MES STRATEGIC PLAN

STRATEGIC DELIVERABLE S-3

MARCH 27, 2018

KEY TOPICS

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SECTION 1

Introduction

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DOCUMENT INFORMATION

Preliminary information about this document.

Background

The Agency for Health Care Administration (AHCA) partnered with North Highland Worldwide Consulting as the Strategic Enterprise Advisory Services (SEAS) Vendor to create a strong Strategic Plan (Strategy) to guide AHCA's transformation of the Florida Medicaid Management Information System (FMMIS) to a modular environment by 2023. This document offers an executive-level view of AHCA's Medicaid Enterprise System (MES) strategy and is accompanied by a detailed Concept of Operations that both demonstrates the alignment between this Strategy and CMS's Goals/Objectives as well as the effects of planned transformations on stakeholders, information exchanges, Medicaid operations, and healthcare outcomes.

Purpose

The purpose of this strategic plan is to guide AHCA by documenting the MES's aspirational end-state and supporting areas for investment through the MES Vision, Guiding Principles, and Strategic Priorities detailed in this document. Interested parties can use AHCA's 2018 Concept of Operations for further detail. From this Strategic Plan, the Portfolio Management process (based off the Strategic Project Portfolio Management Plan) will capture and prioritize detailed initiatives based on alignment with this Strategic Plan and other investment.

Scope

This Strategic Plan identifies the MES Vision, Guiding Principles, Strategic Priorities, and high-level Tactics to transform the MES. The information conveyed throughout this document was gathered via the following:

- A review of external trends within the healthcare and Information Technology spaces
- A scan of MES initiatives in other States
- Interviews with AHCA employees who interact with the MES either as users or as decision makers
- A survey of providers throughout the State of Florida
- North Highland Subject Matter Experts (SMEs) in the areas of technology and healthcare
- Various Agency documents, such as grievance reports

THE STRATEGIC PLAN IS ONE (1) OF SEVENTEEN (17) SEAS VENDOR DELIVERABLES IN THE FIRST YEAR OF THE MES TRANSFORMATION

Enterprise Systems Strategic Plan – Defines the Vision for the future MES and the areas of focus to achieve that Vision.

Enterprise Systems Governance Plan – Sets a system for addressing the issues arising throughout the project.

Enterprise Systems Strategic Planning Training Program – Trains Agency staff on strategic planning to support the transformation.

Strategic Project Portfolio Management Plan – The framework for identifying, prioritizing, and stage-gating MES projects.

SEAS Management Plan – The collection of processes and tools used to manage the MES transformation.

Revised MITA State Self-Assessment and Update Process – The rating of each MITA Business Processes to gauge MITA maturity.

MES Project Management Standards - Establishes the processes and controls to manage project work effort to transform the MES.

MES Project Management Toolkit – The set of tools enabling the MES Project Management Standards.

Medicaid Enterprise Certification Management Plan – Analyzes the Medicaid Enterprise Certification Toolkit and summarizes the Certification Lifecycle process.

Data Management Strategy – Provides a structure to improve information management and data sharing across MES.

Information Architecture Documentation – Connects business process and technical components. Contains Data Management Strategy, Conceptual Data Model, Logical Data Model, and Information Capability Matrix.

Data Standards – Creates consistent definition of the required format, structure, and rules around data usage.

Technical Management Strategy – Sets AHCA's technology management based on outcome-driven, initiative-based management principles.

Technology Architecture Documentation – Documents the conceptual overview of the MES and guides development of technical solutions for the MES.

Technology Standards – Produces standards following guidance defined in MITA 3.0 Part 3 Technical Architecture Chapter 6 Technology Standards.

Design and Implementation Management Standards – Defines development standards and processes for procurement implementation of MES components.

Enterprise Data Security Plan – Defines the required protections, processes, and controls to meet compliance requirements, such as the Health Insurance Portability and Accountability Act.

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GOALS AND OBJECTIVES OF THIS STRATEGY

The objective of this Strategic Plan is to create a clear strategy for a successful MES transformation. This strategy will focus AHCA's time and resources towards high-impact investments with the goal of driving "Better Health Care for all Floridians."

Direction

STRATEGY

Alignment   **Actionability**

THIS STRATEGIC PLAN WILL CREATE

Direction
Prioritize investments that create the largest long-term impact

Alignment
Create organization-wide alignment for the direction of the MES

Actionability
Create the starting point by which AHCA will create detailed project plans to achieve the MES Vision

This Strategic Plan creates direction, alignment, and actionability across the many stakeholders involved with the MES.

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SECTION 2

Roles & Responsibilities

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ROLES AND RESPONSIBILITIES

The table below details the roles and responsibilities required for the development, delivery, and management of the Enterprise Systems Strategic Plan.

ROLE	RESPONSIBILITY
AHCA Executive Management	• Provides guidance on the overall strategic direction of the Agency and how the Medicaid Enterprise System enables that direction • Provide inputs to the Strategic Plan in the form of interviews • Communicate internal and external agency, legislative, or governmental changes that may impact the MES Strategy, priorities, asset, resource, funding commitments
MES Project Leadership Team	• Provides guidance on the overall strategic direction and project activities throughout the duration of the project • Monitor the schedule management process • Resolves major issues, problems, and policy questions • Approves budget, schedule, and scope changes for follow-up work emanating from the Strategic Plan
MES Governance	• Provide executive-level oversight and decision-making for most important MES Program decisions; responsibility over Agency mission • Approves MES strategy along with any annual updates • Sets Strategic Priorities for the MES
MES Portfolio Management Team	• Evaluate and prioritize MES tactics/initiatives based on alignment with the Strategic Plan as well as financial and logistical considerations. The team consists of the SEAS Vendor and the AHCA MES Project Leadership Team.
Independent Verification and Validation Vendor	• Review the Strategic Plan and the Concept of Operations
Centers for Medicare and Medicaid Services (CMS)	• Review the Concept of Operations as part of the Medicaid Enterprise Certification Lifecycle
Other Agencies	• Provide inputs to future iterations of the Strategic Plan in the form of interviews and working sessions
SEAS Director	• Lead and manage completion and performance of deliverable and service requirements described in SEAS Contract MED191
SEAS Domain Project Managers	• Responsible for planning, analysis, development, implementation, execution, and maintenance of procurement, cost, schedule, scope management, quality, risk, issue, and action item activities as required • Identify and negotiate inter-project dependencies

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SECTION 3

Executive Summary

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AHCA IS USING ITERATIVE STRATEGY TO TRANSFORM INTO A MODULAR ENVIRONMENT

AHCA will collaborate with the SEAS Vendor to conduct an annual strategy refresh to deliver a system that isn't out of date upon delivery.

ITERATIVE STRATEGY

Annual Sprints
Iterative Strategy consists of a series of annual "sprints." Each sprint ends with an annual strategy refresh to collect new information, maintain a sense of urgency, and plan the modules for the next year.

Course Corrections
These annual strategy refreshes will account for ongoing trends and learnings to enable a viable system after implementation, which will inform the next cycle of work and procurements.

Consistent Communication
Iterative Strategy relies on consistent communication and decisioning through a strong governance framework.

MODULAR IT ENVIRONMENT

Multiple modules interfacing with one another

CURRENT STATE   FUTURE STATE

Monolithic Environment   *Modular Environment*
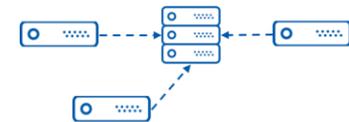
**Modularity increases flexibility, vendor choice, service levels, and innovation.**

Iterative Strategy can deliver a system best suited to meet AHCA's needs, while accounting for changes and updates in technology, healthcare, and policy.

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AN ITERATIVE APPROACH IS IMPERATIVE AS THE MARKET IS IN FLUX

An Iterative Strategy will enable AHCA to take advantage of continued market innovation even when the MES transformation is in flight.

INNOVATIONS IN THE HEALTHCARE AND TECH SPACE[1]
New innovation and methodologies within healthcare and technology

These concepts were reviewed with Executives during a Strategic Visioning Session (held on December 13, 2017) and can be reviewed in Appendix Section A.
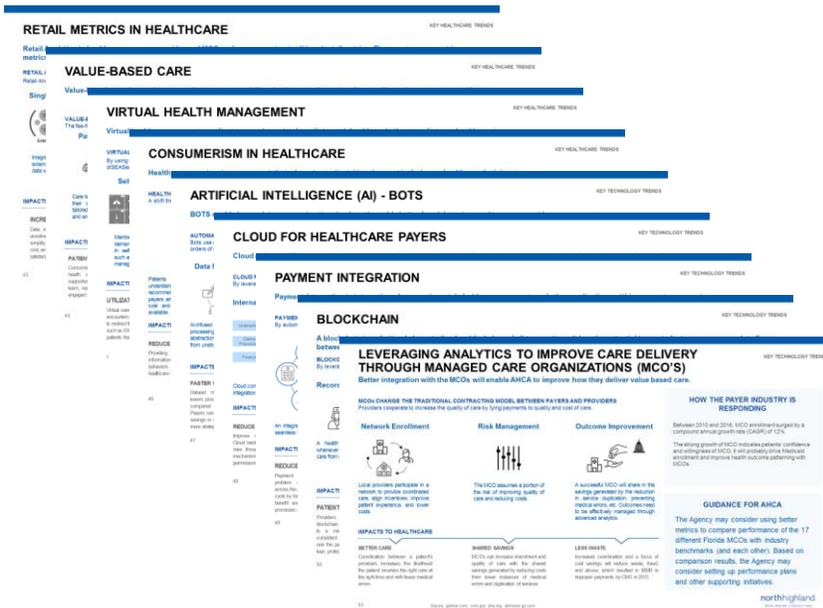
INNOVATIONS IN THE MMIS VENDOR MARKET LANDSCAPE[1]
The MMIS market is transitioning to more discrete modules based on alternate delivery since CMS issued its modularity guidelines
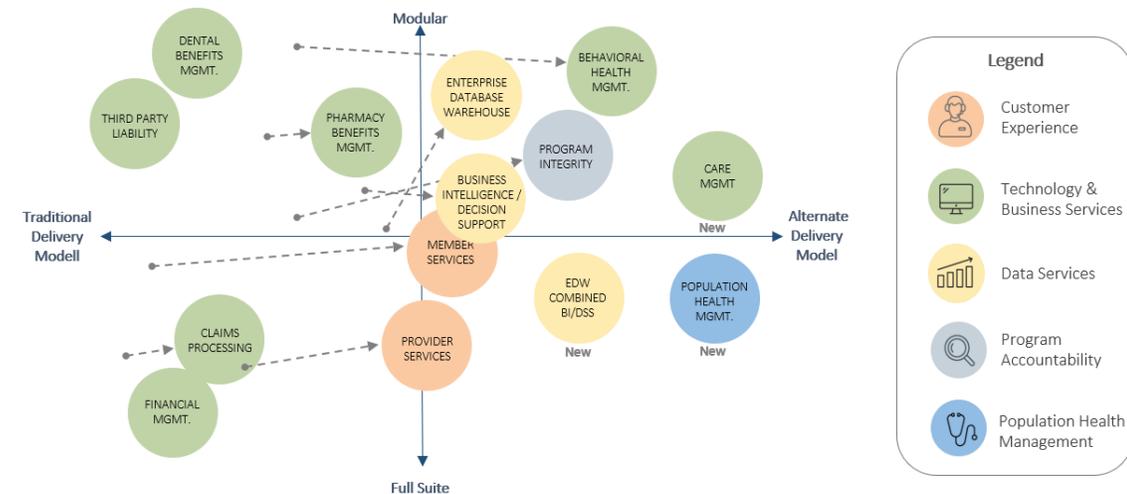
Note: Dotted lines depict module improvements since CMS issued its modular guidelines; Traditional Delivery Model refers to customized systems hosted in a local environment while Alternative Delivery Model refers to Software as a Service or cloud-hosted systems

[1]Source: North Highland research

AHCA'S TRANSITION TO MODULARITY ALIGNS WITH CMS'S MITA FRAMEWORK

AHCA's MES transformation will advance the Agency's Medicaid Information Technology Architecture (MITA) maturity level.[1] This transformation will improve AHCA's delivery of service to both recipients and providers.

Qualities of MITA Maturity[2]

- **Timeliness of Process**
- **Data Access and Accuracy of Data**
- **Effort to Perform / Efficiency**
- **Cost Effectiveness**
- **Quality of Process Results**
- **Utility or Value to Stakeholders**

Levels of MITA Maturity[3]

Level 1	Level 2	Level 3	Level 4	Level 5
The agency focuses on payment of provider claims to encourage participation of providers and, thereby, promote access to care.	Improved healthcare outcomes are a byproduct of programs focused on managing costs, e.g., managed care and waiver programs.	The agency adopts national data standards, collaborates with other agencies, and shares business services resulting in a better base for comparing outcomes.	All stakeholders have access to clinical data resulting in a major leap forward in analysis of healthcare outcomes.	The agency has access to data nationally to compare outcomes across a broad spectrum of other agencies and states.

AHCA's MES transformation to a more modular and higher MITA maturity level will be guided by a strong strategic planning process.

[1]"MITA Information Series – The MITA Maturity Model," *CMS.gov*, pg 8, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidInfoTechArch/downloads/mitamm.pdf
[2]Ibid
[3]Ibid

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STRATEGY AND EXECUTION WORK HAND IN HAND TO PROVIDE THE BEST VALUE

This Strategic Plan sets the direction of the Medicaid Enterprise System for the next 5 years and beyond. From the foundation of this Strategic Plan, the Agency will move into module identification, sequencing, procurement, and implementation.
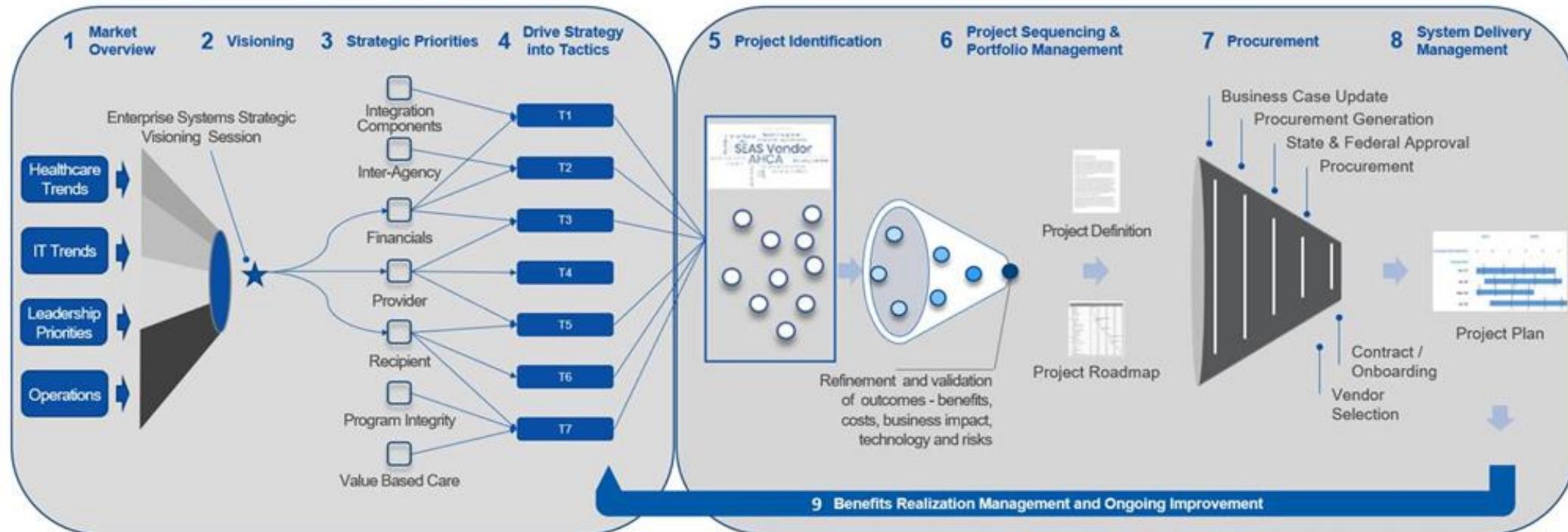
BELOW IS A DESCRIPTION OF EACH STEP IN THE PROCESS

1. Market Overview	The System Strategy process begins with the SEAS Vendor collecting up-to-date information on the state of the MMIS vendor market (see Slide 10 as well as Appendix Section B on how states are responding to modularity), trends in the private healthcare and technology spaces (see Slides 25-26), and AHCA's internal strengths and challenges (see Slides 21-24). The Strategic Plan bases its recommendations on these three areas of research.
2. Visioning	AHCA plans on incorporating the ongoing innovations occurring within the MMIS vendor market as well as the general healthcare and IT spaces. To accomplish this, AHCA is taking an iterative approach to strategy. As this iterative approach encourages periodic course corrections based on ongoing trends, the agency will require a constant vision for its MES. The SEAS Vendor collaborates with agency executives to set the MES Vision, creating consistent focus throughout the transformation.
3. Strategic Priorities	The SEAS Vendor uses the understanding of AHCA's challenges and the trends occurring in the market to prioritize which areas of investment (such as "Provider Experience") should occur first to most efficiently achieve executives' MES Vision.
4. Drive Strategy into Tactics	Once Strategic Priorities have been identified and sequenced, the SEAS Vendor and AHCA highlight high-level tactics ("such as Provider Identity Reconciliation) to achieve a Strategic Priority.
5. Module Identification	SEAS Vendor and AHCA take the business requirements communicated via Strategic Priorities and Tactics to identify which modules should be procured.
6. Module Sequencing and Portfolio Management	SEAS Vendor and AHCA sequence identified modules based on existing contractual obligations as well as logistical considerations. Each modular opportunity goes through a portfolio management process to ensure alignment with the MES Vision and priorities.
7. Procurement	The SEAS Vendor works with AHCA to select the modules based on the output of the Portfolio Management process and contract with the appropriate vendor through the normal procurement process.
8. System Delivery Management	The SEAS Vendor and AHCA manage the delivery of these IT modules. Activities in this stage are the traditional system development lifecycle activities that occur from project start through implementation and ongoing operation.
9. Benefit Realization Management and Ongoing Improvement	After a module's delivery, the SEAS Vendor will assess the level of tangible benefit provided to the Agency. Based on the measurement, the SEAS Vendor may recommend further improvements.

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THE AGENCY DETERMINED THE BELOW STRATEGIC PRIORITIES TO TRANSFORM FMMIS INTO A MODULAR ENVIRONMENT BY 2023

AHCA's iterative approach to strategy includes an annual refresh to address the MES's greatest needs as FMMIS is transformed into modules by 2023 or when its current MES vendor contract sunsets. The staging of these priorities, seen below, will be annually updated via the annual strategy refresh. Further detail on these priorities can be found in Appendix D.

Nearer Term Strategic Priorities ➔ Longer Term Strategic Priorities

Integration Platform	Provider	Recipient	Program Integrity	Financials	Value Based Care	Inter-Agency Focus
Integration Services Platform (ISP)[1]	**Identity Reconciliation**	**User Interface / Recipient Portal**	Automation and Analytics	Enhanced / Real Time Reporting	Health Plan Encounter Data	Data Sharing[2]
Enterprise Data Warehouse (EDW)	**Streamlined Provider Enrollment**	Streamlined Recipient Enrollment	Develop Model for Managed Care & FFS	Reduce & Eliminate Manual Processes & Redundant Systems	Performance/ Contract Management	Social Determinants of Health
	Performance Management & Population Health	Integrated and Accessible Data for the Recipient		Analytics & Dashboarding		Shared Licensure & Credentialing

- The lighter blue boxes highlight the Agency's initially prioritized high-level tactics. The next step will be to further elaborate on these and other tactics to improve the Strategic Priorities through the Strategic Project Portfolio Management Plan.
- Some Strategic Priorities, such as "Inter-Agency Focus," will be partly addressed in an earlier Strategic Priority, such as "Provider," before becoming AHCA's central focus.
- The team will continue to refine these Strategic Priorities during the annual strategy refresh.

[1] See Appendix D for the components making up the ISP.
[2] While inter-agency data sharing would take place across previous Strategic Priority area (e.g. Provider, Recipient), the Agency will make it a central focus during the Inter-Agency Focus Strategic Priority.

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STRATEGIC PRIORITIES WILL BE ACHIEVED THROUGH SUPPORTING TASKS, THE DETAIL OF WHICH WILL BE DETERMINED VIA PORTFOLIO MANAGEMENT

The Strategic Project Portfolio Management process uses the output of this Strategic Plan (MES Vision, Guiding Principles, Strategic Priorities) to provide the Agency with an orderly process for selecting the right tactics to achieve the MES Vision.

STRATEGIC PROJECT PORTFOLIO MANAGEMENT

The MES Portfolio Management process will identify potential initiatives on an ongoing basis to deliver the best system for Florida. Once collected, the portfolio management team will evaluate each initiative via a set of objective decision-making criteria and recommend a decision for each initiative (Discard, Implement, or Wait).

Identify Initiatives → Catalogue Initiatives → Analyze Initiative → Stage-Gate Initiatives → DISCARD / IMPLEMENT / WAIT
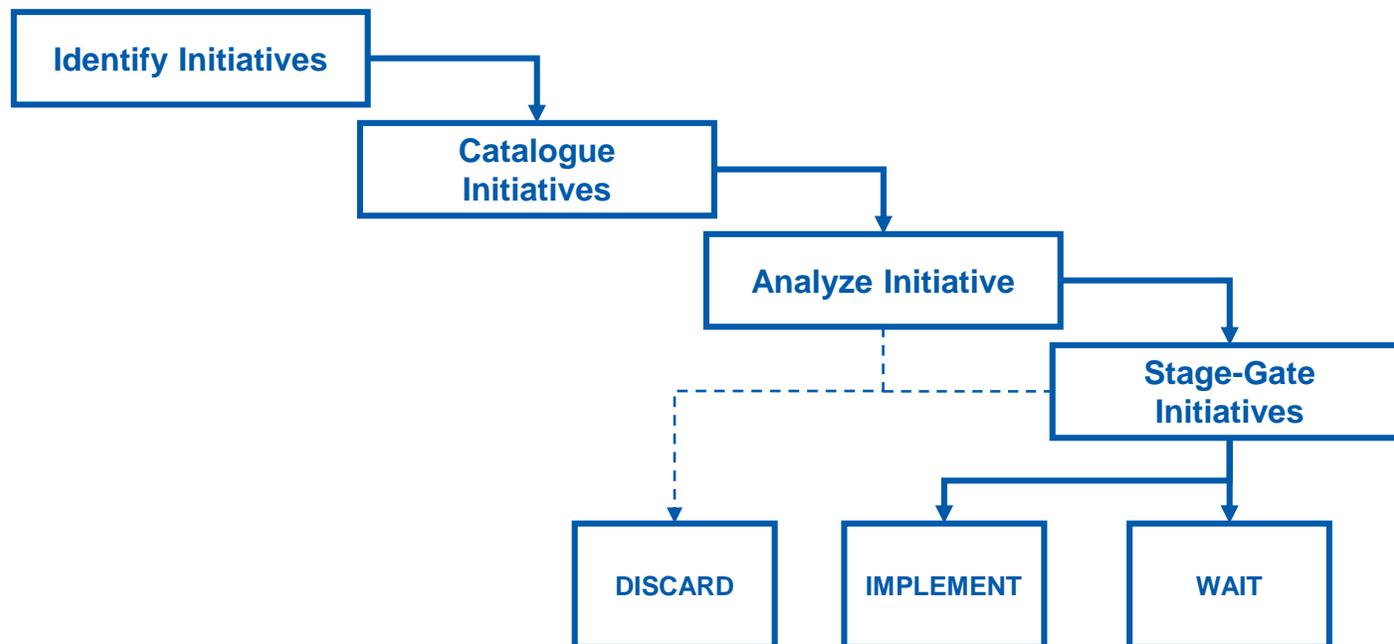
## KEY CONSIDERATIONS

Cost Benefit Analysis

Once collected, the portfolio management team will weigh the likely benefits of each initiative for all MES stakeholders against the likely financial and non-financial costs

Alignment

The portfolio management team will consider the level to which initiatives align with the MES Vision, Guiding Principles, and Strategic Priorities detailed in this Strategic Plan

Prioritization

The portfolio management team will consider the nature of the likely benefits of each initiative so that, all else being equal, initiatives with the greatest effect across the MES and its stakeholders will be prioritized first

Scalability & Flexibility
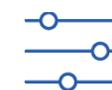
The portfolio management team will consider the level to which an initiative will create room for the Agency to make technology decisions in the future, such as procuring a data-heavy module in the future

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# MES GOVERNANCE WILL SUPPORT THIS VALUABLE, BUT COMPLICATED TRANSFORMATION

Through this engagement, the SEAS Vendor developed an effective enterprise governance to enable management control of this complex transformation by creating accountability at the right levels throughout the organization.

EXECUTIVE

Direction

Accountability

STRATEGIC ALIGNMENT

Continuous alignment with program strategy

BENEFIT CREATION

Achievement of desired benefits throughout program

RISK MANAGEMENT

Identification, assessment, and mitigation of enterprise risks

RESOURCE MANAGEMENT

Optimized utilization of infrastructure, resources, and assets

PERFORMANCE MANAGEMENT

Tracking and monitoring of project delivery

TACTICAL

[1]Note that this Governance Model has not yet been accepted by AHCA as of 3/27/2018.

LEGEND ▢ Organizational Level ▬ Governance Objectives

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GOVERNANCE WILL ENABLE LEVERAGE AND REUSE OF SYSTEMS ACROSS THE MES BY INCORPORATING ALL MES STAKEHOLDERS

As governance expands, so will the opportunity to coordinate around leveraging initiatives, standards, and technology components throughout the entire MES. Once inter-agency leverage is the norm, the Agency can look to opportunities for greater technology leverage and reuse with other states, as appropriate.

STAGE 1	< 2 years	STAGE 2
AHCA MES Governance		Inter-Agency Governance

STAGE 1
AHCA MES Governance

FLORIDA MES

DCF	DOH	APD	DJJ	Others as Identified
DOEA	FHKC	DOE	MFCU	Others as Identified

AHCA

Medicaid

STAGE 2
Inter-Agency Governance

FLORIDA MES

DCF	DOH	APD	DJJ	Others as Identified
DOEA	FHKC	DOE	MFCU	Others as Identified
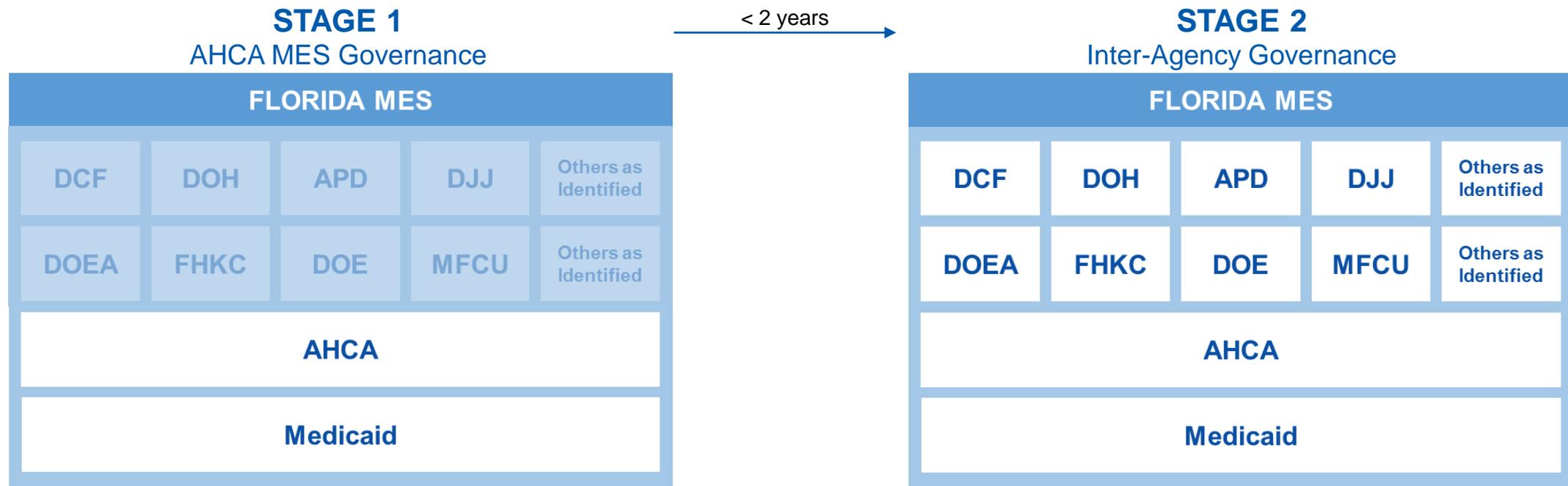
AHCA

Medicaid

*In the current state, MES Governance **includes the AHCA Medicaid organization and other relevant AHCA stakeholders** such as AHCA IT and HQA*

***Governance expands to include all Florida State MES agencies** to better manage & monitor the health of Floridians, provide the best service to providers and recipients, and better manage State resources*

LEGEND ☐ Agencies/Bureaus in-scope for Stage ▧ Agencies/Bureaus not in-scope for Stage

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AHCA'S MES TRANSFORMATION WILL TRANSFORM STAKEHOLDER ROLES ACROSS THE MES

Stakeholders in the MES Vision will receive and transmit information and data differently as a result of the MES transformation. Below are some key benefits of this project, with many more being determined through the entire transformation.

	Current State	Future State
RECIPIENTS	The recipient interacts with multiple systems (e.g. health plans' systems, FloridaHealthFinder), many showing inconsistent information. The recipient is asked to share information with multiple systems that operate in silos and has limited engagement in own care or cost of care.	A recipient-facing system will show informative and actionable information thanks to the EDW and a strong Recipient Portal (see page 54 and 58 respectively). The recipient journey is fully visible (rather than just interactions with providers) and constant improvement occurs. Recipients can carry their health data with them across providers.
LEGISLATURE	Though the Legislature has rising expectations for real-time analysis, AHCA must invest in manually intensive processes to provide the Legislature with information. Agency officials sometimes aren't confident in the data quality.	AHCA fulfills ad hoc requests quickly and accurately while the Legislature has access to real or near-real time dashboards for standard requests through a flexible EDW (see page 56), a strong ISP (see page 55), and greater data integration with the health plans. Analysis is provided using more sources and data types via greater Inter-Agency Data Sharing.
AGENCIES	Agencies duplicate information across siloed systems and data sharing is very limited. Most data and information exchanges are batch exchanges with 1-2 day latency.	Agencies have a 360-degree view of the recipient and provider through appropriate data sharing across agencies. The ESB System (see page 54) enables agencies' applications to speak cleanly via real, or near real-time data access and sharing without duplication across systems. Agencies leverage and reuse each other's systems based on available excess capacity and look to other states to do the same, as appropriate.
PROVIDERS	Providers reference credentialing speed, speed of payment, and the denial process as slow and sometimes cumbersome. Each provider to have multiple identities across the state, making it difficult to tie recipient outcomes to specific providers.	Technology, process, and policy improvements around provider identity reconciliation (see page 56) and a streamlined' enrollment into Medicaid program (see page 57) create a greatly improved provider experience. Providers receive clarity on claims denials and have a 360-degree view of the recipient. Providers have consistent identity across the state, creating the ability to easily tie recipient outcomes to specific providers.
HEALTH PLANS	The currently reported encounter data is of insufficient quality to enable value-based care. The current batch processing creates administration costs to deal with reporting exceptions.	The components of the Integration Platform (see page 54) facilitate greater integration with the state's health plans. Data is high-quality and is reported in real-time as appropriate. Health plans use 360-degree recipient and provider information to coordinate care.
REGULATORS	AHCA provides reports to federal and state regulators. Metrics, such as HEDIS Scores, are more process-oriented than health outcome-oriented.	The components of the Integration Platform (see page 54) and better integration across providers, recipients, and health plans allow regulators to access up-to-date information to implement regulation and policy based on risk and outcomes.

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AHCA'S MES STRATEGY ARTICULATION MAP

FX VISION
How we will achieve this

Transform the Medicaid Enterprise to provide the greatest quality, the best experience, and the highest value in healthcare.

MES GUIDING PRINCIPLES
Our rules of the road

- Enable high-quality and accessible data
- Improve healthcare outcomes
- Reduce complexity
- Use evidenced-based decision making
- Improve integration with partners
- Improve provider and recipient experience
- Enable good stewardship of Medicaid funds
- Enable holistic decision making rather than short-term focus

MES STRATEGIC PRIORITIES
Where we will initially focus

- Integration Components
- Provider Experience
- Recipient Experience

DIFFERENTIATORS:
Proactive operations
Analytics-enabled decision making
Outcomes-focused health management

SISTER AGENCIES
- Interoperable data exchange enabling outcomes-based decision making
- Shared governance to drive better outcomes for all of our recipients

PROVIDERS
- Seamless enrollment and licensure process to maintain a strong provider network
- Data-enabled performance management

RECIPIENTS
- Best-in-class user experience
- Comprehensive & concise information enabling them to make the best decision for their healthcare

HEALTH PLANS
- Proactively manage value-based care delivery through health plans
- Interoperable encounter data between the Agency and health plans

PEOPLE
Empowered and engaged employees

VISION 2023
Achieving World-Class Health Outcomes in Florida

PROCESS
Automated & standardized operations

TECHNOLOGY
Fully integrated, flexible, and modern systems

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SECTION 4

Insight on Current State Operations

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AHCA'S CURRENT STATE ASSESSMENT ENCOMPASSES BOTH AN INTERNAL AND EXTERNAL VIEW

The SEAS Vendor created a panoramic view of the current state of the Agency's position through Stakeholder Interviews and a robust Market Scan.

INTERNAL VIEW

STAKEHOLDER INTERVIEWS

The SEAS Vendor interviewed over 30 AHCA stakeholders and examined data on hundreds of providers' and recipients' interactions with the Agency. These interviews generated:

- General themes on AHCA's current state
- More specific detail on MITA's 10 Business Processes

EXTERNAL VIEW

MARKET SCAN

The SEAS Vendor leveraged its internal expertise to identify trends in both the healthcare and technology landscapes that may affect AHCA's MES in the near to medium future.

- Trends in the general healthcare and tech spaces
- Specific trends in the MMIS market

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INTERNAL INTERVIEWS SURFACED KEY THEMES ON AHCA'S CURRENT STATE

INTERNAL VIEW

STAKEHOLDER INTERVIEWS The Seas Vendor interviewed over 30 AHCA stakeholders and examined data on hundreds of Providers and Recipients' interactions with the Agency

The current system causes significant challenges to operations as seen by interviews with key internal stakeholders.

Provider Experience	Recipient Experience	Value Based Care	Technology	Employee Dedication
The system should streamline provider enrollment and payment	*The system should enable recipients self-service (where appropriate)*	*The system must be improved to provide the data required for Value-Based Care*	*Technology decisions should consider AHCA's long-term goals*	*What makes the system work is the hard-working people at AHCA*

Provider Experience

Credentialing requirements for each health plan and FFS has a financial consequence for providers. A streamlined credentialing process is needed.

It is difficult to get a clear answer on why a payment was denied.

We need a dashboard to monitor and improve credentialing, payment, and service delivery.

Recipient Experience

Enrollees should own their own health data in an app.

Recipients self-serve when they pay their light bill and cell phone bill but not their health plan options. Pushing them to self-serve is also a cost containment option.

Value Based Care

I would never say that data quality is good – it takes a human to verify.

Due to data quality, data cannot be used to plan effectively.

The system requires lots of manual inputs.

Technology

A governance framework is needed to make coordinated IT decisions for the Agency.

The architecture of the FMMIS was designed prior to SMMC, and is in need of modernization.

Employee Dedication

People here get in early and stay late to get the work done.

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INTERNAL INTERVIEWS ALSO GENERATED INSIGHTS ON MITA BUSINESS PROCESSES

INTERNAL VIEW

STAKEHOLDER INTERVIEWS The Seas Vendor interviewed over 30 AHCA stakeholders and examined data on hundreds of Providers and Recipients' interactions with the Agency

As the last MITA State Self Assessment (SSA) occurred in 2014, the SEAS Vendor collected insights on the MES Business Areas based on internal AHCA interviews. The output of these strategy interviews are not meant to replace the upcoming 2018 SSA.

Business Area	*Business Process*
BUSINESS RELATIONSHIP	The management of the exchange of information and trading partner agreements between the Florida Medicaid and its partners, including other agencies and federal partners. This business process within AHCA is usually manual and does not exist within the current MES system according to the 2014 State Self Assessment (pg. 38) and Agency interviews.
CARE	The management of Medicaid recipients' treatment plan needs, health outcomes, and health status. More specifically, the Care Management business area is responsible for case management, authorizations, referrals and treatment plans' data stores. This business area is predominantly executed through AHCA's partnership with health plans. For the portion remaining under the Agency's purview, AHCA routinely relies upon manual processes to execute Care Management according to the 2014 State Self Assessment (pgs. 39 – 40) and Agency interviews.
CONTRACTOR	The management of the selection of contractors and the management of the services they provide. Contractors can be health plans, technology vendors, or other service vendors. According to interviews, the management of health plans is consistent across the system. However, there is little consistency around vendor management outside of the health plans. Key performance indicators are often either not consistently included in contract language or enforced in instances where language is included.
ELIGIBILITY & ENROLLMENT	The management of the activities supporting the determination of both initial and continued eligibility and enrollment of recipients and providers into the Medicaid program. While the Department of Children and Families handles Recipient Eligibility, AHCA and the heath plans execute the Provider Eligibility and Enrollment function. AHCA handles provider enrollment into the Medicaid program. Both of these functions are largely automated, though manual processes do exist.

[1]"The MTIA Business Architecture," *CMS.gov*, 2006, pg 11, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidInfoTechArch/downloads/mitabusiness.pdf

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INTERNAL INTERVIEWS ALSO GENERATED INSIGHTS ON MITA BUSINESS PROCESSES

INTERNAL VIEW

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Business Area	*Business Process*
FINANCIAL	The management of activities performed by AHCA's Finance and Accounting areas. These processes include the payment of contractors, health plans and other agencies, and the receipt of payments from other insurers, providers, and member premiums. While payments are made automatically, reporting is complex and manual, requiring deeply knowledgeable staff to manually key financial information into spreadsheets as the current system does not enable easy use of pre-built reports.
MEMBER	The management of communications between the State Medicaid Agency and the prospective or enrolled member and actions that the Agency takes on behalf of the member. This includes managing the member data store, coordinating communications with both prospective and current members, outreach to current and potential members, and dealing with member grievance and appeals issues.
OPERATIONS	The management of payment and reporting to providers, claims adjudication, and encounter data processing. Each of AHCA's business processes within Operations Management are automated to some degree within the FMMIS. The lack of pre-built templates increases processing time and limits usability.
PERFORMANCE	The monitoring of the Medicaid program to promote program integrity. The areas of responsibilities include auditing and tracking medical necessity and appropriateness, fraud control, erroneous payments and administrative anomalies. This area uses a mixture of automated and manual processes and can be hampered by the current quality of the MES's data.

[1]"The MTIA Business Architecture," *CMS.gov*, 2006, pg 11, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidInfoTechArch/downloads/mitabusiness.pdf

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INTERNAL INTERVIEWS ALSO GENERATED INSIGHTS ON MITA BUSINESS PROCESSES

INTERNAL VIEW

STAKEHOLDER INTERVIEWS — The Seas Vendor interviewed over 30 AHCA stakeholders and examined data on hundreds of Providers and Recipients' interactions with the Agency

As the last MITA State Self Assessment (SSA) occurred in 2014, the SEAS Vendor collected insights on the MES Business Areas based on internal AHCA interviews. The output of these strategy interviews are not meant to replace the upcoming 2018 SSA.

Business Area	Business Process
PLAN >	The management of decision-making activities necessary for management of the actual Medicaid program. This includes managing AHCA's strategic planning, information management, quality assessment, setting Medicaid policy, maintaining the state plan, and managing the rate setting process used to compensate health plans. There are multiple lists of goals and objectives maintained throughout AHCA without consensus as to which takes priority.
PROVIDER >	The management of provider information, enrollment, communications, grievances and appeals, and termination is a mix of manual and automated processes. While there are issues with Provider Identity Reconciliation and enrollment transparency and timeliness, the online enrollment portal works as designed. The provider experience can be improved with more streamlined credentialing and payment along with a more user-friendly enrollment system.

[1]"The MTIA Business Architecture," *CMS.gov*, 2006, pg 11, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidInfoTechArch/downloads/mitabusiness.pdf

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EXTERNAL TRENDS IN HEALTHCARE AND POTENTIAL EFFECTS ON MES

EXTERNAL VIEW

MARKET SCAN The Seas Vendor leveraged its internal expertise to identify trends in both the healthcare and technology landscapes that may affect AHCA's MES in the near to medium future

The MES Strategic Plan is intentionally iterative to provide flexibility to leverage the trends detailed below as they become viable in the short to medium future. Please see Appendix Section A for further detail.

HEALTHCARE TREND	DESCRIPTION	POTENTIAL EFFECTS ON MES	GUIDANCE FOR AHCA
RETAIL METRICS IN HEALTHCARE	Retail Analytics in healthcare measure provider and health plans performance using traditional retail metrics.	Greater measurement flexibility within the different systems making up the MES.	Develop the MES to leverage big data analytics and state-of-the-art metrics to drive and manage more focused outcomes and care delivery.
VALUE BASED CARE	Value-based care aims to improve patient outcomes while reducing costs by paying for coordinated care across providers.	Increase ability to track and correlate encounter and payment data.	Consider technologies, tools, and infrastructure to integrate encounter and payment data.
VIRTUAL HEALTH MANAGEMENT	Virtual health management coordinates care through telemedicine, telehealth, and other at-a-distance health services.	New modules to expand virtual health.	Increase the prevalence of virtual health to improve access across networks, especially for provider types that have limited availability.
CONSUMERISM IN HEALTH CARE	Health consumerism is a movement that advocates patients' involvement in their own healthcare decisions.	Greater integration of Recipient Modules with health records, provider data, and other information.	Build upon AHCA's consumerism-focused culture and educate employees to be more focused on the provider and recipient experience.
BIG DATA IN HEALTHCARE	The healthcare space is quickly improving its data collection efforts to produce "big data," extremely large data sets to be analyzed for patterns and trends.	Most new technology components will need to be capable of storing, organizing, and analyzing extremely large datasets.	Overprepare for the future by procuring components with excess capacity for the future.

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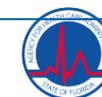
# EXTERNAL TRENDS IN THE TECH SPACE COULD AFFECT THE MES

EXTERNAL VIEW

MARKET SCAN — The Seas Vendor leveraged its internal expertise to identify trends in both the healthcare and technology landscapes that may affect AHCA's MES in the near to medium future

The MES Strategic Plan is intentionally iterative to provide flexibility to leverage the trends detailed below as they become viable in the short to medium future. Please see Appendix Section A for further detail.

TECHNOLOGY TREND	DESCRIPTION	POTENTIAL EFFECTS ON MES	GUIDANCE FOR AHCA
ARTIFICIAL INTELLIGENCE (AI) IN HEALTHCARE	AI Robots (Bots) enable lower claim processing time (and cost), enable better fraud detection, and can improve provider engagement.	Automate and accelerate many manual processes across the MES.	AHCA may consider creating a detailed process map of new modular systems as this is the first step in installing state-of-the-art automation.
CLOUD FOR HEALTHCARE PAYERS	Cloud delivers different services to an organization's computers and devices through the Internet and shared computing services.	Increase security and flexibility across the MES.	Evaluate how other state Medicaid agencies use cloud and consider a low-risk pilot to spur buy-in across the MES.
PAYMENT INTEGRATION	Payment Integration is the integration of accounting, stakeholder management, and other applications within payments processing.	Streamline the payment processes within the MES.	Evaluate current payment solution to identify room for improvements. This evaluation would benefit from a robust analysis of industry best practices.
BLOCKCHAIN	A blockchain is a digitized, decentralized, public ledger of transactions. It can potentially create faster, more secure data flows across the continuum of care.	Reduce inconsistency in transactions between data sources on items varying from provider identity to recipient medical history.	As this technology is in an early stage within the healthcare space, monitor for future opportunities.
LEVERAGING ANALYTICS TO IMPROVE CARE DELIVERY	Better integration with the health plans will enable AHCA to improve how they deliver value based care.	Greater emphasis on analytics-focused modules as part of the MES procurement process.	Develop metrics to compare health plan performance and set performance improvement plans for the poor performers.

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DIFFERENT STATES ARE REACTING TO THESE TRENDS DIFFERENTLY

EXTERNAL VIEW

MARKET SCAN — The Seas Vendor leveraged its internal expertise to identify trends in both the healthcare and technology landscapes that may affect AHCA's MES in the near to medium future

There is no one size fits all reaction to trends in either the general healthcare and technology or the specific MMIS spaces. Please see Appendix Section B for further detail on states of note.
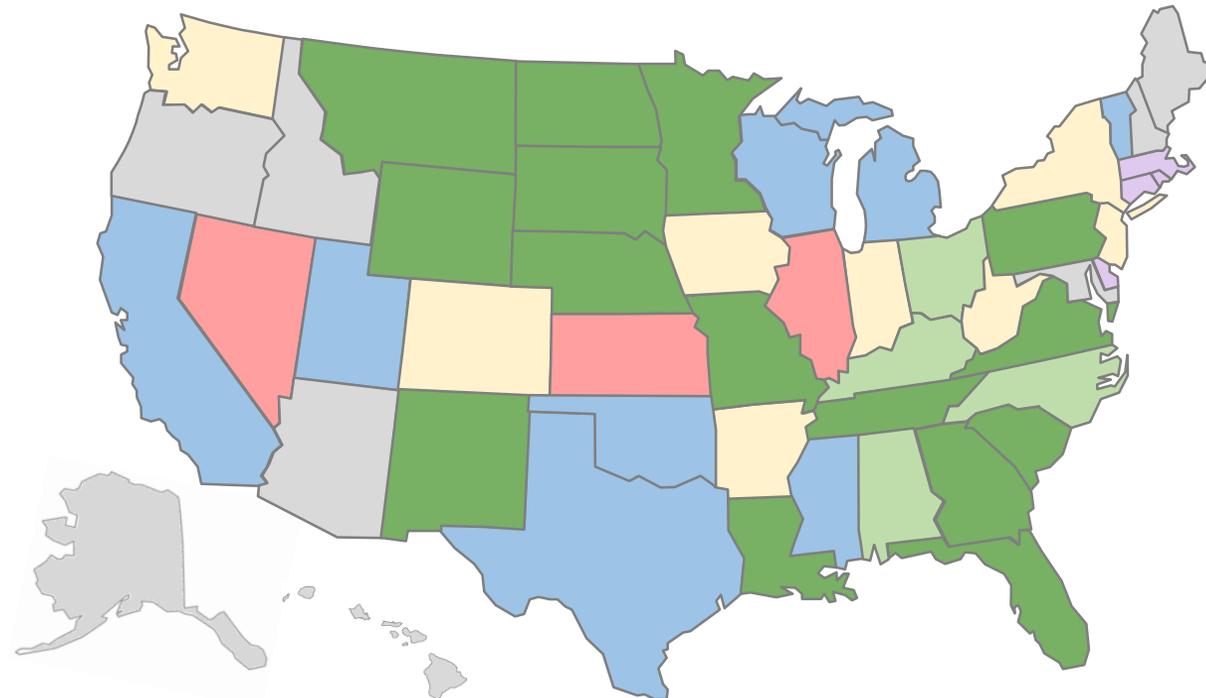
Legend

- **15 Modular:** Replace MMIS with multiple modules
- **8 Takeover:** Takeover or keep current MMIS, then modularize over time with existing or other vendors
- **3 Transition:** Transition to new MMIS, then modularize
- **4 Leaning Modular:** Plans not published, but leaning modular
- **4 Leaning Takeover / Transition:** Plans not published, but leaning toward takeover or transition, then modularize
- **9 Plans Not Released:** No plans or planning underway, direction not yet known
- **8 Pre-Dates New Rules:** Replacement strategy pre-dates new rules, transition recently completed or underway with multiple years remaining on contracts

Note: Based on publicly available information as of June 2, 2017.

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SECTION 5

Vision, Guiding Principles, and Strategic Priorities

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THE STRATEGIC PLAN BEGINS WITH A STRONG VISION AND DRIVES DOWN LEVEL OF DETAIL

Agency Executives generated the Vision, Guiding Principles, and Strategic Priorities during a Strategic Visioning Session on December 13th 2017, out of which high-level tactics were generated.

Definition

Inspirational, High-Level

Detailed, Actionable

Vision	is the definition of the future success of the organization or project
Guiding Principles	are the general rules that guide decision making and support the Vision
Strategic Priorities	are the defined areas of practical focus to achieve the Vision
Tactics	are the actionable buckets of work to fulfill the Strategic Priorities

By adopting this strategic planning model, AHCA's strategy will inspire and align stakeholders while generating meaningful results.

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AHCA EXECUTIVES INFORMED THE STRATEGY DURING THE STRATEGIC VISIONING SESSION

EXECUTIVES WERE ASKED
WHAT IF AHCA….

1 Had the healthiest recipients

2 Offered the best Provider Experience

3 Drove outcomes based on data

4 Had the best system to serve Floridians

TO ANSWER THESE QUESTIONS, AGENCY EXECUTIVES PARTICIPATED IN A STRATEGY SESSION TO….

01/ Examine the Agency's Current State

02/ Examine trends in healthcare and tech

03/ Craft the Vision for the MES

04/ Generate Guiding Principles

05/ Identify Strategic Priorities

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AHCA'S MES VISION SUPPORTS THE AGENCY'S VISION

The MES Vision will guide the entire MES modular transformation and will be supported by the Guiding Principles.

AHCA VISION

"A health care system that empowers consumers, that rewards personal responsibility and where patients, providers, and payers work for better outcomes at the best price."

MES VISION

"Transform the Medicaid Enterprise to provide the greatest quality, the best experience, and the highest value in healthcare."

Executives realize that the MES Vision is more comprehensive than a simple IT upgrade. The MES transformation will be the platform for AHCA to meet its overall Vision.

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THE GUIDING PRINCIPLES CREATE DECISION MAKING CRITERIA FOR THE TRANSFORMATION

The Executives crafted the Guiding Principles, which are short and insightful decision-making guides, to support the MES Vision during the transition to a modular environment by shaping decisions such as the vendor-selection process.

- **Enable high-quality and accessible data**

- **Improve healthcare outcomes**

- **Reduce complexity**

- **Use evidenced-based decision making**

- **Improve integration with partners**

- **Improve provider and recipient experience**

- **Enable good stewardship of Medicaid funds**

- **Enable holistic decision making rather than short-term focus**

These MES Guiding Principles create decision-making criteria to guide the initiative and vendor-selection process throughout the transformation.

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STRATEGIC PRIORITIES DEFINE AREAS OF FOCUS

AHCA's Executives used the MES Vision and MES Guiding Principles to create the MES Strategic Priorities, the initial prioritization of effort to increase performance across the MES.

Nearer Term Strategic Priorities			Longer Term Strategic Priorities			
Integration Platform	Provider	Recipient	Program Integrity	Financials	Value Based Care	Inter-Agency Focus

The SEAS Vendor and the Agency applied the MES Vision and Guiding Principles to steer the Agency's initial prioritization of these Strategic Priorities. The Agency compiled a list of needed and distinct investments that could represent either system modules or system processes that forward the MES Guiding Principles and, by extension, the MES Vision. After compiling this list, the Agency considered two key factors when forming its initial prioritization of investment.

- Should a Strategic Priority occur first due to logistical reasons?

- Would an investment in a Strategic Priority create a large positive impact across the entire Medicaid Enterprise?

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STRATEGIC PRIORITIES ARE SUPPORTED BY HIGH-LEVEL TACTICS

AHCA's iterative approach to strategy includes an annual refresh to address the MES's greatest needs as FMMIS is transformed into modules by 2023. The Portfolio Management process addresses the decisions for each of these tasks, including timing, scope, and cost. Further detail on these tactics can be found in Appendix D.

Nearer Term Strategic Priorities →→→ Longer Term Strategic Priorities

Integration Platform	Provider	Recipient	Program Integrity	Financials	Value Based Care	Inter-Agency Focus
Integration Services Platform[1]	**Identity Reconciliation**	**User Interface / Recipient Portal**	Automation and Analytics	Enhanced / Real Time Reporting	Health Plan Encounter Data	Data Sharing[2]
Enterprise Data Warehouse (EDW)	**Streamlined Provider Enrollment**	Streamlined Recipient Enrollment	Develop Model for Managed Care & FFS	Reduce & Eliminate Manual Processes & Redundant Systems	Performance/ Contract Management	Social Determinants of Health
	Performance Management & Population Health	Integrated and Accessible Data for the Recipient		Analytics & Dashboarding		Shared Licensure & Credentialing

- The light blue boxes highlight the Agency's initially prioritized high-level tactics. The next step will be to further elaborate on these and other tactics to improve the Strategic Priorities through the Strategic Project Portfolio Management Plan.
- Some Strategic Priorities, such as "Inter-Agency Focus," will be partly addressed in an earlier Strategic Priority, such as "Provider," before becoming AHCA's central focus.
- The team will continue to refine these Strategic Priorities during the annual strategy refresh.

[1] See Appendix D for the components making up the ISP.

[2] While inter-agency data sharing would take place across previous Strategic Priority area (e.g. Provider, Recipient), the Agency will make it a central focus during the Inter-Agency Focus Strategic Priority.

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AHCA WILL SUPPORT ITS STRATEGY WITH SMART GOALS

The SEAS Vendor developed draft SMART Goals to increase the Agency's alignment with the MES Vision and Guiding Principles. These goals are based on dozens of interviews with the Agency and providers.

Draft SMART Goal		Data Integration	System Integrity	Automation
01/	Implement an Integration Services Platform by the end of State Fiscal Year 2020.	●	●	○
02/	Decrease the average time it takes a provider to enroll in Medicaid by ___% within ___ months with ___% less errors.	●	○	●
03/	Increase the Recipient User Interface's Net Promoter Score© by ___% within ___ years.	●	●	○
04/	Increase Program Integrity collections within the Fee-for-Service area by ___% within ___ years.	●	●	●
05/	Collect $___ Million in Program Integrity collections within the Managed Care area within ___ years.	●	●	○
06/	Lower the rate of provider enquiries on denial of payments by ___% within ___ years.	●	●	●
07/	Have encounter data be of sufficient quality to set rates within ___ years.	●	○	○

Draft SMART Goals will be finalized through the Portfolio Management and will be visible to the governance process to create accountability.

¹Net Promoter is a gauge of consumer or employee satisfaction and loyalty. It is used across private and public organizations worldwide.

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AHCA WILL CONTINUE TO DEVELOP ITS STRATEGY BY LEVERAGING ENABLERS

AHCA will capitalize on the factors that drive and enable change

Factors that Drive Change

CMS Requirements	CMS's conditions and standards for the certification of the MES is a major driving factor for AHCA's MES Transformation.

Factors that Enable Change

Strategic Mindset	The Agency's mindset and readiness for change will be a key factor in developing a MES that fully meets the need for the state of Florida and their recipients.
Enhanced Governance	As with any new system, AHCA must move from a "steady state" operations mode to more of a procurement and implementation mode. This will require more focus and more robust decision making, and a structured meeting cadence to ensure all activities are coordinated.
Transforming Data into Analytics	AHCA must proactively measure and manage desired outcomes through real time, accessible, and data that is useful for analytics.
Organizational Change Management	As the MES transformation is a large-scale change for the Agency from the technology, policy, and procedure standpoints, formal Organizational Change Management is warranted to enable a successful transition. The SEAS Vendor recommends that the Agency develops a top-notch Organizational Change Management strategy to enable a successful transition.

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AHCA WILL CONTINUE TO DEVELOP ITS STRATEGY BY CONTROLLING CONSTRAINTS

AHCA will control the factors that constrain change.

Factors that Constrain Change

|	
Budget	AHCA's MES investments are rightly constrained by budget considerations. The MES Vision considers this through emphasizing a future system that embodies "highest value."
Complexity	Managing multiple vendors and multiple module installations requires a strong governance operation. To respond, AHCA is building a structured and robust governance model.
Siloed Nature of the MES	The current structure of the MES consists of disparate Agencies, all with their own goals. AHCA is considering a more integrated governance structure to foster better collaboration.
Security Requirements	Potential conflicts exist between the MES Vision of "Transform[ing] the Medicaid Enterprise to provide the greatest quality, the best experience, and the highest value in healthcare" and the security requirements for most data used by the MES. Throughout the transformation, the Agency will use the governance and portfolio management processes to fulfill the MES Vision while adhering to these important security requirements.
Traditional Procurement Cycle	Traditional procurement cycles could take longer than anticipated. Administratively, the more traditional aspects of competitive procurement are burdensome and could add management complexities for the Agency if products and services are competitively bid. The Agency will work closely with its Systems Integrator role to manage this constraint as it onboards new modules.
Procurement and Service Availability	Product or service availability within the marketplace may not have yet evolved and technical/business solutions may not be available or are cost prohibitive which could delay the modular implementation. The Agency will work closely with its SEAS Vendor to identify and analyze new products and services as they come available via the annual strategy refresh.
Resource Capacity	Although the Agency is building a structured and robust governance structure for the project, the Agency realizes that managing multiple vendors and multiple module implementations will be challenging. While the Agency is confident in its plan to meet this objective, the governance structure will rely on participation of personnel who already have significant Agency responsibilities. The ability to keep Agency personnel engaged and active in the modernization program will require active management.

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SECTION 6

Stages of Modularity

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# AHCA IS IMPLEMENTING ITS STRATEGIC PRIORITIES TO TRANSFORM THE MES INTO A MODULAR ENVIRONMENT

AHCA's implementation roadmap will fulfill the MES Strategic Priorities, Guiding Principles, and Vision and will culminate in a fully modular system with greater MITA maturity and greater data exchange.
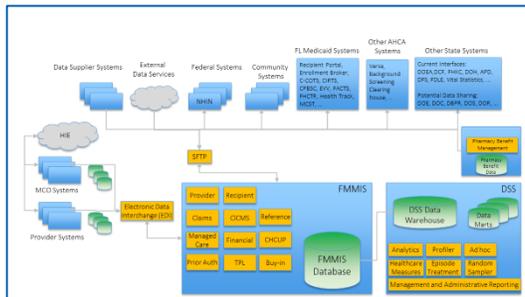

Current State
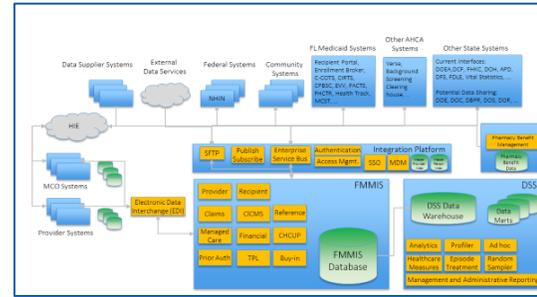
Integration Services Platform Implementation Stage
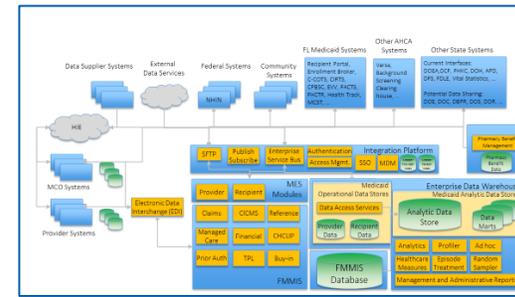
Initial Modularity
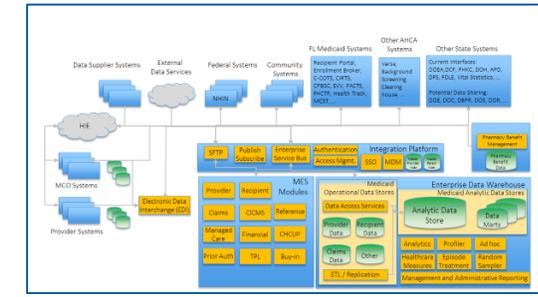
Full Modularity

CURRENT STATE → FUTURE STATE

AHCA is continually looking to fulfill its Mission of providing "Better Health Care for all Floridians." As part of this Mission, the Agency is transforming the MES, the group of systems that execute Medicaid business processes, into a modular environment. Transforming the MES into a modular environment allows AHCA to procure individual solutions that will best meet the needs of Floridians for years to come, while providing a solution that is flexible enough to meet the challenges and opportunities created by the ever-changing healthcare, policy, and technology landscapes. The future of the MES is to enable Florida Medicaid to secure services that can interoperate and communicate without relying on a common platform or technology. Connecting services and infrastructures and developing integration standards are the next steps for advancing the MES level of MITA maturity and system modularity modernization.

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THE CURRENT STATE ENVIRONMENT IS NOT MODULAR AND IS OUTDATED FOR AHCA'S NEEDS

The current MES is partially modular and is adequate to facilitate care for Florida's recipients. The system is not optimized to further AHCA's long-term goals.
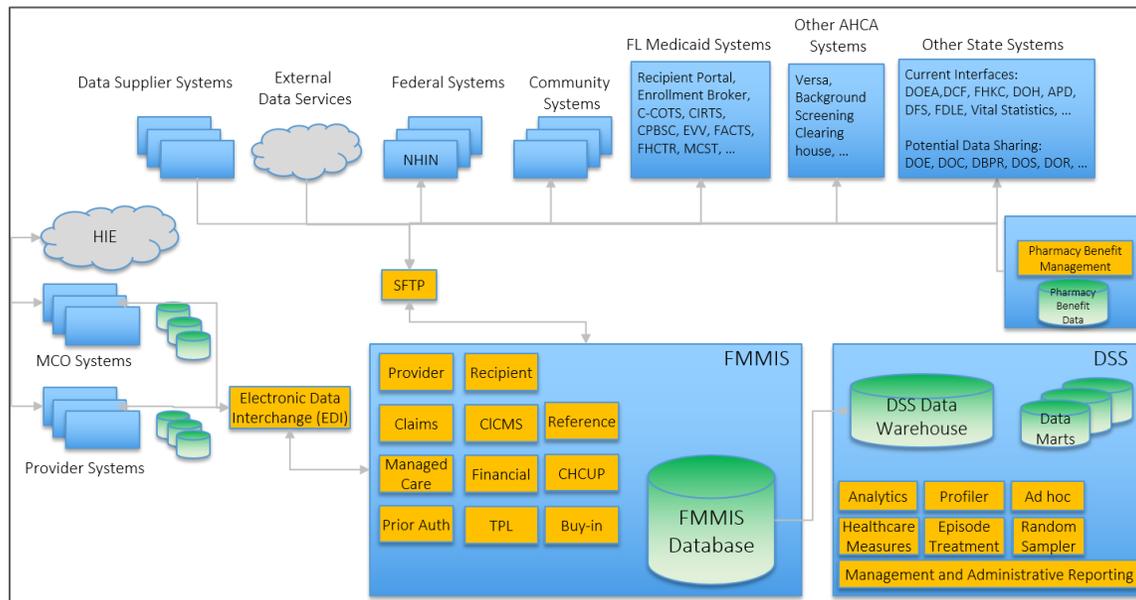
*Current State Context Diagram*

Description of Environment

The Florida Medicaid Enterprise Systems are a collection of many systems of different shapes and sizes, each with its own platform, systems architecture, and proprietary data stores. The systems in the MES are islands of processing and information. Data exchange provides the bridge between these systems.

This state is categorized by the following:

- Providers, health plans, and AHCA systems primarily submit information to FMMIS through Enterprise Data Exchange and FTP batch transmissions

- Pharmacy Benefits is operated by an outside vendor, Magellan

- The enrollment broker vendor is Automated Health Solutions (AHS). AHS operates both the Choice Counseling call center to enroll recipients in health plans and the Provider Network Verification system to monitor health plan provider networks' compliance

- Other Florida Agencies perform Medicaid processes using replicated Medicaid data; there are limited information exchanges

- DSS is the data warehouse that supports analytics, ad hoc inquiry and management and administrative reporting

- The HIE system enables provider to provider exchange of information

- There is no 360-degree view of recipient information or alerting of changes in social determinants of health data

THE INTEGRATION SERVICES PLATFORM SETS THE STAGE FOR FUTURE MODULARITY

The Integration Services Platform (ISP) will enable replacement of batch integration with real-time integration (as appropriate), a 360-degree view of recipient and provider information, and transition of FMMIS processing to MES modular capabilities.
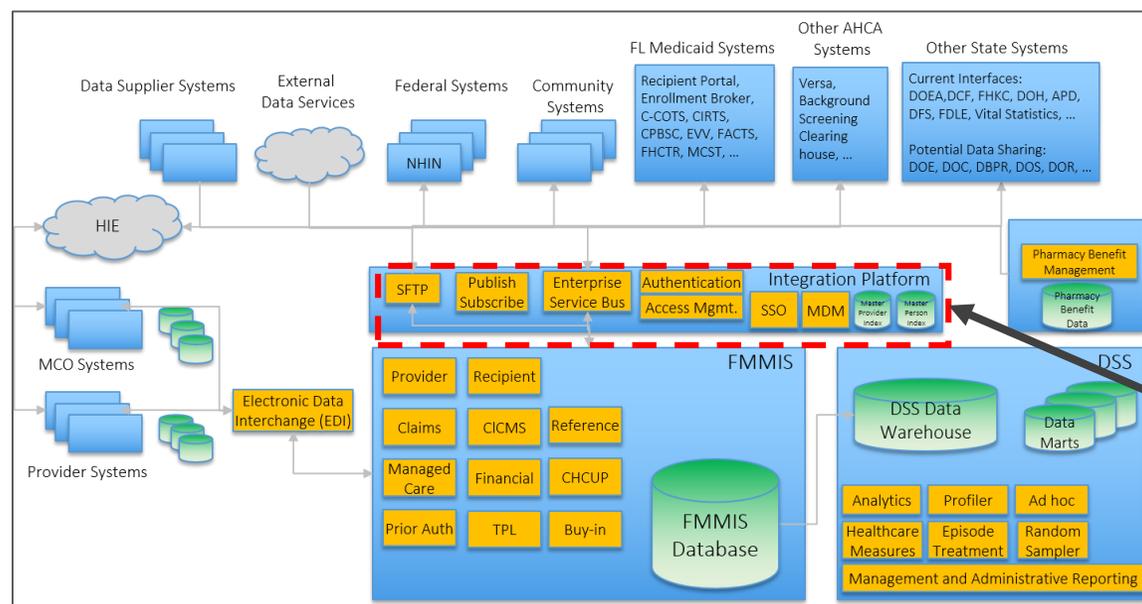
Integration Services Platform Context Diagram

Description of Environment

AHCA is procuring the ISP, which includes the Enterprise Service Bus, System Integrator, and Enterprise Information Management. The ISP will enable secure real-time, or near real-time information exchange between systems while migration to data services occurs. This allows for implementation of modular capabilities that interact with legacy systems and other modular capabilities.

This implementation will also enable integration of non-Medicaid data sources and system integrations with MMIS business processing. Integrations between MMIS modular capabilities and non-Medicaid data sources and information types will use the integration services indefinitely.

To allow for future data types and decisions, the Agency is designing the ISP to be as flexible and scalable as possible.

This state is categorized by the following:

- Real-time, or near real-time, data sharing and reuse through the ISP is routine
- Identify duplicate recipient and provider links, link identified records across systems through Master Person and Master Provider Indexes
- Single sign-on, authorization, and access controls to support sharing data and processing services across systems and modular processing
- Improved secure file transfer capabilities
- An ability to send select real-time transaction data to the data warehouse to support real-time analytics and reporting

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AHCA WILL TRANSITION HIGH-IMPACT SYSTEMS TO A MODULAR ENVIRONMENT IN THE INITIAL MODULARITY STAGE

The Initial Modular Implementation stage continues implementation of modular components until achieving the Future State of Full Modular Implementation.
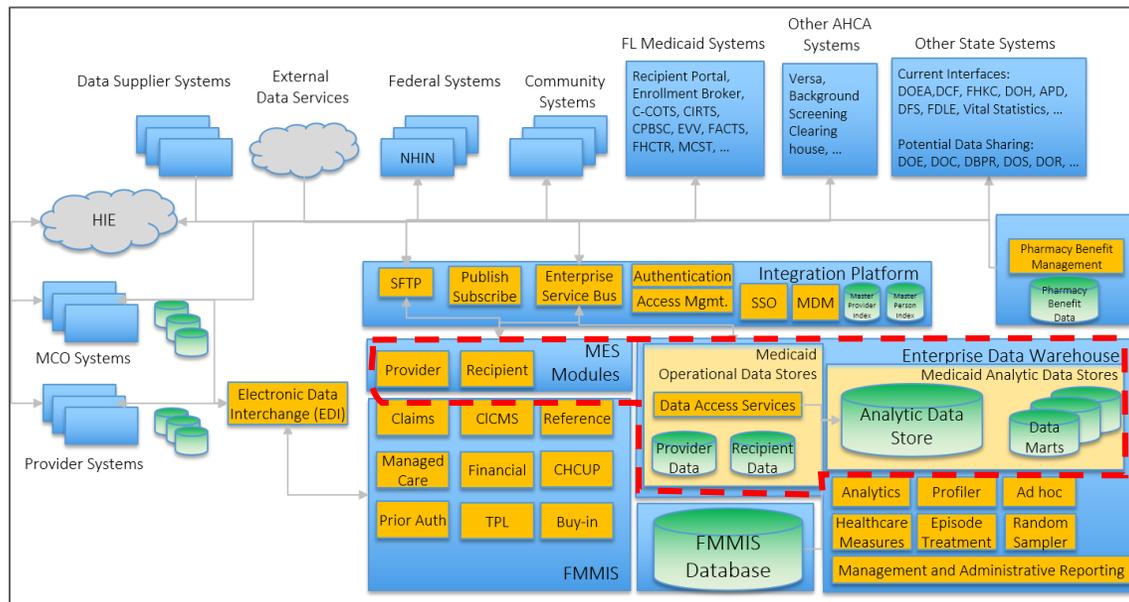
Initial Modularity Stage (Draft)

Description of Environment

Once establishing the infrastructure for transformation via the Integration Services Platform, AHCA will focus on high-impact investing in modules that will create tangible benefit across the Enterprise beyond their immediate areas. AHCA will deepen its collaboration with other Agencies across the MES during this phase of modularity, leveraging the growing flexibility of the system for leverage and reuse.

This state is categorized by the following:

- Business area processing functions currently performed in FMMIS begin to be implemented to perform processing in new MES modular components

- MES Data Services are established to decouple processing from proprietary data stores (e.g. in FMMIS)

- Provider and health plans begin to use the Integration Services platform to access social determinants of care data available from external systems that are connected to the Integration Services platform

- Provider and health plan systems begin to use MES Data Services to contribute and access Medicaid information in real-time, as appropriate

THE GOAL OF AHCA'S TRANSFORMATION IS TO ACHIEVE FULL MODULARITY

The transformation to full modularity is only a step on AHCA's future MES journey. The Agency will continually update and replace components based on service levels; introduce new data sources and types; and evolve and expand MES data services.
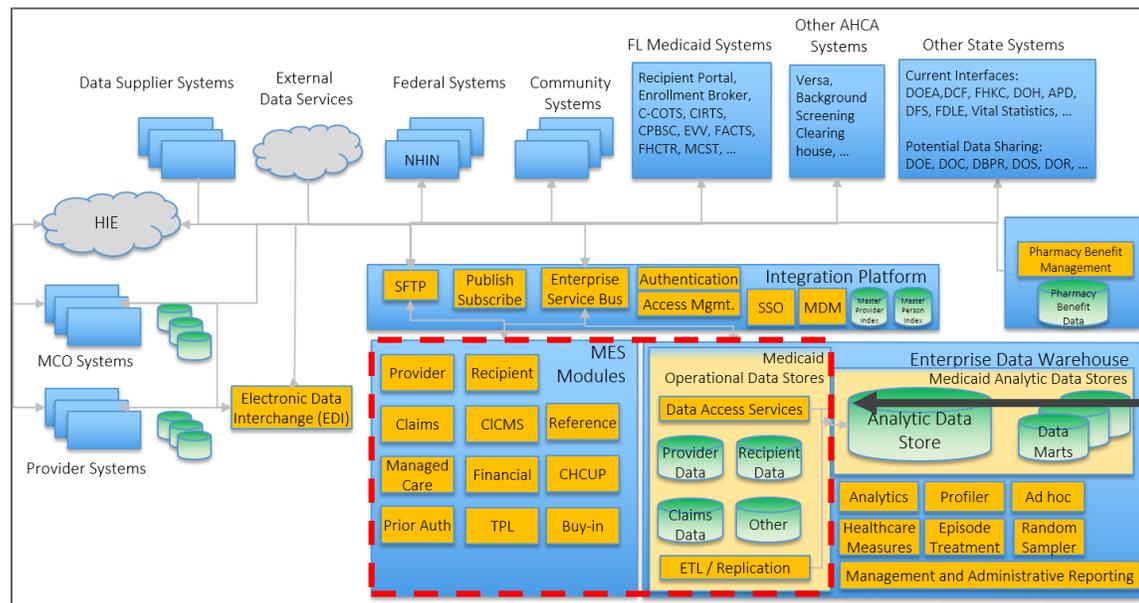
Full Modularity Stage (Draft)

Description of Environment

The final stage of transformation, AHCA will achieve full modularity. Once achieved, the Agency will continue to reassess and improve the modular systems making up the MES.

This state is categorized by the following:

- The FMMIS system has been fully replaced with MES modular components

- The Integration Services Platform includes full integrations with state Medicaid agency systems, other state systems, provider, and health plan systems

- State Medicaid agency systems, provider, and health plan systems use MES Data Services to contribute and access Medicaid information in real time

- State Medicaid agency systems reduce storage of replicated Medicaid data in other systems

- An Enterprise Data Warehouse supports real-time analytics and evaluation of new data sources and data types

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THE MES TRANSFORMATION WILL ACHIEVE SIGNIFICANT BENEFIT FOR ALL STAKEHOLDERS

As described in the Executive Summary section, stakeholders in the MES Vision (e.g., recipients, providers, payer agencies, regulators, legislators, and the public), will each see benefit from the new modular system.

	Current State	Future State
RECIPIENTS	The recipient interacts with multiple systems (e.g. health plans' systems, FloridaHealthFinder), many showing inconsistent information. The recipient is asked to share information with multiple systems that operate in silos and has limited engagement in own care or cost of care.	A recipient-facing system will show informative and actionable information thanks to the EDW and a strong Recipient Portal (see page 54 and 58 respectively). The recipient journey is fully visible (rather than just interactions with providers) and constant improvement occurs. Recipients can carry their health data with them across providers.
LEGISLATURE	Though the Legislature has rising expectations for real-time analysis, AHCA must invest in manually intensive processes to provide the Legislature with information. Agency officials sometimes aren't confident in the data quality.	AHCA fulfills ad hoc requests quickly and accurately while the Legislature has access to real or near-real time dashboards for standard requests through a flexible EDW (see page 56), a strong ISP (see page 55), and greater data integration with the health plans. Analysis is provided using more sources and data types via greater Inter-Agency Data Sharing.
AGENCIES	Agencies duplicate information across siloed systems and data sharing is very limited. Most data and information exchanges are batch exchanges with 1-2 day latency.	Agencies have a 360-degree view of the recipient and provider through appropriate data sharing across agencies. The ESB System (see page 54) enables agencies' applications to speak cleanly via real, or near real-time data access and sharing without duplication across systems. Agencies leverage and reuse each other's systems based on available excess capacity and look to other states to do the same, as appropriate.
PROVIDERS	Providers reference credentialing speed, speed of payment, and the denial process as slow and sometimes cumbersome. Each provider to have multiple identities across the state, making it difficult to tie recipient outcomes to specific providers.	Technology, process, and policy improvements around provider identity reconciliation (see page 56) and a streamlined' enrollment into Medicaid program (see page 57) create a greatly improved provider experience. Providers receive clarity on claims denials and have a 360-degree view of the recipient. Providers have consistent identity across the state, creating the ability to easily tie recipient outcomes to specific providers.
HEALTH PLANS	The currently reported encounter data is of insufficient quality to enable value-based care. The current batch processing creates administration costs to deal with reporting exceptions.	The components of the Integration Platform (see page 54) facilitate greater integration with the state's health plans. Data is high-quality and is reported in real-time as appropriate. Health plans use 360-degree recipient and provider information to coordinate care.
REGULATORS	AHCA provides reports to federal and state regulators. Metrics, such as HEDIS Scores, are more process-oriented than health outcome-oriented.	The components of the Integration Platform (see page 54) and better integration across providers, recipients, and health plans allow regulators to access up-to-date information to implement regulation and policy based on risk and outcomes.

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GREATER DATA INTEROPERABILITY WILL TRANSFORM STAKEHOLDERS' ROLES IN DATA EXCHANGE

Stakeholders in the MES Vision will receive and transmit information and data differently as a result of the MES transformation. Below are some key benefits of this project, with many more being determined through the entire transformation.

	Current State	Future State
RECIPIENTS	Recipients enroll in Medicaid through DCF and receive care through providers. Though care is coordinated by health plans, no single health plan or agency has a comprehensive view of each recipient.	Recipients will take a more active role in the management of their care via improved Recipient Portals (see page 58). These portals will offer greater access to healthcare and financial information.
LEGISLATURE	The State Legislature currently receives periodic snapshots on cost and quality of care in the Florida Medicaid Program.	An integrated MES will provide the State Legislature with near real-time data on the cost and quality of care in the Medicaid Program, enabling legislators to make data-informed decisions on policy.
AGENCIES	Multiple state agencies interact with Medicaid. However, data exchange and collaboration is limited.	Agencies exchange data and insights via interoperable systems built on the ESB (see page 54). Collaboration across agencies via the sharing of data and reuse/leveraging of technology s is common.
PROVIDERS	Providers are enrolled through multiple state agencies and health plans to provide care. Speed of credentialing to provide care to Medicaid recipients is often a source of complaint.	Greater interoperability provided by the Integration Platform between agencies allows providers to quickly enroll into the Medicaid program with less administrative burden. Better tools enable providers to submit encounter data more easily to the health plans and to AHCA when necessary.
HEALTH PLANS	Health plans credential providers and compensate them for care provided. Health plans report that data to AHCA. Discrepancy exists between how each health plan reports encounters.	Health plans report encounter data to AHCA in uniform and clean formats, enabling Value-Based Care through advanced analytics. Data is reported in real-time where appropriate.
REGULATORS	Regulators routinely audit AHCA to confirm care is being delivered in appropriate fashion. These audits often require multiple AHCA employees to manually pull data.	Regulators continue to routinely audit AHCA. However, greater system interoperability and cleaner encounter data make these audits much speedier and less administratively burdensome.

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SECTION 7

Transformation Plan

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EACH YEAR, AHCA WILL MODULARIZE THE CURRENT SYSTEM BY EVALUATING RELEVANT BUSINESS PROCESSES AND SUPPORTING SYSTEMS

The SEAS Vendor will evaluate in-scope MITA Business Processes as they relate to the Strategic Priorities. The staging will change to react to policy, technology, and priority changes. See Appendix Section E for further detail on the makeup of these business processes.

STRATEGIC PRIORITIES

SFY 18/19   SFY 19/20   SFY 20/21   SFY 21/22

Integration Platform	Provider	Recipient	Program Integrity	Financials	Value Based Care	Inter-Agency Focus
Integration Services Platform (ISP)	Identity Reconciliation	Improved User Interface / Recipient Portal	Automation and Analytics	Enhanced / Real Time Reporting	Health Plan Encounter Data	Data Sharing
Enterprise Data Warehouse (EDW)	Streamlined Provider Enrollment	Streamlined Recipient Enrollment	Develop Model for Managed Care & FFS	Reduce & Eliminate Manual Processes & Redundant Systems	Performance/ Contract Management	Social Determinants of Health
	Performance Management & Population Health	Integrated and Accessible Data for the Recipient		Analytics & Dashboarding		Shared Licensure & Credentialing

BUSINESS CATEGORY AND SUPPORTING SYSTEMS TO BE EVALUATED WITHIN CONTEXT OF STRATEGIC PRIORITIES

Provider Management
(Enrollment, Support, Information Management, Contractor Management)

Member Management
(Enrollment, Support, Case Management, Authorization Determination)

Health Plan Administration

Financial Management
(Accounts Payable Management, Payment and Reporting, Claims Adjudication, Accounts Receivable Management, Fiscal Management)

Compliance Management

Standards Management

Note: Each Business Category contains multiple business processes as detailed in the MITA Part I – Business Architecture, Appendix C – Business Process Model Details. These business processes can be found through accessing the following link: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/part-i.zip

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AHCA WILL ACCOMPLISH THIS TRANSFORMATION THROUGH AN ANNUAL STRATEGIC PLANNING PROCESS

To implement the best system for Florida, AHCA is taking an iterative annual approach to its transition to a modular environment.

The Medicaid Management Information System market has been changing and innovating since CMS issued its modularity guidance to states. AHCA's desire is to take advantage of these ongoing innovations even while implementing the MES Procurement Project. To take advantage of new innovations as they become commercially available, AHCA's transformation approach gives focused detail to the modules being procured and implemented during the ensuing eighteen (18) months while maintaining focus on the long-term MES Vision.

Based on these considerations listed above, AHCA's approach to transformation is as follows:

1. Current State Assessment - Understand the current state of the system or system area

2. Annual Strategy Refresh - Refresh the overall MES Vision, Guiding Principles, and Strategic Priorities as needed based on external factors

3. Tactic Planning - Develop an inventory of modernization Tactics, focused projects within an area defined by Strategic Priorities that will be supported by focused project planning during the implementation phase

4. Portfolio Management - Evaluate and prioritize MES-related projects by considering dependencies and overall net benefit

5. Solutioning – Work through the standard agency procurement process to select the right vendor (or internal team) based on the criteria established in steps 3 and 4. This would include the Legislative Budget Request process

6. Procurement and Implementation – Select appropriate solution through internal deliberation or, in the case of a vendor, the procurement process. Implement the solution

7. Benefit Measurement – After implementation, examine benefits created through improved processes

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EACH YEAR, AHCA WILL PLAN THE NEXT YEAR'S MODULES WHILE IMPLEMENTING THE CURRENT YEAR'S MODULES

Modularity will be achieved in annual phases where AHCA will focus on specific Strategic Priorities each year. The timing and staging of effort will change based on AHCA's evolving priorities.

STRATEGIC PRIORITIES

SFY 18/19   SFY 19/20   SFY 20/21   SFY 21/22

Integration Platform	Provider	Recipient	Program Integrity	Financials	Value Based Care	Inter-Agency Focus
Integration Services Platform (ISP)	Identity Reconciliation	Improved User Interface / Recipient Portal	Automation and Analytics	Enhanced / Real Time Reporting	Health Plan Encounter Data	Data Sharing
Enterprise Data Warehouse (EDW)	Streamlined Provider Enrollment	Streamlined Recipient Enrollment	Develop Model for Managed Care & FFS	Reduce & Eliminate Manual Processes & Redundant Systems	Performance/ Contract Management	Social Determinants of Health
	Performance Management & Population Health	Integrated and Accessible Data for the Recipient		Analytics & Dashboarding		Shared Licensure & Credentialing

ANNUAL TRANSFORMATION APPROACH

Current state assessment Integration Platform

Feb: Set MES Strategy

Mar: Create tactics for Provider and Recipient Modules

Jan: Refresh MES Strategy as needed

Jan: Create tactics for Program Integrity and Financial Modules

Jan: Refresh MES Strategy as needed

Jan: Create tactics for Value Based Care and Inter-Agency Modules

Jan: Refresh MES Strategy as needed

Ongoing: Prioritize tactics via Portfolio Mgmt.

SFY 19	SFY 20	SFY 21	SFY 22

June: ITN for ISP

Oct: ITN for EDW

Nov: Implement ISP

Feb: Implement EDW and EIM

June: ITN for Provider and Recipient Modules

August: Measure benefits of the Integration Platform

Nov: Implement Provider and Recipient Modules

June: ITN for Program Integrity and Financial Modules

August: Measure benefits of Provider and Recipient Modules

Nov: Implement Program Integrity and Financial Modules

June: ITN for Value Based Care (VBC) and Inter-Agency (IA) Modules

August: Measure benefits of Integrity and Financial

Nov: Implement VBC and IA through FY '23

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Note: The above high-level procurement timeline reflects the current understanding of the road ahead. This procurement timeline must be flexible enough to react to changes in policy, technology environment, and the Agency's priorities and will be adjusted accordingly.

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THE ANNUAL STEPS TO TRANSFORMATION

These key activities will ensure the Agency has an up-to-date and impactful strategy.

Current State Assessment	AHCA, in collaboration with the SEAS Vendor, will complete an annual current-state assessment of an area related to the relevant Strategic Priorities to understand any upcoming trends in the market that could affect those areas of the MES. For example, the Strategic Plan (as of the time of this March 2018 draft), calls for the Strategic Priority of provider in Fiscal Year 2019. The SEAS Vendor would refresh its assessment of AHCA's needs in the area as well as new technologies coming on line in the MMIS market.
Strategy Refresh	AHCA, in collaboration with the SEAS Vendor, will reexamine the MES Vision, Guiding Principles, Strategic Priorities, and any ongoing Tactics. While the Vision and Guiding Principles are unlikely to change on an annual basis, the SEAS Vendor may change the Strategic Priorities and planned Tactics based on learnings from ongoing Tactics, critical needs, or newly available technologies in the MMIS market.
Tactic Identification	After confirming the MES strategy, the SEAS Vendor will work with teams of SMEs to create detailed initiatives around specific Strategic Priorities (e.g. Provider, Recipient, Program Integrity). These initiatives will be supported by detailed project plans and supporting SMART Goals.
Portfolio Management	AHCA's portfolio management process prioritizes the initiatives generated through the SME meetings. The portfolio management process rates each initiatives based on business, technical, and financial considerations. For example, these considerations may include the following if appropriate for the initiative: Effect on stakeholder service time (business consideration), Complications to future implementations (technical considerations), Total cost of ownership (financial considerations)
Solutioning	The SEAS Vendor and AHCA's MES Project Leadership will determine whether or not the Strategic Priority can be accomplished via an internal process change, an external policy change, an internal technology build, or an external technology vendor.
Procurement and Implementation	The SEAS Vendor will procure the necessary internal resources or work with the AHCA MES Project Leadership team to procure a vendor solution through the State's procurement process.
Benefit Measurement	The SEAS team will analyze the degree of improvement to the Strategic Priority after the implementation of a supporting module. Follow-up initiatives may be created to further the performance improvement, if appropriate.

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THROUGHOUT THE TRANSFORMATION, AHCA WILL LOOK FOR OPPORTUNITIES FOR THE FOLLOWING IMPROVEMENTS

As part of the ongoing Portfolio Management process where new projects and identified and prioritized, the SEAS Vendor will give weight to opportunities that implement the following improvements to directly and indirectly improve the experience of all stakeholders.

IMPROVEMENT	BENEFIT	CURRENT OPPORTUNITIES[1]
Modularity A system design wherein components are divided into a set of functional units called modules that can be bundled into a larger application.	• Access to best of breed and increased innovation • Increased vendor competition • Faster realization of module specific benefits	• Mature modular solutions – Pharmacy, Dental, TPL • New to market modules – Population health • Emerging modules – provider, recipient, claims
Web Services Applications and data sources that speak to each other through standard web protocols such as TCP/IP.	• Standardizes communications for data exchange and processing services • Reuse improves processing consistency	• Migrate batch interfaces to real-time web services, as appropriate • Inventory existing services in registry to encourage reuse
Service Oriented Architecture An architectural style for building applications that use services available in a network, such as the web, to promote reuse of an application's functionality.	• Increased processing consistency • Reuse of technical and business services • Faster lower cost application maintenance	• Consolidate custom non-SOA departmental solutions into enterprise SOA solutions • Use data access services to decouple business logic
Cloud-Based Technologies Technology services that are hosted remotely rather than locally. These services are accessed through web-based tools and applications.	• Reduced security vulnerability and administration • Faster disaster recovery / business continuity • Reduced infrastructure and hosting cost • Increased scalability to increase capacity	• Use cloud based infrastructure • Use cloud for disaster recovery / business continuity • Allow use of cloud based Software as a Services and platform as a Service modules
Open Application Programming Programming using a common or universal language to promote greater access. This enables an organization to use a specific software product in various ways.	• Reduces complexity for modules to reuse proprietary processing services • Reduces dependence on proprietary services	• Create Open API wrappers for proprietary solutions • Use Open API wrappers instead of proprietary APIs (e.g. workflow, authentication, address standardization
Commercial Off-the-Shelf Technologies Technology products that are ready-made rather than custom-built.	• Faster implementation of standardized processing • COTS vendor evolves product capabilities • Development and maintenance costs leveraged by multiple COTS customer	• Use COTS products for complex system service foundational processing – ESB, MPI, MDM, I&AM • Use mature COTS products in standardized business areas – member management, customer contact

[1]Further detailed opportunities will be identified and planned against on a yearly basis via the annual Tactic Identification and Portfolio Management steps referenced on the previous slides.

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AHCA'S MES TRANSFORMATION PLAN WILL IMPROVE ITS MITA PERFORMANCE

The MES Guiding Principles, Strategic Priorities, and Tactics will advance AHCA's MITA performance per CMS's MITA performance metrics found in the MITA Scorecard.[1]

	Automation	Stakeholder Collaboration	Process Standardization	Process Timeliness	Accuracy	Accessibility	Efficiency	Stakeholder Experience	System Interoperability
Integration Services Platform	☑	☑		☑	☑	☑	☑	☑	☑
Enterprise Data Warehouse	☑			☑	☑	☑	☑	☑	
Identity Reconciliation	☑	☑	☑	☑	☑	☑	☑	☑	☑
Streamlined Provider Enrollment	☑	☑		☑	☑		☑	☑	☑
Recipient Portal	☑	☑		☑		☑		☑	☑

[1]These MITA Performance Metrics were taken from the Business Architecture section of CMS's MITA Self Assessment Scorecard.

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INTEGRATION SERVICES PLATFORM

Time Frame: State Fiscal Year 18/19

DIRECT BENEFICIARIES

RECIPIENTS   LEGISLATURE   AGENCIES   PROVIDERS   HEALTH PLANS   REGULATORS

DESCRIPTION

The Integration Services Platform (ISP) implements the enabling capabilities that allow information sharing and business and technology service reuse.

The integration platform capabilities provide the highway and network for information to be used by current MES systems, and subsequent modules and systems that contribute to the health of recipients and effectiveness of providers. A strong ISP is especially relevant for the State of Florida, with its large Medicaid population relative to other states. Specific integration components planned for the ISP include the following:

- Enterprise Service Bus
- Enterprise Information Management
- API Gateway
- Publish and Subscribe Alerting
- Managed File Transfer
- Single Sign-on and Secure Authentication
- Master Person Index and Master Provider Index
- Master Data Management
- Service Registry
- Service Repository

Procurement activities for the ISP are underway in SFY 18/19. The select benefits of this solution will be realized after implementation.

SELECT BENEFITS

As the Integration Services Platform is foundational for the Agency's integration of existing MES systems and installation of future modules, each MES Stakeholder will derive benefit though not directly. The ISP will create benefit by enabling the following:

- Smoothing the integration of diverse modules, enabling greater interoperability, efficiency, and subsequent automation across the MES

- Sharing social determinants of health data across the Medicaid and health and human service ecosystem, enabling a 360-degree view of information about recipients and providers to improve coordination of care via stakeholder collaboration

- Improving the quality and consistency of information, enabling timeliness across the system

- The security and access control framework for role base processing within modules and information sharing across modules and systems, enabling appropriate system accessibility

- Real-time, or near real-time information access and alerting for authorized information consumers, improving stakeholder experience

- Identification and consolidation of duplicated recipient records that result in duplicate payments or incomplete data analysis

Note: underlined text aligns with the MITA performance metrics found in the Business Architecture section of CMS's MITA Self Assessment Scorecard.

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ENTERPRISE DATA WAREHOUSE

Time Frame: State Fiscal Year 18/19

DIRECT BENEFICIARIES

RECIPIENTS LEGISLATURE AGENCIES PROVIDERS HEALTH PLANS REGULATORS

DESCRIPTION

AHCA's current EDW within its current Decision Support System is a one-sized solution for multiple personas of use. The Agency routinely uses a SQL server as a stop-gap measure. The Agency needs a big-data EDW to store growing amounts of information and to consolidate, organize, analyze, and report on Medicaid information, such as information from the All Payers Claims Database and Administrative Discharge Data. This new EDW will create two large benefits.

1. Allow for decoupling data from proprietary applications, thus increasing system interoperability while decreasing intermodular sequencing dependencies.

2. Increase the quality of analytics from better data quality, increased processing capacity, and improved response time by providing a single source of the truth along with the following analytics components:
   - An operational data store to improve the consistency of information used by stakeholders that contribute, use, or analyze data
   - Reporting Data Store & Warehouse containing real-time information
   - Data marts optimized to support the Agency's different analytic needs of different usage profiles
   - Business intelligence and analysis tools for Agency usage profiles

Procurement activities for the new EDW are underway in SFY 18/19. The select benefits of this solution will be realized after implementation.

SELECT BENEFITS

Once installed and configured, the EDW will directly benefit all stakeholders in the MES in the following ways:

- Establishes improved capabilities to consolidate, organize, analyze and report information in the Medicaid enterprise

- Creates the ability to work with large and diverse data sources types without the Agency manually transferring data back and forth via email, as is currently done

- Improve the timeliness, accuracy, and accessibility of reporting, thereby improving both the quality and timeliness of decision making and operational processes (i.e. efficiency) for the Legislature, Agencies, and Regulators

- Enables AHCA to incorporate new data sources to indirectly improve stakeholder experience (e.g. social media data) for Recipient and Providers

Note: underlined text aligns with the MITA performance metrics found in the Business Architecture section of CMS's MITA Self Assessment Scorecard.

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IDENTITY RECONCILIATION

Time Frame: State Fiscal Year 19/20

DIRECT BENEFICIARIES

RECIPIENTS　LEGISLATURE　AGENCIES　PROVIDERS　HEALTH PLANS　REGULATORS

DESCRIPTION

The siloed nature of provider management across Agencies and health plans creates the current state where there is no "single source of truth" for provider Identity. The identity reconciliation module will create a "single source of truth" for Provider Identity across the Agencies, Bureaus, and health plans by creating and maintaining a Master Person Index (MPI) based on real-time identity matching. Using the identity linkages of master records, system processing can take actions considering all master record entries. The MPI can also be used to support account consolidation if the Agency finds account consolidation efforts justified.

The significant elements of data and technology strategy for identify reconciliation will focus investment in validating information at the point of the encounter and to proactively reduce submission of incorrect or invalid fee for service, managed care, and value based care transactions. Strategies to process invalid data identified post submission will focus on cutting down the latency of edit and validation processing so submitters can address errors in near real time.

The select benefits of this solution will be realized after implementation.

SELECT BENEFITS

Once enabled, the Identify reconciliation function will directly benefit recipients, agencies, providers, and health plans in the MES in the following ways:

- Enable stakeholder collaboration by aligning stakeholders' systems (i.e. interoperability) around a single source of truth around provider identity

- Create the ability to automate provider-centric data reports through the greater standardization and accuracy created through agreement on identity

- Potentially standardize processes across Agencies and health plans

- Improve the timeliness, and accuracy of enrollment and un-enrollment, improving the provider experience and Agency efficiency

- Lessen the Agency's administrative burden on the providers during enrollment, improving stakeholder experience

- Improve fraud detection – better Provider Identity Management would allow the Agency to more completely keep Providers with fraudulent track records from re-enrolling in the program

- Improve Encounter Data – stronger Provider Identity Management would allow the Agency to better tie delivery of care to individual providers, enabling cleaner and more useful Encounter Data

Note: underlined text aligns with the MITA performance metrics found in the Business Architecture section of CMS's MITA Self Assessment Scorecard.

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STREAMLINED PROVIDER ENROLLMENT

Time Frame: State Fiscal Year 19/20

DIRECT BENEFICIARIES

RECIPIENTS   LEGISLATURE   AGENCIES   PROVIDERS   HEALTH PLANS   REGULATORS

DESCRIPTION

A major complaint amongst Florida's Medicaid providers is the timeliness and administrative burden of becoming credentialed to provide care in the Medicaid program. The Agency is prioritizing improving the provider experience by investment in the Streamlined Provider Enrollment area to streamline the speed by which a provider can participate in the Medicaid Program while maintaining the proper degree of due-diligence. The module would provide an intuitive user-interface and would pull information from across the State to prepopulate the application(s) to the greatest degree appropriate. The module could potentially act as a single application and credentialing process to provide care across more than one health plan in the State of Florida.

The select benefits of this solution will be realized after implementation.

SELECT BENEFITS

Once installed and configured, Streamlined Provider Enrollment will directly benefit agencies, providers, and health plans in the following ways:

- Improve access to care for Recipients for 2 reasons: 1) more providers would presumably enroll if it was less administratively burdensome to do so and 2) AHCA can quickly fill gaps in access to care through a more timely enrollment process

- Lower administrative burdens for both AHCA, health plans, and providers, improving stakeholder experience, increasing the level of automation across the MES, and increasing efficiency in operation

- Improving integration amongst Agencies and health plans, increasing stakeholder collaboration and interoperability

Note: underlined text aligns with the MITA performance metrics found in the Business Architecture section of CMS's MITA Self Assessment Scorecard.

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RECIPIENT PORTAL

Time Frame: State Fiscal Year 19/20

DIRECT BENEFICIARIES

RECIPIENTS | LEGISLATURE | AGENCIES | PROVIDERS | HEALTH PLANS | REGULATORS

DESCRIPTION

This initiative proposes to provide a comprehensive view of the services provided to a recipient. This strategy will increase the level of involvement of recipients in their care and create continuity of care as the recipient moves amongst providers. The portal will pull from the relevant data sources to give recipients access to their healthcare and provider information. These data sources will grow to include provider performance information and the recipient's health information, including history, as a result of the "Integrated and Accessible Data for the Recipient" high-level tactic. Further information will be pulled into the portal as greater inter-agency collaboration occurs.

The Master Person Index that links identity records will be used to request consolidated information sets from multiple sources. In the future this information could be used to provide behavioral economic recommendations. For providers this information could help in claim authorization, encounter submission, and even care delivery.

The select benefits of this solution will be realized after implementation.

SELECT BENEFITS

Once installed and configured, the Recipient Portal will directly benefit recipients in the following ways:

- Improved recipient <u>experience</u> via a more <u>accessible</u> system where recipients can easily access their healthcare records and make informed decisions about their care

- A more <u>interoperable</u> system to provide recipients with actionable information about their healthcare and healthcare choices

- Improved cost containment as increased member engagement in health care potentially leads to higher frequency of preventative care visits

- Higher accountability for <u>process timeliness</u> through the transparency created by a robust portal

- More <u>automation</u> as recipients will be able to select a health plan and check their Explanation of Benefits documentation

Note: underlined text aligns with the MITA performance metrics found in the Business Architecture section of CMS's MITA Self Assessment Scorecard.

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NEXT STEPS

The SEAS Vendor is now executing against this Transformation Plan.

Nearer Term Initiatives ➜ Longer Term Initiatives

Integration Platform	Provider	Recipients	Program Integrity	Financials	Value Based Care	Inter-Agency
Integration Services Platform	**Identity Reconciliation**	Improved User Interface / Recipient Portal	Automation and Analytics	Enhanced / Real Time Reporting	Health Plan Encounter Data	Data Sharing
Enterprise Data Warehouse	**Licensure & Credentialing**	Enhanced Eligibility	Develop Model for Managed Care & FFS	Reduce & Eliminate Manual Processes & Redundant Systems	Performance/ Contract Management	Social Determinants of Health
	Performance Management & Population Health	Integrated and Accessible Data for the Recipient		Analytics & Dashboarding		Shared Licensure & Credentialing

Integration Platform	The SEAS Vendor is currently going through the procurement process for the components of the Integration Platform and expects a June ITN for Integration Services Platform and an October ITN for the Enterprise Data Warehouse and Enterprise Information Management system.
Provider	The SEAS Vendor is currently coordinating SME meetings around the Provider Strategic Priority to create detailed initiatives. These initiatives will be vetted through the Portfolio Management process.
Strategic Portfolio Management Plan	The SEAS Vendor is currently building the Portfolio Management Plan (PMP). The PMP will offer the Agency a framework by which to evaluate and stage the initiatives generated by the SME meetings.

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APPENDIX TOPICS

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SECTION A

Trends in Healthcare and Technology Spaces

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UNDERSTANDING THE EXTERNAL ENVIRONMENT

As with any large, multi-year initiative, AHCA must seek to better understand the external forces that will affect our industry in the future. This document is being provided to AHCA executives as a summary of the key Healthcare and Technology trends that are either being utilized today, or are on the horizon. Below is a summary of the topics included:

Healthcare Trends	Healthcare is undergoing rapid change, and there are new trends which will have an effect on the industry in the next 5-10 years. While this list is not all-encompassing, it does include the trends which are most likely and could change how we do business going forward. The Healthcare trends we will explore are: • Retail Metrics in Healthcare • Value Based Care • Virtual Health Management • Consumerism in Healthcare
Technology Trends	Similar to Healthcare, technology is changing (seemingly every day) and it is important that we capture the trends that are most likely to affect how we think about our technology needs. The Technology trends we will explore in this document are: • Artificial Intelligence and Bots • Cloud for Healthcare Payers • Payment Integration • Blockchain • Leveraging Analytics to Improve Care Delivery

As we go through the journey of developing our new system over the next 5 years, trends such as these (and others as they arise) will be considered in order to best meet Florida's and the Agency's needs.

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RETAIL METRICS IN HEALTHCARE

Retail Analytics in healthcare measure provider and health plans performance using traditional retail metrics. These consumer-centric metrics can drive health plans and providers to reduce costs while improving service.

RETAIL ANALYTICS ENABLES MEASUREMENT OF RECIPIENT / PROVIDER-LEVEL EXPERIENCE
Retail Analytics leverages data to measure and improve the recipient and provider experience.

Single Data warehouse

External Data   Internal Data
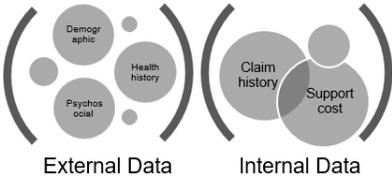
Integrate both internal and external data sets into a single data warehouse.

Real-time Dashboard

Establish customer-centric measurements, such as time-to-serve measures for provider credentialing. Visualize results and generate custom reports for real-time decision making.

Metric Evaluation
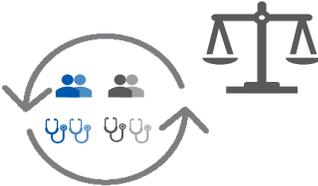
Evaluate cost and efficiency of each patient/provider touch point. Identify areas of concern using benchmarks and deploy Tiger Teams to resolve.

HOW THE PAYER INDUSTRY IS RESPONDING

Anthem Blue Cross

Anthem developed a single data warehouse to integrate internal and external data to build a longitudinal view of members and to boost member engagement.[1]

GUIDANCE FOR AHCA

As analytical capability is limited in AHCA today, it will be important that our system is developed to leverage big data analytics to drive and manage more focused outcomes and care delivery.

To do this, it will be imperative that we integrate data from other key partners, such as health plans, other agencies, and providers.

IMPACTS TO HEALTHCARE

INCREASE ENROLLMENT
Data insights around claims and enrollments may allow payers to simplify process, reduce time and cost, and drive provider and recipient satisfaction.

CREATE ACCOUNTABILITY
Targeted metrics can create more effective benchmarks to hold providers and health plans accountable for the level of service provided to both providers and recipients.

INCREASED SERVICE
Retail metrics may be able to help health plans go beyond current measures when segmenting providers and recipient populations to provide more targeted services.

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1: *Anthem taps retail industry for data analytics expertise,* Aug 11th 2017, Leslie Small, https://www.fiercehealthcare.com/

VALUE-BASED CARE

Value-based care aims to improve patient outcomes while reducing costs by paying for coordinated care across providers.

VALUE-BASE CARE SYSTEMS REWARD PROVIDERS FOR IMPROVED QUALITY OF CARE
The fee-for-service model is being replaced by a more cost-effective payment method that improves outcomes.

Patient Engagement
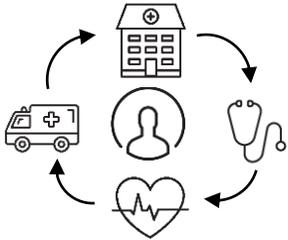
Care teams track patients throughout their care cycle, and establish a tailored process for patient outreach and engagement.

Provider Satisfaction
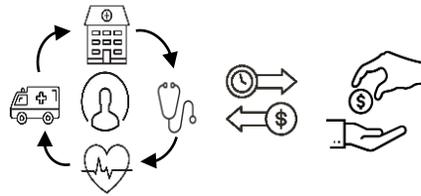
Providers are collectively reimbursed for the expected costs to treat a specific condition that may include several physicians, settings of care, and procedures.

Cost Saving
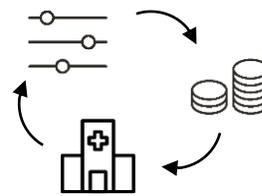
If providers are able to decrease the cost of the services below the bundled payment price, then they can pocket the savings.

IMPACTS TO HEALTHCARE

PATIENT EXPERIENCE

Consumers are at the center of the health care experience and are supported by a more coordinated care team, resulting in a more valued and engaged care experience.

CARE COORDINATION

Care providers are incented financially to use new technology to identify specific health risks, improve access to care, and coordinate care across the entire health care system.

IMPROVED QUALITY

Value is the new standard for insurance companies and care providers, and pay is based on quality and patient health improvements.

HOW THE PAYER INDUSTRY IS RESPONDING

Humana

Humana is partnering with FullWell, a population health management company, to better coordinate care across FullWell's 150 provider under the Colorado Health Neighborhoods Network.[1]

GUIDANCE FOR AHCA

AHCA may want to consider technologies, tools, and infrastructure to integrate encounter data for measuring and monitoring outcomes. AHCA may also consider a system tailored to making and tracking value-based payments.

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VIRTUAL HEALTH MANAGEMENT

Virtual health management coordinates care through telemedicine, telehealth, and other at-a-distance health services.

VIRTUAL HEALTH MANAGEMENT CONNECTS REMOTE PATIENTS WITH THEIR CARE TEAMS

By using this solution, members can receive the attention they need and payers can limit their exposure to preventable diseases across the population.

Self Management

Member requests care via on-demand virtual visit or engages in self-management solutions such as medication compliance management.

Virtual Examination

Provider conducts examination through secure video and messaging or the health care team communicates with member about non-compliance or specific actions that need to be taken.

Health Follow-Up

Provider writes a prescription and/or asks a member to take additional specific actions as part of next steps.

IMPACTS TO HEALTHCARE

UTILIZATION

Virtual care for non-emergency encounters can enable hospitals to redirect their critical resources such as ERs to servicing patients that really need them.

CONVENIENCE & SPEED

Members are able to consult providers at a location of their convenience and without having to wait long for an appointment.

BETTER OUTCOMES

Solutions such as remote ICU monitoring, patient monitoring, and medication adherence enable timely intervention – resulting in improved health outcomes and lower costs.

PROVIDER SATISFACTION

Highly-skilled providers who are semi-retired or need more work-life balance can be tapped via virtual health resulting in improved workforce satisfaction and hence, quality of care.

HOW THE PAYER INDUSTRY IS RESPONDING

COLLABORATION WITH 3rd PARTY VENDORS

Many payers have entered into agreement with third party vendors such as Virtuwell and Teladoc to provide their members access to doctors 24/7/365 for selected medical conditions and at a lower cost than traditional means.

DIRECT TO CONSUMER MODEL

Insurers such as Anthem and UnitedHealth Group are offering their own D2C virtual doctor-visit services rather than paying for members to use third party vendors.[1]

GUIDANCE FOR AHCA

AHCA may consider better and more frequent utilization of virtual health in order to improve access in our various networks. This can be a solution for provider types that have limited access.

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CONSUMERISM IN HEALTHCARE

Health consumerism is a movement that advocates patients' involvement in their own healthcare decisions.

HEALTH CONSUMERISM CHANGES THE RELATIONSHIP BETWEEN PROVIDERS AND PATIENTS
A shift the "doctor says/patient does" model to a "working partnership" model.

Transparency

Patients need to better understand the implications of recommended care, pushing payers and providers to make cost and quality data more available.

Immediate Access

Patients want immediate access to care, such as making an appointment on mobile app, telemedicine, and virtual visits.

Sensitivity to Costs

Patients not only want a better quality, but at a lower cost. This requires healthcare providers to use data, technology, and resources to stay innovative and provide high-quality treatment and services.

IMPACTS TO HEALTHCARE

REDUCE COST

Providing customers with more information may change their behaviors in a way that reduces healthcare costs.

IMPROVE PRODUCTIVITY

Consumerism may ultimately enhance the competition in the healthcare industry as patients will have the ability to select the superior providers and health plans. This trend forces healthcare organizations to drive innovation, lower costs, and improve services.

INCREASED ACCOUNTABILITY

Increased transparency will drive more powerful and effective consumer watchdog groups in the healthcare industry. This may have a powerful effect on waste and abuse.

HOW THE PAYER INDUSTRY IS RESPONDING

Healthcare Bluebook is a marketplace disrupter responding to the need of cost transparency. The online service operates an online database that gives consumers a free tool to conduct price comparisons of services in their local area. Providers can participate by listing their "fair price" services with the site. Payers can also integrate the tool into their own member services platform.[1]

GUIDANCE FOR AHCA

The Agency may consider further developing its consumerism-focused culture and methodology within its organization to educate employees to be more focused on the provider and recipient experience.

1: *How Payers and Providers Are Using Technology to Meet Consumer Needs,* Dec 2th 2016, http://www.emids.com/

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ARTIFICIAL INTELLIGENCE (AI) - BOTS

BOTS enable lower claim processing time (and cost), enable better fraud detection, and improve provider engagement.

AUTOMATED CLAIMS PROCESSING
Bots use advanced algorithms, abundant computing power, and advanced analytics to lower processing time by orders of magnitude while maintaining or improving accuracy.

Data Rationalization
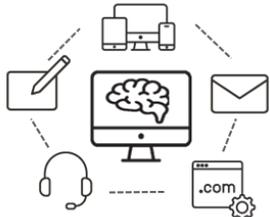
AI-infused natural language processing replaces human chart abstraction and rationalizes data from unstructured sources

Pattern Identification

Supervised and unsupervised algorithms mine vast datasets from multiple platforms to uncover patterns

Real-time Decisions
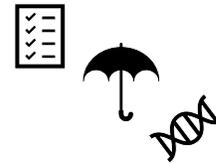
Real-time execution on defined tasks, such as fraud detection, claims automation process, and insights on decision making

HOW THE PAYER INDUSTRY IS RESPONDING

AIG

American International Group Inc. (AIG) deployed ARIES, its first machine learning Bot, to resolve network incidents globally. AIG is currently determining whether Bots can review injury claims and immediately authorize payment checks.[1]

GUIDANCE FOR AHCA

Artificial Intelligence programming has the capability of automating many manual processes, and speeding up data outputs within many operational areas within AHCA. Vendors are currently offering solutions specific to the Medicaid eligibility area. Non-specific solutions exist for other areas.

IMPACTS TO HEALTHCARE

FASTER PROCESS

Dataset mining and abstraction lowers processing time impressively compared to human handling. Payers can either trim their staff for savings or redivert human capital to more strategic pursuits.

INCREASE ACCURACY

Once a process is mapped accurately, Bots perform routine tasks with far greater accuracy than do humans. Bots don't have "fat fingers."

DETECT FRAUD

With real-time access to government, hospital, pharmacy, and public historical data, Bots can quickly identify uncommon patterns of reported care to identify potential fraud.

1: Where Machines and Humans Intersect, July 20th 2017, The Wall Street Journal, http://deloitte.wsj.com/cio/2017/07/20/where-machines-and-humans-intersect/

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CLOUD FOR HEALTHCARE PAYERS

Cloud delivers different services to an organization's computers and devices through the Internet and shared computing services.

CLOUD FACILITATES ORGANIZATIONS TO UNLOCK COMPLEX BUSINESS AND IT PROBLEMS
By leveraging the elasticity, agility, and scalability of cloud computing advantages.

Internal Data Exchange

Underwriting	Health Plan Information
Claims Processing	Member Profile
Finance	HR & Procumbent

Large & Flexible Capacity

External Communication

Provider
Physician
Pharma
Govt.
Researcher
Social

Cloud computing supports application development in a number of areas including process simplification, recipient portal, payment integration, big health analytics, data and system recovery, and cognitive capabilities.

IMPACTS TO HEALTHCARE

REDUCE RISK

Improve disaster recovery via Cloud back up and lower security risks through built-in governance mechanisms such as flexible permissions.

QUALITY & TIMELY DATA

24/7, real-time access to quality and timely data enables the Agency to reduce errors, smooth credentialing and claim processing, and improve the providers' and recipients' experience.

MORE ELASTIC AND AGILE

Unlike in-house IT systems, cloud services allow organizations to scale up and down easily to meet their business and organizational goals.

HOW THE PAYER INDUSTRY IS RESPONDING

The startup Nuna worked with the federal government to develop cloud-based software that houses data on 74 million Medicaid patients, providing aggregated information used to identify trends among low-income individuals.[1]

GUIDANCE FOR AHCA

The Agency may consider evaluating how other state agencies use cloud for Medicaid and evaluate their performance. Begin considering the where, how, and when for cloud-based solutions, including a low-risk pilot to spur buy-in across the MES.

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1: *"Medicaid's Data Gets an Internet-Era Makeover"* Jan 9th 2017, The New York Times

PAYMENT INTEGRATION

Payment Integration is integration of accounting, stakeholder management, and other applications within payments processing.

PAYMENT INTEGRATION STREAMLINED PAYER'S COMPENSATION
By automating steps of in the entire payment life cycle and claim process.

PROVIDERS

PAYERS

Integrated Payment Systems

BANK &
3RD PARTY
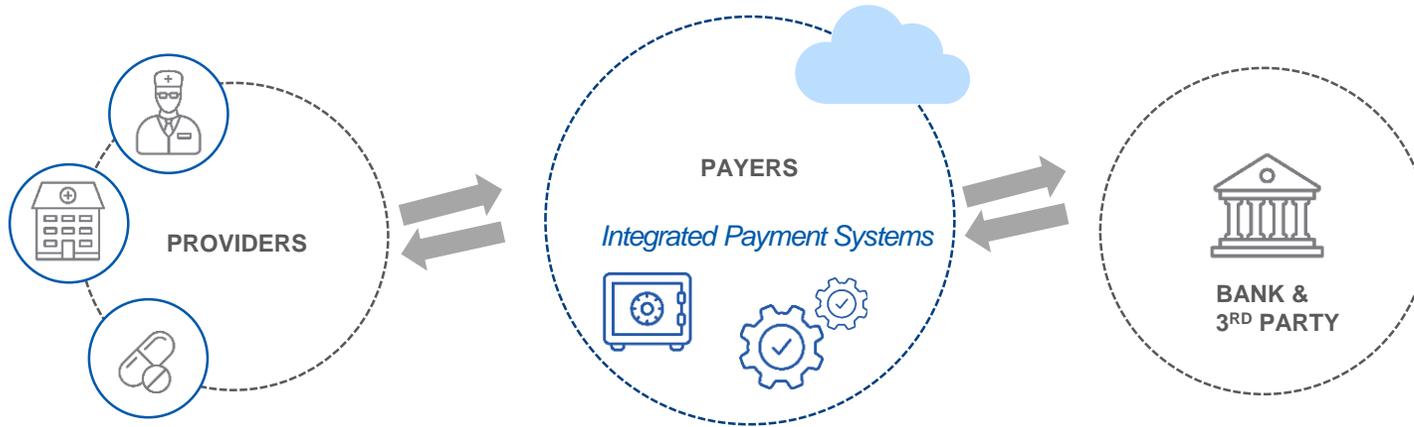
An integrated payment process bridges the gap between electronic payments and the various claim systems by creating a seamless work flow throughout all levels of a Payer's organization and all steps of the payment process.

IMPACTS TO HEALTHCARE

REDUCE OVERPAYMENT

Payment integrity address the problem of improper payments across the payer's entire payment life cycle by tracking inaccurate provider, benefit and coding data, deficient processes and inexpert staff.

INCREASE DETECTION

360-degree view of members, providers, claims, and event data enable payers increase its detection and analysis on fraud, waste, and abuse.

HOW THE PAYER INDUSTRY IS RESPONDING

Horizon
Healthcare Services

Horizon Healthcare Services, Inc. moved from an in-house insurance payments system to an integrated Bill Payment solutions, which allowed Horizon to support exchange enrollment growth of 400% from 2014 to 2016.[1]

GUIDANCE FOR AHCA

The Agency may consider beginning to evaluate and assess its current payment solution to identify any room for improvements. This evaluation would benefit from a robust analysis of industry benchmark of payment best practice.

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BLOCKCHAIN

A blockchain is a digitized, decentralized, public ledger of all transactions. It has the potential to create faster, more secure data flows between patients, providers, and payers.

BLOCKCHAIN WORKS BY CREATING A CONSISTENT RECORD OF CARE
By leveraging a distributed network, blockchain virtually ensures consistent patient records.

Record Creation

A health record is created whenever a patient accesses care from a provider

Information Validation
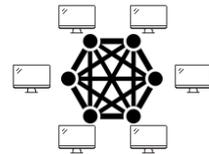
Each node of a distributed network re-confirms the patient's entire health history

New Record Chain

Once the patient's history is re-confirmed, the new record is added to the unbroken "chain"

HOW THE PAYER INDUSTRY IS RESPONDING

While there is wide agreement on the impact of blockchain to the healthcare industry, there is less so around the question of "when." Though early-stage startups are seeing promising results in the blockchain healthcare space, less regulated industries with cleaner data, such as Finance, are just now putting the technology to use.

GUIDANCE FOR AHCA

For stakeholders within the Blockchain network, Blockchain has the potential to enable the 360-degree view or recipients and providers by reducing inconsistency between data sources such as provider identity or recipient medical history. This technology is early state within healthcare.

IMPACTS TO HEALTHCARE

PATIENT PROTECTION

Providers and payers on the blockchain will be able to tie a patient to a medical record using a consistent identifier other than a Social Security code

CONSISTENT RECORDS

Patient records are updated in near real time across approved systems that are on the blockchain, regardless of EHR, reducing administrative record-keeping hassle

FASTER PROCESSES

Consistent records allow for automated processes (approve or disapprove eligibility for example), leading the way for automation

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LEVERAGING ANALYTICS TO IMPROVE CARE DELIVERY THROUGH MANAGED CARE ORGANIZATIONS (MCO'S)

Better integration with the MCOs will enable AHCA to improve how they deliver value based care.

MCOs CHANGE THE TRADITIONAL CONTRACTING MODEL BETWEEN PAYERS AND PROVIDERS
Providers cooperate to increase the quality of care by tying payments to quality and cost of care.

Network Enrollment
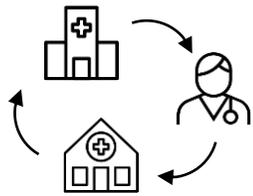
Local providers participate in a network to provide coordinated care, align incentives, improve patient experience, and lower costs.

Risk Management
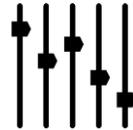
The MCO assumes a portion of the risk of improving quality of care and reducing costs.

Outcome Improvement
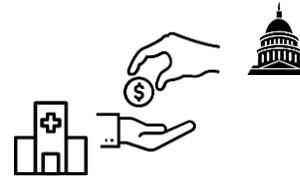
A successful MCO will share in the savings generated by the reduction in service duplication, preventing medical errors, etc. Outcomes need to be effectively managed through advanced analytics.

IMPACTS TO HEALTHCARE

BETTER CARE

Coordination between a patient's providers increases the likelihood the patient receives the right care at the right time and with fewer medical errors.

SHARED SAVINGS

MCOs can increase investment and quality of care with the shared savings generated by reducing costs from lower instances of medical errors and duplication of services

LESS WASTE

Increased coordination and a focus of cost savings will reduce waste, fraud, and abuse, which resulted in $60B in improper payments by CMS in 2015. `

HOW THE PAYER INDUSTRY IS RESPONDING

Between 2010 and 2016, MCO enrollment surged by a compound annual growth rate (CAGR) of 12%.

The strong growth of MCO indicates patients' confidence and willingness of MCO, it will probably drive Medicaid enrollment and improve health outcome patterning with MCOs.

GUIDANCE FOR AHCA

The Agency may consider using better metrics to compare performance of the 17 different Florida MCOs with industry benchmarks (and each other). Based on comparison results, the Agency may consider setting up performance plans and other supporting initiatives.

Source: gartner.com; cms.gov; aha.org; abcnews.go.com

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SECTION B

Select State Medicaid Agency MMIS Strategies

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Modularity is still new - there is no one size fits all strategy sweeping the nation as states are varied in their approach.

A review of current state plans shows modularity is still a new concept that states are beginning to adopt as they replace their legacy systems. CMS has stated that several states are looking to Florida for leadership. The SEAS Vendor recommends that the Agency collaborate with the modular-focused states around lessons learned and around opportunities for interstate technology leverage and reuse.

The table below presents different approaches being taken nationwide. The pages that follow present profiles of states in various stages of their modernizations projects that participated in the market scan interviews, including guiding principles, procurement and implementation approach, challenges, and lessons learned. Notable strategies from additional states not interviewed are also highlighted.

APPROACH	DEFINITION	COUNT OF STATES
Modular	Replace MMIS with multiple modules	16
Takeover	Takeover or keep current MMIS, then modularize	8
Transition	Transition to new MMIS, then modularize	3
Leaning Modular	Plans not published, but leaning modular	4
Leaning Takeover, Transition	Plans not published, but leaning toward takeover or transition, then modularize	4
Plans Not Released	No plans or planning underway, direction not yet known	9
Pre-Dates New Rules	Replacement strategy pre-dates new rules, transition recently completed or underway with multiple years remaining on contracts	8

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STATE STRATEGY PROFILE | COLORADO

AGENCY

Department of Health and Human Services

Medicaid Spending*
$7.9 Billion

Medicaid Enrollment*
1,321,700

Expansion Enrollment*
425,500

*Henry J. Kaiser Family Foundation, June 2017.

APPROACH: Pre-Dates New Rules

GUIDING PRINCIPLE: The more vendors, the more challenging

As a state where one vendor had previously covered everything MMIS, Colorado issued a Request for Information (RFI) in 2012 to receive input directly from the vendor community on what would happen if the future MMIS was broken into five different contracts. At the time, the response was five contracts was too many. As a result, Colorado issued three separate procurements: core MMIS and fiscal agent (FA) operations, pharmacy benefits management (PBM), and business intelligence and data management services (BIDM).

Although the procurements were staggered in design, initially all three systems were scheduled to go live on the same day. The core MMIS contract was signed in February 2014. The first BIDM Request for Proposals (RFP) failed because the budget was set too low due to underestimating decision support system (DSS) licensing costs. The RFP was republished after additional funding was requested, and the contract was signed in April 2015. The PBM procurement was protested and thrown back into the bidding process. As a result, the contract was not signed until September 2015.

An internal team provided project management services and nine months prior to go-live began meeting jointly with all three vendors on a weekly basis. A system integrator (SI) was not procured to support the implementation and integration. Solutions were required to provide the ability to administer and modernize without significant changes to the underlying technology. All three systems were implemented in 2017: PBM in February, core MMIS in March, and BIDM in May.

CHALLENGES

- Working with multiple vendors with the state having to get in the middle proved difficult.

- Controlling scope changes on the state side in terms of requirements included in RFPs was a challenge.

- Vendors were unclear on when they would deliver.

- Going live on the planned date was not achieved.

LESSONS LEARNED

- When implementing large components like claims processing, do not underestimate the number of impacted stakeholders and the resulting call center impact. Stagger the rollout by component to better manage the increased call volume.

- Add language to contracts that requires vendors to hold true to their timelines.

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STATE STRATEGY PROFILE | KANSAS

AGENCY

Department of Health and Environment

Medicaid Spending*
$3.3 Billion

Medicaid Enrollment*
384,900

Expansion Enrollment*
N/A

*Henry J. Kaiser Family Foundation, June 2017.

APPROACH: Transition

GUIDING PRINCIPLE: Stage the implementations by complexity

Kansas contracted with a vendor to take over its legacy system in 2002. Upon conducting a MITA State Self-Assessment (SSA), the State produced goals to implement additional enhancements to its MMIS.

The first round of RFPs were rejected by CMS for not being modular enough, sending a clear message that it would no longer approve RFPs for traditional MMIS procurements. After revising its approach, Kansas released one RFP to procure eight self-contained modules aligned to core functionalities and MITA business processes: provider enrollment, data warehouse, program integrity, customer self-service portal, claims, finance, managed care/enrollment broker, and integration with the eligibility system. Vendors were allowed to bid on all or parts of the RFP, including the SI role. Kansas was the last state permitted to contract with an integrator that also contracted for a module. All eight module contracts, including SI, were ultimately awarded to a single vendor.

During negotiations, vendors recommended grouping implementations. The state has decided to implement four modules at a time, beginning with more discrete modules that require less interaction with the core MMIS. Because these initial modules will integrate initially with the legacy system, the level of effort to integrate was a consideration when sequencing modules. The more complex modules will be implemented last and are expected to take longer to implement than the initial modules. The plan is to move the system into one core enterprise service bus (ESB) and then hire external support to establish the required governance.

A Project Management Office (PMO) vendor has not been procured. Kansas is leaning on specific expertise on the state side, but is considering adding more resources after contracting with a system architect. Also, the State has procured support services for testing and quality assurance (QA).

CHALLENGES

- Maintaining the old system while implementing the new modules will be a challenge.

- The RFP was written using the old certification checklists. The new checklists were released after some contracts were already awarded. Kansas is still trying to reconcile the old and new checklists for these contracts.

LESSONS LEARNED

- Incorporate certification checklist requirements into the RFP. Involve CMS as early as possible to facilitate the certification process.

- During requirements validation, questions and issues on how data and modules would need to interact were uncovered. When reviewing requirements, consider each module individually, but also how it will interact and impact other modules.

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STATE STRATEGY PROFILE | MICHIGAN

AGENCY	APPROACH: Takeover

Department of Health and Human Services

Medicaid Spending*
$16.9 Billion

Medicaid Enrollment*
2,321,200

Expansion Enrollment*
637,200

Henry J. Kaiser Family Foundation, June 2017.

GUIDING PRINCIPLE: Put it in the cloud

Michigan's system was procured in 2009 and certified in 2011. When Illinois began to explore options for a new MMIS, the two states decided to enter into a partnership. Having already made a substantial investment in its MMIS, Michigan is moving functionality to a cloud infrastructure to allow Illinois to leverage its investment and enable both states to save on implementation and maintenance costs. Michigan has discussed its approach with several other states, but to date, Illinois is its only customer.

The state considers the core MMIS a module, with benefits management, provider enrollment, enterprise data warehouse (EDW), PBM, and third party liability (TPL) identified as separate modules. Michigan will migrate its certified core MMIS to a cloud infrastructure to extend to other states as a MMIS as a service (MaaS) offering to include claims processing and TPL.

Michigan implemented a Project Control Office to support the effort, along with additional resources and contractors to help with overall management and testing. Independent Verification & Validation (IV&V) costs incurred as Michigan migrates to the cloud and works with Illinois will be shared.

For Illinois, Michigan supported adoption by performing a gap analysis to determine what needed to be configured versus customized (less than 5 percent). Based its work with Illinois, Michigan developed guidelines for how to work with other states, the first being the sharing model requires other states to fully adopt Michigan's business processes.

CHALLENGES

- Partnering with another state was a totally different approach, with no predecessors to model after or from which to learn.

- Because they were unfamiliar with the approach, some MMIS vendors had concerns that the states were circumventing the procurement process.

- The states had to get CMS on board with their approach.

- Illinois has to adopt a number of Michigan's business processes.

LESSONS LEARNED

- Make sure you have a strong governance model and strong executive support in place.

- Change management is required for a state to adopt both a new system and new business processes.

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STATE STRATEGY PROFILE | NEBRASKA

AGENCY

Human Services Department
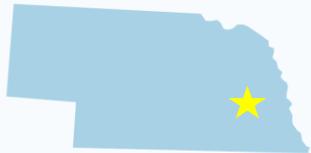
Medicaid Spending*
$2.0 Billion

Medicaid Enrollment*
237,000

Expansion Enrollment*
N/A

Henry J. Kaiser Family Foundation, June 2017.

APPROACH: Modular

GUIDING PRINCIPLE: Break from tradition

As a self-administered state, Nebraska had never replaced its MMIS. Believing the MMIS to be the oldest in the nation, the state planned to replace the system in 2013; however, upon completing an alternatives analysis and in light of the new CMS rules, it chose not to invest in a new MMIS. The state decided to implement a claims broker service within their managed care organization (MCO) to manage FFS claims as a service, allowing Nebraska to eventually sunset its core MMIS and be the first state without an in-house FA. To date, Nebraska is the only state managing claims through their MCO.

A procurement and implementation roadmap was developed based on the complexity and necessity of modules. An early driver was the expiration of enhanced federal funding which eventually got extended. The data management and analytics solution will be procured as one module to include DSS, program integrity, case management, management and administrative reporting /surveillance and utilization review, data warehouse, and analytics tools. A centralized provider management module is in the early planning stages of procurement as well. Budgets were not revealed in the RFPs.

The state's unified IV&V RFP required a fixed bid on the first two modules and an hourly rate for optional projects. A SI was not contracted as the state chose to use state staff enhanced with augmented resources such as an integration architect to support the implementation and integration. The state did not establish a formal PMO, but had an internal executive steering committee and portfolio management group for oversight.

CHALLENGES

- The CMS certification lifecycle has been a challenge as new requirements were released for modules already in procurement or being implemented.
- There were protests on just about every award - many of which were upheld - which is not unusual for Nebraska, but caused delays.

LESSONS LEARNED

- With multiple, overlapping initiatives, the draw on state staff was underestimated. States need to have a plan and budget to augment state staff for operations as early as possible so that SMEs are available to participate in project activities.
- Ensure there is solid turnover language in contracts to secure adequate support for a smooth transition and deployment.

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STATE STRATEGY PROFILE | SOUTH CAROLINA

AGENCY

APPROACH: Modular

Department of Health and Human Services

Medicaid Spending*
$6.2 Billion

Medicaid Enrollment*
1,128,600

Expansion Enrollment*
N/A

Henry J. Kaiser Family Foundation, June 2017.

GUIDING PRINCIPLE: Own the data

Driven by the desire to gain control of its data, South Carolina made a key decision to adhere to modularity in the replacement of its MMIS. Throughout the procurement process, South Carolina updated CMS and kept the vendor community informed by conducting a vendor fair and sharing draft RFPs for each modular component, enabling them to preview and provide feedback on the development of six objectives-based module RFPs: pharmacy benefit administration, business intelligence (BI), medical administrative services organization (ASO), dental ASO, TPL, and electronic visit verification (EVV).

With a five year stretch goal to be fully modular and off the legacy mainframe, the timeline was designed to stagger procurements. While the PBA and BI contracts took priority due to being in emergency status, the remaining modules were sequenced by size, with the largest procurements first.

While an agency PMO will manage the project, a multi-vendor integrator will be contracted to hold all individual module providers to enterprise governance standards and support the coordination of activities for implementation and integration. The SI RFP ended in a cancellation with the state choosing to take a new approach to break up the scope into two SOWs for a Multi-Vendor Integrator (MVI) and a Medicaid Enterprise System Integrator (MESI). The agency is engaging with vendors to build a platform that consists of an enterprise core with a federated identity portal and enterprise data services to enable multi-vendor integration.

CHALLENGES

- As is the case in many other states, some contract awards have been protested or cancelled, impacting the overall procurement schedule and sequencing.

- The enterprise core has not yet been built. South Carolina will integrate at the data layer into the legacy mainframe first, then into the new enterprise core once it is in place. This will not require two separate certifications, but will result in a longer, iterative checklist process.

LESSONS LEARNED

- States should embrace incremental modernization and be flexible when managing multiple RFPs. Modularity gives you the ability to fail on a smaller scale.

- Bring the SI and integration platform on board first to facilitate integration and ensure interoperability.

- OCM should begin when the project is conceived to get stakeholder buy-in.

- Keeping CMS and the vendor community informed drives competition and aligns expectations with what the vendor community understands and has to offer.

STATE STRATEGY PROFILE | VERMONT

AGENCY

Department of Health and Human Services

Medicaid Spending*
$1.7 Billion

Medicaid Enrollment*
209,500

Expansion Enrollment*
63,300

Henry J. Kaiser Family Foundation, June 2017.

APPROACH: Takeover

GUIDING PRINCIPLE: Innovate before you automate

After cancelling two traditional "big bang" procurements, Vermont decided to break up the MMIS procurement into smaller ones. It began by renegotiating and restructuring the existing contract with its legacy MMIS vendor to allow for modularity. Payer functions were outsourced to the FA, and PBM and care management modules were procured individually. Program integrity and provider enrollment modules are planned, but not in procurement.

The Governor issued an executive order applying lean principles throughout the state, challenging agencies to determine what can be improved before applying a new piece of technology. The department found opportunities to reuse technology across domains, including security, identity access and consent, data management, and the directory services driving the client index, as well as opportunities to better measure and control standards.

While IV&V has been contracted, Vermont is still determining the role, function, and need for a SI. A PMO has been established, supported by the internal portfolio planning office and staff augmentation contracts. The Vermont Agency of Human Services had provided a governance structure to support the leadership team and steering committee in making decisions; however, the new administration disbanded this structure, and a new model has not yet been determined.

CHALLENGES

- Not having the end in mind will result in failure. Vermont tried procuring without a roadmap and failed.

- Augmenting state staff for SI and PMO support rather than procuring contractors with structured statements of work and term and conditions can be a challenge for such a complex project.

- Due to onerous state procurement policies, Vermont requested and received a waiver to facilitate the process.

LESSONS LEARNED

- Be intentional by having a model or blueprint, not only for the technology, but also for the business. More than just a timeline is needed to understand how things relate and to plan for how things will change.

- A governance system is vital. Have a single command and control to align to.

- States can expect much more effective delivery with modules, but must rely on good design upfront.

- Everything is interrelated. Leverage opportunities to reuse technology across domains.

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STATE STRATEGY PROFILE | VIRGINIA

AGENCY	APPROACH: Modular

Department of Medical Assistance Services

Medicaid Spending*
$8.6 Billion

Medicaid Enrollment*
992,800

Expansion Enrollment*
N/A

Henry J. Kaiser Family Foundation, June 2017.

GUIDING PRINCIPLE: It's ok to walk away

Virginia initially planned to procure the provider solution first, but upon assessment, delayed the procurement to avoid the risk of needing to integrate the module with the legacy system. Instead, Virginia modified its approach to first get an integrator onboard and place the onus on the SI to come up with a master integration plan and logical sequence of events.

The state built its RFPs using the Uniform RFP Guide published by the Public Sector Technology Group with support from an outside contractor. In just eight months, five RFPs were written: integration services, EDW, PBM, financial management, and core services which included a replacement for FFS and care management. CMS did not approve this approach initially due to it not being modular enough. The core services RFP was rewritten in nine days to include five contracts: operations services, performance management, health plan management, care management, provider services. CMS approved the new RFP in eight days. However, two of the procurements, care management and financial management, resulted in cancellations. After cancelling its financial management procurement, Virginia has decided to run an Oracle solution in-house. TPL is also currently a homegrown Oracle system, but the state is looking to move to a COTS solution. The PMO is run internally as well, with technical staff supporting information management.

The state-centralized IT organization's data center and the service oriented architecture (SOA) environment built for the eligibility and enrollment (E&E) project will be leveraged to integrate the modules.

CHALLENGES

- With only two vendor responses to financial management, Virginia found the market was not ready in this area as the offerings were not COTS or too future-looking, therefore ended up cancelling the procurement. Similarly, the care management procurement was also cancelled due to cost proposals exceeding the budgeted amount for this program.

LESSONS LEARNED

- Keep an open mind. States will not be able to come up with perfect plan the first time. Reassess and make adjustments to the strategy based on the market's response to RFPs. Better off walking away than feeling pressured to award.

- Participate in a state cohort group. Virginia worked with the National Governor Association in DC with five states.

- Utilize a vendor to develop RFPs.

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STATE STRATEGY PROFILE | WYOMING

AGENCY	APPROACH: Modular

Department of Health
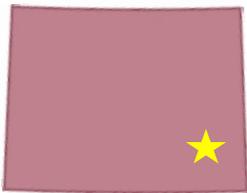
Medicaid Spending*
$581 Million

Medicaid Enrollment*
64,400

Expansion Enrollment*
N/A

Henry J. Kaiser Family Foundation, June 2017.

GUIDING PRINCIPLE: Collaborate with other states and vendors

A small organization with few state staff and heavily outsourced, the Wyoming Department of Health was unable to take on a big, "everything at once" change. Faced with updating an old legacy system and technology environment, a modular strategy looked like a good fit. Planning began with a prioritization of needs to inform the sequencing of the modules: PBM, SI/ESB, EDW/BI, fraud, waste, and abuse (FWA), specialty analytics, TPL, care management, and benefit management services which includes the core MMIS, provider enrollment, claims processing, call center, and financial management.

Prior to releasing RFPs, Wyoming networked with other states working on modular approaches, used RFIs, held vendor fairs, and released draft RFPs to give the vendor community ample opportunity to provide feedback and Wyoming time to modify their approach and procurement documents if requirements were not realistic to the current market. Budgets were disclosed for each procurement, and responding vendors did not exceed the budgets. On future procurements, Wyoming plans to collaborate and partner with Montana who is leading a multi-state purchasing collaborative. Partnering was considered for the SI contract for integration services, governance services, hosting, software licensing, delivering parts of the platform, operational data store, and middleware. QA and testing services were procured separately from IV&V services. Consulting services were procured for organizational change management (OCM) and procurement support. An internal PMO was established with state staff and staff augmentation resources.

CHALLENGES

- As an early adopter of MaaS, Wyoming spent significant time campaigning for changes to funding rules to allow FFP for services, COTS, and other categories in the 2016 rules, helping pave the way for other states.

- The lack of standards is an ongoing challenge. States have to promote standards, open application programming interfaces (APIs), and exposed interfaces to help market adoption.

- The current market is not set-up for modularity, so states need to be innovative and inclusive with the vendor community.

LESSONS LEARNED

- As MaaS modules increase, technical requirements decline, and business requirements increase, it is important to involve the business early and keep it engaged throughout each of the implementation projects.

- Leverage what is commercially available to avoid custom development.

- Ensure vendors are properly resourced for the contracted tasks.

- Be flexible and look at all alternatives objectively, with an open mind.

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Montana Department of Public Health and Human Services

Medicaid Spending*
$1.4 Billion

Medicaid Enrollment*
201,300

Expansion Enrollment*
46,700

APPROACH: Modular

GUIDING PRINCIPLE: Focus on "best of breed" versus "best of suite" functionality

Montana is procuring multiple discrete modules and services to replace its aging legacy MMIS, and meet the goals and business needs identified during its modularity planning process. The state developed its modularity blueprint through a number of planning and decision meetings with stakeholders, guidance received from CMS, discussions with industry vendors, and through collaboration with other states. In addition, Montana mapped procurement exclusions where vendors will be precluded from bidding on other modules within scope to limit potential conflicts of interest and ensure independence.

The state will procure SI services to encompass the modular technology platform: interoperability and enterprise integration, technical coordination, and the operational data store.

Montana had the first module certified under the new certification process in February 2017 for Pharmacy Claims Processing and Management Services.

New Mexico Human Services Department

Medicaid Spending*
$5.4 Billion

Medicaid Enrollment*
855,800

Expansion Enrollment*
243,100

APPROACH: Modular

GUIDING PRINCIPLE: Embrace technology and adaptability

Guided and driven by the new CMS perspectives on MMIS, New Mexico was seeking a modular, enterprise solution that would include multiple state agency partners. Breaking from the traditional Medicaid only, process-oriented requirements approach, the state allowed prospective vendors to propose solutions that could produce the desired outcomes. The new system will be composed of six modules, each with multiple components: SI, enterprise data services, QA, financial services, PHM, and unified public interface.

After getting approval from CMS and releasing the RFP for platform integration, the procurement was cancelled when CMS revised its RFP guidance on new systems.

A SI vendor will provide the infrastructure for connectivity, interoperability, standards, and security, as well as provide project integration management for all modules. When all modules have been sequentially procured and are determined to be ready for implementation, New Mexico plans to run in parallel to the legacy system for two months to confirm valid outcomes.

Henry J. Kaiser Family Foundation, June 2017.

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Tennessee Health Care Finance and Administration

Medicaid Spending*
$9.5 Billion

Medicaid Enrollment*
1,690,000

Expansion Enrollment*
N/A

APPROACH: Modular

GUIDING PRINCIPLE: Maximize modularity

Following the success of its SI approach for the E&E implementation, Tennessee decided to take the same approach to modularize its MMIS. The state took a modular approach to its MMIS system integration by leveraging several independent vendors. An enterprise framework for governance will be facilitated by separate PMO, IV&V, and technical advisory services contracts. By procuring and centralizing these functions first, the state can ensure SI functions are performed effectively, and benefit from efficiencies gained from common governance operations, security, tools, methodologies, and management structures across its Medicaid Enterprise.

While the state maintains the overall architectural and solution governance, each vendor's role will be clearly defined to prevent overlapping activities or duplicate deliverables. Establishing a culture of collaboration amongst the partners, the state enabled each vendor's expertise to be fully utilized. Tennessee's modular system integration framework will afford the state the flexibility and freedom to select the most qualified vendors to implement business modules.

Wisconsin Department of Health

Medicaid Spending*
$7.7 Billion

Medicaid Enrollment*
1,201,800

Expansion Enrollment*
N/A

APPROACH: Takeover

GUIDING PRINCIPLE: Incremental enhancement

Wisconsin issued an RFI to explore options for the MMIS and FA procurement. As a result, the state chose a strategy that includes a takeover of the current system and operations to be enhanced with the staggered procurement of modules over the course of several years. The first RFP released was to procure a vendor for the takeover. A series of RFPs will follow for eight modules: EDW, data analytics and reporting, program integrity, pharmacy pricing consultation, pharmacy medication therapy management (MTM), enrollment services, member services, and care management. Modules will be implemented on a timeline that most effectively meets the needs of the contract while considering the availability of state staff and resources to support the project.

An external PMO vendor will be procured prior to the modules to provide enterprise support for project staff throughout the design, development, and implementation (DDI) phases of the project. The state will also contract for systems integration services to serve as a single point of accountability as modules are implemented, configured, and maintained.

Henry J. Kaiser Family Foundation, June 2017.

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SECTION C

Current State and Future State Data Exchange Diagrams

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INFORMATION HUB – CURRENT
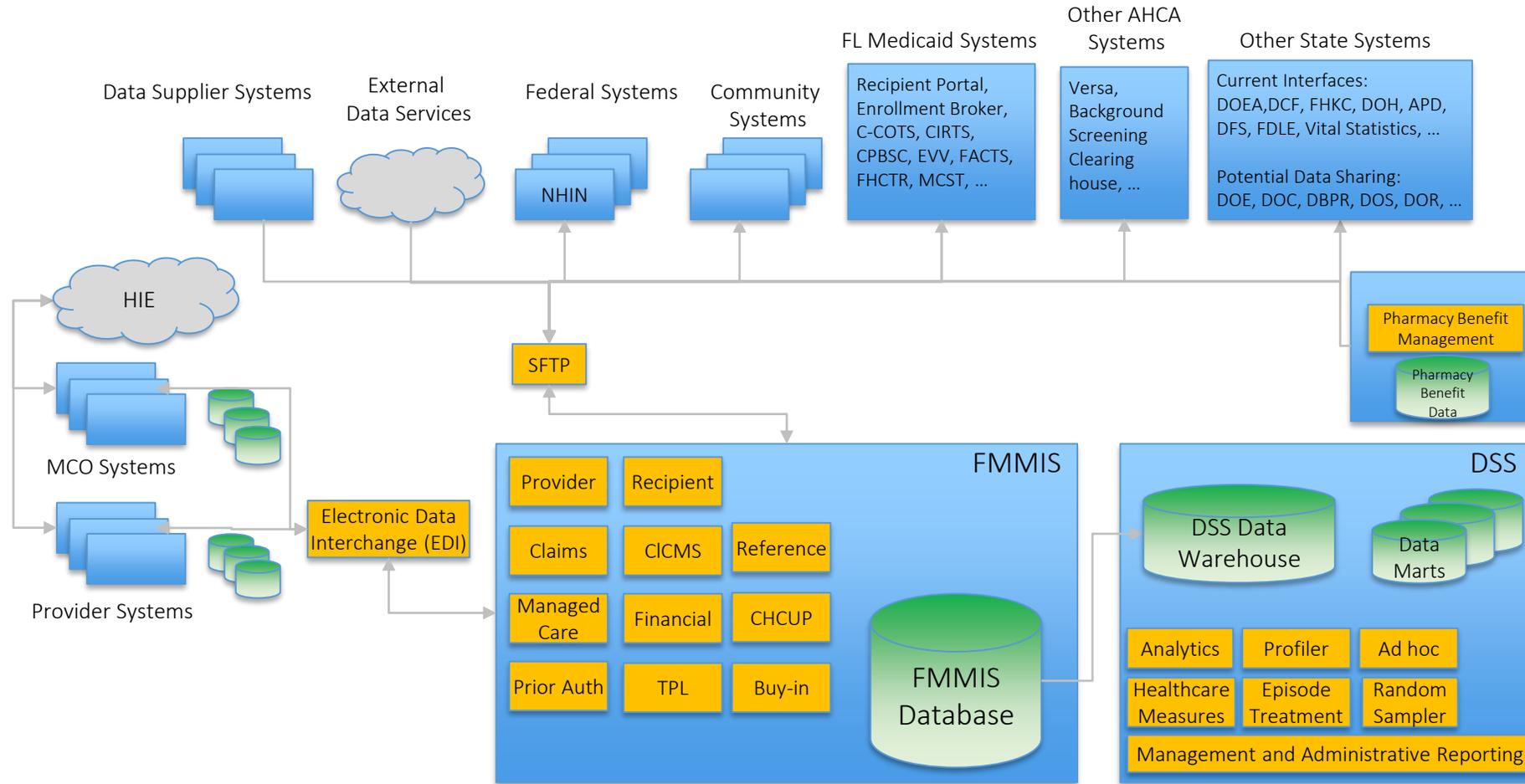
INFORMATION HUB – ISP
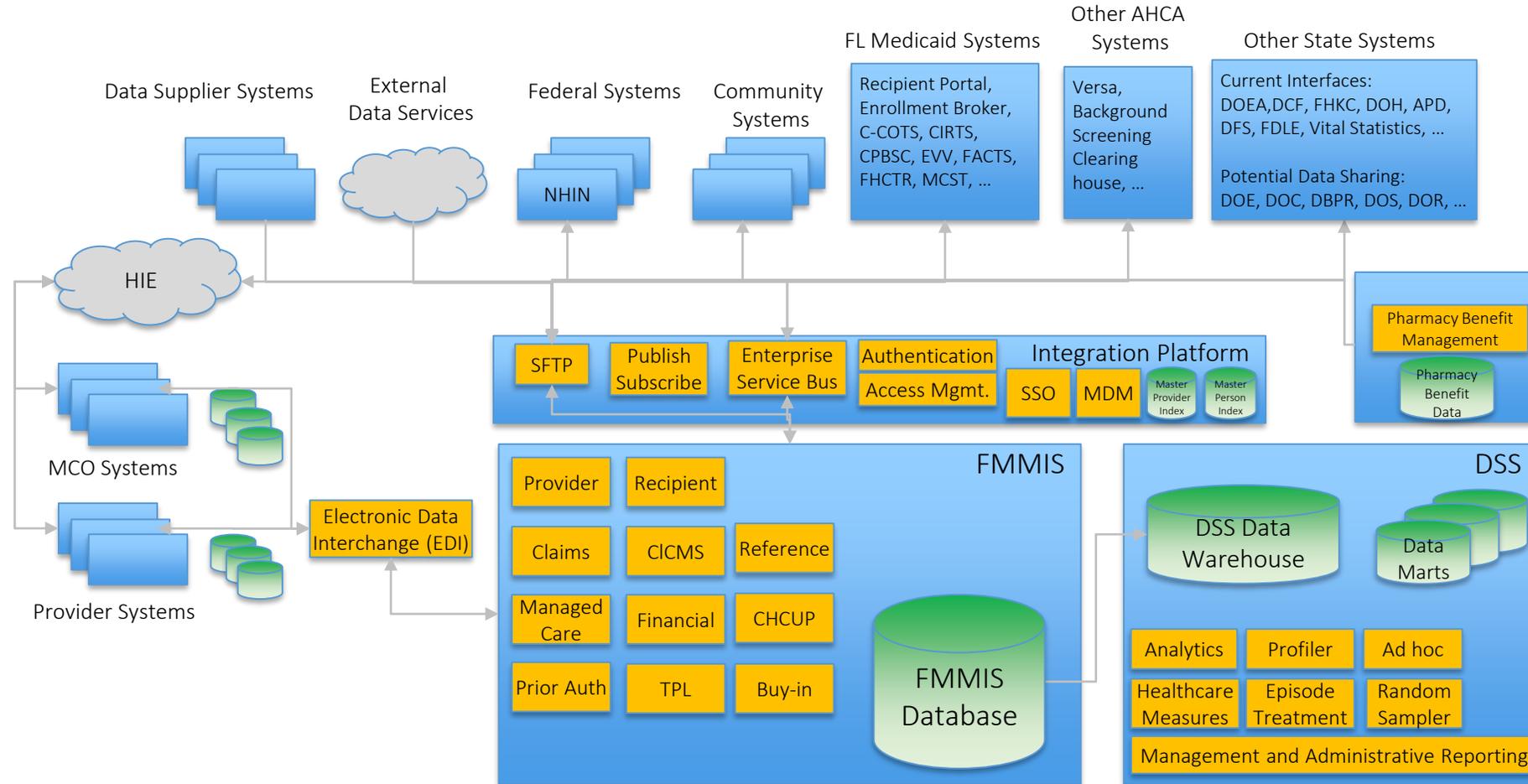
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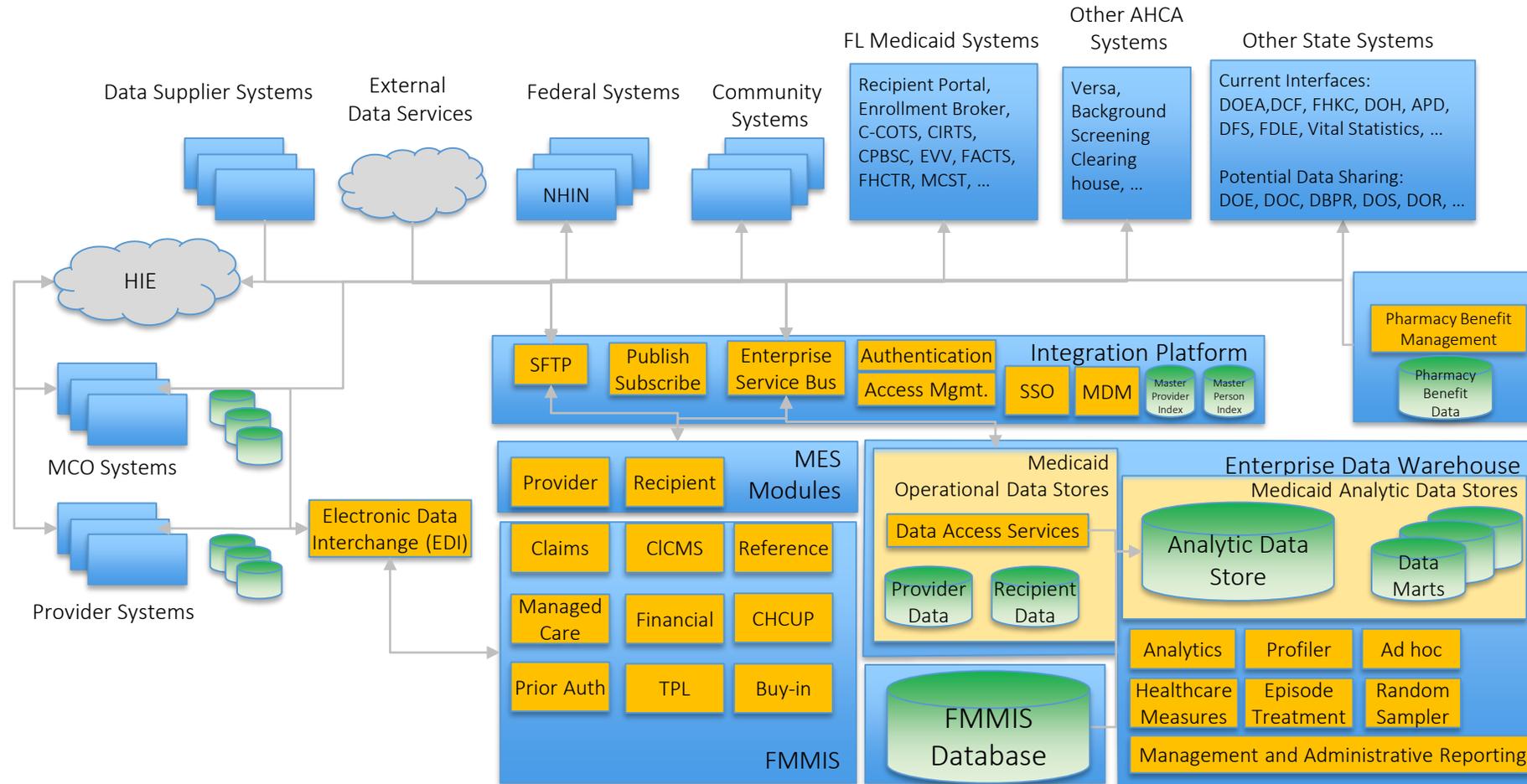
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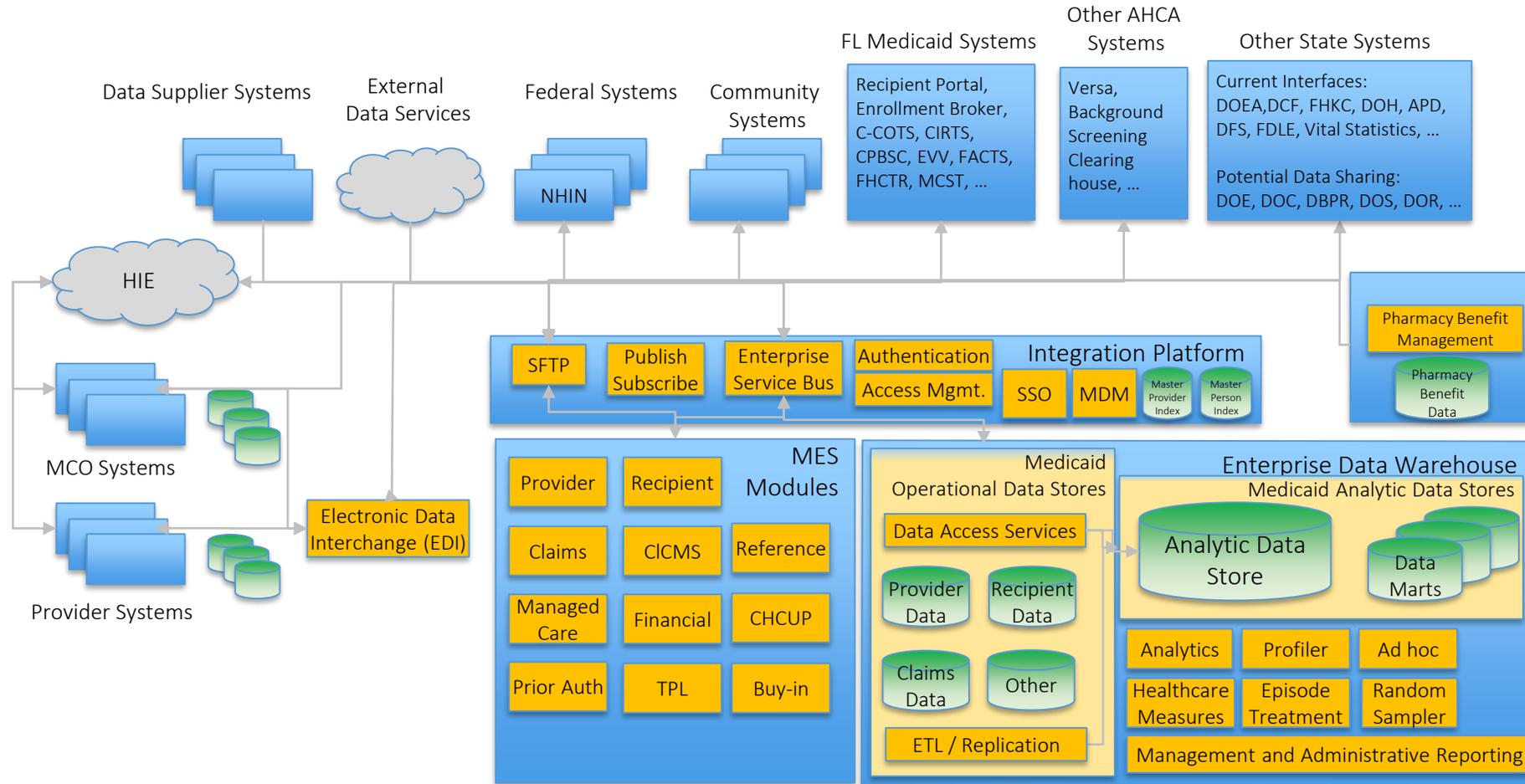
SECTION D

Strategic Priorities and High-Level Tactics Key

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STRATEGIC PRIORITIES AND HIGH-LEVEL TACTICS KEY

|		
Integration Platform	**Integration Services Platform**	The Integration Services Platform implements the enabling capabilities that allow information sharing and business and technology service reuse by providing the highway and network for information to be used by subsequent modules and systems that contribute to the health of recipients and effectiveness of providers. Specific integration components planned for the Integration module include: Integration Services Platform, API Gateway, Publish and Subscribe Alerting, Managed File Transfer, Single Sign-on and Secure Authentication, Master Person Index and Master Provider Index, Master Data Management, Service Registry and Service Repository.
	Enterprise Data Warehouse	The Enterprise Data Warehouse module provides the foundational structure that supports integration of both current data collected by the legacy MMIS system and information through the course of new module implementations as the Agency stores and analyzes new data sources and new data types.
	Enterprise Information Management	The Enterprise Information Management Module establishes data services that decouple business processing from proprietary module specific data sources and data structures, improving data storage and access across modules.
Provider	**Identity Reconciliation**	The identity reconciliation module will create a "single source of truth" for Provider Identity across the Agencies, Bureaus, and plans.
	Streamlined Provider Enrollment	This refers to the speeding of the process by which a previously unenrolled provider could provide care through the Medicaid program. Detailed tactics to accomplish this could be improving the user-interface and pulling information from across the State to prepopulate the application to the greatest degree appropriate.
	Performance Management and Population Health	This area refers to better tying specific providers to health measures of their patients. This area will be the foundation of improving value-based care across the State of Florida.

STRATEGIC PRIORITIES AND HIGH-LEVEL TACTICS KEY

Recipients	**User Interface / Recipient Portal**	AHCA will increase the level of involvement of recipients in their care via a robust recipient portal by which recipients can easily access relevant information. These information sources will grow to include provider performance information, health plan information, and the recipient's health information, including history, as a result of the "Integrated and Accessible Data for the Recipient" high-level tactic. Further information will be pulled into the portal as greater inter-agency collaboration occurs.
	Streamlined Recipient Enrollment	This high-level tactic refers to improving the recipient experience by improving and speeding the recipient enrollment process via new systems and collaborations with the Department of Children and Families. An example of this would be for a potential recipient to sign onto an enrollment wizard, have the system determine eligibility in real-time for simple cases, and have the recipient select a plan.
	Integrated and Accessible Data for the Recipient	This high-level tactic refers to both preparing existing data within the agency and working with stakeholders (e.g. sister agencies, providers) to integrate currently desperate data that could improve the recipient experience, such as provider performance information. These data sets would then be provided to recipients via the Recipient Portal.
Program Integrity	**Automation and Analytics**	While there are opportunities for automation and analytics across the MES, the Medicaid Program Integrity area is an excellent area for the Agency to create tangible results through a series of quick-wins. This high-level tactic refers to leveraging automation and analytics to improve the Agency's Medicaid fraud detection.
	Develop Model for Managed Care and Fee for Service	This high-level tactic refers to improving the recoupment models – the processes and supporting advanced analytics – to recoup Medicaid fraud dollars in both the Fee for Services and Managed Care areas. This is necessary for the Managed Care area as no single health plan has detailed information on fraud in other health plans. A new managed care fraud model could greatly assist in the recoupment of funds across the State of Florida.

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STRATEGIC PRIORITIES AND HIGH-LEVEL TACTICS KEY

Financials	**Enhanced / Real-Time Reporting**	This high-level tactic refers to implementing modular systems with the requisite templates and data feeds to make the reporting functions within Finance and Accounting as real-time as appropriate. This will lower the administrative burden currently experienced through the reporting process.
	Reduce & Eliminate Manual Processes & Redundant Systems	This high-level tactic refers to the selection of new systems with automation components to lessen the manual functions existing within the Finance and Automation functions. It also refers to leveraging current systems to reduce duplication.
	Analytics & Dashboarding	This high-level tactic refers to AHCA establishing the analytical capabilities to implement dashboarding across the Finance and Accounting functions. These dashboards will create transparency around Key Performance Indicators.
Value-Based Care	**Health Plan Encounter Data**	This high-level tactic refers to AHCA implementing the capability for health plans to report encounter data consistently and in real-time or near real-time. AHCA will be able to use advanced analytical capabilities conduct Value-Based Care.
	Performance / Contract Management	This high-level tactic refers to AHCA leveraging advanced analytics and improved health plan encounter data (see above) to continually improve the measurement and management of provider and health plan performance.
Inter-Agency	**Data Sharing**	This high-level tactic refers to AHCA leveraging newly modular systems to share real-time data, as appropriate, with agency partners (Sister Agencies, Academics, and Vendors).
	Social Determinants of Health	This high-level tactic refers to AHCA improving the use of data from across Sister Agencies to correlate appropriate social factors (e.g. criminal records, school absences) with health outcomes.
	Shared Licensure & Credentialing	This high-level tactic refers to AHCA coordinating with Sister Agencies to speed the provider credentialing process.

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SECTION E

In-Scope Business Processes for High-Level Roadmap

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BELOW IS A BREAKDOWN OF EACH BUSINESS PROCESS

In-Scope Processes are taken from Part I – Business Architecture, Appendix C – Business Process Model Details.

AHCA BUSINESS AREA	STATE FISCAL YEAR	IN-SCOPE MITA BUSINESS PROCESSES AND THEIR SUPPORTING SYSTEMS
Provider Management	'19	• EE05 Determine Provider Eligibility • EE06 Enroll Provider • EE07 Disenroll Provider • EE08 Inquire Provider Information • PM02 Manage Provider Communication • PM03 Perform Provider Outreach • PM07 Manage Provider Grievance and Appeal • PM01 Manage Provider Information • PM08 Terminate Provider • CO01 Manage Contractor Information • CO02 Manage Contractor Communication • CO03 Perform Contractor Outreach • CO04 Inquire Contractor Information • CO05 Produce Solicitation • CO06 Award Contract • CO07 Manage Contract • CO08 Close Out Contract • CO09 Manage Contractor Grievance and Appeal
Compliance Management	'19-'20	• PE01 Identify Utilization Anomalies • PE02 Establish Compliance Incident • PE03 Manage Compliance Incident Information • PE04 Determine Adverse Action Incident • PE05 Prepare REOMB

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BELOW IS A BREAKDOWN OF EACH BUSINESS PROCESS

In-Scope Processes are taken from Part I – Business Architecture, Appendix C – Business Process Model Details.

AHCA BUSINESS AREA	STATE FISCAL YEAR	IN-SCOPE MITA BUSINESS PROCESSES AND THEIR SUPPORTING SYSTEMS
Financial Management	'19-'21	• OM14 Generate Remittance Advice • OM18 Inquire Payment Status • OM27 Prepare Provider Payment • OM28 Manage Data • FM09 Manage Contractor Payment • FM10 Manage Member Financial Participation • FM11 Manage Capitation Payment • FM12 Manage Incentive Payment • FM14 Manage Accounts Payable Disbursement • FM15 Manage 1099 • OM04 Submit Electronic Attachment • OM05 Apply Mass Adjustment • OM07 Process Claims • OM20 Calculate Spend-Down Amount • OM29 Process Encounters • FM01 Manage Provider Recoupment • FM02 Manage TPL Recovery • FM03 Manage Estate Recovery • FM04 Manage Drug Rebate • FM05 Manage Cost Settlement • FM06 Manage Accounts Receivable Information • FM07 Manage Accounts Receivable Funds • FM08 Prepare Member Premium Invoice

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BELOW IS A BREAKDOWN OF EACH BUSINESS PROCESS

In-Scope Processes are taken from Part I – Business Architecture, Appendix C – Business Process Model Details.

AHCA BUSINESS AREA	STATE FISCAL YEAR	IN-SCOPE MITA BUSINESS PROCESSES AND THEIR SUPPORTING SYSTEMS
Financial Management (cont.)	'19-'22	• FM13 Manage Accounts Payable Information • FM16 Formulate Budget • FM17 Manage Budget Information • FM18 Manage Fund • FM19 Generate Financial Report
Member Management	'20	• EE01 Determine Member Eligibility • EE02 Enroll Member • EE03 Disenroll Member • EE04 Inquire Member Eligibility • ME01 Manage Member Information • ME02 Manage Applicant and Member Communication • ME03 Perform Population and Member Outreach • ME08 Manage Member Grievance and Appeal • CM01 Establish Case • CM02 Manage Case Information • CM03 Manage Population Health Outreach • CM04 Manage Registry • CM05 Perform Screening and Assessment • CM06 Manage Treatment Plan and Outcomes • CM07 Authorize Referral • CM08 Authorize Service • CM09 Authorize Treatment Plan

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BELOW IS A BREAKDOWN OF EACH BUSINESS PROCESS

In-Scope Processes are taken from Part I – Business Architecture, Appendix C – Business Process Model Details.

AHCA BUSINESS AREA	STATE FISCAL YEAR	IN-SCOPE MITA BUSINESS PROCESSES AND THEIR SUPPORTING SYSTEMS
Standards Management	'21-'22	• BR01 Establish Business Relationship • BR02 Manage Business Relationship Communication • BR03 Manage Business Relationship Information • BR04 Terminate Business Relationship
Plan and Health Plan Administration	'21-'22	• PL01 Develop Agency Goals and Objectives • PL02 Maintain Program Policy • PL03 Maintain State Plan • PL04 Manage Health Plan Information • PL05 Manage Performance Measures • PL06 Manage Health Benefit Information • PL07 Manage Reference Information • PL08 Manage Rate Setting

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SECTION F

Acronyms

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THE GLOSSARY PROVIDES DEFINITIONS FOR ACRONYMS AND ABBREVIATIONS USED IN THIS DELIVERABLE.

ACRONYM	DEFINITION	ACRONYM	DEFINITION	ACRONYM	DEFINITION
AHCA	Agency for Health Care Administration	EVV	Electronic Visit Verification	OCM	Organizational Change Management
AHS	Automated Health Systems	FA	Fiscal Agent	PMO	Project Management Office
AI	Artificial Intelligence	FMMIS	Florida Medicaid Management Info. System	PMP	Portfolio Management Plan
API	Application Programming Interface	FWA	Fraud, Waste, and Abuse	QA	Quality Assurance
ASO	Administrative Services Organization	ISP	Integration Services Platform	RFI	Request for Information
BI	Business Intelligence	ITN	Invitation to Negotiate	SEAS	Strategic Enterprise Advisory Services
BIDM	Business Intelligence and Data Mgmt.	IV&V	Independent Verification and Validation	SFY	State Fiscal Year
CAGR	Cumulative Annual Growth Rate	MaaS	MMIS as a service	SI	Systems Integrator
DDI	Design, Development, and Implementation	MCO	Managed Care Organization	SME	Subject Matter Expertise
DSS	Decision Support System	MES	Medicaid Enterprise System	SOA	Service Oriented Architecture
E&E	Eligibility and Enrollment	MESI	Medicaid Enterprise System Integrator	SSA	State Self-Assessment
EDI	Electronic Data Interchange	MITA	Medicaid Information Technology Architecture	TPL	Third Party Liability
EDW	Enterprise Data Warehouse	MPI	Master Person Index		
EIM	Enterprise Information Management	MTM	Medication Therapy Management		
ESB	Enterprise Service Bus	MVI	Multi-Vendor Integrator		

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