MEDICAID ENTERPRISE SYSTEMS (MES) IMPLEMENTATION ADVANCE PLANNING DOCUMENT UPDATE

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

State of Florida
Agency for Health Care Administration
Division of Medicaid

October 2024

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Date of Submission to CMS Regional Point of Contact: October 24, 2024

CHANGE RECORD

Date	Author	Version	Comments
July 2020	A. Ramsey	Draft	FX 2020 – Transition IAPD
5/9/2022	R. Lasseter	100	Quality Review
5/11/2022	A. Ramsey	FL-2022-06-06-MMIS-IAPDU-MES FX Program	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
2/17/2023	S. Stacknik	FL-2023-03-10-MMIS-MES-IAPDU-FX Program	FX 2023 Update #2 – IAPDU Updates: ➢ Updated FX office lease cost ➢ Revised FX Roadmap ➢ Updated FX Leadership / dedicated state resources ➢ Schedule updates, including increased EDW DDI / stabilization period ➢ Revised budget request through FFY 2025 ➢ MES Business Architecture/Certification Vendor request ➢ Enterprise Penetration Testing planning ➢ FX module and procurement updates
2/16/2024	S. Stacknik	FL-2024-02-28-MMIS-MES-IAPDU-FX Program	FX 2024 IAPDU: ➢ FX Core implementation pause ➢ Revised FFY 2024 and 2025 budget ➢ FMMIS Transition Project update

			➢ Module project updates ➢ Revised FX Roadmap
6/25/2024	S. Stacknik	FL-2024-06-25-MMIS-MES-IAPDU-FX Program	FX Program June 2024 IAPDU: ➢ Revised FX Strategic Roadmap ➢ SEAS Vendor contract update ➢ Management Consulting procurement scope of work ➢ FX Organizational Structure update ➢ FX Governance Structure update
10/24/2024	S. Stacknik	FL-2024-10-24-MMIS-MES-IAPDU-FX Program	FX Program October 2024 IAPDU: ➢ FFY 2025 and 2026 budget request ➢ FX contract amendments for scope and budget (EDW, UOC, PSM) ➢ Office space and staffing update ➢ FMMIS Transition Integration Projects ➢ Program Integrity claims sampling project ➢ Revised project schedules ➢ Revised outcomes and metrics for FMMIS Transition; new outcomes and metrics for the FX Program Support Services contracts

1. Executive Summary

This Implementation Advance Planning Document Update (IAPDU) provides the Centers for Medicare and Medicaid Services (CMS) with an update for the Florida Health Care Connections (FX) /Florida Medicaid Management Information System (FMMIS) Transition Program, hereinafter referred to as the FX Program. Enhanced Federal Financial Participation (FFP) for Federal Fiscal Years (FFYs) 2024 and 2025 was approved in CMS letter number FL-2024-02-05-MMIS-IAPDU-FX, and the most recent IAPDU was approved in CMS letter number FL-2024-06-25-MMIS-NHC-IAPDU-FX.

FX is a multi-year program to modernize Medicaid technology using a modular approach to improve overall functionality and build better connections to other data sources and programs. The components of FX will replace the current functions of the FMMIS, Decision Support System (DSS), and other Medicaid Enterprise Systems (MES). Ultimately, the systems will transition to an interoperable and unified FX where individual processes, modules, and sub-systems work together to support Florida Medicaid.

This IAPDU provides the revised budget request for FFY 2025, and requests funding for FFY 2026. The budget request includes an increase for state staffing for the FX Program and requests approval to procure additional office space for state staffing. This IAPDU does not include any significant changes to project milestones.

The IAPDU budget request represents a change in previously approved funding by the following:

- FFY 2025, Line 2AB (90%) decreased by ($8,500,813), for a new total of $86,761,188.
- FFY 2025, Line 2AB (75%) decreased by ($342,123), for a new total of $1,693,623.
- FFY 2025, Line 2AB (50%) increased by $5,000, for a new total of $67,500.
- FFY 2025, Line 4AB (75%) decreased by ($14,107,805), for a new total of $8,835,836.
- FFY 2025, Line 5AB (50%) decrease by ($7,145,281), for a new total of $4,011,007.
- FFY 2026, Line 2AB (90%) increased by $111,247,274, for a new total of $111,247,274.
- FFY 2026, Line 2AB (75%) increased by $1,693,623, for a new total of $1,693,623.
- FFY 2026, Line 4AB (75%) increased by $24,417,942, for a new total of $24,417,942.
- FFY 2026, Line 5AB (50%) increased by $11,528,393, for a new total of $11,528,393.

In sum, the Agency requests a ($30,091,022) net decrease in federal funding for FFY 2025 ($42,992,480 net decrease in total state and federal funding) and a total $148,887,232 increase in federal funding for FFY 2026 ($181,480,288 net increase in total state and federal funding).

Revised scope of services is provided for the Enterprise Data Warehouse (EDW), Unified Operations Center (UOC), Provider Services Module (PSM), and FMMIS Transition project. Corresponding contract amendments for the EDW, UOC, PSM, and FMMIS vendors that align to the revised budget and scope will be submitted to CMS for review. As part of the EDW Vendor scope change, the FX Program requests approval to initiate a Medicaid Program Integrity claims sampling project with the EDW Vendor to support fraud and abuse detection.

In support of the above requests, the Agency is providing **Attachment I** - Outcomes and Metrics for the FX Program components.

The Florida FX Program will continue to report progress, changes in planning and DDI activities, and request FFP through the federal APD process and the regularly held meetings with our CMS 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 plans to implement the components of FX by using a phased approach to replace the current functions of the Fiscal Agent, FMMIS, DSS, and other MES systems based on CMS conditions and standards. 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 Agency's FX Vision is to "Transform the Medicaid Enterprise to provide the best value, highest quality health care to Floridians." The FX Guiding Principles, identified in the chart below, must be adhered to if the FX Vision is to be achieved.

Exhibit 1: FX Guiding Principles

The FX Guiding Principles also support CMS' Medicaid Information Technology Architecture (MITA) Goals and Objectives. The FX Guiding Principles are supported by Strategic Priorities, which define the areas of practical importance to achieve the FX Vision. The FX Strategic Priorities are provided in the exhibit below.

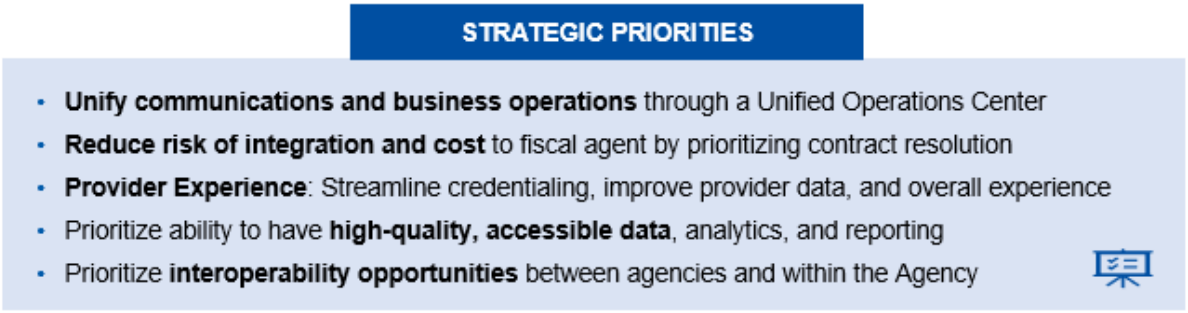

Exhibit 2: FX Program Strategic Priorities

3. Project Scope

The future-state transformation is a four-phased strategy that builds on work completed in Phases 1 and 2 of the original FX Procurement Strategy, which was initiated in 2016. Phases 2 and 3 have been updated to align with the FX Strategic Plan. These phases are overlapping and will be executed concurrently. The current MES components may remain as part of the MES or integrate with other MES components or an FX module. This transition will be

accomplished through the Integration Services / Integration Platform (IS/IP) Vendor. Phase 4 includes implementation of modules not included in the legacy Fiscal Agent contract to upgrade, modernize, and replace the functions performed by existing systems within the MES such as third-party liability and enterprise case management. The FX Program is organized into four phases as shown below.

#	Phase	Component/Module
1	Professional Ongoing Services	• Strategic Enterprise Advisory Services (SEAS) • Independent Verification and Validation (IV&V) Services • FX Support Services
2	FX Infrastructure	• Integration Services and Integration Platform (IS/IP) • Enterprise Data Warehouse (EDW)
3	FX Modules to further the FMMIS/DSS/Fiscal Agent Contract Resolution	• Unified Operations Center (UOC) • Core (Claims / Encounter / Financial / Reference Management / Recipient Data /Necessary TPL Data) • Provider Services Module (PSM) • Pharmacy Benefits Management (PBM) and Pharmacy Services
4	Additional Medicaid Enterprise Systems	• Planning, analysis, and procurement for modules not included in the Fiscal Agent contract, to upgrade, modernize, and replace the functions performed by existing systems within the Medicaid Enterprise

Exhibit 3: FX Program Phases

On December 14, 2023, the FX Executive Steering Committee (ESC) met and voted on a decision to pause the FX Core module implementation for at least twelve months until the Unified Operations Center (UOC) recipient and provider services and Provider Services Module (PSM) are implemented. The Agency is in the process of renewing the legacy FMMIS contract through December 31, 2027, as recommended by the Florida Legislature during the 2024 legislative session and authorized by the (Florida) Implementing the 2024-2025 General Appropriations Act. The legacy FMMIS Vendor will provide Core services until a replacement solution is provided by the FX Program.

Florida created an FX Core Pause Impact Analysis and Planning Project to analyze the impacts of the decision to pause the Core module implementation and to identify the risks, issues, and make recommendations that inform decision-making to ensure continued Medicaid business continuity and FX transformation progress. The project team analyzed the existing FMMIS contract and FX Core contract to identify any dependencies and gaps that may occur during the legacy extension by the FX Core Vendor. The project team documented a transition plan for each impacted area and made recommendations to ensure the continuity of business functions. The project team assessed the business and technology impacts resulting from the pause in the Core module implementation, including assessments on future FX module implementations. Finally, the project team evaluated future state options for the business services conducted by legacy FMMIS.

The FX Core Pause Impact Analysis and Planning Project Charter was approved by the Medicaid Director on February 14, 2024. The assessment was completed at the end of June 2024. The results of the assessment are helping to inform decisions for the FX Core Project. The project team documented the FMMIS current state technical pain points and recommended

that the legacy FMMIS Vendor and the FX Program pursue FMMIS Transition Integration projects. The selected projects were selected to reduce risk for FMMIS integration with FX module releases and continuity of operations through the FMMIS contract end date of December 31, 2027.

The Florida Legislature did not provide funding to the FX Program for state fiscal year 2024-2025 (July 1-June 30) to continue the FX Core implementation. The Agency will resume FX Core implementation activities on July 1, 2025, or later, contingent on state funding authority. The Agency will continue planning efforts and make decisions related to the FX Core solution during state fiscal year 2024-2025.

A visual depiction of the FX implementation strategy, revised June 2024, is provided below. The Agency, in collaboration with FX module vendors, completed a replanning effort to review and align FX milestones with the 2024 Florida legislative session outcomes, FX transformation progress, Agency resource capacity, FX Vision, Guiding Principles, and Strategic Priorities, and the Agency Mission, Vision, and priorities. The changes align to the approved state funding for the FX Program during state fiscal year 2024-2025 and allows time for the Agency to hire and train additional state staff for the FX Program. Additionally, this allows time for the Agency to implement requirements by the state legislature such as creating new contract oversight teams, establishing program finance, contract, and stakeholder working groups, revising the FX Governance structure, complying with additional reporting requirements, executing contracting process changes, and addressing all recommendations made by the independent FX Special Assessment Team. Significant level of additional effort, estimated at 5,000+ hours, will be required for the FX Program team to implement the state legislative changes and onboard new staff.

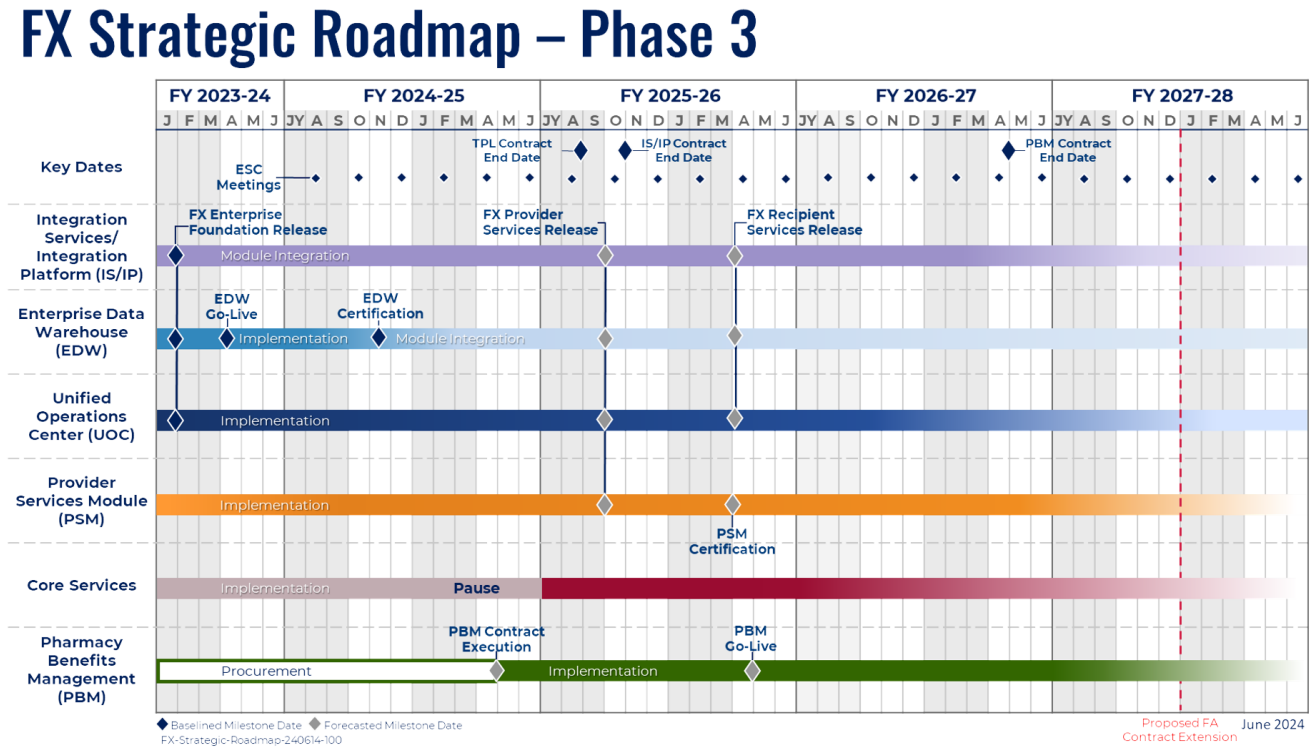

Exhibit 4: FX Strategic Roadmap

A major milestone change includes delaying the Provider Services Module (PSM) implementation originally planned for October 2024 to October 2025, now November 2025. The Unified Operations Center (UOC) Provider Services Release and Module Integration project for Provider Services are shifted to align with the PSM go-live. The focus on provider services will allow the Agency to achieve the FX Strategic Priority of improving provider experience and reducing the administrative burden for enrollment, licensure, and credentialing.

The other major milestone change is delaying the FX Recipient Services Release originally planned for May 2024 to April 2026, now May 2026. This allows the FX Program to prioritize the FX Provider Services release and avoids the risk of recipient release overlap with Statewide Medicaid Managed Care (SMMC) re-procurement implementation. During SMMC implementation recipients will be enrolled in new SMMC plans. The FX Program proposes to avoid the risk of increased call center activity at the same time as the FX UOC recipient solution is implemented. In the interim, recipients will continue to receive stable and proven customer service from the legacy vendor.

As described above, the FX Core implementation is on hold pending state funding and project decisions. The Florida Legislature also did not provide funding to the FX Program for state fiscal year 2024-2025 for Pharmacy Benefits Management (PBM). However, FX Program state staff and staff augmentation resources will continue planning efforts to utilize the National Association of State Procurement Officials ValuePoint competitively solicited multi-state PBM module contract.

4. Project Management

4.1 Project Management Standards

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

Each FX project has an approved project management plan based on a standard template designed to facilitate compliance with the FX Project Management Standards. These standards are based on the best practices and guidelines promoted by the Project Management Institute (PMI) in its Project Management Body of Knowledge (PMBOK®) and PMI's Standards for Program Management. The FX Project Management Standards for risk management includes 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.

The FX Program uses a portfolio management process through which projects are evaluated and prioritized for their ability to achieve the strategic objectives of FX. The FX Strategic Plan identifies the strategy for the Medicaid Enterprise System transformation.

The FX Governance structure facilitates escalated project decision-making at the most appropriate level of management. As FX Governance approves projects identified to achieve the FX strategy, they are managed and/or monitored by the FX Enterprise Program Management Office (EPgMO) at the project-level, integrated at the program-level, and monitored through project close out. Each project within the FX Portfolio follows the FX standards and plans, provided in the exhibit below.

The FX EPgMO provides direction and oversight for approved FX projects and is staffed by a team of experienced project and program managers who establish, maintain, and uphold standards for the management of FX projects. The standards are complemented by process definitions, tools, templates, and mentoring. The monitoring duties of the FX EPgMO include program-wide status reporting; schedule management, change, risk, action item, issue, decision, and lessons learned management, and quality management.

FX Program Standards and Plans	
Standard / Plan	**Description**
FX Governance Plan	Defines the governance structure and processes to enable effective and efficient advancement of FX.
FX Strategic Plan	Serves as an iterative strategy and concept of operations that will continually guide the Agency's transition to a modular technical environment.
Strategic Project Portfolio Management Plan	Develops a documented plan for the identification, categorization, evaluation, selection, and prioritization of projects to accomplish the Agency's FX Program strategies, while balancing conflicting demands by allocating resources based on the Agency's priorities and capacity.
FX Project Management Standards	Establishes the standards for management of FX projects, leveraging the existing Agency, state, and industry standard project management standards and tools.
FX Project Management Toolkit	Complements the FX Project Management Standards by providing project management training materials and corresponding tools and templates.
Medicaid Enterprise Certification Management Plan	Provides an overall plan to manage the MES Certification life cycle for each applicable FX module outlining the steps for the Agency to conduct and comply with the Streamlined Modular Certification process.
Data Management Strategy	Develops and establishes the Data Management Strategy that aligns with the approach defined in the MITA 3.0 Part II Information Architecture – Chapter 2 Data Management Strategy. The Data Management Strategy is the product of discovery, stakeholder input, strategic analysis, program strategy, and direction about techniques and priorities to support overall improvement of FX outcomes.
Information Architecture Documentation	Provides the iterative documentation through the implementation of the modularized solution. Its primary purpose is to serve as the guiding principles of the overall data strategy for the system and the assessment of the business areas level of maturity within that data strategy.
Data Standards	Develops and establishes the Data Standards as per MITA 3.0 Part II Information Architecture – Chapter 5 Data Standards. The Data Standards are the product of discovery, stakeholder input, strategic analysis, program strategy and direction about techniques and priorities to support overall improvement of FX outcomes.

FX Program Standards and Plans	
Standard / Plan	**Description**
Technical Management Strategy	Develops and establishes the Technical Management Strategy that aligns with the approach defined in the MITA 3.0 Part III Technical Architecture – Chapter 2 Technical Management Strategy. The Technical Management Strategy is the product of discovery, stakeholder input, strategic analysis, program strategy and direction about techniques and priorities to support overall improvement of FX outcomes.
Technical Architecture Documentation	Establishes the framework for the Business Services, Technical Services, Application Architecture, and Technical Capability Matrix (TCM) for the enterprise per the MITA 3.0 standards.
Technology Standards	Establishes the Technology Standards Reference Model (TSRM) and the Technology Standards Reference Guide (TSRG) for the enterprise per MITA 3.0 standards. The Technology Standards Reference Model (TSRM) is the common technology vocabulary that organizes, and groups related technology components standardizing the names and descriptions of those components. The Technology Standards Reference Guide (TSRG) is a repository of standards relevant to technology components that identifies and prioritizes the relevance of specific technology standards in the enterprise.
Design and Implementation Management Standards	Establishes guidance and management procedures to establish a uniform, enterprise approach based on industry standards for Requirements Development, Design, Development and Integration, Testing, Change Management, and Implementation activities.
Enterprise Data Security Plan	Provides the iterative documentation through the implementation of the modularized solution. The primary purpose is to serve as the guiding principles of the enterprise data security for the systems and vendors that are involved in the procurement, implementation, and operation of the FX.
FX EPMO Charter and Program Management Plan	Charters the FX EPMO and establishes the guidelines and operational processes by which the FX EPMO shall manage and/or monitor FX projects assigned by FX Portfolio Management.

Exhibit 5: FX Program Standards and Plans

The Risk Management Plan component of the FX Project Management Standards includes 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.

4.2 Organizational Change Management

The Agency created an Organization Change Management (OCM) team composed of state staff and contracted staff augmentation to analyze, strategize, and plan critical organizational and workforce transitions in a phased approach during the transition to FX. The funding request for OCM is included in the funding request for state staffing and staff augmentation. FX module vendors are also required to provide OCM services to adhere to the FX OCM Standards. The Agency is contracting with a vendor to provide an OCM

Center of Excellence by integrating FX module vendors' OCM activities into a unified center. Please refer to Section A.6. FX Program Support Services for additional details.

The Agency developed FX OCM Standards and published the new standards in November 2022. The OCM Standards represent a repeatable set of processes and templates developed to ensure consistent change management implementations. The Agency OCM Standards are included in FX standards and are to be adhered to by FX vendors and Agency resources. This standardization facilitates integration of OCM with the larger FX program to best facilitate the management of people impacts across FX project implementations. OCM promotes ongoing employee and stakeholder engagement and provides customized change management plans and reusable tools to assist with successful long-term results. OCM assists with better integration across modules and other FX activities and creates a more standardized approach with acceptance criteria, clearer requirements, and similar expectations on outputs and deliverables across FX OCM.

The scope of FX OCM has the following components:

- **Stakeholder Coordination** focuses on working with each impacted stakeholder group, both internal and external to the Agency, to understand and be engaged with the change.
- **Communications** support OCM efforts to build understanding and drive adoption of the changes being made.
- **Training** provides the necessary knowledge, skills, and abilities to identified stakeholders to be successful in a new environment.
- **Organizational (Re) Design** determines how the structure and workforce will be organized to support business functions in the new environment.
- **Implementation Logistics** entails assessing the business operations' readiness for the impending changes.

The UOC implementation will transform the enterprise Medicaid customer service operations in the State of Florida. Organizational Change Management brings the people, process, and technology together to build and execute the transformational 'people' changes. The FX module vendors have been working with the Modular Integration team to lead the Agency through work sessions to discover current state, define future state vision, detail end-to-end business processes, and decomposed workflows that describe the customer and provider experience. The FX Program OCM team facilitates integrated dynamic Organizational Change Management services across the multi-vendor FX

software releases to integrate all change impacts, consolidate integrated people, process, and technology training and communication needs across FX module technology stacks for a unified messaging.

4.3 Program Key Dates

The FX Master Program Schedule includes all individual project schedules for FX module projects. Project work is subject to spending authority and funding release by the Florida Legislature and approval from CMS for enhanced FFP.

The Master Program Schedule is updated weekly using the individual FX project schedules. The Master Program Schedule as of October 17, 2024, is included as **Attachment II.** A high-level program milestone chart is provided in the exhibit below. The Agency continues to submit the monthly project status report to CMS as required by the federal approval conditions for FFP.

Project	Milestone	Status
Core	Core Implementation Pause Decision	12/14/2023
Core	Resume Core or initiate Core Procurement Project	7/1/2025
EDW	Stabilization Iterative Release 1	10/10/2023
EDW	Stabilization Iterative Release 2	2/1/2024
EDW	Stabilization Iterative Release 3	3/14/2024
EDW	FX EDW Solution Go-Live	4/9/2024
EDW	Execution Phase Complete	5/16/2024
EDW	Close Out Phase Complete	5/31/2024
EDW	EDW Certification	1/2025
PSM	Project Charter Complete	2/9/2024
PSM	Project Schedule Complete	10/2024
PSM	Planning Phase Complete	10/2024
PSM	Design and Development Complete	3/2025
PSM	Initiate Go-Live	11/2025
UOC	FX Enterprise Foundation Release Complete	2/26/2024
UOC	Service Desk Pilot Release	12/2024
UOC	Provider Services Release	11/2025
UOC	Service Desk Operational Release	6/2025
UOC	Recipient Services Release	5/2026

Exhibit 6: FX Program Upcoming Milestones

4.4 Project Organization

The FX Program is staffed by a combination of state employees 100% dedicated to the FX Program, contracted staff augmentation resources, and state employee subject matter experts who dedicate a percentage of their time to FX projects. The FX Governance and Executive Steering Committee provides the structure and processes to facilitate the decision-making required for planning, procuring, and implementing FX solutions.

The Florida Legislature and Governor's office mandated that an independent Special Assessment Team provide an assessment of the FX Program. The team determined that

the FX Program was understaffed and recommended 47 additional state resources to administer, manage, and perform work for the FX Program. Beginning with the state fiscal year on July 1, 2024, these additional staff are funded by the Florida Legislature. The funding for these resources reflects the Florida Legislature's investment in the FX transformation and modernization program. The Agency has been planning for how to best utilize the resources and decided to create additional management positions to lead new staff and develop the structure and procedures to comply with the legislative conditions imposed on the Agency with the state fiscal year 2024-2025 funding authority.

The organizational chart is provided below to represent the Agency leadership resources associated with the FX Program. The structure creates additional lead and staff positions to support FX Program finance, procurement, contracting, vendor management, portfolio management, program management, project management, OCM, certification, knowledge and training, data governance and management, solution implementation, solution integration, testing, and business and technical architecture. The status of hiring for the additional positions is provided below in Section 4.6 State Personnel Resources.

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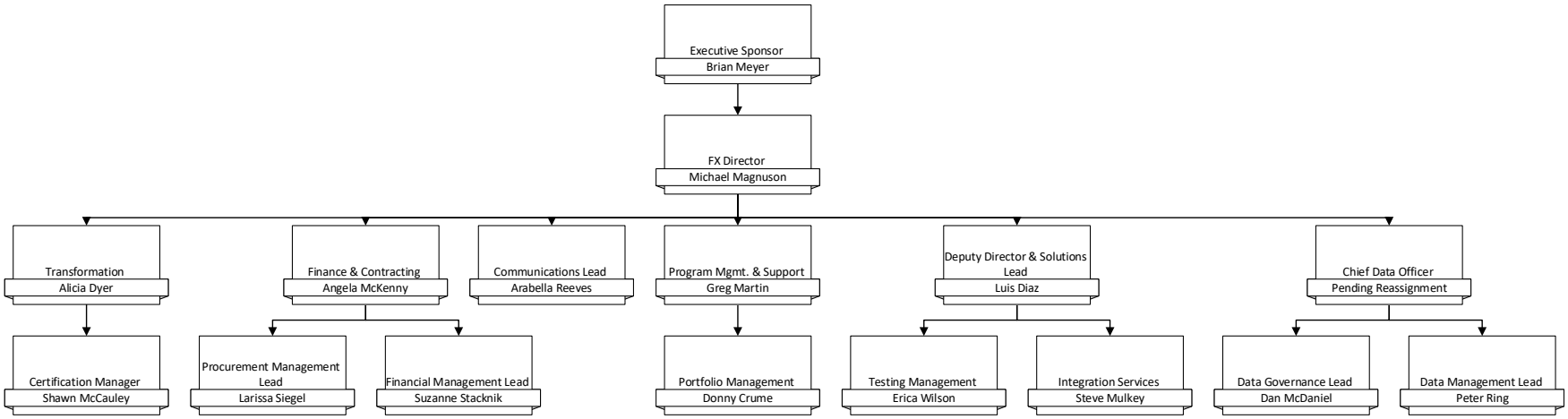

Exhibit 7: Project Organizational Chart

4.5 FX Governance

The Florida Legislature mandated requirements for the FX Program that impacted the FX Governance structure. Effective July 1, 2024, the FX Program governance framework is made up of a governing body, new advisory working groups, and project execution teams. The FX Executive Steering Committee (ESC) and the Agency Secretary hold decision-making authority for the FX Program. Supporting the FX ESC are two new advisory working groups: the FX Program Finance and Contracting Working Group and the FX State Agency Stakeholder Working Group.

The FX Governance framework is divided into three discrete tiers of decision-making. Tier 1 is the FX Program execution level and is comprised of the FX Enterprise Program Management Office, Transformation Enablement Team, Continuing Oversight Teams, and Technology Teams including the Technology Standards Committee, Architecture Review Board, Enterprise Data Governance, and the Enterprise Release Group. Tier 1 enables projects to operate and resolve items independently and escalate decisions, changes, and other governance topics to Tier 2 and Tier 3 for awareness or approval.

The FX Enterprise Program Management Office is responsible for project, program, and portfolio management. The team is responsible for facilitating successful program and project delivery by enforcing and mentoring teams on the application of FX Program and project management standards, administering FX SharePoint, managing the integrated master program schedule and change, risk, action item, decisions, and lessons learned log, portfolio management, resource and capacity management, and compliance and administration including vendor management and program accountability.

The FX Transformation Enablement Team is responsible for organizational change management, program communications, MITA business architecture, and certification. The team provides oversight of and coordination with vendor modules.

The Agency established continuing oversight teams for each FX contract. The teams provide quarterly reports to the FX ESC summarizing the status of the contract, the pace of deliverables, the quality of deliverables, contractor responsiveness, and contractor performance.

The Technology Standards Committee (TSC) serves as a structure to define and communicate FX technology direction and provides approval on technology standard-related decisions. The TSC is responsible for creating specific rules to help identify new technologies and standards, approving or denying new Technology Standards Reference Model and Technology Standards Reference Guide list entries, and reviewing and approving or denying all technology standards.

The Architecture Review Board (ARB) serves as a single team of senior architects from the Agency, contracted staff, the EDW Vendor, the IS/IP Vendor, and FX module vendors. The ARB provides architectural perspectives and deep technical subject matter expertise on architectural issues related to information, integration, application, technology, and security. The ARB ensures technology alignment with business strategy and conformance to all business, information, and technology architectures by monitoring FX vendors' adherence to the FX technology standards. Architectural designs for components of systems that will become an integrated part of the FX must conform to the program

architecture to ensure that all components and technology decisions will lead to highly interoperable systems, components, information, and capabilities.

The Enterprise Data Governance (EDG) develops and implements standards, policies, and procedures to facilitate data quality improvement, management, and utilization across the FX Enterprise, proactively manage the enterprise data and analytics portfolio, individual data and information assets, data standards and specifications, and information life cycles, and develop technology standards recommendations and escalate to the TSC.

The Enterprise Release Group (ERG) manages and coordinates the release of software products. This includes planning, testing, and deploying software updates and new versions to various environments, such as development, staging, and production.

Tier 2 of FX Governance consists of two advisory groups, the FX Program Finance and Contracting Working Group, which replaces the previous Tier 2 Program Governance Group, and the FX State Agency Stakeholder Working Group. These working groups are responsible for developing and reviewing recommendations and advising the FX ESC.

The FX Program Finance and Contracting Working Group is chaired by the FX Director and focuses on financial and contractual aspects of FX. This group is responsible for reviewing the program status and all contract and program operations, policies, risks, and issues related to budget, reviewing spending plans and contractual obligations, developing recommendations to bring to the FX ESC, and reviewing all change requests that impact the program's scope, schedule, or budget related to contract management and vendor payments and submit those recommended for adoption to the FX ESC. Members of this group include the Strategic Roadmap Manager, project managers, risk managers, FX Continuing Oversight Teams, Office of the General Counsel, and contract administration.

The FX State Agency Stakeholder Working Group is chaired by the FX Executive Sponsor and focuses on broader program operations and stakeholder engagement that impact external agencies. The chair is responsible for escalating recommendations developed by the group. The State Agency Stakeholder Working Group is comprised of representation from the FX Executive Sponsor, State Chief Information Officer or designee, Department of Children and Families, Department of Health, Department of Financial Services, Agency for Persons with Disabilities, Department of Elder Affairs, and Florida Healthy Kids Corporation.

Tier 3 of FX Governance is the FX ESC and Agency Secretary. The FX ESC and the Agency Secretary hold decision-making authority for the FX Program. Voting members of the ESC includes the Agency Secretary or FX Executive Sponsor and six representatives from the Agency. The FX ESC has the overall responsibility for ensuring that the program to replace FMMIS and the Medicaid fiscal agent meets its primary objectives and must:
(1) identify and recommend to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives any statutory changes needed to implement the modular replacement to standardize, to the fullest extent possible, the state's health care data and business processes;
(2) review and approve any changes to the program's scope, schedule, and budget;
(3) review and approve any changes to the program's strategic roadmap;

(4) review and approve change requests that impact the program's scope, schedule, or budget recommended for adoption by the program finance and contracting working group;
(5) review recommendations provided by the program working groups;
(6) review vendor scorecards, reports, and notifications produced by the continuing oversight teams;
(7) ensure that adequate resources are provided throughout all phases of the project;
(8) approve all major project deliverables; and
(9) review and verify that all procurement and contractual documents associated with FX align with the scope, schedule, and anticipated budget for the program.

The revised FX Governance frameworks is illustrated in the exhibits below.

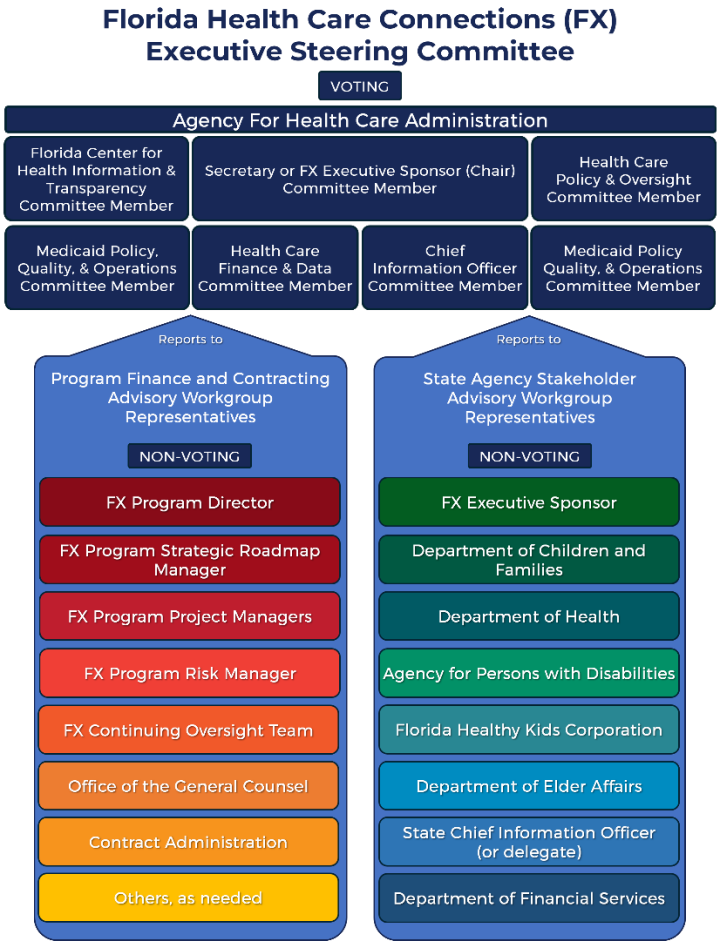

Exhibit 8: FX Executive Steering Committee

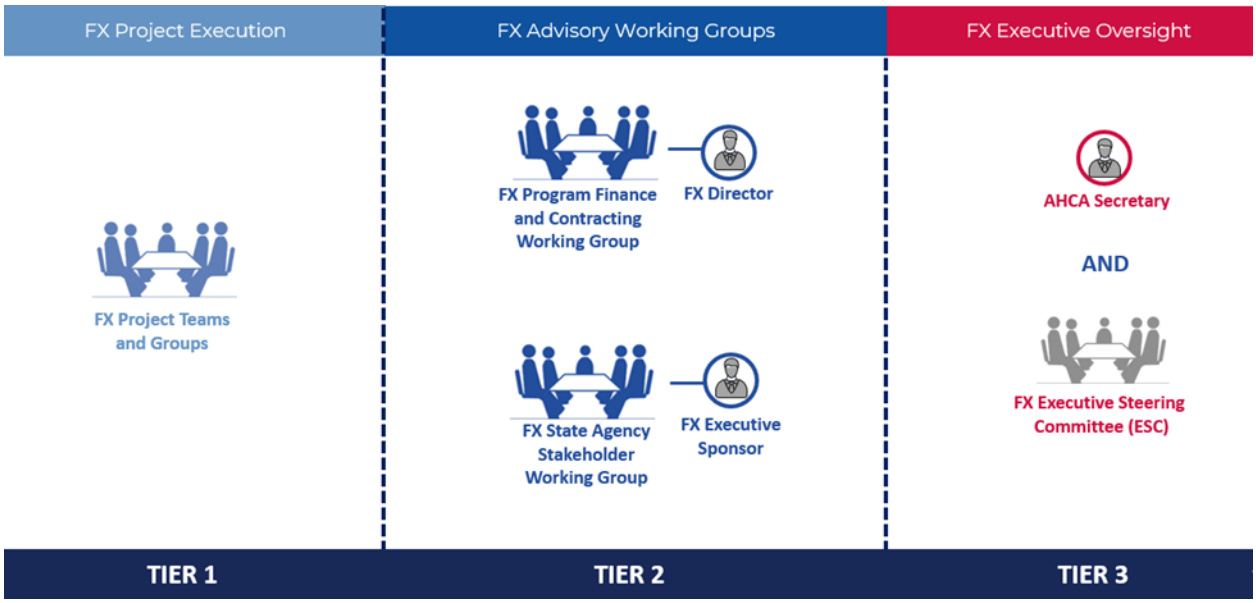

Exhibit 9: FX Governance Operating Structure

The FX Governance framework supports each phase of the FX Program. Each of the phases of the FX Program includes modules with specific objectives tied to business benefits of a more technologically advanced solution to support improved health care.

4.6 State Personnel Resources

The Agency has dedicated the personnel and resources necessary to assure successful transition of the FMMIS and DSS and implementation of the FX Program. The Agency has been providing resources for the FX Program by utilizing existing Agency staff, new hires, contracted staff augmentation, and FX vendor resources. Resources throughout the Agency provide subject matter expertise, work oversight, review of work products, recommendations, liaisons with all stakeholder groups, organizational design input, standards and guidelines toward vendor compliance, oversight of integration across the modules, and documentation of issues, risks, and decisions.

The Agency's Office of FX Program Administration (FXPA), under the leadership of the FX Director, administers the FX Program. FXPA is composed of multiple teams. The FXPA Compliance and Administration team manages the FX contracts and FX spend plan, develops funding requests, and performs human resource functions. The FXPA Project and Program Management team operates the Enterprise Program Management Office, performs project schedule and resource management, and manages state and federal project health reporting. The FXPA Solutions and Products team provides technical expertise, performs transition planning and implementation, and manages technical release. The FXPA Transformation team performs organizational change management, manages FX communications, outreach, and stakeholder engagement, administers ESC governance, performs business and MITA alignment, and manages CMS certification for FX modules. The FXPA Data Management team is responsible for data governance, data management, data quality, data policies and procedures, reporting and analytic portfolio management, and content management.

The Agency has built capacity within the Division of IT to support FX for systems integration and interoperability and support the Agency's FXNet and Application Lifecycle Management platform, as well as the enterprise network, disaster recovery coordination, cyber security, and job scheduling. Agency resources who support the legacy FMMIS contract will support the replacement FX modules as the modules are implemented and operational.

As described above in Section 4.4, the Florida Legislature and Governor's office mandated that an independent Special Assessment Team provide an assessment of the FX Program. The team determined that the FX Program was understaffed and recommended 47 additional state resources to administer, manage, and perform work for the FX Program. To fill the new and vacant positions, the FX Program must first formally reorganize the FX Program through the Florida Department of Management Services and secure additional office space. The reorganization requires changes to every position description for existing and new positions and completion of human resource forms to properly document the changes made. The FX Program has completed approximately 65% of this work effort. Additionally, to procure additional office space, the FX Program must work with the state leasing brokers to issue a competitive procurement. The procurement for additional office space is planned for March 2025. The proposed budget request for the additional space is provided below in Section 4.8 FX Program Office Space. In the interim, the FX Program has space for 10 additional staff at the existing office location.

The FX Program's guiding principle for additional staffing is to start with hiring the leadership positions first and then hire each next level of leads or staff with the help of the newly established leader. The FX Program will prioritize new hires based on the most understaffed areas which include contract management, budget support, and technical support. The FX Program created a blended salary rate representing the full compensation package with benefits for calculating the enhanced FFP request.

The following revised exhibits represent the costs for state staff for the FX Program for FFYs 2025 and 2026. The blended annual rate represents the average salary for state staff administering the FX Program and includes all benefits paid by the State of Florida. As module projects are implemented, such as the Enterprise Data Warehouse in April 2024, FFP is not claimed for state resources continuing to support modules in operations, apart from technical staff who perform systems operations qualifying for 75% FFP. FX business and technical SMEs report time worked on FX modules in the state's time tracking system for accurate enhanced FFP claims with CMS. State employee resources are approximately $990,000 FFP, per each FX module implementation project, for FFY 2025, and $1,450,000 FFP for FFY 2026, with fluctuations based on staffing vacancies.

State Staff	Project Phase	# FTE	Blended Annual Rate	Allocation	Federal	Federal Amount	State	State Amount
FX Dedicated	Planning, DDI	40	$ 116,334	100%	90%	$ 4,188,024	10%	$ 465,336
FX Business & Technical SMEs	Planning, DDI	50	$ 101,039	15%	90%	$ 682,016	10%	$ 75,780
FX System Operations IS/IP	M&O	5	$ 142,648	10%	75%	$ 53,493	25%	$ 17,831
FX System Operations EDW	M&O	5	$ 142,648	10%	50%	$ 35,662	50%	$ 35,662
Total FFY 2025						$ 4,959,195		$ 594,609

Exhibit 10: Cost of State Personnel Resources – FFY 2025

State Staff	Project Phase	# FTE	Blended Annual Rate	Allocation	Federal	Federal Amount	State	State Amount
FX Dedicated	Planning, DDI	62	$ 116,334	100%	90%	$ 6,491,437	10%	$ 721,271
FX Business & Technical SMEs	Planning, DDI	50	$ 101,039	15%	90%	$ 682,016	10%	$ 75,780
FX System Operations IS/IP	M&O	5	$ 142,648	10%	75%	$ 53,493	25%	$ 17,831
FX System Operations EDW	M&O	5	$ 142,648	10%	50%	$ 35,662	50%	$ 35,662
Total FFY 2026						$ 7,262,608		$ 850,543

Exhibit 11: Cost of State Personnel Resources – FFY 2026

The state purchases software licenses from the FX budget for use by state staff while they perform planning and DDI activities for the FX Program. Ownership of software licenses is retained by the state. Software tools include licensing for program and project management, certification, MITA business architecture, information architecture, technical architecture, job scheduling, and automated testing software. FX Enterprise software may include, but is not limited to, Microsoft Project online and Power BI (business intelligence), Hammerhead reporting tool, enterprise job scheduler, MITA Source Pulse, Microsoft Azure, Equinix, Palo Alto Next-Generation firewall, and Sharegate migration and governance solution for Microsoft. Refer to the FX Enterprise Hardware, Software Licenses, and Services – Initial, and FX Enterprise Software Licenses and Services – Renewal budget lines on Attachment II, FX Program Budget, for a summary of these costs.

The following chart, revised October 2024, represents the state resources 100% dedicated to the FX Program. As required by CMS conditions, the state personnel are identified by name, type, and time commitment assigned to each project. These resources work on multiple FX projects. The percentage of time spent on each FX projects varies from week to week and depends on whether the project is in the procurement phase, initiation, planning, or DDI. For example, after the EDW solution was implemented, resources rolled-off that project. Therefore, the chart below removed EDW as a project. Once the PBM solution is procured and DDI begins, more resources will be allocated to that project. Resources dedicated to Core are assigned to Core planning. Resources reflected under the FX Enterprise column perform state and federal financial management for the FX Program, certification activities, governance management, staff augmentation procurement, human resources activities for FX state staff, SharePoint and software maintenance, FX Enterprise contract management including SEAS, IV&V, and FX Program Support Services.

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FX Enterprise Dedicated State Resources							
Role/Position	**Name**		**Projects**				
		Enterprise	**Core***	**MI**	**PSM**	**UOC**	**PBM**
Program Director	Michael Magnuson	30%	5%	20%	20%	20%	5%
Implementation Lead, Deputy Program Director	Luis Diaz	0%	5%	30%	30%	30%	5%
Contracts, Procurements, Budget Lead	Angela McKenny	60%	5%	10%	10%	10%	5%
Project and Program Management Lead	Greg Martin	50%	0%	30%	10%	10%	0%
Change & Transformation Lead	Alicia Dyer	10%	0%	30%	30%	30%	0%
Enterprise Testing Lead	Erica Wilson	50%	0%	30%	10%	10%	0%
State and Federal Funding	Suzanne Stacknik	100%	0%	0%	0%	0%	0%
Contract Administrator	Larissa Siegel	55%	0%	5%	20%	20%	0%
Contract Administrator	Amber Sloniker	40%	0%	40%	10%	10%	0%
Contract Administrator	Dennise Sutton	40%	0%	20%	20%	20%	0%
Management Analyst	Heidi Fox	55%	0%	20%	0%	20%	5%
SharePoint Administration	Rebecca Lasseter	100%	0%	0%	0%	0%	0%
SharePoint Administration	Roger Newsome	100%	0%	0%	0%	0%	0%
Project Manager – Staffing	Josh Davis	100%	0%	0%	0%	0%	0%
Project Management	Matthew Bucci	40%	0%	20%	20%	20%	0%
Certification Lead	Shawn McCauley	75%	0%	10%	10%	5%	0%
Communications Lead	Arabella Reeves	70%	0%	10%	10%	10%	0%
Communications	Michael Brown	40%	0%	20%	20%	20%	0%
Solution Integration Lead	Steve Mulkey	30%	0%	25%	20%	25%	0%
Systems Manager	David Powers	0%	45%	15%	25%	15%	0%
Provider Lead	Michael Bolin	0%	0%	0%	70%	20%	10%
Data Management	Dan McDaniel	0%	0%	100%	0%	0%	0%
Data Management	Peter Ring	0%	0%	100%	0%	0%	0%
Systems Project Consultant	Fred Howell	0%	0%	50%	25%	25%	0%
Government Analyst / HR coordinator	Tayna Hand	100%	0%	0%	0%	0%	0%

* Represents Core Planning

Exhibit 12: FX Enterprise Dedicated State Resources

The following chart, revised October 2024, represents state subject matter experts who dedicate a percentage of their time to FX projects. SMEs with less than 5% FX hours during the most recent quarter are not displayed.

FX State Subject Matter Experts							
			Projects				
Role/Position	Name	%	Core*	MI	PSM	UOC	PBM
Information Security Manager / HIPAA Privacy Officer	William Armstrong	15%		✓	✓	✓	
Systems Project Consultant	Micheal Boston	27%		✓		✓	
Provider Analyst	Roberta Brewer	16%			✓		
Chief of Medicaid Recipient & Provider Assistance	Dietra Cole	13%				✓	
Chief of Strategic Information Technologies	Lori Freeman	6%		✓	✓	✓	
Data Processing Manager	Shaun French	43%		✓			
Field Office Manager - Recipient & Provider Assistance	Donald Fuller	5%				✓	
Medicaid Fiscal Agent Operations Manager	Lucy Gibson	9%	✓				✓
Medicaid Fiscal Agent Operations - Recipient Manager	Jennifer Giddens	6%				✓	
Medicaid Fiscal Agent Operations Manager	Pamela Gilman	11%				✓	
Chief, Medicaid Program Finance	Staci Griffis	40%		✓	✓	✓	
Medicaid Fiscal Agent Operations Manager	Janice Johnson	5%				✓	
Medicaid Fiscal Agent Operations - Provider Manager	Neil Kelly	14%			✓		
Data Management Administrator	Matt Kline	30%		✓			
Field Office Manager - Recipient & Provider Assistance	Bridget Lopez	16%			✓	✓	
Medicaid Fiscal Agent Operations Manager	Nancy Massey	7%		✓		✓	
Systems Project Consultant	Terry Schmidt	22%		✓		✓	
Network Systems Administrator	Michael Tatum	5%		✓		✓	
Chief of Medicaid Fiscal Agent Operations	Cheryl Travis	40%	✓	✓	✓	✓	
Systems Project Consultant	Tommy Vanbibber	6%		✓			
Chief Information Officer	Scott Ward	8%		✓	✓	✓	

* Represents Core Planning

Exhibit 13: FX Enterprise Subject Matter Experts

4.7 Staff Augmentation

The following chart, revised October 2024, represents contracted staff augmentation resources, dedicated to the FX Program. Like state resources, staff augmentation resources work on multiple FX projects. The percentage of time spent on each FX projects varies from week to week and depends on whether the project is in the procurement phase, initiation, planning, or DDI. Staff augmentation resources are approximately $1.5 million per year, per each FX module implementation project, for a total of $7,753,308. Resources reflected under the FX Enterprise column perform activities related to portfolio management, program management, governance management, delivery assurance, testing governance, or technical governance. The state purchases computer equipment and software licenses from the FX budget for use by staff augmentation resources while they perform planning and DDI activities for the FX Program. Ownership of the computer equipment and software licenses are retained by the state. Refer to the FX Enterprise Hardware, Software Licenses, and Services – Initial, and FX Enterprise Software Licenses and Services – Renewal budget lines on Attachment II, FX Program Budget, for a summary of these costs.

FX Dedicated Staff Augmentation Resources							
Role/Position	**Name**		**Projects**				
		Enterprise	**Core***	**MI**	**PSM**	**UOC**	**PBM**
Business Process Consultant	Amy Jenks	✓		✓	✓	✓	
Procurement Support	Anne Frost	✓					
OCM Support	Ashley Johnson	✓		✓	✓	✓	
Procurement Support	Barbara Vaughan	✓			✓	✓	✓
Business Intelligence Architect	Brett Powell	✓					
Data Management	Burnette Hanley			✓	✓	✓	✓
FX Reporting, Project Management	Carol Williams			✓	✓	✓	✓
Business Analyst	Casimiro Cosme	✓					
Delivery Assurance	Charles Coldwell	✓					
Portfolio Management	Coland Caswell	✓					
Project Management	Crystal Schleicher	✓					✓
Resource Management	David Sinclair	✓					
Program Support, Delivery Assurance	Dawood Sadiqi	✓					
Portfolio Management	Donny Crume			✓	✓	✓	✓
Program Mgmt., CRAIDL Support	Doug Holleman	✓					

FX Dedicated Staff Augmentation Resources							
Role/Position	**Name**		**Projects**				
		Enterprise	**Core***	**MI**	**PSM**	**UOC**	**PBM**
Finance Specialist	Drew Anderson	✓					
Delivery Assurance	Ed Rogers	✓	✓				✓
Portfolio Management	Fred Knapp	✓					
FX Portfolio	Gary Lee			✓	✓	✓	✓
Test Lead	Janani Babu			✓	✓		
Test Analyst	Janice Ingle	✓		✓			
CRAIDL Management	Jeff Wehling	✓					
OCM Training Lead	John Beaver	✓		✓	✓	✓	
Business Intelligence Architect	Joshua White	✓					
Program Management, Governance	Kimberly Watts	✓					
OCM Support	Lisa Brooks			✓	✓	✓	
Program Management	Madhushree Sakar	✓				✓	
Procurement Management	Marc Slager	✓					
OCM, Transformation	Mark Olson	✓		✓	✓	✓	
Module Test Lead	Mary Burgess			✓			
Program Management	Michael Stephens	✓					
Business Intelligence Architect	Mike Griffiths		✓	✓	✓	✓	✓
Project Management	Mindy Fike	✓					
Data Architect	Naveen Bandari		✓	✓	✓	✓	
Business Process Consultant	Parampreet Sidana			✓		✓	
JIRA Access Administrator	Phil Harman	✓					
Data Architect	Rajesh Peddi			✓	✓	✓	
Testing Lead	Robert Ford			✓			
Technical Advisor	Sachin Mathur	✓					
Business Intelligence Architect	Sanjay Tumula			✓	✓	✓	
Release Management	Satya Sandeep			✓	✓	✓	✓
Information Technology Leader	Som Khot		✓	✓	✓	✓	✓

FX Dedicated Staff Augmentation Resources							
Role/Position	**Name**		**Projects**				
		Enterprise	**Core***	**MI**	**PSM**	**UOC**	**PBM**
Test Analyst	Sowmya Sivalanka			✓		✓	
Delivery Assurance	Stephanie Shields	✓		✓			
Business Analyst	Sunny Patel	✓					
Testing Lead	Supriya Yerra	✓			✓		✓
Special Projects/Module Test Lead	Tara Swelstad	✓		✓	✓	✓	
Program Management	Tom Hoth	✓					
Network Architect	Vidyarayna Gujju			✓	✓	✓	

* Represents Core planning

Exhibit 14: FX Enterprise Staff Augmentation Resources

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4.8 FX Program Office Space

The FX Program team works at office space funded by enhanced FFP. The office space is fully dedicated to the FX Program state employee staff on the campus of the Agency headquarters state office in Tallahassee, Florida. Effective May 1, 2023, the leased office space reflects the non-discounted cost in accordance with the lease agreement. The FXPA office space costs are provided in the exhibit below.

FX Program Administration Office Space	
State Fiscal Year (July 1 – June 30)	Annual Cost
SFY 2022-23	$127,955
SFY 2023-24	$160,864
SFY 2024-25	$161,696
SFY 2025-26	$161,696

Exhibit 15: Current FX Program Administration Office Space Costs

The FX Program is proposing to issue a competitive procurement for additional office space or a larger office space that can accommodate all FX state staff in accordance with the revised staffing plan described in Section 4.6. The competitive procurement is planned for January 2025 release. The state's leasing broker estimates $26 per square foot with a 3% annual increase. The competitive procurement will request bids for office space in the range of 10,000 to 15,000 square feet. The annual lease is estimated to cost between $260,000 - $390,000.

5. Proposed FX Program Budget

The FX Program budget is provided below and as **Attachment III**.

The Agency requests a decrease for FFY 2025 to align with the budget approved for the FX Program by the Florida Legislature, and an increase for the FFY 2026 as the initial, proposed planned budget.

FX Program Budget			FL-2024-02-05-MMIS-IAPDU-FX		OCT 2024 IAPDU		Change from FEB 2024 to SEP 2024	
Components	Module	Match	FFY 2025	FFY 2026	FFY 2025	FFY 2026	FFY 2025 (difference)	FFY 2026 (difference)
Strategic Enterprise Advisory Services (SEAS) Tasks								
SEAS Strategic Planning, Finanical Management, and Benefits Management	FX Enterprise	90/10-2B	$ 9,746,661	$ -	$ 1,889,948	$ 2,000,000	$ (7,856,713)	$ 2,000,000
Independent Verification and Validation (IV&V) Tasks								
Independent Verification and Validation	FX Enterprise	90/10-2B	$ 3,230,996	$ -	$ 3,230,996	$ 3,230,996	$ -	$ 3,230,996
FMMIS Transition Support								
FMMIS Transition Support Services	FX Enterprise	90/10-2B	$ 3,652,500	$ -	$ 5,362,304	$ 7,428,943	$ 1,709,804	$ 7,428,943
FMMIS Transition Support Software and Hardware - Renewal and Support	FX Enterprise	75/25-2B	$ -	$ -	$ 2,258,164	$ 2,258,164	$ 2,258,164	$ 2,258,164
FMMIS Transition Support Software and Hardware - Operations	FX Enterprise	75/25-4B	$ -	$ -	$ 213,750	$ 855,000	$ 213,750	$ 855,000
Infrastructure Phase								
Integration Services/Integration Platform (IS/IP) - Operations	IS/IP	75/25-4B	$ 4,217,372	$ -	$ 4,431,203	$ 4,428,037	$ 213,831	$ 4,428,037
Integration Services/Integration Platform (IS/IP) - Software Renewal - Operations	IS/IP	75/25-4B	$ 1,981,505	$ -	$ 2,020,341	$ 2,814,645	$ 38,836	$ 2,814,645
Integration Services/Integration Platform (IS/IP) - Task Orders	IS/IP	90/10-2B	$ 1,875,000	$ -	$ -	$ -	$ (1,875,000)	$ -
Enterprise Data Warehouse (EDW) - Implementation	EDW	90/10-2B	$ 4,307,634	$ -	$ 5,431,963	$ 4,497,319	$ 1,124,329	$ 4,497,319
Enterprise Data Warehouse (EDW) - Operations	EDW	50/50-5B	$ 13,153,962	$ -	$ 7,268,729	$ 7,768,919	$ (5,885,233)	$ 7,768,919
Enterprise Data Warehouse (EDW) - Software Renewal - Operations	EDW	75/25-4B	$ 2,213,684	$ -	$ 3,672,033	$ 3,800,299	$ 1,458,349	$ 3,800,299
Enterprise Data Warehouse (EDW) - Task Orders	EDW	90/10-2B	$ 5,093,858	$ -	$ -	$ -	$ (5,093,858)	$ -
CMS - Interoperability - Implementation	CPARI	90/10-2B	$ -	$ -	$ 1,273,750	$ 3,821,250	$ 1,273,750	$ 3,821,250
CMS - Interoperability - Operations - EDW	EDW	75/25-4B	$ 110,369	$ -	$ -	$ -	$ (110,369)	$ -
Program Integrity Sampling Calculation Extrapolation System (PISCES) - Implemer	PISCES	90/10-2B	$ -	$ -	$ 1,513,750	$ 1,586,250	$ 1,513,750	$ 1,586,250
FX Enterprise Software Licenses and Services - Initial	FX Enterprise	90/10-2B	$ 50,000	$ -	$ 162,845	$ 62,830	$ 112,845	$ 62,830
FX Enterprise Software Licenses and Services - Renewal	FX Enterprise	75/25-4B	$ 308,703	$ -	$ 227,720	$ 361,103	$ (80,983)	$ 361,103
FX MITA MES Certification - Contract Services	FX Enterprise	90/10-2B	$ 3,000,000	$ -	$ 2,052,874	$ -	$ (947,126)	$ -
FX Enterprise Contract Services	FX Enterprise	90/10-2B	$ 12,035,762	$ -	$ 18,694,072	$ 21,682,040	$ 6,658,310	$ 21,682,040
FX Enterprise Security Assessor - Contract Services	FX Enterprise	90/10-2B	$ 1,167,750	$ -	$ 309,800	$ -	$ (857,950)	$ -
Phase 4 Procurement Services - Contract Services	FX Enterprise	90/10-2B	$ 979,880	$ -	$ -	$ -	$ (979,880)	$ -
FX Testing Center of Excellence Services	FX Enterprise	90/10-2B	$ 1,505,318	$ -	$ -	$ -	$ (1,505,318)	$ -
Module Existing Systems Integrations Services - ISIP - ISIP	Module Integration	90/10-2B	$ 6,903,485	$ -	$ 11,423,496	$ 11,423,496	$ 4,520,011	$ 11,423,496
Module Existing Systems Integrations Services - ISIP - Core	Module Integration	90/10-2B	$ 14,518,782	$ -	$ -	$ -	$ (14,518,782)	$ -
Module Existing Systems Integrations Services - ISIP - PSM	Module Integration	90/10-2B	$ 892,316	$ -	$ 5,846,917	$ -	$ 4,954,601	$ -
Module Existing Systems Integrations Services - ISIP - UOC	Module Integration	90/10-2B	$ -	$ -	$ 1,351,671	$ -	$ 1,351,671	$ -
Module Existing Systems Integrations Services - ISIP - PBM	Module Integration	90/10-2B	$ 1,523,715	$ -	$ 625,000	$ 1,875,000	$ (898,715)	$ 1,875,000
Module Existing Systems Integrations Services - EDW - EDW	Module Integration	90/10-2B	$ -	$ -	$ 3,929,127	$ 3,929,127	$ 3,929,127	$ 3,929,127
Module Existing Systems Integrations Services - EDW - Core	Module Integration	90/10-2B	$ 13,304,964	$ -	$ -	$ -	$ (13,304,964)	$ -
Module Existing Systems Integrations Services - EDW - PSM	Module Integration	90/10-2B	$ -	$ -	$ 4,053,929	$ 5,558,965	$ 4,053,929	$ 5,558,965
Module Existing Systems Integrations Services - EDW - UOC	Module Integration	90/10-2B	$ 285,149	$ -	$ 2,220,652	$ 5,973,219	$ 1,935,503	$ 5,973,219
Module Existing Systems Integrations Services - EDW - PBM	Module Integration	90/10-2B	$ 2,450,035	$ -	$ 625,000	$ 1,875,000	$ (1,825,035)	$ 1,875,000

Exhibit 16: FX Program Budget (page 1 of 2)

FX Program Budget			FL-2024-02-05-MMIS-IAPDU-FX		OCT 2024 IAPDU		Change from FEB 2024 to SEP 2024	
Components	Module	Match	FFY 2025	FFY 2026	FFY 2025	FFY 2026	FFY 2025 (difference)	FFY 2026 (difference)
Module Acquisition Phase								
Provider - Implementation	Provider	90/10-2B	$ 385,222	$ -	$ 7,939,860	$ 1,465,699	$ 7,554,638	$ 1,465,699
Provider - Operations	Provider	50/50-5B	$ 9,158,613	$ -	$ 681,960	$ 11,856,735	$ (8,476,653)	$ 11,856,735
Provider - Task Orders	Provider	90/10-2B	$ 652,800	$ -	$ -	$ -	$ (652,800)	$ -
Core - Implementation	Core	90/10-2B	$ 6,889,674	$ -	$ 4,356,239	$ 19,071,208	$ (2,533,435)	$ 19,071,208
Core - Task Orders	Core	90/10-2B	$ 652,800	$ -	$ -	$ -	$ (652,800)	$ -
Unified Operations Center - Implementation	UOC	90/10-2B	$ 1,983,777	$ -	$ 5,819,612	$ 11,052,615	$ 3,835,835	$ 11,052,615
Unified Operations Center - Software Renewal - Implementation	UOC	75/25-4B	$ 2,714,328	$ -	$ -	$ -	$ (2,714,328)	$ -
Unified Operations Center - Operations	UOC	75/25-4B	$ 21,759,888	$ -	$ 1,144,743	$ 20,226,848	$ (20,615,145)	$ 20,226,848
Unified Operations Center - Task Orders	UOC	90/10-2B	$ 652,800	$ -	$ -	$ -	$ (652,800)	$ -
Pharmacy Benefits Management - Implementation	PBM	90/10-2B	$ 3,681,994	$ -	$ 2,487,164	$ 8,551,926	$ (1,194,830)	$ 8,551,926
Pharmacy Benefits Management - Operations	PBM	50/50-5B	$ -	$ -	$ -	$ 3,359,808	$ -	$ 3,359,808
Pharmacy Benefits Management - Task Orders	PBM	90/10-2B	$ 652,800	$ -	$ -	$ -	$ (652,800)	$ -
Outside Legal Counsel - ISIP	FX Enterprise	50/50-2B	$ -	$ -	$ 135,000	$ -	$ 135,000	$ -
Outside Legal Counsel - Phase 4	FX Enterprise	50/50-2B	$ 125,000	$ -	$ -	$ -	$ (125,000)	$ -
State Agency Costs								
Additional FFP for existing FTEs - FX Dedicated	FX Enterprise	90/10-2A	$ 3,609,300	$ -	$ 4,653,360	$ 7,212,708	$ 1,044,060	$ 7,212,708
Additional FFP for existing FTEs - FX Business & Technical SMEs	FX Enterprise	90/10-2A	$ -	$ -	$ 757,795	$ 757,795	$ 757,795	$ 757,795
Additional FFP for existing FTEs - FX System Operations IS/IP	FX Enterprise	75/25-4A	$ -	$ -	$ 71,324	$ 71,324	$ 71,324	$ 71,324
Additional FFP for existing FTEs - FX System Operations EDW	FX Enterprise	50/50-5A	$ -	$ -	$ 71,324	$ 71,324	$ 71,324	$ 71,324
Additional FFP for facility costs	FX Enterprise	90/10-2A	$ 161,696	$ -	$ 389,196	$ 551,696	$ 227,500	$ 551,696
IAPD Total Request by FFP			**$ 161,590,092**	**$ -**	**$ 118,597,611**	**$ 181,480,288**	**$ (42,992,481)**	**$ 181,480,288**

Exhibit 16: FX Program Budget (page 2 of 2)

5.1 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.

5.2 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.

FX is a multi-year program with costs and benefits estimated throughout the life of the program. The FX Program strategy and roadmap are assessed continually, with cost and benefit estimates being fine-tuned to incorporate new information. As such, cost and benefit amounts may change year-over-year as the FX strategy evolves and planned activities are conducted.

The Agency has identified existing program operational costs versus the expected program operational costs resulting from implementing each module. The Agency will identify the expected changes in operational costs for the program(s) that will be impacted by the module as well as estimates for tangible benefits resulting from implementation of the module. This will correspond to the benefits identified in an FX Enterprise Benefits Realization Table.

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)

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, 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	

#	Condition Name and Description	Compliance	
		Yes	No
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 MITA maturity for business, architecture, and data.	X	
12	The Florida AHCA ensures alignment with, and incorporation of, standards and implementation specifications for health information technology adopted by the Office of the National Coordinator for Health IT in accordance with 45 CFR part 170, subpart B. The Agency also ensures alignment with the HIPAA privacy, security, breach notification and enforcement regulations in 45 CFR parts 160 and 164; and transaction standards and operating rules under HIPAA and/or section 1104 of the Affordable Care Act; 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 1561 of the Affordable Care Act; and standards and protocols for reporting on the Child and Adult Core Sets and Health Home Care Sets.	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	

#	Condition Name and Description	Compliance	
		Yes	No
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 17: CMS Conditions and Standards Compliance Matrix

7.3 Procurement Assurances

The Agency uses open and competitive procurements for all contracted work related to design, development, and implementation of the FX. The procurement process will comply with all applicable federal regulations and provisions as indicated in the exhibit below.

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 18: Procurement Assurances

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APPENDIX A: MMIS DETAILED BUDGET TABLE

Federal Fiscal Years 2025 through 2026

MES/FX as of 10/2024	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 2025	$81,540,872	$9,060,097	$1,693,623	$564,541	$67,500	$67,500	**$83,301,995**	**$9,692,138**
FFY 2026	$103,577,295	$11,508,588	$1,693,623	$564,541	$0	$0	**$105,270,918**	**$12,073,129**
Total	**$185,118,167**	**$20,568,685**	**$3,387,246**	**$1,129,082**	**$67,500**	**$67,500**	**$188,572,913**	**$21,765,267**

MES/FX as of 10/2024	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 2025	$5,220,316	$580,035	$0	$0	$0	$0	$5,220,316	$580,035
FFY 2026	$7,669,979	$852,220	$0	$0	$0	$0	$7,669,979	$852,220
Total	**$12,890,295**	**$1,432,255**	**$0**	**$0**	**$0**	**$0**	**$12,890,295**	**$1,432,255**

MES/FX as of 10/2024	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 2025	$88,522,311	$10,272,173	$8,835,836	$2,945,279	$4,011,007	$4,011,007	$101,369,153	$17,228,458	**$118,597,611**
FFY 2026	$112,940,897	$12,925,349	$24,417,942	$8,139,314	$11,528,393	$11,528,393	$148,887,232	$32,593,056	**$181,480,288**
Total	**$201,463,208**	**$23,197,522**	**$33,253,778**	**$11,084,593**	**$15,539,400**	**$15,539,400**	**$250,256,385**	**$49,821,514**	**$300,077,899**

ATTACHMENT A — PHASE 1: PROFESSIONAL CONTRACTS

The objective of Phase 1 was to procure professional service partners to support strategic planning and independent evaluation of the FX transformation.

A.1 Strategic Enterprise Advisory Services (SEAS) Vendor

The state funding for the SEAS Vendor was reduced by the Florida Legislature for the 2024-2025 State Fiscal Year starting on July 1, 2024. As a result, the Agency amended the SEAS Vendor contract for budget and scope. The Agency assessed the contract to prioritize the services required from the SEAS Vendor while staying within the appropriated budget. The SEAS Vendor continues to support strategic planning, financial management, and benefits realization for the FX Program. The Agency transitioned project and program management services, project delivery assurance, reporting, quality management, module DDI readiness support, business process analysis, and technical advisory services from the SEAS Vendor to the Agency, staff augmentation resources, and the FX Program Support Services procurement and resulting contracts described below in Section A.6. The amended SEAS Vendor contract, executed September 6, 2024, includes the following:

- Strategic Planning
  - Strategic advisory services for the Agency and executive-level communications support with the FX Executive Steering Committee, Executive Office of the Governor, Office of Policy and Budget, and Florida Legislature.
  - Maintenance and revisions to the FX Strategic Plan such as reviewing FX strategic priorities based on federal and state direction, FX transformational progress, and Agency strategic initiatives.
  - Maintenance and revisions to the FX Strategic Roadmap including conducting formal elaboration sessions with the Agency and FX vendors.
  - FX Summit planning, leadership, and facilitation to promote collaboration, communication, and continuous improvement among FX module vendors.
- Financial Management
  - Maintain and update the FX Program budget planning tool which contains all historical, actual, and estimated future budget.
  - Create budget scenarios based on changes to the FX Strategic Roadmap.
  - Provide budget workbooks and cost analyses for planning documents submitted to federal and state entities.
  - Provide analyses on proposed legislative budgets and provide assistance with questions related to the FX budget.
  - Develop preliminary and initial fiscal year spending plans and review monthly spending plans.
- Benefits Realization Support
  - Manage and conduct the ongoing benefits realization work within FX module teams.
  - Collect and update baseline data as needed.
  - Adjust benefit calculations and information based on changes with the FX Program.
  - Provide a quarterly Benefits Realization Dashboard for the FX Program.

Medicaid Program Outcomes Statement

The following outcomes and metrics document how the SEAS Vendor benefits the Medicaid Program.

Reference	Outcome Statement	Metric
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

Exhibit 19: SEAS Vendor Outcomes and Metrics

SEAS IAPDU Cost

SEAS Vendor costs are $1,889,948 for FFY 2025 and $2,000,000 for FFY 2026.

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

The IV&V Vendor provides a rigorous independent evaluation and review that evaluates adherence to the standards, correctness, and quality of FX Program and projects' solutions to help the Agency ensure that projects are being developed and managed in accordance with Federal, State, and Agency requirements. IV&V services are recommended by federal regulation 45 CFR 95.626 to represent the interests of the Centers for Medicare and Medicaid Services (CMS) and required pursuant to the Florida

Information Technology Project Management and Oversight Standards in Rules 60GG-1.001 through 60GG-1.009, Florida Administrative Code (F.A.C.).

The IV&V purchase order with NTT Data is effective through June 30, 2025. In accordance with the (Florida) General Appropriations Act for State Fiscal Year 2024-2025, IV&V services must include (1) oversight of all Agency staff and vendor work needed to implement the project, (2) an annual, comprehensive assessment of the project schedules, and (3) a thorough review of all project budget requests and monthly and quarterly reporting submitted by the Agency to the Legislature. Comprehensive IV&V activities include:

- Monitor and Assess portfolio management, budget requests, monthly and quarterly reports, project management, project governance, data governance, procurement activities, DDI activities, organizational change management, quality assurance, test strategy, test plans, test procedures, test execution, and module integration.
- Assess FX Program and FX vendor deliverables and work products.
- Participate in periodic FX Program calls with CMS.
- Provide guidance and monitor CMS certification preparation.
- Participate in CMS certification reviews.
- Assess privacy, security, and disaster recovery plans.
- Facilitate weekly performance and progress updates.
- Complete an FX monthly assessment report.
- Complete a written FX project assessment for Core, Provider, and Pharmacy Benefits Management.
- Complete a quarterly FX Program focused assessment.
- Complete FX budget artifact reviews and affidavits.
- Complete FX Program and project schedule assessments.

Medicaid Program Outcomes Statement

The following outcomes and metrics document how the IV&V Vendor benefits the Medicaid Program.

Reference	Outcome Statement	Metric
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	Affidavit of review.

	the Quarterly Operational Work plan (OWP) and the Monthly Spend Plan.	

Exhibit 20: IV&V Vendor Outcomes and Metrics

IV&V IAPDU Cost

IV&V Vendor costs are $3,230,996 per year.

A.3 Testing Center of Excellence

The Agency created the Testing Center of Excellence (TCoE) to establish and govern a strategic, enterprise-level, multidisciplinary, quality program complementing Florida's organizational fluidity. The SEAS Vendor delivered recommended components and considerations for an FX TCoE framework to the Agency in January 2023. The IS/IP Vendor provides TCoE services for the FX Program. The Agency reprocured TCoE services via the FX Program Support Services procurement described below in Section A.6.

The FX TCoE serves as the overall testing authority for the FX Program by:

- Creating and managing an FX Enterprise Test Management Plan and Framework for the delivery of FX solutions across one or more projects throughout the FX Program life (management includes alignment with appropriate program standards, technical standards, CMS certification guidelines).
- Overseeing testing activities across FX phases and milestones, across all FX projects and work efforts, by implementing the proper processes, procedures, and controls across all vendors for proper authorization and approval of testing results and traceability to requirements.
- Coordinating and implementing User Acceptance Testing from a centralized project and library of test cases and test plans with a dedicated testing team to consult with the Agency as needed.
- Normalizing and centralizing the usage of the FX Program's Application Life Cycle Management (ALM) solutions for testing across all vendors and across all projects and work efforts.

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.

The IS/IP Vendor performed the initial planning for the TCOE in fiscal year 2022-2023 by defining the TCOE governance structure, testing procedures and processes, metrics for testing reporting, and the end-to-end UAT testing methodology. The IS/IP Vendor will continue TCOE management and operations until transitioned to the replacement vendor, which is the same vendor.

Streamlined Modular Certification (SMC)

The Testing Center of Excellence is not a certifiable component of the MMIS replacement.

Medicaid Program Outcomes Statement

The Agency proposes the following outcomes and metrics to document how the TCoE benefits the Medicaid program.

Reference	Outcome Statement	Metric
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

Exhibit 21: TCOE Vendor Outcomes and Metrics

TCoE IAPDU Cost

Refer to section A.6 FX Program Support Services.

A.4 Security and Privacy Assessments

The Agency received CMS-prior approval to procure FX Enterprise Security and Privacy Assessments (SAPA) services. Network integrity and security are critical to the success of the FX Program. SAPA activities will mitigate the risk of potential breaches to protected health information and personally identifiable information maintained within the FX Enterprise by performing independent and autonomous penetration (pen) testing and security assessments of the FX Enterprise and all FX modules. The SAPA Vendor is responsible for providing standardized and consistent services for the FX Enterprise with Agency oversight and providing independent assessment of the security and privacy of the FX Enterprise and each of the modules, as defined by the CMS Streamlined Modular Certification for Medicaid Enterprise Systems Certification Guidance, Appendix D: Framework for the Independent Third-Party Security and Privacy Assessment. The Agency completed the procurement in July 2024 and selected RSM US LLP to serve as the SAPA Vendor.

Streamlined Modular Certification (SMC)

SAPA services are not a certifiable component of the MMIS replacement.

Medicaid Program Outcomes Statement

The following outcomes and metrics document how SAPA services benefit the Medicaid program.

Reference	Outcome Statement	Metric
SAPA1	The solution will ensure compliance with federal certification requirements related to the independent assessment of security and privacy across the FX Enterprise.	Security and Privacy Assessment and Penetration Testing findings
SAPA2	The solution will ensure the integrity of the security and privacy assessment process.	Enterprise FX Security and Privacy Assessment Plan
SAPA3	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 SAPAs and penetration testing.

Exhibit 22: SAPA Vendor Outcomes and Metrics

SAPA IAPDU Cost

Planning activities were performed by FX Agency resources and contracted staff augmentation resources. SAPA Vendor costs are $309,800 per year. The SAPA Vendor costs are consolidated to the FX Enterprise Contract Services line on the FX Program budget displayed in Exhibit 16.

A.5 MITA Business Architecture and MES Certification

The Agency seeks prior approval to procure the services of a MITA Business Architecture (BA) and Medicaid Enterprise System (MES) Certification Vendor. The contract with the selected vendor, Public Consulting Group, LLC, was executed on November 2, 2023, and is effective through June 30, 2025. CMS provided prior approval of the solicitation and contract documents.

Scope of work planned for the MITA BA and MES Certification Vendor includes building and maintaining the MITA functional representation of FX MES business services, processes, modules, and capabilities. The vendor BA team will map prioritized program business processes; identify, track, and validate project and program outcomes and benefits; and identify, track, and validate metrics and evidence for outcomes. The vendor Certification team will map outcomes to business and technical requirements for inclusion in procurement documents, populate the MITA Source Pulse tool, develop materials and support the Operational Readiness Review (ORR), perform Production Operational activities, support the Certification review, and support the Operational reporting phase.

Initiation and planning activities have been completed and the MITA BA and MES Certification Vendor is assisting the Agency with the EDW certification. The Agency

intends to reprocure MITA BA and MES Certification services via the proposed FX Program Support Services procurement described below in Section A.6. The Agency decided to maintain the existing contract with Public Consulting Group for MITA BA and MES Certification services and not reprocure the services under the FX Support Services contract described in the next section.

Streamlined Modular Certification (SMC)

The MITA BA and MES Certification scope of work is not a certifiable component of the MMIS replacement.

Medicaid Program Outcomes Statement

The following outcomes and metrics document how MITA BA and MES Certification (MITACert) services benefit the Medicaid program.

Reference	Outcome Statement	Metric
MCert1	The MITACert 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 MITACert 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 MITACert 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

Exhibit 23: MITA BA and MES Certification Vendor Outcomes and Metrics

MITA BA and MES Certification IAPDU Cost

The budget for the MITA BA and MES Certification Vendor has been consolidated to FX Enterprise Contract Services line on the FX Program budget displayed in Exhibit 16. The MITA BA and MES Certification Vendor costs are $2,428,376 for state fiscal year 2025.

A.6 FX Program Support Services

The Agency received CMS prior approval to procure one or more qualified vendors from the Florida State Term Contract for Management Consulting Services to replace the services previously provided by the SEAS Vendor, and to replace the services currently provided by the Testing Center of Excellence Vendor and MITA BA and MES Certification Vendor. The Agency proposes to streamline the services into one contract and one vendor, referred to as FX Program Support Services, to the extent one vendor can adequately provide all services, to reduce the administrative tasks related to contract management and oversight for Agency resources. The Agency completed the evaluation of vendor responses to the procurement in September 2024. The selected vendors are described within each FX Support Services component below. Required services include the following:

1) Enterprise Program Management Office
2) Delivery Assurance and CRAIDL Management Support
3) Reporting Support
4) Organizational Change Management (OCM) Center of Excellence
5) Testing Center of Excellence (TCoE)
6) MITA & Certification Support

Enterprise Program Management Office includes providing centralized oversight and support for executing project management across the FX Program. Enterprise Program Management enhances cross-functional collaboration across FX vendors and promotes the standardization of project management practices across the FX Enterprise. The vendor will facilitate ongoing alignment of the program with strategic objectives and escalate appropriate items, including CRAIDL items to governance. The vendor will provide consultative support to the Agency on improving standards and processes for assessing and reporting on the performance of the FX Program and projects, including performance metrics, escalation procedures, and recommending corrective actions. The vendor will provide or support preparation of formal communications about the FX Program, make updates to FX Standards, provide responses to assessment recommendations and findings, facilitate FX vendor awareness and education regarding FX project management standards, conduct deliverable review meetings, and provide draft program status narrative for reports. The Agency intends to award the contract to The North Highland Company, LLC., for these services.

Delivery Assurance includes providing guidance to FX project teams to help address issues and improve project delivery. The vendor will facilitate the identification, remediation, and communication of items that have program level impacts. The vendor will engage FX project teams to ensure schedule, narrative, and CRAIDL (Change Requests, Risks, Action Items, Issues, Decisions, and Lessons Learned) data used to populate reports is accurate, adheres to FX Standards and associated process definitions and artifacts, and is appropriate for the report's audience. The vendor will provide escalation narratives and supporting documentation for corrective action plans, and support, monitor, report on, and make recommendations for adherence to compliance with FX Standards and associated process definitions, artifacts, and best

practices. The Agency intends to award the contract to The North Highland Company, LLC., for these services.

Reporting Support includes coordinating and facilitating biweekly and monthly project reporting. The vendor will provide program-level narrative and finalize executive reports about project status. The vendor will provide quality assurance for content and verbiage, coordinate with delivery assurance staff to ensure deficiencies in reports are remediated, ensure reports are produced timely, and streamline reporting processes. The Agency intends to award the contract to The North Highland Company, LLC., for these services.

The OCM Center of Excellence will advance OCM maturity for the FX Program by integrating disparate FX module vendor OCM activities into a unified model. The selected vendor will develop an FX Program OCM Transformation Strategy and Roadmap to User Adoption Plan to supplement the FX Strategic Plan and provide elaborated focus on the business services and people who will experience changes based on change events in the FX Roadmap. The vendor will define and perform operational services across the FX Program to keep all stakeholders informed and engaged, provide stakeholders with timely business services transformation information and guidance to aid operations and decision-making, and ensure FX change champions and stakeholders are provided with unified and integrated communications. The vendor will identify areas of stakeholder resistance and develop mitigation strategies, and the vendor will develop a culture receptive to change. The vendor will lead integrated OCM, communications, training activities across FX multi-module vendor releases, and build the FX Enterprise Data Warehouse Data Literacy curriculum and customized learning plans for Agency business units. The Agency intends to award the contract to KPMG, LLP, for these services.

TCoE includes the services described in Section A.3, above. In sum, the vendor will collaborate with FX module vendor test leads on milestones and critical path for testing within the project schedule, collaborate with the enterprise schedule manager to define testing tasks, the testing plan and the testing schedule, map testing processes to Jira features, and provide testing outcomes. The vendor will maintain the testing tool architecture, manage cross module defect management, test planning, execution status, and reporting. The Agency intends to award the contract to Accenture, LLP, for these services.

MITA and Certification Support includes the services described in Section A.5, above. In sum, the vendor will plan and achieve MITA goals, process improvements, and CMS certification of FX modules. The vendor will manage FX Program certification activities, coordinate with FX vendors, track progress, and develop the monthly certification project status reports. The vendor will manage federal and state outcome metrics development and validation, and maintain the FX Program master outcomes, metrics, and benefits tool. The Agency decided to maintain the existing contract with Public Consulting Group for MITA BA and MES Certification services and not reprocure the services under the FX Program Support Services contract at this time.

Streamlined Modular Certification (SMC)

The FX Program Support Services scope of work is not a certifiable component of the MMIS replacement.

Medicaid Program Outcomes Statement

The following proposed outcomes and metrics will document how the FX Program Support Services benefit the Medicaid program.

Reference	Outcome Statement	Metric
EPgMO1	Ongoing alignment of the program with strategic objectives and quality and consistency with project and program schedules.	Project and program schedules that document alignment.
EPgMO2	Improved project delivery through Delivery Assurance and CRAIDL management documenting appropriate escalation to FX Governance.	Change Requests, Risks, Action Items, Issues, Decisions, and Lessons Learned (CRAIDL) items logged and updated as required.
EPgMO3	Timely and accurate reporting for the FX Program is assured and facilitated.	FX Dashboard, Monthly Status Report, and Executive Steering Committee reports are documented and issued on schedule.
OCM1	Executive stakeholders are provided timely business services transformation information to aid Medicaid Enterprise services operations and workforce transition decision making.	Visuals and executive summary narratives are documented and explain the FX Program view of future-state business services.
OCM2	FX Stakeholders are provided with detailed “what is in it for me” information prior to changes and during post-implementation support.	Documentation of integrated communications, training, readiness, and post adoption engagement in FX change event release activities.
OCM3	Stakeholder awareness, understanding, and readiness activities are integrated for FX Program and project change event releases.	Integrated change event workbook is updated for each FX release.

Exhibit 24: FX Program Support Services Outcomes and Metrics

FX Enterprise Contract Services IAPDU Cost

The budget for the FX Program Support Services contract, including the services components described above, the SAPA Vendor, and staff augmentation resources has been consolidated into one category, referred to as FX Enterprise Contract Services. For the initial contract year, Enterprise Program Management Office services, Delivery Assurance and CRAIDL Management Support, and Reporting Support vendor costs are $3,535,048, OCM Center of Excellence vendor costs are $1,822,385, and TCoE vendor costs are $1,119,320.

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ATTACHMENT B — PHASE 2: FX INFRASTRUCTURE

Phase 2 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. The 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 focuses on establishing and maintaining interoperability through the central integration platform. The Integration Platform went live in March 2021. The contract with the IS/IP vendor was renewed through October 31, 2025. The IS/IP will be re-procured during FFY 2025.

The Agency amended the IS/IP Vendor contract to remove the provision for the use of Task Orders as required by the Florida Legislature, and modify security requirements due to the procurement of the FX Enterprise Security and Privacy Assessments Vendor. The contract amendment was executed on October 15, 2024.

In operations and maintenance, the Integration Platform serves as the centralized connections hub for all FX modules. The Integration Services function orchestrates and coordinates the connections by integrating them into the platform. The IS/IP Vendor is the systems integrator to plan, schedule, test, and validate connections to the platform for all future module vendors.

The components of the Integration Platform solution are illustrated in the exhibit below and then described in further detail.

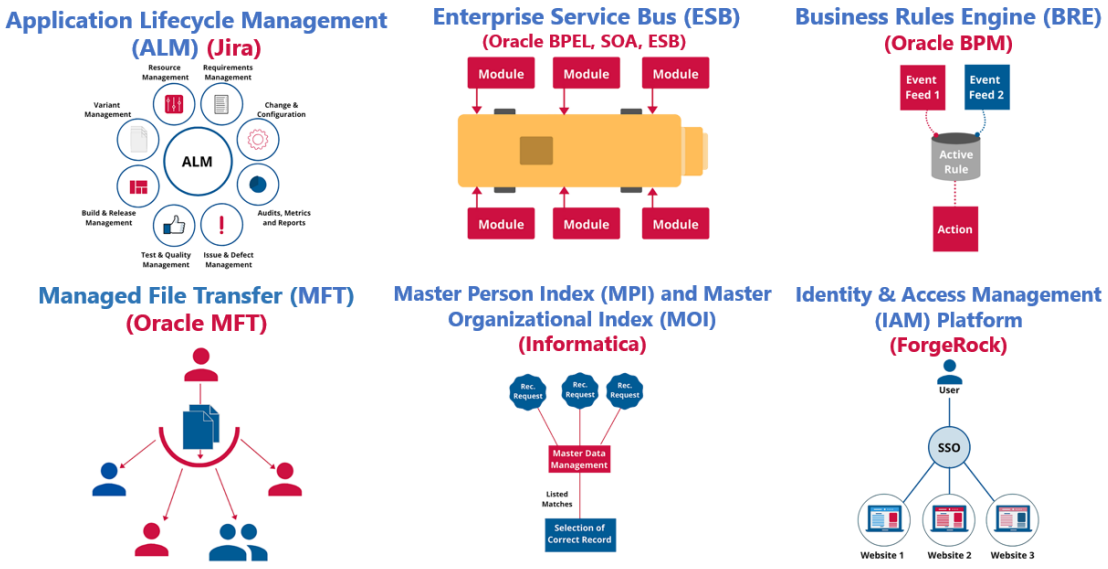

Exhibit 25: IS/IP Overview

The Enterprise Service Bus (ESB) supports various application integration architectures. It provides application connectivity, security checking, messaging and routing,

transformation and formatting, and service interaction services. It provides the following key functions:

- Highly scalable and reliable service-oriented integration, service management, and traditional message brokering across heterogeneous systems.
- Routes, transforms, and virtualizes services through the highly scalable Oracle Service Bus (OSB).
- Orchestrates and builds process automation with Oracle BPEL Process Manager.
- Builds agility by externalizing specific blocks of logic using Oracle Business Rules.
- Oracle Business Rules enable dynamic business decisions at runtime, enabling the user to automate policies, computations, and reasoning while separating rule logic from underlying application code.
- Oracle Service Bus supports xQuery and xslt mapping transformation for the web services payload.
- Performs real-time detection of specific patterns across multiple data streams and time windows through Oracle Event Processing.
- Gains real-time visibility into operation and performance of business processes, including the ability to respond to specific situations, through Oracle Business Activity Monitoring.
- Consistently and easily secures all services through a policy-driven integrated security framework and the global policy manager.
- Oracle Service Bus is a configuration-based, policy-driven ESB.
- Intelligent message brokering with routing and transformation of messages, along with service monitoring and administration.
- Built-in human workflow services such as task, notification, and worklist management are provided to enable the integration of people and manual tasks into BPEL business flow instances.
- Oracle Managed File Transfer (MFT) is a high performance, standards-based, end-to-end managed file gateway, featuring design, deployment, and monitoring of file transfers using web-based, design-time console that includes file encryption, scheduling, and embedded FTP and SFTP servers.
- End-to-End Native REST and JavaScript in SOA composites and Service Bus pipelines.
- Oracle Service Bus supports this list of protocols, (ODBC, JDBC, POP3, SMTP, SSH, Web Service (WSDL, WS-*, SOAP, REST, UDDI, ODATA) XML, JSON-WDP, FTPS, SFTP, HTTP, HTTPS, JMS, MSMQ, COBOL, VSAM).
  OSB supports the following technology adapters (File, FTP, JMS, DB2, Healthcare, CICS,IMS/DB, IMS/TM, VSAM, CDC adapter for IMS/DB, CDC adapter for VSAM, REST, SOAP, LDAP, UMS, ERP – Systems).

The Managed File Transfer (MFT) provides services to manage, monitor, and secure file transfers. It is protected using the standard WebLogic Service Security Roles, Users and Groups with integration to SOA/OSB to extend business process for further orchestration and transformation. It provides the following functional functions:

- MFT enables secure file exchange with internal and external partners.

- MFT provides out of box dashboard metrics to track file size, file volume for inbound and outbound endpoints and reporting capabilities for status of file transfer.
- MFT supports PGP encryption/decryption, so it can support the practice that allows only encrypted data into the systems.

The Business Rules Engine (BRE) provides consistent advice and policies across channels and business processes. It is a tool used for capturing, managing, deploying and automating legislation, regulations, requirements and other document-based policies. The BRE provides the following functions:

- Author rules in natural language using Microsoft Word and Microsoft Excel.
- Provides comprehensive policy creation integrated development environment (IDE) using the desktop tool.
- Provides transparency on how decisions were made and applied through rule modeling and what-if feature in the OPM.

During the integration service phase, the rules engine can be integrated with OSB to provide decision services. It also can be integrated with SOA/BPM to handle complex rules workflows.

The Service Registry is a lifecycle management component which allows users to build a catalog of services. Application Programming Interface (API) designers can register services on the platform. API managers can approve and publish services and configure and specify security policies to these services. API consumers can subscribe to the published services and incorporate them into the interface development. The Service Registry provides the following functions:

- A single source for visibility to both On-Premise Services (Service supplied by FX IS/IP) and external Services (Service supplied by external systems).
- Tight integration with Oracle SOA Suite and Service Bus.
- Harvesting of REST and SOAP services into the Service Registry.
- Streamlined API editing and publishing.
- An Oracle Access Protocol (OAP) developer portal to discover, understand and test APIs.
- Secure APIs with designed security policies.
- Operational analytics providing pre-built views to monitor API usages and activities.
- API users' roles and grants provide access control to APIs with API-level entitlements.
- Ability to provide ratings and reviews for APIs.
- Ability to monitor usage of APIs at run-time.

The Application Lifecycle Management (ALM) solution architecture provides a platform to provide a centralized application lifecycle management capability. ALM is comprised of the following components and functions:

- Jira is an issue tracker that allows teams to manage multiple projects and the stories/tasks that makes up that project. Jira has been extended using plugins like Requirements for Jira (R4J) to better manage requirements for the solution

and ease the process of importing requirements from other tools such as Excel. Jira has also been extended with Test Management for Jira (TM4J) to manage reporting and quality assurance of in progress requirements. Jira is an Atlassian product.

- Confluence is an Atlassian product that manages documentation for any part of the project. Documentation is stored via a markup language that creates efficient and manageable web pages for users to document their work. It has seamless integration with Jira/Bitbucket in the sense that Jira requirements/issues and Bitbucket repositories can be referenced in documentation via custom links.
- Bitbucket is an Atlassian product that manages git code repositories.
- Artifactory is a binary/artifact repository that will allow for easy access to objects through protocols like https. Artifactory will be structured in a way to compartmentalize each set of artifacts so that each team can work and store artifacts independently of others.
- Jenkins is a work orchestration tool that will allow us to coordinate/schedule jobs that will work/deploy to any environment in the solution. Jenkins will also be structured in a way to compartmentalize jobs into a project like structure so that teams can run/edit jobs independent of each other. Jenkins will also be scalable through the deployment of Jenkins' agents and independent Virtual Machines (VM's) that Jenkins will use to run jobs in parallel with itself.
- The IS/IP Vendor provides the Informatica PowerCenter, Informatica Data Quality, and Informatica Master Data Management (MDM) Hub.
- Informatica PowerCenter is a widely used data extraction, transformation, and loading (ETL) tool. The tool provides components to extract data from multiple agency sources, transform the data according to business logic built in the MDM, and load the transformed data into relational targets such as MDM staging areas (landing tables). Informatica PowerCenter also provides the ability to view and analyze business information and browse and analyze metadata from disparate metadata repositories.
- Informatica Data Quality is used to analyze, cleanse, standardize, profile, and score data which are essential steps to increase the matching rate during module integration. The tool offers interfaces to create and run mappings, as well as create and run rules. It also performs profiling that includes using the enterprise discovery profile to discover functional dependency, primary keys, foreign keys, etc. It will also curate inferred profile results and score carding to export objects to Informatica PowerCenter.
- Informatica MDM Hub is a user interface that is comprised of a set of tools for administrators and data stewards. Each tool allows users to perform a specific action or a set of related actions. These consist of building the data model, running batch jobs, configuring the data flow, configuring external application access to Informatica MDM Hub resources, and other system configuration and operation tasks. In addition, Informatica also has a hub store that contains the Master Person Index (MPI) or Master Organizational Index (MOI) for all entities across different source systems. It contains the metadata and the associated rules needed to determine and continually maintain only the most reliable cell-level attributes in each MPI or MOI and the logic for data consolidation functions, such as merging and unmerging data. This allows the FX IS/IP to have an improved consistency of organizations and people.

The IS/IP MOI and MPI solution architecture provides a platform to facilitate linking the organization and person among various future FX modules or other agency's systems

together. The IS/IP MOI/MPI can receive, cleanse, match, and connect organization and person information from various FX modules. It will also allow these modules to retrieve index information via services connected through the ESB system.

The IS/IP Vendor provides the Identity and Access Management (IAM) solution, ForgeRock, and the Security Information and Event Management (SIEM) solution, Splunk. The Access Management solution provides a centralized authentication and authorization platform for applications and systems with features such as single sign-on (SSO), multifactor authentication (MFA), fine grained authorization, external user store, and identity proofing. ForgeRock, includes the following components:

- The Identity Gateway (IG) serves as a front-door to the AM services and can act as a Policy Enforcement Point for applications. The IG provides HTTP level protection both for internal and external traffic, performs complex logic when integrating with applications, and acts as a central point of ingress to the AM system.
- AM is the overall engine that produces and manages the authentication and authorization functions of the platform. The AM centralizes authentication processes, evaluates constraints on a global and application-specific base, and manages the session of the entity.
- Identity Management (IDM) manages user profiles and automates the identity lifecycle from one central location. The IDM synchronizes data across multiple resources, provides workflow configuration for managing how users sign up for their accounts, and provides users self-service, including updating attributes and new user registration.
- The Directory Services (DS) is the Lightweight Directory Access Protocol (LDAP) directory that provides services to other ForgeRock components and data storage. The DS provides LDAP services which are utilized by the AM and IDM, Core Token Service (CTS) storage for access and authentication, User Store (USR) storage, Configuration (CNF) storage, and delegates authentication to another LDAP directory service, if desired.

The LexisNexis InstantID® solution is also utilized in conjunction with the IDM product for Identity Proofing during account registration. When an external user attempts to create an account via self-registration, validation checks must be made to ensure the user is who they say they are. For this reason, Identity Proofing must take place. Identity Proofing is the process of verifying and authenticating the identity of a user prior to account registration. LexisNexis InstantID® is the identity proofing solution that will be integrated with ForgeRock IDM when a user attempts to self-register. The LexisNexis Identity Proofing solution determines whether the identity a user claims is real, prevents identity-based account fraud, and integrates with ForgeRock IDM to ensure an external user is who they say they are prior to account creation.

The SIEM solution, Splunk, includes two core components: Splunk Enterprise and Splunk Enterprise Security. Splunk shall also integrate with several free Apps and Technology Add-ons available on Splunk's online marketplace, Splunkbase.

Splunk Enterprise is the basic building block of the Splunk Engine and is a prerequisite for implementing Splunk Enterprise Security. Splunk Enterprise is a data analytics and querying tool which includes the following features:

- Ingestion and indexing of logs from various data sources
- Execution of search queries against data indexes
- Creation and configuration of alerts/reports/dashboards
- Generation of alerts and scheduling of reports for email notification
- Role-based access control
- Support for LDAP authentication with Active Directory integration.

Splunk Enterprise Security is the actual SIEM offering built on the Splunk Enterprise platform, which inherits all the Splunk Enterprise capabilities. Splunk Enterprise Security allows for rapid threat and anomaly detection due to continuous and real-time event monitoring of the FX IS/IP. From a SIEM alerts (commonly known as notable events) standpoint, Splunk Enterprise Security provides a workflow for SIEM teams to appropriately prioritize, respond, and mitigate notable events.

There are several Splunk components that are part of the overall SIEM architecture which enable Splunk to function effectively across four categories:

- Searching - Search Heads: These instances have a web interface where the users leverage the Splunk querying language to search for indexed data. Search requests are distributed out to indexers.
- Indexing - Indexers: These are instances that process incoming data from forwarders and store results in the indexes as events. Indexes can be created for each incoming data source. For example, all incoming logs from the Palo Alto devices can be classified as part of the “Palo Alto” index, or further stratified to have indexes for the disparate Palo Alto device data sources, such as separate indexes for firewall logs, IDS/IPS logs, and system logs.
- Forwarding - Forwarder: A Splunk component that can collect or consume data and send it to the indexers.
    - Universal Forwarder: A type of forwarder that can only forward data. This is installed on the machines where the data resides, such as Linux or Windows servers.
    - Heavy Forwarder: A type of forwarder that can forward data and has a built-in capability to parse data. It can also ingest data from REST API’s, database tables, and has a web interface.
- Management
    - Index Cluster Master: Instance that centrally manages the functionality of the index cluster.
    - Deployment Server: Instance that acts as a centralized configuration manager for “deployment clients”, which are universal forwarders and heavy forwarders.
    - License Master: Instance that tracks the amount of data being ingested daily. This is where the Splunk license is installed.
        - Collocated with the Index Cluster Master since it does not possess resource-intensive workloads and can coexist with another Splunk instance.
        - Monitoring Console: Instance that provides dashboards for Splunk health monitoring and is equipped with prepackaged alerts tied to Splunk operational issues such as search performance, indexing performance, and license usage alerts. Collocated with the

Deployment Server since it does not possess resource-intensive workloads and can coexist with another Splunk instance.

Splunk Enterprise Security is also capable of creating data correlations across a variety of activities to handle notable event investigations by streamlining incoming data. This enables Splunk Enterprise Security to be an analytics-driven program that can assist in reducing risk within the environment. The monitoring of the FX IS/IP security posture and alerting of notable security events shall occur within the Splunk Enterprise Security platform.

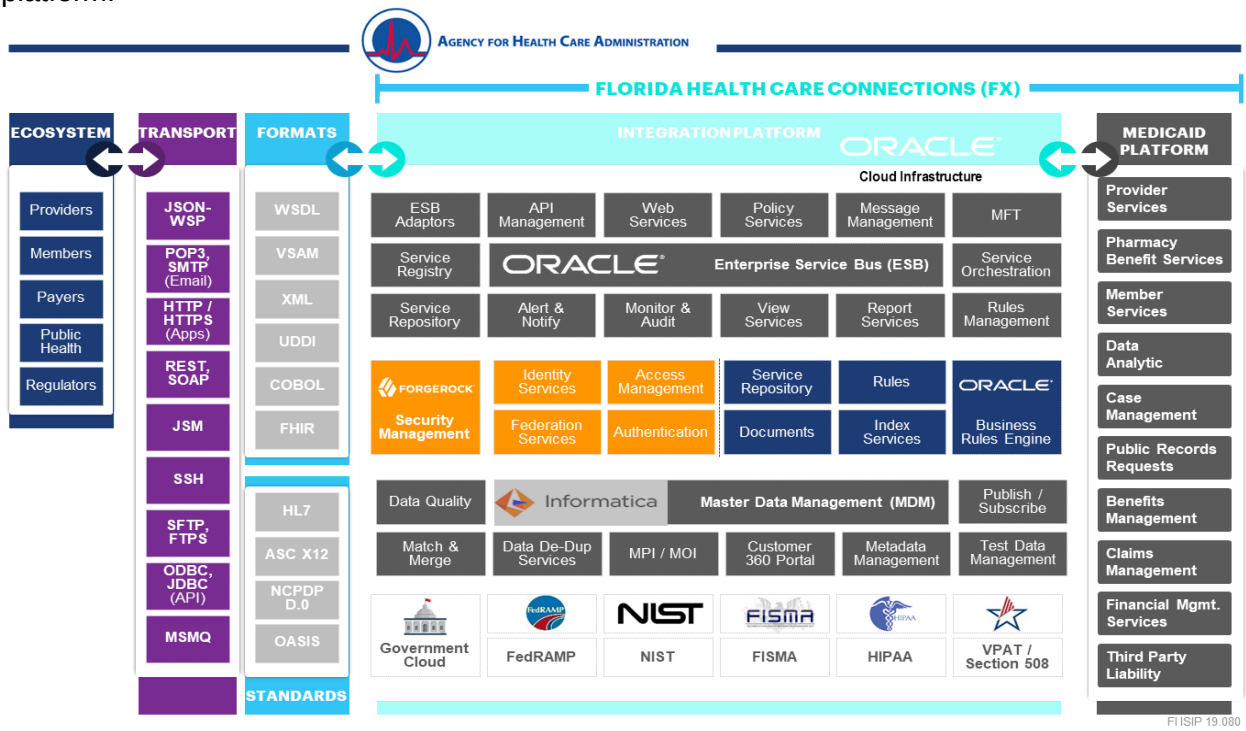

Exhibit 26: IS/IP Architecture

The IS/IP provides a secure, standard communication mode to exchange data between FX modules and across different systems using SOA architecture. It allows Florida Medicaid to leverage a common set of tools for security, authentication, and project delivery. The IS/IP Vendor provides ongoing Operations and Maintenance (O&M) support for the Integration Platform solution through the end of the contract term. O&M includes architecture/hosting operations, monitoring daily operations performance, performing routine maintenance, maintaining user and system documentation, correcting any defects, reporting status against performance standards. The IS/IP Vendor is paid a fixed priced monthly fee for O&M for the duration of the contract term.

Streamlined Modular Certification (SMC)

IS/IP is not a certifiable component of the Medicaid Enterprise System.

Medicaid Program Outcomes Statement

The following outcomes and metrics document how the IS/IP Vendor benefits the Medicaid program. The IS/IP Vendor submits a monthly operations performance report to the Agency which includes these metric results.

Reference	Outcome Statement	Metric
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.

Exhibit 27: IS/IP Vendor Outcomes and Metrics

IS/IP IAPDU Cost

IS/IP Vendor maintenance and operations costs are $4.4 million per FFY. IS/IP Vendor software renewal costs are $2,020,341 for FFY 2025 and $2,814,645 for FFY 2026. The Agency anticipates $135,000 for legal counsel costs to support the IS/IP re-procurement during FFY 2025.

B.2 Enterprise Data Warehouse (EDW) Vendor

The EDW contract was awarded to Deloitte in December 2020 and is effective through December 2027. The EDW solution allows 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 is a modern data management solution that enables improved data integration across the entire Medicaid Enterprise.

The Agency is in the process of amending the EDW Vendor contract for the following:

- Remove the provision for the use of Task Orders as required by the Florida Legislature
- Add requirements related to EDW integration with the UOC and PSM modules that were previously required by Task Orders
- Modify security requirements due the procurement of the FX Enterprise Security and Privacy Assessments Vendor
- Add a requirement for the EDW Vendor to provide an Enhancement Services Team, described further below
- Add a requirement for the EDW Vendor to provide a Module Integration Services Team
- Add Provider Network Verification operations and maintenance
- Revise the contract budget, and

- Add a requirement to implement the Medicaid Program Integrity Sampling Calculation Extrapolation System (PISCES), described further below.

The EDW Enhancement Services Team will build additional reports and dashboards for Medicaid Program Integrity, develop data tables for Medicaid Data Analytics to allow migration from their analytic server and complete other prioritized and Agency approved enhancements that fall outside of O&M support. Tasks related to these enhancements are identified iteratively, prioritized, assigned a level of effort, approved by the Agency, and tracked within Jira.

Medicaid Program Integrity's claim sampling and extrapolation tool is not supported and is obsolete. A modernized replacement PISCES is required to identify and subsequently recover Medicaid provider overpayments in accordance with section 409.913 Florida Statutes and 42 CFR 455. The FX Program proposes to utilize the EDW data from the analytical data store claims database and implement Deloitte Pallium's PISCES framework using Medicaid Program Integrity's existing claims sampling algorithm. Pallium is a Software-as-a-Service product which proactively detects and prevents fraud, waste, abuse, and errors. The Pallium PISCES solution will be well-supported and less costly to maintain which will increase efficiencies and reduce expenses while creating a strong return on investment through overpayment recovery. The FX Program is requesting state match during the upcoming Florida legislative session for state fiscal year 2025-2026. If funded, implementation of the PISCES will be scheduled to occur during state fiscal year 2025-2026.

The EDW implementation was successfully completed on April 9, 2024. The EDW solution consists of the following business architecture components:

Access Layer – The access layer of the solution includes the methods and components end users use to interact with the system. This includes the use of mobile or desktop-based browsers and desktop-based applications.

Security Layer – The security layer of the solution constitutes components that are required for integration with enterprise solutions for authentication and authorization of system users. The security layer also includes components that protect the confidentiality and integrity of the data. Management of system users is restricted to application end-user management. It also includes management of user accounts necessary for back-end processing, web services account management, and internal connectivity between various system components.

Presentation Layer – The presentation layer consists of the means that are used by the access layer to interact with the solution, including the use of web services, application HTML pages, and custom applications through direct connections.

Business Function Layer – The business function layer comprises the components deployed in the solution to support the needs of individual business areas for the state, in alignment with the Medicaid Information Technology Architecture definition of business functions for Medicaid Enterprise Systems. Data needs for these individual functions are supported using the underlying integration layer and application layer components of the solution.

Application Layer – The application layer of the solution lists individual solution components performing specific functions, including features that are used in the background for data processing and functions which are directly leveraged for the representation of information for the end users. These tools and engines are utilized to

support the business functions identified in the business layer by providing information in a consumable format to the end users, thus aiding in informed decision-making processes.

Integration Layer – The integration layer includes the components of the solution used to harvest and disseminate the data acquired from various source systems. These components include an Extract, Transform, and Load (ETL) engine, data replication, web services, representational state transfer (REST) and simple object access protocol (SOAP) and Secure File Transfer Protocol (SFTP). This layer of the solution also includes any outbound interfaces where the EDW solution is used to provide data to internal or external entities.

Data Layer – The data layer of the solution contains the back-end data storage units, including the relational databases, file storage, and log components. The data layer of the solution consists of the following main database regions:

- **Operational Data Store (ODS)** – The Operational Data Store is the primary landing zone for the source data in its native form. Data is replicated in the ODS and remodeled for downstream use. The ODS functions as the single source of truth for all healthcare related data retained and utilized for the FX Enterprise. The ODS centralizes the online transaction processing database of the Medicaid enterprise into a single repository. The EDW Vendor provides professional services for ongoing maintenance, upgrades, and operational support for the ODS, supports future system use of the ODS and ODS data services, and provides data conversion and migration support to modernize existing systems to use ODS data services
- **Reporting Data Store (RDS)** – The RDS is used for operational reporting where pre-configured reports are generated using Cognos. This data store is available to authorized end users for dashboarding and ad hoc reporting for information needs closer to the transactional structures. In addition, this data store also acts as the source for downstream data structures such as the Enterprise Analytics Data Store (ADS), data marts, and specialized data stores.
- **Enterprise Analytics Data Store (EADS)** – The EADS is utilized by the authorized end users for advanced data analysis, ad hoc reporting, dashboarding, and standard analytics. In addition, the power users have direct access to this data store for query-based data analysis.
- **Data Marts** – Data Marts are a logical segregation of the database objects to support business units for the Agency. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) store provides reporting on HEDIS measures using information available in the EDW solution.
- **Specialized Data Stores** – Specialized data stores serve a specific purpose for subject area-specific reports.

Infrastructure Layer – The infrastructure layer reflects the actual hardware being used to support the application and primarily consists of a Linux-based cloud infrastructure. This layer also includes the networking components important for the integration of different solution components, as well as end-user access.

The EDW solution is a cloud-hosted solution, which uses a combination of Commercial Off the Shelf (COTS) products and cloud services for delivery of the EDW solution. The

exhibit below provides a graphical representation of the production system's technical architecture of the EDW solution.

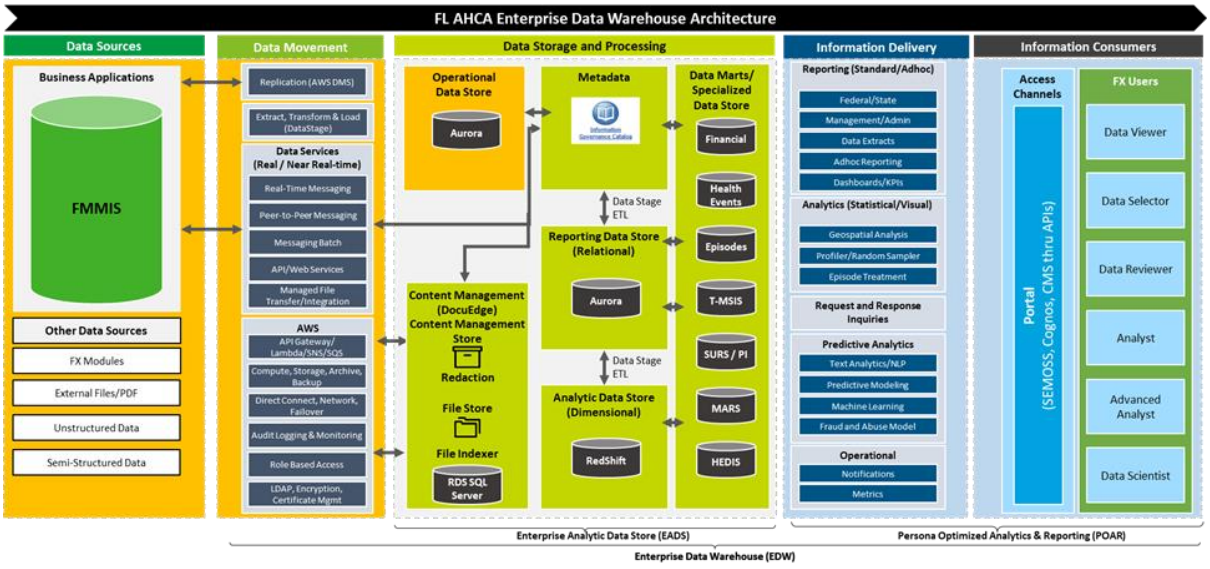

Exhibit 28: EDW Solution Components

The Agency and EDW Vendor successfully launched the ODS, and it is a fully operational component of the EDW. The ODS replicates data from the legacy FMMIS in real-time or near real-time then transforms the information into the modernized data model and structures to serve the FX enterprise.

The Agency and EDW Vendor are preparing for certification of the EDW module. The Agency submitted the Intake Form to CMS on February 9, 2024, and completed the Operational Readiness Review on March 19, 2024. The Agency intends to complete all certification requirements for the EDW module.

The Agency and EDW Vendor are preparing for the transition from legacy systems to the EDW. The EDW Vendor completed a gap analysis of data needs related to the legacy Decision Support System, the Automated Survey Processing Environment (ASPEN), VERSA Regulation Health Facility Licensing System, and the Background Screening Clearinghouse systems used by the Agency that will be transitioned to the EDW. Upon direction by the Agency, the EDW Vendor operations team will develop a transition strategy plan and roadmap that includes activities and time estimates for transitioning each system. The Agency intends to decommission the DSS during fiscal year 2024-2025.

The Provider Network Verification (PNV) will be transitioned from the legacy enrollment broker vendor to the EDW Vendor. Health plans submit PNV reports to the Agency for provider network adequacy validation. The EDW Vendor completed the foundation release for PNV in February 2024, which included implementing initial health plan provider network file processing, validation, and reporting; and implementing health plan network adequacy time and distance calculations and reporting. Next steps for the PNV transition will be planned when the activities are funded and prioritized.

Anubis is an SQL server containing extracts of claims, encounter, and eligibility data used by Medicaid Data Analytics to support the analysis and reporting needs of the Agency. Based on an FX assessment, Anubis will be retired with the decommissioning of the DSS and the data needs will be provided by the EDW.

Streamlined Modular Certification (SMC)

The Agency supports implementation of the EDW designed to achieve the CMS required outcomes described below for Decision Support System (DSS) / Data Warehouse (DW). The Agency leverages the Streamlined Modular Certification process to assess the initial readiness for go-live and ongoing success of the module. Refer to the exhibit below for the EDW outcomes and metrics.

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
DSS/DW1	The solution supports various business processes' reporting requirements including generation of Federal reports.	Generation and CMS acceptance of the following reports: - CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report - T-MSIS: Transformed Medicaid Statistical Information System (T-MSIS)	42 CFR 431.428
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	42 CFR 433.112

Exhibit 29: 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.

Reference	State-Specific Outcome Statement	Metric(s)
ST_DSS/DW1	The solution supports understanding of patient health	The EDW solution provides data on recipients with diabetes, management

Reference	State-Specific Outcome Statement	Metric(s)
	events related to chronic conditions, management of which may reduce risk of, or impact from, other serious illnesses.	of which may reduce the risk of, or impact from, other serious illnesses. The measure results include the statewide rates for the following HEDIS measures: -Hemoglobin A1c Control for Patients with Diabetes. The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c was at the following levels: HbA1c control (<8.0%); HbA1c poor control (>9.0%) -Eye Exam for Patients with Diabetes. The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam. -Blood Pressure Control for Patients with Diabetes. The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose blood pressure was adequately controlled (<140/90) -Data on recipients with childhood obesity, management of which may reduce the risk of, or impact from, other serious illness. Measure results will include the statewide rate for sub-measures for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents HEDIS measure. This includes the statewide rate for BMI percentile, statewide rate for counseling for nutrition, statewide rate for counseling for physical activity.
ST_DSS/DW2	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 First-Line Psychological Care for Children and Adolescents on Antipsychotics HEDIS measure. -Sub-measures for the Prenatal and Postpartum Care HEDIS measure.

Reference	State-Specific Outcome Statement	Metric(s)
		- Statewide Rate for Timeliness of Prenatal Care. - Statewide Rate for Postpartum Care.
ST_DSS/DW3	The solution supports reduction of overpayments	Generate pre-defined PI/SURS reports or dashboard to support analysis of provider outlier information.
ST_DSS/DW4	The solution assists in the identification of service misutilization.	Generate pre-defined PI/SURS reports or dashboard to support analysis of service misutilization.
ST_DSS/DW5	The solution supports more efficient reporting.	Report on progress of transforming the CMS-64 from an all manual effort to an automated report.
ST_DSS/DW6	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.
ST_DSS/DW7	The solution is well-positioned to support future business needs by being extensible, accurate, and highly available.	The EDW solution maintains the following performance metrics as additional data sources are added: 1) Response to data service requests: Simple: less than 125 ms, Medium: less than 140 ms, Complex: less than 170 ms. 2) Response to direct access queries: Simple: less than 25 ms, Medium: less than 40 ms, Complex: less than 70 ms. 3) Response to reports: Simple: one second or less, Medium: two seconds or less, Complex: three seconds or less. 4) The solution adheres to the performance standard that the EDW is available 99.5% of the time for every component of the solution 24/7, excluding Agency approved downtime.

Exhibit 30: EDW State-Specific Outcomes and Metrics

EDW IAPDU Costs

Cost Component	FFY 2025	FFY 2026
Maintenance & Operations	$7,268,729	$7,768,919
Software Renewal	$3,672,033	$3,800,299
Enhancement Implementation	$5,431,963	$4,497,319
PISCES Implementation	$1,513,750	$1,586,250
Total	$17,886,475	$17,652,787

Exhibit 31: EDW Costs by FFY

B.3 CMS Requirements

CMS Interoperability Requirements

On March 9, 2020, CMS released the Interoperability and Patient Access final rule (CMS-9115-F), which provides patients access to their health information. Florida is committed to implementing the CMS Interoperability rule to ensure a more effective management of Florida Medicaid. The Agency created the CMS Interoperability Project to meet this goal in partnership with the IS/IP and EDW vendors.

Project planning and initial implementation was completed during SFY 2022-2023. The implementation included development of Application Programming Interfaces (APIs) to allow recipients access to their patient data as well as access to provider and formulary data through third party applications. Additionally, a workgroup convened to identify policy and documentation related to consent and authorization for various entities to access recipients' health data. The release of the endpoints will occur with the FX Recipient Services Release in May 2026. This release includes launching a recipient portal for Medicaid recipients to establish portal accounts that will support the patient access API.

The exhibit below provides a summary of Florida Medicaid's planned compliance dates for the CMS Interoperability and Patient Access final rule requirements.

CMS Patient Access Rule Requirements Planned Compliance Dates Fee-for-Service Medicaid	
Requirement	**Planned Date**
Develop a secure, standards-based API for patients to access their claims and encounter information, including cost	Complete
Develop and implement a provider directory API	May 2026
Implement the recipient portal including consent and authorization requirements that support the patient access API	May 2026
Implement the patient access API	May 2026

Exhibit 32: CMS Patient Access Rule Implementation

On February 8, 2024, CMS published the CMS Interoperability and Prior Authorization final rule to require specified health care programs, including Medicaid and Children's Health Insurance Program fee-for-service and Medicaid managed care plans, to implement by January 1, 2027, and maintain 1) information about prior authorization added to the data available via the patient access API, 2) a provider access API for payers to share patient data with in-network providers, 3) a payer-to-payer API for previous and concurrent payers to provide current payers with patient data, and 4) a prior authorization API for payers to identify whether an item or service requires prior

authorization and identify documentation requirements for prior authorization approval, and supports a prior authorization request and response. These prior authorization APIs must also communicate whether the payer approves the prior authorization request and the date or circumstance under which the authorization ends, denies the prior authorization request and the specific reason for the denial, or request more information.

The FX Program plans to develop and implement the patient, provider, and payer-to-payer APIs in coordination with the Medicaid fee-for-service prior authorization vendor, EQHealth Solutions / Acentra, and the Agency for Persons with Disabilities for prior authorization information for waiver services, contingent upon state and federal funding. The IS/IP, EDW, and UOC Vendors will perform the required planning, design, development, and implementation. Acentra and the Agency for Persons with Disabilities will implement the requirements for the prior authorization API to automate the prior authorization processes.

Streamlined Modular Certification (SMC)

CMS Interoperability is not a certifiable component of the MMIS replacement on its own.

Medicaid Program Outcomes Statement

The following outcomes and metrics document how the CMS Interoperability project benefits the Medicaid Program. Additional outcomes and metrics for Interoperability and Prior Authorization will be developed as that project is funded and initiated.

Reference	Outcome Statement	Metric
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.

Exhibit 33: CMS Interoperability Outcomes and Metrics

CMS Interoperability IAPDU Costs

CMS Interoperability costs are $1,273,750 for FFY 2025 and $3,821,250 for FFY 2026.

Provider Directory

Section 5123 of the Consolidated Appropriations Act, 2023 (CAA, 2023) introduced new requirements for provider directories for Medicaid programs and codifies into statute existing regulatory requirements. The CAA, 2023 requires searchable provider directories published on a public website to be updated quarterly, adds minimum required information, specifies provider types that must be in the directory, and adds a compliance deadline of July 1, 2025.

The Agency intends to comply with CMS requirements for a searchable provider directory on a public website in accordance with Section 1902(a)(83) in November 2025. The FX Program is coordinating with the PSM Vendor to implement this requirement with the PSM go-live in November 2025. The searchable provider directory includes data requirements not maintained in the legacy FMMIS. The FX Program is implementing the requirements with the FX PSM rather than expending state and federal funds to modify and enhance the legacy FMMIS that will be sunset. Due to the timing of PSM implementation, the FX Program is unable to meet the July 1, 2025, deadline and intends to be in compliance in November 2025.

Incarcerated Youth

The Consolidated Appropriations Act, 2023 (CAA, 2023) signed into law on December 29, 2022, includes provisions impacting the availability of certain Medicaid state plan services for incarcerated youth. During FFY 2025, the IS/IP Integration Services Team and the EDW Vendor will perform technical enhancements to support the Medicaid Program's implementation of the statutory requirements in the CAA, 2023. Activities may include updating interfaces with the Department of Juvenile Justice and the Department of Corrections for the receipt of required data through the IS/IP to be stored in the EDW.

B.4 Module Integration

FX Module Integration (MI) includes the activities required to integrate the components of the Medicaid Enterprise System, including FX modules and partner systems (state, federal, external). The MI Project includes the transition stage of interfacing with the legacy FMMIS, while incrementally integrating FX modules in alignment with the FX Roadmap. Module integration is essential for securely sharing data, providing a seamless log-in experience, increasing interoperability with FX partners, and realizing the Florida Medicaid stakeholder benefits provided with each module. The FX MI transition approach is described in the exhibit below.

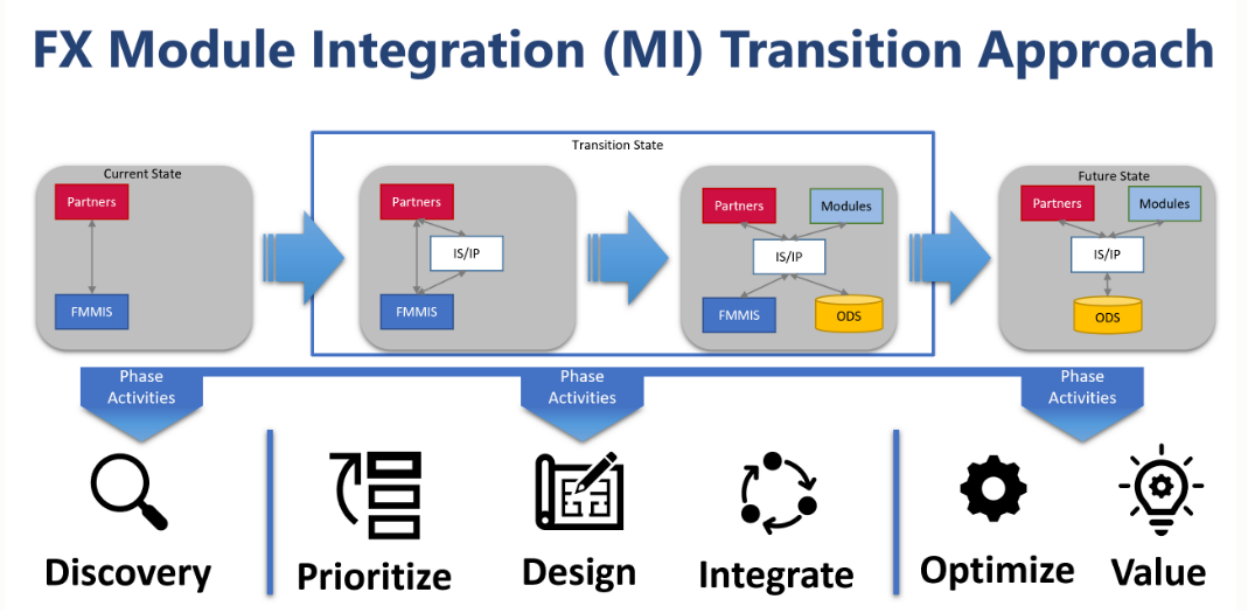

Exhibit 34: FX MI Transition Approach

The FX Integration Services / Integration Platform (IS/IP) Vendor is responsible for integration planning, design, development, and implementation (DDI) for FX modules. The IS/IP Vendor provides the foundational technical platform and technical integration services which will enable the transformation from the monolithic Medicaid system to the FX by integrating FX modules into the platform.

The IS/IP Vendor provides a Base Integration Services Team responsible for planning, scheduling, testing, and validating connections to the platform for FX vendors to enable interoperability across FX modules, as well as other enterprise systems. This team provides prioritized integration services focused on meeting the Agency's needs for interoperability, enterprise integration, and technical coordination of module component implementations for FX, including the integration of health care data (e.g., recipient, provider, and claims data) from modules, as well as other enterprise system health care programs.

The Enterprise Data Warehouse (EDW) Vendor provides functional integration for module data and data management integration including data exchange, data mapping, and data standardization. These enterprise data integration capabilities will allow the Medicaid Enterprise System to be more efficient in sharing data and services between systems within and among state agencies.

The IS/IP Vendor developed and maintains the FX MI Integrated Master Project Schedule. This schedule collates tasks from the state, IS/IP, EDW, FX module vendors, and legacy FMMIS teams. The IS/IP Vendor collaborates with the state and FX vendor teams to maintain and update the FX MI Integrated Master Project Schedule on a weekly basis.

In preparation for module integration, the IS/IP Vendor created the MI Architecture and MI Program Structure, processes, and procedures to coordinate and oversee architecture planning, interoperability, and testing efforts across FX modules. The MI

Architecture and MI Program Team supports FX module vendors, the state, partner state entities, and stakeholders to integrate with the systems within the FX solution.

The state issued fixed-price, deliverable-based task orders to the IS/IP and EDW Vendors related to the scope of the contracts. Each task order was developed in coordination between the vendor and state and reviewed by the IV&V Vendor prior to execution. Each task order includes:

a. Scope of Services
b. Activities to be performed by the vendor
c. Activities the vendor expects the state to perform
d. Timelines
e. Vendor staffing plan
f. Fixed price deliverables
g. Milestones and delivery dates
h. Bill of materials purchased with no profit or overhead to the state and paid as a cost-reimbursement to the vendor (if applicable).

Effective July 1, 2024, the Agency no longer issues task orders. All vendor requirements are included in fixed-price, deliverable-based contract amendments. This section of this IAPDU is revised to remove issued task order descriptions which are now all closed.

During FFYs 2025 and 2026, the IS/IP, EDW, PSM, and UOC Vendors are performing module integration to prepare for the FX Service Desk Release, FX Provider Services Release, and FX Recipient Services Release. The results of module integration for the FX Service Desk Release will streamline technical support for FX systems and associated applications into one contact center. The results of module integration for the FX Provider Services Release will facilitate improved data quality by integrating with the master person index, master organizational index, and ForgeRock, the provider identity and access management solution. The results of module integration for the FX Recipient Services Release will enable chat functionality for faster resolution of inquiries, access to customer history to expedite inquiries, access to near real time data to provide Medicaid recipients with up-to-date information, and improved operations and reduction of manual processes.

Future scope includes module integration for the remaining Phase 3 modules, Core Services Module and Pharmacy Benefits Management, and Phase 4- Additional Medicaid Enterprise Systems, such as third-party liability and enterprise case management.

Medicaid Program Outcomes Statement

The FX MI Project is not a certifiable component of the Medicaid Enterprise System. The following outcomes and metrics document how the MI Project benefits the Medicaid program.

Reference	Outcome Statement	Metric
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.

Exhibit 35: Module Integration Outcomes and Metrics

MI IAPDU Costs

MI Costs for FFYs 2025 and 2026 include the following:

Module(s)	FFY 2025	FFY 2026
IS/IP for IS/IP MI	$11,423,496	$11,423,496
IS/IP for PSM MI	$5,846,917	$0
IS/IP for UOC MI	$1,351,671	$0
IS/IP for PBM MI	$625,000	$1,875,000
EDW for EDW MI	$3,929,127	$3,929,127
EDW for PSM MI	$4,053,929	$5,558,965
EDW for UOC MI	$2,220,652	$5,973,219
EDW for PBM MI	$625,000	$1,875,000
Total	**$30,075,792**	**$30,634,807**

Exhibit 36: Module Integration Costs by FFY

B.5 FMMIS Transition

FMMIS Transition is a collaborative effort between the Agency, the FMMIS Vendor, the IS/IP Vendor, and FX module vendors. The IS/IP Vendor provides integration planning and technical services to support the transition of legacy services and components to FX modules. The FMMIS Vendor supports FMMIS Transition by providing resources to participate in technical requirements and business process sessions, respond to information requests, and provide FMMIS interface information. The FMMIS Vendor will coordinate with the successor FX module vendors and the Agency in the planning and transfer of system functionality and the related operational functions. The FMMIS Vendor will perform iterative phases of transition and turnover activities for each FX module, including training, documentation transfer, and resource support.

During Fiscal Years 2024 and 2025, the FMMIS Transition Project team will enhance the Fiscal Agent / Operational Data Store Unit and Development Test Replication Supportive Environment (FORTE), and support testing for FX module integration. The FORTE environment will be enhanced with hardware, software, and license purchases to support minimum specification requirements. Additionally, under the FMMIS Transition Project, hardware will be purchased to complete an upgrade to the FMMIS production and non-production servers by migrating to RedHat Enterprise Linux version 8 or higher, adding host bus adapters (HBAs), and adding storage area network (SAN) for improved efficiency and better data management as part of the FX Program's development, testing, and implementation phases.

The FMMIS Transition Project team will maintain the replication solution between FMMIS and the EDW Operational Data Store and will maintain the enhanced testing environment created to support transition activities until the legacy FMMIS is sunset. Maintenance includes the annual or ongoing purchase of hardware and software such as SAN, backup and recovery, and Oracle.

The Agency is proposing to pursue the following FMMIS Transition Integration Projects. The proposed projects have been identified based on value and level of effort. The projects will support data exchange and integration with FX modules for the duration of the legacy FMMIS contract and support the FX Provider Services Release. The Agency and FMMIS Vendor are targeting an October 2025 implementation for each of the projects.

FMMIS Transition Integration Projects	Value	Effort
Implement API integration framework	High	Moderate
Sunset legacy MEUPS* and integrate with ForgeRock SSO	High	Moderate
Cloud migration discovery	High	High
Integrate with the FX Enterprise Disaster Recovery process	High	Low

*Medicaid Enterprise User Provisioning System

Exhibit 37: FMMIS Transition Integration Projects

The Agency requires fixed-priced deliverables for each project including a project schedule, requirements management plan, system design plan, test plan, training plan, implementation plan, and warranty plan. The FMMIS Transition Project team is required to comply with the FX Project Management Standards and FX Project Standards for deliverables and project documentation. The FMMIS Vendor is required to designate key personnel for the FMMIS Transition Integration Projects to facilitate successful project implementation.

An API integration framework is required to facilitate system-to-system interactions between FMMIS and the FX modules. The integration framework will provide secure communication, data transformation, logging and monitoring capabilities, and secure Application Programming Interface (API) endpoints that can be invoked by the FX integration platform and other FX modules to send data back to FMMIS.

ForgeRock is the Agency's approved FX enterprise solution for authentication, Single Sign-On (SSO), and authorization. The FMMIS interChange application is currently accessed from MEUPS for authentication and authorization. Upon completion of testing and integration with ForgeRock, MEUPS will sunset, and all FMMIS applications will be authenticated through ForgeRock.

The cloud migration discovery project will include research, analysis, and development of plans to migrate the legacy data center to the cloud. The FMMIS Vendor will perform tasks to assess application readiness for the cloud, identify immediate, short-term, and long-term opportunities to leverage cloud services over legacy hosting services to reduce costs and complexity, identify regional and secondary cloud placement, and define the overall architecture.

Integration with the FX Disaster Recovery process is a quick win to align the legacy FMMIS to the FX standards and procedures to recover and protect FX systems in the event of a disaster. The FMMIS Vendor will align to the FX failover plan, testing schedule, and business continuity plans.

Streamlined Modular Certification (SMC)

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

Medicaid Program Outcomes Statement

The following outcomes and metrics document how FMMIS Transition benefits the Medicaid Program.

Reference	State-Specific Outcome Statement	Metric
FT1	FMMIS Transition services support the transition of legacy services and components to FX modules.	Documented and implemented processes for data exchange.
FT2	FMMIS Transition services minimize risk for the Agency, IS/IP Vendor, and FX vendors for transition activities.	Integration with the FX Single Sign-On (SSO) solution, integration with the FX Enterprise Disaster Recovery process.

Exhibit 38: FMMIS Transition Vendor Proposed Outcomes and Metrics

FMMIS Transition Costs

FMMIS Transition costs for FFYs 2025 and 2026 include the following:

FMMIS Transition	FFY 2025	FFY 2026
Implementation deliverables	$5,362,304	$7,428,943
Hardware and Software renewals	$2,258,164	$2,258,164
API maintenance support	$213,750	$855,000
Total	**$7,834,218**	**$10,542,107**

Exhibit 39: FMMIS Transition Costs by FFY

ATTACHMENT C — PHASE 3: FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM (FMMIS) TRANSITION

Phase 3 leverages the infrastructure established in Phase 2 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 includes 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 contract. The UOC includes the network, 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.

The UOC procurement concluded with the posting of the Notice of Intent to Award on June 14, 2022. The Agency executed the UOC contract with Automated Health Systems (AHS) on October 13, 2022, and is effective through September 2029, with an option to renew.

The Agency is in the process of amending the UOC Vendor contract for the following:

- Remove the provision for the use of Task Orders as required by the Florida Legislature
- Revise security requirements due the procurement of the FX Enterprise Security and Privacy Assessments Vendor
- Revise the detailed budget

- Revise the implementation stages to align with the updated FX Roadmap
- Adds support services for the Service Desk release

The UOC Project is a multi-release implementation that aligns with the implementation of FX modules and business services and supports iterative decommissioning of legacy vendor systems and operations. The FX Enterprise Foundation Release was implemented on February 26, 2024, and established the required UOC infrastructure platform components which are integrated with the Integration Services/Integration Platform (IS/IP) and Enterprise Data Warehouse (EDW) infrastructure. An extension of the FX Enterprise Foundation Release is an operational Service Desk.

The Service Desk Pilot Release is planned for December 2024, and the operational release is planned for June 2025. The Service Desk will serve as a centralized point of contact where FX system users can seek assistance, guidance, and solutions for their technical issues or inquiries related to an FX application, service, or system. The Service Desk is a module within the Microsoft Dynamics 365-based system that helps organizations manage their IT services by tracking issues and improving technical support processes. The Service Desk will be adopted by FX modules to log and manage incidents and service requests. The UOC Service Desk includes requirements for ticket management, escalation, communication, documentation, collaboration, compliance, customer satisfaction, workforce planning, scheduling, performance management, resource allocation, training and development, and process improvement.

The FX Provider Services Release is planned for November 2025 in alignment with the FX Provider Services Module implementation. This release will transition provider-related contact centers and operations. The UOC Vendor will coordinate the transition of the provider enrollment call center operations with the Fiscal Agent and the FX Provider Services module vendor, and will assume responsibility for provider communications, outreach, and training. In addition, the Agency Provider Assistance call center will transition to the UOC platform during this release.

The FX Recipient Services Release transitions the recipient-related contact centers and operations. This includes transition from the enrollment broker customer service and business operations to the UOC, transition from the Agency Recipient Assistance Call Center to the UOC platform, transitioning the Agency's IT Help Desk to the UOC platform, and transitioning the Agency's background screening clearinghouse call center and mail operations to the UOC platform. In this release, the UOC Vendor will perform recipient mail operations, and recipient outreach and communication activities. The FX Recipient Services Release is planned for May 2026.

Additional releases will be planned to coincide with the implementation of the FX Core System and Pharmacy Benefits Management (PBM) Modules. The releases will include claim support, including provider outreach, communication, training, and on-site support for claims, and PBM customer support activities. Complaints, including recipient grievances, appeals, complaints, and fair hearings will transition to the UOC Vendor. In addition, Agency Complaints Administration Unit will transition to the UOC platform.

Additional Agency business areas may be transitioned to UOC operations or to the UOC platform in the future under FX Phase 4 activities, such as plan management, third party liability, enterprise case management, and contractor management.

Streamlined Modular Certification (SMC)

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

Medicaid Program Outcomes Statement

The following outcomes and metrics document how the UOC benefits the Medicaid program.

Reference	Outcome Statement	Metric	Regulatory Sources
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.	Not Applicable
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.	Not Applicable
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.	Not Applicable
UOC4	The UOC Platform solution will ensure consistent messaging, facilitate better and more cost-effective training, and boost first-call resolutions.	Calculate savings trends by comparing consecutive quarterly training and contact center costs.	Not Applicable
MM2	The system sends notice, or facilitates, to the enrolled member with an initial assignment, a	- 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	CFR 42 438.10, 438.54

	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.	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.	
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	- 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.	42 CFR 438.10(e)

	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.		
PM16	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.	- 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 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	- 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

	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)		

Exhibit 40: UOC Vendor Outcomes and Metrics

UOC IAPDU Costs

UOC implementation costs are $5,819,612 for FFY 2025 and $11,052,615 for FFY 2026. UOC maintenance and operations costs are $1,144,743 for FFY 2025 and $20,226,848 for FFY 2026.

C.2 FX Core Systems Module

The FX Core Systems Module (Core) 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 represents the most fundamental functionality required for Medicaid transition, and involves the longest combined timeframe for planning, procurement, and implementation. The FX Core procurement concluded with the Notice of Intent to Award on October 18, 2022. The FX Core contract with Gainwell Technologies was approved by CMS on December 27, 2022, and the contract was executed on March 15, 2023. The FX Core contract includes ongoing support of remaining FMMIS and fiscal agent services not yet cutover to an FX module vendor by December 31, 2024, thereby resolving the current FA contract. The Agency does not intend to exercise this option. The Agency intends to renew the legacy FMMIS contract through December 31, 2027, as recommended by the Florida Legislature during the 2024 legislative session and authorized by the (Florida) Implementing the 2024-2025 General Appropriations Act. The Agency requested and received CMS approval in the legacy FMMIS Operational APDU. The Agency had the option of implementing the awarded FX Core vendor's Pharmacy Benefits Management (PBM) solution, which would eliminate the need for the PBM procurement. The Agency decided not to implement Gainwell's PBM solution.

As a result of the FX ESC decision on December 14, 2023, to place FX Core implementation on hold, all deliverables and work in process for the FX Core Systems Module were paused. The legacy FMMIS vendor will continue providing legacy core services until the contract expires. During FFY 2025, the FX Program ESC will decide whether to resume the FX Core implementation, reprocure the solution, or issue a takeover procurement for the legacy FMMIS as the FX Core solution with modernization and modularization requirements.

The current Core FMMIS functions include claims/encounters transaction processing, banking, financial processing, including capitation payments for Statewide Medicaid Managed Care (SMMC) health plans, claims payments, and pharmacy claims payments. Core FMMIS functions also include reference file management for edits and audits, benefit plans, coverage rules, reimbursement rules, diagnosis codes, procedure codes, modifiers, diagnosis related groups, revenue codes, and error codes. As the name "Core" suggests, this module represents the most essential functionality required for Medicaid processing and involves the longest combined timeframe for planning, procurement, and implementation. The defined scope of the Core Systems Module includes the following:

Edits, Processing, and Adjustments - The Core Systems Module will adjudicate all claim and encounter transactions and apply edits based on configurable business rules to manage, edit, and audit disposition criteria and disposition status including, but not limited to, duplicates, history, bundling, procedure, service limit(s), diagnosis codes, procedure code relationships, service authorizations, age, gender, eligibility, provider type, specialty, category of service, National Correct Coding Initiative (NCCI) editing, expanded benefits for encounters, and added benefits for encounters. The Core Systems Module will perform configurable claim and encounter transaction adjustment and resubmission processes with automated and ad-hoc functions to support retroactive rate changes/adjustments, procedure or diagnosis code revisions, benefit plan updates, audit activities, or encounter specific rules, including encounter resubmission, established by the Agency.

Pricing and Payment - The Core Systems Module will accurately calculate and price using the appropriate reimbursement methodologies for services including, but not limited to, Fee-for-Service, percent-of-charges, professional claim, transportation, waiver, Regional Perinatal Intensive Care Center, Ambulatory Surgical Center, Enhanced Ambulatory Patient Grouping, Child Health Checkup, Long Term Care, inpatient claim, outpatient claim, Diagnosis Related Groups, out of state, Medicare Part A and B, capitation, Prospective Payment System, manual pricing, other deductions (e.g., Copay, Medicare Coinsurance, Medicare Deductibles, Patient Liability, TPL), and shadow pricing for encounters.

Benefits and Reference Data Management - The Core Systems Module will store and support a variety of pricing methodologies and provider contracts with the flexibility to support multiple payers and financial management processes. In support of claims adjudication, the Core Systems Module will also process against service authorizations and third-party insurance liability. The Core Systems Module will provide and maintain configurable reference data to support configurable and complex business rules utilized for claim adjudication, provide the most up-to-date and complete NCCI edit definitions with clear descriptions for submitters to resolve issues, and deliver a detailed and efficient User Interface (UI) for the full display and visibility of claims details, including but not limited to, rules processed, and claim value associated with the rule.

Claims Data and Reporting - The Core Systems Module will include configurable, automated, and ad-hoc reporting functionality based on current and historical medical and non-medical transaction data including paid, suspended, and denied claims, encounters, rate updates, and provider payment. These reports and analysis may be used to support State and federal reporting and support the information requirements necessary for the evaluation, comparison, and management of claims. The Core Systems Module reporting functionality will collect, and group data required to support the Enterprise Data Warehouse (EDW) Vendor's solution in meeting all Agency and federal reporting guidelines, requirements, and periodicity. The Core Vendor shall coordinate with the EDW Vendor to ensure that required data elements which are available are stored in the enterprise ODS for use by the EDW Vendor for report production. The Core Vendor will comply with any new CMS reporting requirements.

System Administration and Operations - The Core Systems Module will act as the Electronic Data Interchange (EDI) gateway to process all inbound and outbound HIPAA mandated X12 compliant transactions and Trading Partner management. The Core Systems Module will provide a self-service portal with enhanced web-based capabilities to support the following:

- On-line, real-time transactions processing and direct data entry for claims
- Claim status inquiry
- Batch upload, download, view, and print HIPAA transactions
- Submission and retrieval of documents
- Secure messaging
- EDI help-desk functions.

Service Authorizations - The Core Systems Module will include functionality to interface with the Agency's utilization management vendor for service authorizations and referrals. This functionality must be configurable to meet the needs of diverse programs. Service authorizations are used to allow for specific services, track utilization, and monitor outcomes. The Core Systems Module will interface with the utilization management vendor's solution to create and update referrals for service authorizations.

Fiscal Management -The Core Systems Module will allow data required for financial business processes to be entered manually, received from other sources, or automatically generated based on a configurable business rules engine. Data received from other systems will be translated into consistent financial account coding to report back to the Agency's financial and accounting systems and support the Agency's banking vendor. The Core Systems Module will have the capability to translate transactions into summary level and detailed data and will assign financial information to each healthcare claim and financial transaction at the line and header level. The Core Systems Module will generate adjustments to change financial information assigned to a healthcare or financial claim as appropriate without requiring re-adjudication of the to-be adjusted claims.

Federal and State Reporting - The Core Systems Module will carry the source data required for the EDW Vendor to generate all applicable federal and state reports and processes (CMS37.7, CMS64, CMS21E, CMS416, CMS372, MAR, SUR, and TMSIS). The Core Vendor will coordinate with the EDW Vendor for report production. The Core Vendor will be responsible through quality assurance activities for the accuracy of the

Core generated data used within the reports and participate in any needed corrective action resulting from report deficiencies.

Financial Reporting - The Core Systems Module will have the capability for a user to view financial transactions related to one payee at the detail level, including remittance advice, accounts receivable, recoupments, and recoveries. Information will be captured and shared for required State and federal processes.

Capitation Payments - The Core Systems Module will calculate and generate payments made to managed care plans on behalf of the Agency for enrolled eligible recipients for approved dates of enrollment, in accordance with the payment rules and policies of the Agency. The Core Systems Module will generate a per-member, per-month capitation, including adjustments, based on calculated rates for each recipient defined by their geographic region, age, eligibility category, benefit plan during the payment period. The Core Systems Module will be configurable to allow for the adjustment of capitation rates that occur due to historical utilization, projected cost, or other risk factors associated with the pool of recipients.

Recipient Management - Recipient Title XIX Medicaid eligibility is determined by the Florida Department of Children and Families and the Social Security Administration for Supplemental Security Income, Florida Healthy Kids for Title XXI children, and by CMS for Medicare buy-in eligible recipients. The Core Systems Module will receive eligibility information from these source systems including, but not limited to, identifiers, demographics, aid categories, patient responsibility, Medicare and buy-in information, and third-party insurance coverage. The Core Systems Module will rely on this information to maintain eligibility files for benefit plan assignment, to support claims and encounter processing, eligibility inquiries, calculate provider and plan reimbursement, cost sharing, managed care plan assignment, and to facilitate utilization review and analysis. The Core Systems Module will auto assign mandatory recipients to managed care plans based on defined algorithms. The Core Vendor shall coordinate with the Integration Services/Integration Platform (IS/IP) Vendor to develop interfaces with internal and external partners and multiple data sources that support the recipient management process. The Core Vendor will maintain the reliability of the recipient data through ongoing reconciliation processes to ensure the integrity of the data and to support other Core business functions that utilize recipient data.

Correspondence Management - The Core Vendor will coordinate with the UOC Vendor to generate enterprise correspondence and coordinate the print and distribution of approved print and mail. The Core Systems Module will support the capacity to configure and maintain correspondence management functionality. The Core Systems Module will leverage the EDW Vendor's Enterprise Content Management (ECM) solution to store all sent and received documents and their meta data.

The Core Vendor will continuously maintain, enhance, and modify its Core Systems Module, as directed by the Agency, to ensure the ability to comply with new federal and State regulations and mandates, healthcare delivery models, and to support interoperability with all other data sharing entities. The goal of the Core Systems Module 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.

The objectives of the Core Systems Module are:

- Transition claims, encounters, financial processing, managed care capitation payments, recipient, and reference data from the current Fiscal Agent to the Core Systems Module.
- Reduce the number of claim resubmissions by improving communications of claim status.
- Improve the reliability of health plan encounter data.
- Reduce claim validation processing costs in Agency systems.
- Reduce Agency financial staff time on manual data re-entry and processing.
- Separate business rules, including State and Federal pricing business rules, and edit/audit processing capabilities for claims and encounters.
- Eliminate remaining paper claims and associated manual processes.
- Implement an accessible and efficient UI with enhanced visibility to information, rules and reference sources impacting a claim.
- Improve data quality and management and increase automation to reconcile and update recipient information

A high-level list of deliverables and milestones completed or partially completed prior to the Core pause decision is provided in the exhibit below.

FX Core Systems Module	
Deliverable/Milestone	**Date Completed**
Contract Executed	March 2023
Project Kick-off Presentation	April 2023
Project Management Plan Approved	May 2023
Project Charter Approved by FX ESC	June 2023
Initiation Phase Completed	September 2023
High-Level Technical Design	November 2023
Baselined Project Schedule	December 2023
Requirements Management Plan	December 2023
System Security Plan	Partial- December 2023*
Data Conversion and Data Migration Plan	Partial- December 2023*
Bill of Materials Analysis	Partial- December 2023*
Testing Management Plan Deliverable	Partial- December 2023*

**Payment prorated based on percentage complete as determined by the FX Program Office.*

Exhibit 41: Core Project Deliverables

Streamlined Modular Certification (SMC)

The Agency leverages the Streamlined Modular Certification process to assess the initial readiness for go-live and ongoing success of the FX modules. The Core System Module is designed to achieve the CMS required outcomes and state developed outcomes, as relevant, for Claims Processing (CP), Encounter Processing System (EPS), Financial Management (FM), and Member Management (MM). Outcomes and metrics for the Core System Module are described in the chart below. State-specific metrics will be defined during requirements gathering and system design.

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
CP1	The system receives, ingests, and retains claims, claims adjustments, and supporting documentation submitted both electronically and by paper in standard formats.	- Count/percentage of claims received by submission channel (paper vs. electronic). - Median processing time for ingestion 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 re-priced post-payment by underpayment/ overpayment and, if applicable, reason code or other applicable categorization available to the State.	42 CFR 431.052

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
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)	- Count/percentage of claims suspended for correction/corrected by reason code. - 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
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

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
EPS1	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).	- Percentage of timely encounter submissions from MCOs.	42 CFR 438.242
EPS2	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 dis-enrolled 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 non-compliance 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

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
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	42 CFR 431.152

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
		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	- Count/Percentage of on-time reporting for designated reporting	42 CFR 431.428

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
	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
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)

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(e)
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)

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
	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 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 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-for-service (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

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
	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

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
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 real-time (Pass/fail)	For states, District of Columbia, Northern Mariana Islands, and American Samoa: - 42 CFR 435.1200

Exhibit 42: FX Core Outcomes and Metrics

Core IAPDU Costs

Core implementation will resume in FFY 2025 or will be reprocured. Planning implementation costs are $4,356,239 for FFY 2025 and $19,071,208 for FFY 2026.

C.3 Provider Services Module

Florida Medicaid issued a competitive procurement for the FX Provider Services Module (PSM). The Invitation to Negotiate was completed in June 2023, and the contract was awarded to HHS Technology Group, LLC. The FX PSM contract was executed on October 11, 2023, and is effective through September 14, 2030, with an option to renew.

The PSM solution will improve provider experience and reduce the administrative burden for enrollment and credentialing. The PSM solution aims to create a module for Medicaid provider management allowing for concurrent processing of enrollment and plan credentialing activities for both initial enrollment and renewals. The PSM will 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.

In addition to provider enrollment and credentialing activities, the functions of the PSM include provider account management processes such as name change, address change, change of ownership, and specialty addition or change. The PSM will consist of the following features:

- A simple and seamless provider experience across all interactions and channels.
- An overall provider enrollment and maintenance solution that will accept and process applications through a web-based provider self-service tool.
- 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.
- An automated screening and monitoring component to complete required screening and monitoring activities for applicants and actively enrolled providers compliant with 42 CFR 455.436, in addition to state specific requirements and policy.

- The ability to coordinate with the Enterprise Data Warehouse (EDW) Vendor to develop and publish reports and dashboards on the EDW's Enterprise Reporting Solution.
- A solution with a high degree of configurability.
- A self-service portal including the following minimum functionality:
    - An inbox for providers to receive and respond to messages.
    - 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.
    - A provider search feature for both authenticated users and public users to search for providers using a variety of search criteria.
    - Account administration for users to add or remove provider account users and change user roles for all self-service functions.
    - Online resource links to relevant websites and key contact information.
- A recipient eligibility inquiry tool that performs real-time recipient eligibility verification including benefit plan enrollment, care management enrollment, waiver program information, program limits, service limits, and third-party liability information.
- A claim status inquiry function that performs in real-time to allow providers to check the status of their claims.
- A remittance advice inquiry feature that provides authorized user access to provider remittance advice information.
- 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.
- Primary source verification based on Credentials Verification Organization National Committee for Quality Assurance standards.
- Account management.
- Communications.
- Performance management including system performance, user performance, and business process performance.
- Workflow and assignment management.
- Customer care.

The objectives of the PSM Module:

- Medicaid enrollment, including re-enrollment and renewal, and plan credentialing into a concurrent process.
- Single source for provider credentialing.
- Streamlined enrollment process with workflow assignment and efficient business processes.
- Reduced administrative burden on Agency staff and providers through automation.
- Reduced time to enroll a Medicaid provider.
- Reduced cost per enrollment for providers.
- Automated account management updates triggered through electronic interfaces or initiated by the provider.
- Single source for providers to report a change.
- Enhanced communication channels with providers.
- Supports enhanced fraud reduction capabilities.

- Quality data and analytics supported by IS/IP and EDW.

The Agency is in the process of amending the PSM Vendor contract to remove the provision for the use of Task Orders as required by the Florida Legislature, modify security requirements due to contracting with the FX Enterprise Security and Privacy Assessments Vendor, revise the detailed budget with a $384,151 increase to the total contract amount, and to exercise the contract provision related to mitigating FMMIS transition risk through innovative staffing. The PSM vendor will employ up to 32 provider staff from the legacy FMMIS vendor to mitigate risk during turnover. The net increase in total contract amount is due to an increase in bill of materials, decrease/delay in the start of the operations and maintenance phase, and the election to use innovative staffing.

Streamlined Modular Certification (SMC)

The Agency leverages the Streamlined Modular Certification process to assess the initial readiness for go-live and ongoing success of the FX modules. The Provider Services Module is designed to achieve the CMS required outcomes for Provider Management (PM). Outcomes and metrics for the Provider Services Module are described in the chart below.

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
PM1	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	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	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 providers upon initial application with Return to Provider time included	42 CFR 455.412

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
		Total time to screen all providers/Total # providers screened - Average Time to credential providers Total time to credential providers/Total # of credentialed providers	
PM4	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	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	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	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.	42 CFR 455.422
PM8	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.	- 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)

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
PM9	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	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	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.	- Number of providers in each category by category for each new application, re-enrollment/revalidation - Number of providers with changes from moderate to high due to payment suspension or moratorium	42 CFR 455.450
PM12	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	A state user can set CMS and state-imposed temporary	- Number of providers in temporary moratoria status and duration range	42 CFR 455.470

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
	moratoria on new providers or provider types in six-month increments.	- Number of providers in temporary moratoria outside of 6 months	
PM14	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	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	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.	- Provide a copy of relevant notices and communications submitted to providers for each outcome category.	42 CFR 455.23
PM17	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
PM18	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	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

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
PM20	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 entity due to: - Change in state residence - Investigation of FWA - Death - Others as defined by state - Include provider state Medicaid status	42 CFR 438.608(a)
PM21	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.	42 CFR

Exhibit 43: PSM Outcomes and Metrics

PSM IAPDU Costs

PSM implementation costs are $7,939,860 for FFY 2025 and $1,465,699 for FFY 2026. PSM maintenance and operations costs are $681,960 for FFY 2025 and $11,856,735 for FFY 2026.

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.

The proposed scope for the FX PBM Module includes the following:

- Adjudicate fee-for-service (FFS) pharmacy claims submitted by pharmacy providers via their point-of-sale or through integration with e-prescribing systems, and process pharmacy encounters received from Medicaid health plans.
- Integrate Agency reimbursement methodology and incorporate clinical edits and drug limits during the adjudication process.
- Perform clinical reviews of prior authorization for certain required drugs as well as automate prior authorization.
- Monitor prospective and retrospective drug utilization and coordinate clinical reviews for the Drug Utilization Review Board.
- Provide clinical support as requested by the Agency for drug criteria development, edits, and drug limitation recommendations.
- Create and maintain the weekly comprehensive drug list used by all managed care plans to ensure the Preferred Drug List compliance.

- Provide support for identification and processing of specifically identified disease management participants.
- Operate a Therapeutic Consultation Call Center to advise drug prescribers on best practices for recipients and to provide prior authorization assistance to prescribers, including operational staff to provide information to providers, pharmacists, and recipients.
- Operate the Pharmacy Ombudsman's Office, staffed by pharmacists, for intervention on behalf of Medicaid recipients to facilitate the timely resolution of claim reimbursement rejections and denials.

On December 14, 2023, the FX Executive Steering Committee (ESC) met and voted on FX Program recommendations. The ESC decided to reduce procurement risks and the resource burden of the FX PBM module by utilizing a National Association of State Procurement Officials (NASPO) ValuePoint competitively solicited multi-state PBM module contract. FX will work with Georgia and other states already in the process of procuring a PBM solution. Utilizing NASPO will benefit FX by leveraging the expertise of resources across states to produce a single solicitation to obtain best value from vendors considering price, quality, reliability, warranties, and service, while protecting states' interests with favorable terms and conditions. Responding vendors benefit by avoiding repetitive bid preparation expenses across states and potentially factor in greater volume when determining pricing.

Streamlined Modular Certification (SMC)

The Agency leverages the Streamlined Modular Certification process to assess the initial readiness for go-live and ongoing success of the FX modules. The FX PBM solution will be designed to achieve the CMS required outcomes and state developed outcomes, as relevant, for Pharmacy Benefits Management (PBM) and Point of Sale (POS). Outcomes and metrics for the FX PBM solution are described in the chart below. State-specific metrics will be defined during requirements gathering and system design.

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
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	- Accurately identifies enrolled providers. - Pharmacy claims and encounters are priced according to the correct pricing algorithm.	42 CFR 456.722

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
	resubmit to ensure timely provider claims payments.		
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
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

Reference	CMS Required Outcomes	Metrics	Regulatory Sources
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 44: PBM Outcomes and Metrics

Reference	State-Specific Outcome Statement	Metric(s)
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.	TBD
SSO2	The Pharmacy Benefit Manager (PBM) module will improve the accuracy and timeliness of the acquisitions and integration of pharmacy encounter data.	TBD

Reference	State-Specific Outcome Statement	Metric(s)
SSO3	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.	TBD

Exhibit 45: PBM State-Specific Outcomes and Metrics

PBM IAPDU Costs

PBM implementation costs are $2,487,164 for FFY 2025 and $8,551,926 for FFY 2026.
PBM maintenance and operations costs are $3,359,808 for FFY 2026 ($0 for FFY 2025).

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ATTACHMENT D — PHASE 4: REMAINING FUNCTIONAL MODULES

The objective of Phase 4 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 FMMIS, and certain parts of their functionality will need to be accounted for before the end of the legacy 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 IAPDU.

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.

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.

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)

Third Party Liability, currently operated by Health Management Systems (HMS), includes 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. The Agency contract with HMS expires on August 31, 2025. Re-procurement may result in introducing new functionality for legal liability, estate recovery, data matching, and post-payment support.

Phase 4 IAPDU Planning Cost

There are no phase 4 planning costs requested with this IAPDU.

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 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 currently provided through the Enrollment Broker contract with Automated Health Systems (AHS), which ends February 29, 2027.

E.2 Prior Authorization (Utilization Management)

The Agency is contracted with a federally designated Quality Improvement Organization for the management and maintenance of statewide comprehensive Medicaid utilization management program for specified Medicaid services provided through the Medicaid fee-for-service delivery system. These functions will interface in FX through IS/IP, similarly to the current state, but with a higher level of maturity. The Agency's contract with EQHealth Solutions is effective through December 2027.