DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-22-16
Baltimore, Maryland 21244-1850

July 19, 2024

Thomas Wallace
Deputy Secretary for Medicaid
State of Florida, Agency for Health Care Administration (AHCA)
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

RE: FL-2024-06-25-MMIS-NHC-IAPDU-FX

Dear Deputy Secretary Thomas Wallace:

This letter is in response to Florida's submission dated June 25, 2024, requesting that the Centers for Medicare & Medicaid Services (CMS) review and approve the state's Medicaid Management Information System (MMIS) Implementation Advance Planning Document-Update (IAPD-U) for the Florida Health Care Connections Exchange (FX) program and the state's contract with North Highland Group, LLC for the state's Florida Health Care Connections Exchange (FX) program.

The Florida's IAPD-U submission focuses on updates to the State's strategic roadmap that reflect milestone changes in the Provider Services Modules, Unified Operations Center, and other module integration projects. Additionally, this update notifies CMS of the expansion of strategic advisory services and changes to the Enterprise Systems Strategic Plan that enhance Medicaid operations in Florida.

To accomplish these changes, AHCA submitted Amendment No. 12 to Contract No. MED191 which includes essential funding for key deliverables aimed at improving service efficiency and user experience. Additionally, the amendment incorporates financial management improvements to ensure budgetary compliance and cost-effectiveness, along with a market analysis to integrate innovative solutions into strategic planning, ensuring alignment with industry standards and compliance measures, including the SEAS Turnover Plan.

As part of this submission, the State also submitted several outcomes for the FX program with a focus on benefitting the Medicaid program (See Appendix C).

CMS previously approved Florida's FX IAPD-U FL-2024-02-05-MMIS-IAPDU-FX on February 05, 2024.

CONTRACT

Florida's MED191 contract with North Highland Group, LLC aims to advance strategic objectives through enhanced advisory services and updates to the Enterprise Systems Strategic Plan. This will be achieved by focusing on outcomes such as timely deliverables, stakeholder satisfaction, and improved financial management aimed at enhancing service delivery timelines and recipient/provider experiences. The amendment includes a focused market scan to assess industry trends, integrating innovative solutions into strategic planning, ensuring compliance, and ensuring a smooth service transition through the SEAS Turnover Plan.

Contract Amendment #12 contains no-additional cost, as the budget was previously approved on February 05, 2024, in the aforementioned FX IAPD-U. The performance period remains July 1, 2024, to June 30, 2025.

CMS approves Florida's IAPD-U and Contract Amendment #12 effective June 25, 2024, in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR 433, Subpart C, 45 CFR 95, Subpart F, and the State Medicaid Manual, Part 11. CMS is authorizing expenditures under this APD in amounts not to exceed those in the below Medicaid Detailed Budget Tables (MDBTs). CMS' Consolidated MDBT includes approved funding for all Medicaid Enterprise System (MES) Planning, Implementation, and Operational APDs for the listed FFYs. This project's federal funding authorization will expire on September 30, 2025. This approval letter supersedes all prior APD approval(s) for the FFY approved in the MDBT.

As per 45 CFR 95.611, any subsequent revisions and/or amendment(s) to the contract will require CMS' prior written approval to qualify for Federal financial participation (FFP). Additionally, any changes in the related approved APD project scope, duration, or cost, requires CMS prior approval of an APD Update. Please provide an electronic copy of the final signed Statement of Work to your MES State Officer.

Please note: CMS is approving this state Medicaid IT project and the associated funding; however, this APD approval does not constitute approval of any Medicaid program policies. Medicaid program policies must be reviewed and approved through the appropriate state plan amendment or waiver processes.

Per regulations at 42 CFR 433.116, FFP is available at 75 percent of expenditures for operating a Medicaid Enterprise System (MES) module or solution approved by CMS, in accordance with CMS' MES certification requirements. The state may claim 75 percent FFP on Lines 4A/B, 28C/D, or 28E/F from the first day of the calendar quarter after the date the system meets the initial approval conditions, as established by CMS. This may include a retroactive adjustment of FFP, if necessary, to provide the 75 percent rate beginning on the first day of that calendar quarter. As outlined in the State Medicaid Manual, Section 11255, FFP for the operation of a non-certified MES solution is reimbursed at 50 percent on Lines 5A/B, 28G/H pending system certification and CMS approval of retroactive operational funding.

This project is subject to all the requirements specified in Appendix B, which includes federal regulations and additional information about the state's responsibilities concerning activities

described in the APD. The funding and scope of work approved in the APD are subject to these requirements. **Failure to comply with Appendix B's federal requirements and state responsibilities may result in FFP disallowance.** If the state's project deviates from its description in the CMS-approved APD, FFP for project activities could be suspended or disallowed as provided in federal regulations at 45 CFR 95.611(c)(3) and 95.612.

The state must submit quarterly status reports for projects under design, development, and implementation (DDI). These reports should measure progress against the approved APD. Status reports must be submitted to your MES State Officer by the last day of each quarterly, continuing through project completion or transition to steady-state operations.

The state must obtain CMS' prior approval for APDs, Requests for Proposals (RFPs), contracts, and contract amendments as specified in regulations at 45 CFR 95.611. Per 45 CFR 95.611(d), CMS has 60 days to review and respond to a state's submission. The state is reminded that funding for each FFY expires on September 30 of the corresponding FFY**. Failure to submit an annual or as-needed APD update in a timely manner may put the state at risk of having a gap in approved FFP.**

An annual APD update may be submitted at any time, but CMS approval is required before the funding expires in the current FFY. Therefore, if you have not already, CMS requests that you submit an annual APD update outlining budget and implementation activities before the end of the current FFY.

Formal submissions of MES APDs, RFPs, and contracts should be sent to the CMS dedicated MES electronic mailbox: MedicaidMMIS@cms.hhs.gov, with a cover letter addressed to the following: Dzung Hoang, Director of Division of HITECH and MMIS.

If you have any questions, please contact the MES State Officer, Richard "Rick" Anderson, at 470-890-4153 or richard.anderson@cms.hhs.gov.

Sincerely,

Ricardo Melendez -S

Digitally signed by Ricardo Melendez -S
Date: 2024.07.19 13:18:14 -06'00'

Ricardo Melendez, Deputy Director
On behalf of
Dzung Hoang, Director
Division of HITECH and MMIS

CC:
MESClearance@cms.hhs.gov
Vi Luu CMS/FMG

Appendix A

Florida – FX MES –Medicaid Detailed Budget Table*

Covers Federal Fiscal Years (FFYs) 2024-2026 (ending September 30, 2026)

The table represents no increase to line items.

	MMIS CMS Share (90% FFP) DDI	State Share (10%)	MMIS CMS Share (75% FFP) DDI	State Share (25%)	MMIS CMS Share (75% FFP) M&O	State Share (25%)	**MMIS ENHANCED FUNDING FFP Total**	State Share Total	MMIS ENHANCED FUNDING TOTAL COMPUTABLE
	2A† + 2B†	--	2A† + 2B†	--	4A† + 4B†	--			
FFY 2024	$112,597,038	$12,510,782	$2,413,336	$804,445	$15,038,609	$5,012,870	$130,048,983	$18,328,097	$148,377,080
FFY 2025	$95,262,001	$10,584,667	$2,035,746	$678,582	$22,943,641	$7,647,880	$120,241,388	$18,911,129	$139,152,517
FFY 2026	$-	$-	$-	$-	$-	$-	$-	$-	$-

	MMIS CMS Share (50% FFP) DDI	State Share (50%)	MMIS CMS Share (50% FFP) M&O	State Share (50%)	**MMIS NOT ENHANCED FUNDING FFP Total**	State Share Total	MMIS NOT ENHANCED FUNDING TOTAL COMPUTABLE
	2A† + 2B†	--	5A†+5B†+5C†	--			
FFY 2024	$133,258	$133,258	$3,322,091	$3,322,091	$3,455,349	$3,455,349	$6,910,698
FFY 2025	$62,500	$62,500	$11,156,288	$11,156,288	$11,218,788	$11,218,788	$22,437,57
FFY 2026	$-	$-	$-	$-	$-	$-	$-

	MMIS ENHANCED FUNDING FFP Total	**MMIS NOT ENHANCED FUNDING FFP Total**	**TOTAL FFP**	STATE SHARE TOTAL	APD TOTAL COMPUTABLE
FFY 2024	$130,048,983	$3,455,349	$133,504,332	$21,783,446	$155,287,778
FFY 2025	$120,241,38	$11,218,788	$131,460,176	$30,129,917	$161,590,093
FFY 2026	$-	$-	$-	$-	$-

*Funding amounts described here are summarized by FFY; however, funding is only approved to be used according to the approval dates described in this letter.

Florida - Consolidated Detailed Budget Table*
Covers Federal Fiscal Years (FFYs) 2024-2026 (ending September 30, 2026)

	MMIS CMS Share (90% FFP) DDI	State Share (10%)	MMIS CMS Share (75% FFP) DDI	State Share (25%)	MMIS CMS Share (75% FFP) M&O	State Share (25%)	**MMIS ENHANCED FUNDING FFP Total**	State Share Total	MMIS ENHANCED FUNDING TOTAL COMPUTABLE
	2A† + 2B†	--	2A† + 2B†	--	4A† + 4B†	--			
FFY 2024	$113,110,919	$12,567,880	$2,413,336	$804,445	$64,878,135	$21,626,045	$180,402,390	$34,998,370	$215,400,760
FFY 2025	$95,262,001	$10,584,667	$2,035,746	$678,582	$35,779,512	$11,926,504	$133,077,259	$23,189,753	$156,267,012
FFY 2026	$0	$0	$0	$0	$0	$0	**$0**	$0	$0

	MMIS CMS Share (50% FFP) DDI	State Share (50%)	MMIS CMS Share (50% FFP) M&O	State Share (50%)	**MMIS NOT ENHANCED FUNDING FFP Total**	State Share Total	MMIS NOT ENHANCED FUNDING TOTAL COMPUTABLE
	2A† + 2B†	--	5A†+5B†+5C†	--			
FFY 2024	$147,008	$147,008	$4,698,593	$4,698,593	$4,845,601	$4,845,601	$9,691,202
FFY 2025	$62,500	$62,500	$11,605,414	$11,605,414	$11,667,914	$11,667,914	$23,335,828
FFY 2026	$-	$-	$105,000	$105,000	$105,000	$105,000	$210,000

	MMIS ENHANCED FUNDING FFP Total	**MMIS NOT ENHANCED FUNDING FFP Total**	**TOTAL FFP**	STATE SHARE TOTAL	APD TOTAL COMPUTABLE
FFY 2024	$180,402,390	$4,845,601	$185,247,991	$39,843,971	$225,091,962
FFY 2025	$133,077,259	$11,667,914	$144,745,173	$34,857,667	$179,602,840
FFY 2026	$-	$105,000	$105,000	$105,000	$210,000

*Consolidated funding amounts described above are summarized by FFY; funding is only approved to be used according to approval dates described in this letter.

†MBES Line Item	
2A	MMIS- Design, Development, or Installation of MMIS: Cost of In-house Activities
2B	MMIS- Design, Development, or Installation of MMIS: Cost of Private Contractors
4A	MMIS- Operations of MMIS: Cost of In-house Activities
4B	MMIS- Operations of MMIS: Cost of Private Contractors
5A	MMIS- Mechanized Systems, not approved under MMIS procedures: Cost of In-house Activities
5B	MMIS- Mechanized Systems, not approved under MMIS procedures: Cost of Private Contractors
5C	MMIS- Mechanized Systems, not approved under MMIS procedures: Cost of Interagency Activities

FFP rates for specific activities and costs can be found at 76 FR 21949, available at https://federalregister.gov/a/2011-9340

Appendix B

This APD project is subject to the federal regulations and state responsibilities as follows:

- 42 CFR 433, Subpart C, "Mechanized Claims Processing and Information Retrieval Systems"
- 45 CFR 75, "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards"; and Subpart D, "Procurement Standards."
- 45 CFR 95, Subpart F, "Automatic Data Processing Equipment and Services—Conditions for Federal Financial Participation (FFP)"
- 42 CFR 457.230, "FFP for State ADP expenditures"
- State Medicaid Manual (SMM), Part 11
- SMD Letter #16-004 Re: Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding, and SMD Letter #16-009 Re: Mechanized Claims Processing and Information Retrieval Systems-APD Requirements, which contain additional details on specific FFP rates for qualifying activities
- SMD Letter #22-001 Re: Updated Medicaid Information Technology Systems Guidance: Streamlined Modular Certification for Medicaid Enterprise Systems

Approved Funding
The amounts allocated per Federal Fiscal Year in the above MDBT(s) cannot be reallocated between FFYs, even within the period of this letter's approval, without submission and approval of an APD update. Only actual costs incurred are reimbursable.

Systems Software
All software development receiving 90 percent FFP must be state-owned and in the public domain in accordance with 42 CFR 433.112(b)(5) and (6) and 45 CFR 95.617. Federal regulations under 45 CFR 95.617(c) specify that 90 or 75 percent FFP is available for the license for proprietary software, but no FFP is available for the development of that software.

Per 45 CFR 95.617, the Department reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal Government purposes, such software, modifications, and documentation.

Data Safeguarding and Data Breach Reporting
The state's MES projects and operations are subject to federal regulations at 42 CFR Part 431, subpart F, "Safeguarding Information on Applicants and Beneficiaries," and the Administrative Simplification provisions under the Health Insurance Portability and Accountability Act (HIPAA) requirements as specified in 45 CFR Part 160 and Part 164. Further, the state is bound by the requirements in section 1902(a)(7) of the Social Security Act, which requires states to provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries for purposes directly connected with the administration of the Medicaid program.

In the event of a data breach, the state must immediately report the incident to the CMS IT Service Desk by email at cms_it_service_desk@cms.hhs.gov, or by calling the 24/7 CMS Service Desk phone number: 1-800-562-1963.

Transformed Medicaid Statistical Information System (T-MSIS) Compliance
Timely, accurate, and complete T-MSIS data submission continues to be a CMS priority and is even more critical to national analyses of Medicaid and CHIP services, activities, and expenditures. To comply with T-MSIS Data Quality Assessment criteria, CMS requests that States continue to submit monthly T-MSIS data and continue, as much as possible, to work towards the recommended timelines for resolving T-MSIS data quality (DQ) issues. CMS will continue to measure and report on T-MSIS DQ issues and provide ongoing technical assistance to states.

As of the June 2024 T-MSIS reporting period, Florida complies with T-MSIS data submission currency and Data Quality requirements. Specifically, Florida is current on T-MSIS data submissions and has not met the targets for **if has not met;** at least one of three underlying Outcomes Based Assessment (OBA) criteria in critical priority Data Quality checks, high priority Data Quality checks, and the expenditure data content category.

If you need access to the T-MSIS State Support Site, please contact the CMS T-MSIS Help Desk at T-MSIS_Helpdesk@cms.hhs.gov. CMS expects the state to consider and incorporate T-MSIS requirements in every phase of the Software Development Life Cycle (SDLC) as applicable for any changes to state systems that impact T-MSIS data reporting.

APPENDIX C – Approved Outcomes and Metrics

Reference #	CMS Required Outcomes	Metric (s)
SEAS1	The SEAS Vendor supports the Agency's strategic planning efforts through development and maintenance of a strategic vision to assist the Agency in transforming the Medicaid Enterprise	Documentation of annual analysis of the strategic roadmap -Documentation of communications support for executive-level meetings with the executive branch, legislative branch, and FX Governance Executive Steering Committee -Documentation of planning and facilitation support for up to two (2) FX Summit programs per year
SEAS2	The SEAS Vendor supports the Agency in Financial Management and obtaining the appropriate funding to support FX.	Monthly maintenance data on the FX estimation, forecasting, budget planning tool -Provide annual fiscal year budget request -Create annual cost benefit analysis -Develop workbook to translate budget projections for state fiscal year to federal fiscal year such that it conforms to CMS reporting requirements for Advance Planning Documents
SEAS3	The SEAS Vendor supports the Agency through the implementation and maintenance of an effective benefits realization management approach.	Development and maintenance of Framework Tool and Dashboards Generate quarterly or as needed Framework reporting
IVV1	IV&V provides rigorous independent evaluation and review that evaluates adherence to the standards, correctness, and quality of the FX Program and project solutions.	IV&V Monthly reports documenting activities related to operational readiness assessments, module release assessments, vendor integration process and activity assessments, and FX Operational Change Management (OCM) process and performance assessments.
IVV2	IV&V will provide review and assessment of all artifacts related to budget for the FX Program, including the Quarterly Operational Work plan (OWP) and the Monthly Spend Plan.	Affidavit of review
TCOE1	The TCOE will provide standardization of the testing processes across all FX Modules.	- Verify 100% of FX Modules are executing the standardized test phases and activities defined by the TCOE - Verify 100% of FX Modules report testing outcomes using the testing metrics defined by the TCOE - Verify 100% of FX Module vendors are using the Jira folder structure defined by the TCOE
TCOE2	The TCOE will provide an optimum level of testing governance across all FX Modules	- Verify 50% reuse of test cases across test types - Verify 100% of the requirements are tested through the requirements traceability process

SPA1	The solution will ensure compliance with federal requirements related to the independent assessment of security and privacy across the FX Enterprise.	Assessment findings
SPA2	The solution will ensure the integrity of the security and privacy assessment process.	Enterprise FX Security and Privacy Assessment Plan
SPA3	The solution will provide streamlined insights to the Agency related to the status of security and privacy assessment across the FX Enterprise.	Reporting or dashboard on status of SPAs and penetration testing.
MCert1	The MITA Business Architecture and MES Certification Vendor will support a holistic framework and methodology for managing certification at the enterprise level.	-Update P-4: Medicaid Enterprise Certification Plan -Documentation of the required artifacts for each FX Modular System Production Release Operational Readiness Review (ORR) and evidence needed to demonstrate the project is ready to enter production and that outcomes are likely to be achieved. -Documentation of activities for resolution of ORR, and preparation for each CMS FX Modular System Certification Review
MCert2	The MITA Business Architecture and MES Certification Vendor will establish and support methods to monitor solution outcomes and metrics and assure module compliance.	-Documentation of MITA compliance using the Agency's MITA Compliance Tracking Tool, including Outcome Based Certification (OBC) tracking. -Documentation of usage of the tool. -Documentation of the inclusion of other agency partners for tracking MITA processes outside AHCA control.
MCert3	The MITA Business Architecture and MES Certification Vendor will support an approach to leveraging the MITA framework to modernize the Agency’s enterprise business processes.	Documentation of MES Business Architecture for each release for all FX Vendors building new and transitioning old functionality
ISIP1	The solution promotes an Enterprise Service Bus (ESB) end-to-end response time to maximize processing speed.	Generate report demonstrating ESB response time. Transaction response time must be less than one (1.000) second.
ISIP2	The solution promotes efficient and error-free ESB system processing. Generate report demonstrating ESB transaction errors.	Errors must not exceed .001% per calendar day.
ISIP3	The solution promotes a stable and available production environment.	The IS/IP platform shall be available 99.5% of the time, twenty-four (24) hours a day, seven (7) days a week.

DSS/DW1	42 CFR 433.112 Exhibit 35: Reference State-Specific Outcome Statement Metric(	The solution supports various business processes' reporting requirements including generation of Federal reports. Regulatory Sources Generation and CMS acceptance of the following reports: - CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report - T-MSIS: Transformed 42 CFR 431.428 EDW Outcomes and Metrics The Agency and EDW Vendor developed state-specific outcomes and metrics that will be reported to CMS through the certification process.
DSS/DW2	The solution includes analytical and reporting capabilities to support key policy decision making.	The EDW solution provides the ability to report on and analyze data pertaining to institutional and community care to inform long term care policy: -Admission to an Institution from the Community - Minimizing Institutional Length of Stay - Successful Transition after Long Term Institutional Stay
CPAR1	Provider Directory API will provide a comprehensive list of enrolled Medicaid providers.	-Documentation of testing per Agency requirements following Fast Healthcare Interoperability Resources (FHIR) standards. -Documentation of user guide content developed and deployed in FX Enterprise Portal.
CPAR2	Formulary API will provide a comprehensive list of Medicaid medications on the preferred drug list.	-Documentation of testing per Agency requirements following FHIR standards. -Documentation of user guide content developed and deployed in FX Enterprise Portal.
CPAR3	Patient Access API will provide Medicaid recipients access to their clinical, claims, and encounter data through third parties.	-Documentation of testing per Agency requirements following FHIR standards. -Documentation of process established for user authentication and authorization to allow valid recipients can only access data in a secured manner. -Documentation of user guide content developed and deployed in FX Enterprise Portal. -Documentation of development and deployment of information for third party developers.

MI1	The MI Project will improve integration across the Florida health and human services enterprise.	Generate a report on the number of interfaces compared to the following: - Number of interfaces modernized - Number of interfaces transformed to real or near real time.
MI2	The MI Project will implement interface modernization to support successful modular integration.	Generate a report on the number of interfaces compared to the following: - Number of interfaces migrated as-is in accordance with the project schedule - Number of interfaces modernized in accordance with the project schedule - Number of interfaces transformed to real or near real-time in accordance with the project schedule.
MI3	The MI Project will work to decommission systems and applications.	Generate a report on the number of interfaces compared to the number of legacy systems decommissioned.
UOC1	The solution will support enhanced accessibility for recipients to health information while reducing contact center dependence.	Calculate adoption of text, chat, and self-service trends through comparison of statistical data on eHealth tool adoption between Medicaid and non-Medicaid populations to determine a quarterly benchmark
UOC2	The UOC Platform will enhance customer satisfaction.	Demonstrate an initial 10% improvement in customer satisfaction and report ongoing trends through biannual customer satisfaction surveys.
UOC3	The State Medicaid Agency will achieve cost savings and enhanced quality controls through streamlined operations and procedures.	Calculate quarterly savings trends as modules are transitioned to the solution by comparing current expenses against historical costs on a rolling basis.
UOC4	The UOC Platform solution will ensure consistent messaging, facilitate better and more cost-effective training, and boost firstcall resolutions.	Calculate savings trends by comparing consecutive quarterly training and contact center costs.
MM2	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 informed choice. If no selection is made, the system either confirms the original assignment, or assigns the member to FFS.	- Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. - For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 calendar days before the start of each enrollment period. CFR 42 438.10, 438.54
MM5	The system notifies enrollees of their disenrollment rights at least 60 days before the start of each enrollment period. This notification is in writing.	- The system notifies enrollees, in writing, of their disenrollment rights at least 60 days before the start of each enrollment period. 42 CFR 438.56(f)

MM7	The system allows beneficiaries or their representative to receive information through multiple channels including phone, Internet, in person, and via auxiliary aids and services.	– Percentage of beneficiaries or their representative received outreach communication by the following channels: phone, internet, in-person, and via auxiliary aids and services 42 CFR 438.71
MM8	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.	- An electronic provider directory must be updated no later than 30 calendar days after the MCO, PIHP, PAHP, or PCCM entity receives updated provider information. 42 CFR 438.10(c) MM9 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. - Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.
PM16	The system can generate relevant notices or communications to providers to include, but not limited to, application status, requests for additional information, reenrollment termination, investigations of fraud, suspension of payment in cases of fraud.	- Provide a copy of relevant notices and communications submitted to providers for each outcome category. 42 C.F.R. §455.23
CP5	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 predefined 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). - Count/percentage of inquiries/responses/communications by submission/response channel. 45 CFR Part 162.1402(c) 45 CFR Part 162.1403 (a) & (b) 42 CFR 431.60 (a) & (b) SMM Part 11 Section 11325 -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)
CP1	The system receives, ingests, and retains claims, claims adjustments, and supporting documentation Regulatory Sources	- Count/percentage of claims received by submission channel (paper vs. electronic). - Median processing time for ingestion Regulatory Sources submitted both electronically and by paper in standard formats. of non-electronic claims/documentation (from receipt to correct ingestion of/association with the associated claims record). 45 CFR 162.1102
CP2	The system performs comprehensive validation of claims and claims adjustments, including validity of services.	-Count/percentage of claims/claims adjustments accepted/suspended/rejected for processing. 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
CP3	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).	-Count/percentage of claims/claims adjustments requiring prior authorization accepted/suspended/rejected for processing based on prior authorization or lack thereof. SSA 1927(d)(5) 42 CFR 431.630 42 CFR 431.960 SMM Part 4 SMM Part 11 Section 11325
CP4	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.	-Count/percentage of transactions by reason code. -Count/percentage of transactions repriced post-payment by underpayment/ overpayment and, if applicable, reason code or other applicable categorization available to the State. 42 CFR 431.052
CP5	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) reason code. - Count/percentage of

		inquiries/responses/communications by submission/response channel. 45 CFR Part 162.1403 (a) & (b) 42 CFR 431.60 (a) & (b) SMM Part 11 Section 11325
CP6	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.	- Records must be retained for a minimum of 3 years for fiscal records, 5 years for records related to cost reports, 6 years for medical records of covered entities, and 10 years for managed care records (or greater if required under State laws) – periods are measured from the date of closure of all related actions for a given record. - Pass/Fail that the state can demonstrate that 100% of records were retained for the appropriate number of years indicated above. 42 CFR 447.45 42 CFR 431.17 SMM Part 11 Section 11325
EPS1	The system ingests encounter data (submissions and resubmissions) 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).	- Percentage of timely encounter submissions from MCOs. 42 CFR 438.242
EPS2	The system ingests encounter data (submissions and resubmissions) 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.).	- Percentage state receives timely encounter re-submissions from MCOs. 42 CFR 438.604, 438.818, and 438.242
EPS3	The state includes submission requirements (timeliness, re-submissions, etc.), definitions, data specifications and standards, and consequences for noncompliance in its managed care contracts. The state enforces consequences for non-compliance.	- This is a state specific requirement, for the most part, states have encounters submission/re-submission processes based on 30/60/90/180 days and 365 days. 42 CFR Part 438.3
EPS4	The state uses encounter data to calculate capitation rates and performs payment comparisons with FFS claims data.	- State can validate that solution supports capability to set and edit capitation targets – Pass/Fail - State can validate that solution supports the capability to flag cases where MCO payments exceed FFS upper limit – Pass/Fail 42 CFR Part 438
EPS5	The state complies with federal reporting requirements. - SMA submits federal reports in a timely, and agreed upon, manner	– Pass/Fail - Reports are those currently required by applicable federal regulations, state plans, waivers etc. This include, but are not limited to: - T-MSIS (monthly) - CMS 416 (monthly) - CHIPRA core set (quarterly) - CMS 37 (biannually) - CMS 372 (semi-annually) - CMS 64 (quarterly) 42 CFR 438.818, 438.242

FM1	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.	- Count/percentage and amount/percentage of corrected claims by program, service category, and payment model. Report Medicaid and CHIP metrics separately. 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
FM2	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. - 90% Clean Claims<=30 Days - 99% Clean Claims <=90 Days - 100% All Other Claims <=12 Months 42 CFR 447.45 42 CFR 447.46 FM3 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.	- Records must be retained for a minimum of 3 years for fiscal records, 5 years for records related to cost reports, 6 years for medical records of covered entities, and 10 years for managed care records (or greater if required under State laws) periods are measured from the date of closure of all related actions for a given record. - Pass/Fail that the state can demonstrate that 100% of records were retained for the appropriate number of years indicated above.
FM4	The system accurately pays per member/per month capitation payments electronically in a timely fashion. Payments account for reconciliation of withholds, incentives, payment errors, beneficiary cost sharing, and any other term laid out in an MCO contract.	- Count/percentage and amount/percentage of payments by assistance program (Medicaid, CHIP, etc.), and service category. Report Medicaid and CHIP metrics separately. 42 CFR 438 42 CFR 447.56(d)
FM5	The system accurately tallies recoupments by tracking repayments and amounts outstanding for individual transactions and in aggregate for a provider.	- Repayment aging report showing counts/aggregate received/outstanding 60 days or less, >60 days, and any additional periods useful for State management of receivables. 42 CFR 447
FM6	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.	- Third party recovery aging report showing counts/aggregate received/outstanding 60 days or less, >60 days, and any additional periods useful for State management of receivables. 42 CFR 433.139
FM7	The system processes drug rebates accurately and quickly.	- Count/Percentage & Amount/Percentage on time (within 45 days of end of quarter)/late. 42 CFR 447.509
FM8	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. period according to reporting schedule(s). 42 CFR 433.32	- Count/Percentage of on-time reporting for designated reporting 42 CFR 431.428
FM9	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.	- Count/percentage of family's below/at/exceeding threshold. (The last of these indicates an overpayment by the household.) 42 CFR 447.56(f)

MM1	The system auto-assigns managed care enrollees to appropriate managed care organizations, per state and federal regulations.	- Percentage of system auto assignment for MCO enrollees ongoing basis. CFR 42 438.54
MM2	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 informed choice. If no selection is made, the system either confirms the original assignment, or assigns the member to FFS.	- Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. - For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 calendar days before the start of each enrollment period. CFR 42 438.10, 438.54
MM3	The system disenrolls members at the request of the plan and in accordance with state procedures.	- Disenrollment requested by the enrollee. Without cause, at the following times: - During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days 42 CFR 438.56(b) (c), and (d) Florida Medicaid Management Information System Implementation Advance Planning Document Update: FX/FMMIS Transition Page 85 of 100 Reference CMS Required Outcomes Metrics Regulatory Sources following the date the State sends the beneficiary notice of that enrollment, whichever is later. - At least once every 12 months thereafter.
MM4	Disenrollments are effective in the system the first day of the second month following the request for disenrollment.	- Disenrollments are effective the first day of the second month following the request for disenrollment. 42 CFR 438.56€
MM5	The system notifies enrollees of their disenrollment rights at least 60 days before the start of each enrollment period. This notification is in writing.	- The system notifies enrollees, in writing, of their disenrollment rights at least 60 days before the start of each enrollment period. 42 CFR 438.56(f)
MM6	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).	- The MCO, PIHP or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful. 42 CFR 438.208(b)
MM7	The system allows beneficiaries or their representative to receive information through multiple channels including phone, Internet, in-person, and via auxiliary aids and services	. - Percentage of beneficiaries or their representative received outreach communication by the following channels: phone, internet, in-person, and via auxiliary aids and services 42 CFR 438.71

MM8	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.	- An electronic provider directory must be updated no later than 30 calendar days after the MCO, PIHP, PAHP, or PCCM entity receives updated provider information. 42 CFR 438.10(c)
MM9	Potential enrollees are provided information about the state's managed care program when the individual	- Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after 42 CFR 438.10(e) becomes 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. receipt or issuance of the termination notice.
MM10	The system maintains an up to date (updated at least annually) fee-for-service (FFS) or primary care casemanagement (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 The physician/provider's cultural capabilities and a list of languages supported (for PCCM providers).	- The system maintains an up to date (updated at least annually) fee-forservice (FFS) or primary care case management (PCCM) provider directory. Section 1902(a)(83), 1902(mm), SMD # 18-007
MM11	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).	- Calculate accessibility of members to providers' network based on state and federal regulations. 42 CFR 438.68
EE3	Individuals eligible for automatic Medicaid eligibility are promptly enrolled (e.g., SSI recipients in 1634 states, individuals receiving a mandatory state supplement under a federally- or state administered program, individuals receiving an optional State supplement	- Percentage of individuals receiving SSI automatically eligible (1634 states only) For states, District of Columbia, Northern Mariana Islands, and American Samoa: - 42 CFR 435.117 per 42 C.F.R. 435.230 and deemed newborns). (Automatic enrollment in Guam, Puerto Rico, and the U.S. Virgin Islands is required only for individuals receiving cash assistance under a state plan for OAA, AFDC, AB, APTD, or AABD, and deemed newborns.) - 42 CFR 435.909 For Guam, Puerto Rico, and the Virgin Islands: - 42 CFR 436.909 - 42 CFR 436.124
EE10	Individuals receive electronic notices and alerts as applicable via their preferred mode of communication (e.g., email, text that notice is available in online account).	- Percentage of notices automatically generated and sent For all states, District of Columbia, and territories: - 42 CFR 431.210-214 For states, District of Columbia, Northern Mariana Islands, and American Samoa: - 42 CFR 435.917-918 For Guam, Puerto Rico, and the Virgin Islands: - 42 CFR 436.901 EE20 Individuals are promptly enrolled with the accurate effective date of eligibility in accordance with the

		approved State Plan. - Outcome Attestation - Possibly: Test results (automated if possible) verifying that the system sets eligibility effective date according to state policy (pass/fail) - Demonstration of process for assigning correct effective dates in sub-production environment (pass/fail) For states, District of Columbia, Northern Mariana Islands, and American Samoa: - 42 CFR 435.915 For Guam, Puerto Rico, and the Virgin Islands: - 42 CFR 436.901
EE25	The system receives and responds to requests from the FFE in real-time to confirm whether an individual applying for coverage through the FFE currently has Minimum Essential Coverage through Medicaid or CHIP.	- Outcome Attestation - Possibly: Test results (automated if possible) verifying that the system receives and responds to requests from the FFE for MEC check in realtime (Pass/fail) Exhibit 59: FX Core Outcomes and Metrics Core IAPDU Costs For states, District of Columbia, Northern Mariana Islands, and American Samoa: - 42 CFR 435.1200
PM1	Application A provider can initiate, save, and apply to be a Medicaid provider.	- Number of requests to help desk for problems with initiating, saving, and applying. - Average time to enroll from point of submit. a. Total time to enroll all providers/ b. Total # of enrolled providers 42 CFR 455.410(a)
PM2	Screening A state user can view screening results from other authorized agencies (Medicare, CHIP, other related agencies) to approve provider if applicable.	- Average Time to screen providers upon initial application without Return to Provider time. (Total time to screen all providers – RTP time)/Total # providers screened - Average Time to screen providers upon initial application with Return to Provider time included. Total time to screen all providers/Total # providers screened 42 CFR 455.410(c)
PM3	Screening 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.	- Number of enrollment denials and reasons for denials. - Average Time to screen providers upon initial application without Return to Provider time (Total time to screen all providers – RTP time)/Total # providers screened - Average Time to screen 42 CFR 455.412 Florida Medicaid Management Information System Implementation Advance Planning Document Update: FX/FMMIS Transition Page 91 of 100 Reference CMS Required Outcomes Metrics Regulatory Sources providers upon initial application with Return to Provider time included Total time to screen all providers/Total # providers screened - Average Time to credential

		providers Total time to credential providers/Total # of credentialed providers
PM4	Revalidation The system tracks the provider enrollment period to ensure that the state initiates provider revalidation at least every five years	. - Number of providers scheduled for revalidation by year. (Total # of providers in Medicaid) - Percentage of providers enrolled in the state system that are in the CMS Adverse Actions List. - # of state providers enrolled that are on the CMS Adverse Actions List/ - # state providers enrolled 42 CFR 455.414
PM5	Termination 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).	Number of providers denied enrollment or termination of participation with reason. Provide denial or termination reason. 42 CFR 455.416
PM6	Reactivation 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	. - Number of providers seeking reactivation and TAT for enrollment. - Number of providers seeking reactivation with submittal of payment and TAT for enrollment. 42 CFR 455.420 PM7 Appeal 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. - Number of provider (by provider type) appeals and status of appeal: include TAT to final determination.
PM8	Site Visits A state user can manage information for mandatory pre-enrollment and postenrollment site visits conducted on a provider in a moderate or high-risk category.	- Number of providers scheduled for site visit categorized by moderate and high risk. - Number of Providers with past due site visits. Include number of days past due FR 455.432(a)
PM9	Background Checks A state user can view the status of criminal background checks, fingerprinting, and site visits for a provider as required based on their risk level and state law.	- List of providers in pending status due to checks listed in outcome. Provide screen shots of high-risk providers. - Number of provider enrollments in process listed by outcomes check and status of outcome check and duration for each check. For example: 10 providers undergoing background checks. Aging range from 1 -10 days. 42 CFR 455.434
PM10	External Systems Checks 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.	- Number of providers in pending status due to other database confirmations. Include the reason for pending. For example: # of providers pending for NPPES verification or mismatch and or # of providers found in the Death Master File - Number of providers by provider type found in the Death Master File and the enrollment status of each 42 CFR 455.436

PM11	Risk Level Assignment 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.	- Include provider state Medicaid status 42 CFR 438.608(a) entity due to: - Change in state residence - - Number of providers in each category by category for each new application, reenrollment/revalidation - Number of providers with changes from moderate to high due to payment suspension or moratorium 42 CFR 455.450 Investigation of FWA - Death - Others as defined by state
PM12	Application Fees The system can collect application fees. A state user ensures any applicable application fee is collected before executing a provider agreement.	- Total number of providers in the network, # of providers in pend status due to lack of application fee, # of providers denied due to lack of application fee payment - Aging report of number of providers with lack of application fee payment in enrollment pend status 42 CFR 455.460
PM13	Moratoria A state user can set CMS and state-imposed temporary moratoria on new providers or provider types in six-month increments.	- Number of providers in temporary moratoria status and duration range - Number of providers in temporary moratoria outside of 6 months 42 CFR 455.470
PM14	Network Adequacy A state user can determine network adequacy based upon federal regulations and state plan.	- Network adequacy is already reported on 42 CFR 438.68
PM15	Sanctions and Terminations 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.	- Provider enrollment stats for providers in pend and denied status due to sanction and or pending sanction and Medicare information. 42 CFR 455.416(c)
PM16	Notices and Communications The system can generate relevant notices or communications to providers to include, but not limited to, application status, requests for additional information, reenrollment termination, investigations of fraud, suspension of payment in cases of fraud.	- Provide a copy of relevant notices and communications submitted to providers for each outcome category. 42 CFR 455.23
PM17	Fraud A state user can report required information about fraud and abuse to the appropriate officials.	- Number of open FWA investigations by provider type and status (This may already be submitted by states) 42 CFR 455.17 Florida Medicaid Management Information System Implementation Advance Planning Document Update: FX/FMMIS Transition Page 94 of 100 Reference CMS Required Outcomes Metrics Regulatory Sources
PM18	Payment Suspension The system, or a state user, can suspend payment to providers in cases of fraud.	- Number of providers in suspend status due to fraud include reasons and aging by provider type 42 CFR 455.23
PM19	Agreements and Disclosures A state user can view provider agreements and disclosures as required by federal and state regulations. - These are related to ownership regulations.	- Number of providers identifying as one or more of the ownership relationships. List by ownership relationship type 42 CFR 455.104 42 CFR 455.105 42 CFR 455.106 42 CFR

		455.107
PM20	Change in Circumstances 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.	- List of providers by provider type who have been released from the managed care
PM21	Directory A beneficiary can view and search a provider directory.	. - Number of help desk tickets logged for inaccessibility to provider directory. - Number of website hits on provider directory page.
PBM1	The system adjudicates claims within established time parameters to ensure timely pharmacy claims payments.	- Timely adjudication of pharmacy claims and encounters. - Percentage of claims paid on time (only if payment is included in Rx module) – N/A Florida - N/A if payments are issued from the MMIS system. Note: The legacy FMMIS generates the payment. Section 1927(h) of the SSA 42 CFR 456.722 - POS requirement to support claims adjudication or payment
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.	- Accurately identifies enrolled providers. - Pharmacy claims and encounters are priced according to the correct pricing algorithm. 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.	- The system has the capability to accept/store/apply the rebate and covered outpatient drug (COD) information received from CMS and manufacturers necessary to generate rebate invoices. - Timely identification of eligible PAD claims/encounters that do not convert to NDC units. 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.	- Percentage Rebate Invoiced per Dollar (Note if invoice period is behind the actual reporting period). - Issue timely invoicing within established parameters (+/- 5 days). 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. - Provide a sample of the CMS rebate report and the manufacturer rebate report with production data.	- Provide the post-production operational measure of rebates collection. Section 1927 of the SSA 42 CFR 447.520 Section 1927(b)(2) of the SSA 42 CFR 447.511 Florida Medicaid Management Information System Implementation Advance Planning Document Update: FX/FMMIS Transition Page 97 of 100 Reference CMS Required Outcomes Metrics Regulatory Sources

PBM6	The system enables the beneficiary to have timely access to medication if the system has the capability to perform prior authorization and provide a response by telephone or other telecommunication devices within 24 hours of a request and provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (unless excluded under the SSA).	- Timely Access: Response to a Prior Authorization request provided within 24 hours. - Timely Access: Emergency 72-hour fill requests reject rate - this can be the % of total POS claims not authorized with a 72-hour emergency fill. Section 1927(d)(5) of the SSA
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.	- Provide a copy of the State's DUR Report 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.	- Provide a sample report showing the ability to provide prospective review data with a timestamp prior to adjudication. 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.	- Provide a sample report of post-production operational measures that calculate the average cost avoidance per claim. 42 CFR 456.703, 456.705(b) 456.709 Section 1927 (g) of the SSA Exhibit 63: PBM Outcomes and Metrics
SSO1	The Pharmacy Benefit Manager (PBM) module will provide accurate and timely processing of pharmacy claims utilizing fully transparent pricing and payment methodologies as determined by the Florida Medicaid Program.	
SSO2	TBD The Pharmacy Benefit Manager (PBM) module will improve the accuracy and timeliness of the acquisitions and integration of pharmacy encounter data.	
SSO3	TBD The Pharmacy Benefit Manager (PBM) module will evaluate the overall administrative and pharmacy benefit costs by comparison of the Florida Medicaid fee-for-service delivery system to the Statewide Medicaid Managed Care (SMMC) plans' targeted utilization management tools.	
Reference #	**State Specific Outcomes**	**Metric (s)**
DSS/DW3	The solution supports understanding of patient health events related to chronic conditions, management of which may reduce risk of, or impact from, other serious illnesses.	Generate detailed reports or dashboard including statewide rates for the following HEDIS measures: - Hemoglobin A1c Control for Patients with Diabetes -Eye Exam for Patients with Diabetes -Blood Pressure Control for Patients with Diabetes -Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

DSS/DW4	The solution supports understanding of the delivery of healthcare services through a holistic view of data.	The EDW solution provides data on psychiatric treatment for enrollees under 21 and prenatal services, understanding the management of which will impact healthcare coverage and delivery business decisions. Metric results include: -Statewide rate for the Use of FirstLine Psychological Care for Children and Adolescents on Antipsychotics HEDIS measure. -Sub-measures for the Prenatal and Postpartum Care HEDIS measure. - Statewide Rate for Timeliness of Prenatal Care. - Statewide Rate for Postpartum Care.
DSS/DW5	The solution supports reduction of overpayments	Generate pre-defined PI/SURS reports or dashboard to support analysis of provider outlier information.
DSS/DW6	The solution assists in the identification of service misutilization.	Generate pre-defined PI/SURS reports or dashboard to support analysis of service misutilization.
DSS/DW7	The solution supports more efficient reporting.	Report and metrics on progress of transforming the CMS-64 from an all manual effort to an automated report.
DSS/DW8	The solution supports reliable data analytics in the Medicaid program.	The EDW solution replicates data from the source system (FMMIS) to ODS. The EDW solution generates an aggregate number of records that do not comply with the selected data quality checks.
DSS/DW9	The solution is well-positioned to support future business needs by being extensible, accurate, and highly available.	Generate reports demonstrating the solution maintains performance metrics for being extensible, accurate, and available.
FT1	FMMIS Transition services support the transition of legacy services and components to FX modules.	Enhanced research and documentation services provided to support module activities.
FT2	FMMIS Transition services minimize risk for the Agency, IS/IP Vendor, and FX vendors for transition activities.	Project plans provided for each turnover iteration as well as supplemental turnover plans specific to the FX module that is replacing the FMMIS functionality.