IMPLEMENTATION
ADVANCE PLANNING DOCUMENT

Florida Health Care Connections (FX) Program

(FX 004)

State of Florida
Agency for Health Care Administration
Division of Medicaid

July 2020

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EXECUTIVE SUMMARY

The purpose of this Implementation Advance Planning Document (IAPD) is to provide the Centers for Medicare and Medicaid Services (CMS) with the status of current project activities for the Florida Agency for Health Care Administration's (AHCA, Agency) Florida Health Care Connections (FX) Program, including an overview of the FX Strategy that was recently updated, and to request enhanced federal support in order to continue with the implementation of FX Phase II and III activities.

The FX Program is currently operating under the authority of an approved Planning Advance Planning Document Update (Florida FX-003 PAPDU Update April 2019), for which CMS approved funding through September 30, 2020.

The FX Program includes the business, data, services, technical processes, and systems necessary for the administration of the Agency's business functions. Systems include, but are not limited to, the Florida Medicaid Management Information System (FMMIS), the Decision Support System (DSS), enrollment broker, third party liability, pharmacy benefits management, fraud and abuse case tracking, prior authorization, home health electronic visit verification, Provider Data Management System, and Health Quality Assurance licensure system. The scope of the FX Program also includes interconnections and touch points with systems residing outside the Agency, across the Florida Medicaid Enterprise, including systems hosted by the Social Security Administration, as well as Florida's Department of Children and Families, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities, Florida Healthy Kids Corporation, Department of Financial Services, Department of Law Enforcement, Department of Juvenile Justice, and Vital Statistics.

During the 2020 Legislative Session, the Florida Legislature, through the General Appropriations Act (GAA) Implementing Bill, directed the Agency to implement an Executive Steering Committee (ESC) for FX to ensure the Agency has the resources necessary to provide better integration with subsystems supporting Florida's Medicaid program. This new governance body will be responsible for ensuring FX meets its primary business objectives of replacing the Medicaid Management Information System and the current Medicaid fiscal agent. The ESC is comprised of seven representatives from the Agency, two representatives from the Department of Children and Families, and one representative from Department of Health, Department of Financial Services, Agency for Persons with Disabilities, Department of Elder Affairs, Department of Management Services, and Florida Healthy Kids Corporation.

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1 STATEMENT OF NEED AND OBJECTIVES

AHCA is seeking federal support to continue the FX Program according to the refreshed FX Strategy that was completed in January 2020.

FX is a multi-year transformation project that modernizes the current Medicaid technology using a modular approach, while simultaneously improving overall Agency functionality and building better connections to other data sources and programs, resulting in the ability to provide better healthcare for all Floridians.

The refreshed FX Strategy and future state Transformation Roadmap build upon the FMMIS transition work completed in Phase I and Phase II and continue with the procurement and implementation of a set of transformation activities in Phase II, III, and IV that are prioritized and aligned with the FX Vision. The primary focus of Phase III, currently in process, is to transition FMMIS and subsystems that are specifically required to resolve the fiscal agent contract.

The FX Strategy Refresh, detailed in Section 1.1, supports the Agency as it progresses through the stages of the Centers for Medicare and Medicaid Services (CMS) Medicaid Enterprise Certification Life Cycle (MECL). The following sections provide a description of the refreshed FX Strategy and Transformation Roadmap phases, including objectives, approach, and status to date.

Florida Medicaid supports the CMS transition of the systems certification process to one that evaluates how well Medicaid information technology systems support desired business outcomes while reducing the burden on states. Outcomes-Based Certification (OBC) is being designed to ensure that systems that receive federal financial participation are meeting the business needs of the state. Solicitations for modular replacements will include requirements for the successful vendor to work with the Agency to develop:

1. Outcome statements. These describe the desired results once the system is implemented.
2. Certification evaluation criteria and required evidence. These correspond to outcome statements and are used by the state and CMS to evaluate the system's functionality and its compliance with laws, regulations, and industry good practices.
3. Key performance indicators (KPIs). These metrics support the outcome statements and are used to track the performance of the system over time.

The Agency anticipates a streamlined process for preparation and performance of the certification process that produces meaningful results to improve the operation of Medicaid.

1.1 Florida Health Care Connections (FX) Strategy Refresh

FX is defined as the transformation of the business, data, services, technical processes, and systems necessary for the administration of the Florida Medicaid program. FMMIS has historically been the central system within the Florida Medicaid Enterprise, functioning as the single, integrated system of claims processing and information retrieval. As the Medicaid program has grown more complex, the systems needed to support the Florida Medicaid Enterprise have grown in number and complexity.

The FX Program includes a phased approach to replace the current functions of FMMIS, based on the CMS Standards and Conditions, to ultimately transition to an interoperable and unified Medicaid Enterprise where individual processes, modules, sub-systems, and systems work together to support the Medicaid program. This approach is intended to provide the most efficient and cost-effective long-term solution for FX, while complying with federal regulations, achieving federal certification, and obtaining enhanced federal funding.

The Agency recently refreshed its 2017 FX Strategy with the objective of ensuring the Agency meets the goals of the program in a timely and cost-effective manner; while minimizing risk, enabling continued operations, and incorporating new innovations in the marketplace. The previous strategy laid the groundwork for a focused transformation guided by CMS standards and conditions, as well as the Agency's guiding principles, to improve service and outcomes.

Several significant factors have changed since the original Strategic Plan was created. These include changes in CMS guidance, Florida Legislative guidance, and lessons learned from investment to-date in Phase I and II of the FX Program.

The goal of the Strategy refresh was to scale the FX Program to align with manageable risk and investments, while ensuring the FX Program and Roadmap still align to the mission and guidance of the Governor, Legislature, and Agency Executive Leadership, and to make the needed modifications to adapt to any variances. The rationale in the development of the refreshed roadmap was to continue to systematically address the pain points with the largest impacts to the Agency, its healthcare providers, and its recipients.

In addition, the MMIS market has evolved since CMS issued its modularity guidance to states. The Agency's intent is to take advantage of these ongoing innovations, while implementing the early components and modules of FX. The Agency learned a great deal in the first two years of this transformation and experienced some internal change as well. For example, interoperability with other HHS agencies is more complex to achieve than initially anticipated but still represents enormous potential efficiencies for the State. The Agency also welcomed a new Secretary in 2019 and updated its mission and vision in the most recent Long-Range Program Plan.

To take advantage of new innovations as they become commercially available and to include this new knowledge in the FX Program as it evolves, the 2019 strategy refresh focused on incorporating all of this context into the planning, procurement strategy, and scope of the FX modules, while maintaining the long-term FX Vision to *Transform the Medicaid Enterprise to provide the greatest quality, the best experience, and the highest value in healthcare.*

The Agency defined the following *FX Guiding Principles* that must be adhered to if the FX Vision is to be achieved.

FX Guiding Principles

- 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
- Provide good stewardship of Medicaid funds
- Enable holistic decision-making rather than short-term focus

FX Guiding Principles are, in turn, supported by *FX Strategic Priorities* which define the areas of practical importance to achieve the FX Vision. The following five *Strategic Priorities* emerged as the most impactful.

Top Five FX Strategic Priorities

1. Reduce risk of integration and cost associated with legacy FMMIS by accelerating procurements to resolve/replace its functionality
2. Improve provider experience by streamlining enrollment, credentialing and licensing, and developing a Master Person Index and a Master Organization Index
3. Prioritize high-quality accessible data, analytics, and reporting
4. Prioritize joint efficiencies with interoperability within the Agency
5. Strategically leverage efficient procurement vehicles where possible

The refreshed FX Strategy supports CMS' Medicaid Information Technology Architecture (MITA) Goals and Objectives as illustrated in **Exhibit 1-1: FX/MITA Goals and Objectives** below.

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FX GOALS AND OBJECTIVES	MITA GOALS	MITA OBJECTIVES
Enable high-quality and accessible data	▪ Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards ▪ Promote an enterprise view that supports enabling technologies that align with Medicaid business processes and technologies ▪ Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision-making for health care management and program administration	▪ Adopt data and industry standards ▪ Support interoperability and integration using open architecture standards ▪ Promote good programmatic practices ▪ Break down artificial boundaries between systems, geography, and funding
Improve healthcare outcomes	▪ Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision-making for health care management and program administration ▪ Provide performance measurement for accountability and planning ▪ Coordinate with public health and other partners and integrate health outcomes within the Medicaid community	▪ Promote efficient and effective data sharing to meet stakeholders' needs ▪ Provide a beneficiary-centric focus ▪ Support interoperability and integration using open architecture standards ▪ Support integration of clinical and administrative data for decision-making
Reduce complexity	▪ Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards ▪ Promote an enterprise view that supports enabling technologies that align with Medicaid business processes and technologies	▪ Adopt data and industry standards ▪ Support interoperability and integration using open architecture standards ▪ Promote good programmatic practices ▪ Break down artificial boundaries between systems, geography, and funding
Use evidenced-based decision making	▪ Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision-making for health care management and program administration ▪ Provide performance measurement for accountability and planning	▪ Support integration of clinical and administrative data for decision-making

FX GOALS AND OBJECTIVES	MITA GOALS	MITA OBJECTIVES
Improve integration with partners	▪ Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards ▪ Promote an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology ▪ Promote an enterprise view that supports enabling technologies that align with Medicaid business processes and technologies ▪ Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision-making for health care management and program administration ▪ Coordinate with public health and other partners and integrate health outcomes within the Medicaid community	▪ Promote efficient and effective data sharing to meet stakeholders' needs ▪ Support interoperability and integration using open architecture standards ▪ Promote good programmatic practices ▪ Break down artificial boundaries between systems, geography, and funding
Improve Provider and Recipient experience	▪ Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision-making for health care management and program administration ▪ Provide performance measurement for accountability and planning	▪ Promote efficient and effective data sharing to meet stakeholders' needs ▪ Provide a beneficiary-centric focus ▪ Support interoperability and integration using open architecture standards ▪ Break down artificial boundaries between systems, geography, and funding

FX GOALS AND OBJECTIVES	MITA GOALS	MITA OBJECTIVES
Provide good stewardship of Medicaid funds	▪ Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards ▪ Promote an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology ▪ Promote an enterprise view that supports enabling technologies that align with Medicaid business processes and technologies ▪ Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision-making for health care management and program administration ▪ Provide performance measurement for accountability and planning	▪ Promote secure data exchange ▪ Promote reusable components through modularity ▪ Promote efficient and effective data sharing to meet stakeholders' needs ▪ Support interoperability and integration using open architecture standards ▪ Break down artificial boundaries between systems, geography, and funding
Enable holistic decision making rather than short-term focus	▪ Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision-making for health care management and program administration ▪ Provide performance measurement for accountability and planning ▪ Coordinate with public health and other partners and integrate health outcomes within the Medicaid community	▪ Provide a beneficiary-centric focus ▪ Support integration of clinical and administrative data for decision-making

Exhibit 1-1: FX/MITA Goals and Objectives

In addition to the activities described above, the Agency and the Strategic Enterprise Advisory Services (SEAS) vendor conducted the following analyses which influenced the updated transformational roadmap:

- Executive alignment on FX module scope, and sequencing
- Detailed system inventory to determine contract costs and termination dates
- In-depth review of the provider and recipient experience
- Analysis of current state processes, pain points, and recommendations
- Analysis of state HHS agency technology opportunities to work collaboratively
- Targeted review of other states' transformation planning and strategies
- Assigned cost and benefits to each module based on refined scope

The result is an updated FX Strategy that includes a roadmap of current and future initiatives prioritized and aligned with the Agency's vision and strategic priorities, which takes advantage of new innovations and learnings, and supports the program in advancing its capabilities and MITA maturity level.

1.2 FX Future-State Transformation Roadmap

The future-state Transformation Roadmap is a four-phased strategy that builds on work completed in Phases I and II of the original FX Procurement Roadmap, which was initiated in 2016. Phases II–IV have been updated to align with the refreshed FX Strategy. These phases are overlapping and will be executed concurrently.

Some of the key improvements that will occur through the new transformation roadmap include:

- Consolidated and modernized business processes leading to reduced administrative costs, accelerated service delivery, and improved processing timelines for the Agency, its providers, and recipients
- Dramatically improved data enabling vendor accountability, real-time decision-making, and predictive analytics
- Modernized technology infrastructure supporting more efficient and error-free processing and improved real-time fraud detection and prevention

A description of each phase is included in **Exhibit 1-2: FX Transformation Roadmap Phases** below.

#	PHASE	COMPONENT / MODULE
I	Professional Services Support	Strategic Enterprise Advisory Services Independent Verification and Validation
II	FX Infrastructure	Integration Services and Integration Platform Enterprise Data Warehouse
III	FX FMMIS Resolution	Unified Operations Center Core (Claims/Encounter/Financial/Reference Management) Provider Management Recipient/Enrollment Broker Pharmacy Benefit Management
IV	Remaining Functional Modules	Plan Management Third Party Liability Enterprise Case Management Contractor Management

Exhibit 1-2: FX Transformation Roadmap Phases

1.2.1 Phase I: Professional Services Procurements (SEAS and IV&V)

The objective of Phase I, completed in 2017, was to procure professional service partners to support strategic planning and independent evaluation of the FX transformation. This phase also included operating an interim Project Management Office (PMO) using existing Agency resources in advance of the SEAS Vendor and extending the existing fiscal agent contract for two years

through July 31, 2020 to ensure continued operations. (Note: The fiscal agent contract was recently extended again to December 31, 2024).

- The SEAS vendor provides ongoing strategic advice, technical guidance, and programmatic support for the FX strategy implementation. The SEAS vendor was tasked with providing the consulting expertise needed to develop the strategic plan for FX in accordance with the MITA Framework 3.0 and the CMS Standards and Conditions, develop and manage FX Governance, manage a PMO for individual FX projects, develop data and technical management strategy and standards, develop and maintain information and technical architecture documentation, and establish an enterprise data security plan. The SEAS vendor also provides strategic project portfolio management services, including completion of federal funding requests and managing the Medicaid Enterprise Certification process.
- The Independent Verification and Validation (IV&V) Vendor provides federally required oversight and reporting of the FX Program, including an independent evaluation and review of deliverables produced by FX vendors (including SEAS) to ensure that projects adhere to standards and quality expectations, and are developed and managed in accordance with Agency and Federal requirements. The IV&V Vendor assesses and reports on each FX project's organization along with planning, procurement, management, technical solution development and implementation, and produces IV&V progress reports and related checklists required for CMS certification.

1.2.2 Phase II: FX Infrastructure

The objective of Phase II (currently underway) is to establish the technical foundation of the FX modular transformation through the procurement and implementation of an Integration Services and Integration Platform (IS/IP) Solution, an Enterprise Data Warehouse (EDW) Solution, and an Enterprise Job Scheduler solution. In addition, a Data Governance framework was initiated in Phase II that establishes data standards, including data quality, metadata management, and data architecture, as well as provides new efficiencies for managing data across the program and new opportunities for interoperability across the State.

- The IS/IP vendor was engaged in November 2019 to provide the integrated platform that will serve as the critical interface through which all information is requested and returned. The IS/IP platform will provide a standards-based integration platform to connect diverse applications and enable a common information exchange process between systems. The IS/IP platform includes an Enterprise Service Bus, which controls information flow in and out of all modules, a Business Rules Engine to help ensure all federal and state rules are accurately applied, and a Service Registry that maintains an inventory of services across all systems. IS/IP is coupled with the Master Person Index/Master Organization Index and Single Sign-On. The IS/IP Design, Development, and Implementation (DDI) project includes implementing the IS/IP components across three workstreams over an approximate16-month schedule. The DDI is in progress and is targeted for completion in early April 2021.
- The planned solution for EDW combines software, hardware, infrastructure, and services to enable data management and analytics of healthcare data for the FX program. The planned EDW solution provides comprehensive data management and reporting to advance the Agency's goal of transforming to an enterprise-wide, modular, and flexible MMIS solution. The Florida EDW is intended to provide a best-in-class data repository with a common platform for future modules to store and access data. Procurement for

the EDW vendor is underway. The Agency issued an Invitation to Negotiate (ITN) to select an EDW vendor in July 2019 and intends to award a contract in the summer of 2020.

- The Agency has procured, but not implemented or operationalized, an Enterprise Job Scheduler solution that will be scalable for use by the Medicaid Enterprise and will be managed by the AHCA IT division. The project will identify and procure needed resources to implement and operationalize the centralized Job Scheduler solution. Funds for this project are anticipated to be needed in State Fiscal Years (SFY) 2021-2022.
- Data governance is the management of the availability, usability, accuracy, and security of data used in an organization. Data governance includes a governing body, standards and procedures for the management and use of data, and a plan for executing the standards and procedures. The purpose of the Data Governance project is to establish an Agency data governance organizational structure (known as the Data Governance Working Group) responsible for defining the standards and processes for making business-wide decisions from information assets. This project establishes a framework for data ownership, management, stewardship, and data sharing.

1.2.3 Phase III: FX Florida Medicaid Management Information System (FMMIS) Transition

The primary objective of Phase III is to transition from the current fiscal agent contract (i.e., FMMIS and Decision Support System (DSS)) by the statutory date of December 31, 2024, to enable the modular, integrated business, and IT transformation vision to be realized. Phase III includes activities to procure modules to transform and improve the business processes currently limited to the FMMIS and DSS; replacing this functionality with solutions that are interoperable with other systems within FX and eventually within the larger Florida HHS ecosystem, which includes agencies in the Medicaid enterprise and partner entities such as health plans and providers.

The Agency will complete these procurements using open source solutions, configurable commercial-off-the shelf (COTS) products, and other modular approaches that reduce the reliance on custom development.

Phase III activities started in the fall of 2019 and are being executed concurrently with activities in Phase II. As Phase III is completed, the functions currently performed in the fiscal agent contract will be decommissioned and replaced with IS/IP, EDW, and other modules that will provide greater efficiency and effectiveness in the administration of the Medicaid program. Additionally, the FX Program is currently conducting an impact analysis to understand the modifications that are needed to meet the CMS Interoperability mandate. Any changes needed will be reflected in future updates to this IAPD.

Phase IV will run concurrently with Phase III and will continue with the implementation of modules not included in the fiscal agent contract.

Included in **Exhibit 1-3: Phase III: FX FMMIS Transition** below is a visual depiction of the FX roadmap strategy, including the end of Phase II and all of Phase III, and summaries of the modules required in Phase III to resolve FMMIS.

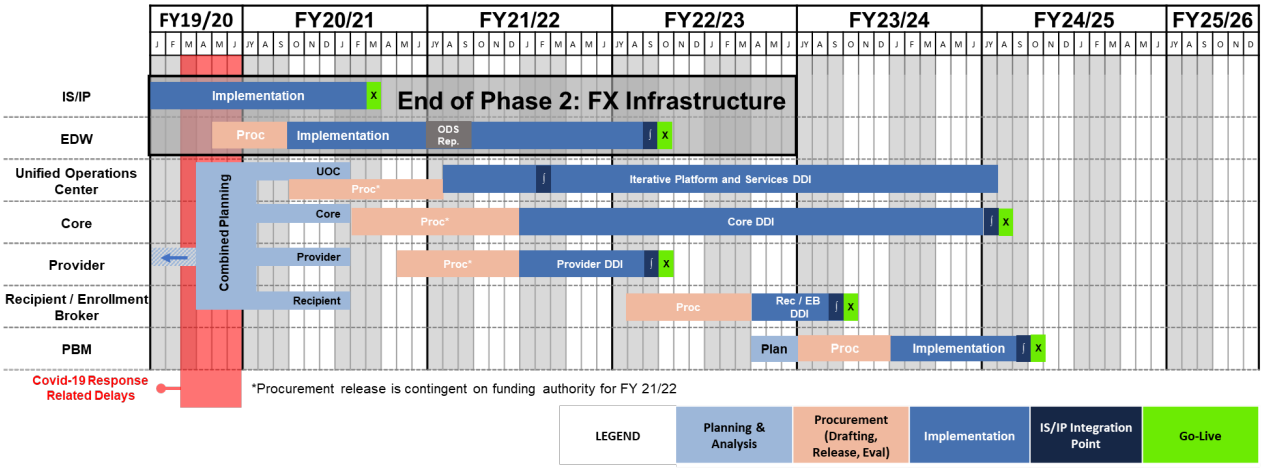

Exhibit 1-3: Phase III: FX FMMIS Transition

Unified Operations Center

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

Core Module (Claims/Encounters/Financial Management)

The FX Core Module will adjudicate fee-for-service claims for Medicaid reimbursement, process managed care encounter claims, and support all Medicaid financial activity. The Core Module represents the most fundamental functionality required for Medicaid processing, and involves the longest combined timeframe for planning, procurement, and implementation.

A comprehensive analysis of the existing Core FMMIS functions is in progress, including claims and encounters transaction processing, banking, and financial processing (including capitation payments for health plans), claims payments, and pharmacy claims payment. Core FMMIS functions also include reference file management for edits and audits, third party liability, recipient coverage dates, benefit plans and coverage rules, reimbursement rules, diagnosis codes, procedure codes, modifiers, diagnosis-related groupings, revenue codes, and error codes. These

functions are interconnected and are planned to be transitioned from the current FMMIS into a Core Module with multiple components integrated with FX. Planning and Analysis began in April 2020, including exploring innovative options such as the National Association of State Procurement Officials (NASPO) procurement vehicle to accelerate the procurement and implementation of this critical component.

Provider Management Module

The Provider Management Module includes licensure, credentialing, enrollment, and maintenance. The Provider solution will consolidate existing professional and facility licensure, Medicaid enrollment, and health plan credentialing processes into a single source to minimize errors and simplify the process for the provider community. The Provider solution will leverage the Master Person Index and Master Organization Index developed in the Phase II IS/IP implementation to improve provider identity reconciliation. A Provider Experience Project was completed in April 2019 that identified opportunities to improve the provider experience and reduce the administrative burden for enrollment and credentialing, as well as streamline the overall enrollment process. The Agency is utilizing this information to develop a portion of the requirements for the Provider Management Module procurement and has gathered requirements for Medicaid Enrollment and Facility Licensure and Credentialing. The Agency is considering the National Association of State Procurement Officials (NASPO) ValuePoint procurement vehicle for this module, which would enhance and streamline the procurement process. The Agency is also exploring new opportunities to expand interoperability with partner agencies.

Recipient/Enrollment Broker Module

The Enrollment Broker functionality includes the systems, contact center/platform, and operations that allow recipients to evaluate and select a health plan. This scope represents the largest element of the Agency's vision for the Recipient Module that will enhance and improve the experience of Medicaid recipients and enhance coordination with authorized eligibility-determination agencies. Other scope items planned for this module include:

- Recipient management functions to maintain and reconcile recipient eligibility-related information required for accurate claim and encounter processing and to coordinate grievances, appeals, communication, and interactions.
- Population and recipient outreach functions to notify recipients about relevant changes or updates to health plans, their benefits, a provider, or other relevant information.
- A portal to house required Recipient functionality, and communications tools to support a unified and consistent Recipient user experience.

Planning for both the Unified Operations Center and Recipient Management have been aligned to ensure the best communication and stakeholder experiences.

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Pharmacy Benefit Management Module

The Pharmacy Benefits Management (PBM) Module will perform designated financial and clinical services for the fee-for-service (FFS) Medicaid population and services that are used in both FFS and managed care (i.e., drug rebate negotiation with manufacturers and maintenance of the preferred drug list). The PBM solution includes a system to process pharmacy claims, e-prescribing functionality, integration with pharmacy point-of-sale systems, pharmacy fee collection, and pharmacy rate negotiation and rebate processing. Prior authorization for specified required drugs is also included in the PBM solution. The PBM vendor is required to monitor prospective and retrospective drug utilization and oversee preferred drug lists. The PBM vendor will also provide operational staff to deliver information to providers, pharmacists, and recipients. The PBM Module functions are currently included in the FMMIS/fiscal agent contract and are fulfilled through a sub-contract.

Existing Florida Enterprise Modules and Subsystems

The Agency currently operates subsystems outside of the Medicaid Management Information System, but within the Medicaid Enterprise. Transition costs are included for integration of existing systems to the FX infrastructure as Florida transitions to a modular environment. These projects are dependent upon the IS/IP and EDW platforms being in production to accomplish the full FX integration. Currently, the integration is accomplished through file transfers, and the module systems will greatly benefit from the move to the FX program. This budget is needed for the design, development and implementation of each module to transition the communication linkages between existing FX systems and the new integration platform. Existing modules and subsystems include, but are not limited to, Third Party Liability and prior authorization services.

- **Third Party Liability** includes integration of all existing systems and processes used to determine the legal liability of third parties to pay for care and services available under the Medicaid state plan. This includes legal liability, estate recovery, data matching, and post-payment functionality.
- **Prior Authorization Services**. The Agency for Health Care Administration has contracted with a certified Quality Improvement Organization Inc., to provide medical necessity reviews for fee-for-service Medicaid services.

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1.2.4 Phase IV: Remaining Functional Modules

The objective of Phase IV of FX is to implement the remaining functional modules necessary to accomplish the FX vision. This includes modules that are not included in the current fiscal agent contract.

This phase is not expected to formally begin until SFY 2023-2024, but some activities overlapping with Phase III modules may start in that phase. This phase is where the Agency coordination with other Florida HHS agencies is expanded as there is a leadership commitment to leverage existing technologies and ensure interoperability. See **Exhibit 1-4: Remaining Functional Modules** below.

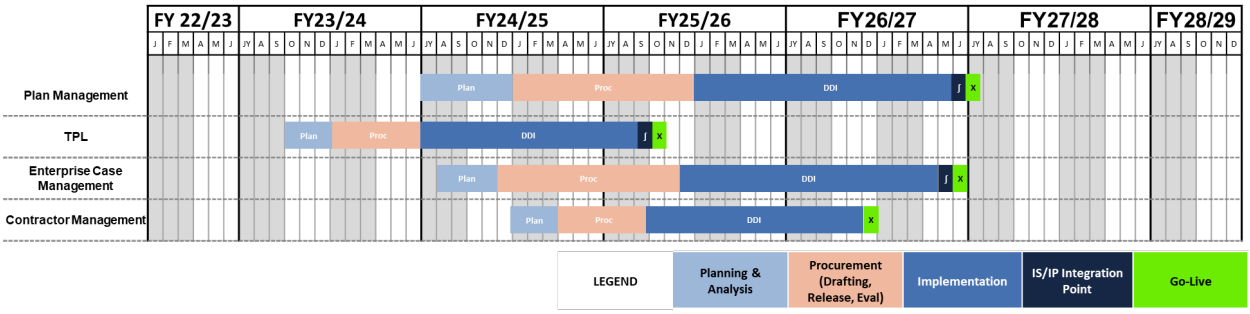

Exhibit 1-4: Remaining Functional Modules

Exhibit 1-4 provides a high level visual of the Phase IV modular components, including:

- A **Plan Management Module** supporting collaboration between the Agency and the Statewide Medicaid Managed Care plans enabling increased accountability and transparency and drive positive outcomes for recipients.
- **Third Party Liability Module** including all systems and operations necessary to determine the legal liability of third parties to pay for care and services available under the Medicaid state plan. This module would replace existing legacy systems and introduce new functionality for legal liability, estate recovery, data matching, and post-payment support.
- An **Enterprise Case Management Module** solution streamlining and consolidating case management information from across the Medicaid enterprise into a single system to facilitate the availability of complete and comprehensive information for state agencies, entities, providers, and recipients. Existing case tracking systems will be retired as the information and business processes are migrated to the enterprise solution; thereby reducing costs and promoting sharing and the reuse of technologies and systems, in accordance with CMS Standards and Conditions.
- A **Contractor Management Module** improving the ability to manage contracts across the Agency's contract lifecycle from procurement through contract termination, and monitor and track contract performance in critical areas such as service-level agreements and performance standards. The solution will include reporting and business intelligence analysis to measure the performance of contractor activities and programs against widely accepted outcome metrics.

1.3 Transformation Approach (Describe State Analysis of Requirements, Feasibility and Alternatives)

1.3.1 Transformation Alternatives and Approach

As a part of the FX Strategy refresh effort, the Agency and the SEAS Vendor researched and re-evaluated the business process transformation alternatives for FX. The to-be FX solution is an integrated collection of systems built from modular components performing defined business functions allowing improved business agility, reduced dependence on a single vendor, and enablement of improved business outcomes. The to-be FX solution includes the scope to modernize inter-related processes and applications supporting the Medicaid infrastructure to improve overall Agency functionality. Phase III will focus on FMMIS and subsystems specifically required to resolve the fiscal agent contract.

A thorough research effort and market-scan of other states' strategies (with a bias towards those states further along on their modularity journey than Florida) to modernize their Medicaid program delivery capability identified the following potential alternatives:

- **Modular Incremental Cutover**– Replace FMMIS with multiple modules and integrate pieces as they are developed.
- **Modular Single-Cutover** – Build a complete stand-alone modular solution before cutover.
- **Takeover to Modular –** Have vendor(s) takeover the current FMMIS, then modularize over time.
- **Modular Cohort Procurements –** Combine business areas into fewer procurements, forcing possible vendor partnerships on larger modules.

The Agency considered the pros and cons of each alternative as outlined in **Exhibit 1-5: Transformation Approach Alternatives – Pros and Cons Table**:

APPROACH	PROS	CONS
Modular Incremental-Cutover	▪ Allows states to sunset elements of their current solution more quickly ▪ Allows states to begin realizing the benefits of their transformation more quickly ▪ Less complexity and risk among smaller implementations and integrations ▪ Less disruption occurs during incremental smaller implementations of each module or group of modules	▪ May lengthen the total transformation timeline ▪ May result in some throw-away integration activities to the legacy MMIS solution ▪ Creates duplicate costs before legacy system resolution, as some functionality from the legacy solution remains live until cutover

APPROACH	PROS	CONS
Modular Single-Cutover	▪ Decreases time and effort necessary to integrate with legacy system ▪ Minimizes transformational-related changes to the legacy MMIS solution	▪ Creates duplicate costs before legacy system resolution, as full legacy solution remains live until cutover ▪ Carries more complexity and risk with single large implementation and integration ▪ Introduces the complexity of maintaining an integrated schedule across all modules
Takeover to Modular	▪ Allows ability to retain select elements of the legacy solution that may be functional ▪ Minimizes disruption with current stakeholders ▪ Provides a longer runway for modularity transition due to restart of the contract terms on the legacy system	▪ Reduces ability to leverage improved technology, especially in the short term ▪ Delays realization of the benefits of modularity ▪ Provides risk of limited vendor response to a takeover procurement ▪ Possibly lower levels of Federal funding participation due to these efforts (Note: CMS has been less open to takeover procurements in recent years.)
Module Cohorts	▪ Possibly reduce the overall transformation timeline due to fewer procurements	▪ Limited experience by vendor community responding to these combined procurements ▪ Results in increased dependence on a small number of vendors ▪ Increases potential for increased risk from complex sub/prime vendor relationships necessitated by the cohorts of business functionality

Exhibit 1-5: Transformation Approach Alternatives - Pros and Cons Table

The Agency selected the **Modular Incremental Cutover Approach** for FX because it achieves the best balance across these transformation priorities. Leveraging this option, the Agency expects to achieve the transformation objectives at the lowest risk and realize transformation benefits more quickly, all while minimizing unnecessary staff impact and maximizing the efficiency of transformation resources. The Modular Incremental Cutover Approach will enable the Agency to replace FMMIS with multiple modules and integrate pieces as they are developed. Each Modular integration will involve changes to four key areas: IS/IP, EDW, the new module, and the impacted legacy system.

At a broad level, the benefits of FX that will be accelerated by the modular incremental cutover approach are:

- Integrated systems that can interoperate and communicate
- The ability to leverage technologies and systems for multiple functions in the FX Program through procurement of modules and COTS technologies

- Meets CMS MITA certification requirements, resulting in enhanced Federal funding and advancing along the MITA maturity model

1.3.2 FX Module Requirements

The functional and technical requirements for the FX Phase II–IV modules define the processing requirements to accomplish the Agency mission and administration of the FX Program. These requirements align with the standard requirements of the healthcare insurance payer industry and include the unique aspects of administration of the Medicaid program. All FX functional and technical requirements are developed in accordance with MITA 3.0 and CMS Standards and Conditions and are aligned with CMS certification process requirements and reviews.

The functional and technical requirements for each module use the following sources as inputs:

- Requirements corresponding to each module business area included in the functions of State of Florida fiscal agent operations in previous fiscal agent replacement procurements
- Module requirements included in procurements developed by other states
- Module requirements developed by the NASPO consortium of states
- Standard healthcare industry payer requirements
- Requirements included in other recent Florida agency procurements for similar functionality (e.g., licensing and enrollment systems)
- Requirements included in the CMS Medicaid Enterprise Certification Toolkit checklists

Requirements included in the scope of services of each module will follow a standardized structure to promote consistency. The technical, security, information management, operations and maintenance, and project implementation methodology requirements are largely the same for most modules. The requirements also provide guidance on the desired degree of standardization and reuse of certain technology components used with module processing.

The Agency has adopted the FX Project Life Cycle to support consistent system development and project management methodologies. The FX Project Life Cycle is a system development life cycle based on the CMS eXpedited Life Cycle and customized to the Agency and Florida-specific project implementation processes. Requirements are defined and used throughout the phases of the FX Project Lifecycle. During planning, high level requirements focused on process improvements are defined. During procurement, procurement level requirements describing the scope and expected services of vendors are defined. During project implementation, vendors may validate and elaborate procurement requirements to a more detailed level which are comprehensive and discretely testable. In operations and maintenance, the detailed requirements are used to perform impact analysis and define what types of regression testing are needed when changes occur.

The high-level requirements for Phase II IS/IP and EDW modules have been defined. The functional requirements for Phase III and IV modules will be developed in accordance with MITA 3.0 and CMS Standards and Conditions and are aligned with CMS certification process requirements and reviews that are in effect at the time the work is being done.

1.3.3 FX Technical Solution and Standards

To enable effective and responsive delivery of health-related services, the Agency is pursuing modular technology and processing solutions that work together seamlessly, enabled by the IS/IP and EDW infrastructure developed in Phase II. Using modular solutions provides processing and operational agility and increases the opportunity to select the best technology and services from vendors, while simultaneously avoiding vendor lock-in and the risks associated with a single solution.

As mentioned in Section 1.3.1 above, the Agency will follow the *Modular Incremental Cutover Approach* to replace FMMIS and related Medicaid systems with multiple modules and integrate pieces as they are developed. Currently, the State of Florida Medicaid Enterprise is supported by a large, complex portfolio of systems and applications, totaling over 60 systems, subsystems and applications. The Agency's strategy includes a plan to assimilate modular solutions to replace current functional systems or subsystems quickly and efficiently as technology evolves.

To ensure the technical solutions for each module are consistent and aligned with the FX technical vision, the SEAS vendor worked with the Agency to develop data management, technology, system design and implementation, and enterprise security management strategies and standards for the program. These standards will be included in the procurement requirements for all FX modules.

FX module solutions will be selected based on the specific technical requirements and evaluation criteria described in each competitive solicitation, including the following high-level criteria:

- Return on investment and business process improvement impact
- Adherence to the Agency's data management and technology strategies
- Alignment with expected market evolution in data management
- Level of business agility and reliance on proprietary vendors

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2 PROJECT MANAGEMENT PLAN FOR IMPLEMENTATION ACTIVITIES

The Agency collaborates with the SEAS vendor to operate the Enterprise Program Management Office (EPMO) for the FX Program. The EPMO is based on three guiding principles:

- Implement standardized, lean, and effective project management processes across the FX Program and vendor project teams and stakeholders
- Employ project management tools commensurate with the scale and complexity of the FX Program
- Use best practice approaches and establish a culture of continuous improvement

The guiding principles support the following critical aspects. These project characteristics are applied to the FX Program, as well as the multiple FX projects that are completed in the program:

- Decision-Making – Effective project management processes, tools, and practices provide the team with information needed to make informed decisions keeping the project on track and on schedule.
- Alignment – Employing the proper tools and processes ensures the project activities and outcomes are aligned with objectives defined in the planning phase, reducing re-work and increasing acceptance.
- Control – Proper application of project management processes, tools, and practices allows the EPMO to maintain control of the scope, schedule, cost, and quality of the project.
- Support – Well-designed processes, practices, and tools support all project management activities, as well as support the team in reaching project objectives, including timeliness.
- Tracking – Effective project management relies on timely and accurate information. The EPMO processes, tools, and practices are focused on tracking critical aspects of the project to help ensure the team has information needed to proactively correct problems that could affect timely delivery of the project.
- Consistency – Given the complexity of the FX Program, project management processes, tools, and practices must lead to consistency in the operation of the EPMO and the overall program to achieve successful and timely delivery.
- Predictive modeling – The use of tracking data, experience, and trend analysis to identify risks and roadblocks before they happen. This allows corrective actions to be implemented before issues and project delays occur.
- Continuous Improvement – The use of performance metrics, quality checklists, and lessons learned to identify and address process inefficiencies and gaps in a timely manner.

Project Management Standards were established to support integrated project management processes. Inclusive to the Project Management Standards are the integrated project management plans and processes that are part of the SEAS vendor responsibility, including:

- Integrated risk, action item, issue, and decision tracking
- Integrated master schedule for the FX Program
- Integrated change management
- Integrated cost management
- Integrated status reporting

3 PROPOSED BUDGET / COST ALLOCATION

3.1 APD Summary Budget

The following budget table in **Exhibit 3-1: APD Summary Budget Table** is a summary of the budget and federal financial participation for each state fiscal year for which federal funds are requested. The conversion of state fiscal year to federal fiscal year can be found in **Appendix A**.

State Fiscal Year	Federal Match 90%	State 10%	Federal Match 75%	State 25%	Federal Match 50%	State 50%	Total
20/21	$48,561,887	$5,395,765	$3,377,702	$1,125,901	$115,000	$115,000	$58,691,255
21/22	$73,302,878	$8,144,764	$4,411,445	$1,470,482	$75,000	$75,000	$87,479,569
22/23	$99,321,247	$11,035,694	$11,514,567	$3,838,189	$37,500	$37,500	$125,784,697
Totals	$221,186,012	$24,576,223	$19,303,714	$6,434,572	$227,500	$227,500	$271,955,521

Exhibit 3-1: APD Summary Budget Table

3.2 Alternatives Explored for Cost / Benefits

As stated in Section 1.3.1. above, the Agency conducted extensive research to identify potential implementation alternatives for the FX Program and chose the Modular Incremental Cutover approach because it achieves the best balance across transformation priorities.

One of the primary FX Strategic Priorities set by executive leadership was to resolve the fiscal Agent contract as quickly as possible by sequencing modules that would decommission functionality and, in turn, reduce the fiscal agent contract expenditure. The SEAS vendor conducted an analysis of the fiscal agent contract to help the Agency determine the best sequencing option for resolving the contract. The fiscal agent contract was parsed by deliverable to determine contract value associated with specific business functions, contract administration, system platforms, and fixed cost. The SEAS Vendor then used this analysis to determine which modules would reduce the fiscal agent contract at the most reasonable pace.

Another factor in determining the sequencing of modules was the desire to accelerate the realization of benefits from the transformation. The SEAS vendor conducted a comprehensive cost-benefits analysis to validate existing benefits and assess the benefits of the future modules.

Module scope and projected benefits were reviewed to ensure the sequencing of modules would accelerate the realization of benefits.

In addition to the analysis described above, the SEAS vendor conducted visioning sessions with Agency executive leadership where they reviewed key considerations and tactics impacting the sequencing of FX modules and projects and made key decisions that informed the prioritization of modules in the Transformation Roadmap.

3.3 Basis for Chosen Alternative is Reasonable

The rationale for the FX Strategy and Roadmap implementation based on the Modular Incremental Cutover transformation approach is to:

- Focus on the transition of operations performed by the current fiscal agent to different vendors and Agency staff by December 31, 2024 to align with the legislative mandate and revised Agency Strategic Priorities
- Improve the effectiveness of spending on the fiscal agent contract by prioritizing Phase III on systems and services required to resolve the fiscal agent contract
- Support the Florida Medicaid Enterprise as it progresses through the stages of the Medicaid Enterprise Certification Life Cycle (MECL) and advances MITA Maturity
- Reduce peak Agency staffing requirements by extending the overall FX Roadmap schedule and deferring transformational improvements that benefit stakeholders external to the Agency
- Reduce FX Program management complexity by reducing the number of projects and interim production implementations
- Reduce risk to current production operations by reducing and delaying interim changes to production operations
- Increase consistency of stakeholder communication and visibility to stakeholder experience information about health plan, provider, and recipient interactions with the Agency by using a single Unified Operations Center vendor
- Simplify communications and increase understanding of the FX approach and schedule

This approach is also expected to provide the following overall benefits. Additional considerations can be found in the 2020 MITA ConOps Addendum:

- Allows time for vendor solutions to mature and vendors and the Agency to increase delivery capacity and capability
- Market solutions may force business process changes and reduction or elimination of Florida specific requirements
- Enables new solutions to reflect expected healthcare legislative, industry-driven, technology driven, market-driven disruptions
- Reduces fiscal agent contract extension negotiation complexity and transition management effort

During the FX Strategy refresh process an extensive cost-benefits analysis was conducted to validate existing benefits and assess the benefits of the future modules. A comprehensive FX Outcome Management Framework was developed that aligns the FX Guiding Principles and Strategic Priorities to a defined set of outcomes, drivers, and benefits.

Exhibit 3-2: FX Benefits by Business Area (Phase II and III) below highlights these benefits and maps them to specific FX business areas aligned with the scope of services in Phases II and III of the Transformation Roadmap. The benefits will be considered in the planning phase for each FX module, and associated data will be refreshed for accuracy as needed.

MODULE	BENEFITS
Integration Services and Integration Platform	▪ Creates a platform that allows Agency and HHS systems to integrate as a service, reducing escalating future costs of integrations with technology vendors ▪ Provides a single sign on and administrative layer for all AHCA systems connected to IS/IP, simplifying password resets ▪ Reduces user provisioning and off-boarding costs ▪ Master Person and Master Organization Index helps resolve identity information on providers and recipients ▪ Improves the accuracy and speed of data sharing internally and with sister agencies ▪ Potentially reduces duplicate communications ▪ Enables integration of policy and business rule processing
Enterprise Data Warehouse	▪ A single source of truth to improve data quality, accuracy, and accessibility ▪ Improved data analytics and dashboards to enhance monitoring of plan performance, network adequacy, and quality improvement activities ▪ Improved analytic tools and machine learning to increase identification and recovery of fraud and improper payments ▪ Improved staff productivity ▪ Reduced system maintenance and operations cost (software) ▪ Improved analytic tools, processing speed, and persona optimized data stores ▪ Reduced data protection risk and cost
Unified Operations Center	▪ Reduced cost of contact center multi-topic interactions ▪ Reduced cost of contact center interaction – recipient/provider/stakeholder time ▪ Creates centralized access to contacts and correspondence information to manage service delivery ▪ Reduced contact and interaction management cost to Agency ▪ Reduced turnover costs associated with bundled service and systems procurements ▪ Reduced mailing costs through consolidated correspondence functions

MODULE	BENEFITS
CORE (Claims / Encounters / Financial)	▪ Reduced number of wrongly rejected claims and encounters, lessening the administrative burden and cost on the Agency, providers, and health plans ▪ Improved communications of claim status or rejection reason will reduce the number of claim resubmission ▪ Specified scope of encounter processing will improve the reliability of plan encounter data eliminating the need, cost, and duplicate submission of the 'special feed' from the plans ▪ Reduced claim validation processing costs in Agency systems ▪ Reduced Agency financial staff time on manual data re-entry and processing
Provider	▪ Unified enrollment, licensure and credentialing processes across Agency divisions and partner agencies ▪ Reduced time to enroll, license and credential a Medicaid provider ▪ Single source of credentialing, as well as single source to report a change across agencies ▪ Remove disincentives for provider participation in Medicaid and plan networks ▪ Reduced cost per enrollment for providers ▪ Reduced number of FTEs needed to process enrollment ▪ Reduced call center volumes ▪ Expedited ramp from start-up to operations for facilities ▪ Improvement in Change of Ownership applications being processed
Recipient / Enrollment Broker	▪ Increased integration with DCF will better enable recipients to select their plan and provider prior to enrollment, assisting families in continuing a care relationship with their current provider ▪ Reduced recipient time spent to contact Enrollment Broker ▪ Reduced interaction management cost to the Agency through self-service portal functionality for plan selection and change reporting ▪ Reduced Enrollment Broker contact center infrastructure costs
Pharmacy Benefits Management	▪ Increased Agency recovery of drug manufacturer rebates ▪ Reduced recipient trips to pharmacy by aligning refill dates for multiple prescriptions ▪ Reduced pharmacy mailing costs ▪ Reduced pharmacy point of sale operations costs ▪ Reduced claims administration costs (Providers) ▪ Reduced total managed care and FFS pharmacy expenditures

Exhibit 3-2: FX Benefits by Business Area (Phase II and III)

3.4 Clear Need for Investment

The FX Program enables the Agency to advance in accomplishing the CMS MITA goal of a seamless and integrated collection of systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards. The FX system will be built from modular components that perform defined business functions, allowing for improved business agility, reduced dependence on a single vendor, and enablement of improved business outcomes. The improvements of the supporting systems will create more efficient and effective Medicaid operations.

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3.5 Details Investment Cost/Cost Allocation

The Agency, in coordination with the SEAS vendor, has developed the anticipated budget for State Fiscal Years (SFY) 2020-2021, 2021-2022, and 2022-2023 required for FX Program activities. The budget amounts may be refined over time to reflect costs more in line with executed contracts and industry norms. The total budget with costs provided by planning tasks is shown in **Exhibit 3-3: Implementation Planning Budget/FFP by SFY** below. A written description of the identified planning tasks is provided in Section 1.2 FX Future State Transformation Roadmap. Medicaid Budget Detail tables based on Federal Fiscal Years (FFY) can be found in Appendix A. Each SFY budget quarter was aligned with the appropriate FFY quarter to determine the proper conversion. Included are State Fiscal Years: 2020-2021, 2021-2022, and 2022-2023 and Federal Fiscal Years: 2020 (quarter 4), 2021, 2022, and 2023 (the chart can be resized for readability).

FLORIDA MEDICAID ENTERPRISE SYSTEMS (MES) IMPLEMENTATION PLANNING BUDGET																		
PLANNING TASKS	**SFY 2020-2021**						**SFY 2021-2022**						**SFY 2022-2023**					
	FFP 90%	**State 10%**	**FFP 75%**	**State 25%**	**FFP 50%**	**State 50%**	**FFP 90%**	**State 10%**	**FFP 75%**	**State 25%**	**FFP 50%**	**State 50%**	**FFP 90%**	**State 10%**	**FFP 75%**	**State 25%**	**FFP 50%**	**State 50%**
Strategic Enterprise Advisory Services (SEAS) Tasks																		
SEAS Strategic Planning, Program and Project Management	$ 3,813,997	$ 423,777	$ -	$ -	$ -	$ -	$ 3,813,997	$ 423,777	$ -	$ -	$ -	$ -	$ 3,813,997	$ 423,777	$ -	$ -	$ -	$ -
SEAS Task Order for Professional Services	$ 4,925,363	$ 547,263	$ -	$ -	$ -	$ -	$10,947,592	$1,216,399	$ -	$ -	$ -	$ -	$ 13,215,592	$ 1,468,399	$ -	$ -	$ -	$ -
Infrastructure Phase																		
Integration Services/Integration Platform (IS/IP) - Implementati	$ 5,300,420	$ 588,936	$ -	$ -	$ -	$ -	$ 3,806,247	$ 422,916	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Integration Services/Integration Platform (IS/IP) - Task Orders	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,643,840	$ 293,760	$ -	$ -	$ -	$ -	$ 2,643,840	$ 293,760	$ -	$ -	$ -	$ -
Integration Services/Integration Platform (IS/IP) - Operations	$ -	$ -	$ 3,377,702	$1,125,901	$ -	$ -	$ -	$ -	$3,377,702	$1,125,901	$ -	$ -	$ -	$ -	$ 5,041,854	$1,680,618	$ -	$ -
Enterprise Data Warehouse (EDW) - Implementation	$27,226,951	$3,025,217	$ -	$ -	$ -	$ -	$20,834,928	$2,314,992	$ -	$ -	$ -	$ -	$ 5,769,936	$ 641,104	$ -	$ -	$ -	$ -
Enterprise Data Warehouse (EDW) - Task Orders	$ -	$ -	$ -	$ -	$ -	$ -	$ 489,600	$ 54,400	$ -	$ -	$ -	$ -	$ 2,937,600	$ 326,400	$ -	$ -	$ -	$ -
Enterprise Data Warehouse (EDW) - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 285,600	$ 95,200	$ -	$ -	$ -	$ -	$ 3,968,820	$1,322,940	$ -	$ -
CMS - Interoperability	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,468,800	$ 163,200	$ -	$ -	$ -	$ -	$ 2,937,600	$ 326,400	$ -	$ -	$ -	$ -
Contract Services - Implementation	$ 216,209	$ 24,023	$ -	$ -	$ -	$ -	$ 199,800	$ 22,200	$ -	$ -	$ -	$ -	$ 66,600	$ 7,400	$ -	$ -	$ -	$ -
Contract Services - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 194,400	$ 64,800	$ -	$ -	$ -	$ -	$ 305,400	$ 101,800	$ -	$ -
Software Support Licenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 58,249	$ 19,416	$ -	$ -	$ -	$ -	$ 58,249	$ 19,416	$ -	$ -
Enterprise Job Scheduler - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 291,494	$ 97,165	$ -	$ -	$ -	$ -	$ 291,494	$ 97,165	$ -	$ -
Integration Phase																		
Module Existing Systems Integrations	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,406,400	$ 489,600	$ -	$ -	$ -	$ -	$ 4,406,400	$ 489,600	$ -	$ -	$ -	$ -
Module Acquisition Phase																		
Provider - Procurement	$ 135,000	$ 15,000	$ -	$ -	$ -	$ -	$ 453,600	$ 50,400	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Provider - Implementation	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,943,728	$ 438,192	$ -	$ -	$ -	$ -	$ 3,583,872	$ 398,208	$ -	$ -	$ -	$ -
Provider - Task Orders	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,350,080	$ 261,120	$ -	$ -	$ -	$ -
Provider - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 204,000	$ 68,000	$ -	$ -	$ -	$ -	$ 1,644,750	$ 548,250	$ -	$ -
Core - Procurement	$ 1,260,720	$ 140,080	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Core - Implementation	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,141,215	$1,015,691	$ -	$ -	$ -	$ -	$ 40,314,429	$ 4,479,381	$ -	$ -	$ -	$ -
Recipient - Procurement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,101,600	$ 122,400	$ -	$ -	$ -	$ -
Recipient - Implementation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,897,523	$ 321,947	$ -	$ -	$ -	$ -
Recipient - Task Orders	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 391,680	$ 43,520	$ -	$ -	$ -	$ -
Recipient - Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 204,000	$ 68,000	$ -	$ -
Unified Operations Center - Implementation	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,569,906	$ 507,767	$ -	$ -	$ -	$ -	$ 6,307,272	$ 700,808	$ -	$ -	$ -	$ -
Pharmacy Benefits Management - Procurement †	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contract Services - Procurement	$ -	$ -	$ -	$ -	$ -	$ -	$ 468,000	$ 52,000	$ -	$ -	$ -	$ -	$ 468,000	$ 52,000	$ -	$ -	$ -	$ -
Contract Services - Implementation	$ -	$ -	$ -	$ -	$ -	$ -	$ 432,000	$ 48,000	$ -	$ -	$ -	$ -	$ 432,000	$ 48,000	$ -	$ -	$ -	$ -
Outside Legal Counsel	$ -	$ -	$ -	$ -	$115,000	$115,000	$ -	$ -	$ -	$ -	$75,000	$ 75,000	$ -	$ -	$ -	$ -	$37,500	$ 37,500
IV&V Tasks																		
Monitor State and SEAS activities and report to CMS and the Florida Department of Management Services	$ 2,907,896	$ 323,100	$ -	$ -	$ -	$ -	$ 2,907,896	$ 323,100	$ -	$ -	$ -	$ -	$ 2,907,896	$ 323,100	$ -	$ -	$ -	$ -
State Agency Staff Costs																		
Additional FFP for existing FTEs	$ 2,775,330	$ 308,370	$ -	$ -	$ -	$ -	$ 2,775,330	$ 308,370	$ -	$ -	$ -	$ -	$ 2,775,330	$ 308,370	$ -	$ -	$ -	$ -
IAPD Total Request by FFP	**$48,561,887**	**$5,395,765**	**$ 3,377,702**	**$1,125,901**	**$115,000**	**$115,000**	**$73,302,878**	**$8,144,764**	**$4,411,445**	**$1,470,482**	**$75,000**	**$ 75,000**	**$ 99,321,247**	**$11,035,694**	**$11,514,567**	**$3,838,189**	**$37,500**	**$ 37,500**
IAPD Total Request by SFY	**$58,691,255**						**$87,479,569**						**$125,784,697**					

† - Pharmacy Benefits Management - Procurement begins July 2023, outside the SFY table cost data and within the FFY cost data

Exhibit 3-3: Implementation Planning Budget/FFP by SFY

3.5.1 State Personnel Resources

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

State Agency Staff Costs for SFY 2020--2023				12 Months		
Position	**No. FTE**	**Time Allocation to Project**	**Cost Per Month**	**Cost Per Year**	**90% FFP**	**10% State**
Project Sponsor	1	25%	$3,750	$45,000	$40,500	$4,500
Project Advisor	1	10%	$800	$9,600	$8,640	$960
Project Directors	2	100%	$20,000	$240,000	$216,000	$24,000
Project Team Leads	2	100%	$15,000	$180,000	$162,000	$18,000
Senior Management Analyst	7	100%	$45,500	$546,000	$491,400	$54,600
Subtotals	**15**		**$85,050**	**$1,020,600**	**$918,540**	**$102,060**
Work Groups						
AHCA IS/IP Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA IS/IP Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
IS/IP Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
IS/IP Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
IS/IP SMEs	5	10%	$3,250	$39,000	$35,100	$3,900
AHCA EDW Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA EDW Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
EDW Technical Analyst	4	25%	$6,500	$78,000	$70,200	$7,800
EDW Business Analyst	4	25%	$6,500	$78,000	$70,200	$7,800
EDW SMEs	4	10%	$2,600	$31,200	$28,080	$3,120
AHCA Provider Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Provider Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
Provider Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Provider Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Provider SMEs	4	10%	$2,600	$31,200	$28,080	$3,120
AHCA Core Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Core Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
Core Technical Analyst	5	25%	$8,125	$97,500	$87,750	$9,750
Core Business Analyst	5	25%	$8,125	$97,500	$87,750	$9,750
Core SMEs	5	10%	$3,250	$39,000	$35,100	$3,900

State Agency Staff Costs for SFY 2020--2023				12 Months		
Position	**No. FTE**	**Time Allocation to Project**	**Cost Per Month**	**Cost Per Year**	**90% FFP**	**10% State**
AHCA Business Matrix Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Business Matrix Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
Business Matrix Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Business Matrix Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Business SMEs	3	10%	$1,950	$23,400	$21,060	$2,340
AHCA Recipient Lead	1	100%	$10,000	$120,000	$108,000	$12,000
AHCA Recipient Contract Manager	0.5	100%	$3,000	$36,000	$32,400	$3,600
Recipient Technical Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Recipient Business Analyst	3	25%	$4,875	$58,500	$52,650	$5,850
Recipient SMEs	6	10%	$3,900	$46,800	$42,120	$4,680
OCM Technical Analyst	1	25%	$1,625	$19,500	$17,550	$1,950
OCM SMEs	10	10%	$6,500	$78,000	$70,200	$7,800
Totals	**102**		**$256,975**	**$3,083,700**	**$2,775,330**	**$308,370**

Exhibit 3-4: State Personnel Resources

3.5.2 Cost Allocation Methodology

The Agency is currently developing a cost allocation plan in accordance with OMB Circular A-87 and Section 45 of the Code of Federal Regulations (CFR), Part 95.507 to appropriately allocate costs for each of the projects identified in the IAPD. The cost allocation plan will contain sufficient information to describe the Agency's procedures for identifying, measuring, and allocating Medicaid costs of projects. Upon CMS' approval of the plan, data will be gathered to complete the allocation.

There are several statistical approaches currently being evaluated to determine Medicaid costs, including data points for Medicaid providers, Medicaid recipients, FTE positions, and claims processed. The approach will distinguish Medicaid and Non-Medicaid counts based on the selected data point, producing a percentage to be applied against each estimated project cost. Once the Medicaid cost portion is determined, the appropriate FFP rates (90/10, 75/25, 50/50) will be applied to the Medicaid costs.

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3.5.2.1 Agency Organizational Chart

The following AHCA organizational chart in **Exhibit 3-4: AHCA Organizational Chart** shows the placement of each unit whose costs are charged to the programs operated by the Agency, with those units most impacted highlighted yellow.

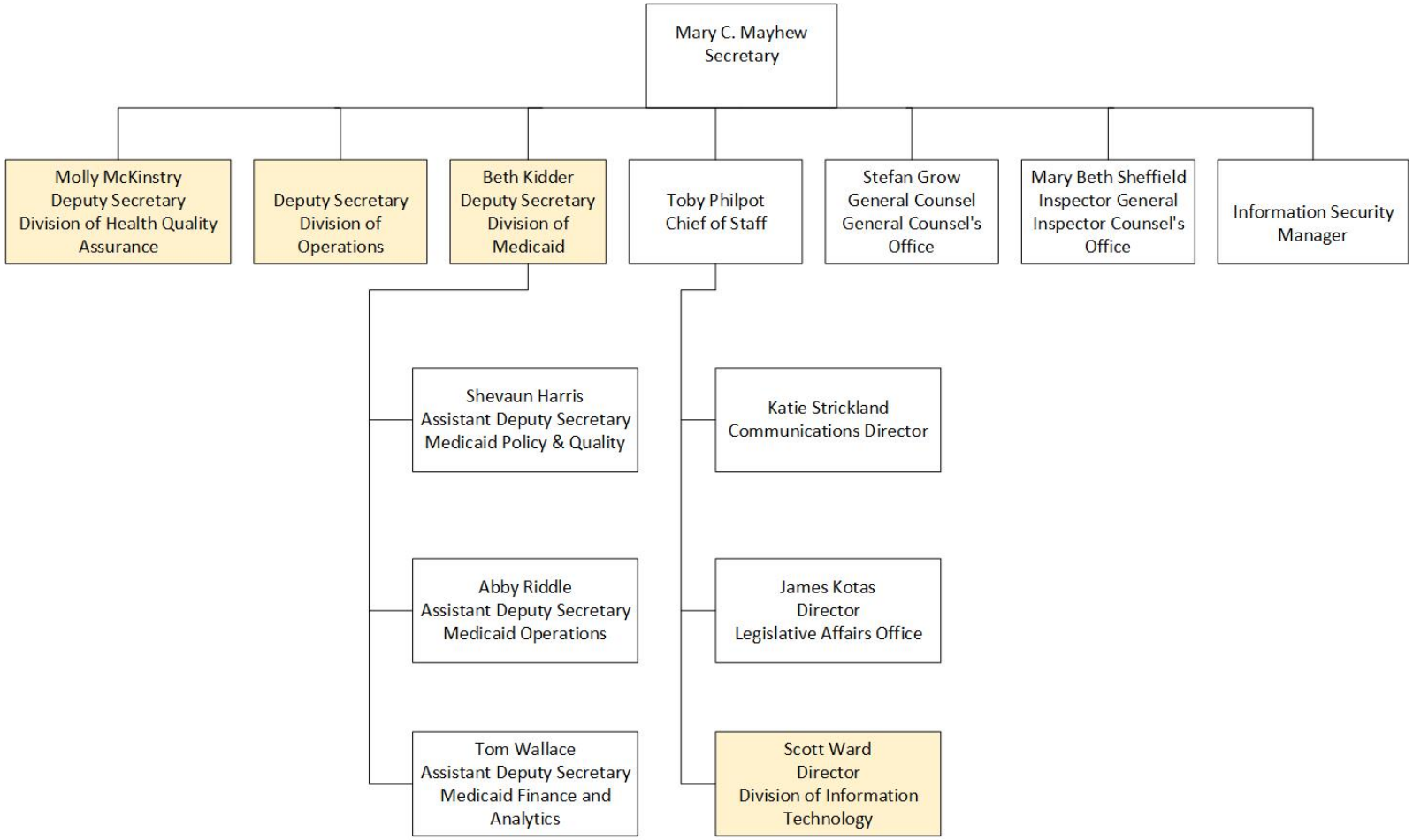

Exhibit 3-5: AHCA Organizational Chart

3.5.2.2 Agency Organizational Units

A description of the activities performed by each AHCA organizational unit is described in **Exhibit 3-5: AHCA Organizational Units** below.

		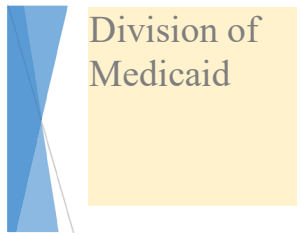	
AHCA Health Quality Assurance licenses and/or certifies and regulates more than 30 different types of healthcare providers, including hospitals, nursing homes, assisted living facilities, home health agencies, and managed healthcare companies. The primary duties include: ▪ Licensure and Regulation ▪ Health Information and Transparency ▪ Medicaid Program Integrity ▪ Background Screening ▪ Financial Analysis ▪ The Central Intake Unit ▪ Training and Support Unit	The Division of Operations is responsible for the: ▪ Administration of Human Resources ▪ Finance and Accounting ▪ Budgeting ▪ Grants Management ▪ Revenue Management ▪ Procurements ▪ Purchasing ▪ Facility Management	The Agency for Health Care Administration (AHCA) is Florida‘s single state Medicaid agency. It is responsible for the administration of Medicaid services. The Department of Children and Families acts as our agent by enrolling people in Medicaid. AHCA partners with other public and private organizations to provide the broad range of services that Medicaid offers its participants. AHCA is also the lead agency for the Children’s Health Insurance Program (Title XXI–CHIP), which is the state's children health insurance program for uninsured children.	Information Technology (IT) plays an integral role in identifying opportunities for the Agency to meet its goals through the strategic use of technology. IT serves the Agency's divisions by providing enterprise-wide integrated system solutions and high-quality customer service to ensure the efficient utilization of technology resources and investments.

Exhibit 3-6: AHCA Organizational Units

4 PROPOSED ACTIVITY SCHEDULE

The key dates of the years included in this IAPD request are listed in **Exhibit 4-1: Key Dates** as follows:

KEY DATE*	IMPORTANCE AND RELEVANCE TO THE PROJECT
January 2018	Planning and Procurement for IS/IP Vendor Begins
April 2019	Planning and Procurement for the EDW Vendor Begins
November 2019	Contract for IS/IP Vendor Executed
November 2019	Design and Development Phase of IS/IP Begins
October 2020	Contract for EDW Vendor Anticipated
October 2020	Design and Development Phase of EDW Anticipated
April 2020	Planning and Procurement for Unified Operations Center Module Begins
April 2020	Planning and Procurement for Core Module Begins
August 2019	Planning and Procurement for Provider Management Module Begins
August 2021	Contract for Unified Operations Center Module Anticipated
August 2021	Design and Development for Unified Operations Center Module Anticipated
January 2022	Contract for Core Module Anticipated
January 2022	Design and Development for Core Module Anticipated
January 2022	Contract for Provider Management Module Anticipated
January 2022	Design and Development for Provider Management Module Anticipated
*Key Dates are subject to change	

Exhibit 4-1 – Key Dates

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5 CMS REQUIRED ASSURANCES

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

Security/Interface and Disaster Recovery/Business Continuity Requirements Statement

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

☑ The State Agency will have disaster recovery plans and procedures available.

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

☑ 42 CFR 431, Subpart F (Safeguarding Information on Applicants and Beneficiaries)

☑ 42 CFR 435.960 (Standardized formats for furnishing and obtaining information to verifying income and eligibility)

☑ 45 CFR 95.617 (Software and Ownership Rights in Specific Conditions for FFP)

☑ 45 CFR 95.601 (Scope and Applicability)

☑ 45 CFR 205.50 (Safeguarding Information for the Financial Assistance Programs)

☑ 45 CFR 303.21 (Safeguarding and disclosure of Confidential Information)

Required assurances of compliance with cited Code of Federal Regulations (CFR) and CMS MITA Conditions and Standards attestation

In its Medicaid IT supplement *(MITS-11-01-v1.0) Enhanced Funding Requirements: Seven Conditions and Standards* and final rule, "Mechanized Claims Processing and Information Retrieval Systems (90/10), CMS issued conditions and standards to be met by states to be eligible for enhanced match funding." As indicated in **Exhibit 5-1: CMS MITA Conditions and Standards Compliance Matrix** below, the State of Florida Agency for Health Care Administration attests that the project will comply with the CMS MITA Conditions and Standards.

#	MITA Condition Name and Description	Compliance	
		Yes	No
1	Modularity Standard Use a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces (API); the separation of business rules from core programming; and the availability of business rules in both human and machine-readable formats.	X	
2	MITA Condition Align to and advance increasingly in MITA maturity for business, architecture, and data. Complete and continue to make measurable progress in implementing MITA roadmaps.	X	

#	MITA Condition Name and Description	Compliance	
		Yes	No
3	Industry Standards Condition Ensure alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy, and transaction standards; accessibility standards established under Section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with federal civil rights law; standards adopted by the Secretary under Section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under Section 1561 of the Affordable Care Act.	X	
4	Leverage Condition Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states.	X	
5	Business Results Condition Support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.	X	
6	Reporting Condition Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.	X	
7	Interoperability Condition Ensure seamless coordination and integration with the Exchange (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.	X	

Exhibit 5-1: CMS MITA Conditions and Standards Compliance Matrix

The Agency plans to use open and competitive procurements for all contracted work related to the design, development, and implementation of enhancements to the FX. The procurement process will comply with all applicable federal regulations and provisions as indicated in **Exhibit 5-2: Procurement Assurances**.

Procurement Standards		Compliance	
		Yes	No
45 CFR Part 95.613	Procurement Standards	X	
45 CFR Part 75	Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments	X	
SMM Section 11267	Required Assurances	X	
SMD Letter of 12/04/1995	Letter to State Medicaid Directors regarding the policy on sole source procurements and prior approval requirements for certain procurements	X	
Access to Records		**Compliance**	
		Yes	**No**

45 CFR Part 95.615	Access to Systems and Records	X	
SMM Section 11267	Required Assurances	X	
Software & Ownership Rights, Federal Licenses, Information Safeguarding, HIPAA Compliance and Progress Reports		**Compliance**	
		Yes	**No**
42 CFR Part 431	Safeguarding Information on Applicants and Beneficiaries	X	
42 CFR Part 433.112 (b)(1-22)	FFP for Design, Development, Installation or Enhancement of Mechanized Claims Processing and Information Retrieval Systems	X	
45 CFR Part 95.617	Software and Ownership Rights	X	
45 CFR Part 164	Security and Privacy	X	
SMM Section 11267	Required Assurances	X	
IV&V		**Compliance**	
		Yes	**No**
45 CFR Part 95.626	Independent Verification and Validation	X	

Exhibit 5-2: Procurement Assurances

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APPENDIX A: DETAILED BUDGET TABLE—FEDERAL FISCAL YEAR

Florida Health Care Connections (FX) Program

Covers Federal Fiscal Years 2020 (Quarter 4) through 2023 (Quarter 4)

MES/FX Phase II as of 7/2020	CMS Share (90% FFP)	State Share -10%	CMS Share (75% FFP)	State Share -25%	CMS Share (50% FFP)	State Share -50%	**FUNDING FFP Total**	**State Share Total**
	2B†		2B†		2B†		**2B**	
FFY 2020 ‡	$5,697,631	$633,070	$844,425	$281,475	$115,000	$115,000	**$6,657,057**	**$1,029,545**
FFY 2021	$54,751,493	$6,083,499	$3,592,445	$1,197,482	$0	$0	**$58,343,938**	**$7,280,981**
FFY 2022	$86,489,702	$9,609,967	$7,492,776	$2,497,592	$75,000	$75,000	**$94,057,478**	**$12,182,559**
FFY 2023	$91,883,031	$10,209,226	$12,103,362	$4,034,454	$37,500	$37,500	**$104,023,893**	**$14,281,180**
Total	**$238,821,857**	**$26,535,762**	**$24,033,008**	**$8,011,003**	**$227,500**	**$227,500**	**$263,082,365**	**$34,774,264**

MES/FX Phase II as of 7/2020	CMS Share-- State Staff Costs (90% FFP)	State Share-- State Staff Costs -10%	CMS Share (75% FFP)	State Share -25%	CMS Share (50% FFP)	State Share -50%	**FUNDING FFP Total**	**State Share Total**
	2A†		--		**2A†**		**2A**	
FFY 2020 ‡	$693,833	$77,093	$0	$0	$0	$0	$693,833	$77,093
FFY 2021	$2,775,330	$308,370	$0	$0	$0	$0	$2,775,330	$308,370
FFY 2022	$2,775,330	$308,370	$0	$0	$0	$0	$2,775,330	$308,370
FFY 2023	$2,775,330	$308,370	$0	$0	$0	$0	$2,775,330	$308,370
Total	**$9,019,823**	**$1,002,203**	**$0**	**$0**	**$0**	**$0**	**$9,019,823**	**$1,002,203**

MES/FX Phase II as of 7/2020	CMS Share	State Share	CMS Share	State Share	CMS Share	State Share	**TOTAL FFP**	**STATE SHARE TOTAL**	**APD TOTAL (TOTAL COMPUTABLE)**
	2A&B†	--	4A&B†	--	5A,B&C†	--			
FFY 2020 ‡	$7,350,889	$1,106,638					$7,350,889	$1,106,638	**$8,457,527**
FFY 2021	$61,119,268	$7,589,351					$61,119,268	$7,589,351	**$68,708,618**
FFY 2022	$96,832,808	$12,490,929					$96,832,808	$12,490,929	**$109,323,736**
FFY 2023	$106,799,223	$14,589,550					$106,799,223	$14,589,550	**$121,388,772**
Total	**$272,102,187**	**$35,776,467**	**$0**	**$0**	**$0**	**$0**	**$272,102,187**	**$35,776,467**	**$307,878,654**

‡ - *FFY 2020 includes only quarter 4*