated submissions with a response provided within required time limits for specified drugs is also included in the PBM solution. A vendor, yet to be determined, is required to monitor prospective and retrospective drug utilization, drug criteria, prepare reports, facilitate and preside over quarterly Drug Utilization Review (DUR) Board. A vendor, yet to be determined, will facilitate and preside over Pharmaceutical and Therapeutics (P&T) Committee meetings, including negotiating with manufacturers for drug rebates, making recommendations to the Agency related to the Preferred Drug List (PDL), preparing, and updating cost sheets which include federal and state rebate amounts, verifying that all drugs are included in therapeutic drug class reviews on the pharmacy and medical web-sites. The PBM vendor will also provide operational staff to deliver information to providers, recipients, and other stakeholders. PBM initial calls are anticipated to be handled by the Unified Operations Center (UOC):

a. Providing Tier 1 general support to callers regarding pharmacy benefits (e.g., who should they call, covered drugs, complaint intake, etc.);
b. Routing fee-for-service recipients to the PBM Ombudsman for pharmacy related issues and to the health plan for SMMC recipients; and
c. Process for communicating to the provider or recipient the result of the review through various communication channels (mail, email, text, web-portal, etc.).

The PBM vendor will include an Ombudsman to assist with recipient inquiries.

PBM IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	1. Plan for procurement activities for PBM 2. Begin design and development activities	2023-2024	1. Begin design and development activities

PBM IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$439,280	$4,917,846

Streamlined Modular Certification (SMC)

The Agency, FX PBM vendor, and SEAS will develop specific desired outcomes and required metrics that will be reported to CMS as the outcomes evolve. The following are PBM outcomes that form the baseline and that will be refined in the development efforts as a part of design, development, and implementation (DDI). Additional desired outcomes and required metrics will be reported to CMS in the future.

Pharmacy Benefit Management (PBM) Outcomes

Reference #	Outcome	Source(s)
PBM1	The system adjudicates claims within established time parameters to ensure timely pharmacy claims payments.	Section 1927(h) of the SSA 42 CFR 456.722 - POS requirement to support claims adjudication or payment F.S. 409.912 (5)(a)1
PBM2	The system adjudicates claims accurately within established parameters. The module can be configured to provide authority/ability to override a reject/edit/denied claim and then resubmit to ensure timely provider claims payments.	42 CFR 456.722
PBM3	The system captures the necessary data to ensure timely processing of manufacturer rebates as well as the capability to track rebates to promote beneficiary cost savings.	Section 1927 of the SSA 42 CFR 447.509
PBM4	The system has the capability to support cost savings by capturing, storing, and transferring data to the payment process system to generate invoices of participating drug manufacturers within 60 days of the end of each quarter.	Section 1927 of the SSA 42 CFR 447.520 Section 1927(b)(2) of the SSA 42 CFR 447.511
PBM5	The system supports cost savings by enabling the tracking, monitoring, and reporting of manufacturer's pharmacy drugs and rebate savings.	Section 1927 of the SSA 42 CFR 447.520 Section 1927(b)(2) of

Reference #	Outcome	Source(s)
		the SSA 42 CFR 447.511
PBM6	Capability to perform automatic and electronic prior authorizations, providing a response by telephone or other telecommunication devices within 24 hours of receipt of a request. Provides for the dispensing of a 72-hour supply of a covered outpatient prescription drug in an emergency situation (unless excluded under the SSA).	Section 1927(d)(5) of the SSA F.S. 409.912 (5)(a)1
PBM7	The system supports CMS oversight of the safe, effective, and appropriate dispensing of medications by enabling the capability to provide data to support the creation of the CMS annual report on the operation and status of the state's DUR program.	Section 1927(g)(3)(D) of the SSA 42 CFR 456.712 Section 1944(e)(1) of the SSA
PBM8	The system supports the safe, effective, and appropriate dispensing of medications by enabling the capability to provide point-of-sale or point of distribution prospective review of drug therapy based upon predetermined standards, including standards for counseling. This includes quantity, age, dose, diagnosis limitations and prior authorizations both automated and electronically submitted.	42 CFR 456.703, 456.705(b) 456.709 Section 1927 (g) of the SSA
PBM9	The system supports the identification of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, or prescribing or billing practices indicating abuse or excessive utilization among physicians, pharmacists and individuals receiving benefits by enabling the collection of pharmacy data to be used in retrospective drug utilization reviews.	42 CFR 456.703, 456.705(b) 456.709 Section 1927 (g) of the SSA

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C.5 Organizational Change Management

The Agency seeks prior approval from CMS for the development of an Organization Change Management (OCM) team to assist the FX Program Administration (FXPA) to analyze, strategize, and plan critical organizational and workforce transitions in a phased approach that can be implement over the next few years. During the period covered by this IAPDU, the Agency intends to procure the services of state-funded, contracted staff to develop plans for ongoing OCM activities. A contract will then be developed to procure the services of an OCM vendor to implement the plans developed by the Agency over the coming state fiscal year. The planning phase of the OCM activities will cover, at a minimum, the following:

a. Conduct analysis and review of the current Agency FX Organizational Change Management (OCM) Plan and FX standards/processes.

b. Validate Integrated Organizational Change Management approach and FX Modular projects pre-design activities for integrated OCM activities in multi-vendor environment.

c. Identify Integrated Organizational Change Management approach enhancements, FX OCM Plan Revisions, and FX Modular pre-design recommendations to achieve FX Integrated Change Management success across the Agency.

d. Provide recommendations for Organizational Design and Operating Model.

e. Develop strategy/planning for workforce transitions and workforce development where needed.

f. Conduct analysis and develop a detailed phased 2022-2025 Enterprise Change Management implementation roadmap, resources levels, and budget for how the Agency should fully operationalize the FX OCM Plan across an integrated multi-vendor project/program roadmap.

g. Work collaboratively with the FX Program Administration, SEAS, IS/IP Vendor, EDW Vendor, and FX projects teams to build the Integrated Organizational Change Management Plan through June 2025.

h. Assist in the development of an Organizational Change Management Methodology that encompasses People Readiness, Support Readiness, and Post Implementation Support.

i. Work collaboratively with the FX Program Administration, SEAS, IS/IP Vendor, EDW Vendor, and FX projects teams to develop an FX Program communication plan and FX Program Training plan that aligns to all project milestones in the FX roadmap.

j. Disseminate information to all Project Support Team members through electronic methods directed by the Agency and consistent with the project communication plan.

As the Agency develops the OCM plans as outlined, APD updates will be issued as needed to keep CMS informed of the modular plans, the results, and progress of OCM activities and to request Federal Financial Participation (FFP) to engage a vendor to execute the Agency-approved OCM plans. The OCM Vendor will develop, implement, and train agency personnel on a suite of OCM tools. The OCM contract will state, as is true in all Medicaid contracts, that the suite of tools must be solely and wholly owned by the Agency after implementation.

OCM IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	1. Form OCM team to plan OCM and work force transition activities. 2. Produce a solicitation document and procure the services of an OCM vendor.	2023-2024	Implement OCM plans as approved by the Agency.

OCM IAPDU Planned Costs

OCM activities in the SFY 2022-2023 will include the Agency enterprise and will be state-funded. The funding for the OCM expenditures planned for an OCM vendor is included in the funding request for the FX modules. OCM expenditures are expected to be cost allocated to reflect the reuse of the MES services outside of the Medicaid program and will be reported in a future IAPDU.

Streamlined Modular Certification (SMC)
Organizational Management is not a certifiable component of the MMIS replacement.

C.6 Testing Center of Excellence

The Agency seeks prior approval for the development of a Testing Center of Excellence (TCoE) designed to establish and govern a strategic, enterprise-level, multidisciplinary, quality program complementing Florida's organizational fluidity. Detailed information of the TCoE is forthcoming in the FX TCoE Framework.

Implementing automated testing is a key element of the overarching TCoE framework to ensure successful and sustainable achievement of the highest quality of excellence for the future of the Agency's Medicaid Management Information System (MMIS) modular components.

a. Accountability and Traceability: Follow Agency standards and processes to ensure requirements are met.
b. Integration: Determine how the automated test solution is woven into the holistic TCoE approach.
c. Staff and training: Assess skill availability and determine the need for resource reassignment, training, additional hiring, and augmentation aligned with the TCoE framework.
d. Infrastructure and tools: Estimate the cost and resource requirements for procuring and maintaining the new testing infrastructure, test management, and automation platform.
e. Governance: Define and monitor strategic automated testing Key Performance Indicators (KPIs) aligned with the TCoE framework and inclusive of key Agency objectives – such as cost efficiency, software quality level, time-to-market, flexibility, and agility. The governance process also helps ensure continuous evaluation and improvement for test processes, tools, and standards.

Automated web application testing comprises numerous off-the-shelf components to provision an integrated holistic testing solution aligned with the TCoE approach to meet or exceed Agency objectives.

This holistic approach ensures performance, scalability, traceability, risk and issue identification and resolution, quality of service, product and data transference, reliability, and interoperability to satisfy customer requirements before operationalizing. Repeatable methodologies are long term solutions for quality assurance.

TCoE IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023	1. Complete preliminary planning tasks. 2. Form testing team to plan testing standards. 3. Produce a solicitation document to procure the services of an testing vendor.	2023-2024	1. Complete procurement activities for a testing vendor. 2. Implement testing plans as approved by the Agency.

TCoE IAPDU Planned Costs

TCoE activities will include development of testing standards and development of a solicitation document to procure the services and expertise of industry standard testing processes and procedures. The funding for the planned testing activities is included in the funding request for the FX modules. Testing expenditures are expected to be cost allocated after the initial development to reflect the reuse of the MES services outside of the Medicaid program. CMS will be informed of the Agency's planning through a future IAPD update.

Streamlined Modular Certification (SMC)
The Testing Center of Excellence is not a certifiable component of the MMIS replacement.

C.7 Third Party Liability (TPL) (Core functions)

Third Party Liability Module, currently operated by Health Management Systems, including all systems and operations necessary to determine the legal liability of third parties to pay for care and services available under the Medicaid state plan. This module, scheduled for Phase IV, would replace existing legacy systems and introduce new functionality for legal liability, estate recovery, data matching, and post-payment support. TPL functions that support claims adjudication will be incorporated in the Core Module, as necessary. TPL is part of the currently certified MMIS.

TPL IAPDU Planned Activities

State Fiscal Year	Activities	State Fiscal Year	Activities
2022—2023		2023-2024	Planning to identify the components that need to be available to Core

TPL IAPDU Planned Costs

State Fiscal Year 2022—2023	State Fiscal Year 2023—2024
$0	$1,071,200

Streamlined Modular Certification (SMC)

The Agency, TPL vendor, and SEAS will develop specific desired outcomes and required metrics that will be reported to CMS as the outcomes evolve.

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ATTACHMENT D — PHASE IV: REMAINING FUNCTIONAL MODULES

The objective of Phase IV of FX is to implement the remaining functional modules necessary to accomplish the FX vision. In some cases, these modules are part of the certified MMIS, and certain parts of their functionality will need to be accounted for before the end of the current fiscal agent contract. Also included are modules that are not part of the current fiscal agent contract and are intended to enhance the management of the Medicaid program. More detail and pricing will be added to a future IAPD Update.

D.1 Plan Management

A Plan Management Module is planned to support collaboration between the Agency and the Statewide Medicaid Managed Care plans, enabling increased accountability and transparency and drive positive outcomes for recipients. Agency planning is identified as an expenditure during the term of this IAPD for $208,000.

D.2 Enterprise Case Management

An Enterprise Case Management Module solution is planned to streamline and consolidate case management information from across the Medicaid enterprise into a single system. This system will facilitate the availability of complete and comprehensive information for state agencies, providers, and recipients. Agency planning is identified as an expenditure during the term of this IAPD for $280,800.

D.3 Contractor Management

A Contractor Management Module is planned to improve the ability to manage contracts across the Agency's contract lifecycle from procurement through contract termination. The solution will include reporting and business intelligence analysis to measure the performance of contractor activities and programs against widely accepted outcome metrics.

D.4 Third Party Liability (TPL) (Module contract)

Third Party Liability Module (operated by HMS) including all systems and operations necessary to determine the legal liability of third parties to pay for care and services available under the Medicaid state plan. This module would replace existing legacy systems and introduce new functionality for legal liability, estate recovery, data matching, and post-payment support. TPL is part of the currently certified MMIS.

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ATTACHMENT E — MODULES WITHOUT ENHANCED FFP

The Agency is not requesting enhanced FFP for the following functions of the Medicaid Enterprise System (MES). Information regarding these functions is provided in the IAPDU to inform CMS of the Agency's plan to maintain these important components to ensure smooth and accurate management of the MES and the Medicaid program.

E.1 Choice Counseling Services

The Agency intends to procure the services of a Vendor to provide choice counseling services. After determining the appropriate recipient group based on eligibility criteria the choice counselor will assist recipients in selection of a Managed Care Plan. The Agency reserves the right to bring these services in-house if that is determined to be best value for the state and federal funding. Any change in direction will be communicated to CMS through an IAPDU.

The Choice Counselors will provide unbiased assistance to recipients regarding selection of a Managed Care Plan using an Enrollment and Recipient Support System. Choice Counselors will be able to use other Agency-approved tools and information available to the recipients for the purpose of making plan selections. Choice Counselors shall provide general education, approved by the Agency, aimed at enhancing Health Literacy.

The staff will be trained to assist recipients who have Special Needs, such as assisting enrollees with complex medical issues, and assisting all recipients with complaints, exemptions, and continuity of care.

These services are now provided through the Enrollment Broker contract with Automated Health Systems (AHS), which ends August 31, 2023. The Agency plans to procure continued Choice Counseling services through a non-competitive contract using the health exemption regulations in Florida Statutes (F.S.): 287.0 57 (e) (3) 5. Enhanced FFP is not planned at this time. The term of the contract is unknown as of the development of this IAPDU.

E.2 Prior Authorization (Utilization Management)

The Agency is contracted with a certified Quality Improvement Organization Inc., to provide medical necessity reviews for fee-for-service Medicaid services from the FMMIS contract. These functions will interface in FX through IS/IP, similarly to the current state, but with a higher level of maturity. The current contract, MED192, is being extended through 12/31/22. A new non-competitive contract will be procured with the same vendor, Kepro, with a start date of 1/1/2023, using the health exemption regulations in F.S. 287.057 (e) (3) 5. Enhanced FFP is not planned at this time. The term of the contract is unknown as of the development of this IAPDU.