
# February 2020
# Strategy Refresh

Better Health Care for All Floridians
AHCA.MyFlorida.com

# STRATEGY REFRESH
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# SECTION A

## *Executive Summary*

# FX ENTERPRISE SYSTEMS STRATEGIC PLAN UPDATE

**SEAS updated the FX Enterprise Systems Strategic Plan for the purposes of recommending revisions and approved modifications based on the following:**

## ADDITIONAL ANALYSIS

- **An updated strategic plan was needed** to extend the 3-year original timeline to a complete future state view
- **Several additional analyses** were considered including:
  - An updated scan of **other states' lessons learned**
  - A complete **inventory of all existing technology systems** with an in-depth contract analysis
  - An in-depth evaluation of **procurement alternatives**
  - A study of **provider and recipient experiences and touchpoints**

## LESSONS LEARNED

- A holistic understanding of the Agency and its program constraints (including timelines and resources) is critical for strategic planning
- **Flexibility exists within CMS guidelines for modularity**
- **CMS is shifting toward an outcome-based certification model**
- **Interoperability** with other HHS agencies is **more complex** to achieve than initially anticipated
- **AHCA leadership consensus** is a **critical component** of program success
- **Developing and maintaining partnerships with other states aides AHCA** in understanding both strategic perspectives to modularity and the marketplace response

## WHAT HAS CHANGED

- Florida Agency for Health Care Administration welcomed its **new Secretary, Mary C. Mayhew in 2019** who was not directly involved in the previous strategic plan
- **Several key senior leadership roles** within AHCA (and the FX program) have evolved
- **AHCA's mission and vision** has been updated
- Legislature has mandated **DXC contract to resolve by 2024**
- FX is **further along than its original roadmap** (i.e., IS/IP award and contract, EDW procurement progression)

# STRATEGY REFRESH – SCOPE

## The scope of the three Strategy refresh workstreams created baseline analysis used in the future state roadmap.

| | | |
|---|---|---|
| **PROCESS AND ORG** | **Organizational Scan** | Map the functions and modules to AHCA business units to articulate the impact |
| | **Process Flow** | Develop process flows for Provider and Recipients to identify pain points and opportunities |
| | **Experience Maps** | Develop experience maps for Provider and Recipients to identify and streamline touchpoints |
| | **Inter-Agency Interaction Ecosystem Analysis** | Analyze AHCA's interactions with other agencies to identify opportunities to re-use systems |
| **SYSTEMS AND TECHNOLOGY** | **State Market Scan** | Gather insights and best practices from Medicaid stakeholders in other states on MMIS transformation progress |
| | **Medicaid Enterprise System Inventory** | For each component, capture a description, crucial user groups, the vendor, contract cost, renewal options, interfaces, and alignment to FX modules |
| **COST BENEFIT ANALYSIS** | **Research** | Conduct information gathering and document review sessions |
| | **Validate CBAs** | Review existing Cost Benefit Analyses (CBAs), identify drivers, confirm assumptions, and document calculations |
| | **Conduct Benefit Analysis for Future Modules** | Identify benefits for upcoming FX projects with no drafted CBAs |
| | **Strategy Refresh** | Updated FX Strategic Plan and Strategic Project Portfolio Management Plan, including Legislative communication materials |

# STRATEGY REFRESH – METHODOLOGY

**The strategy refresh focused on analyzing the current state, envisioning a future state, and making recommendations across the organization, its processes, and its systems.**

**The methodology below was used to gain alignment and consensus with Agency Leadership.**

## WORKSTREAMS

### Process and Org
Documented impact on organization and processes, and identified pain points and opportunities

### Systems and Technology
Conducted multi-state market scan, built system inventory, and analyzed technology impacts

### Cost-Benefit Analysis (CBA)
Validated existing benefits and conducted future module benefits analysis

## METHODOLOGY

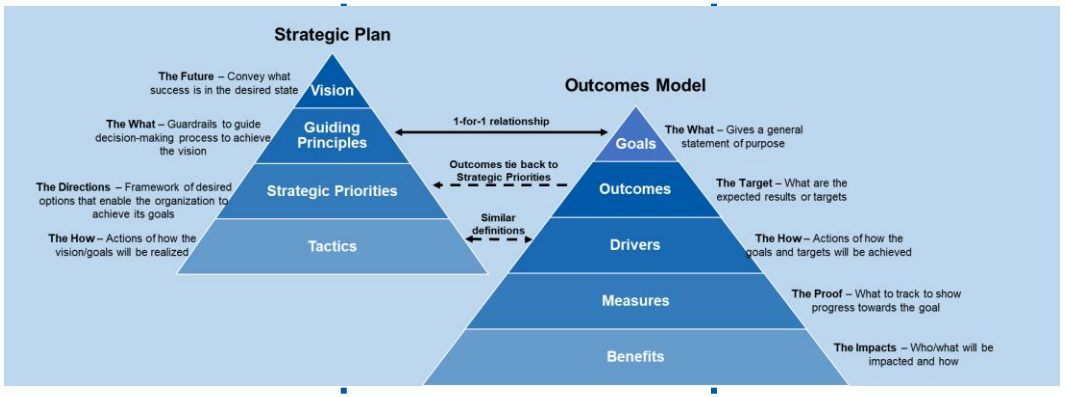
### 1 ASSESS CURRENT STATE
*Identified **Pain Points, Gaps, and Opportunities***

- Identified AHCA & HHS Ecosystem Initiatives
- Process Pain Points and Experience Maps
- State Agency Perspectives
- Analysis of IT Systems and Contracts
- ROI Model Analysis

### 2 ALIGN ON VISION AND GUIDING PRINCIPLES
*Gathered from **Original S3** plan*

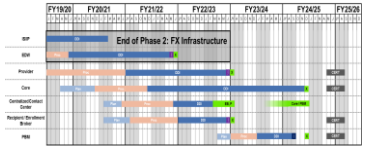
### 3 UPDATE STRATEGIC PRIORITIES
***Identified, validated, and prioritized** Strategic Priorities*

### 4 TRANSLATE PRIORITIES INTO TACTICS
*Leveraged **Strategic Priorities** and Executive Decisions to prioritize projects*

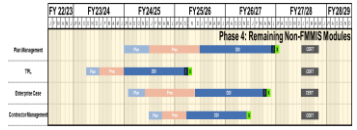



### 5 DEVELOP FUTURE STATE ROADMAP
*Generated **draft roadmap** and **validated with Agency***

*Phase 3*




*Phase 4*



# FUTURE STATE ROADMAP – OVERVIEW

## ROADMAP GUIDELINES

1. **Resolve DXC contract** by 2024
2. **Ensure continuity of operations**
3. **Promote interoperability** among HHS agencies and within AHCA
4. **Pursue transformational improvements** if they do not distract from Roadmap Guideline #1

**DXC contract resolution** by 2024

Includes a plan to ensure **continuity of operations**

**Enables interoperability** through technology and best value

**Provides transformational benefits**

**Minimizes AHCA's resource needs** compared to original approach

**Lowest risk alternative** to Agency with least financial impact

## KEY OUTCOMES

**The Roadmap meets updated Guidelines and Outcomes**

# RECOMMENDATION – OVERVIEW

## TOP 5 STRATEGIC PRIORITIES

- **Reduce DXC costs and integration risk** by accelerating contract resolution
- **Provider Experience**: Streamline credentialing, licensing, improve provider data, and overall experience
- Prioritize ability to have **high-quality, accessible data**, analytics, and reporting
- Prioritize **interoperability opportunities** between Agencies and within AHCA
- Strategically leverage **efficient procurement vehicles** where possible

## RECOMMENDATION

- **Incremental implementation approach** that resolves the DXC contract by December 2024
- **Include transformational items** if they do not delay DXC contract resolution

## KEY BENEFITS

- **Incrementally reduces** scope of DXC contract
- **Accelerates realization of benefits** including resolution of high cost vendor contracts
- Focuses work with fewer **peak resource** requirements
- Provides ability to **continue certifications into cohorts**
- **Reduces costs** from previous Roadmap

# CONDITIONS OF SUCCESS

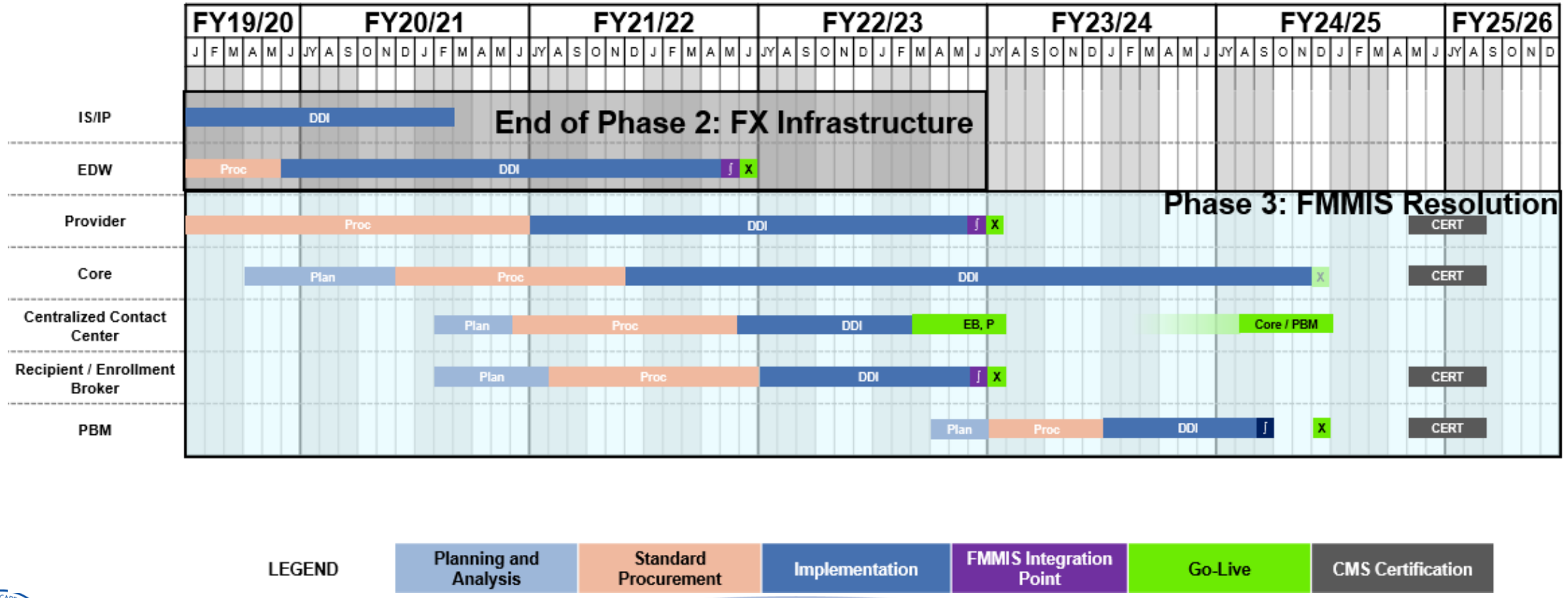
**The Agency identified the following conditions necessary to the success of FX:**

- **Prioritize FX roadmap** plan over other Agency commitments
- **Align staffing plan** with new roadmap to ensure **continuity of operations**
- **Consider alternative procurement** approaches for all modules
- Create a **thorough Organizational Design** as soon as possible
- **Freeze any major enhancements** during critical project cutover – Jan 2024-Dec 2024
- **Streamline decision-making and Governance**

# SEAS RECOMMENDATION: PRIORITIZE FX FMMIS RESOLUTION

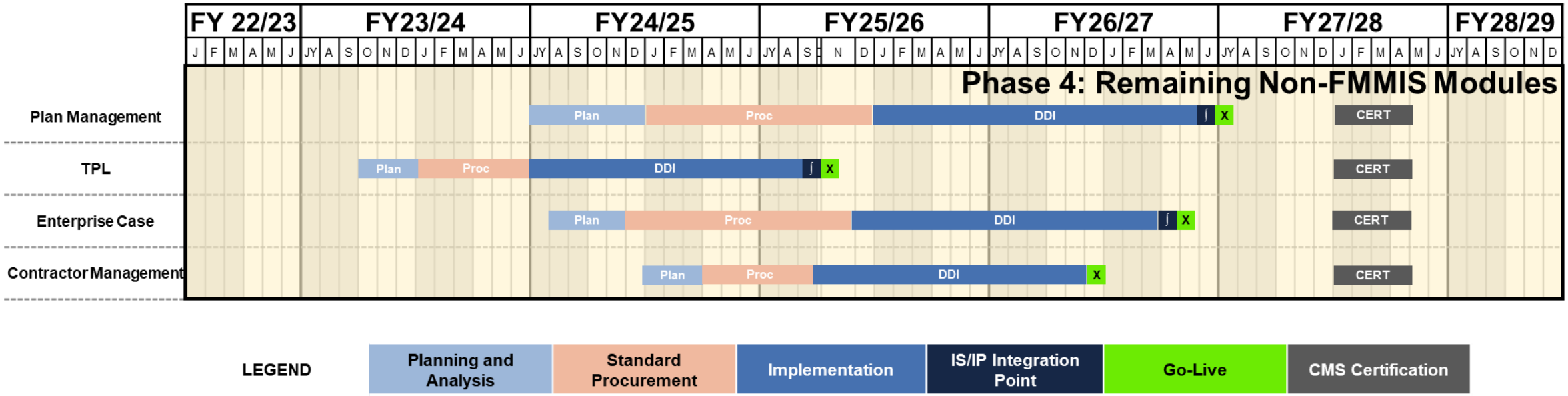
**The initial Phase of the FX transformation is focused on the procurement and implementation of those modules that will fully replace the FMMIS functionality by the required 2024 DXC contract resolution date.**

**These modules include Provider, Core, Centralized Contact Center, Recipient/Enrollment Broker, and Pharmacy Benefit Management.**



# SEAS RECOMMENDATION: REMAINING NON-FMMIS MODULES

**The final phase (Phase 4) of the FX transformation is focused on the procurement and implementation of the remaining modular components required or necessary for delivering world-class health outcomes in Florida that are not tied to the original FMMIS contract with DXC.**



# AGENCY COST IMPACTS – PHASE 3

| Year | Original | Refresh* | Variance | Why? |
|---|---|---|---|---|
| **FY 19-20** | $46.3M | $37.0M | ($9.3M) | • Applied IS/IP actuals |
| **FY 20-21** | $107.8M | $77.5M | ($30.3M) | • **IS/IP Implementation and Operation estimates** reduced to align with executed contract<br>• **Provider Implementation delayed** to future fiscal year reducing estimated costs<br>• **Reduce/Transfer a portion of SEAS support to AHCA**<br>• Core Procurement cost reduced by extending Core Planning by two months |
| **FY 21-22** | $127.5M | $102.6M | ($24.9M) | • **IS/IP Implementation and Operation estimates reduced** to align with executed contract<br>• **Provider Implementation effort decreased** based on new release schedule for Phase 1<br>• Core Implementation reduced to reflect later start date<br>• PBM Planning and Procurement moved from FY21/22 to FY22/23<br>• TPL Planning and Procurement moved from FY21/22 to FY23/24<br>• Recipient Planning effort accelerated to start in FY20/21 reducing costs for planning in FY21/22<br>• SEAS Data Governance operations removed |
| **FY 22-23** | $170.6M | $160.7M | ($9.9M) | • **IS/IP DDI contracted costs lower than estimates**<br>• **Estimated operations and call center costs from Centralized Contact Center lower than estimates of operational staff from module vendors ($170 → $98)**<br>• **TPL, Plan Management, and Contractor Management all moved to Phase 2**<br>• PBM Planning delayed to end of FY 22/23 |
| **FY 23-24** | $172.4M | $114.1M | ($58.3M) | • **Estimated operations and call center costs from Centralized Contact Center lower than estimates of operational staff from module vendors ($170 → $98)**<br>• **TPL, Plan Management, and Contractor Management all moved to Phase 2**<br>• **Care Management pushed to Phase 2**<br>• Recipient/Enrollment Broker Implementation and SW/HW reduced |
| **FY 24-25** | $139.7M | $88.4M | ($51.3M) | • **Estimated operations and call center costs from Centralized Contact Center lower than estimates of operational staff from module vendors ($170 → $98)**<br>• **TPL, Plan Management, and Contractor Management all moved to Phase 2**<br>• **Care Management pushed to Phase 2**<br>• Recipient/Enrollment Broker Implementation and SW/HW reduced |
| **FX Total** | **$764.4M** | **$580.3M** | **($184.0M)** | |

# AGENCY BENEFITS IMPACTS

| Year | Original | Refresh | Variance | Why? |
|---|---|---|---|---|
| **FY 21-22** | $30.0M | $ - | ($30.0M) | • Benefits validation process removed certain intangible, hard to quantify, or low-confidence benefit items<br>• Moved benefits previously realized with IS/IP to Core (starting in FY 2025-26)<br>• EDW benefits moved out to reflect updated timeline |
| **FY 22-23** | $33.0M | $14.3M | ($18.7M) | • Benefits validation process removed certain intangible, hard to quantify, or low-confidence benefit items<br>• Moved benefits previously realized with IS/IP to Core (starting in FY 2025-26)<br>• EDW benefits moved out to reflect updated timeline<br>• Data refreshed with most recent transaction volume and cost factor projections |
| **FY 23-24** | $164.1M | $49.1M | ($115.0M) | • Benefits validation process removed certain intangible, hard to quantify, or low-confidence benefit items<br>• Provider benefits lowered and moved out to reflect updated timeline (partial year benefits realization in FY 2023-24)<br>• Benefits of phased module implementation (e.g., Core) deferred to reflect single module implementation approach<br>• Data refreshed with most recent transaction volume and cost factor projections<br>• Removed benefits of transformational scope that was deferred |
| **FY 24-25** | $161.7M | $130.6M | ($31.1M) | • Estimated Provider benefit lowered in course of benefits validation process<br>• Benefits of phased module implementation (e.g., Core) deferred to reflect single module implementation approach<br>• Data refreshed with most recent transaction volume and cost factor projections<br>• Removed benefits of transformational scope that was deferred |
| **FY 25-26** | $311.7M | $292.9M | ($18.8M) | • Data refreshed with most recent transaction volume and cost factor projections<br>• Removed benefits of transformational scope that was deferred |
| **FY 26-27** | $311.7M | $294.8M | ($16.9M) | • Data refreshed with most recent transaction volume and cost factor projections<br>• Removed benefits of transformational scope that was deferred |
| **FY 27-28** | - | 296.8M | 296.8M | • Additional year added to the FX roadmap – both benefits and costs<br>• Removed benefits of transformational scope that was deferred |
| **FX Total** | **$1,012.1M** | **$1,078.5M** | **$66.3M** | |

# SECTION B

***FX History***

# AGENCY FOR HEALTHCARE ADMINISTRATION (AHCA) OVERVIEW

**AHCA is the chief health policy and planning entity for the State of Florida.**

**Its ~$30B annual budget is the largest in the State.**

- Principal function is providing $27B in Medicaid services to 3.9M recipients, 4th highest in US*
- FL Medicaid pays for:**
  - 47% of all children
  - 63% of birth deliveries
  - 61% nursing home days
- Responsible for licensing ~50,000 healthcare facilities

**AHCA is a complicated, matrixed organization responsible for the following areas:**

**Business Processes**

- Provider and recipient management
- Case management tracking
- Fraud prevention
- Fiscal Agent processing
- Financial administration

**Technical Processes**

- File interfaces with external partners
- Manage business rules
- Manage interfaces with 10 large healthcare Agencies and 18 Health plans

**Services**

- Health Quality Assurance
- Field operations
- Facility regulation
- Facility and Provider licensure and enrollment
- Rate setting
- Plan management

**Data Processes**

- Acquire, validate, store, protect, and process data
- Combine, structure, and cleanse data from multiple external sources

*** 19/20**
****18/19**

# THE AGENCY FACES MULTIPLE CHALLENGES

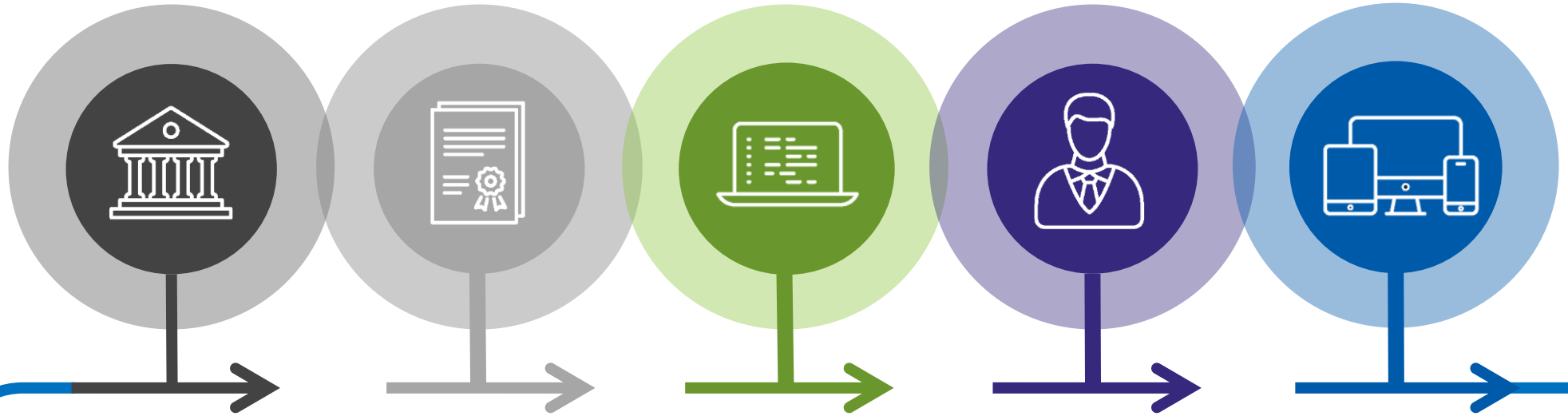
**AHCA has several opportunities to enhance technologies and streamline operations, further enabling the Agency to meet its mission.**

| PAIN POINTS | OPPORTUNITIES |
|---|---|
| ▪ **Existing data quality** limits ability to analyze, manage contracts, set rates, and improve policy, leading to complex data sharing agreements | ✓ Better integrated and maintained data helps improve decision making, and identify **potentially preventable events and fraudulent activity** |
| ▪ **Current processes create a subpar experience** for providers, health plans, and recipients | ✓ **Consolidated contact centers** and streamlined processes greatly improve the experience |
| ▪ The **payment system is an outdated solution** not designed for a managed care environment | ✓ An updated payment system **reduces processing time** |
| ▪ **Fragmented business functions multiply costs** for the Agency, recipients, and providers | ✓ Streamlined processes reduce **costs** and **accelerate service delivery** |
| ▪ **Many current IT vendors are unresponsive** and have made minimal updates to their technology | ✓ More responsive vendors leverage web services to **improve responsiveness** |

***The Florida Healthcare Connections (FX) transformation resolves key Pain Points by delivering focused Outcomes***

# FX REPRESENTS THE AGENCY'S MOST SIGNIFICANT TRANSFORMATION

**The scope of the FX transformation includes replacing the Agency's largest, oldest systems and improving its major processes by an incremental, modular approach.**



### Interagency Collaboration

- FX projects enable better connections to other data programs in FL Health and Human Services (HHS)
- Supports interoperability through flexible solutions and seamless integrations

### Federal Compliance

- Advances Medicaid Information Technology Architecture (MITA) maturity through enabling modularity
- Revised MITA state self-assessment and update process

### Data Quality & Data Analytics

- Real-time data exchange and integration of data and services across systems
- Technologies procured through FX provide ability to conduct complex data analysis of program data

### Operations

- Improved data analytics and reporting enables operating groups to make quicker and better decisions
- Consolidated provider licensure and enrollment streamlines processes
- Centralized Contact Center reduces siloes and creates efficiencies

### Technology

- Provides support for consolidation of disparate technologies and modularity
- Follows MITA technology standards
- Guides procurements to select flexible solutions that can adjust to changing HHS landscape

# ORIGINAL GUIDING FACTORS TO AHCA'S TRANSFORMATION

**The previous Strategic Plan laid the groundwork for a focused transformation guided by Centers for Medicare & Medicaid Services (CMS) mandates and AHCA's Guiding Principles to improve service and healthcare outcomes.**

## Align with CMS IT Priorities

- ***Reduce reliance on one vendor*** providing an integrated system* by mandating multiple vendors providing point solutions
- ***Consolidate data sources*** for Medicaid recipient healthcare and wellness
- Reduce avoidable costs of ***potentially preventable events***
- ***Integrate electronic health records*** with claims and encounter data
- Increasing cross state ***data sharing and integration***

## Leverage New Technologies

- ***"Big Data"*** healthcare organizations have developed solutions to leverage healthcare data to improve health outcomes and reduce fraud
- ***Digital Healthcare requires more and better data*** to leverage AI and algorithms
- ***Telemedicine*** is eliminating state and national geographic boundaries of healthcare regulation and service delivery

## Navigate CMS MMIS

- ***Lack of reliable vendors*** with an established solution
- Previous MMIS replacement projects had been mismanaged: ***over budget by $200M+, implemented 2-3 years later*** than planned
- ***Long implementation timeframes*** meant business processing in system were often obsolete by the time of implementation
- High system maintenance costs and lack of competition greatly ***increased total cost of ownership***

## Consider State of FL IT Landscape

- ***High failure rate for large FL IT projects*** (80% for projects > $40M)
- ***Low spend on systems modernization / replacement***
- Most state systems using ***outdated, legacy technology***
- ***Lack of centralized IT*** leadership and management
- ***Preference to outsource processing*** to get resources and systems
- Data center cost allocation has ***constrained cloud adoption***

***Since 2017, CMS has modified its guidance, technologies have changed, and the FL IT Landscape has created additional learnings***

*Known as Florida Medicaid Management Information System (FMMIS)

# HISTORY OF FX

**Florida Health Care Connections (FX) represents the Agency's largest transformation. It includes replacing the Agency's largest, oldest systems and improving its major processes by an incremental, modular approach.**

## 2013

### Statewide Medicaid Managed Care (SMMC) "Program"

- Implemented in FY 2013-14
- Enables most of Florida's Medicaid population through a managed care delivery system

## 2014

### Florida Medicaid Management Information System (FMMIS) Replacement Initiation

- Contract with North Highland
- Project Management Office established
- FMMIS replacement

## 2016

### Centers for Medicare & Medicaid Services (CMS) Modularity Direction

- Risk of reduced federal funding match from 90/10 to 50/50, additional corrective action plans and financial penalties
- Increased opportunities to maximize Florida's tax dollars

## 2016

### Revised Strategy for Modularity

- Initiated a modular FMMIS replacement
- Developed Strategic Enterprise Advisory Services (SEAS) procurement

## 2017-2019

### FX Project Execution

- Integration Services and Integration Platform (IS/IP) Vendor procured
- Enterprise Data Warehouse (EDW) procurement in process
- Work products for modules in progress
- Original strategic plan and roadmap created (S-3)

## 2020

### Roadmap Update

- Updated module scope and procurement roadmap
- Refreshed staffing and budget estimates for legislature

# KEY ANALYSIS AND CHANGES FROM PREVIOUS PLAN

## Refresh Analysis That Influenced Roadmap Changes

- Executive alignment on **Strategic Priorities, FX Module scope, and sequencing**
- Detailed **system inventory** to determine contract costs and termination dates
- Analysis of **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

## Key Changes from 2020-21 LBR to Recommended Solution

- Roadmap is separated into four Phases:
  - **Phase 3** – Modules that are critical to **DXC Contract Resolution** by 12/31/2024
  - **Phase 4** – Non-critical modules to complete the transformation
- **Centralized Contact Center** allows Agency to reduce call center and operations cost
- Includes a **Customer Relationship Management** (CRM) system to greatly improve provider and recipient experience
- Timing aligns with **contract expiration dates**
- Adjusted to **reduce peak Agency staffing**
- IS/IP, EDW, and Core mostly unchanged

**Additional analysis informed a more detailed and comprehensive Roadmap**

# SECTION C

## *S3/S4 Methodology, Vision, and Guiding Principles*

# STRATEGY REFRESH OVERVIEW

**The strategy refresh focused on analyzing the current state, envisioning a future state, and making recommendations across the organization, its processes, and its systems. The methodology below was used to gain alignment and consensus with Agency Leadership.**

## METHODOLOGY

| 1 ASSESS CURRENT STATE | 2 ALIGN ON VISION AND GUIDING PRINCIPLES | 3 UPDATE STRATEGIC PRIORITIES | 4 TRANSLATE PRIORITIES INTO TACTICS | 5 DEVELOP FUTURE STATE ROADMAP |
|---|---|---|---|---|
| *Identified **Pain Points, Gaps and Opportunities*** | *Gathered from **Original S3** plan* | ***Identified, validated, and prioritized** Strategic Priorities* | *Leveraged **Strategic Priorities** and Executive Decisions to prioritize projects* | *Generated **draft roadmap** and **validated with Agency*** |

- Identified AHCA & HHS Ecosystem Initiatives
- Process Pain Points and Experience Maps
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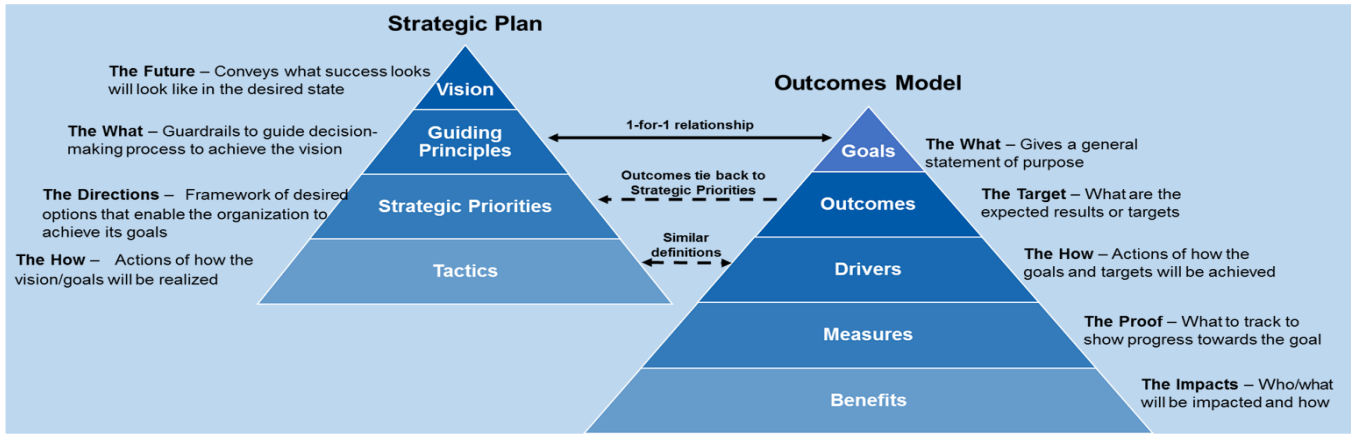
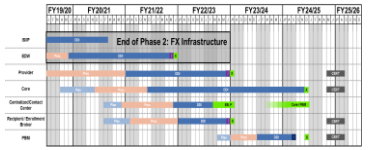
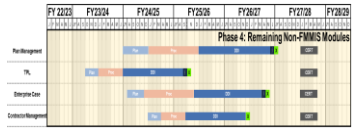



*Phase 3*




*Phase 4*




**The following slides provide further detail on how the team accomplished key project tasks.**

# STRATEGY REFRESH OVERVIEW – METHODOLOGY DETAILS

**SEAS used the methodology below to gain alignment and consensus with Agency Leadership. Below are the specific tasks executed during each part of the methodology.**

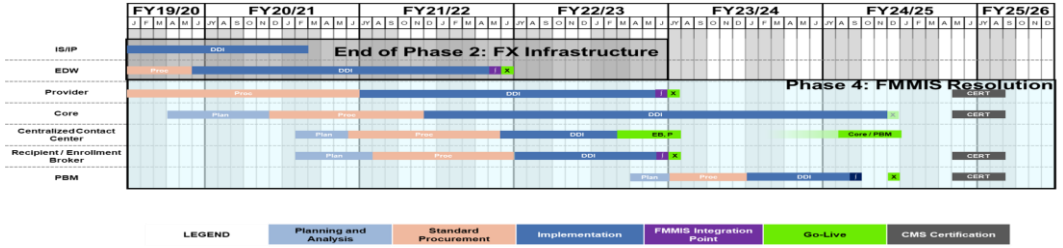
## METHODOLOGY

| 1 ASSESS CURRENT STATE | 2 ALIGN ON VISION AND GUIDING PRINCIPLES | 3 UPDATE STRATEGIC PRIORITIES | 4 TRANSLATE PRIORITIES INTO TACTICS | 5 DEVELOP FUTURE STATE ROADMAP |
|---|---|---|---|---|
| *Identified **Pain Points, Gaps and Opportunities*** | *Gathered from **Original S3** plan* | ***Identified, validated, and prioritized** Strategic Priorities* | *Leveraged **Strategic Priorities** and Executive Decisions to prioritize projects* | *Generated **draft roadmap** and **validated with Agency*** |
| ▪ Identified and assessed AHCA and Health and Human Services (HHS) opportunities<br>▪ Documented current state processes using process mapping, and documented pain points<br>▪ Completed market scan of Medicaid transformations in other states<br>▪ Created a comprehensive sys-tems inventory<br>▪ Documented all existing contract details, expiration dates, and extension options<br>▪ Assessed all existing CBAs and associated benefits<br>▪ Analyzed organization maps, impacts, and resources | ▪ Reviewed and confirmed the Agency's vision and FX guiding principles with Agency leadership<br>▪ Updated the FX vision with input from Agency leadership | ▪ Generated list of recommended Strategic Priorities from industry and AHCA SMEs<br>▪ Agency leadership built on and refined list<br>▪ Agency leadership ranked the new drafted Strategic Priorities<br>▪ Strategy team combined all rankings and inputs to create an updated list of Strategic Priorities | ▪ Conducted a scenario-building session to identify major tactical and sequencing decisions<br>▪ Developed an inventory of decisions requiring Agenc y leadership input<br>▪ Conducted multiple tactical decisions evaluating each approach<br>▪ Strategic Priorities helped provide guardrails when making sequencing decisions<br>▪ Translated decisions made into key tactics | ▪ Based on agreed-upon sequencing decisions and tactics, SEAS developed a new future state roadmap<br>▪ SEAS presented the draft future state roadmap to the Agency and incorporated suggestions |

**The following slides provide further detail on how the team accomplished key project tasks.**

# PHASE III - ROADMAP INFLUENCERS

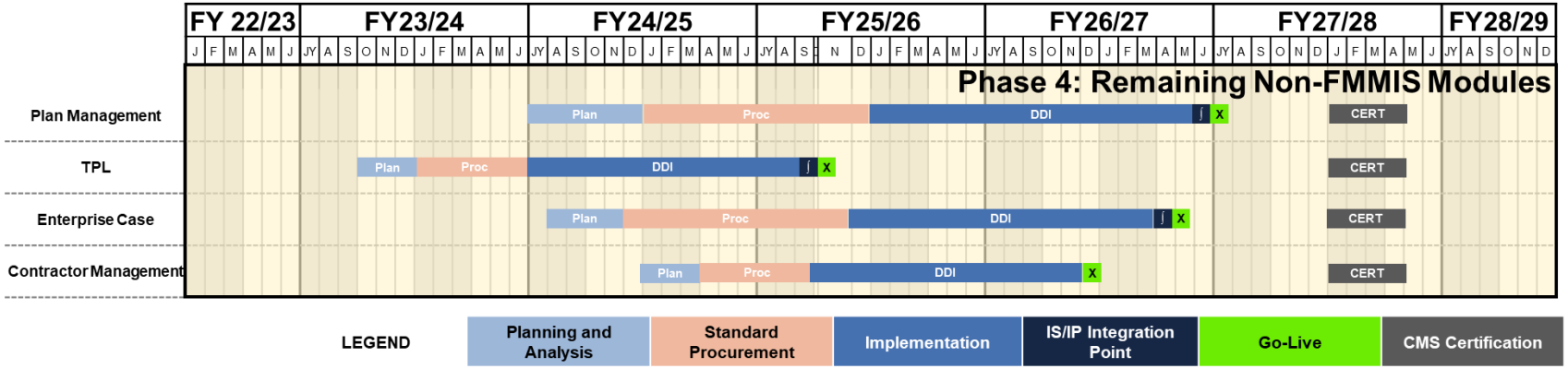
**The initial phase of the roadmap development was influenced by several variables and factors linked to the statutory requirement of contract resolution by December 31, 2024.**




- Do not impact or modify existing in-flight projects (IS/IP, EDW, Provider)
- Focus on top five Strategic Priorities
- Identify modules necessary to resolve the Fiscal Agent Contract
- Consider contract expiration dates and extension options as constraints (Enrollment Broker, Pharmacy Benefit Manager)
- Recognize that there is little leeway for the timing of the Core module, it has the longest timeline
- Maximize the value of reducing the Fiscal Agent contract by bringing new functionality live in two integrations
- Group modules into Cohorts for Certification
- Consolidate operational and phone-based personnel into a Centralized Contact Center to improve stakeholder experience and reduce operational cost

# PHASE IV - ROADMAP INFLUENCERS

**The final phase of the roadmap development focused on non-FMMIS transformational modules and was impacted by fewer influencers.**




- Consider contract expiration dates and extension options (Electronic Visit Verification and Third-Party Liability)
- Recognize the effects of delaying the re-procurement of Statewide Medicaid Manage Care
- Maximize the ability to hold Managed Care vendors accountable by the Plan Management Module

# FX'S VISION SUPPORTS THE AGENCY'S VISION

**The FX Vision will guide the entire MES modular transformation, supported by the Guiding Principles.**

**AHCA VISION**

"A high-quality, safe, and affordable health care delivery system for all Floridians."

**FX VISION**

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

# FX GUIDING PRINCIPLES

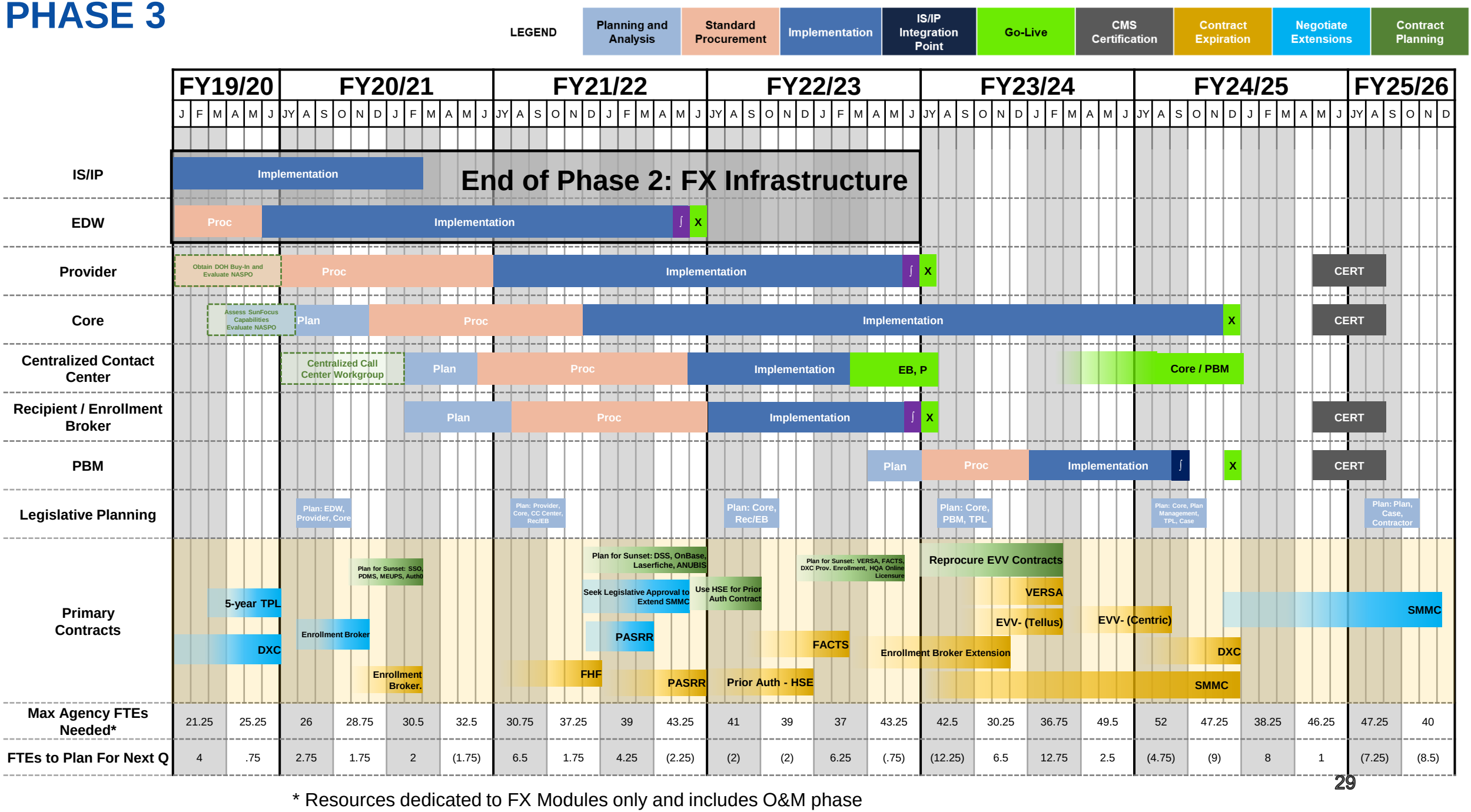
**The "Guardrails" to guide the decision-making process to achieve the vision**

- Enable High-Quality and Accessible Data
- Improve Health Care Outcomes
- Reduce Complexity
- Use Evidence-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

# SECTION D

***Next Steps***

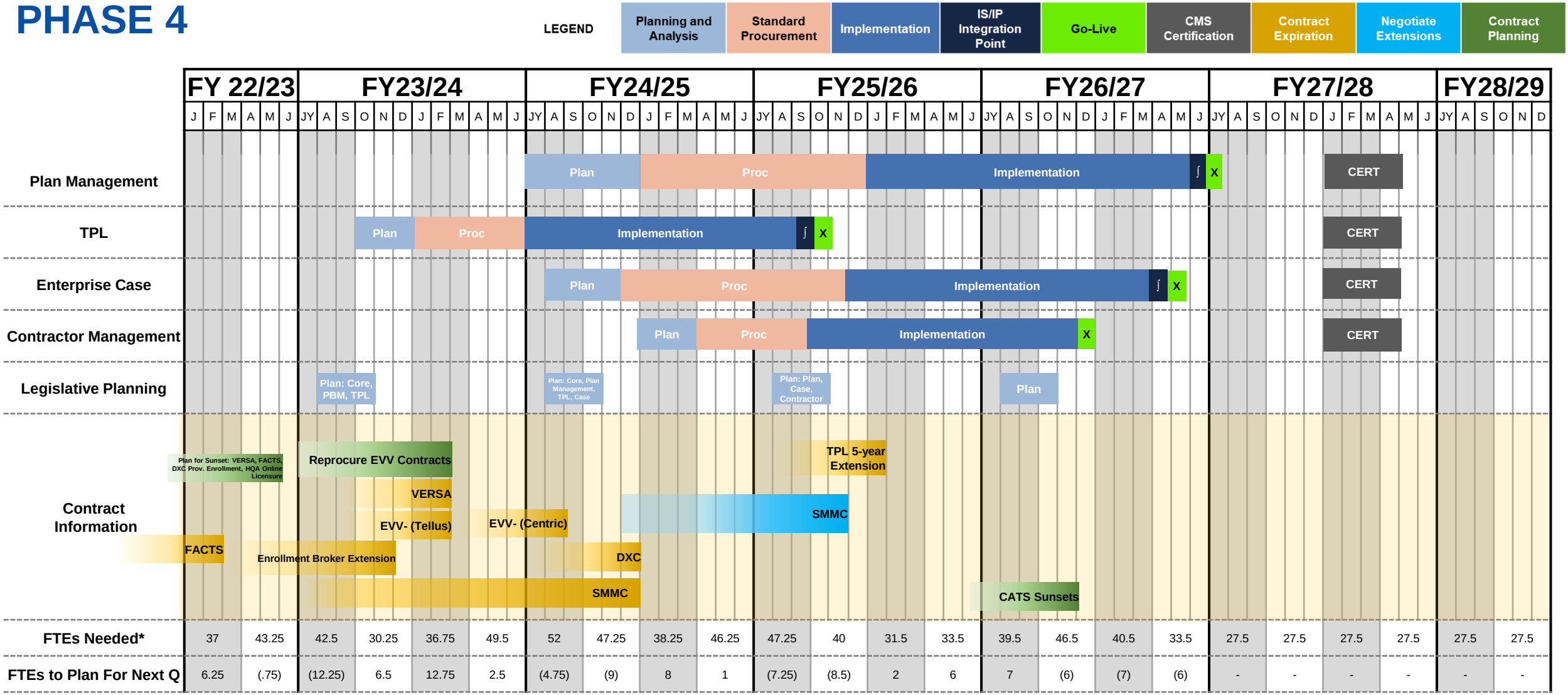
# PHASE 3




| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Max Agency FTEs Needed* | 21.25 | 25.25 | 26 | 28.75 | 30.5 | 32.5 | 30.75 | 37.25 | 39 | 43.25 | 41 | 39 | 37 | 43.25 | 42.5 | 30.25 | 36.75 | 49.5 | 52 | 47.25 | 38.25 | 46.25 | 47.25 | 40 |
| FTEs to Plan For Next Q | 4 | .75 | 2.75 | 1.75 | 2 | (1.75) | 6.5 | 1.75 | 4.25 | (2.25) | (2) | (2) | 6.25 | (.75) | (12.25) | 6.5 | 12.75 | 2.5 | (4.75) | (9) | 8 | 1 | (7.25) | (8.5) |

* Resources dedicated to FX Modules only and includes O&M phase

# PHASE 4




| | FY 22/23 | | FY23/24 | | | | FY24/25 | | | | FY25/26 | | | | FY26/27 | | | | FY27/28 | | | | FY28/29 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FTEs Needed* | 37 | 43.25 | 42.5 | 30.25 | 36.75 | 49.5 | 52 | 47.25 | 38.25 | 46.25 | 47.25 | 40 | 31.5 | 33.5 | 39.5 | 46.5 | 40.5 | 33.5 | 27.5 | 27.5 | 27.5 | 27.5 | 27.5 | 27.5 |
| FTEs to Plan For Next Q | 6.25 | (.75) | (12.25) | 6.5 | 12.75 | 2.5 | (4.75) | (9) | 8 | 1 | (7.25) | (8.5) | 2 | 6 | 7 | (6) | (7) | (6) | - | - | - | - | - | - |

* Resources dedicated to FX Modules only and includes O&M phase

# IMPLEMENTATION NEXT STEPS

**The Strategy Team has compiled detailed implementation steps for consideration by the FX Team based on the development of the new strategic plan and its associated future state roadmap.**

## Phase 3

Phase 3 includes all of the FX Program's modules that represent existing business areas and operations. These are critical items to resolve the DXC contract:

- ***Module timeline*** for all modules ***related to DXC.*** Includes each module's planning, procurement implementation, Go Live, and certification timing.
- ***Primary contracts*** related to the modules. Includes ***contract expiration, negotiation, and planning*** recommendations.
- ***# of FTEs needed per quarter***
- ***# of FTEs to plan*** for in the ***following quarter***

## Phase 4

Phase 4 is the FX Project's final phase and includes technologies that are intended to transform AHCA's business processes. It includes the following:

- ***Module timeline*** for all modules ***not related to DXC.*** Includes each module's planning, implementation, Go Live, and certification timing.
- ***Primary contracts*** related to the modules. Includes ***contract expiration, negotiation, and planning*** recommendations.
- ***# of FTEs needed per quarter***
- ***# of FTEs to plan*** for in the ***following quarter***

## Contract Details by FY

Describes considerations particular to each fiscal year. Considerations are related to the following:

- ***Contract extensions / negotiations***
- ***Stakeholder engagement***
- ***Module capabilities***
- ***Procurement Options***
- ***Centralized Contact Center Workgroup***
- ***Sunset Plans***

# CONTRACT DETAILS BY FISCAL YEAR

## 7/1/2019 – 6/30/2020

The Agency is advised to negotiate extensions of contracts, get buy-in from stakeholders, assess module capabilities, and review the appropriate procurement method for upcoming modules.

### Contract Extensions/Negotiations

- Begin negotiations with Fiscal Agent (FA) immediately. Need to extend through December 2024
- TPL contract expires 8/31/2024. Can extend through 5 years. Assess vendor in March 2020, and negotiate for 5-year extension

### Stakeholder Engagement

- Engage DOH to confirm participation in development, procurement, funding, and interoperability

### Module Capabilities

- Begin planning for Core April 2020
- Initiate SunFocus evaluation

### Procurement Options

- Assess NASPO capabilities for the Provider module.
- NASPO is currently working with states on requirements for a claims and encounter module. Start Core NASPO assessment in March 2020

## 7/1/2020 – 6/30/2021

The Agency is advised to negotiate or execute extensions of contracts, form a workgroup to scope the Centralized Contact Center, and plan for the sunsetting of current functionality or systems..

### Contract Extensions/Negotiations

- Extend DXC contract through December 2024. Continue negotiations this year to ensure cooperation.
- Continue TPL negotiations. TPL contract expires 8/31/24. Can extend up to 5 years.
- Enrollment Broker contract expires 3/31/21, so begin negotiations in January.

### Centralized Contact Center Workgroup

- Form workgroup in July 2020 to review infrastructure, operations, communication, and print and mail operations.
- Evaluate resources from Agency to support.

### Sunset Plan

- Plan sunsetting of systems due to IS/IP Go Live

# CONTRACT DETAILS BY FISCAL YEAR

## 7/1/2021 – 6/30/2022

The Agency is advised to negotiate extensions of contracts, execute renewal options or a reduction in services under an existing contract, begin discussions with Legislative staff to seek approval of an extension for the Statewide Medicaid Managed Care contracts, and plan for the sunsetting of current functionality or systems.

### Contract Extensions/Negotiations

- Florida Health Finder contract expires 12/31/21, which has options for 5 one-year renewals. Agency should extend renewals to extend the contract beyond July 2023. Contract includes 3, 1-year renewal options.
- Phase 1 of Centralized Contact Center goes live July 2023, including Recipient functionality.
- Start negotiations with enrollment broker in January 2023.

### Stakeholder Engagement/Legislative Discussions

- Statewide Medicaid Managed Care contracts expire 12/31/2023. Extend contracts prior to session SFY 23/24.
- Address staffing prior to December 2021.

### Sunset Plan

- Plan sunset functionality affected by EDW Go Live that occurs on July 2022.

## 7/1/2022 – 6/30/2023

The Agency is advised to procure a prior authorization vendor, execute a new purchase order to extend cloud services for the Fraud Abuse Case Tracking System (FACTS), and plan for the sunsetting of current functionality or systems.

### Contract Extensions/Negotiations

- Prior Authorization contract expires on 12/31/2022. Agency should follow the Health Services Exemption.
- FACTS contract expires 2/1/2023. Agency will need a new purchase order to continue FACTS throughout module implementation.

### Sunset Plan

- Plan for system functionality sunsetting associated with the Provider module, scheduled to go live July 2023. Begin planning in December 2022.

# CONTRACT DETAILS BY FISCAL YEAR

## 7/1/2023 – 6/30/2024

The Agency is advised to procure a prior authorization vendor, execute a new purchase order to extend cloud services for the Fraud Abuse Case Tracking System (FACTS), and plan for the sunsetting of current functionality or systems.

**Contract Extensions/Negotiations**

- Both Electronic Visit Verification (EVV) contracts expire 2024.
- The agency should begin procurement process at beginning of the fiscal year.

## 7/1/2024 – 6/30/2025

The Agency is advised to sunset the Pharmacy Rebate Information Management System (PRIMS) and the Pharmacy Benefit Management System (PBMS).

**Sunset Plan**

- Pharmacy Benefits module goes live October 2024. Then, the Agency will no longer need PRIMS and PBMS services from DXC and Magellan. These contracts expire January 2025.
- Core module completes 2024, so the Agency can then eliminate the Fiscal Agent.

## 7/1/2025 – 6/30/2026

The new TPL module will go-live in November 2025. The contract with the current vendor expires on 2/1/2026, allowing contingency for any delay in implementation.

## 7/1/2026 – 6/30/2027

The new Contractor module will go-live in December 2026. Beginning in July 2026, the Agency should begin planning for the sunset of the Contract Administration Tracking System (CATS).

# SECTION E

## *Module Definition and Scope*

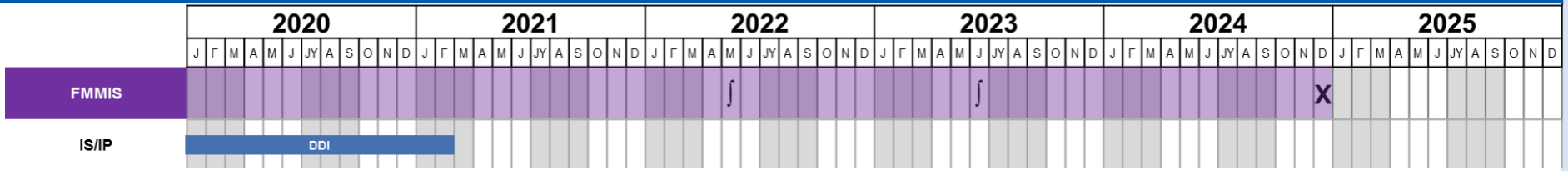
# MODULE DEFINITION

## MODULE DEFINITION

Includes the scope and services of each module. Describes details on each module component. Components include technological functions that the proposed module software needs to address during implementation.  Also includes description of the current and future state, and anticipated benefits of the business area associated with each module. These defined module definitions will ensure the Agency procures vendors that are able to provide the required services, and helps the Agency, SEAS, and future vendors conduct activities that are within scope of the project.

# PHASE 2:FX INFRASTRUCTURE – IS/IP IS IN-FLIGHT

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- Continue the current strategy for implementation for IS/IP with Accenture.

**Implementation**

- Estimated Design, Development, and Implementation (DDI) duration of 14 months, ending in February 2021.

## PEAK RESOURCE DEMANDS BY QUARTER (AGENCY | SEAS)

| FY 2019-20 | | | | | | | | FY 202020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | | Q1 | | Q2 | | Q3 | | Q4 | |
| **7** | 1.25 | **3** | 6.5 | **6** | 6.5 | **6** | 6.75 | **7.5** | 6.75 | **7.5** | 6.75 | **7.5** | 6.75 | ***2.5*** | - |

**Agency** | SEAS

## VENDOR / SYSTEM CONTRACTS RESOLVED WITH MODULE

**February 2021**

- MEUPS (the DXC single sign-on) and the Provider Data Management System can be sunset. Additional annual hosting expenses for Provider Data Management System ($200K) will be avoided.

## IS/IP Scope

*Enterprise Service Bus, Service Registry, Business Rules Engine, Managed File Transfer, Application Monitoring and Lifecycle Management, Master Person Index, Single Sign-On*

# IS/IP: SCOPE OF SERVICES AND DEFINITIONS (1/2)

| | |
|---|---|
| **IS/IP** | IS/IP serves as the conduit, or interface, through which all information is requested and returned. It includes an Enterprise Service Bus, which controls information flow in and out of all modules. It also includes a Business Rules Engine, to help ensure all federal and state rules are accurately applied, while the Service Registry maintains an inventory of services across all systems. IS/IP is coupled with the Master Person Index/Master Organization Index and Single Sign-On. |
| **ENTERPRISE SERVICE BUS** | The ESB is a tool that connects modular systems and simplifies components talking to each other. The ESB provides the technical connections, data format transformation, and the business policy rules for accessing other services and modules. |
| **SERVICE REGISTRY** | The Service Registry is a directory or list of services available to the user. When information in modules becomes available, they are published. You are able to find services and to be notified of availability. |
| **BUSINESS RULES ENGINE** | The Business Rules Engine is what holds rules to permit appropriate actions. The Business Rules Engine holds internal security requirements, federal and state legal requirements, and business requirements. |
| **MANAGED FILE TRANSFER** | MFT is the system that handles incoming data files and directs the files to the correct groups, roles, or individuals. |
| **APPLICATION MONITORING** | Application Monitoring helps ensure that applications meet performance standards and provides a quality user experience, while tracking and measuring application performance and availability. |

# IS/IP: SCOPE OF SERVICES AND DEFINITIONS (2/2)

| | |
|---|---|
| **APPLICATION LIFECYCLE MANAGEMENT** | ALM is a repository and processing methodology to develop and maintain systems. The ALM leverages requirements, design details, and validates against previous testing results to help ensure quality and reduce long-term maintenance costs. |
| **MASTER PERSON AND ORGANIZATION INDEX** | Master Person Index and Master Organization Index processes person or organization record requests to find and present a list of matches from across HHS agencies. The reviewing employee then selects and confirms the correct record. |
| **SINGLE SIGN-ON** | SSO is a service that simplifies user access to multiple systems by managing authentication of users across multiple systems. |

# IS/IP – INTEGRATION SERVICES AND INTEGRATION PLATFORM

## CURRENT STATE

- Point-to-point to/from system integrations
- Multiple sign-on/ authentication solutions
- Minimal testing of business rule changes
- Batch file interfaces
- Proprietary data interface formats

## FUTURE STATE

- Reduced number of interfaces
- Single sign-on and authentication solution
- Real-time data requests
- Standardized data names and types
- Single source of policy / business rules
- Real-time identity matching
- Master Person and Master Organization Index

## BENEFITS

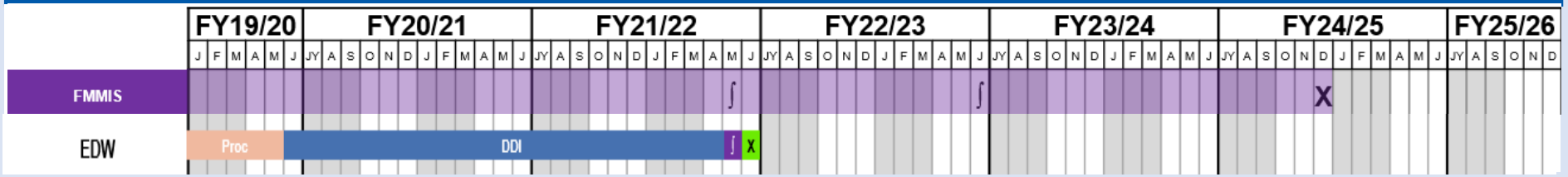
- Creates a platform that allows AHCA and HHS systems to integrate as a service, reducing escalating future costs of integrations with later technology vendors
- Provides a single sign on and administrative layer for all AHCA systems connected to IS/IP, simplifying password resets
- Reduces user provisioning and off-boarding costs
- Master Person and Master Organization Index helps identify duplicate providers
- 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
- Reduces liability for audit findings of duplicated payment

$0

**Benefits figure represents total validated benefits through FY27-28**

# PHASE 2:FX INFRASTRUCTURE – EDW IS IN-FLIGHT

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- Continue the current strategy for procurement and implementation of EDW – currently in evaluations.

**Implementation**

- Estimated DDI duration of 24 months, ending in May 2022.

## PEAK RESOURCE DEMANDS BY QUARTER (AGENCY / SEAS)

| FY 2019-20 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 7 | 1.25 | 5.25 | 2.75 | 9 | 0.75 | 7 | 6 |

| FY 2020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 6.25 | 12 | 9 | 9.5 | 9 | 5.5 | 9 | 5.5 |

| FY 2021-22 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 11 | 5.5 | 12 | 8.5 | 14.5 | 9.5 | 14.5 | 9.5 |

| FY 2022-23 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 9.5 | 8.5 | 2.5 | - | | | | |

**Agency** | SEAS

## VENDOR / SYSTEM CONTRACTS RESOLVED WITH MODULE

**June 2022**

- The DSS and Onbase scope of the DXC contract ($2.2M and $705K annually respectively), and the Laserfiche system ($230K annually) can be sunset.

## EDW Scope

*Operational Data Management, Analytics Data Management And Tools, Content Management, and Data Management Organizational Transformation*

# EDW: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **EDW** | The EDW solution is the combination of software, hardware, infrastructure, and services to enable data management and analytics of healthcare data for the Florida Health Care Connections. EDW provides comprehensive data management and reporting to advance the Agency's goal of transforming to an enterprise, modular, and flexible MMIS solution. EDW provides a common platform for future modules to store and access data. |
| **OPERATIONAL DATA MANAGEMENT** | EDW will establish a modernized operational data management platform Operational Data Store (ODS) and migrate Agency data to the new platform. Agency systems and business users will access the data using data services. The ODS will be organized by subject area to support the high volume, extremely large data needs of the healthcare ecosystem. |
| **ANALYTICS DATA MANAGEMENT AND TOOLS** | This includes a reporting data store used for real-time dashboards and ad hoc access, a data warehouse for standard analytics, data marts optimized for specific business units or types of analysis, specialized data marts (e.g., dynamic data marts to address specialized analysis), and provides data analysis tools. |
| **CONTENT MANAGEMENT** | Content management includes the document management needs of all Agency systems. This scope includes the provision of scanning equipment, and workflow solutions to support content ingestion processes. |
| **DATA MANAGEMENT ORGANIZATIONAL TRANSFORMATION** | This scope includes managing the organizational change and the evolution of the Agency data assets required by the EDW Solution, and the provision of tools to enable systems and stakeholders to use the EDW Solution. |

# ENTERPRISE DATA WAREHOUSE

## CURRENT STATE

- Poor and inconsistent data quality across units
- Limited access to operational data, with 2-3 week latency period
- Complex adjustment processing and historical reporting
- High conversion costs
- Poor query and analytic processing response time
- Manual manipulation of data; large number of reports not used

## FUTURE STATE

- Own and control operational data store
- Retire unused reports
- Access operational data in near real-time Reporting Data Store
- Easily updated analytic capability built on a cloud platform

## BENEFITS

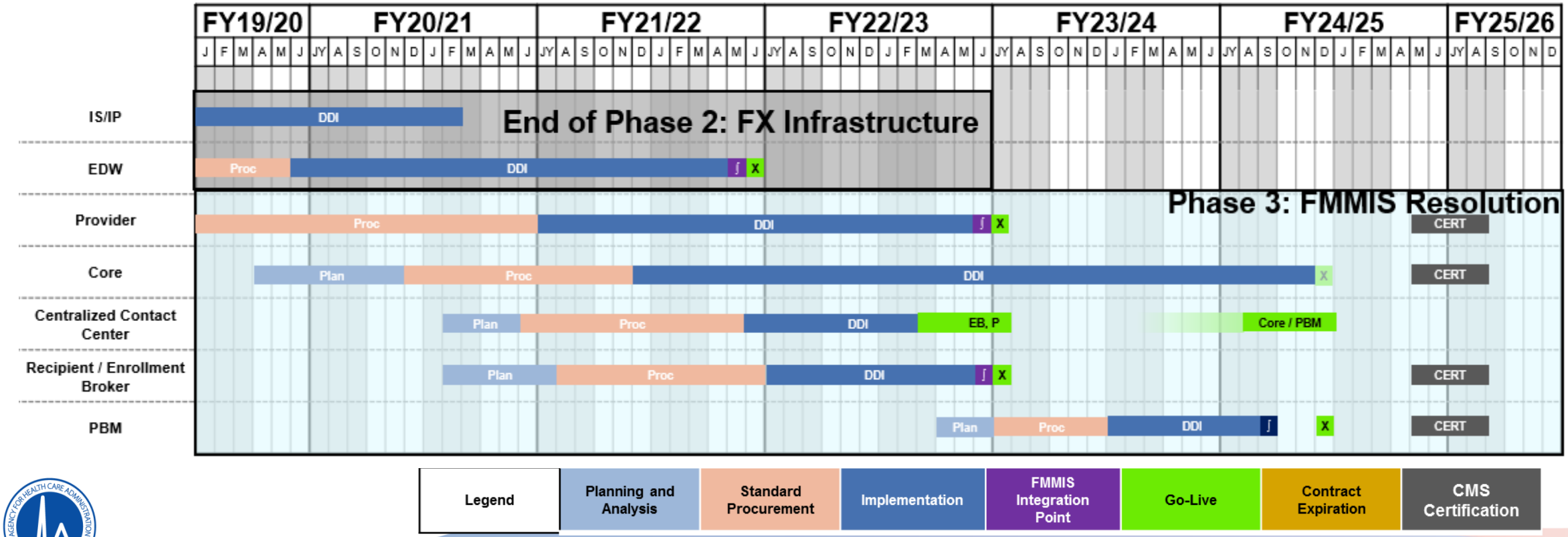
- Improved data analytics and dashboards will enable Agency staff to enhance their monitoring of plan performance, network adequacy, and quality improvement activities
- Improved analytic tools and machine learning will increase identification and recovery of fraud and improper payments
- Improved staff productivity
- Reduced system maintenance and operations cost (software)
- Improved analytic tools, processing speed, and persona optimized data stores
- Reduced data protection risk and cost

**$102M**

**Benefits figure represents total validated benefits through FY27-28**

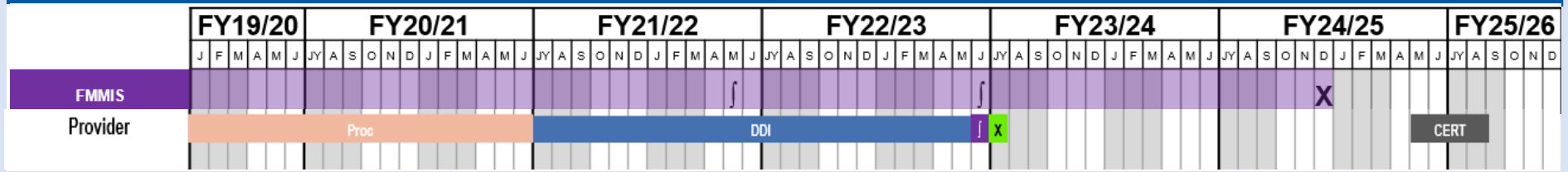
# PHASE 3: FX FMMIS RESOLUTION

**The current FMMIS contract with DXC Technology supports contract extensions through 12/31/2024. It is anticipated that the functions currently performed in the Fiscal Agent contract, FMMIS, or DSS will be replaced with a robust, modern group of health care modules, incorporating other Agency business processes and related processes from the entire Medicaid enterprise. Phase 3 of the FX transformation is focused on the procurement and implementation of these modules that will fully replace the FMMIS functionality by the required 2024 DXC contract resolution date. These modules include Provider, Core, Centralized Contact Center, Recipient/Enrollment Broker, and Pharmacy Benefit Management.**



# PHASE 3: PROVIDER IS IN-FLIGHT

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- The roadmap above reflects conservative estimates on the maximum possible length remaining for a competitive ITN procurement on Provider: 18 months remaining. SEAS recommends the Agency utilize National Association of State Procurement Officials (NASPO) procurement vehicle which will significantly reduce this timeline.

**Implementation**

- Estimated DDI duration of 24 months, ending in June 2023 at the latest.

## PEAK RESOURCE DEMANDS BY QUARTER (AGENCY / SEAS)

| FY 2019-20 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 7 | 7 | 7 | 7.5 | 6.25 | 6 | 7 | 4.5 |

| FY 2020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 7 | 3.5 | 7 | 3.5 | 7 | 3.5 | 7 | 3.5 |

| FY 2021-22 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 3.25 | 6 | 4 | 6.5 | 5 | 7.5 | 5 | 7.5 |

| FY 2022-23 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 5 | 7.5 | 7.5 | 7.5 | 9.5 | 8.5 | 9.5 | 8.5 |

| FY 2023-24 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 6.5 | 7.5 | *2.5* | - | | | | |

**Agency** | SEAS

## VENDOR / SYSTEM CONTRACTS RESOLVED WITH MODULE

**July 2023**

- The Provider Enrollment and Provider Field Services scope of the DXC contract ($4.3M and $1.4M annually respectively), the Versa Regulation system ($201K annually), and the Fraud and Abuse Case Tracking system can be sunset. In addition, the PNV scope from the AHS enrollment broker contract should be sunset which will result in a reduction in the $15M annual contract.

**Provider Scope**

*Licensure, Credentialing, Enrollment, Maintenance, PNV*

# PROVIDER: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **LICENSURE** | Provider Licensure is currently performed by DOH (Individual) and Health Quality Assurance (Facility) which requires providers to submit required information to multiple systems. The Provider Management Module will consolidate the Licensure process into a single source, which will streamline this process and minimize errors and confusion in the Provider community. |
| **CREDENTIALING** | Provider Credentialing is required for each Health Plan that a Medicaid provider seeks to be affiliated with. Providers are currently required to submit duplicative information to each Health Plan, which creates significant administrative burden. The PMM will provide a single source for the Provider community to enter required information, which will alleviate much of the administrative burden. |
| **ENROLLMENT** | Provider Enrollment is currently performed by the Fiscal Agent (DXC) in coordination with Medicaid Fiscal Agent Operations (MFAO). The process is a mix of manual and automated processes which can lead to errors and cause delays in enrolling providers. This process also requires providers to submit information which may be duplicative to the licensure process. The Provider Management Module will significantly automate this process, reducing data entry errors and time to become enrolled as a Medicaid provider. |
| **MAINTENANCE** | Provider Maintenance currently requires the provider community to log into multiple systems to make any changes to their information on file. This creates confusion for providers and can also create inconsistent provider information across the Medicaid ecosystem which can cause deficiencies in areas such as claims processing. The PMM will allow providers to make any necessary changes to their information in a single source, thereby reducing administrative burden and errors in provider related business processes. |
| **PROVIDER NETWORK VERIFICATION** | Each health plan must contain a certain number of providers based on geographic characteristics. The PNV scope includes gathering the information to validate that provider networks meet these requirements for each plan. |

# PROVIDER

## CURRENT STATE

- Multiple systems and portals with conflicting provider data between disparate systems
- Incomplete and inaccurate data is submitted due to key validation steps not included in portal
- Paper application submitted by facilities with 85% containing omissions
- Lack of visibility into provider licensure or Medicaid application status

## FUTURE STATE

- Consolidated licensure (professional & facility), Medicaid enrollment (re-enrollment and renewal), and plan credentialing into a concurrent process
- Automated account management updates triggered through electronic interfaces or initiated by the provider
- Streamlined licensure/enrollment process with workflow assignment and efficient business processes for Agency staff reviews and approvals
- Easily updated analytic capability built on cloud platform
- Quality data and analytics supported by IS/IP and EDW

## BENEFITS

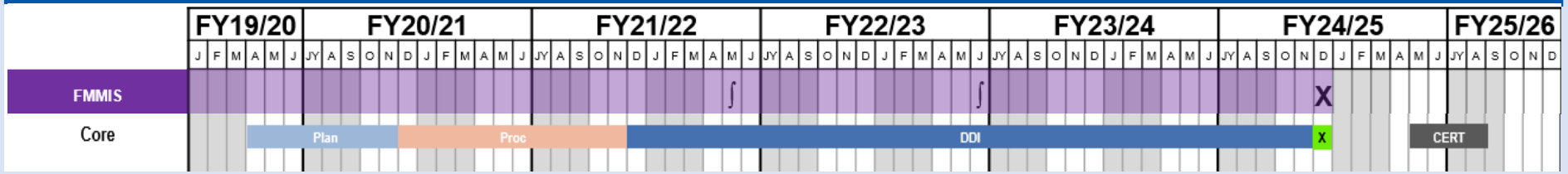
- Unified enrollment process across AHCA divisions and partner agencies
- Reduced time to enroll and license a Medicaid provider
- Single source of credentialing, as well as single source to report a change across agencies
- Incentivize providers to participate in Medicaid and strengthen plan networks
- 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 CHOW being denied by Agency

**$204M**

**Benefits figure represents total validated benefits through FY27-28**

# PHASE 3: CORE

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- Initiate planning immediately, analyzing use of NASPO.
- Review existing financial management functions to see if they meet needs for healthcare payment submission, processing, and payment activities for claim and encounter processing.
- Evaluate if Core vendor can also provide Third Party Liability scope.

**Implementation**

- Conservative estimated DDI duration of 36 months, ending in November 2024.
- Conduct testing for a single cutover of Core and PBM functions as early as possible to mitigate risk – no later than November 2024.

**Action Items**

- AHCA to confirm SunFocus project led by current vendor will suffice for the financial component of Core
- Due to high volume of procurements in 2023 and 2024 (both EB and Core) the Agency should seek special legislative approval to delay the SMMC procurement by 2 years, to 2025

## PEAK RESOURCE DEMANDS BY QUARTER (AGENCY / SEAS)

| FY 2019-20 | | | | | | | | FY 2020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | | Q1 | | Q2 | | Q3 | | Q4 | |
| | | | | | | 5.25 | 8 | 5.25 | 8 | 5.25 | 8 | | | | |

| FY 2021-22 | | | | | | | | FY 2022-23 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | | Q1 | | Q2 | | Q3 | | Q4 | |
| | | 5.5 | 10.5 | 5.5 | 10.5 | 7 | 11.5 | 13 | 19.5 | 13 | 19.5 | 9 | 13.5 | 9 | 13.5 |

| FY 2023-24 | | | | | | | | FY 2024-25 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | | Q1 | | Q2 | | Q3 | | Q4 | |
| 9 | 13.5 | 9 | 13.5 | 11 | 13.5 | 15.5 | 15.5 | 15.5 | 15.5 | 9.5 | 9.5 | 2.5 | - | | |

## VENDOR / SYSTEM CONTRACTS RESOLVED WITH MODULE

**December 2024**

- The EDI, Claims, Encounters, Banking, and all remaining scope of the DXC contract (representing about $44.5M annually) can be sunset.

**Core Scope**

*EDI, Claims, Encounters, Financial Management (claims payments and banking operations)*

# CORE (1/3) – CLAIMS: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **PROCESS CLAIMS** | New fee for service operations management module designed to handle all functions related to fee for service claims processing (editing and auditing), payment calculation, and related operations. |
| **ELECTRONIC DATA INTERCHANGE** | The new EDI processing will include enhanced claim validation processing of the claim using reference data. The front-end validation business rules and policy will become the source of truth for claim logic. All transaction data for payment models will pass directly to the EDW. |
| **EDITS** | This process includes performing of SNIP-level ASC X12N edits for valid syntax and format, identifiers and codes, and dates. In addition, non-fatal edits to determine claim status as initial, adjustment to a processed claim, or a duplicate submission that is already in the adjudication process but not yet completed and loaded into payment history. It includes the validation of provider information (e.g., provider taxonomy, National Provider Identification (NPI), enrollment status, approved to bill for service) and validates member information (e.g., member's eligibility status on the date of service, apply third-party resources to the claim). |
| **AUDITS** | This process includes checking payment history for duplicate processed claims. The process also includes: reviews for service authorization, referral, or treatment plan; checks for clinical appropriateness of the services provided based on clinical, case, and disease management protocols; performance of prospective payment integrity checks; and validation of National Correct Coding Initiative (NCCI). |
| **EXPLANATION OF BENEFITS** | Generate descriptions of the edits and audits that are associated with a submitted claim. Descriptions will be in a format that is easier to understand and process for providers. |
| **PRICING** | Process applies Diagnosis Related Group (DRG) / Ambulatory Payment Classification (APC) business rules, as appropriate. Perform pricing by calculating State allowed payment amount by applying pricing algorithms. |
| **SUSPEND** | Process for claims assigned a suspended status that triggers a review and an alert to the provider for additional information for resubmission and adjudication. |
| **MANAGE REFERENCE INFO** | Systems to manage reference information beyond information managed in the core business areas for processing claims. Includes addition of a new health plan or benefit, or the modification to an existing program due to the passage of new state or federal legislation, or budgetary modifications and many types of approved service and drug codes. |

# CORE (2/3) – ENCOUNTERS: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **PROCESS ENCOUNTERS** | The Process Encounter business process receives initial (paid or denied), adjusted encounter (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction and determines its submission. |
| **ELECTRONIC DATA INTERCHANGE** | The new EDI processing provided by the claims module will include enhanced encounter validation processing of the encounter using reference data. The front-end validation business rules and policy will become the source of truth for encounter logic. |
| **EDITS** | This process includes performing of SNIP-level ASC X12N edits for valid syntax and format, identifiers and codes, and dates. In addition, non-fatal edits to determine encounter status as initial, adjustment to a processed encounter, or a duplicate submission that is already in the adjudication process but not yet completed and loaded into the encounter payment history. It includes the validation of provider information (e.g., provider taxonomy, National Provider Identification (NPI), enrollment status, approved to bill for service), validates member information (e.g., member's demographics and eligibility status on the date of service), and appropriateness of service codes including code sets. |
| **AUDITS** | This process includes checking encounter history for duplicates. The process also includes: the reviews for service authorization, referral, or treatment plan; checks for clinical appropriateness of the services provided based on clinical, case, and disease management protocols; performance of prospective payment integrity checks; and validation of National Correct Coding Initiative (NCCI). |
| **EXPLANATION OF BENEFITS** | Generate descriptions of the edits and audits that are associated with a submitted encounter. Descriptions should be in a format that is easier to understand and process for providers. |
| **SHADOW PRICING** | Process calculates state allowed payment amount by applying pricing algorithms (e.g., member specific-pricing, DRG, APC) and calculates to-be-paid amount. The module will also capture the health plan paid amount. |

# CORE (3/3)- FINANCIAL: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **REMITTANCE ADVICE** | Generate a detailed remittance advice (e.g., paid claims, denied claims, reason, and remark codes) for each Payee that reflects all financial activity in a payment cycle. |
| **MEDICARE PAYMENTS** | Manage the payment processes for Medicare programs (e.g., buy-in, claw back, Part D) related to Agency Healthcare Program. |
| **CLAIM PAYMENTS** | Manage payment process for all claims to be paid in the financial cycle. |
| **OTHER FINANCIAL PAYMENTS** | All other non-claim specific Financial Payment Activity such as Incentive Payments, Premium Payments, Capitation Payments, Contractor Payments, and No Emergency Transport Payments. |
| **PROGRAM INTEGRITY** | Processes to suspend, terminate, withhold, or continue processing payments to Providers under investigation. |
| **FINANCIAL ACTIVITY** | Processes to maintain non-claim specific financial activity such as Account Receivables (Cost Settlement, Drug Rebate, Estate Recovery, TPL Recovery), Cash Receipts, Account Payables, bank lockboxes, etc. |
| **IRS 1099 ACTIVITY** | Produce accurate annual 1099 forms in accordance with IRS specifications for all providers and vendors that reflect all payments and adjustments made through the financial system (e.g., claims, adjustments, voids, and any other financial transactions). |
| **REPORTING** | Produce all financial reports such as payment cycle reports, financial activity reports, IRS 1099 reports, etc. |

# CORE (CLAIMS/ENCOUNTERS/FINANCIAL)

## CURRENT STATE

- Limited visibility into claim and encounter processing status
- High volume of submitted claims result in denials (~33% of FFS)
- Encounters are processed in same manner as Fee For Service Claims
- Submissions to EDI Gateway are primarily periodic batch files
- Claim validation performed after submission to Agency
- Multiple fragile interim processing spreadsheets
- Various systems manage business rules
- Time consuming and manual process for edit and audit resolution

## FUTURE STATE

- Continuous flow of transactions and batch submissions to EDI Gateway
- Claim validation performed prior to submission to Agency
- Same business rules and policy validation used for systems
- Eliminate use of claim processing rules, validations, and system for encounters
- Plain language claim status notification

## BENEFITS

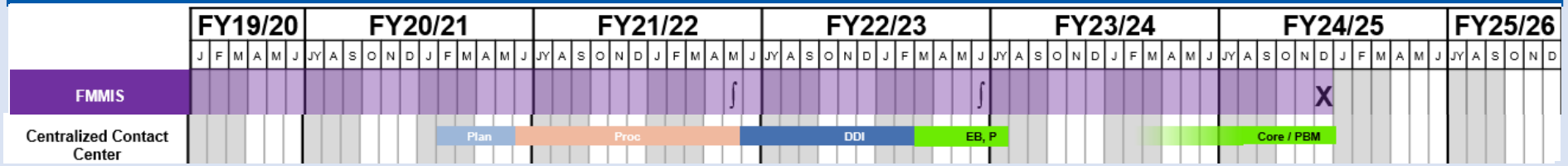
- Reduced number of wrongly rejected claims lessening the administrative burden and cost on the Agency, Providers, and Health Plans
- Improved communications of claim status or rejection reason will reduce the number of claim resubmissions
- Eliminated cost of ‘special feed’ processing
- Specified scope 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

**$747M**

**Benefits figure represents total validated benefits through FY27-28**

# PHASE 3: CENTRALIZED CONTACT CENTER

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- Procure a single vendor to provide the CRM, call center infrastructure, and resources to address communication and simple operating tasks for all business areas.
- Align procurement so vendor can go-live in support of Provider and Enrollment Broker implementations.
- Select vendor who specializes in similar call center and business process outsourcing with ability to scale and healthcare experience.

**Implementation**

- Define shared SLA responsibilities with module vendors that drive contact center interactions.
- Phase transition to a unified communications strategy; Transition phases: Provider, Enrollment Broker, Pharmacy Benefit Management, and Core.

**Action Items**

- SEAS to initiate/schedule a contact center workgroup with Agency staff to confirm the feasibility/scope of a consolidated contact center

## PEAK RESOURCE DEMANDS BY QUARTER (AGENCY / SEAS)

| FY 2020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| | | | | 2.5 | 5.5 | 7 | 5.5 |

| FY 2021-22 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 7 | - | 6.25 | - | 5.25 | - | 5.25 | 6 |

| FY 2022-23 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 4 | 6.5 | 4 | 6.5 | 4 | 6.5 | 8.5 | 8.5 |

| FY 2023-24 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 8.5 | 8.5 | 2.5 | - | 2.5 | 1 | 8.5 | 8.5 |

| FY 2024-25 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 8.5 | 8.5 | 2.5 | - | | | | |

## VENDOR / SYSTEM CONTRACTS RESOLVED WITH MODULE

**May 2023**

- Consolidates Enrollment Broker, and Provider contact centers.

**November 2024**

- Adds functionality to support contact center needs of Core and PBM.

## Centralized Contact Center Scope

*Unified Communication Infrastructure, Contact Center Operations, Outbound Communication Management, Print and Mail Operations, Business Area Operations, Customer Contact Analytics*

# CENTRALIZED CONTACT CENTER

## CURRENT STATE

- Multiple call centers in place with unclear strategy of how to add inbound call functions during modular growth
- Multiple contact center platforms resulting in redundant agency license fees
- Contact center vendors manage and control contact data with no central source of truth for provider/recipient touchpoints

## FUTURE STATE

- Procure a single vendor to provide a suite of services across a variety of call types and stakeholder audiences
- Cost reduction from consolidation and scale
- Integration of contact center data into a central repository
- Multi-agency access to integrated contact data

## BENEFITS

- Reduce cost of contact center multi-topic interactions
- Reduce cost of contact center interaction – recipient/provider/stakeholder time
- Creates access to contacts and interactions information to manage service delivery
- Reduce contact and interaction management cost to Agency

**$10M**

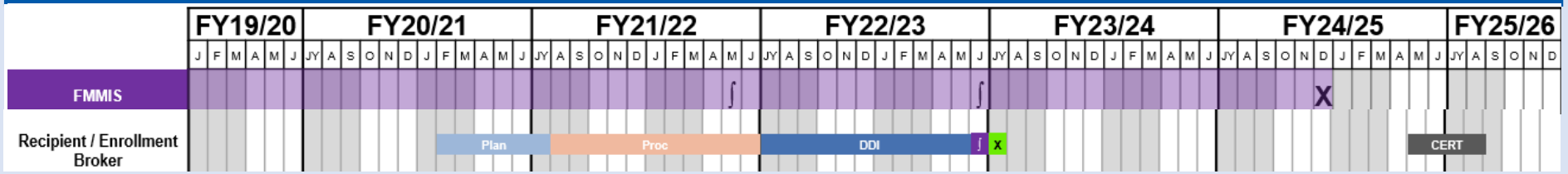
**Benefits figure represents total validated benefits through FY27-28**

# CENTRALIZED CONTACT CENTER: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **CENTRALIZED CONTACT CENTER INFRASTRUCTURE** | Systems and infrastructure to support inbound and outbound multi-channel communications between the Agency and its stakeholders. Includes the network, telephony, and systems used in contact management. Supports interactions by phone, email, chat, SMS text, social media, voice assistant, internal / external conference, physical mail, and in person channels. Major components include unified contact distribution and routing, self-service interaction capabilities (e.g., IVR and chatbots), workforce management, quality assurance, contact recording and translation, multi-language support, and contact knowledge management. |
| **CONTACT CENTER OPERATIONS** | Provides skilled resources to communicate with stakeholders via inbound and outbound supported channels. Vendor is to provide flexible capacity to meet cyclical and event-based spikes in communication volumes. |
| **OUTBOUND COMMUNICATIONS MANAGEMENT** | Manages and tracks the release of outbound communications from the Agency to recipients and providers. Coordinates the release of information and ensures consistency of message and format. Optimizes use of electronic delivery and provides an electronic message box of outbound electronic communications originating from the Agency. |
| **PRINT AND MAIL OPERATIONS** | Manages printing and release of outbound mail including address validation and returned mail handling. Handles receipt of inbound mail to the Agency. |
| **BUSINESS AREA OPERATIONS** | Provides skilled resources to perform business area operations tasks that relate to stakeholder contacts. Examples include file maintenance and enrollment application processing. |
| **CUSTOMER CONTACT ANALYTICS** | Provides historic and real-time analytic capabilities to understand issues, trends, and opportunities to improve the communication experience with Agency stakeholders based on contact related information. Enables improvements affecting the general population and better personalization to improve the efficiency and effectiveness of contacts. |

# PHASE 3: RECIPIENT / ENROLLMENT BROKER

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- Modify scope of future Enrollment Broker (EB) contract to move communications to Centralized Contact Center vendor.
- Pursue solution that increases self-service adoption.

**Implementation**

- Cutover module in June 2023 prior to expiration of current Enrollment Broker contract in September 2023.
- Align Planning, Procurement, and DDI processes to reduce the impact on the new SMMC plans.
- Estimated DDI duration of 12 months, ending in June 2023.

**Action Items**

- Due to high volume of procurements in 2023 and 2024 (both EB and Core) the Agency should seek special legislative approval to delay the SMMC procurement by 2 years, to 2025.

## PEAK AGENCY RESOURCE DEMANDS BY QUARTER

| FY 2020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| | | | | | | 2.75 | 5.5 |

| FY 2021-22 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 2.75 | 5.5 | 7 | - | 6.25 | - | 9 | - |

| FY 2022-23 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 7 | 6 | 9.5 | 11 | 9.5 | 7.5 | 9.5 | 8.5 |

| FY 2023-24 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| 6.5 | 7.5 | 2.5 | - | | | | |

## VENDOR / SYSTEM CONTRACTS RESOLVED WITH MODULE

**July 2023**

- The File Maintenance and Buy-In aspects of the DXC contract (representing about $2.5M annually) can be sunset. In addition, the AHS enrollment broker contract can be completely resolved (about $15M annually).

**Recipient / Enrollment Broker Scope**

*Enrollment Broker (Plan Assignment), Portal, Recipient Management and Ongoing Maintenance, Population & Recipient Outreach*

# RECIPIENT: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **RECIPIENT MANAGEMENT** | Recipient Management includes business functions to manage recipient information, grievances, appeals, communication, and interactions. Recipient communication will be generated by the recipient module but will leverage the Centralized Contact Center. |
| **ENROLLMENT BROKER** | The Enrollment Broker is the systems, contact center, platform, and operations that allow a recipient to select a health plan. The enrollment system will increase integration with DCF's ACCESS to improve a recipient's ability to perform self-service in plan selection and choice counseling. Enrollment Broker operations will stay with the Agency (as opposed to transitioning to DCF) and use the Centralized Contact Center platform. The current enrollment broker vendor performs PNV functionality that will be included in the provider management module. |
| **POPULATION & RECIPIENT OUTREACH** | Provides recipient and population outreach to improve program awareness and effectiveness. This will include functionality to notify recipients of the termination of a health plan, a health benefit, a provider, or a contractor. |
| **RECIPIENT PORTAL** | The recipient portal will present standardized and integrated content. A scope of work is required to rationalize the number and types of portals that recipients use (health plan portals, multiple state agency portals, etc.). |

# RECIPIENT

## CURRENT STATE

- Medicaid recipients interact primarily with the DCF ACCESS system
- Siloed activities amongst Health and Human Services Agencies
- Multiple data stores collecting recipient interactions
- Disparate look, feel, and functionality across health plan portals
- Enrollment system and contact center

## FUTURE STATE

- Multiple systems can access and update recipient information in real-time
- Single source of truth for recipient information
- Self-service by recipients in plan selection
- Single consolidated view of all eligibility and use of services
- Standardized recipient experience
- Enrollment system integrated with ACCESS

## BENEFITS

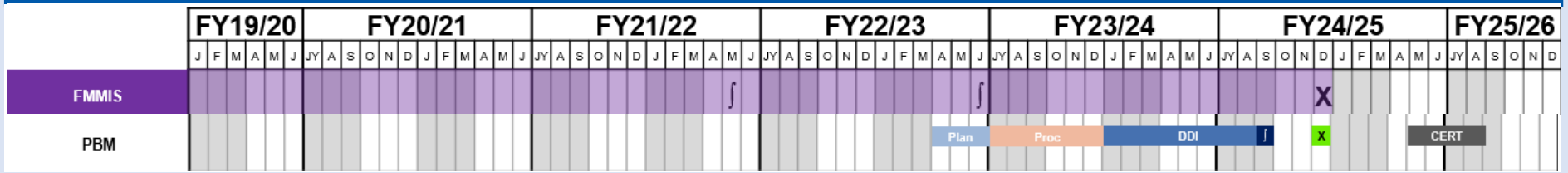
- Increased integration with DCF will enable recipients to select their plan and provider prior to enrollment, assisting families in continuing a care relationship with their current provider
- Reduced recipient time spent to contact Enrollment Broker
- Reduced interaction management cost to the Agency through self-service portal functionality for plan selection and change reporting
- Reduced Enrollment Broker contact center infrastructure costs

**$0M**

**Benefits figure represents total validated benefits through FY27-28**

# PHASE 3: PHARMACY BENEFITS MANAGEMENT

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- Explore leveraging a managed care PBM to replace FFS PBM.
- Explore whether Pharmacy Rebate Collection and Negotiation should be scoped separately.

**Implementation**

- Implement new PBM capabilities after other modules but before Core to reduce resource demands and implementation risk.
- Integrate PBM claims data into EDW to improve real time analytic capabilities.
- Complete integration testing with PBM in September 2023, 3 months before go-live with Core December 2023 to reduce risk and combined effort.

**Action Items**

- Confirm the scope of PBM module with Agency staff.

## PEAK RESOURCE DEMANDS BY QUARTER (AGENCY / SEAS)

| FY 2022-23 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| | | | | | | **1.75** | 4.5 |

| FY 2023-24 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| **7** | | **7** | | **6.25** | 11 | **8.5** | 5 |

| FY 2024-25 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q1 | | Q2 | | Q3 | | Q4 | |
| **8.5** | 7 | **6.5** | 7 | ***2.5*** | - | | |

**Agency** | SEAS

## VENDOR / SYSTEM CONTRACTS RESOLVED WITH MODULE

**December 2024**

- The PBM scope of the DXC MED037 contract ($12.1M) can be resolved. Depending on final PBM scope decisions during planning this module PBM may also resolve a separate DXC contract for the Pharmaceutical Rebate Information Management System (PRMIS) system dealing with rebates ($1.3M annually).

**Pharmacy Benefits Management Scope**
*Financial and Clinical, Rebate Administration, Monitoring, Drug Education, and Operations*

# PBM: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **FINANCIAL AND CLINICAL** | The Pharmacy Benefits Management (PBM) module performs financial and clinical services for the FFS Medicaid population including drug price negotiation with manufacturers. PBM also includes a system to process pharmacy claims and e-prescribing and integration with pharmacy point of sale systems, pharmacy fee collection, and pharmacy rate negotiation. PBM also includes prior authorization for certain required drugs. |
| **MONITORING** | The Pharmacy Benefits Manager can monitor prospective and retrospective drug utilization and oversee preferred drug lists. |
| **DRUG EDUCATION** | PBM includes recipient outreach and education on prescribed medication. |
| **OPERATIONS** | PBM includes operational staff to provide information to providers, pharmacists, and recipients. The PBM vendor administers the Drug Utilization Review and Pharmaceutical and Therapeutics committees. |

---

| | |
|---|---|
| **REBATE ADMINISTRATION** | PBM may handle the reporting and administration of drug rebates. Because of potential conflict of interest this functionality is currently required to be administered on a different contract than core PBM functionality. Whether Rebate Administration is in scope for the PBM vendor or handled separately will be determined during module planning. |

# PHARMACY BENEFITS MANAGEMENT

## CURRENT STATE

- Limited transparency into rebate compensation
- Excessive spread pricing captured by PBM that can be clawed back to Agency
- High pharmacy expenditures due to complicated benefits structure
- Significant compensation received by PBM through rebates from drug companies

## FUTURE STATE

- PBM required to pass through rebates to payers or to patients
- PBM use of ‘spread pricing’ not allowed

## BENEFITS

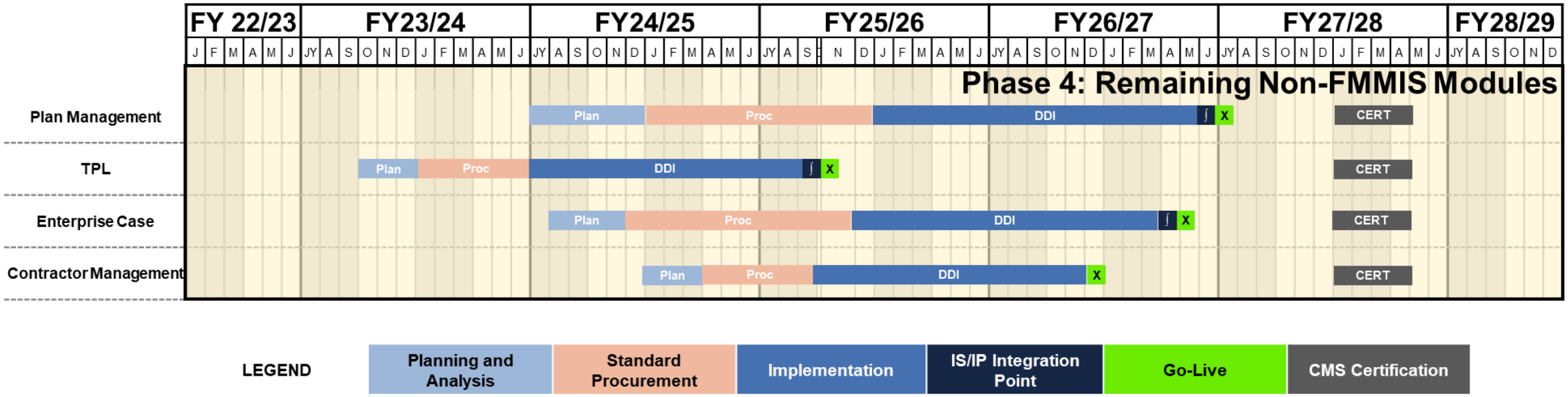
- Increased Agency recovery of drug company rebates
- Reduced recipient trips to pharmacy
- Reduced pharmacy mailing costs
- Reduced pharmacy point of sale operations costs
- Reduced claims administration costs (Providers)
- Reduced total managed care and FFS pharmacy expenditures

**$0.3M**

**Benefits figure represents total validated benefits through FY27-28**

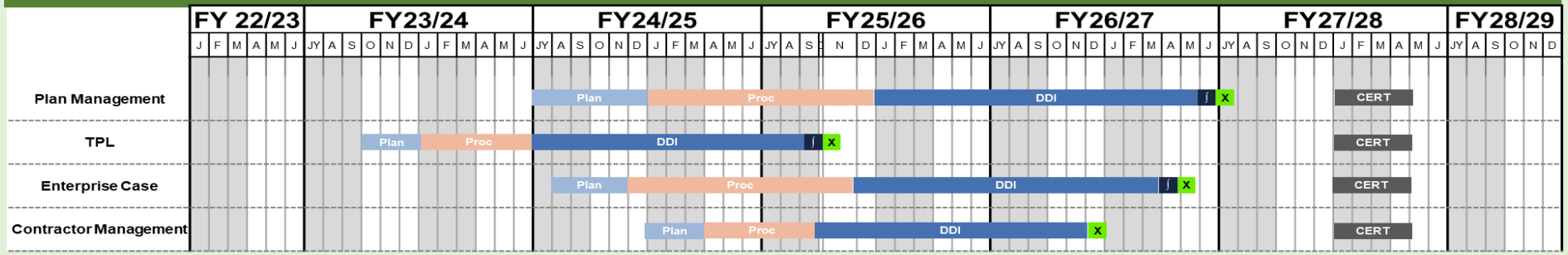
# PHASE 4: REMAINING NON-FMMIS MODULES

**Phase 4 of the FX transformation is focused on the procurement and implementation of the remaining modular components required or necessary for delivering world-class health outcomes in Florida that were not tied to the original FMMIS contract with DXC.**



# PHASE 4 – PLAN MGMT, TPL, CASE MGMT, CONTRACTOR MGMT

## ROADMAP




## PROCUREMENT & IMPLEMENTATION

**Procurement**

- Evaluate if Plan Management and Contractor Management can leverage same procurement.
- Evaluate if Case Management can be built with an existing contracted platform.

**Implementation**

- Scope does not impact DXC contract resolution.
- Managed Care environment requires the early release of Plan Management.
- Third Party Liability implementation driven by contract execution.

## STRATEGIC PRIORITIES ALIGNMENT

3 Prioritize Ability to Have High-Quality Accessible Data, Analytics, and Reporting

4 Prioritize Interoperability Opportunities between Agencies and within AHCA

6 Maximize Staff Efficiency

8 Minimize Impacts of Procurements on Agency Staff

10 Maximize Accountability for Vendor Performance

**Plan / Contractor Management Scope**
*Contractor Management, Performance Management, Document Repository, Contractor Communications and Outreach, Business Relationship Management*

**Case Management Scope**
*Enterprise Case Management Module, Content Management, Automated Workflow & Assignment, Redaction, Electronic Signature*

**TPL Scope**
*Legal Liability, Estate Recovery, Data Matching, Post-Payment Recovery*

# PLAN/CONTRACTOR MANAGEMENT: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **PROCUREMENT MANAGEMENT** | System and processes to manage development, negotiation, award, and execution of contracts for services and solutions used in the delivery of Agency mission. This solution integrates with the Application Life Cycle Management solution providing interoperability between procurements, system implementation, and ongoing operations. |
| **CONTRACT MANAGEMENT** | Contract management system that manages the contract life cycle from procurement through contract termination. The system centralizes all contract information, provides an in-depth understanding of contract terms and compliance requirements, and provides customized stakeholder views to help manage compliance and support automated imposition and collection of liquidated damages – from measuring the quality of service to the timeliness of reporting requirements. |
| **DOCUMENT REPOSITORY** | Use of EDW content management solution to be the central repository for all contract documents. |
| **CONTRACTOR COMMUNICATION & OUTREACH** | Manage and track contractor communications by providing responses to individual entities for information, appointments, and assistance related to a Service Level Agreement (SLA). Contractor Outreach develops, manages, and distributes content targeting both prospective and current contractor populations for distribution of information regarding programs, policies, and other issues. |
| **BUSINESS RELATIONSHIP MANAGEMENT** | Manage business partner relationships between the Agency and its partners, including collaboration amongst intrastate, interstate, and federal agencies. It contains functionality for interoperability, establishment of inter-agency service agreements, identification of the types of information exchanged, and security and privacy requirements. |
| **PERFORMANCE MANAGEMENT** | Systems and business process operations that develops the reports and other mechanisms that it uses to track activity and effectiveness at all levels of monitoring. Business Intelligence analysis (i.e., historical, current, and predictive views of business operations) measures activities and programs (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures). These solutions leverage the EDW tools and infrastructure. |

# THIRD PARTY LIABILITY: SCOPE OF SERVICES AND DEFINITIONS

**Current TPL contract has a final termination date of 2/28/2026 if all available renewals and extensions are exercised. TPL functionality must be re-procured and integrated with the new FX Infrastructure before that date.**

| | |
|---|---|
| **DETERMINES LEGAL LIABILITY** | Determines the legal liability of third parties to pay for care and services that are available under the Medicaid state plan. |
| **ESTATE RECOVERY** | TPL includes operational functionality to recover benefits paid for deceased individuals by filing liens against the estate. This includes receiving estate recovery information from multiple sources (e.g., vital statistics and Social Security Administration (SSA) date of death matches, probate petition notices, tips from caseworkers, and reports of death from nursing homes). |
| **DATA MATCHING** | TPL includes data matching functionality to identify liable third-parties. This process begins by receiving TPL information from various sources such as external and internal information matches, tips, referrals, attorneys, compliance management incident, Medicaid Fraud Control Unit (MFCU), providers, and insurance companies. |
| **POST-PAYMENT RECOVERY** | This includes post-payment recovery of claims from providers that should have been paid by other responsible parties. |

# ENTERPRISE CASE MANAGEMENT: SCOPE OF SERVICES AND DEFINITIONS

| | |
|---|---|
| **ENTERPRISE CASE MANAGEMENT MODULE** | This could include (but not be limited to) developing requirements for case intake, workflow, redaction, electronic signatures, reporting, dashboards, storage, retrieval, etc. Case management is a process or solution designed to support and manage collaboration across the entire AHCA Enterprise. The solution should support electronic workflow, status and activity tracking, document storage and retrieval, content management, alerts, notifications, redaction, and reporting capabilities. The Case Management System will provide a comprehensive 360-degree view of case activity across systems and data sources to support decision-making. |
| **CONTENT MANAGEMENT** | Leverage EDW capability to automate the case intake, storage, and retrieval processes to ensure the Agency has timely access to case related documentation. |
| **AUTOMATED WORKFLOW AND ASSIGNMENT** | Assigns and notifies staff when a task is awaiting them, which makes case review and processing more efficient. This will also assist in overall organization and timely processing of all case management related documentation. This includes intake and tracking of public records requests. |
| **REDACTION** | Automates a process which can be time consuming and laborious. Sensitive information is properly masked to ensure privacy of the selected information. |
| **ELECTRONIC SIGNATURE** | Reduces time and administrative burden of this manual task. This will require Agency policy change requiring wet signature. |

# SECTION F

***Strategic Priorities and Tactical Decisions***

# 2019 FX STRATEGIC PRIORITIES UPDATE

## SEAS conducted a workshop with Agency staff to update the Strategic Priorities as listed below.

| FX STRATEGIC PRIORITIES | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Integration Platform | Provider | Recipient | Program Integrity | Financials | Value Based Care | Inter-Agency Focus | New Priorities Not Aligned with 2017 Priorities | | |
| | | | | | | | Organizational Impact | CMS Alignment | Contracts |
| Prioritize Ability to Have High-Quality Accessible Data, Analytics, and Reporting | Streamline Credentialing, Licensing, Master Person Index, and Master Organization Index | Improve Visibility and Experience through Portal and Contact Center | | | Maximize Accountability for Vendor Performance | Prioritize Joint Efficiencies with Interoperability Across Other HHS Agencies (external) | Reduce Impact to Agency and Staff | Align to CMS Modularity to Streamline Transformation & Modernization | Reduce Risk of Integration and Cost to DXC by Accelerating Contract Resolution |
| | | | | | | | Minimize Impacts of Procurements on Agency Staff | | Prioritize Renegotiating and Improving Functionality and Technology for Large (non-DXC) Systems Contracts |
| | | | | | | | Maximize Staff Efficiency | | Strategically Leverage Efficient Procurement Vehicles Where Possible |
| | | | | | | | Prioritize Joint Efficiencies with Interoperability Within AHCA | | |

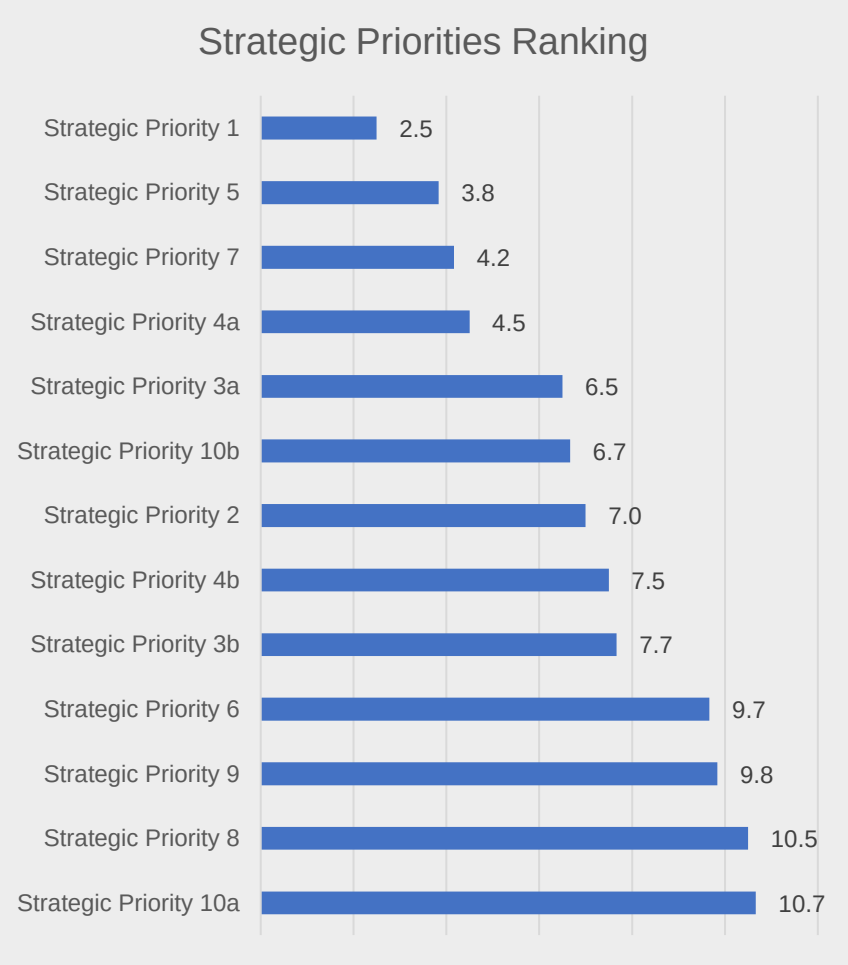
**LEGEND**

- 2019 Proposed Strategic Priority
- 2017 Priority
- Category
- Updated Strategic Priority
- New Strategic Priority
- 12/12 – Updated Strategic Priorities
- 12/12 – Updated Strategic Priorities

***SEAS partnered with AHCA to align on previous Strategic Priorities, update where necessary, and developed new Priorities based on AHCA Executive feedback (Executive Visioning Session held December 13, 2019)***

# STRATEGIC PRIORITIES SCORING

## The executive team originally ranked 13 Strategic Priorities to identify the top priorities to achieve the FX vision.




| Rank | Strategic Priority | Description |
|---|---|---|
| 1 | 1 | Reduce Risk of Integration and Cost to DXC by Accelerating Contract Resolution |
| 2 | 5 | Provider: Streamline Credentialing, Licensing, Master Person Index, and Master Organization Index |
| 3 | 7 | Prioritize Ability to Have High-Quality Accessible Data, Analytics, and Reporting |
| 4 | 4a | Prioritize Joint Efficiencies with Interoperability Within AHCA |
| 5 | 3a | Strategically Leverage Efficient Procurement Vehicles Where Possible |
| 6 | 10b | Maximize staff efficiency |
| 7 | 2 | Prioritize Renegotiating and Improving Functionality and Technology for Large (non-DXC) Systems Contracts |
| 8 | 4b | Prioritize Joint Efficiencies with Interoperability Across Other HHS Agencies (external) |
| 9 | 3b | Minimize Impacts of Procurements on Agency Staff |
| 10 | 6 | Improve Visibility and Experience through Portal and Contact Center |
| 11 | 9 | Maximize accountability for vendor performance |
| 12 | 8 | Align to CMS modularity to streamline system transformation & modernization |
| 13 | 10a | Reduce impact to Agency and Staff |

# STRATEGIC PRIORITIES SCORING

**Since the ranking exercise, SEAS worked with Agency leadership to refine the list of 13, down to 12 Strategic Priorities. The top 4 priorities are outlined below.**

| Rank | Description |
|---|---|
| 1 | Reduce DXC costs and integration risk by accelerating contract resolution |
| 2 | Provider Experience: Streamline credentialing, licensing, improve provider data, and overall experience |
| 3 | Prioritize ability to have high-quality, accessible data, analytics, and reporting |
| 4 | Prioritize interoperability opportunities between agencies and within AHCA |
| 5 | Strategically leverage efficient procurement vehicles where possible |
| 6 | Maximize staff efficiency |
| 7 | Prioritize renegotiating and improving functionality and technology for large (non-DXC) systems contracts |
| 8 | Minimize impacts of procurements on Agency staff |
| 9 | Improve visibility and experience through portal and Contact Center |
| 10 | Maximize accountability for vendor performance |
| 11 | Align to CMS modularity to streamline system transformation & modernization |
| 12 | Reduce impact to Agency and staff |

# FX STRATEGIC PRIORITIES

## "The Directions" or framework of desired options that enables AHCA to achieve its goals.

| 1 / Reduce DXC costs and integration risk by accelerating contract resolution | 2 / Provider Experience: Streamline credentialing, licensing, improve provider data, and overall experience | 3 / Prioritize ability to have high-quality, accessible data, analytics, and reporting | 4 / Prioritize interoperability opportunities between agencies and within AHCA | 5 / Strategically leverage efficient procurement vehicles where possible |
|---|---|---|---|---|
| Procure and build a standalone system to replace DXC functionality. Forego any integration with existing DXC. Prioritize those projects and procurements to allow resolution of $85M contract as early as possible. | Improve the major process issues faced by Providers in measurable ways. Improve the Provider experience. Improve AHCA's ability to recognize and match providers for multiple program functions (e.g., program integrity, outreach, customer service). | Expedite the ability to have a 'single source of truth' for major data and reporting areas by focusing on past and current pain points including reducing overpayments, identifying and reducing fraud, and managing health plans. Leverage data across divisions to identify and address gaps in (or improve) quality and performance. | Actively identify and solve ways to improve the exchange between technical systems and business processes across all bureaus, divisions, and units within AHCA, as well as external state Agencies that provide critical HHS data to AHCA. | Consider and/or leverage other procurement methods (i.e., re-use, public business requirements documentation, NASPO) when appropriate to maximize efficiencies. |

# FX STRATEGIC PRIORITIES

## "The Directions" or framework of desired options that enables AHCA to achieve its goals.

| 6 / Maximize staff efficiency | 7 / Prioritize renegotiating and improving functionality and technology for large (non-DXC) systems contracts | 8 / Minimize impacts of procurements on Agency staff | 9 / Improve visibility and experience through portal and Contact Center | 10 / Maximize accountability for vendor performance |
|---|---|---|---|---|
| Streamline processes to maximize staff efficiency. Eliminate redundant processes, reduce the number of workarounds, and move from paper based to automated workflows. Maximize staff time to enable staff to focus on higher value tasks. | Initially, focus on the other large dollar contracts to increase the amount of benefits realization early in the project. Focus on updating the technology and improving the functionality. | Focus on improving the procurement process. Increase visibility and project management skills to the process. Cut out parts of process that involve excess people or call for multiple revisions. Review other contracting vehicles that can save time and effort. | Streamline the way Recipients receive information and interact with Medicaid across multiple agencies. | Improve ability to identify and manage vendors to contract terms. |

# FX STRATEGIC PRIORITIES

**“The Directions” or framework of desired options that enables AHCA to achieve its goals.**

| 11 / Align to CMS modularity to streamline system transformation & modernization | 12 / Reduce impact to Agency and staff |
|---|---|
| Follow a modular roadmap to increase likelihood of receiving federal match. Implement modularly in the most streamlined manner possible, using methods such as cohorts where reasonable. | Identify and minimize those areas that will create impact and risk to Agency. Leverage systems and processes that are similar or duplicative to improve efficiency. |

***“Better Health Care for All Floridians”***


# RECAP OF DECISIONS TO-DATE

# FX S-3/S-4 REFRESH KEY DECISIONS TO DATE

| Mtg | ID | Title | Description | Status | Update / Decision Made | Assigned To (Owner/Reviewer) | Decision Date |
|---|---|---|---|---|---|---|---|
| 12/12 Executive Visioning Session | 1 | Florida Health Care Connections (FX) Strategy Current State Analysis | Analysis covering the current state of FX | Closed | SEAS recirculated work products for review and approval by AHCA team members | SEAS/AHCA (refer to Current State Index List) | Review due by 1/13 |
| | 2 | FX Strategic Priorities | AHCA Executives and SEAS drafted 13 updated Strategic Priorities; Executives voted to create relative ranking of Strategic Priorities | Closed | Strategic Priorities and rankings established; language may still be refined | AHCA/SEAS | 12/12/2019 |
| 12/13 Executive Visioning Session | 3 | AHCA Vision & FX Vision | Future success of the organization and the project | Closed | SEAS updated documents with AHCA LRPP vision | AHCA/SEAS | 12/13/2019 |
| | 4 | Why FX? | Pain points addressed, opportunities, and risks avoided | Developed, To Be Reviewed | SEAS captured notes on 12/13 | SEAS/AHCA | 12/13/2019 |
| | 5 | FX Guiding Principles | General rules that guide decision-making and support the FX vision | Closed | Reviewed and approved by AHCA | SEAS/AHCA | 12/13/2019 |
| | 6a | Key Consideration: Tactic 1 | Procure an enterprise-wide contact center platform OR keep multiple disparate contact centers | Deferred | Establish a working group with staff members to review with SEAS | SEAS/AHCA | 12/13/2019<br>12/18/2019 |
| | 6b | Key Consideration: Tactic 2 | Combine modules in procurement to accelerate timeline OR keep procurement separate | Closed | Yes, combine modules in procurement to accelerate timeline where appropriate | SEAS/AHCA | 12/13/2019 |

# FX S-3/S-4 REFRESH KEY DECISIONS TO DATE

| Mtg | ID | Title | Description | Status | Update / Decision Made | Assigned To (Owner/Reviewer) | Decision Date |
|---|---|---|---|---|---|---|---|
| 12/13 Executive Visioning Session (cont'd.) | 6c | Key Consideration: Tactic 3 | Consider takeover of all, or a portion of, DXC as a procurement approach OR do not pursue takeovers | Closed | Consider takeover of all or a portion of DXC as a procurement approach | SEAS/AHCA | 12/13/2019 |
| | 6d | Key Consideration: Tactic 4 | Initiate a business rules documentation project as a targeted effort OR do not | Closed | Yes, but ensure it is a targeted effort | SEAS/AHCA | 12/13/2019 |
| | 6e | Key Consideration: Tactic 5 | Consider NASPO documentation and procurement vehicles to accelerate procurements OR do not consider NASPO | Closed | Yes, consider NASPO documentation and procurement vehicles | SEAS/AHCA | 12/13/2019 |
| | 6f | Key Consideration: Tactic 6 | Procure an enterprise financial module OR procure financial functionality in the Core module | Open | More information needed to determine an outcome based on the SunFocus project | SEAS/AHCA | 12/13/2019<br>12/18/2019 |
| | 6g | Key Consideration: Tactic 7 | Consolidate Enrollment Broker with DCF OR keep Enrollment Broker at AHCA | Closed | Keep Enrollment Broker at AHCA | SEAS/AHCA | 12/13/2019 |
| | 6h | Key Consideration: Tactic 8 | Procure an enterprise portal OR procure separate portals for provider and recipient | Deferred | Establish work group to consider enterprise portal or enterprise user experience design requirements | SEAS/AHCA | 12/13/2019<br>12/18/2019 |
| | 6i | Key Consideration: Tactic 9 | Establish an interagency planning & analysis committee and associated workgroup representation from HSS agencies OR do not | Closed | Do *not* establish an interagency planning & analysis committee | SEAS/AHCA | 12/13/2019 |

# FX S-3/S-4 REFRESH KEY DECISIONS TO DATE

| Mtg | ID | Title | Description | Status | Update / Decision Made | Assigned To (Owner/Reviewer) | Decision Date |
|---|---|---|---|---|---|---|---|
| 12/19 Executive Visioning Session | 7a | Roadmap Sequence: Tactical Constraint 1 | Consider overlapping projects OR conduct all projects separately | Closed | Overlap projects as much as Agency and SEAS resources can support | SEAS/AHCA | 12/18/2019 |
| | 7b | Roadmap Sequence: Tactical Constraint 2 | Determine whether to frontload planning projects OR to execute rolling planning projects | Closed | Frontload planning to the extent Agency and SEAS resources can support | SEAS/AHCA | 12/18/2019 |
| | 7c | Roadmap Sequence: Tactical Constraint 3 | Determine whether DXC contract resolution should influence procurements OR not | Closed | DXC contract resolution is a Strategic Priority and should influence the overall FX program | SEAS/AHCA | 12/18/2019 |
| | 7d | Roadmap Sequence 1: Consolidated Contact Center | Procure and implement an enterprise consolidated contact center in time for Provider Go-Live OR do not | Deferred | Establish a working group with staff members to review with SEAS | SEAS/AHCA | 12/18/2019 |
| | 7e | Roadmap Sequence 2: Provider Module | Consolidate Licensure, Enrollment, and Credentialing with DOH OR do not | Closed | Consolidate Licensure, Enrollment, and Credentialing with DOH | SEAS/AHCA | 12/18/2019 |
| | 7f | Roadmap Sequence 3: Core Module | Determine whether the Core module should follow Provider OR not | Closed | The Core module should follow Provider | SEAS/AHCA | 12/18/2019 |

# FX S-3/S-4 REFRESH KEY DECISIONS TO DATE

| Mtg | ID | Title | Description | Status | Update / Decision Made | Assigned To (Owner/Reviewer) | Decision Date |
|---|---|---|---|---|---|---|---|
| 1/9 Executive Visioning Session | 8a | Key Consideration: Procurement Process Improvement | Initiating a procurement process improvement project OR handle process improvements internally | Closed | Initiate a Procurement Process Improvement Project (initiated and led by AHCA only) | SEAS/AHCA | 1/14/2019 |
| | 8b | Key Consideration: Procurement Process Improvement | Confirm scope of services as worded OR review further | N/A | Initiate a Procurement Process Improvement Project (initiated and led by AHCA only) | SEAS/AHCA | 1/14/2019 |
| | 8c | Key Consideration: Procurement Process Improvement | Begin the Procurement Process Improvement in Q1 2020 OR do not | N/A | Initiate a Procurement Process Improvement Project (initiated and led by AHCA only) | SEAS/AHCA | 1/14/2019 |
| | 9a | Key Consideration: Recipient | Confirm scope of services as worded OR review further | Closed | Scope revised; now includes Enrollment Broker (Plan Assignment), Recipient Benefit Plan Assignment and Ongoing Maintenance | SEAS/AHCA | 1/14/2019 |
| | 9b | Key Consideration: Recipient | Integrate plan selection into DCF Access eligibility system OR keep as-is process | In review | “Require” plan selection rather than “enable” it; more analysis needed. | SEAS/AHCA | 1/14/2019 |
| | 10a | Key Consideration: PBM | Confirm scope of services as worded OR review further | In Review | Scope to be confirmed. Important to consider possibility to roll call center into unified contact center | SEAS/AHCA | 1/14/2019 |

# FX S-3/S-4 REFRESH KEY DECISIONS TO DATE

| Mtg | ID | Title | Description | Status | Update / Decision Made | Assigned To (Owner/Reviewer) | Decision Date |
|---|---|---|---|---|---|---|---|
| 1/9 Executive Visioning Session | 11a | Key Consideration: Care Management | Confirm scope of services as worded OR review further | Closed | Scope revised; now limited to Prior Authorization | SEAS/AHCA | 1/14/2019 |
| | 11b | Key Consideration: Care Management | Should Care Management and Enterprise Case Management be combined into one procurement OR not | Closed | Scope now includes only waiver management | SEAS/AHCA | 1/14/2019 |
| | 12a | Key Consideration: Enterprise Case Management | Confirm scope of services as worded OR review further | Closed | Scope confirmed; CM needed before Recipient | SEAS/AHCA | 1/14/2019 |
| | 12b | Key Consideration: Enterprise Case Management | Should AHCA use DCF's Case Management solution OR not | Deferred | Preference to scale AHCA's legal case management solution if possible; if not possible, pursue joint procurement with DCF | SEAS/AHCA | 1/14/2019 |
| | 13a | Key Consideration: Plan/Contractor Management | Confirm scope of services as worded OR review further | Closed | Scope confirmed; AHCA agrees both required inputs into FX Roadmap | SEAS/AHCA | 1/14/2019 |
| | 13b | Key Consideration: Plan/Contractor Management | Should AHCA combine Plan/Contractor Management into one procurement OR keep them as separate procurements | Closed | Keep separate; further analysis needed to determine whether this fits within FX scope | SEAS/AHCA | 1/14/2019 |

# FX S-3/S-4 REFRESH KEY DECISIONS TO DATE

| Mtg | ID | Title | Description | Status | Update / Decision Made | Assigned To (Owner/Reviewer) | Decision Date |
|---|---|---|---|---|---|---|---|
| 1/9 Executive Visioning Session | 14a | Key Consideration: Third Party Liability | Confirm scope of services as worded OR review further | Closed | Scope confirmed | SEAS/AHCA | 1/14/2019 |
| | 14b | Key Consideration: Third Party Liability | Should AHCA continue with contract extensions OR pursue procuring a new TPL solution | Closed | Yes, continue with extensions for 5 years | SEAS/AHCA | 1/14/2019 |
| | 15a | Key Consideration: Org Strategy & Design | Should AHCA include an Org Strategy & Design Project in the roadmap OR exclude | Closed | SEAS will need to continue to scope this project and build business case | SEAS/AHCA | 1/14/2019 |

# SECTION G

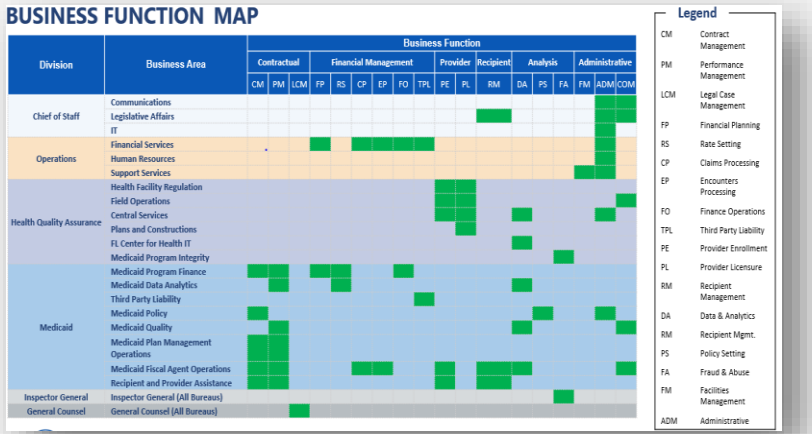
***Insights and Analysis of Current Operations***

# ORGANIZATIONAL IMPACT ANALYSIS OVERVIEW

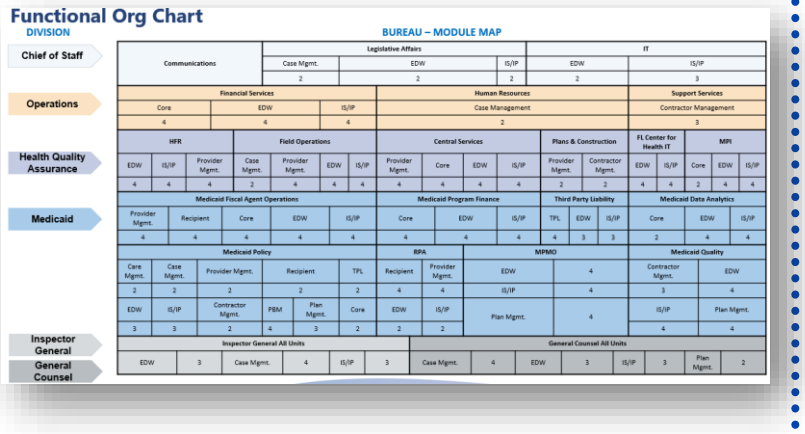
**The Strategy team used existing documentation and organizational maps, interviews, and analysis to evaluate business processes, systems, tools, job roles, and organizational structures.**

- During Step 1, the team assembled data gathered from existing organizational maps and in-depth interviews to assemble the AHCA Business Function Organization Chart and map the appropriate business function to its respective MITA Business Process.
- During Step 2, the team determined the degree of organizational impact by business function. After validating with operational teams, the team assessed the degree of change anticipated on a scale (1-4).
- During Step 3, the team mapped the number of resources to each module to quantify the employee impacts

## Step 1 – Business Function Organization Chart




## Step 2 – FX Module Impact Map




## Step 3 – Employee Impact Analysis

# BENEFITS ANALYSIS AND VALIDATION OVERVIEW

**In Step 1, the benefits team reviewed and deconstructed benefits from existing FX Cost Benefit Analyses (CBAs), and analyzed the drivers of the benefits. They also reviewed all assumptions and data sources and identified areas that required further validation. For modules with no CBA, the team drafted benefits, identifying benefit drivers, assumptions, and data required to validate.**

**In Step 2, the team began validating all benefits gathered and identified from Step 1. The benefit validation process includes gathering available baseline data which will be used as measures during the Benefits Realization process post-implementation. The new FX benefits have an assigned confidence level. SEAS is prioritizing analysis of benefits with low confidence levels.**

## Step 1 - Benefits Analysis *Complete*

### Analyzed Existing Benefits

- **Reviewed existing benefits** in the Cost Benefit Analyses for IS/IP, EDW, PMM, and CMT
- **Identified drivers**, **confirmed assumptions**, **identified measures, and adjusted benefits** as necessary
- **Identified next steps** to update the CBAs
- **Realigned benefits** as needed based on updated module scope

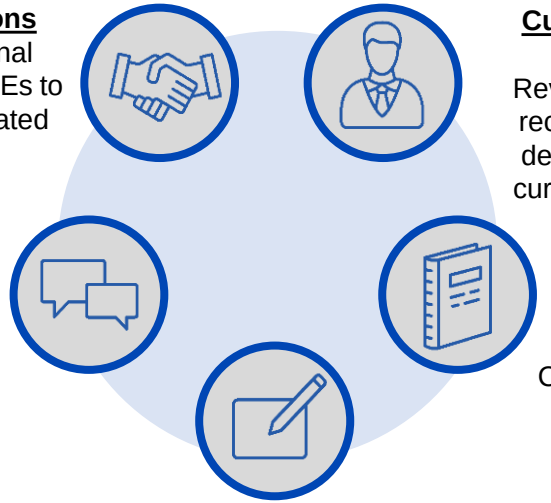
### Identified New Benefits

- Conducted a **preliminary benefits analysis for future modules**, including Core, Centralized Contact Center, Recipient, PBM, TPL, Enterprise Case Management, Plan Management, and Contractor Management
- A full identification of benefits requires the diligence of reviewing existing processes, pain points, recommendations, and hypotheses available through technology enablement and process improvements. This work is presently planned to be completed during the initial planning phase of each module.

## Step 2 – Benefits Validation *In Process*

**Test Assumptions**
Conducted internal interviews with SMEs to document anticipated future state

**Current/Future State Articulation**
Review pain points and recommendations and develop description of current and future state of benefit



**Validate Current / Future State and Assumptions**
Review all assumptions and articulated current state/future state with operators and data SMEs

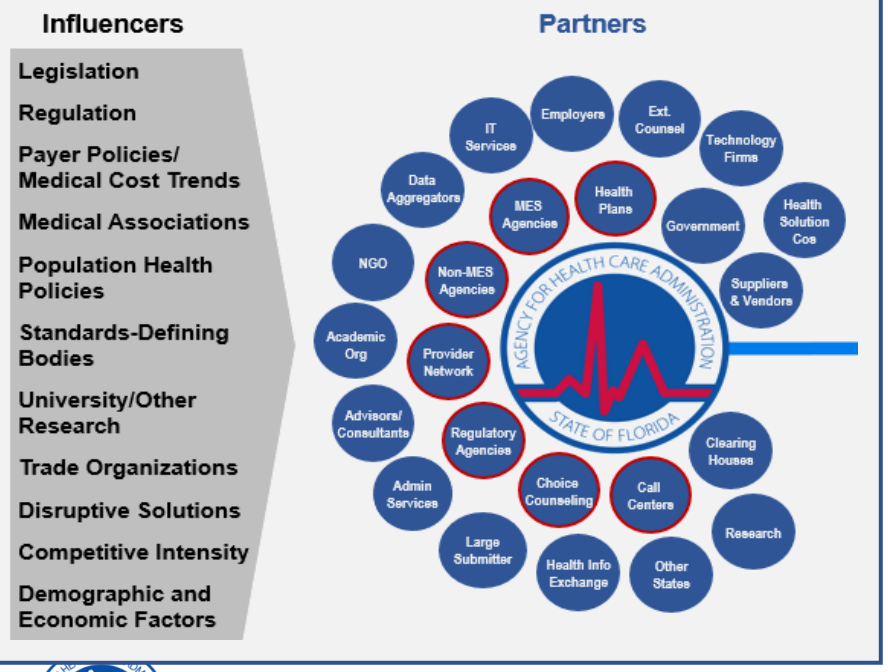
**Develop Benefit Computation**
Create specific formulas for benefits identifying all assumptions

**Data Analysis**
Analyze all existing data and competing projects to ensure computations are correct

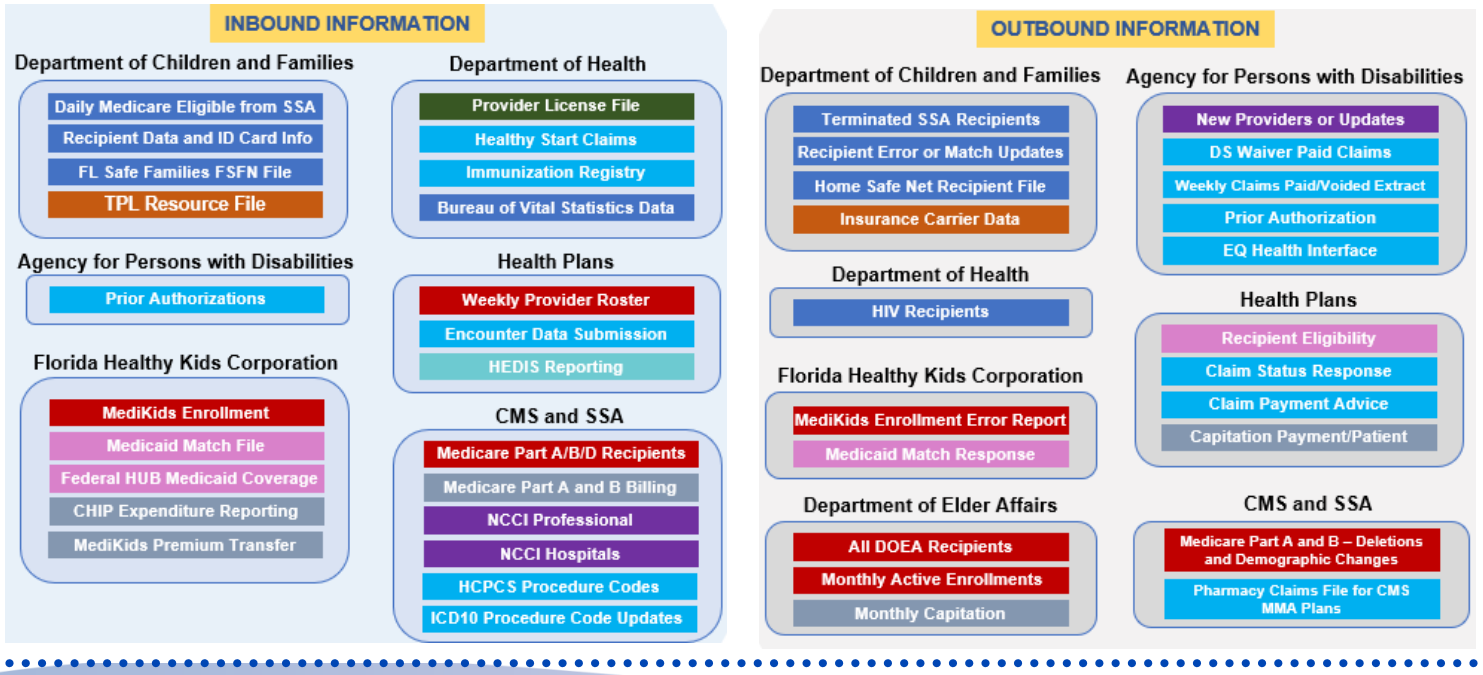
# HHS OPPORTUNITY RECOMMENDATIONS

**The objective of this research was to inform the identification of interoperability and reuse opportunities in FX with the goal of increasing operational capabilities and improving service to providers and recipients. Analysis included a broad HHS ecosystem outlook identifying the various stakeholders and organizations across the HHS landscape, as well as a current state assessment of the Agency's collaboration with those organizations. Recommendations were made after thorough initial research and focused discussions with Agency leadership.**

## HHS Ecosystem Outlook




## Agency Interaction Landscape



# APPROPRIATE TIMING TO ENGAGE HHS AGENCIES

**The Provider team has begun conversations with the Department of Health (DOH) around the opportunity of consolidating licensure between the agencies into the Provider module.**

## Next Steps

- Setup another working session with DOH to continue conversations
- Executive level communication to Unit leaders on opportunity

# STAKEHOLDER CURRENT STATE ANALYSIS

**This research provides insight into business processes, pain points, business unit impacts, and opportunities to be addressed by the modular transformation.**

| | 1 INFORMATION GATHERING (OCT-NOV 2019) | 2 FUTURE STATE DEFINITION (NOV 2019) | 3 OPPORTUNITIES VALIDATION (DEC 2019) |
|---|---|---|---|
| OBJECTIVE | **Assess Processes and Consolidate Information** | **Identify Opportunities and Align on FX Future State** | **Validate Opportunities** |
| HIGHLIGHTS | • **Map** business functions to the divisional units<br>• Build **process flows for Provider and Recipients**<br>• **Review** Provider Business Case<br>• **Interview** Agency Subject Matter Experts<br>• Current state **pain point identification** | • Map the **modules to the divisional units**<br>• Ideate opportunities to **address pain points** | • **Finalize and consolidate** issues<br>• **Socialize and validate opportunities** with stakeholders |
| OUTPUT | • Provider and Recipient process flows, experience map, and pain points | • Organizational Module Impact Heat Map<br>• Provider and Recipient Opportunities | • Summary of Opportunities |

# STATE MMIS RESEARCH APPROACH AND OBJECTIVES

## This research provides insight to other states' MMIS strategy and transformation approach to modularity.

| | OCT 2019 | NOV 2019 | DEC 2019 |
|---|---|---|---|
| | 1 IDENTIFY RESEARCH SCOPE | 2 INFORMATION GATHERING | 3 ANALYSIS |
| **OBJECTIVE** | **Determine List of States for Research** | **Complete Interviews with State Stakeholders** | **Perform Analysis and Develop Insights** |
| **HIGHLIGHTS** | • **Review published information** on state strategies<br>• **Identified states furthest along in transformation** with similar characteristics to Florida | • **Created interview guide focused on lessons learned** and changes made to previous plans<br>• **Updated state information by conducting additional** 5-8 interviews with other state transformations . | • **Identify most beneficial decisions** and processes from other state experiences<br>• **Leverage learnings** from other states into recommendations<br>• **Group state lessons learned** and best practices by theme |
| **OUTPUT** | • Target state list and interview schedule<br>• Background research to prepare for interviews<br>• Develop and distribute interview guide | • Interview Guide<br>• State interview transcripts and notes | • State interview analysis, implications, and recommendation summary<br>• PowerPoint visualization |

# FLORIDA MEDICAID ENTERPRISE SYSTEM (MES) AND APPLICATION INVENTORY APPROACH & OBJECTIVES

## Holistic current state inventory, information reference, and analysis of technology comprising the Florida MES.

| | 1 | 2 | 3 |
|---|---|---|---|
| | OCT 2019 | OCT - NOV 2019 | NOV 2019 |
| | IDENTIFY AND VALIDATE SYSTEM AND APPLICATION LIST FOR INVENTORY INCLUSION | GATHER DETAILED INFORMATION TO COMPLETE INVENTORY | CATEGORIZATION, ANALYSIS, AND VISUALIZATION |
| OBJECTIVE | The technology comprising the Florida MES includes hundreds of elements. **Apply 80/20 rule to identify the 50-100 most important technology components** | Collaborate with stakeholders across AHCA to gather required inventory data on each system and application component | Analyze inventory across fields to categorize, and visualize the current state Florida MES as an essential input into future business case analysis |
| HIGHLIGHTS | • **Review and cross-walk a wide range of current state documentation** on current systems and applications<br>• **Develop initial list of technology components** for inventory inclusion<br>• **Validate and refine inventory list** with SEAS and Agency stakeholders to ensure the critical components are included | • **Develop basic profile of each component** including its official name, a description of its function, and information on the vendor or maintaining organization<br>• For relevant systems **identify the contract number, value, expiration, and renewal terms**<br>• Capture an **estimate of the top business user groups of each component** | • **Catalog the full list of inventory components** across the Florida Medicaid Management Information System (MMIS), MES, and by business owner<br>• **Identify systems impacted at relevant times of the FX roadmap**<br>• **Capture timeline for future component upgrades and transitions**<br>• **Visualize electronic interfaces among inventory components**<br>• **Inform business case analysis of component sunsetting as future modules go live** |
| OUTPUT | • Full list of systems and applications to be included in resulting inventory | • Excel data/information repository on each inventory component<br>• List of recommended data fields for AHCA IT to add to their Configuration Management Database (CMDB) | • PowerPoint visualization and analysis of the inventory components |

# CURRENT STATE OPERATIONS ASSESSMENT - OVERVIEW

| Organizational Maps | Systems Inventory | Stakeholder Current State Analysis | Stakeholder Experience Maps | Benefits Identification and Analysis | State MMIS Research | HHS Opportunities | Background Research | Module Definitions |
|---|---|---|---|---|---|---|---|---|
| ▪ **Mapping of modules and business functions** to business areas | ▪ Summary of all **existing systems and contracts**<br>▪ Details in Appendix | ▪ Summarizes **stakeholder current state processes** and primary **pain points**<br>▪ Focuses on **providers and recipients** | ▪ Portrays the **stakeholder experience** with primary touchpoints<br>▪ Focuses on **providers and recipients** | ▪ **Assessment of existing benefits and identification of new benefits**<br>▪ Describes **data gathering** processes<br>▪ Details in Appendix | ▪ Describes results of **interviews with external states** transitioning to a modular environment<br>▪ Details in Appendix | ▪ Analysis of **current HHS interoperability initiatives**<br>▪ Identification of **opportunities for collaboration** within HHS environment | ▪ Background research materials used<br>▪ Includes **interagency reuse, federal performance measures, certification, and Medicaid data** | ▪ Includes details on each **module scope of services**<br>▪ Describes each **module component** in detail |

# ORGANIZATIONAL MAPS

## ORGANIZATIONAL MAPS

Mapped both business functions and modules to divisions and business areas in the organization. Mapped the number of contractual, financial management, provider, recipient, analysis, and administrative functions to the appropriate division and business area. Business areas included Contract Management, Performance Management, Legal Case Management, Financial Planning, Rate Setting, Claims Processing, Encounters Processing, Finance Operations, Third Party Liability, Provider Enrollment, Provider Licensure, Recipient Management, Data & Analytics, Policy Setting, Fraud & Abuse, Facilities Management, and Administrative.

# BUSINESS FUNCTION MAP

**Description**

The chart below shows the business functions that are performed in each bureau.

| Division | Business Area | Business Function | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Contractual | | | Financial Management | | | | | | Provider | | Recipient | Analysis | | | Administrative | | |
| | | CM | PM | LCM | FP | RS | CP | EP | FO | TPL | PE | PL | RM | DA | PS | FA | FM | ADM | COM |
| Chief of Staff | Communications | | | | | | | | | | | | | | | | | 4 | 4 |
| | Legislative Affairs | | | | | | | | | | | | 4 | | | | | 4 | 4 |
| | IT | | | | | | | | | | | | | | | | | 4 | |
| Operations | Financial Services | | | | 4 | | 4 | 4 | 4 | 4 | | | | | | | | 4 | |
| | Human Resources | | | | | | | | | | | | | | | | | 4 | |
| | Support Services | | | | | | | | | | | | | | | | 4 | 4 | |
| Health Quality Assurance | Health Facility Regulation | | | | | | | | | | 4 | 4 | | | | | | | |
| | Field Operations | | | | | | | | | | 4 | 4 | | 4 | | | | | 4 |
| | Central Services | | | | | | | | | | 4 | 4 | | 4 | | | | 4 | 4 |
| | Plans and Constructions | | | | | | | | | | | 4 | | | | | | | |
| | FL Center for Health IT | | | | | | | | | | | | | 4 | | | | | |
| | Medicaid Program Integrity | | | | | | | | | | | | | | | 4 | | | |
| Medicaid | Medicaid Program Finance | 4 | 4 | | 4 | 4 | | | 4 | | | | | | | | | | |
| | Medicaid Data Analytics | | 4 | | | 4 | | | | | | | | 4 | | | | | |
| | Third Party Liability | | | | | | | | | 4 | | | | | | | | | |
| | Medicaid Policy | 4 | | | | | | | | | | | | | 4 | | | 4 | |
| | Medicaid Quality | | 4 | | | | | | | | | | | 4 | | | | | 4 |
| | Medicaid Plan Management Operations | 4 | 4 | | | | | | | | | | | | | | | | |
| | Medicaid Fiscal Agent Operations | 4 | 4 | | | | 4 | 4 | | | 4 | | 4 | 4 | | | | | 4 |
| | Recipient and Provider Assistance | 4 | 4 | | | | | | | | 4 | | 4 | | | | | | |
| Inspector General | Inspector General (All Bureaus) | | | | | | | | | | | | | | | 4 | | | |
| General Counsel | General Counsel (All Bureaus) | | | 4 | | | | | | | | | | | | | | | |

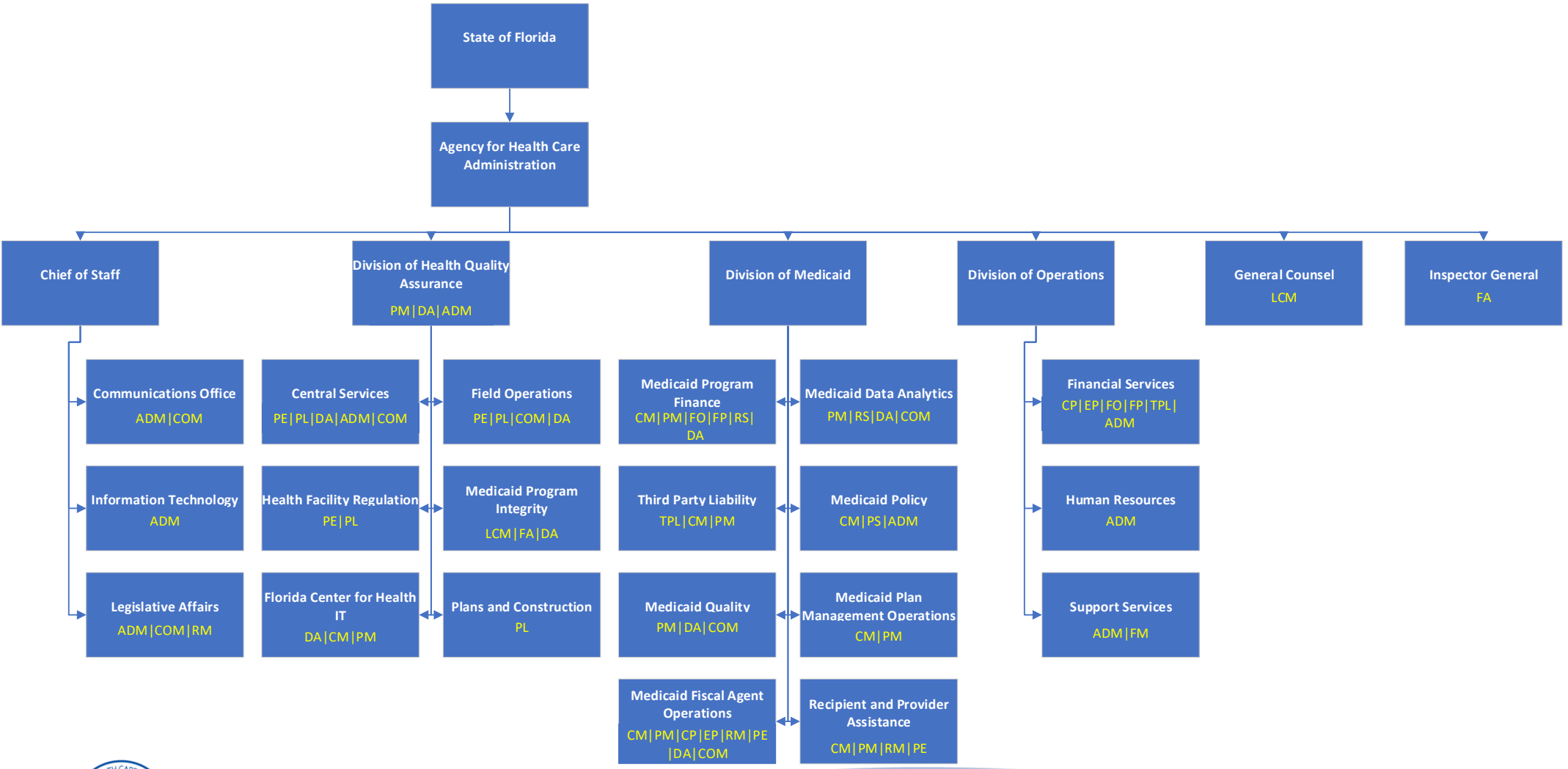
## Legend

| | |
|---|---|
| CM | Contract Management |
| PM | Performance Management |
| LCM | Legal Case Management |
| FP | Financial Planning |
| RS | Rate Setting |
| CP | Claims Processing |
| EP | Encounters Processing |
| FO | Finance Operations |
| TPL | Third Party Liability |
| PE | Provider Enrollment |
| PL | Provider Licensure |
| RM | Recipient Management |
| DA | Data & Analytics |
| RM | Recipient Mgmt. |
| PS | Policy Setting |
| FA | Fraud & Abuse |
| FM | Facilities Management |
| ADM | Administrative |

# FUNCTIONAL ORG CHART

| DIVISION | BUREAU | | | | | |
|---|---|---|---|---|---|---|
| Chief of Staff | Communications<br>• Admin/Other<br>• Communications | Legislative Affairs<br>• Admin/Other<br>• Communication<br>• Recipient Management | IT<br>• Admin/Other | | | |
| Operations | Financial Services<br>• Claims/Encounters Processing<br>• Finance Operations/Planning<br>• TPL<br>• Admin/Other | Human Resources<br>• Admin | Support Services<br>• Admin<br>• Facilities Management | | | |
| Health Quality Assurance | HFR<br>• Provider Enrollment/ Licensure | Field Operations<br>• Provider Enrollment/ Licensure<br>• Communication<br>• Data/Analytics | Central Services<br>• Provider Enrollment/Licensure<br>• Data/Analytics<br>• Admin<br>• Communication | Plans & Construction<br>• Provider Licensure | FL Center for Health IT<br>• Data/Analytics | MPI<br>• Legal Case Management<br>• Fraud/Abuse |
| Medicaid | Medicaid Program Finance<br>• Contract/Performance Management<br>• Financial Operations/Planning<br>• Rate Setting | Medicaid Policy<br>• Contract Management<br>• Policy Setting<br>• Admin/Other | Third Party Liability<br>• Third Party Liability | Medicaid Data Analytics<br>• Performance Management<br>• Rate Setting<br>• Data/Analytics | | |
| | MFAO<br>• Contract/Performance Management<br>• Claims/Encounters Processing<br>• Recipient Management<br>• Provider Enrollment<br>• Data/Analytics<br>• Communication | Medicaid Quality<br>• Performance Management<br>• Data/Analytics<br>• Communication | MPMO<br>• Contract/Performance Management | Recipient/Provider Assistance<br>• Contract/Performance Management<br>• Recipient Management<br>• Provider Enrollment | | |
| Inspector General | All Bureaus | • Fraud/Abuse | | | | |
| General Counsel | General Counsel | • Legal Case Management | | | | |

# BUSINESS FUNCTION ORG CHART




## Legend

| | |
|---|---|
| CM | Contract Management |
| PM | Performance Management |
| LCM | Legal Case Management |
| FP | Financial Planning |
| RS | Rate Setting |
| CP | Claims Processing |
| EP | Encounters Processing |
| FO | Finance Operations |
| TPL | Third Party Liability |
| PE | Provider Enrollment |
| PL | Provider Licensure |
| RM | Recipient Management |
| DA | Data & Analytics |
| PS | Policy Setting |
| FA | Fraud & Abuse |
| FM | Facilities Management |
| ADM | Administrative |
| COM | Communications |

# MODULE MAP

**Description**

The chart below displays the amount of impact each modular procurement will have on individual bureaus.

| Division | Business Area | Module | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | IS/IP | EDW | Provider | Core | Contact Center | Recipient/ Enrollment Broker | PBM | Plan Management | TPL | Legal/ Enterprise Case | Contractor Management |
| **Dates of DDI** | | **11/19-2/21** | **6/20-4/22** | **7/21-5/23** | **12/21-5/23** | **6/22-2/23** | **7/22-5/23** | **1/24-8/24** | **1/26-5/27** | **7/24-8/25** | **12/25-3/27** | **10/25-11/26** |
| **Chief of Staff** | **Communications** | | | | | | | | | | | |
| | **Legislative Affairs** | 2 | 2 | | | | | | | | 2 | |
| | **IT** | 3 | 2 | | | 4 | | | | | | |
| **Operations** | **Financial Services** | 4 | 4 | | 4 | | | | | | | |
| | **Human Resources** | | | | | | | | | | 2 | |
| | **Support Services** | | | | | | | | | | | 3 |
| **Health Quality Assurance** | **Health Facility Regulation** | 4 | 4 | 4 | | 4 | | | | | | |
| | **Field Operations** | 4 | 4 | 4 | | 4 | | | | | 2 | |
| | **Central Services** | 4 | 4 | 4 | 4 | 4 | | | | | | |
| | **Plans and Constructions** | | | 2 | | | | | | | | 2 |
| | **FL Center for Health IT** | 4 | 4 | | | | | | | | | |
| | **Medicaid Program Integrity** | 4 | 4 | | 2 | | | | | | | |
| **Medicaid** | **Medicaid Program Finance** | 4 | 4 | | 4 | | | | | | | |
| | **Medicaid Data Analytics** | 4 | 4 | | 2 | | | | | | | |
| | **Third Party Liability** | 3 | 3 | | | 4 | | | | 4 | | |
| | **Medicaid Policy** | 3 | 3 | 2 | 2 | | 2 | 3 | 3 | 2 | 2 | 2 |
| | **Medicaid Quality** | 4 | 4 | | | | | | 4 | | | 3 |
| | **Medicaid Plan Management Operations** | 4 | 4 | | | | | | 4 | | | |
| | **Medicaid Fiscal Agent Operations** | 4 | 4 | 4 | 4 | 4 | 4 | | | | | |
| | **Recipient and Provider Assistance** | 3 | 3 | 4 | | 4 | 4 | | | | | |
| **Inspector General** | **Inspector General** | 3 | 3 | | | | | | | | 4 | |
| **General Counsel** | **General Counsel** | 3 | 3 | | | | | | 2 | | 4 | |

**Degree of Impact**

| | |
|---|---|
| 25% | **1** |
| 50% | 2 |
| 75% | 3 |
| 100% | 4 |

# FUNCTIONAL ORG CHART

## DIVISION

## BUREAU – MODULE MAP

### Chief of Staff

| Communications | Legislative Affairs | | | IT | |
|---|---|---|---|---|---|
| | Case Mgmt. | EDW | IS/IP | EDW | IS/IP |
| | 2 | 2 | 2 | 2 | 3 |

### Operations

| Financial Services | | | Human Resources | Support Services |
|---|---|---|---|---|
| Core | EDW | IS/IP | Case Management | Contractor Management |
| 4 | 4 | 4 | 2 | 3 |

### Health Quality Assurance

| HFR | | | Field Operations | | | | Central Services | | | | Plans & Construction | | FL Center for Health IT | | MPI | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EDW | IS/IP | Provider Mgmt. | Case Mgmt. | Provider Mgmt. | EDW | IS/IP | Provider Mgmt. | Core | EDW | IS/IP | Provider Mgmt. | Contractor Mgmt. | EDW | IS/IP | Core | EDW | IS/IP |
| 4 | 4 | 4 | 2 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 2 | 2 | 4 | 4 | 2 | 4 | 4 |

### Medicaid

| Medicaid Fiscal Agent Operations | | | | | Medicaid Program Finance | | | Third Party Liability | | | Medicaid Data Analytics | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provider Mgmt. | Recipient | Core | EDW | IS/IP | Core | EDW | IS/IP | TPL | EDW | IS/IP | Core | EDW | IS/IP |
| 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 3 | 3 | 2 | 4 | 4 |

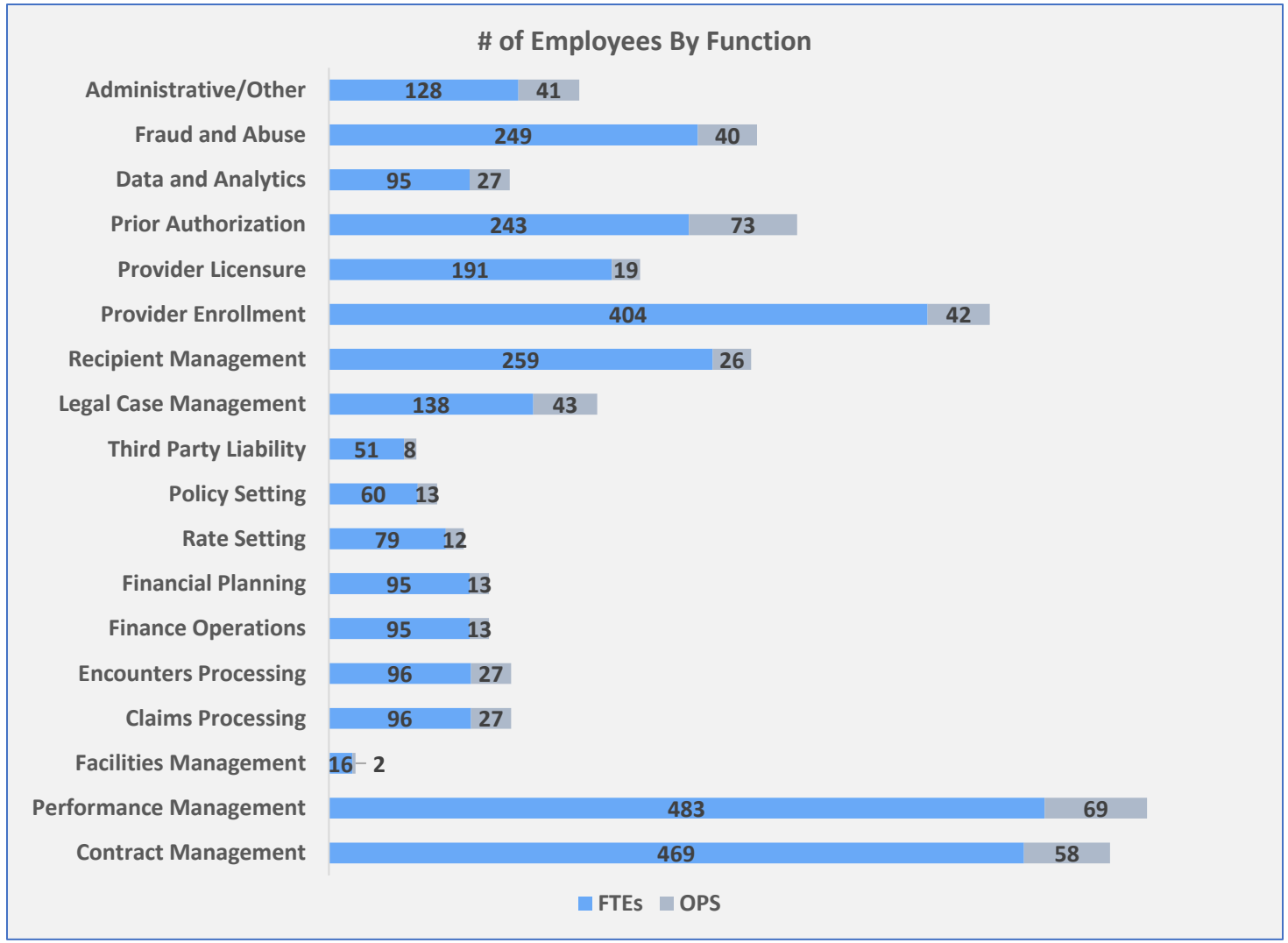
| Medicaid Policy | | | | | | RPA | | MPMO | | Medicaid Quality | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Care Mgmt. | Case Mgmt. | Provider Mgmt. | Recipient | | TPL | Recipient | Provider Mgmt. | EDW | 4 | Contractor Mgmt. | EDW |
| 2 | 2 | 2 | 2 | | 2 | 4 | 4 | IS/IP | 4 | 3 | 4 |
| EDW | IS/IP | Contractor Mgmt. | PBM | Plan Mgmt. | Core | EDW | IS/IP | Plan Mgmt. | 4 | IS/IP | Plan Mgmt. |
| 3 | 3 | 2 | 4 | 3 | 2 | 2 | 2 | | | 4 | 4 |

### Inspector General

### General Counsel

| Inspector General All Units | | | | | | General Counsel All Units | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EDW | 3 | Case Mgmt. | 4 | IS/IP | 3 | Case Mgmt. | 4 | EDW | 3 | IS/IP | 3 | Plan Mgmt. | 2 |

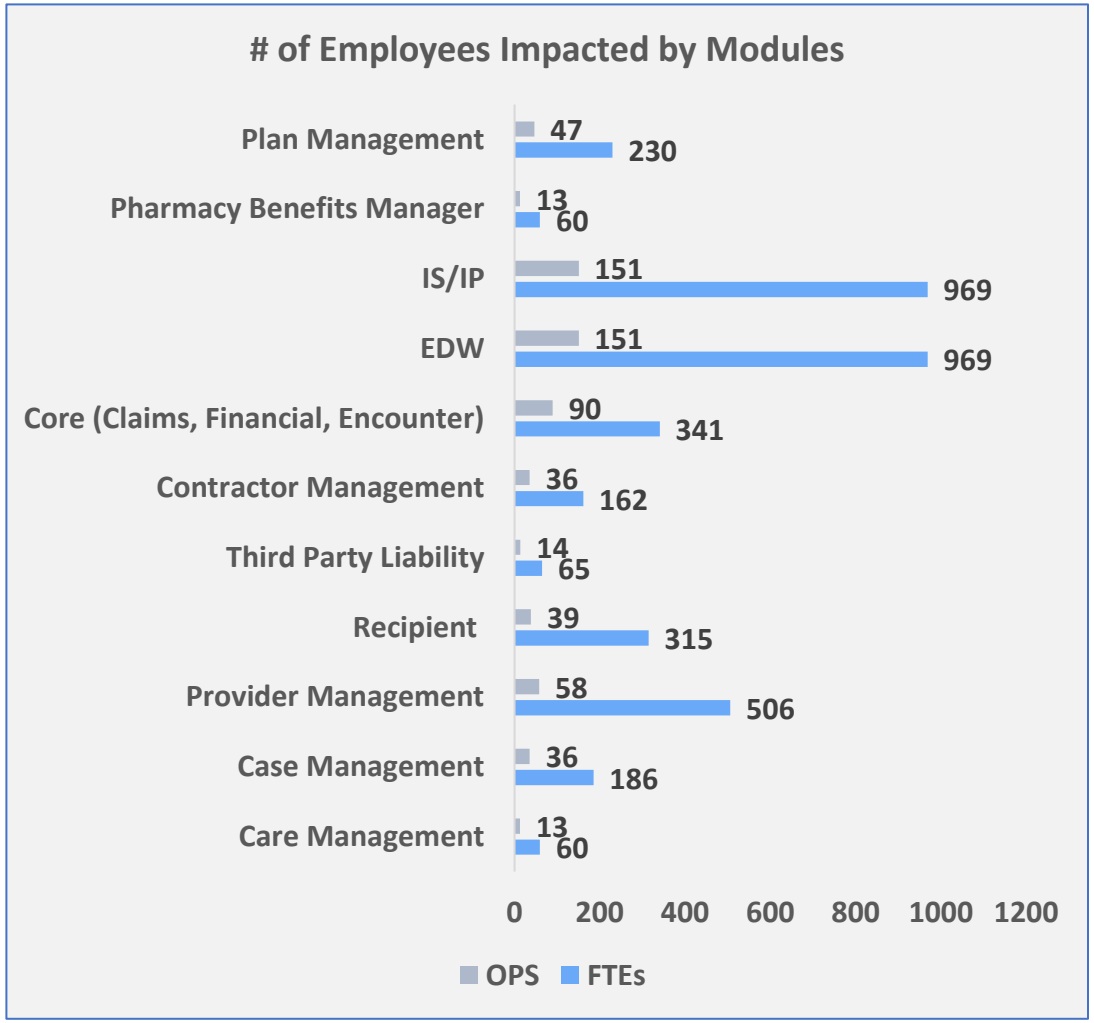
# EMPLOYEE IMPACT ANALYSIS : BUSINESS FUNCTIONS




## Key Insights

- Top 3 functions by employee impact:
  - Performance Management
  - Contract Management
  - Provider Enrollment
- Modules impacting these business functions need to be prioritized
- Additional change management support will be needed to address these functional areas

# EMPLOYEE IMPACT ANALYSIS : MODULES




## Key Insights

- The analysis validates the Agency's decision to prioritize the EDW and IS/IP modules since they each impact ~1,120 employees
- The impact analysis also supports the current prioritization of modular implementation
- Time and cost to implement the IS/IP and EDW modules will be higher


# STAKEHOLDER CURRENT STATE ANALYSIS

# STAKEHOLDER CURRENT STATE ANALYSIS

## STAKEHOLDER CURRENT STATE

Background information to complement the research on the current state of provider and recipient business processes, pain points, and recommendations for the future state. Obtained this information from reviewing the Provider Business Case, Agency business processes, and interviews with Agency subject matter experts across Agency business areas. The objective of this research was to understand pain points and opportunities to improve current business processes through a future state modular environment.


# PROVIDER PROCESS FLOW, PAIN POINTS, AND RECOMMENDATIONS

# PROVIDER PROCESS FLOW

## The provider flow can be mapped to 4 distinct stages : Licensure, Enrollment, Provider Management, and Financial Management.

| | 1 LICENSURE | 2 ENROLLMENT | 3 PROVIDER MANAGEMENT | 4 FINANCIAL MANAGEMENT |
|---|---|---|---|---|
| **Objective** | Facilitate certification and/or licensure for individuals and facilities | Onboard and credential a Medicaid provider in Fee For Service and Managed Care | Maintain up to date information on a provider's license or enrollment status | Adjudicate claims and encounters submitted by providers and plans |
| **Sub-Processes** | • **Individual Licensure:** Process governed by the Florida Board of Medicine within the Department of Health that allows practice in the state<br>• **Facility Licensure:** Process governed by AHCA that enables facilities to conduct business in the state | • **Limited Enrollment:** Enroll in Medicaid with health plans<br>• **Full Enrollment:** Enroll in Medicaid to include Fee-for-Service<br>• **Enhanced Screening:** Review process for federally defined specialty types<br>• **Field Office Inspection:** Additional field office review defined as high risk in FL statutes<br>• **Provider Credentialing:** Ensure providers enrolled in plan networks meet their standards | • **Renewal:** Re-evaluate a license or enrollment every 2-3 years<br>• **Change of Ownership:** Sale or change in majority ownership of a facility or practice<br>• **Change of Name/Address:** Demographic or a physical change in office location<br>• **Change of Sub-Specialty:** Changing sub-specialty categories by provider<br>• **Provider Network Verification:** Process to verify plan adequacy, and provide provider roster for choice counseling weekly | • **Claims Processing:** Adjudicate claims submitted by providers for services<br>• **Encounter Processing:** Adjudicate encounters submitted by the health plans<br>• **Funds Disbursement:** Process accounts payable or funds recoupment from claims adjudication |
| **Key Pain Points Themes** | • **Manual** processes<br>• **Multiple touchpoints**<br>• **Paper** applications<br>• Poor **communication** | • **Manual processes**<br>• **Limited** data sharing<br>• **Lack of workflow** capabilities<br>• Limited **information sharing** | • **Multiple data points and** entries<br>• High % of **denials of Change of Ownership (CHOW)**<br>• Renewal **timeframe misalignment**<br>• **Inefficient re-credentialing** process | • **Multiple data** entries, data mismatch<br>• High % of **claims/encounters denials**<br>• **Lack of information**<br>• Poor **web portal functionality** |

# CURRENT STATE MEDICAID PROCESS HIGHLIGHTS

**The limitations with current provider process flow are driven by the initial application submission and validation shortfalls, long onboarding process, and high percentage of claims/encounter denials, among others.**

**49%**
of Medicaid applications are returned for additional info

**~9 months**
taken to complete Medicaid Provider onboarding process

**~35%**
of claims denied or returned with errors between 2018 - 2019

**~30%**
of encounters denied or returned with errors between 2018 -2019

Notes: (1) Data from Stakeholder Interviews and NH research
DXC Applications process historical trending (2019)

# CURRENT STATE LICENSURE PROCESS HIGHLIGHTS

**The limitations with current provider process flow are driven by the manual initial license submission and validation shortfalls, and long onboarding process survey requirements.**

**100%**
of Initial License applications are submitted manually

**85%**
of Initial License applications contain omissions

**~2 months**
taken to complete License process without a survey

**~3 months**
taken to complete License process with a survey

Notes: (1) Data from Stakeholder Interviews and HQA Data

# IMPACT TO AGENCY AND PROVIDERS

**The limitations with current provider process flow negatively impacts the provider experience and results in additional administrative work for the providers, reducing the time available to provide care to the recipients.**

## AGENCY IMPACT

- High administrative costs associated with multiple handling of provider documents
- Long onboarding times prevents providers from enrolling with Medicaid
- High % of denials makes it difficult to have a robust provider network and results in poor data reporting
- Denials reduce ability to leverage data for forecasting, rate-setting, and monitoring plan performance

## PROVIDER IMPACT

- Correcting a rejected application requires the provider to start at the beginning of the process
- Providers incur costs without generating any revenue until enrollment is complete
- High % of denials results in additional paperwork and poor provider experience
- Denials results in additional work that includes document resubmission and follow-up with plans

# ADDRESSING THE PAIN POINTS : LICENSURE

## Key pain points: Paper applications, multiple document submissions, manual processes, and poor communication.


| PROCESS | CURRENT STATE | FUTURE STATE |
|---|---|---|
| LICENSURE | **Paper applications** are required for all initial facilities licensure. **Data entry clerks transcribe** the applications **manually** | • Allow provider to **submit initial application** through the portal |
| | Providers submit the **same documentation to multiple entities**, **multiple times** to obtain their credentials | • **Online portal with single sign-on** capabilities to address the needs of multiple agencies with data sharing capabilities<br>• Agency should exercise the **single source provision** in the contract with the managed care organizations and expand the capabilities to better utilize Council for Affordable Quality Healthcare to monitor plans |
| | Providers are **unaware of the time allowed to correct errors** and are **unable to track status** of their licensure or Medicaid application | • Enhance portal to provide **real time status** for provider applications with adequate information to address the providers needs<br>• Improve **Certification and Licensure communications** to include time frame allowed to correct deficiencies |
| | Providers **experience delays and challenges** in becoming operational which delays their ability to recoup the start-up costs | • **Procure workflow management system** to track applications and tasks related to their processing through the lifecycle |
| | Providers must contact the Agency for surveys as there is currently **no electronic way** to check status, cancel, or reschedule surveys | • **Procure workflow management system** to track applications and tasks related to their processing through the lifecycle<br>• **Clearly state the expectation** in the initial notification and in the web portal for site visit |

# ADDRESSING THE PAIN POINTS : ENROLLMENT

## Key pain points: Manual processes, limited data sharing, lack of workflow capabilities, and multiple contact points.


| PROCESS | CURRENT STATE | FUTURE STATE |
|---|---|---|
| ENROLLMENT | Employees must **manually cross-check every license** in the DOH system | • Online portal with **single sign-**on capabilities that has functionality to address all licensure, enrollment, and credentialing needs |
| | Tasks are shifted between the contracted Fiscal Agent and Agency staff for processing, which can lead to **delays or missed** hand-offs | • **Procure workflow management system** to track applications and tasks related to their processing through the lifecycle<br>• **Multiple tasks could be handled** by the Fiscal Agent without Agency intervention while maintaining sufficient control |
| | Providers experience delays and inefficiencies in enrollment due to **lack of dedicated work queues** | • Creation of **dedicated work queues** and **assignment to specific user groups** to complete tasks |
| | Providers requiring a Field Office site visit indicated the **process is manual and time consuming with no automation** | • **Procure workflow management system** to track applications and tasks related to their processing through the lifecycle |
| | Providers **call Agency employees directly** rather than the designated channel for inquiries due to lack of guidance, multiple call centers, and lack of confidence in the Fiscal Agent call center | • **Enhanced self-help features** to assist provider in navigating through the enrollment process<br>• **Streamline the contact methods** for the provider (e.g., implementation of intelligent contact routing) |

# ADDRESSING THE PAIN POINTS : PROVIDER MANAGEMENT

## Key pain points: Multiple data submissions, high denial rate, timeframe misalignment, and inefficient credentialing process.


| PROCESS | CURRENT STATE | FUTURE STATE |
|---|---|---|
| PROVIDER MANAGEMENT | **No single source to report a change**. The provider must contact and provide supplemental information to multiple entities | Data should be collected through a **single online portal** and used by multiple agencies, divisions, and plans |
| | **17.2% of Change of Ownership** (CHOW) license applications are initially denied by the Agency and providers report that CHOW process **can take up to ~9 months to complete** | **Upfront edits built into portal** to ensure all the needed data is provided<br>**Enhanced communications** through portal |
| | Recredentialing is not a standard process amongst the plans and providers are required to **recredential with each contracted plan** | Execute provision in contract for **single source credentialing** |
| | **Medicaid renewal and plan credentialing** are on different timeframes, creating a continuous process of document submission | **Align timeframes** for Enrollment, Licensure, and Credentialing |
| | **Multiple data sources are required** to verify Medicaid providers in a health plan's network and the Agency is entirely reliant on the plans to update their roster to reflect current provider status | **Utilize automated data matches** with IS/IP, EDW, and the Provider Module to verify network adequacy |

# ADDRESSING THE PAIN POINTS : FINANCIAL MANAGEMENT

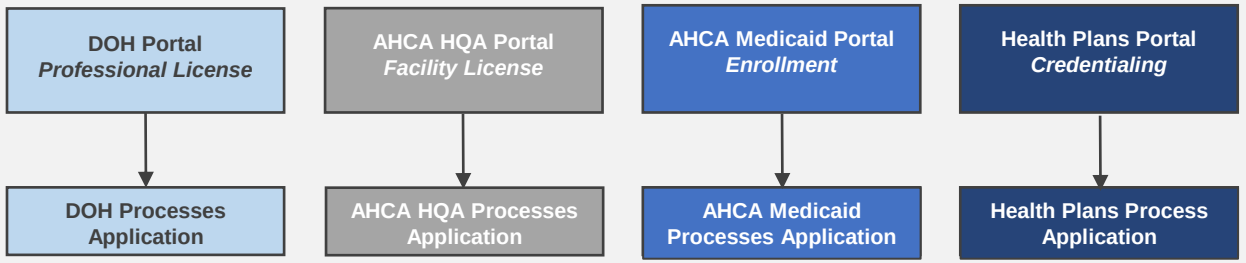
## Key pain points: Multiple data entries, data mismatch, high claims/encounter denials, and poor web portal functionality.

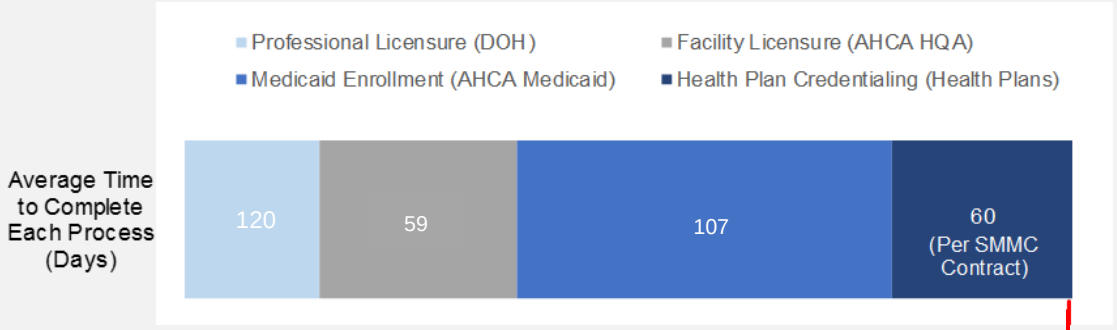

| PROCESS | CURRENT STATE | FUTURE STATE |
|---|---|---|
| FINANCIAL MANAGEMENT | **Claims/encounters that are denied or returned** with errors creates an unnecessary administrative burden for the providers | **Automated upfront edits** with intuitive on-screen messages to be built into the portal to enhance the quality of data upon submission |
| | Providers need to **submit claims to multiple health plan portals**, each with unique requirements | **Single online portal for claim entry and submission** that supports fee-for-service and managed care with capability to parse files to the format unique to each individual plan |
| | **Inability to match the provider's Medicaid Provider Information** was among the primary reasons for denial of claims | **Utilize Master Person Index (MPI) and Master Organization Index (MOI) with IS/IP** for provider identity reconciliation |
| | Providers must **enter detailed identifying information** on each claim which must match the Agency's information. **Mismatched data** can cause claims to be denied or delayed | **Automate validation of checklist items reviewed** in the portal prior to submission for immediate feedback |
| | Providers indicated that **payment codes are not intuitive or easy to understand** which can take time for the provider to resolve | **Clear and concise communications** to assist providers in understanding error and payment codes prior to submission<br>**Improved timeliness** of updating Handbooks and Manuals |
| | Claims Web Portal does **not clearly indicate which fields are mandatory**, which can result in providers filling out unnecessary fields which costs them time | **Enhanced self-help features** and **online assistance** to assist providers in the submission of claims |

# FUTURE STATE: CONCEPTUAL MODEL

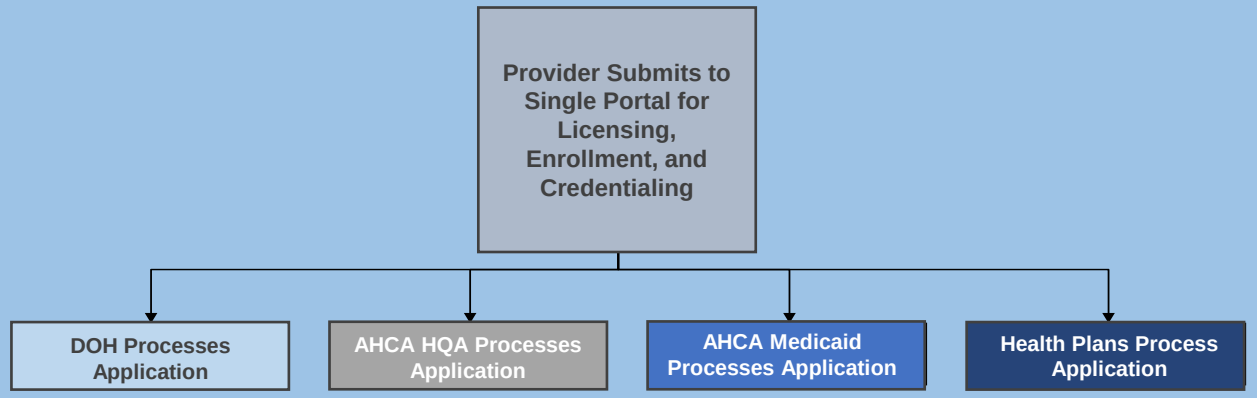
**The future state model envisions streamlined provider licensure, facility licensure, Medicaid enrollment, account maintenance, and plan credentialing processes which will reduce the onboarding time by ~4 months.**

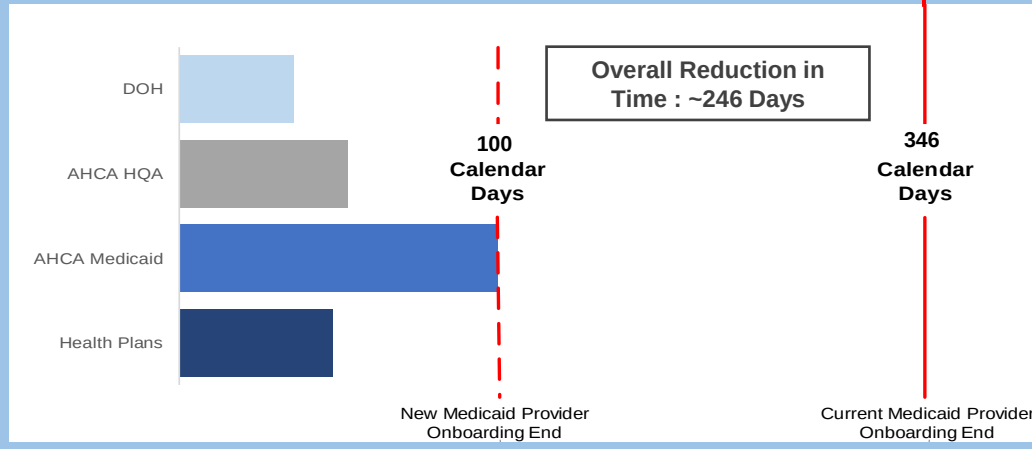
## CURRENT STATE : MULTIPLE PORTALS




## CONCEPTUAL FUTURE STATE : SINGLE PORTAL




# RECIPIENT PROCESS FLOW, PAIN POINTS, AND RECOMMENDATIONS

# RECIPIENT PROCESS FLOW

## The recipient flow can be mapped to 3 distinct stages : Eligibility, Enrollment, and Case Maintenance.

| | 1 ELIGIBILITY | 2 ENROLLMENT | 3 CASE MAINTENANCE |
|---|---|---|---|
| **Definition** | *Process to determine if an individual meets the federal and state requirements to receive Medicaid benefits* | *Process to enroll or disenroll an individual in health benefits and assignment to a health plan* | *Ongoing process to maintain up to date information on an individual's enrollment status* |
| **Sub-Processes** | • **Initial Eligibility:** Application process governed by federal and state laws that requires verification of financial and non-financial factors of eligibility to assess if an individual meets the criteria to qualify for Medicaid.<br>• **Annual Redetermination:** Annual process to re-evaluate financial and non-financial factors of eligibility to assess if an individual still meets the criteria to qualify for Medicaid.<br>• **Change Processing:** The ongoing process to determine if an individual's change in financial and non-financial circumstances impacts their eligibility to qualify for Medicaid. | • **Benefit Plan Assignment:** Process to assign an individual to the benefit plan based on the individual's age and assistance category<br>• **Provider Choice:** Process to review and select a health and dental plan participating in the individual's region<br>• **Plan Enrollment:** Process to auto assign an individual into a plan or into the plan that they selected<br>• **Disenrollment:** Process to remove an individual from the active Medicaid Roster and Plan assignment | • **Renewal:** Process to re-evaluate enrollment annually<br>• **Monthly Plan Assignment (Monthly Magic):** Process to validate continued Medicaid enrollment for the following month<br>• **Change of Name/Address/Demographics:** Process triggered by a demographic change or a physical change of residence<br>• **Change in Plan Assignment:** Process triggered by an individual's desire to change health plans within an open enrollment period or present a good cause exemption<br>• **Change in Benefit Plan Assignment:** Process to change an individual's benefit plan based on a change in their circumstances<br>• **File Reconciliation:** Process to validate and correct enrollments that are erroneously removed or included |
| **Pain Points** | • Multiple entry points and unique web portals causes confusion on where to apply<br>• Documentation and annual redetermination processes vary amongst processing entities<br>• Recipient receives communications from multiple entities causing confusion.<br>• Multiple contact centers support different agencies and the applicant does not know which one to contact | • Recipient can have multiple Medicaid ID numbers<br>• Individual family members enroll in different programs/plans<br>• Delay in receiving files from fiscal agent causes a lag time for an individual's plan enrollment<br>• Bad addresses from external agencies leads to returned mail<br>• Incorrect county codes leads to erroneous plan assignments<br>• DCF will not accept an updated address from the Enrollment Broker | • Recipients may need to renew eligibility with multiple entities<br>• Recipients report changes to multiple entities<br>• Recipients enrolled in both Title XIX and XXI in the same month<br>• Changes initiated from eligibility agency overwrites recipient data in enrollment system<br>• Manual processes to reconcile recipient files to delete duplicates<br>• Need to review data from multiple systems to reconcile |

# ADDRESSING THE PAIN POINTS : ELIGIBILITY

## Key pain points: Multiple entry points, lack of process standardization, and multiple contact centers.


| PROCESS | CURRENT STATE | FUTURE STATE |
|---|---|---|
| | • Recipients are required to apply through multiple web portals across several Agencies, causing a poor experience<br>• The eligibility process can be confusing requiring applicants to be transferred between processing entities | • Single recipient portal that supports all eligibility for Title XIX and XXI<br>• Single department responsible for all eligibility determinations |
| ELIGIBILITY | • Documentation and annual redetermination processes vary amongst processing entities<br>• Recipient receives communications from multiple entities causing confusion<br>• Conflicting correspondence is generated and sent to applicants | • Single process to determine and redetermine eligibility utilizing real-time determinations through web interfaces<br>• Single source of eligibility generates all necessary correspondence to applicants<br>• Recipient portal has secure electronic mail capabilities |
| | • Because multiple contact centers support different agencies, the applicant may not know which one to contact and may have to explain their situation multiple times | • Single consolidated contact center with CRM software capturing past information about applicant<br>• Expanded channels of communications (web-chat, text, mobile app) |

# ADDRESSING THE PAIN POINTS : ENROLLMENT

## Key pain points: Multiple enrollments, manual file exchange, multiple Medicaid IDs, and lack of data validation.


| PROCESS | CURRENT STATE | FUTURE STATE |
|---|---|---|
| ENROLLMENT | • Individual family members can be enrolled in different programs and plans | • Agency contracts with plans to provide networks for all Title XIX and XXI recipients<br>• Transition all Title XXI children into MMA plans |
| | • Delay in receiving files from fiscal agent causes a lag time for an individual's plan enrollment<br>• Batch enrollment files received nightly | • Move enrollment broker functions for plan assignment to a single recipient portal for eligibility and enrollment at DCF<br>• Choice of plans and providers displayed in recipient portal<br>• Real-time enrollment through web interface |
| | • Recipient can have multiple Medicaid ID numbers | • Master person index utilized to cleanse data |
| | • Lack of common systems lead to incorrect addresses from other HHS agencies (DCF, SSA, HK) resulting in returned mail and lack of ability to communicate to recipients<br>• Incorrect county code in file from DCF leads to erroneous plan assignments<br>• DCF will not accept an updated address from the Enrollment Broker | • Expand communications through a secure mail function in the portal<br>• Expand communications through webchat, text, or mobile apps<br>• Recipient portal will utilize postal verification software to ensure correct address<br>• Workflow created when postal software reports an address change |

# ADDRESSING THE PAIN POINTS : CASE MAINTENANCE

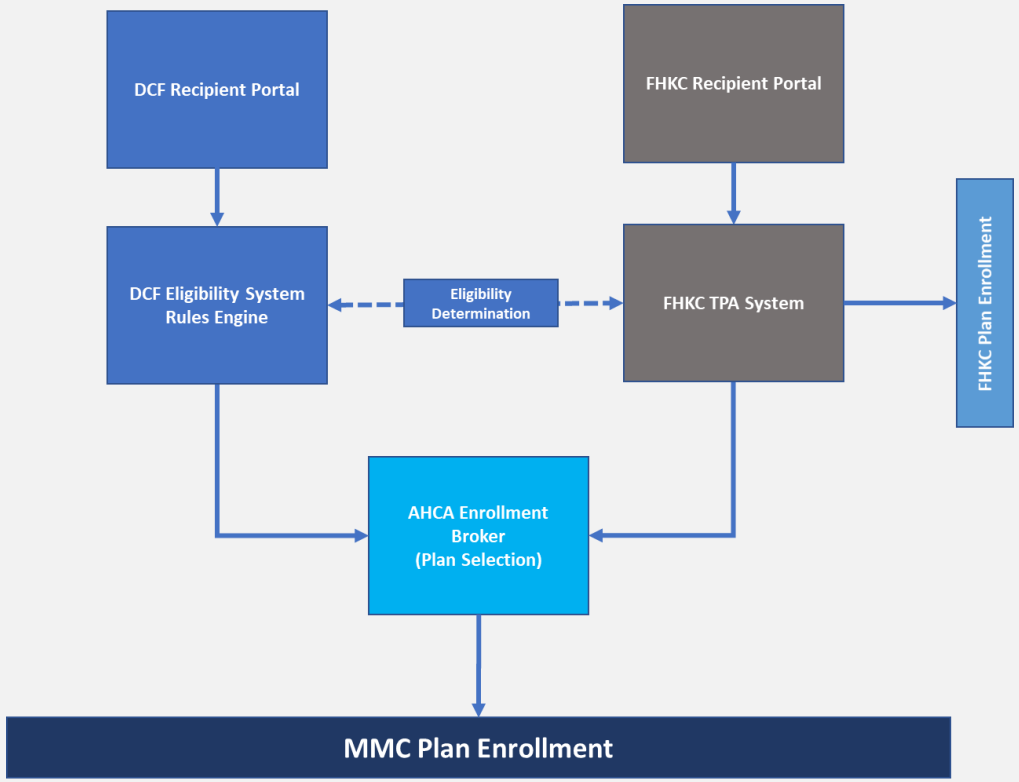
## Key pain points: Diverse touchpoints, workflow inefficiencies, manual processes, and poor data quality.


| PROCESS | CURRENT STATE | FUTURE STATE |
|---|---|---|
| CASE MAINTENANCE | • Recipients may need to renew eligibility with multiple entities<br>• Recipients report changes to multiple entities | • Single recipient portal that supports all eligibility renewal for Title XIX and XXI<br>• Single recipient portal to report all changes that potentially impact enrollment in Title XIX or XXI<br>• Single department responsible for all eligibility determinations and case maintenance activities<br>• Consolidated contact center and communications channels for change reporting |
| | • Recipients enrolled in both Title XIX and XXI in the same month | • Seamless transition between programs with a single eligibility system transmitting enrollment |
| | • Changes initiated from eligibility agency overwrites recipient data in enrollment system | • Single source of data through the recipient portal<br>• Changes reported through the recipient portal will replicate change across the eligibility and enrollment systems |
| | • Manual processes to reconcile recipient files to delete duplicates<br>• Need to review data from multiple systems to reconcile | • Master person index utilized to cleanse data |

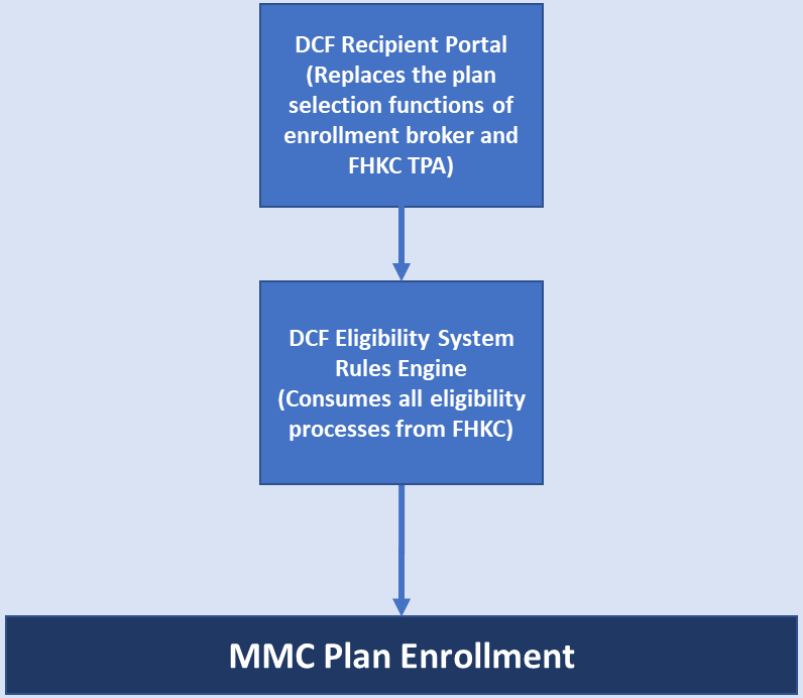
# FUTURE STATE: CONCEPTUAL MODEL

**The future state model envisions a single portal for recipients to interact to streamline eligibility, enrollment, and account maintenance which will reduce confusion and administrative burden on the recipients.**

## CURRENT STATE : MULTIPLE PORTALS




## CONCEPTUAL FUTURE STATE : SINGLE PORTAL




*FHKC TPA= Florida Health Kids Corporation Third Party Administrator

# SUMMARY OF RECOMMENDATIONS

**Addressing the provider experience and process needs will improve access to care for recipients by enabling providers to focus on delivering quality services.**

### Redesign the Onboarding and Enrollment Processes

Redesign the provider process into a single simplified workstream that intersects AHCA divisions and crosses over Agency boundaries

**Single Data Source | Online Portal | Data Sharing**

### Develop Workflow and Assignment Management

Reduce the overall cycle time for Onboarding and Enrollment process by improving the assignment, tracking, and measurement of all process flows

**User-Specific Work Queue | Tracking and Reporting**

### Redesign Claims Web Portal

Redesign the provider Claims Portal into a single simplified workstream that supports the provider's ability to submit claims to Agency or plans

**Single Portal | Self-Help | Standardized Data**

### Augment Performance Management Measurement

Enhance performance monitoring activities throughout the lifecycle of the provider's interactions throughout the enterprise and with the Agency's vendors

**Dashboard Metrics | Quality and Process Indicators**

### Upgrade Customer Care to Improve Provider Management

Improve customer care through improved call routing, agent knowledge management, communication, and service level agreement management

**Self-Service Channels | Streamline Contact Process**

### Enhance Communications Quality and Content

Enhance communication between the Agency, plans, and providers leading to a greater alignment in understanding of Agency requirements

**Automated Alerts | Concise Messaging | Frequency**


# BENEFITS IDENTIFICATION AND ANALYSIS

# BENEFITS IDENTIFICATION AND ANALYSIS

## BENEFITS IDENTIFICATION/ANALYSIS

SEAS conducted benefits identification and analysis in two phases. In Phase 1, SEAS deconstructed benefits from existing FX CBAs, analyzed the CBA benefits, and identified areas that required further validation in Phase 2. For modules with no CBA, SEAS drafted benefits and conducted initial benefits analysis to serve as a foundation for Phase 2. In Phase 2, SEAS is validating all drafted benefits. Benefits realization includes gathering of baseline data and post-implementation data. SEAS is in the process of re-assessing baseline data gathered in previous CBAs and is gathering initial baseline for newly drafted benefits. The new FX benefits have an assigned confidence level. SEAS is prioritizing analysis of benefits with low confidence levels.


# STATE MMIS RESEARCH

# STATE MMIS RESEARCH

## STATE RESEARCH

Background information to complement our research on the current market landscape of Medicaid Enterprise transformation. Obtained this information from interviews with Medicaid and MMIS transformation stakeholders across the country including State Agency executive leaders. The objective of this research was to understand the strategies and approaches taken by other states to achieve modularity.

# STATE RESEARCH

## EXECUTIVE SUMMARY OF MMIS TRANSFORMATION STAKEHOLDER INTERVIEWS

# MEDICAID ENTERPRISE TRANSFORMATION APPROACH

## Overview of state MMIS procurement and implementation strategies from select states across the country.

### Four Transformation Themes Identified*

#### Modular Incremental – Cutover

Replace MMIS with multiple modules and integrate pieces as they are developed

+ Allows states to sunset elements of their current solution
+ Less disruption during incremental implementations of each module
- Incremental implementation may result in some integrations that are unneeded for the final solution adding time and costs

#### Modular Single – Cutover

Build complete stand-alone modular solution before cutover

+ Decreases time and effort necessary to integrate with legacy system
- Full legacy solution remains live until cutover
- Introduces the complexity of maintaining an integrated schedule across all modules

#### Takeover to Modular

Takeover of current MMIS, then modularize over time

+ Allows ability to retain select MMIS elements
+ Minimizes disruption with current stakeholders
- Reduces ability to leverage improved technology

#### Module Cohorts

Combine business areas into fewer procurements, forcing possible vendor partnerships

+ Fewer procurements could reduce the overall timeline
- Vendor community has not yet responded to these procurements
- Increased dependence on a smaller number of vendors

*Note: Category themes identified above are loose groupings of complex state strategies unique to each state's MMIS Transformation. Significant variation exists among states in these groupings.*
*(+/-) symbols denotes pros/cons*

# LESSONS LEARNED FROM INTERVIEWING OTHER STATES

## Adapting to a Growing and Evolving Market.

### Key Themes Identified Across States

- **7/7** Changed strategic direction and/or procurement timelines for their MMIS/MES modularity strategy after initial plan/approach
- **6/7** Updated strategies due to strained business relationships with legacy system vendors (e.g., DXC)
- **7/7** Identified people-centered change management as a key element of overall project success
- **3/7** Prioritized EDW/DSS due to current pain points around data and analytics
- **2/7** Transitioned from an Incremental to Modular Single-Cutover approach
- **5/7** Leveraged NASPO for procurements

### Implications for Florida

All states have had to revise their transformation plans; States highlight a need to remain flexible and responsive to new challenges and opportunities

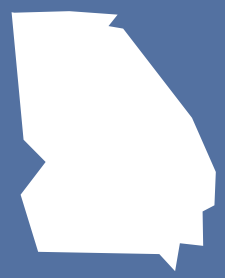
Some states have transitioned from Incremental Modular to “Modular Single-Cutover” approach due to risks and challenges integrating with their legacy system, similar risk exists for FL

Reuse is an accelerator that has not been optimized in FX; of states furthest along in modularity, NASPO and reuse are common (e.g., *see state summaries for VA/NC reuse, TN APD dashboards in VA*)

Organizational change management has been a crucial factor in completing a successful MES transformation

# EXECUTIVE SUMMARY—GEORGIA DEPARTMENT OF COMMUNITY HEALTH

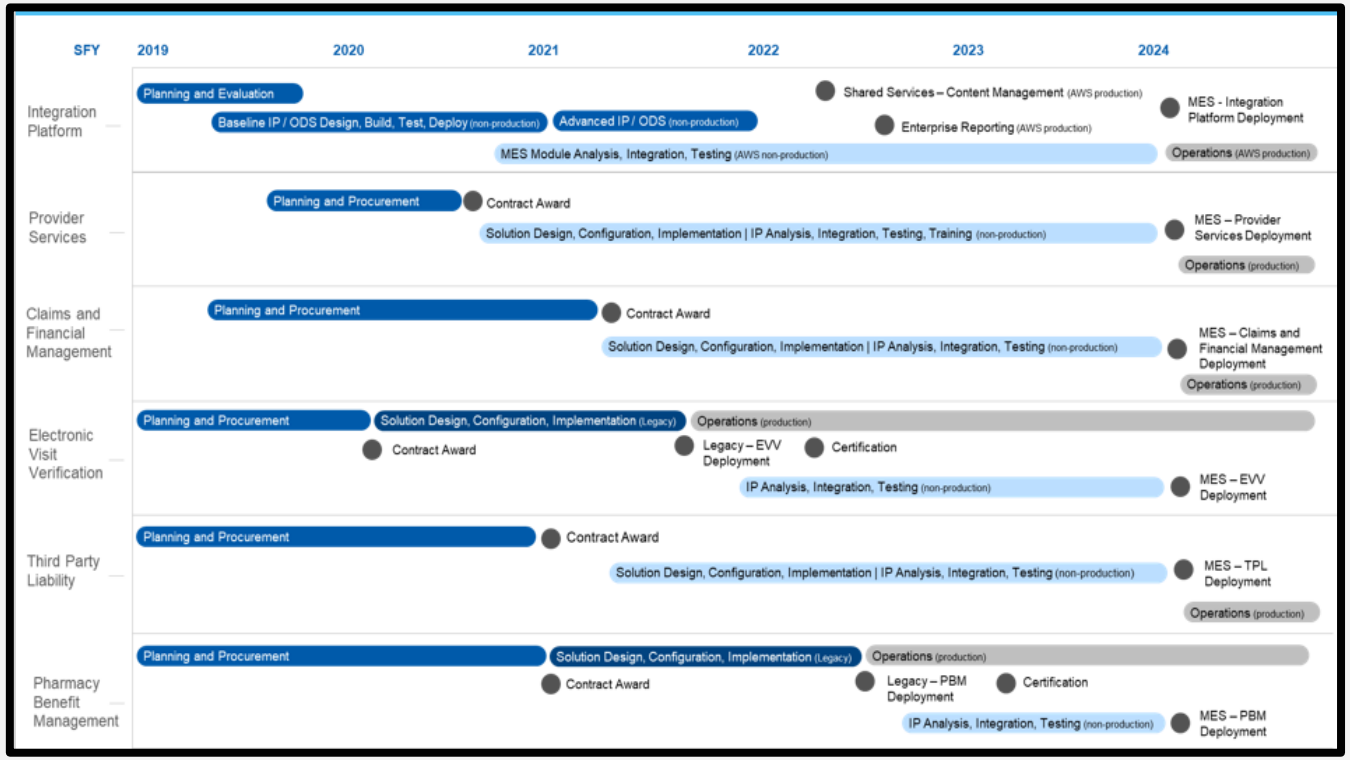
## 12/4/2019 Interview with Matt Jarrard, DCH Chief Information Officer



| Population (#, and as a % of FL) | |
|---|---|
| 10,519,475 | 49% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,812,703 | 44% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $10.9B | 47% |

## Key Interview Highlights

- Transitioned from a Modular Incremental-Cutover approach to a Modular Single-Cutover approach to mitigate risk related to integrating with legacy system
- Hired an external vendor to administer Strategic EPMO services (North Highland)
- Currently using NASPO for 3 procurements (Core, Provider, and TPL)




Source: Georgia DHHS MES Procurement Timeline

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State Population Source: U.S. Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid Services, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
Medicaid Spend Source: Centers for Medicare and Medicaid Services, Medicaid Spend, www.Medicaid.gov, Accessed Oct. 2019

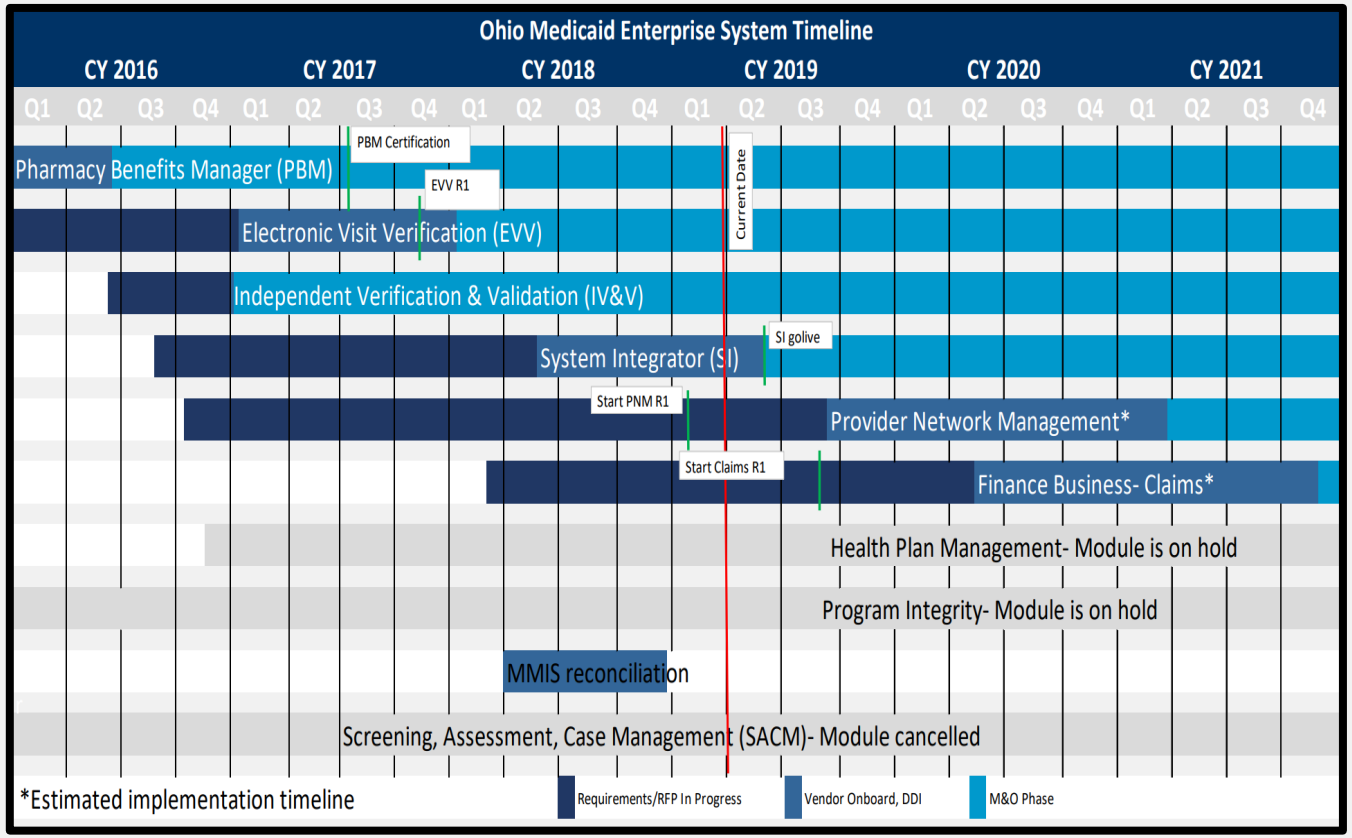
# EXECUTIVE SUMMARY—OHIO DEPARTMENT OF MEDICAID

## 11/26/2019 Interview with Candi Layman, Chief of MITS & Systems Operation for the Ohio Department of Medicaid (ODOM)

| Population (#, and as a % of FL) | |
|---|---|
| 11,689,442 | 55% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 2,635,478 | 63% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $21.9B | 95% |

## Key Interview Highlights

- State went “live” with Systems Integrator (Deloitte) in summer 2019
- Transitioned to a Modular Single-Cutover approach (previously Modular Incremental-Cutover) due to legislative influence challenges with legacy system
- Recommends open, honest, and consistent two-way communication with DXC and to define module requirements for future procurements as clearly and specifically as possible




Source: Ohio Department of Medicaid Enterprise System Timeline

State Population Source: U.S. Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
Medicaid Spend Source: Centers for Medicare and Medicaid, Medicaid Spend, www.Medicaid.gov, Accessed Oct. 2019

# EXECUTIVE SUMMARY—SOUTH CAROLINA DEPARTMENT OF HEALTH & HUMAN SERVICES

## 11/13/2019 Interview with David Ulmer, Deputy Director and CIO and Joe Cooper, Replacement MMIS/MES Program Director – South Carolina Department of Health & Human Services (SCDHHS)

| Population (#, and as a % of FL) | |
|---|---|
| 5, 084, 127 | 24% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,036,851 | 25% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $6.25B | 27% |

## Key Interview Highlights

- Internal resource capacity must be properly planned for overall success of the Medicaid Enterprise transformation project
  - SCDHHS has an 80/20 (consultant/state resource) ratio to manage the project and provide for necessary capacity
- Hired a Multi-Vendor Integrator (Cognosante) to provide Enterprise Project Management Office (EPMO) & Strategy
- Emphasized the importance of Organizational Change Management (OCM) to ensure sustained project success
- Minimum complications working with legacy system vendor to sunset (Clemson University Computing & Information Technology)

### Replacement MMIS and MMRP

MMRP: Member Management Replacement Project

MES: Medicaid Enterprise System

RMMIS: Replacement Medicaid Management Information System

| Project | Module | Status (Completion) |
|---|---|---|
| MMRP | Curam HCR | Operational (Oct 2018) |
| | Curam CGIS | In Development (Feb 2020) |
| MES | NoSQL | Operational (Dec 2018) |
| | ePortal | In Development (July 2019) |
| | MESI | Procurement Cancelled |
| | SMMP | Operational (Dec 2018) |
| | Integration Hub | Operational (Dec 2018) |
| RMMIS | PBA | Operational (Nov 2017) |
| | BIS | Operational (Dec 2018) |
| | TPL | Operational (Aug 2018) |
| | Dental | Development on hold |
| | ASO | Procurement in Protest |
| | EVV | RFP Posted - Due Jan 2019 |
| | APD Mgmt. | IFB in draft |
| | MVI | Contract Started (April 2018) |
| | ICMIS | IFFR in draft |
| | LASRAI | In Development (Aug 2019) |

Healthy Connections MEDICAID

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Source: SC DHHS Replacement MMIS Timeline

State Population Source: U.S. Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
Medicaid Spend Source: Centers for Medicare and Medicaid, Medicaid Spend, www.Medicaid.gov, Accessed Oct. 2019

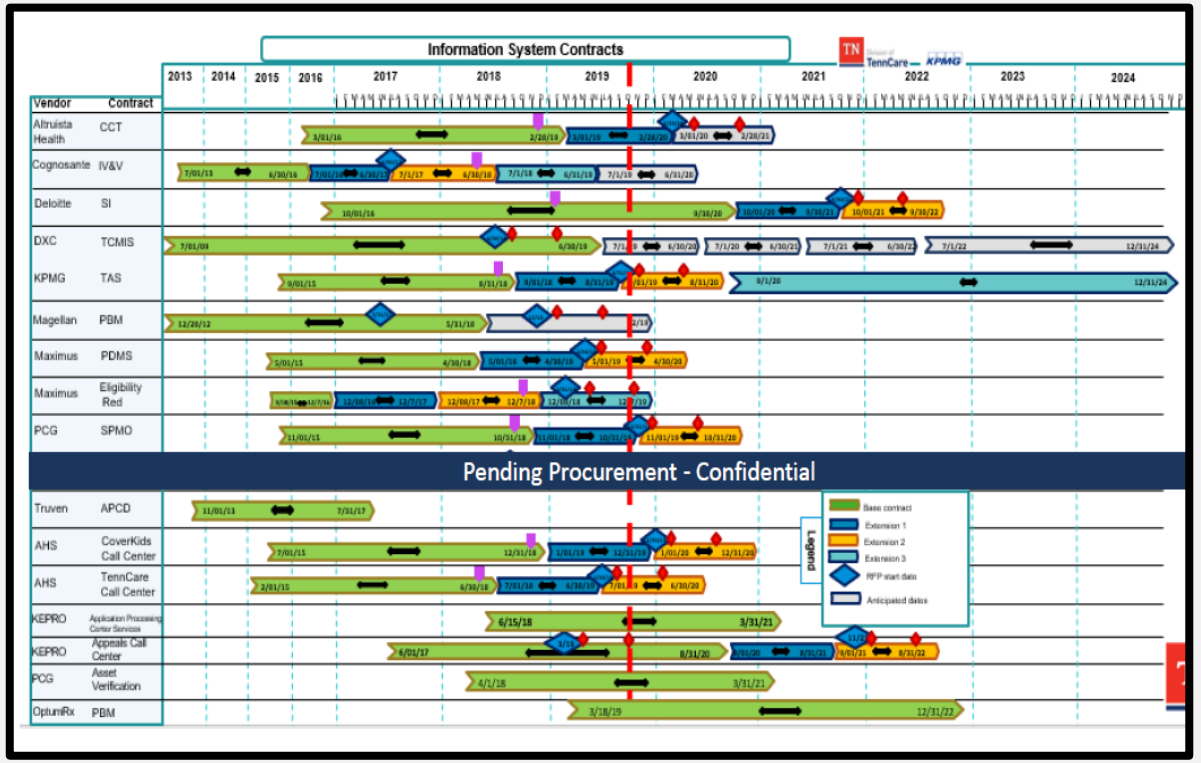
# EXECUTIVE SUMMARY—TENNCARE (TENNESSEE MEDICAID)

## 11/15/2019 Interview with Diane Langley, TennCare Director of IS Compliance and Strategy Funding, Leads MMIS Transformation

| Population (#, and as a % of FL) | |
|---|---|
| 5,830,000 | 32% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,440,235 | 35% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $9.7B | 42% |

## Key Interview Highlights

- Hired KPMG as the Strategic EPMO vendor and decentralized technical executive decision-making to IT SMEs (Technical Advisory Review Board)
- Has developed an Advanced Planning Document (APD) Dashboard
  - APD dashboard has been shared with 16 other states and CMS
- TennCare will be procuring modules as cohorts and certifying as cohorts beginning with the following:
  - Cohort 1: Pharmacy Benefits Manager
  - Cohort 2: Provider Management
  - Cohort 3: Data Warehouse & Analytics

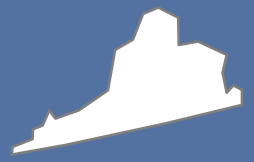



Source: TennCare Project Iris (MMIS) Timeline

State Population Source: U.S.Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
Medicaid Spend Source: Centers for Medicare and Medicaid, Medicaid Spend, www.Medicaid.gov, Accessed Oct. 2019

# EXECUTIVE SUMMARY—VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

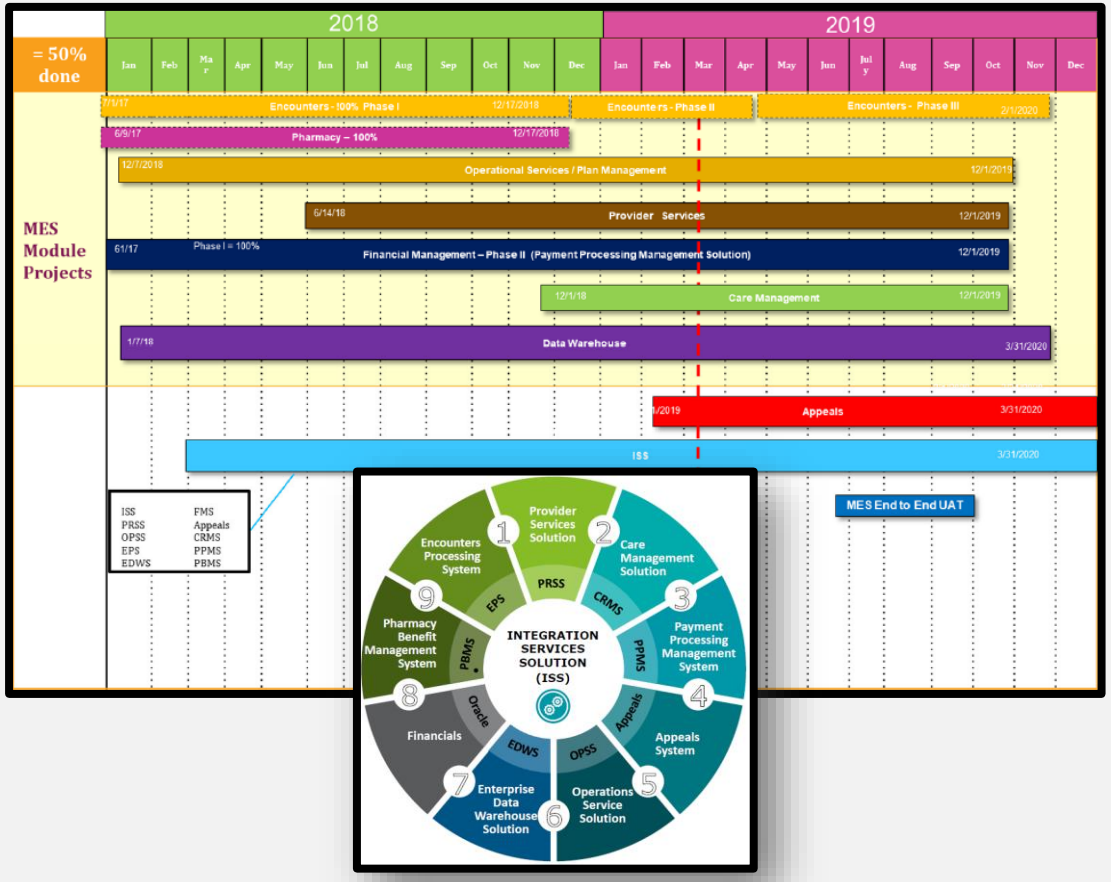
## 11/22/2019 Interview with Frank Guinan, Virginia DMAS Information Technology Program Manager



| Population (#, and as a % of FL) | |
|---|---|
| 8,517,685 | 40% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,328,805 | 32% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $9.6B | 42% |

## Key Interview Highlights

- EPS:
  - Developed an inhouse module for Encounters Processing: Encounters Processing Solution (EPS)
  - Is reusing the EPS module with North Carolina (NC), reducing NC's speed and reducing its costs
- Experienced two failed procurement (Claims and Financial) due to splitting Core module. The market did not respond receptively to this approach at the time.



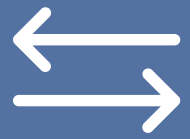

Source: Virginia DMAS MES Module Projects Timeline

State Population Source: U.S.Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
Medicaid Spend Source: Centers for Medicare and Medicaid, Medicaid Spend, www.Medicaid.gov, Accessed Oct. 2019

# EXECUTIVE SUMMARY—WISCONSIN DEPARTMENT OF HEALTH SERVICES

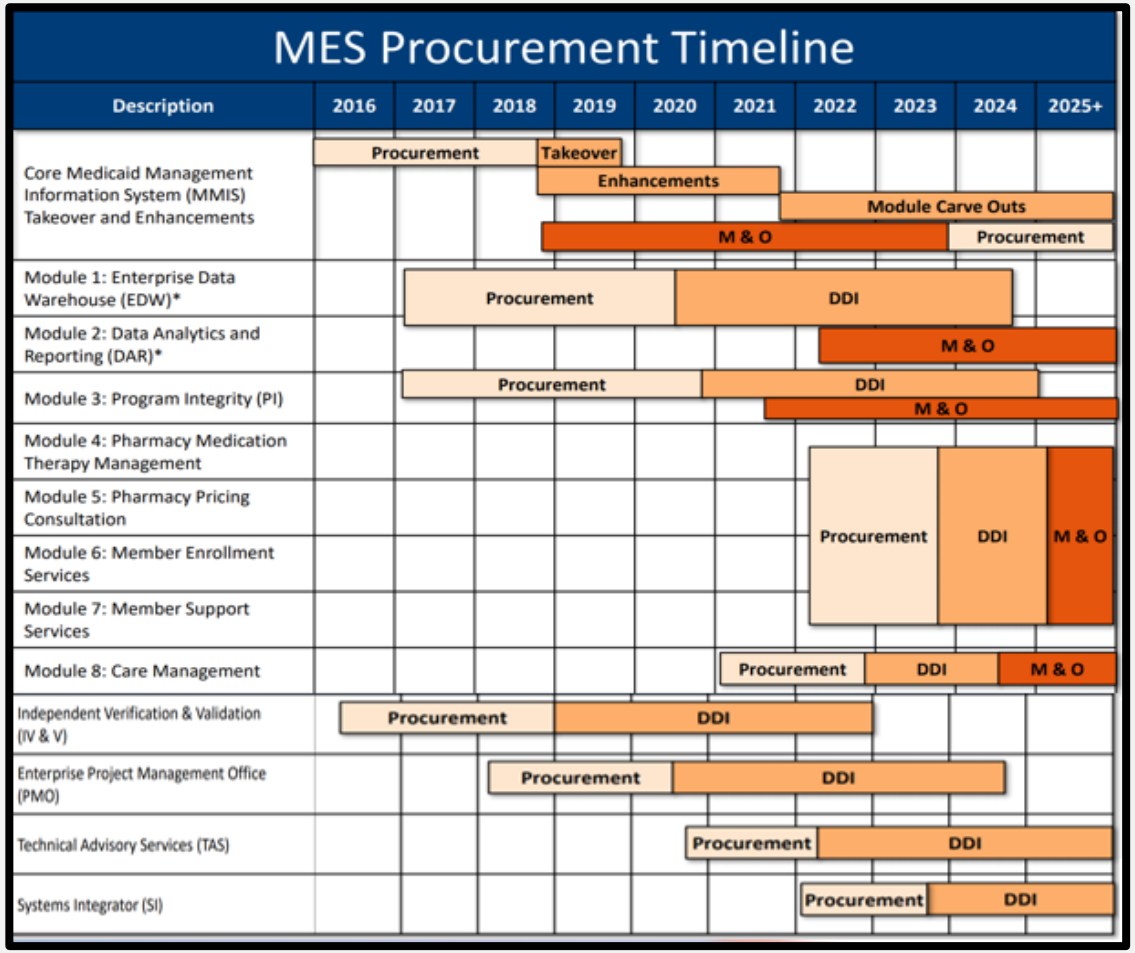
## 11/12/2019 Interview with Nick Havens, Wisconsin Department of Health Services (DHS) Data and Vendor Management Section Chief, Leads MMIS Transformation

| Population (#, and as a % of FL) | |
|---|---|
| 5,830,000 | 27% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,033,551 | 25% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $8.85B | 38% |



## Key Interview Highlights

- State is satisfied with current Core module functionality with its current MMIS legacy vendor system (DXC)
  - Pursued a “takeover” procurement and only the incumbent bid
  - DXC awarded takeover in 11/18 and will include enhancements
- Hired full-time Business Analysis Coordinators to provide oversight for the Medicaid Enterprise transformation project for each bureau/division/unit
- No new modules currently being procured as the takeover is in process




Source: Wisconsin DHS
MES Procurement Timeline

State Population Source: U.S.Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
Medicaid Spend Source: Centers for Medicare and Medicaid, Medicaid Spend, www.Medicaid.gov, Accessed Oct. 2019

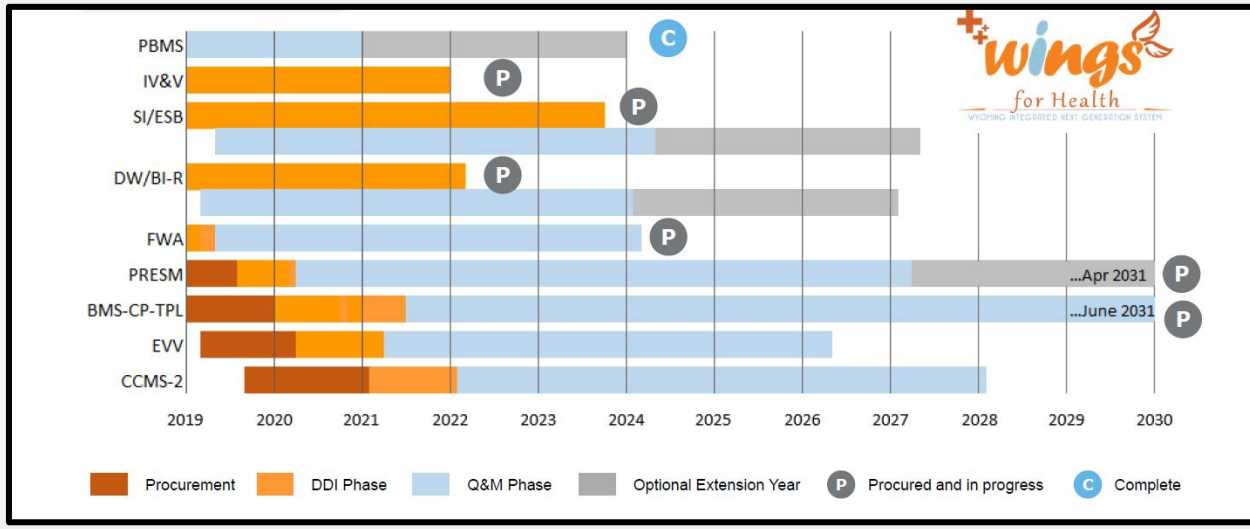
# EXECUTIVE SUMMARY—WYOMING DEPARTMENT OF HEALTH

## 11/29 Interview (conducted via email) with Jesse Springer, Wyoming Department of Health (DOH) Medicaid Technology and Business Operations Unit Manager

| Population (#, and as a % of FL) | |
|---|---|
| 577,737 | 3% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 53,586 | 1% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $602.6MM | 2.6% |

## Key Interview Highlights

- IT-focused MMIS will transition to modules owned by business units
- Changed direction due to two failed procurements (Third Party Liability and Care Case Management)
  - TPL—failed due to budget constraints for the required budget scope and requirements, procurement rewritten, and combined with Benefit Management system
  - Care Case Management—contracted with the vendor but the solution and project management did not align with the Agency's Medicaid program goals




Source: WINGS for Health Project Timeline

# SECTION H

***Appendix***

# 2017 EXECUTIVE VISIONING SESSION STRATEGIC PRIORITIES

## SEAS interviewed AHCA executives in 2017 to develop the original Strategic Priorities

## Below are the previous Agency Strategic Priorities

**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)** | **Identity Reconciliation** | **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 |

- The darker blue boxes highlight 2017 priorities
- The lighter blue boxes highlight the Agency's initially prioritized high-level tactics


# STATE MMIS RESEARCH

# INTERVIEW DETAILS

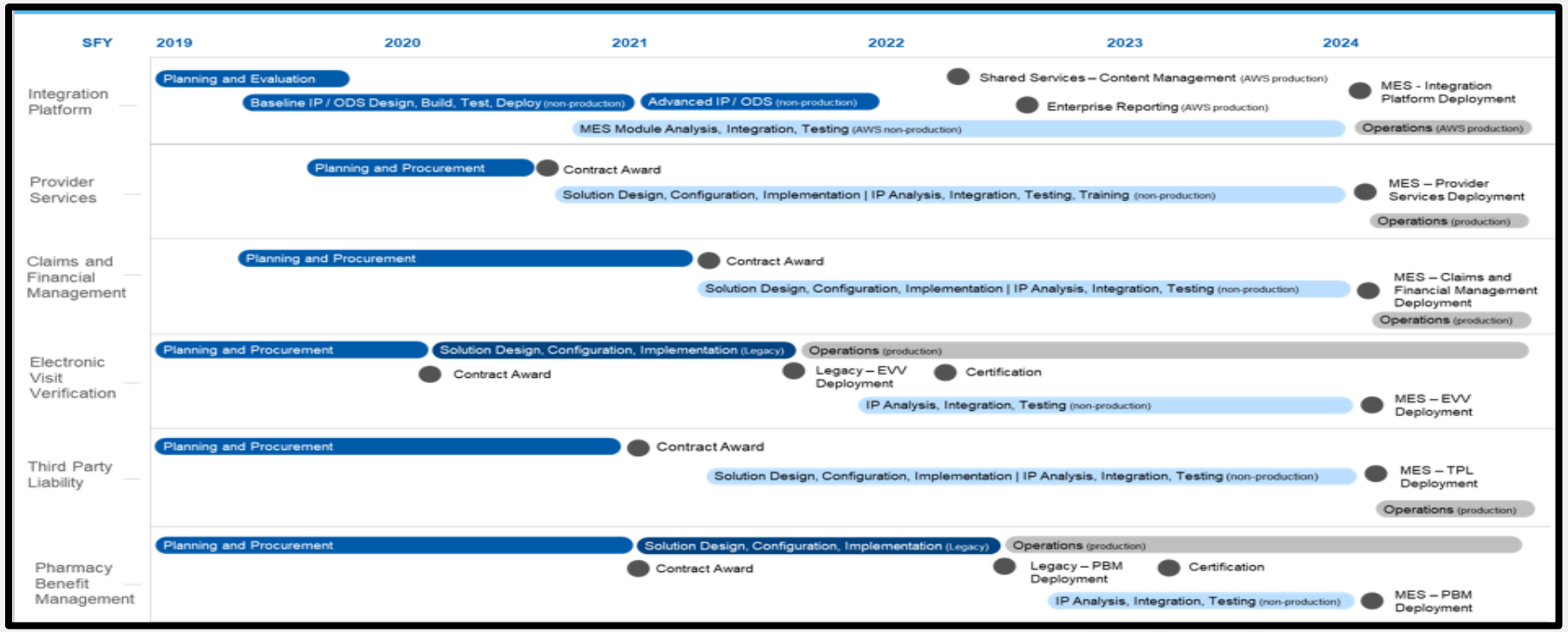
STATE MMIS TRANSFORMATION STAKEHOLDER INTERVIEWS

# GEORGIA – MODULAR SINGLE-CUTOVER

**Due to an evolution of strategic objectives, Georgia's approach has evolved from Modular Incremental-Cutover to Modular Single-Cutover, expediting the sunset of the legacy system to control costs and minimize risk associated with incremental interface development.**

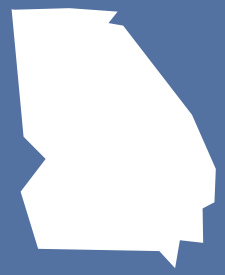
## Georgia

Georgia Medicaid Management Information System (GAMMIS) includes claims processing for the Department of Community Health (DCH) managed programs. GAMMIS began operations with DXC as the legacy system vendor in 2010. GA cancelled their contract with Truven as their EDW/EDS solution in September 2019. The system integrator Georgia Tech Research Institute (GTRI) will onboard in early 2020. In addition, GA has hired an EMPO vendor to support program strategy (North Highland).



# GEORGIA – MODULAR SINGLE-CUTOVER

## Interview with Matt Jarrard, DCH Chief Information Officer (pending interview)



| Population (#, and as a % of FL) | |
|---|---|
| 10,519,475 | 49% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,812,703 | 44% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $10.9B | 47% |

| | |
|---|---|
| **Key Strategic Inputs Driving GA Transformation** | • **Expedite sunset of the legacy system**<br>• **Control costs by minimizing throw-away integration** into the legacy system and resulting layers of integration testing<br>• **Minimize risk** of transformation through incremental development of interface standards and integrations in a collaborative manner with modular vendors<br>• **Show progress** through incremental build of business functions and execution of use cases<br>• **Minimize complex contract negotiations** with the legacy vendor and other trading partners |
| **Transformation Organization and Ownership Within DHS** | • Georgia Department of Community Health's Medicaid Enterprise transformation is supported by the Agency's Chief Information Officer, Matt Jarrard. A governance model was designed to provide the leadership, structure, and processes necessary for overall project success. GA's transformation project has a dedicated project director who oversees the project alongside the Enterprise Project Management Office (North Highland). The system integrator (Georgia Tech Research Institute) handles all technical requirements and partners with each modular vendor. In addition to the project team, GA has multiple enterprise governance teams: Enterprise Technical Governance, Enterprise Data Governance, and Enterprise Business Ops Governance, with supporting work groups. |
| **NASPO Participation** | • GA is participating in NASPO cooperative procurements for three modules: Claims and Financial Management, Provider Services, and Third-Party Liability.<br>• One key benefit GA has recently seen from using NASPO has been the avoidance of risk of protests as that is done through a posting at the beginning that requires a legitimate reason to not use the consortium process.<br>• In addition, NASPO allows the project team to have more flexibility negotiating between vendors who all meet technical requirements as opposed to having to negotiate to a single best and final vendor. |
| **Lessons Learned** | • Get more comfortable with ambiguity in this process (modularity has not been done before by any state)<br>• Learn from unique project lessons, reflect on them, and pivot when necessary<br>• Use all resources available to ensure a collaborative effort amongst all stakeholders<br>• Ensure the right decision makers are collaborative (i.e., PMO, Strategy/Planning, S/I vendor) |

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AHCA.MyFlorida.com

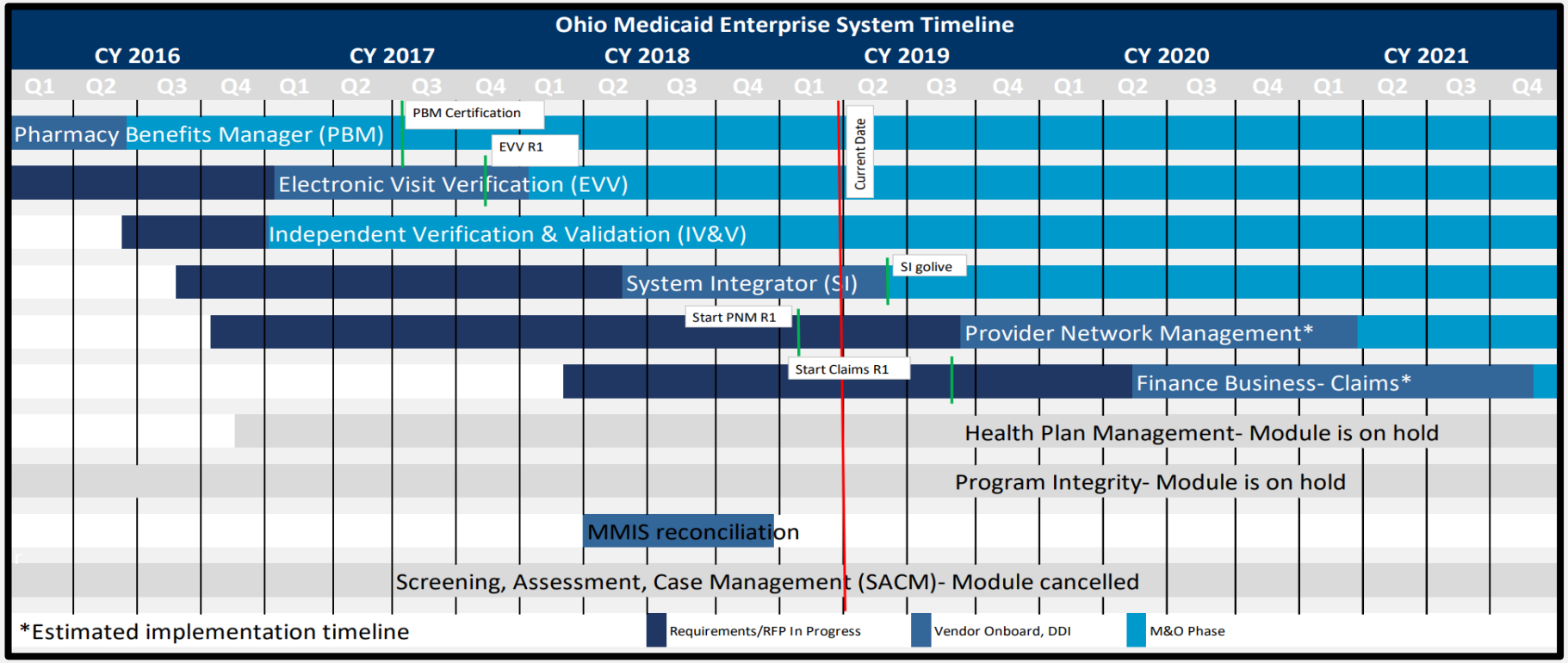
State Population Source: U.S.Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
Medicaid Spend Source: Centers for Medicare and Medicaid, Medicaid Spend, www.Medicaid.gov, Accessed Oct. 2019

# OHIO – MODULAR SINGLE-CUTOVER

## Ohio recently transitioned from a Modular Incremental-Cutover approach to a Modular Single-Cutover approach

### Ohio

Replaced PBM with McKesson before 2017. Began procurement for Deloitte as SI even before the modularity rules were fully implemented in 2017. Electronic Visit Verification went live on January 8, 2018 and is currently in R2 of Certification. Sandata is the vendor. Provider Management was awarded to Maximus in September 2019. Working on an RFP for Finance/Claims/Core.



# OHIO – MODULAR SINGLE-CUTOVER

## 11/26/2019 Interview with Candi Layman, Chief of MITS & Systems Operation for the Ohio Department of Medicaid (ODOM)

| Population (#, and as a % of FL) | |
|---|---|
| 11, 689, 442 | 55% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 2,635,478 | 63% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $21.9B | 95% |

| | |
|---|---|
| **Key Strategic Inputs Driving OH Transformation** | • **Transitioning from a Modular Incremental-Cutover to a Modular Single-Cutover approach**<br>• **Data Use & Sharing:** Agency is currently focusing on data governance to facilitate collaboration with entities outside of the Agency while also protecting individuals' privacy. Ohio is pursuing new opportunities to partner with other state agencies in sharing and combining datasets, creating an opportunity to better utilize Medicaid data to improve quality of care and lower costs.<br>• **Make it easier to do business:** The Ohio team considered how they would ideally want the system to run (business and technical processes) to drive toward better healthcare outcomes for Ohio residents. An example would be to alleviate staff and other business costs associated with provider credentialing; Ohio is interested in creating a single centralized process for credentialing all providers.<br>• **Improve Access to Care:** Ohio is proposing budget investments to expand access to telehealth services in new locations. New flexibilities will reduce existing barriers to treatment.<br>• **Improve Collaboration & Outcomes:** Ohio Medicaid is creating an integrated data environment that encompasses a data lake and Enterprise Data Warehouse. These approaches will enhance data analytics and collaboration among state agencies and stakeholders. Medicaid will leverage these data capabilities to measure and improve the program's performance and outcomes. |
| **Transformation Organization and Ownership Within ODOM** | • Ohio Department of Medicaid uses a team approach between the internal PMO team and Operations team. Each module has a dedicated project manager who reports through the PMO and reports out to the Governance team.<br>• Ohio attributes its team success thus far to their ability to remain nimble throughout their modularity journey and adjust where necessary according to program/business needs. |
| **NASPO Participation** | • Ohio has not participated at NASPO at this time. However, the team considered NASPO for Provider and Claims. Due to internal issues that were focused on interoperability among state agencies and specific requirements that were unique to Ohio, leaders within the organization will not pursue modules procured through NASPO at this time. Ohio will continue to consider NASPO as a plausible option in the future. |
| **Lessons Learned** | • Ohio currently has Deloitte as its system integrator. Ohio recommends detailing as many requirements as possible to ensure all stakeholders are on the same page. Ensure you know what is included in each module. Co-location of S/I when handling business (i.e., meetings) to ensure you are having the right conversations with the right people in the room. Sunsetting the DXC system has been difficult to manage. State recommends starting direct conversations earlier about plans to sunset. |

State Population Source: U.S.Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
Medicaid Enrollment Source: Centers for Medicare and Medicaid, Medicaid Enrollment, www.Medicaid.gov , Accessed Oct. 2019
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# SOUTH CAROLINA – MODULAR INCREMENTAL-CUTOVER

## South Carolina focuses on designing a replacement system with the "end user in mind"

### South Carolina

South Carolina Department of Health and Human Services (SCDHHS) is actively involved in replacing the decentralized MMIS legacy systems. This includes the following modules: Pharmacy Administrative Services Only (ASO), Dental ASO, Medical ASO, EVV, Business Analytics, and Finance and Accounting. The Replacement MMIS will initially integrate with the legacy MMIS, except the ASO.

SCDHHS Project Management Office (PMO) and Enterprise Services (ES) units have established technical architecture platform standards, and systems integration standards. These standards will be utilized by the Contractor and Vendors when implementing solutions and by the system integrator when integrating the solutions.

SCDHHS procured Cognosante as a Multi-Vendor Integrator (MVI) to execute the Agency's strategies and is in negotiations with a Medicaid Enterprise System Integrator (MESI) vendor for the Enterprise Services frameworks, and standards associated with standing up the framework for the virtual MMIS. The Agency will provide flexibility for third parties and their subsystem solutions through clearly communicated standards, expectations, and artifacts.

### Replacement MMIS and MMRP

MMRP: Member Management Replacement Project

MES: Medicaid Enterprise System

RMMIS: Replacement Medicaid Management Information System

| Project | Module | Status (Completion) |
|---|---|---|
| MMRP | Curam HCR | Operational (Oct 2018) |
| | Curam CGIS | In Development (Feb 2020) |
| MES | NoSQL | Operational (Dec 2018) |
| | ePortal | In Development (July 2019) |
| | MESI | Procurement Cancelled |
| | SMMP | Operational (Dec 2018) |
| | Integration Hub | Operational (Dec 2018) |
| RMMIS | PBA | Operational (Nov 2017) |
| | BIS | Operational (Dec 2018) |
| | TPL | Operational (Aug 2018) |
| | Dental | Development on hold |
| | ASO | Procurement in Protest |
| | EVV | RFP Posted - Due Jan 2019 |
| | APD Mgmt. | IFB in draft |
| | MVI | Contract Started (April 2018) |
| | ICMIS | IFFR in draft |
| | LASRAI | In Development (Aug 2019) |

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# SOUTH CAROLINA – MODULAR INCREMENTAL-CUTOVER

## 11/13/2019 Interview with David Ulmer, Deputy Director and CIO and Joe Cooper, Replacement MMIS/MES Program Director – South Carolina Department of Health & Human Services (SCDHHS)

| Population (#, and as a % of FL) | |
|---|---|
| 5, 084, 127 | 24% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,036,851 | 25% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $6.25B | 27% |

| | |
|---|---|
| **Key Strategic Inputs Driving SC Transformation** | • **Evolving approach,** constantly evaluating the strategic plan by considering "what works" and "what does not work" along the way<br>• South Carolina considers its transformation using a "lean approach" starting with modules with **upcoming expiration dates** and evaluated the overall performance of each vendor<br>• **Focus on agility** throughout the transformation by partnering with Organizational Change Management (OCM) to drive the change |
| **Transformation Organization and Ownership within SCDHHS** | • Decisions are made via a master integrated program which consists of RMMIS Executive Governance Committee<br>• South Carolina's transformation initiative is constantly evolving taking into consideration their organization's structure<br>• Transformation work is divided into two Design Develop Implement (DDI) programs. Components include: Replacement of MMIS Program, the Medicaid Enterprise System Program (Data Program), and Member Management Replacement Plan (MMRP)<br>• The ratio of contractors to state employees is: 80:20 |
| **NASPO Participation** | • South Carolina is participating in the NASPO provider procurement |
| **Lessons Learned** | • Ensure that there is clarity around accountability for data breaches. The legal teams for both the Agency and the IS/IP vendor should have a mutual understanding of this matter<br>• Do diligent capacity planning for Subject Matter Experts within the Agency<br>• Prioritize organizational change management efforts. "We are turning things upside down and you can have the best tech, best code, etc. but if people are not brought along, we will fail" |



State Population Source: U.S.Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
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# TENNESSEE – MODULAR INCREMENTAL-CUTOVER

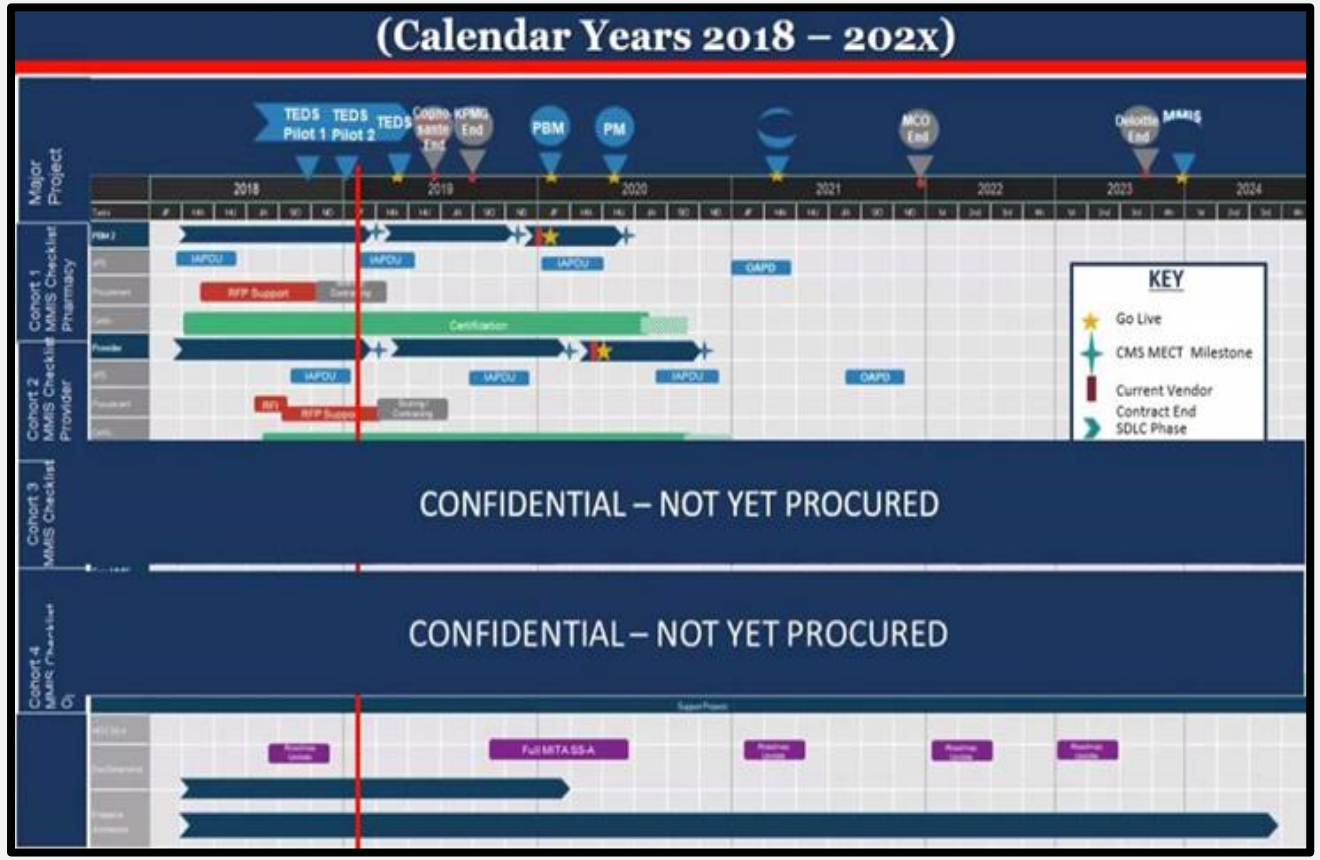
## Tennessee has been on the modular journey longer than other states and have built robust program and project management standards within their organization

### Tennessee

Tennessee's current MMIS, TennCare Management Information System is a comprehensive Medicaid claims processing system that supports both traditional fee for service and managed care delivery models. The MMIS solution is managed by DXC Technologies. The Department contracts with the Fiscal Agent for a wide range of services including: front-end claims, automated eligibility verification, online pharmacy claims capture and adjudication including provider and user training; ePrescribing; plastic Medicaid ID card production; a Fraud and Abuse Detection System ("FADS"); document management; financial processing including capitation payments; and various web-based applications.

TennCare will be procuring modules as cohorts and certifying as cohorts beginning with the following:

- Cohort 1 - Pharmacy Benefits Manager solution
- Cohort 2 - Provider Management module
- Cohort 3 – Data Warehouse and improved analytics



# TENNESSEE – MODULAR INCREMENTAL-CUTOVER

## 11/15/2019 Interview with Diane Langley, TennCare Director of IS Compliance and Strategy Funding, *Leads MMIS Transformation*

| | |
|---|---|
| **Population (#, and as a % of FL)** | |
| 5,830,000 | 32% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,440,235 | 35% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $9.7B | 42% |

| | |
|---|---|
| **Key Strategic Inputs Driving TN Transformation** | • Maintain and operate the MMIS and plan for an **Enterprise Data Governance solution**<br>• **Improve security and governance of data** for improved decision-making and better program outcomes<br>• **Meet federal qualifications** for 90/10 match and MITA certification<br>• **Improve quality of care**<br>• **Reduce cost of care**<br>• Take advantage of **marketplace innovations**<br>• **Design for future business needs** detailing business processes and organization of project by business capability |
| **Transformation Organization and Ownership Within DHS** | • TennCare Project “Iris,” Tennessee’s transformation project is supported by TennCare Office of Compliance & Strategic Funding (TennCare Information Systems) group<br>• TennCare operates as “one team” with KPMG serving as the Strategic Program Management Office, KPMG as Technical Advisory Services, Cognosante as IV&V, and DXC as the legacy system vendor<br>• Governance and architecture work together through the Technical Architecture Review Board (TARB) to make required decisions establishing broader architecture capabilities to manage assets |
| **NASPO Participation** | • Tennessee is participating in a collaborative NASPO procurement for their provider module. A contract has been awarded to Maximus<br>• Considering leveraging a Utah NASPO cloud-based solution |
| **Lessons Learned** | • Ensure program and project management governance structure are consistent<br>• Do not underestimate the power of organizational change management (OCM) services<br>• Embrace the “one team” model and establish clear expectations from all stakeholders involved to ensure the team is constantly collaborating – provide periodic vendor forums for teams with the State to address concerns and provide feedback (two-way communication)<br>• Establish “health checks” of contractual deliverables throughout the lifecycle of the project to help identify potential risks earlier or |

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State Population Source: U.S.Census Bureau Quick Facts, www.census.gov, Accessed Nov. 2019
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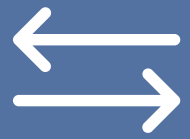
# WISCONSIN – "TAKEOVER"(DXC →DXC) TO MODULAR

## Strategy was takeover; only one vendor bid, so State selected DXC

| Population (#, and as a % of FL) | |
|---|---|
| 5,830,000 | 27% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,033,551 | 25% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $8.85B | 38% |

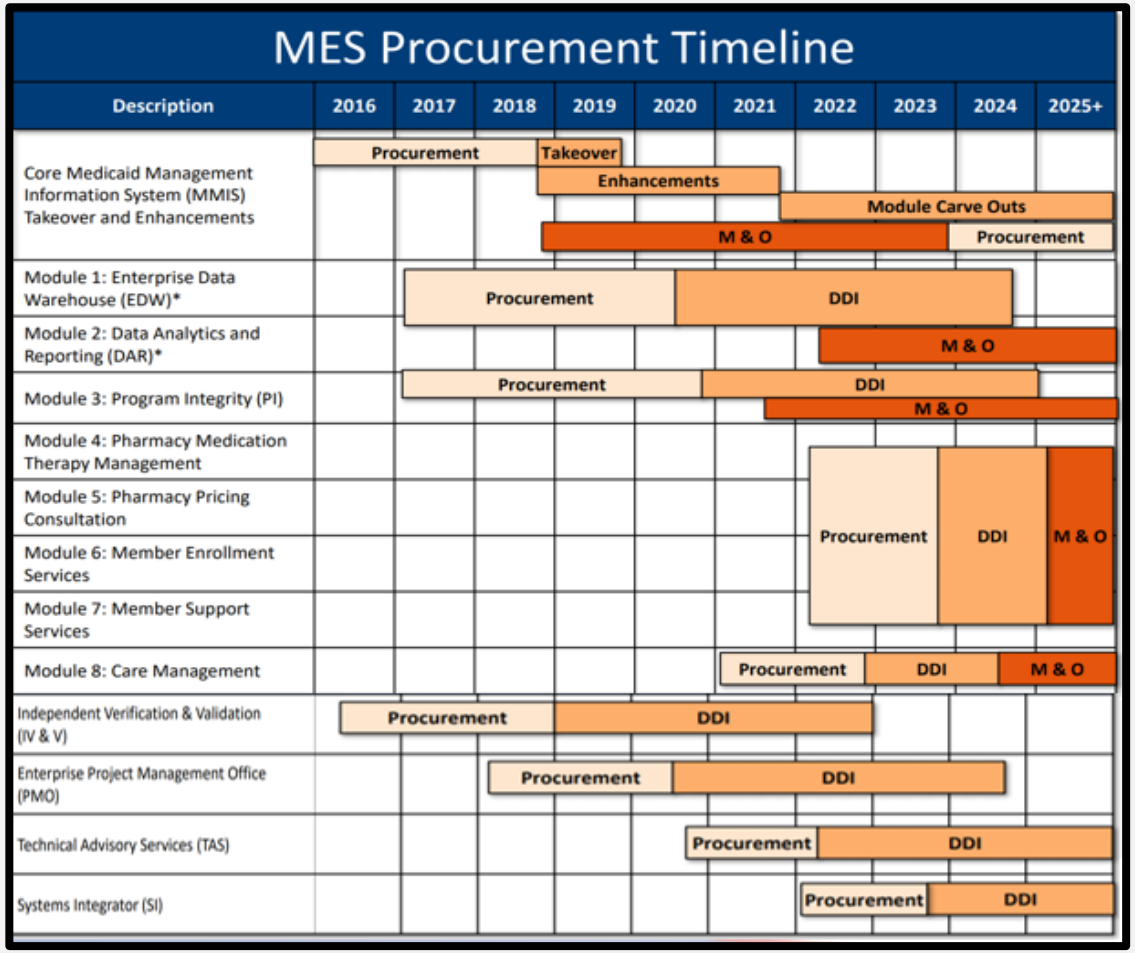


## Wisconsin

Wisconsin's strategy can be summarized in three phases:

- Procure a takeover of the legacy system (DXC) with required enhancements (integrate LTC) that will allow them to eventually retain their legacy core processing as their core module.
- Build the infrastructure (Enterprise Data Warehouse (EDW)), Data & Analytics (D&A), and find strategic partners (Technology Advisory Services, Program & Project Management Office (PPM)) to support a modular transition.
- Procure modules like Program Integrity (PI), Pharmacy Benefits Management System (PBMS), Recipient, and Case Management while executing "carve out" project to decommission all the upgraded legacy systems except the core claims processing.

Takeover and enhancement was awarded 11/10/2018. Originally an HP system, **HP (DXC) was the only vendor to eventually bid on the takeover and enhancement in August 2017**. Intent to award was issued April 2018, and the contract was finalized November 2018.

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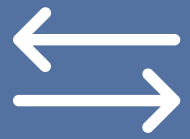
# WISCONSIN – "TAKEOVER"(DXC →DXC) TO MODULAR

## 11/12/2019 Interview with Nick Havens, Wisconsin Department of Health Services (DHS) Data and Vendor Management Section Chief, *Leads MMIS Transformation*

| Population (#, and as a % of FL) | |
|---|---|
| 5,830,000 | 27% |

| Medicaid Enrollment (#, and as a % of FL) | |
|---|---|
| 1,033,551 | 25% |

| Medicaid Spend (#, and as a % of FL) | |
|---|---|
| $8.85B | 38% |



| | |
|---|---|
| **Key Strategic Inputs Driving WI Transformation** | • **Minimize Cost, Enhance Funding**: Biggest driver of "takeover" approach was that WI had a working core system and did not want to invest the dollars to modularly replace a working core. Enhanced funding made investment decisions for modules to address pain points more appealing.<br>• **Pain Points Are Major Driver of Module Order**: Long-term pain point around data and analysis quality drove the prioritization of EDW/ Data & Analytics Reporting (DAR) as the first bundled procurement. A poorly performing contact center is driving the acceleration of a member support services module.<br>• **Legislative Directives:** Requirement for a new program integrity module with new requirements. Their current contract was expiring which drove the timing of the legislative interest. |
| **Transformation Organization and Ownership Within DHS** | • Data and Vendor Management Section is leading the transformation for the State. Enterprise PMO will be onboarding soon.<br>• Each Medicaid bureau has hired a business analysis coordinator fully staffed to lead transformation activities for that bureau. Business Analysts (BAs) will keep bureau leadership informed and lead pulling bureau SMEs into meetings, projects, etc.<br>• Multi-tier governance structure with strong vendor engagement. Critical project decisions are managed at the project level and oversight is provided by governance. |
| **NASPO Participation** | • No planned NASPO participation. The team does not currently have subject matter expertise on their team working with NASPO and hesitant to consider NASPO as a viable solution due to Wisconsin state procurement law. |
| **Lessons Learned** | • **Understand your staff capabilities:** When the strategy was first developed several years ago the team considered a Modular Single-Cutover implementation of the modules in late 2025-2026. Now they realize that State staff capacity is one of the largest challenges impacting the length of their timeline. Staffing up has helped. Vendors cannot fully supplement the capacity gap because State staff requirement of development and validation and buy-in/acceptance has been critical as well.<br>• Now accelerating a System Integrator (SI) procurement because WI is **concerned that legacy vendors will have too much strategic influence** over the integration process.<br>• Poor documentation of the existing system has cased problems with vendor onboarding.<br>• Budget will drive tradeoffs. After seeing the cost responses on some of their procurements they scaled back requirements to focus on needs vs. wants. |



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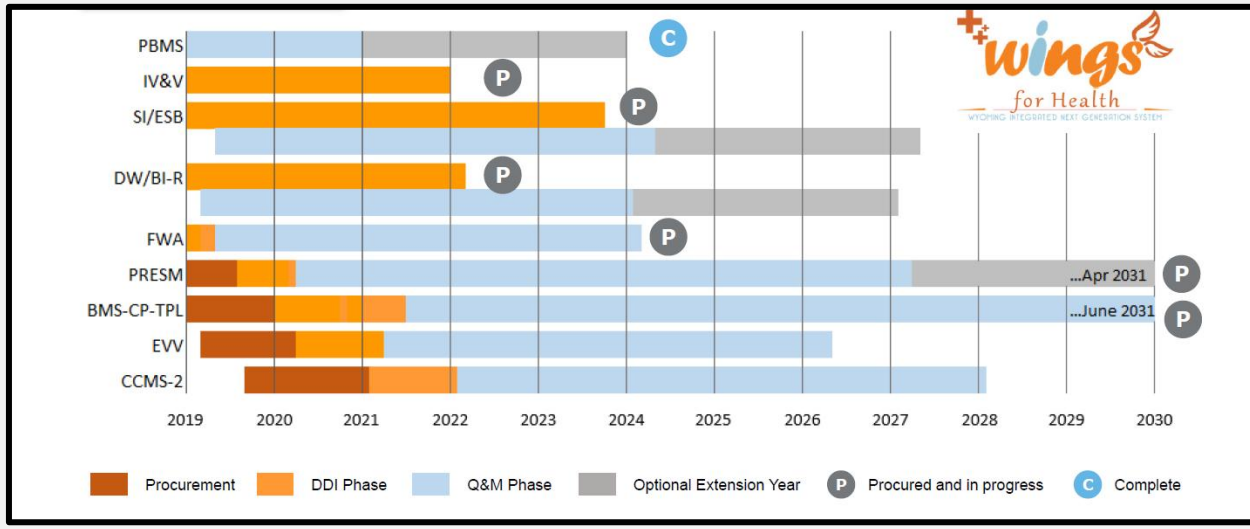
# WYOMING – MODULAR INCREMENTAL-CUTOVER

## Wyoming Next Generation System (W.I.N.G.S.) will replace the current MMIS through separate procurements

### Wyoming

Wyoming's approach has been to peel functionality off the current mainframe MMIS, and to source that functionality by enhancing other systems (moving all rebate to Pharmacy, moving Medicare buy-in to the eligibility system). Also WY is procuring small standalone modules (EDW, Provider Enrollment, fraud/waste/abuse) to reduce the scope of the replacement MMIS (referred to as Benefit Management Services)

- 1 module certified (Pharmacy Benefit Management)
- 4 modules currently in production (Pharmacy Benefit Management, Data Warehouse and Reporting, System Integrator, Fraud Waste, and Abuse Case tracking and analytics)
- 2 additional modules procured (Provider Enrollment Screening and Monitoring, Benefit Management Services/Core MMIS)
- 1 module in procurement (Electronic Visit Verification)
- 1 module in planning (Care Case Management)



# WYOMING – MODULAR INCREMENTAL-CUTOVER

## Interview with Jesse Springer, Wyoming Department of Health (DOH) Medicaid Technology and Business Operations Unit Manager was conducted by email week of 11/18/2019

| Population (#, and as a % of FL) | |
|---|---|
| 577,737 | 3% |

| Medicaid Enrollment (#, and as a % of FL) | |
|---|---|
| 53,586 | 1% |

| Medicaid Spend (#, and as a % of FL) | |
|---|---|
| $602.6MM | 2.6% |

| | |
|---|---|
| **Key Strategic Inputs Driving WY Transformation** | • **Pain Points from Providers:** Wyoming looked at areas of complaints from providers (provider enrollment process is slow and cumbersome), opportunities for enhanced revenue (Pharmacy Rebate, TPL), and general system pain points (Program Integrity unit was struggling with current system and needed a new system to move to desired business model).<br>• **Short, incremental module implementations.** Not doing too many modules at one time to limit disruption to stakeholders. |
| **Transformation Organization and Ownership Within DOH** | • The WINGS team has organized the transformation along a technology track, a policy modernization track, and a reorganization. The Medicaid Technology and Business Operations Unit (MTBOU) manages the technology track and supported the reorganization. The reorganization was owned by the Medicaid Director with support from outside consultants. The Policy modernization track was owned by the different Medicaid business units.<br>• The modules are owned by the different business units, and supported in contracting, technology, and project management by the MTBOU. Final approvals and decision-making is vested in the business, but fully supported by MTBOU<br>• Before the transformation, the WY MMIS lived in one group, so the various units owning their own systems is a big change. This approach requires a lot of support for technology, contract management, project management, business analysis, and other common services from the MTBOU to ensure the business groups can be successful. |
| **NASPO Participation** | • Wyoming served as a participating state in Montana's provider enrollment procurement. The WINGS team recommends this approach for developing procurements. The Wyoming team advises that NASPO is leveraged for implementation, obtain assistance with this process early, as this can be challenging to procurement and legal bodies (it was in Wyoming). Wyoming's main benefit of the collaboration has been in joint development of requirements and procurements with other states. |
| **Lessons Learned** | • Before the SI onboards make sure they are fully and properly staffed.<br>• Ensure that your team is clear on your expectations for the SI in their early months.<br>• Begin documenting all interfaces ASAP.<br>• Don't be afraid to change from initial direction:<br>  • Third Party Liability- Did not have any bidders due to budget being too low for work and requirements. Team considered scope and budget and combined with the Benefit Management System RFP and was able to secure a solution (minor setback).<br>  • Care Case Management-- Contracted with vendor but solution and project management of selected vendor was a poor fit for Agency goals. Terminated early without cause and are fully reworking the procurement. This was not a major setback because Wyoming has a working system currently that can continue to be used. |

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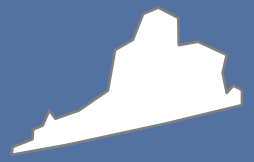
# VIRGINIA – MODULAR SINGLE-CUTOVER

## Virginia chose a Modular Single-Cutover approach to modularity and to procure all modules before retiring the current legacy vendor. A key driver in selecting this approach was the need to include Fee for Service (FFS) processing

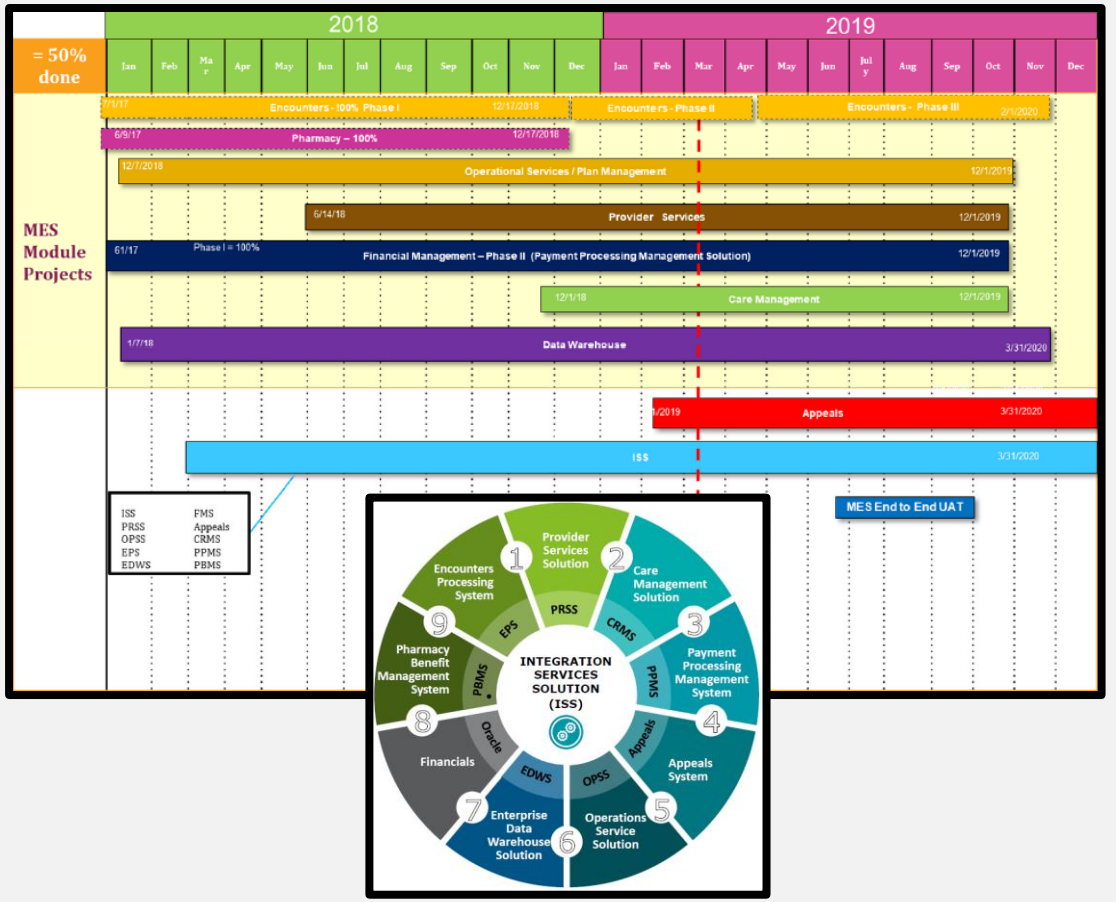


### Virginia

Between June 15 and July 15, 2016, Virginia Department of Medical Assistance Services (DMAS) released the following five (5) MES RFPs: Integration Services Solution (ISS), Enterprise Data Warehouse Solution (EDWS), Financial Management Solution (FMS), Modular Core Services Solution (MCSS), and Pharmacy Benefit Management Solution (PBMS). As part of the MES Program, DMAS added an in-house Encounter Processing Solution (EPS) project. Released the 5 RFPs simultaneously.

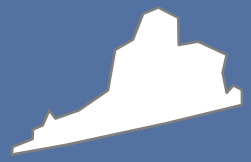
The FMS procurement was eventually cancelled.

There remains one new procurement associated with the MES. Through market responses and awards, DMAS has determined that a Payment Processing Management Solution (PPMS) is required. An appropriate procurement process is being determined for the PPMS.



# VIRGINIA – MODULAR SINGLE-CUTOVER

## 11/22/2019 Interview with Frank Guinan, Virginia Department of Medical Assistance Services (DMAS) Information Technology Program Manager



| Population (#, and as a % of FL) | |
|---|---|
| 8, 517, 685 | 40% |
| **Medicaid Enrollment (#, and as a % of FL)** | |
| 1,328,805 | 32% |
| **Medicaid Spend (#, and as a % of FL)** | |
| $9.6B | 42% |

| | |
|---|---|
| **Key Strategic Inputs Driving VA Transformation** | • **Transformation to a Modern Medicaid Program**: Providing services to populations that are shifting to a smaller percentage Fee-for-Service model to a higher percentage of Managed Care model<br>• Customer-centric services environment<br>• Ability to measure performance of Medicaid programs<br>• **Nimble speed-to-market** environment responsive to change<br>• Creating environments that can be monitored for fraud and abuse incidents through algorithms and analytics<br>• Create an environment that fosters transition from a customized software environment to one in which business needs are met through configuration of commercial off-the-shelf and software as a services (SaaS) or Cloud-based solutions with advanced security solutions<br>• Utilize integration services vendor to keep solutions loosely coupled for easier disengagement at the end of contracts |
| **Transformation Organization and Ownership Within DMAS** | • DMAS is led by an Agency Director who oversees a team of people with different areas of responsibilities including the Deputy Director of Finance. Within the Department of Finance is the Office of Enterprise & Project Management which has direct responsibility for managing VA's Medicaid Enterprise transformation. The project team consists of technical architects, security officers, multiple project managers who oversee module implementations, and a governance committee that is responsible for weighing in on key decisions. |
| **NASPO Participation** | • Using NASPO for Appeals module, contract awarded to Micropact |
| **Lessons Learned** | • Start with integration vendor before attempting to bring on other modules<br>• Recommend states do not split Claims/Financial (Core) module<br>• Find the commonalities between data interfaces prior to implementation<br>• Recommend all vendors are on their own clouds and their own servers while integrating (VA is currently experiencing latency issues) |

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# HHS ECOSYSTEM

# HHS OPPORTUNITY RECOMMENDATIONS

## HHS OPPORTUNITIES

Analysis included a broad HHS ecosystem outlook identifying the various stakeholders and organizations in the HHS landscape, as well as a current state assessment of the Agency's collaboration with those organizations. The objective of this research was to support identification of interoperability and reuse opportunities with the goal of improving operational capabilities and improving service to providers and recipients across the State. Recommendations were made after thorough initial research and focused discussions with Agency leadership.

# HHS ECOSYSTEM OUTLOOK

## An ecosystem outlook will enable AHCA to improve provider experience and capture value through collaboration

Potential Near Term FX Opportunities

FLORIDA HEALTH CARE CONNECTIONS

### Influencers

- Legislation
- Regulation
- Payer Policies/ Medical Cost Trends
- Medical Associations
- Population Health Policies
- Standards-Defining Bodies
- University/Other Research
- Trade Organizations
- Disruptive Solutions
- Competitive Intensity
- Demographic and Economic Factors

### Partners


### Services

**Provider Services**

- Licensing
- Credentialing
- Eligibility
- Enrollment / Onboarding
- Quality
- Provider Mgmt.
- Claims and Encounter
- Financial Mgmt.

**General Services**

- Data Analytics
- Communi-cation
- Admin. Services
- Other

### Service Channels

- Call Centers
- Web Portal
- Field Offices
- Inter-Agency Collaboration
- Email
- Paper
- EDI
- Mail
- Modules

### Stakeholders

- Providers
- Recipients

# AHCA INTERACTION LANDSCAPE

## AHCA interfaces with state agencies, health plans, and regulatory bodies along the provider and recipient journey

**LEGEND**

- Recipient Info
- Licensure
- Provider Data
- Financial Mgmt.
- Quality
- Third Party Liability
- Claims & Encounters
- Enrollment Info
- Eligibility

FLORIDA HEALTH CARE CONNECTIONS

## INBOUND INFORMATION

### Department of Children and Families

- Daily Medicare Eligible from SSA
- Recipient Data and ID Card Info
- FL Safe Families FSFN File
- TPL Resource File

### Department of Health

- Provider License File
- Healthy Start Claims
- Immunization Registry
- Bureau of Vital Statistics Data

### Agency for Persons with Disabilities

- Prior Authorizations

### Health Plans

- Weekly Provider Roster
- Encounter Data Submission
- HEDIS Reporting

### Florida Healthy Kids Corporation

- MediKids Enrollment
- Medicaid Match File
- Federal HUB Medicaid Coverage
- CHIP Expenditure Reporting
- MediKids Premium Transfer

### CMS and SSA

- Medicare Part A/B/D Recipients
- Medicare Part A and B Billing
- NCCI Professional
- NCCI Hospitals
- HCPCS Procedure Codes
- ICD10 Procedure Code Updates

## OUTBOUND INFORMATION

### Department of Children and Families

- Terminated SSA Recipients
- Recipient Error or Match Updates
- Home Safe Net Recipient File
- Insurance Carrier Data

### Agency for Persons with Disabilities

- New Providers or Updates
- DS Waiver Paid Claims
- Weekly Claims Paid/Voided Extract
- Prior Authorization
- EQ Health Interface

### Department of Health

- HIV Recipients

### Health Plans

- Recipient Eligibility
- Claim Status Response
- Claim Payment Advice
- Capitation Payment/Patient

### Florida Healthy Kids Corporation

- MediKids Enrollment Error Report
- Medicaid Match Response

### Department of Elder Affairs

- All DOEA Recipients
- Monthly Active Enrollments
- Monthly Capitation

### CMS and SSA

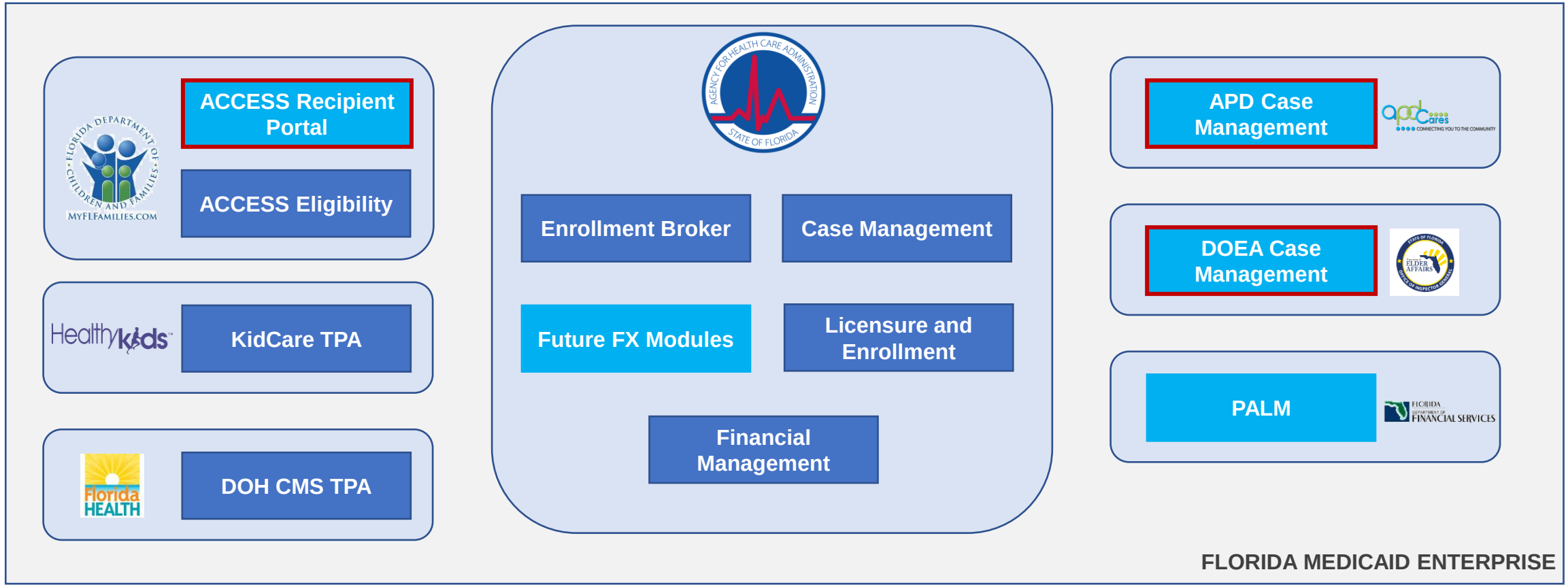
- Medicare Part A and B – Deletions and Demographic Changes
- Pharmacy Claims File for CMS MMA Plans

# FUTURE STATE OPPORTUNITY MAP

## The HHS ecosystem will help capture benefits and improve operational capabilities by exploring the reuse of systems

LEGEND

ACTIVE INITIATIVES | OPERATIONAL OPPORTUNITIES | INITIATIVES WITH OPPORTUNITIES



# FX PROCUREMENT OPPORTUNITIES

## The stage agencies have an opportunity to collaborate and capture value by leveraging system procurements

| BASE AGENCY | INTERFACING AGENCY | OPPORTUNITY |
|---|---|---|
| AHCA | APD | Explore reuse of the APD iConnect case management system for the FX Enterprise |
| | DOEA | Explore reuse of the DOEA eCIRT case management system for the FX Enterprise |
| | DFS | Ensure the sequencing of AHCA financial activities coincide with the DFS PALM Phase II Agency cutover |
| | DOH | Continue to work with DOH on combining licensure and enrollment functions across the HHS Enterprise |
| | DCF | Consider building consolidated recipient portal for eligibility and enrollment |
| DCF | AHCA | Utilize the procurements that are underway at AHCA for an IS/IP and EDW vendor to support the DCF Enterprise operations |
| DOH | AHCA | Continue to work with AHCA on combining licensure and enrollment functions across the HHS Enterprise |
| | AHCA | Consider rolling the CMS TPA functions into AHCA |

Acronyms: (1) AHCA = Agency for Health Care Administration (2) DCF = Florida Department of Children and Families (3) DOH = Florida Department of Health (4) APD = Agency for Persons with Disabilities (5) DOEA = Florida Department of Elder Affairs (6) FKHC = Florida Healthy Kids Corporation

# FX PROCUREMENT OPPORTUNITIES

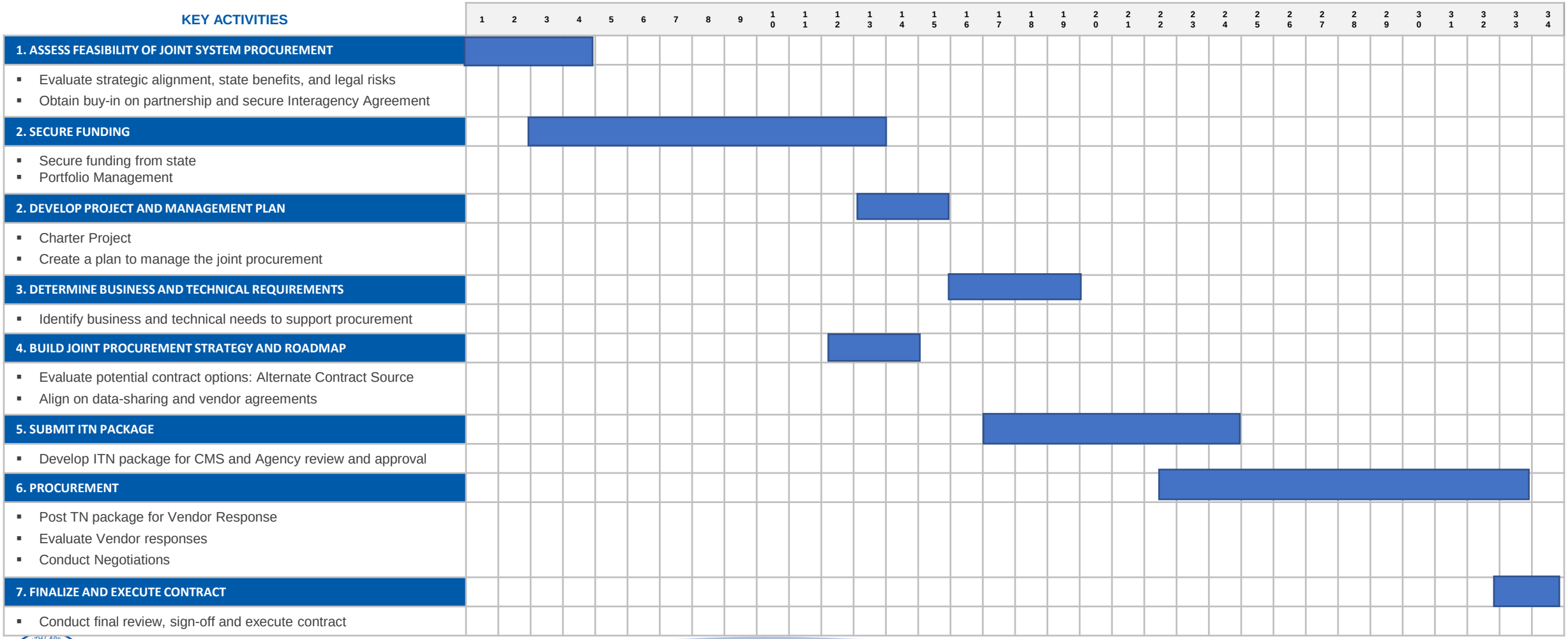
## The stage agencies have an opportunity to collaborate and capture value by leveraging system procurements

| BASE AGENCY | INTERFACING AGENCY | OPPORTUNITY |
|---|---|---|
| APD | AHCA | Explore utilizing and storing APD data at an enterprise level through the AHCA EDW |
| DOEA | AHCA | Explore utilizing and storing DOEA data at an enterprise level through the AHCA EDW |
| FHKC | DCF | Transfer all eligibility determinations to DCF since it houses the single rules engine for the state |
| | AHCA | Enroll and maintain enrollment of all HK eligible children in AHCA managed care plans |
| | DCF/AHCA | Transfer premium collection activities to either DCF or AHCA |
| HEALTH PLANS | AHCA | Accept the determination of provider credentials from AHCA or a contracted single source |

Acronyms: (1) AHCA = Agency for Health Care Administration (2) DCF = Florida Department of Children and Families (3) DOH = Florida Department of Health (4) APD = Agency for Persons with Disabilities (5) DOEA = Florida Department of Elder Affairs (6) FKHC = Florida Healthy Kids Corporation

# APPROACH

## We have designed a phased approach that can be modified to support each inter-agency procurement



# APPROACH

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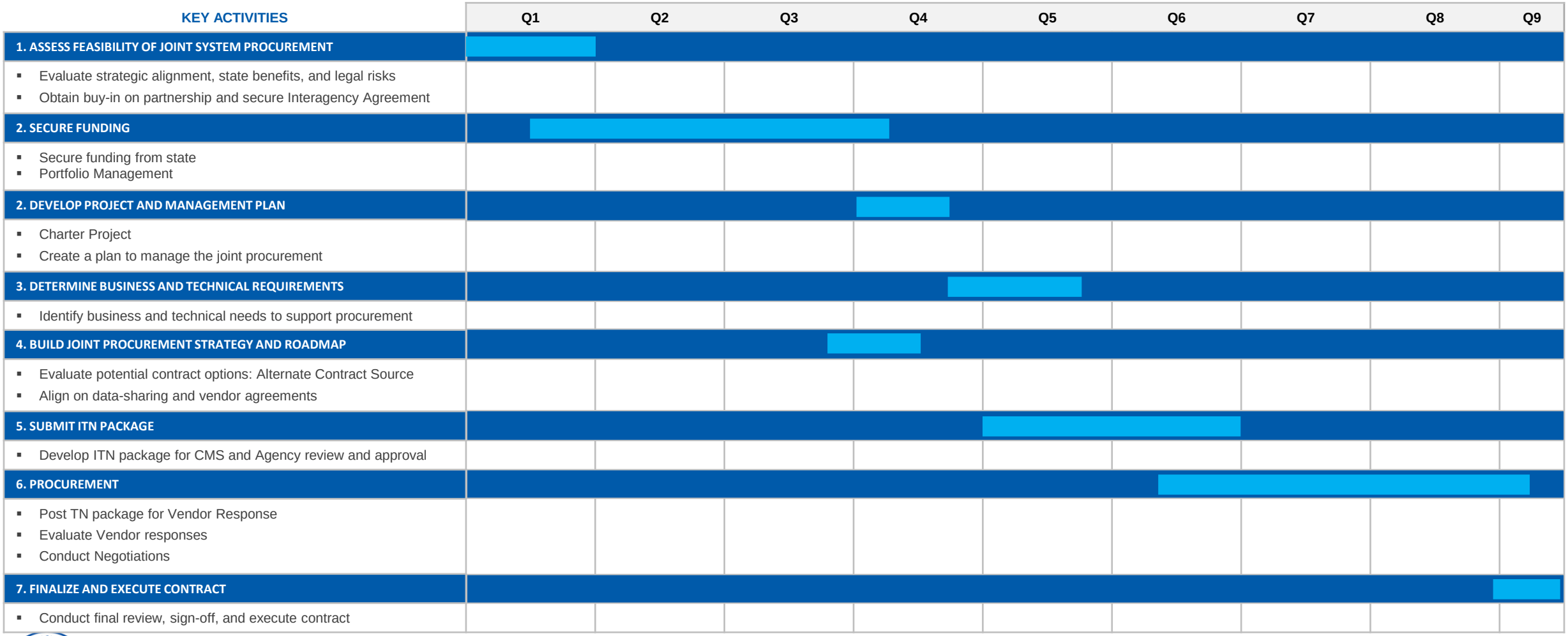


| KEY ACTIVITIES | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 |
|---|---|---|---|---|---|---|---|---|---|
| **1. ASSESS FEASIBILITY OF JOINT SYSTEM PROCUREMENT** | | | | | | | | | |
| ▪ Evaluate strategic alignment, state benefits, and legal risks<br>▪ Obtain buy-in on partnership and secure Interagency Agreement | | | | | | | | | |
| **2. SECURE FUNDING** | | | | | | | | | |
| ▪ Secure funding from state<br>▪ Portfolio Management | | | | | | | | | |
| **2. DEVELOP PROJECT AND MANAGEMENT PLAN** | | | | | | | | | |
| ▪ Charter Project<br>▪ Create a plan to manage the joint procurement | | | | | | | | | |
| **3. DETERMINE BUSINESS AND TECHNICAL REQUIREMENTS** | | | | | | | | | |
| ▪ Identify business and technical needs to support procurement | | | | | | | | | |
| **4. BUILD JOINT PROCUREMENT STRATEGY AND ROADMAP** | | | | | | | | | |
| ▪ Evaluate potential contract options: Alternate Contract Source<br>▪ Align on data-sharing and vendor agreements | | | | | | | | | |
| **5. SUBMIT ITN PACKAGE** | | | | | | | | | |
| ▪ Develop ITN package for CMS and Agency review and approval | | | | | | | | | |
| **6. PROCUREMENT** | | | | | | | | | |
| ▪ Post TN package for Vendor Response<br>▪ Evaluate Vendor responses<br>▪ Conduct Negotiations | | | | | | | | | |
| **7. FINALIZE AND EXECUTE CONTRACT** | | | | | | | | | |
| ▪ Conduct final review, sign-off, and execute contract | | | | | | | | | |

# DEPARTMENT OF CHILDREN AND FAMILIES

**Work in partnership with local communities to protect the vulnerable and promote economically self-sufficient families**

## RESPONSIBILITIES

- Promotes the safety and well-being of Florida's most vulnerable citizens
- Investigates abuse of children, elderly, or disabled individuals
- Determines eligibility for Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and Medicaid
- State portal to the Federal Marketplace and Federal Data Services Hub
- Transmits eligible Medicaid recipients to AHCA for enrollment

## INTERACTION MAP

### INBOUND INFORMATION

- Daily Medicare Eligible from SSA Recipient
- Recipient Data and ID Card Information
- Home Safe Net File (Children in Foster Care)
- TPL Resource File

### OUTBOUND INFORMATION

- Terminated SSA Recipients
- Recipient Error or Match Updates
- Insurance Carrier Data
- Home Safe Net Recipient File

## Agency Opportunities

- Utilize the ongoing procurements for an IS/IP and EDW vendor at AHCA
- Consume all eligibility processing for KidCare beyond the current Medicaid responsibility

# DEPARTMENT OF HEALTH

**Protects the public health and safety of the residents and visitors of the State of Florida**

## RESPONSIBILITIES

- Lead agency for community and public health
- Licenses all individual providers
- Administers the Children's Medical Services Network Plan (CMSN), the Women Infant and Children (WIC), and the Healthy Start and Early Steps programs.
- Maintains all birth records through the Bureau of Vital Statistics
- Maintains immunization records through Florida State Health Online Tracking System (SHOTS)

## INTERACTION MAP

### INBOUND INFORMATION

- Provider License File
- Healthy Start Claims
- Bureau of Vital Statistics Data
- Immunization Registry

### OUTBOUND INFORMATION

- HIV Recipients

## Agency Opportunities

- Continue to work with AHCA on combining licensure and enrollment functions across the HHS Enterprise
- Roll CMS TPA functions into AHCA

# AGENCY FOR PERSONS WITH DISABILITIES

**Partners with local communities and private providers to assist people who have developmental disabilities**

## RESPONSIBILITIES

- Works with local communities and private providers to support people who have developmental disabilities
- Educates the public on disability issues while focusing attention on employment for people with disabilities
- Supports Home and Community Based waiver programs for disabled individuals administered by AHCA
- Manages the waiting list for Medicaid waiver services for disabled individuals
- Provides case management services through the iConnect system and utilizes Electronic Visit Verification services

## INTERACTION MAP

### INBOUND INFORMATION

- Prior Authorization

### OUTBOUND INFORMATION

- New Providers or Updates
- DS Waiver Paid Claims
- Weekly Claims Paid Extract
- Weekly Claims Voided Extract
- Prior Authorization
- EQ Health Interface

## Agency Opportunities

- Explore reuse of the APD iConnect case management system for the FX Enterprise
- Explore utilizing and storing APD data at an enterprise level through the AHCA EDW

# DEPARTMENT OF ELDER AFFAIRS

**Helps Florida's elders remain healthy, safe, and independent**

## RESPONSIBILITIES

- Provides most direct services through its Division of Statewide Community-Based Services
- Works through the state's 11 Area Agencies on Aging and local service providers to deliver essential services
- Administers the Long-Term Care Ombudsman Program and Communities for a Lifetime to SHINE
- Administers the Comprehensive Assessment and Review for Long-Term Care Services (CARES) to assess the placement needs for the elderly

## INTERACTION MAP

**INBOUND INFORMATION**

**OUTBOUND INFORMATION**

- All DOEA Recipients
- Monthly Capitation
- Monthly Active Enrollments for Next Month

## Agency Opportunities

- Assess the functional requirements and flexibility of the eCIRT case management system to determine if it could scale to support the FX enterprise
- Explore utilizing and storing DOEA data at an enterprise level through the AHCA EDW

# FLORIDA HEALTHY KIDS CORPORATION

## Provides health and dental insurance for children in the State of Florida

### RESPONSIBILITIES

- Administers the Children's Health Insurance Program (CHIP)
- Determines financial eligibility utilizing the DCF rules engine
- Enrolls eligible children in contracted health plan networks
- Refers eligible children to DCF for Medicaid determinations
- Collects monthly premium payments from families

### INTERACTION MAP

**INBOUND INFORMATION**

- MediKids Enrollment
- Medicaid Match File
- Federal HUB Medicaid Coverage Check
- CHIP Expenditure Reporting
- MediKids Premium Transfer

**OUTBOUND INFORMATION**

- MediKids Enrollment Error Report
- Medicaid Match Response

### Agency Opportunities

- Enroll and maintain enrollment of all HK eligible children in AHCA managed care plans
- Transfer premium collection activities to either DCF or AHCA

# HEALTH PLANS

## Eighteen health plans within the State of Florida

### RESPONSIBILITIES

- Credentials individual providers and facilities
- Supplies adequate networks to meet contractual ratio
- Provides case management services for recipients
- Ensures services rendered by network providers are appropriate and authorized under the contract
- Provides for medical review and prior authorization for certain services
- Processes claims from providers
- Submits encounter data to the Agency

### INTERACTION MAP

**INBOUND INFORMATION**

- Weekly Provider Roster
- Encounter Data Submission
- Healthcare Effectiveness Data and Information Set (HEDIS) Reporting

**OUTBOUND INFORMATION**

- Claim Status Response
- Claim Payment Advice
- Capitation Payment per Recipient

### Agency Opportunities

- Accept the determination of provider credentials from AHCA or a contracted single source

# CENTERS FOR MEDICARE AND MEDICAID SERVICES AND SOCIAL SECURITY ADMINISTRATION

**The agency within the U.S. Department of Health and Human Services (HHS) that administers the nation's major health care programs**

## RESPONSIBILITIES

**CMS**

- Federal regulatory Agency for Medicaid
- Promulgates federal rules to enable implementation of laws
- Approves federal funding request from states
- Reviews Advance Planning Documents (APD)
- Administers the Medicaid Enterprise Certification process

**SSA**

- Determines eligibility for Supplemental Security Income (SSI) recipients
- Provides to AHCA a roster of SSI recipients to enroll in Medicaid
- Provides to AHCA a roster of Medicare part A and B recipients

## INTERACTION MAP

**INBOUND INFORMATION**

- Medicare Part A/B/D Recipients
- Medicare Part A and B Billing Information
- NCCI Professional
- NCCI Hospitals
- HCPCS Procedure Codes
- ICD10 Procedure Code Updates

**OUTBOUND INFORMATION**

- Medicare Part A and B – Deletions and Demographic Changes
- Pharmacy Claims File for CMS MMA Plans


# STAKEHOLDER EXPERIENCE MAPS

# STAKEHOLDER EXPERIENCE MAPS

## STAKEHOLDER EXPERIENCE MAPS

Background information to map stakeholder's experience to identify strategic opportunities, understand customer pain-points, and generate innovative ideas. The objective of this research was to understand stakeholder interactions with the enterprise to identify projects and build a roadmap of work, identify opportunities for innovation, and understand where the user experience is currently being well supported or if opportunities for improvements through a future state modular environment is needed.


# PROVIDER EXPERIENCE MAPS

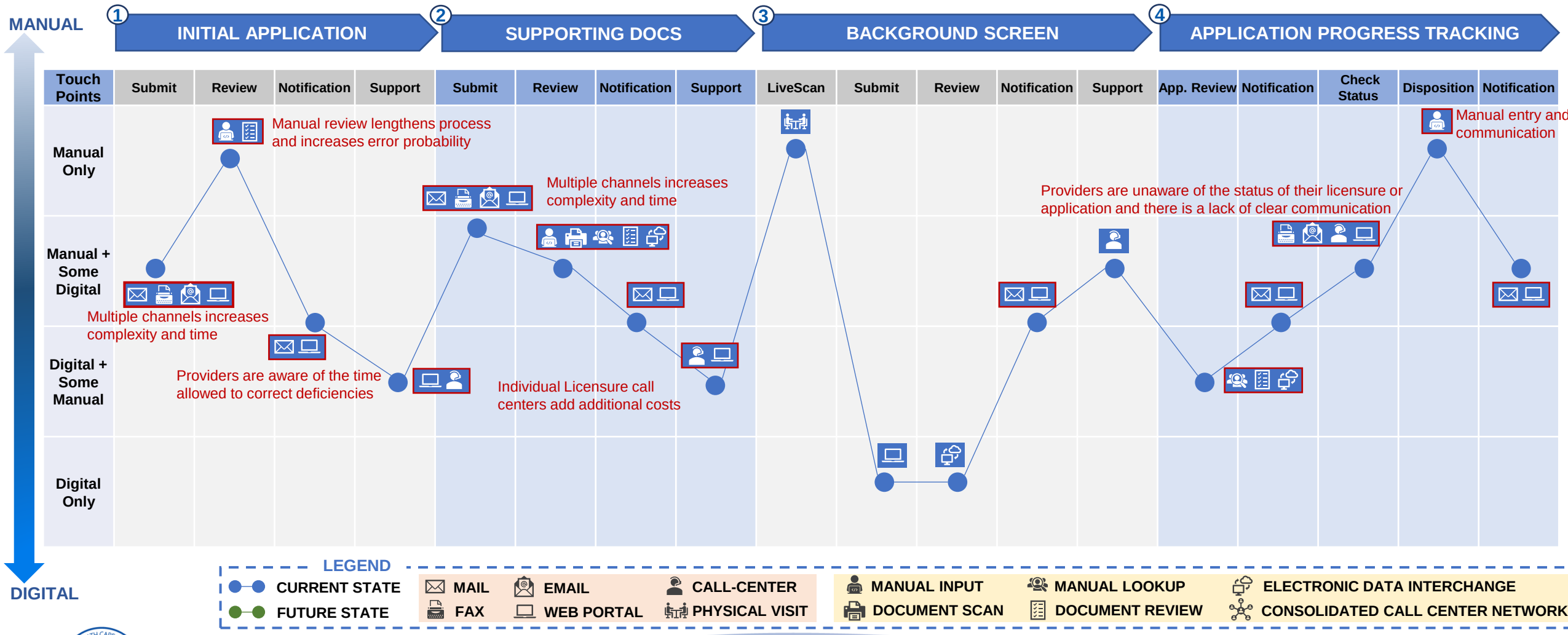
# STAKEHOLDER EXPERIENCE MAPS

**This research provides insight into stakeholder's journey and to map all possible touchpoints and channels or communications.**

| | 1 | 2 | 3 |
|---|---|---|---|
| | OCT-NOV 2019 | NOV 2019 | DEC 2019 |
| | INFORMATION GATHERING | FUTURE STATE DEFINITION | OPPORTUNITIES VALIDATION |
| OBJECTIVE | **Assess Processes And Consolidate Information** | **Identify Opportunities and Align on FX Future State** | **Validate Opportunities** |
| HIGHLIGHTS | • Develop Provider and Recipient **experience maps**<br>• Identify **stakeholder touchpoints**<br>• Review **interaction channels** (manual/automated) | • Ideate opportunities **to improve stakeholder experience**<br>• Recommend **ways to streamline** touchpoints | • **Finalize and consolidate** experience maps<br>• **Socialize and validate opportunities** with stakeholders |
| OUTPUT | • Provider and Recipient touchpoints, experience map, and pain points | • Provider and Recipient Automation Opportunities<br>• Provider and Recipient Process Opportunities | • Visualization in the reduction or simplification of stakeholder touchpoint |

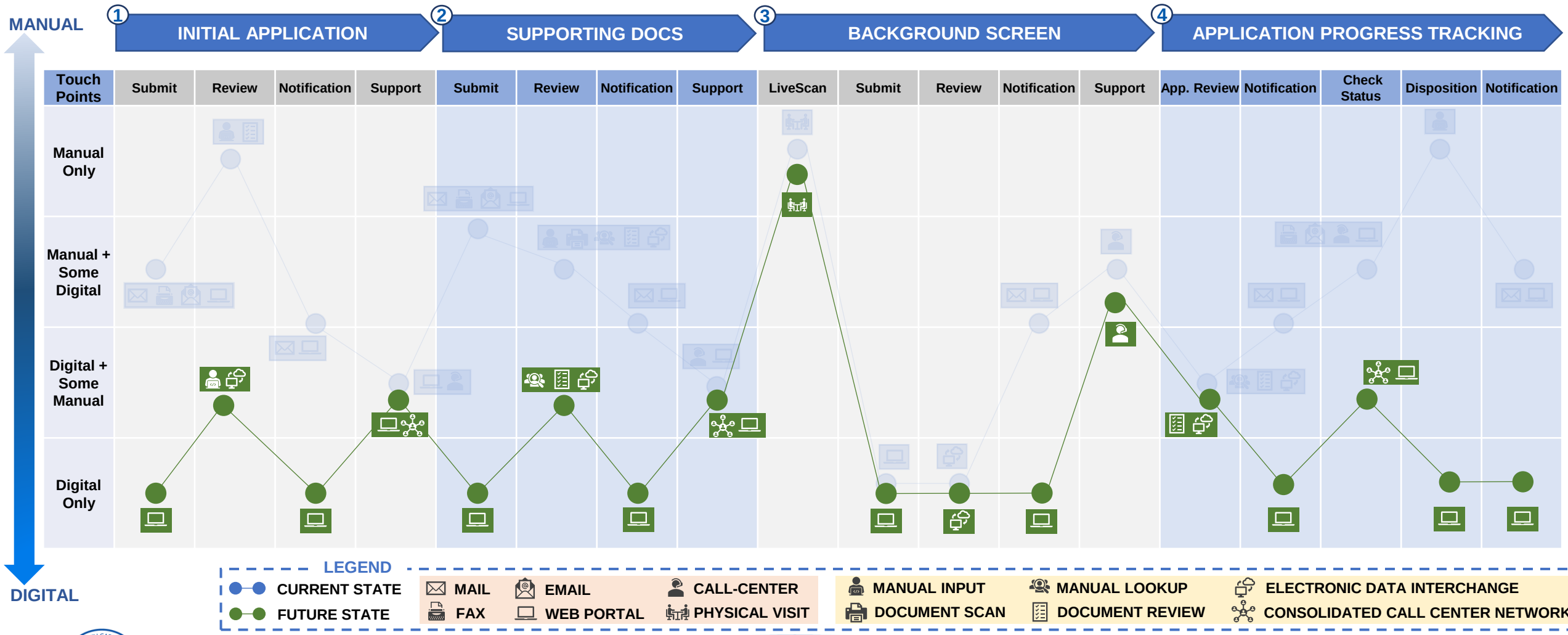
# PROVIDER EXPERIENCE: PROVIDER LICENSURE CURRENT STATE

## The current provider experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints



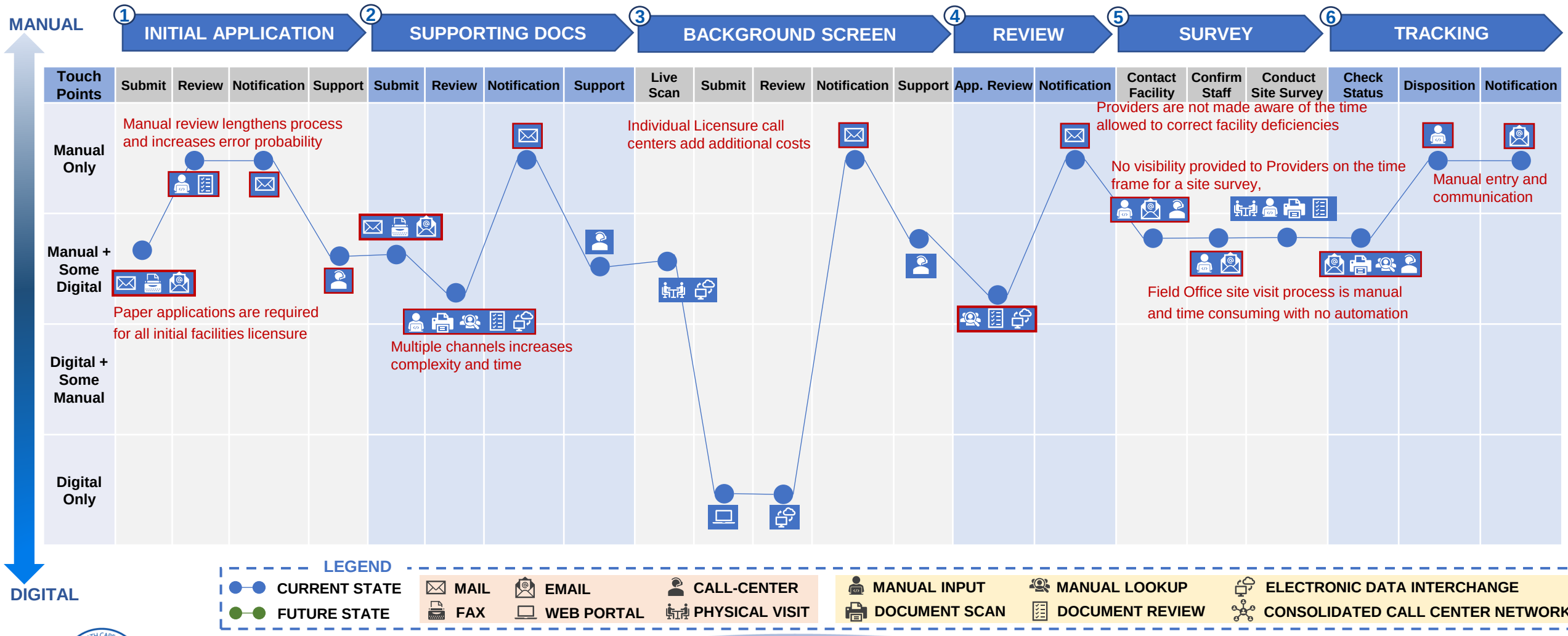
# PROVIDER EXPERIENCE: PROVIDER LICENSURE FUTURE STATE

## The provider module will digitize the provider experience and reduce the complexity of operations



# PROVIDER EXPERIENCE: FACILITY LICENSURE CURRENT STATE

## The current provider experience is poor and time consuming driven primarily by manual processes and multiple touchpoints



# PROVIDER EXPERIENCE: FACILITY LICENSURE FUTURE STATE

## The current provider experience is poor and time consuming driven primarily by manual processes and multiple touchpoints

MANUAL

DIGITAL

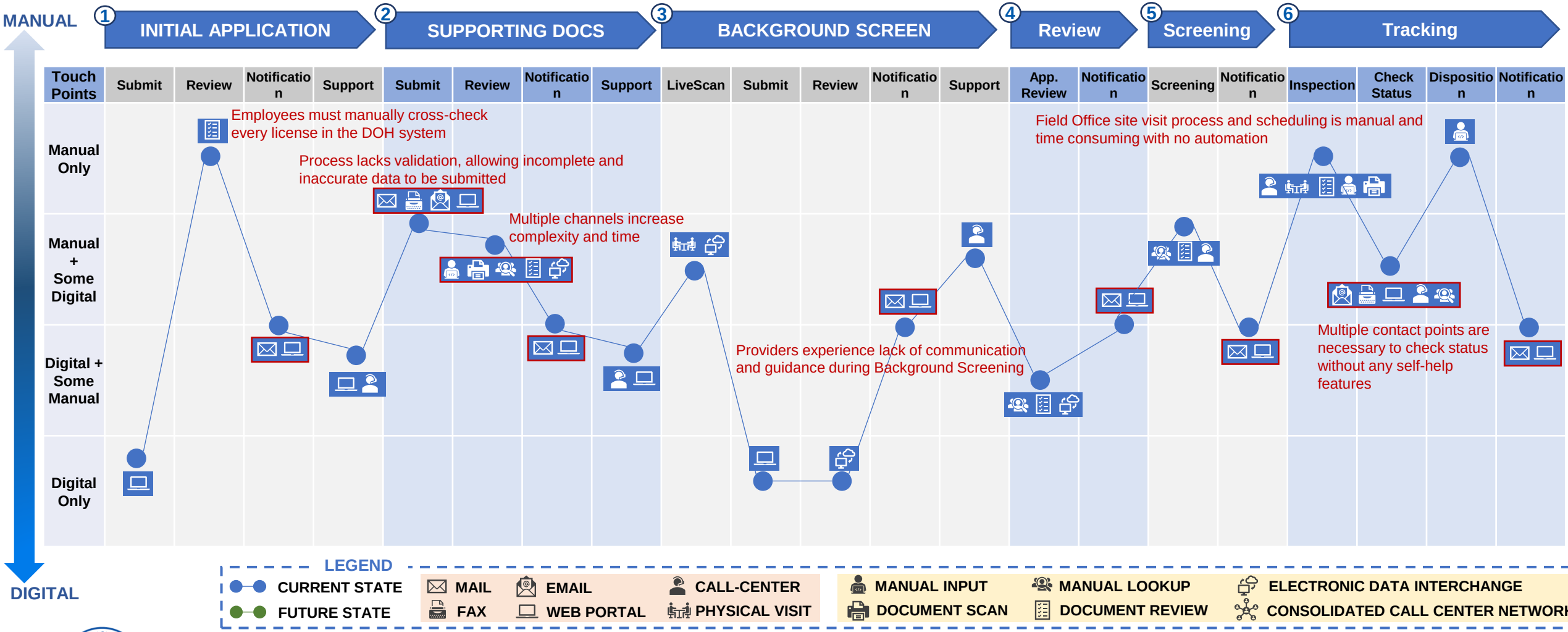
| | 1 INITIAL APPLICATION | | | | 2 SUPPORTING DOCS | | | | 3 BACKGROUND SCREEN | | | | | 4 REVIEW | | 5 SURVEY | | | 6 TRACKING | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Touch Points** | Submit | Review | Notification | Support | Submit | Review | Notification | Support | Live Scan | Submit | Review | Notification | Support | App. Review | Notification | Contact Facility | Confirm Staff | Conduct Site Survey | Check Status | Disposition | Notification |
| **Manual Only** | Online portal with single sign-on capabilities address the needs of multiple agencies with data sharing capabilities | | | | | | | | | | | | | | | | | | | | |
| **Manual + Some Digital** | | | | | Install online workflow to track applications and tasks throughout the lifecycle | | | | | | | | | | | | | | | | |
| **Digital + Some Manual** | | | | | | | | | | | | | | | Create clear notifications for expectation and process of site visits in web portal. | | | | | | |
| **Digital Only** | Enable provider to submit initial application through the portal | | | | | | Enhance portal to provide real time status for provider applications with adequate information | | | | | | | | | Improve Certification and Licensure communications to include time frame allowed to correct deficiencies | | | | | | |

**LEGEND**

- CURRENT STATE
- FUTURE STATE
- MAIL
- EMAIL
- CALL-CENTER
- FAX
- WEB PORTAL
- PHYSICAL VISIT
- MANUAL INPUT
- MANUAL LOOKUP
- ELECTRONIC DATA INTERCHANGE
- DOCUMENT SCAN
- DOCUMENT REVIEW
- CONSOLIDATED CALL CENTER NETWORK

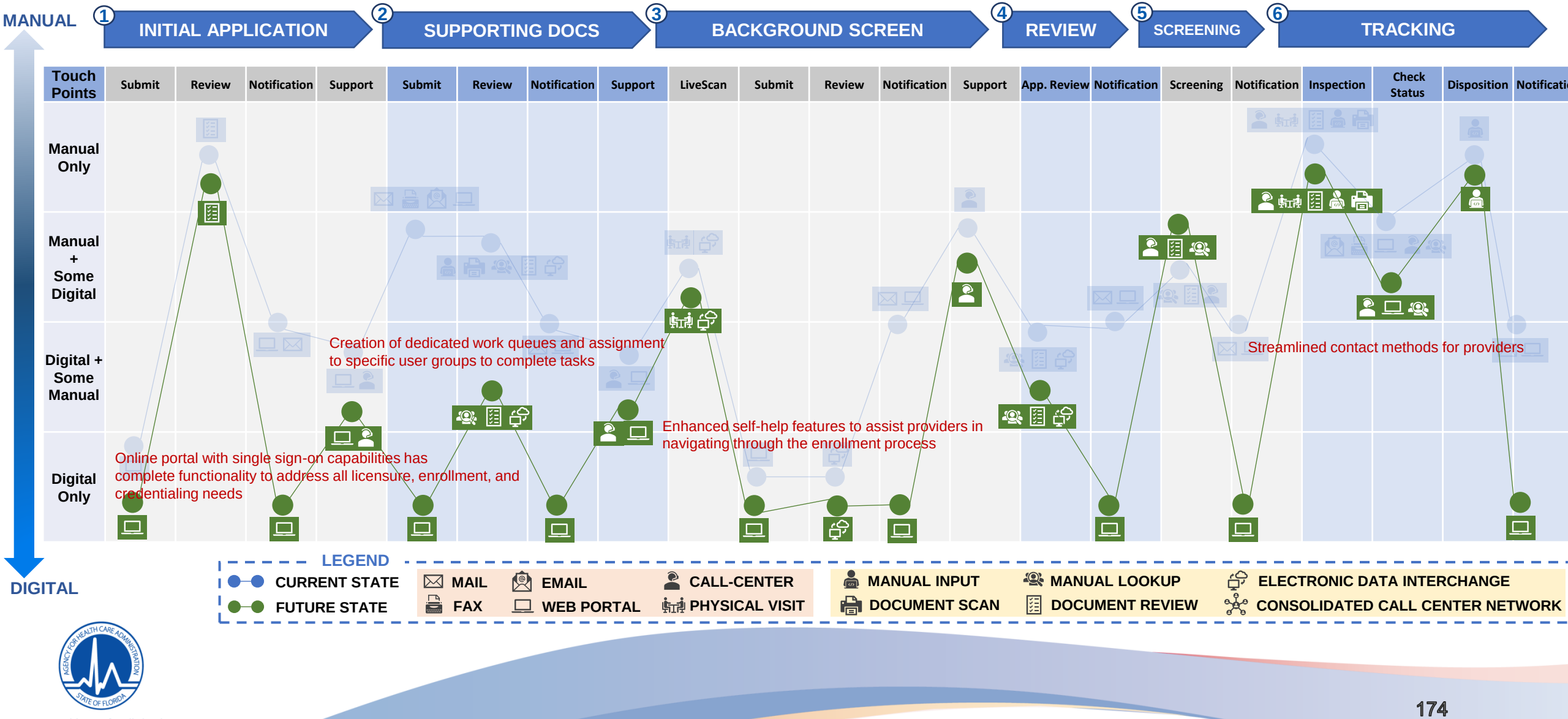
# PROVIDER EXPERIENCE: MEDICAID ENROLLMENT CURRENT STATE

## The current provider experience is limited due to manual processes, limited data sharing, and multiple contact points



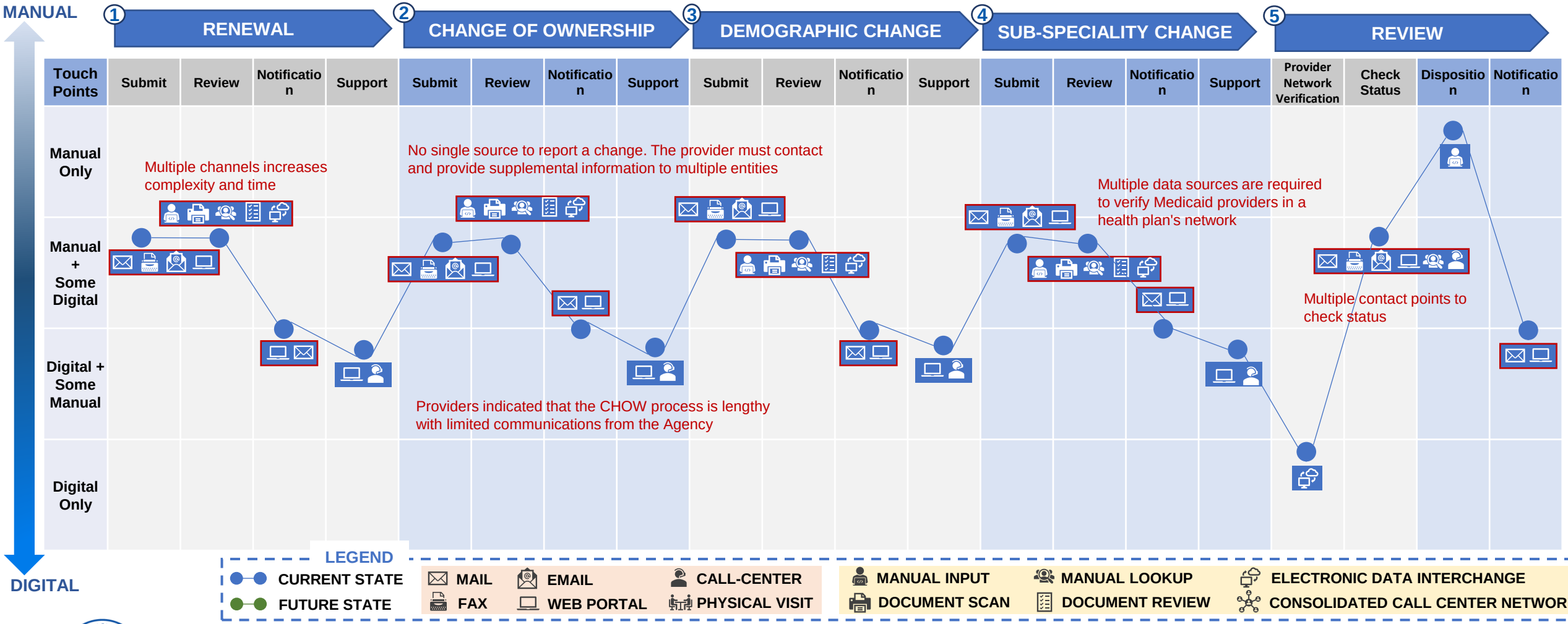
# PROVIDER EXPERIENCE: MEDICAID ENROLLMENT FUTURE STATE

## The current provider experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints



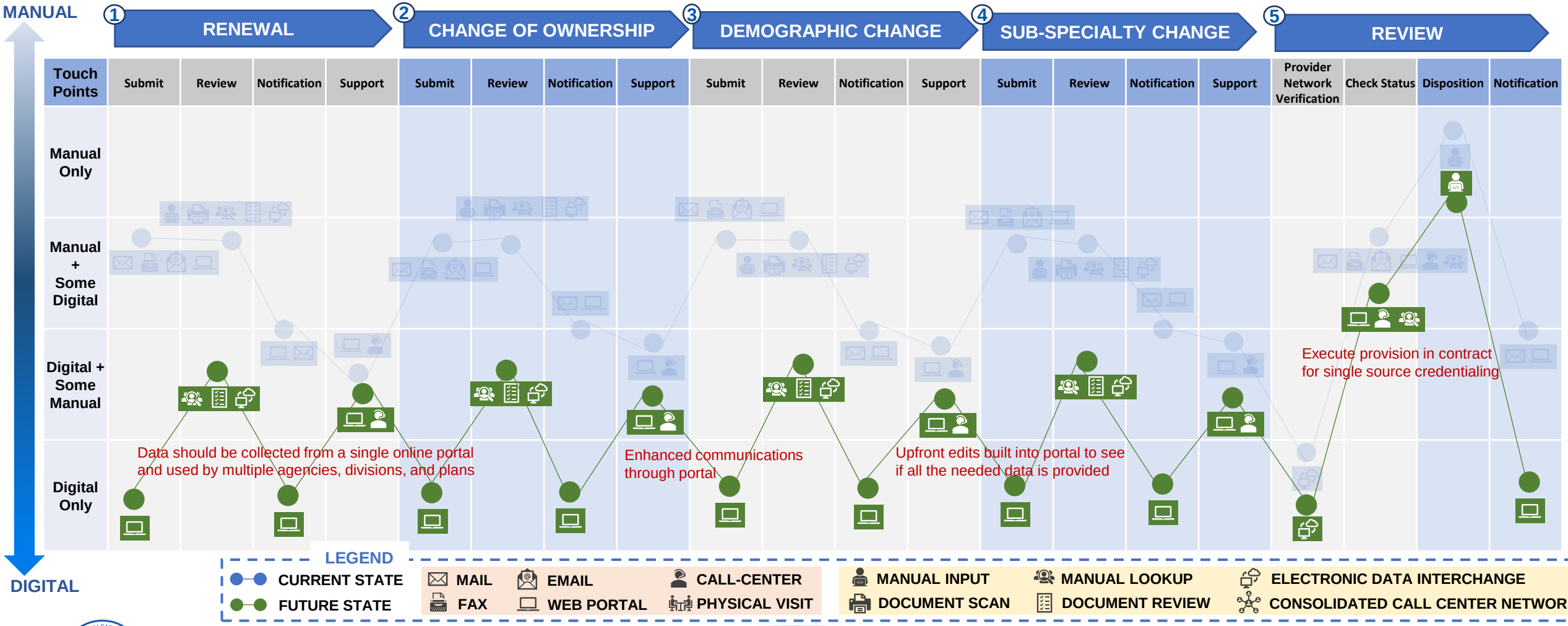
# PROVIDER EXPERIENCE: PROVIDER MANAGEMENT CURRENT STATE

## The poor provider experience is driven primarily by inefficient processes, multiple data submissions, and lack of communication



# PROVIDER EXPERIENCE: PROVIDER MANAGEMENT FUTURE STATE

## The current provider experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints



# PROVIDER EXPERIENCE: FINANCIAL MANAGEMENT CURRENT STATE

## The current provider experience is poor with multiple data entries and mismatch, high denial rate, and poor web portal functionality

MANUAL

DIGITAL

| Touch Points | 1 CLAIMS PROCESSING | | | | 2 ENCOUNTERS PROCESSING | | | | 3 FUNDS DISBURSEMENT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Submit | Review | Notification | Support | Submit | Review | Notification | Support | Disbursement | Support |
| Manual Only | | | | | | | | | | |
| Manual + Some Digital | | | | | | | | | | |
| Digital + Some Manual | | | | | | | | | | |
| Digital Only | | | | | | | | | | |

Inability to match the provider's Medicaid Provider Information was among the primary reasons for denial of claims

The Health Plans noted that a significant number of encounter denials are related to Provider Master List and National Provider Identifier (NPI) Crosswalk issues

Inadequate support from the plan's contact centers, and limited-to-no response on submission-related questions results in claims delay

Providers indicated that payment codes are not intuitive or easy to understand which can take time for the provider to resolve

LEGEND

CURRENT STATE
FUTURE STATE
MAIL
FAX
EMAIL
WEB PORTAL
CALL-CENTER
PHYSICAL VISIT
MANUAL INPUT
DOCUMENT SCAN
MANUAL LOOKUP
DOCUMENT REVIEW
ELECTRONIC DATA INTERCHANGE
CONSOLIDATED CALL CENTER NETWORK
CLEARINGHOUSE

Better Health Care for All Floridians
AHCA.MyFlorida.com

# PROVIDER EXPERIENCE: FINANCIAL MANAGEMENT FUTURE STATE

## The current provider experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints

MANUAL

DIGITAL

| | 1 CLAIMS PROCESSING | | | | 2 ENCOUNTERS PROCESSING | | | | 3 FUNDS DISBURSEMENT | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Touch Points** | **Submit** | **Review** | **Notification** | **Support** | **Submit** | **Review** | **Notification** | **Support** | **Disbursement** | **Support** |
| **Manual Only** | | | Single online portal for claim entry and submission that supports FFS and managed care with capabilities to parse files to the format unique to each individual plan | | | | | | | |
| **Manual + Some Digital** | | | | | | | | | | |
| **Digital + Some Manual** | | Utilize MPI and MOI with IS/IP for provider identity reconciliation | | | | Automated upfront edits with intuitive on-screen messages to be built into the portal to enhance the quality of data upon submission | | | Clear and concise communications to assist providers in understanding error and payment codes prior to submission | |
| **Digital Only** | | | Enhanced self-help features and online assistance to assist providers in the submission of claims | | | | | | | |

**LEGEND**

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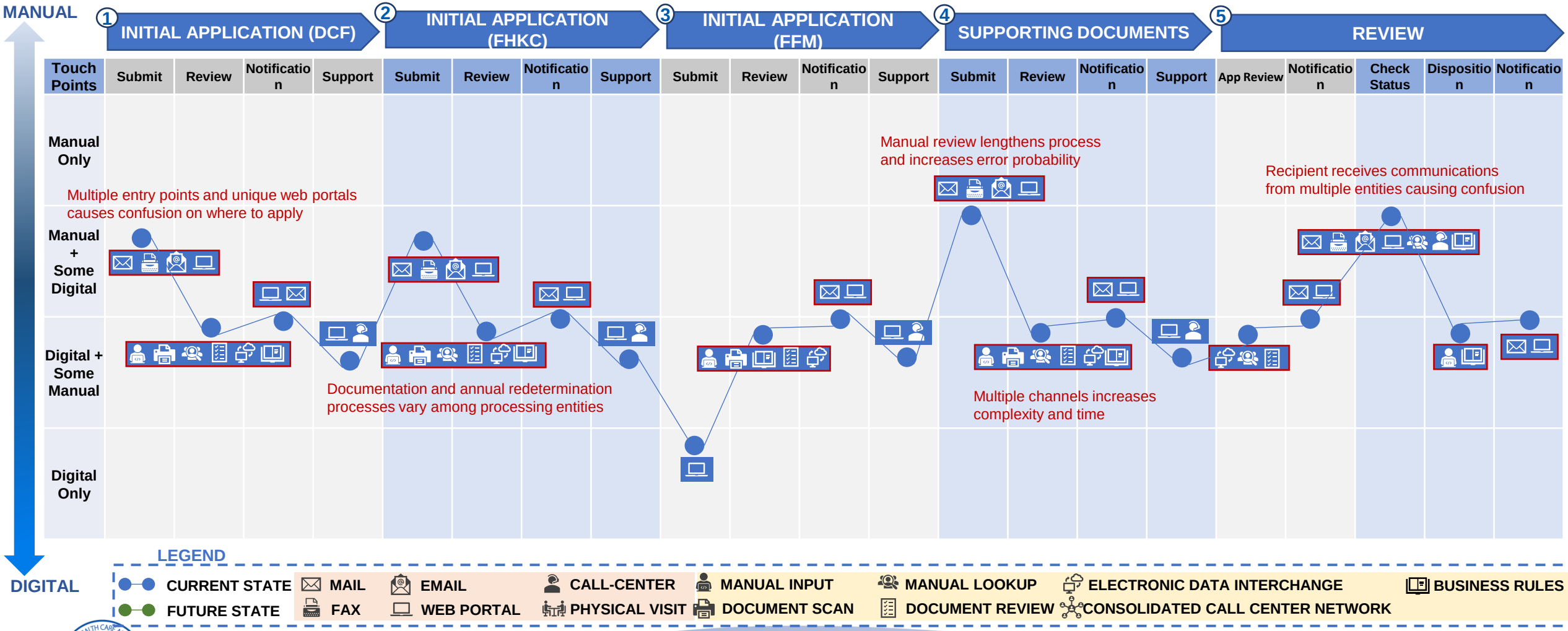
MANUAL LOOKUP
DOCUMENT REVIEW
ELECTRONIC DATA INTERCHANGE
CONSOLIDATED CALL CENTER NETWORK
CLEARINGHOUSE


# RECIPIENT EXPERIENCE MAPS

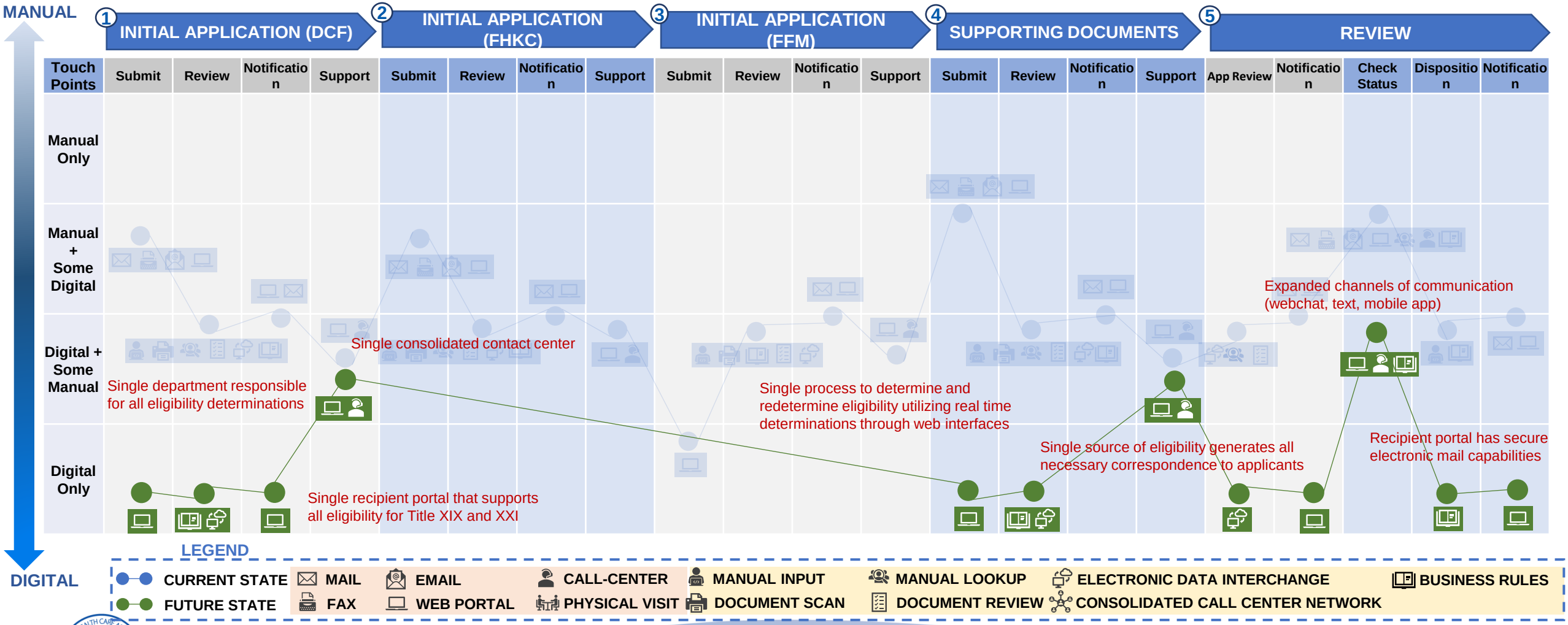
# RECIPIENT EXPERIENCE: RECIPIENT ELIGIBILITY CURRENT STATE

## The current recipient experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints



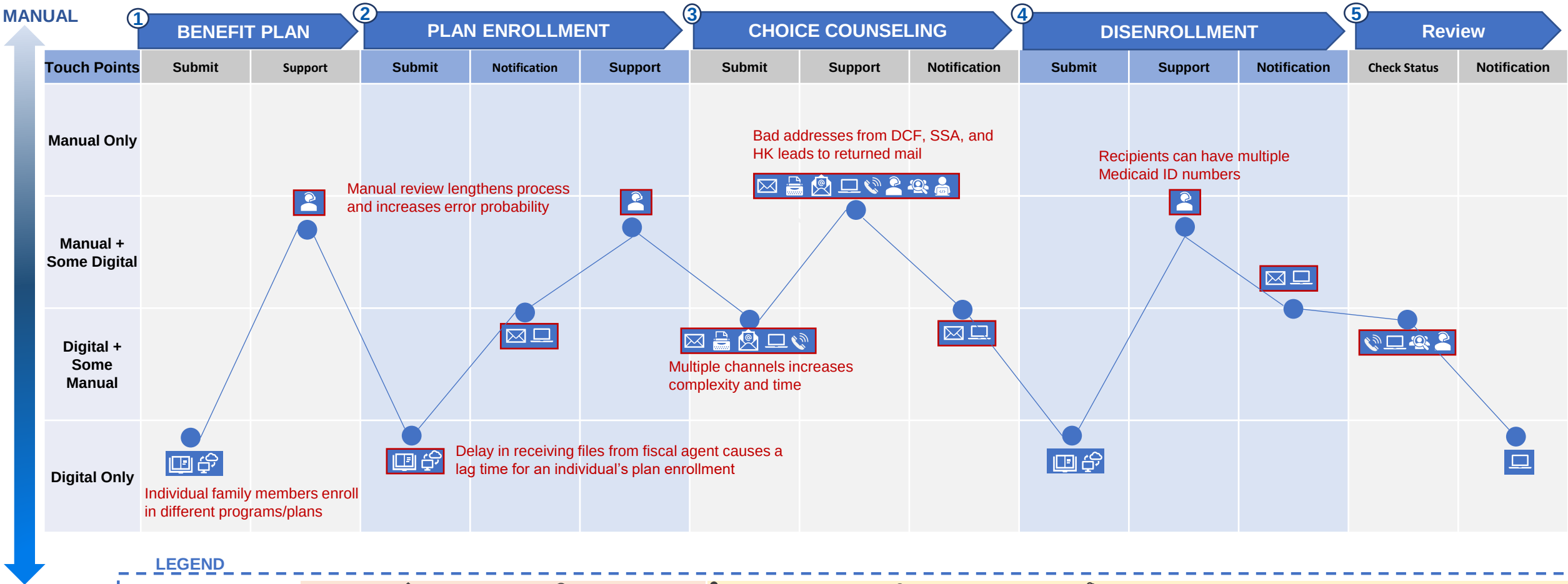
# RECIPIENT EXPERIENCE: RECIPIENT ELIGIBILITY FUTURE STATE

## The current recipient experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints



# RECIPIENT EXPERIENCE: RECIPIENT ENROLLMENT CURRENT STATE

## The current recipient experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints




LEGEND

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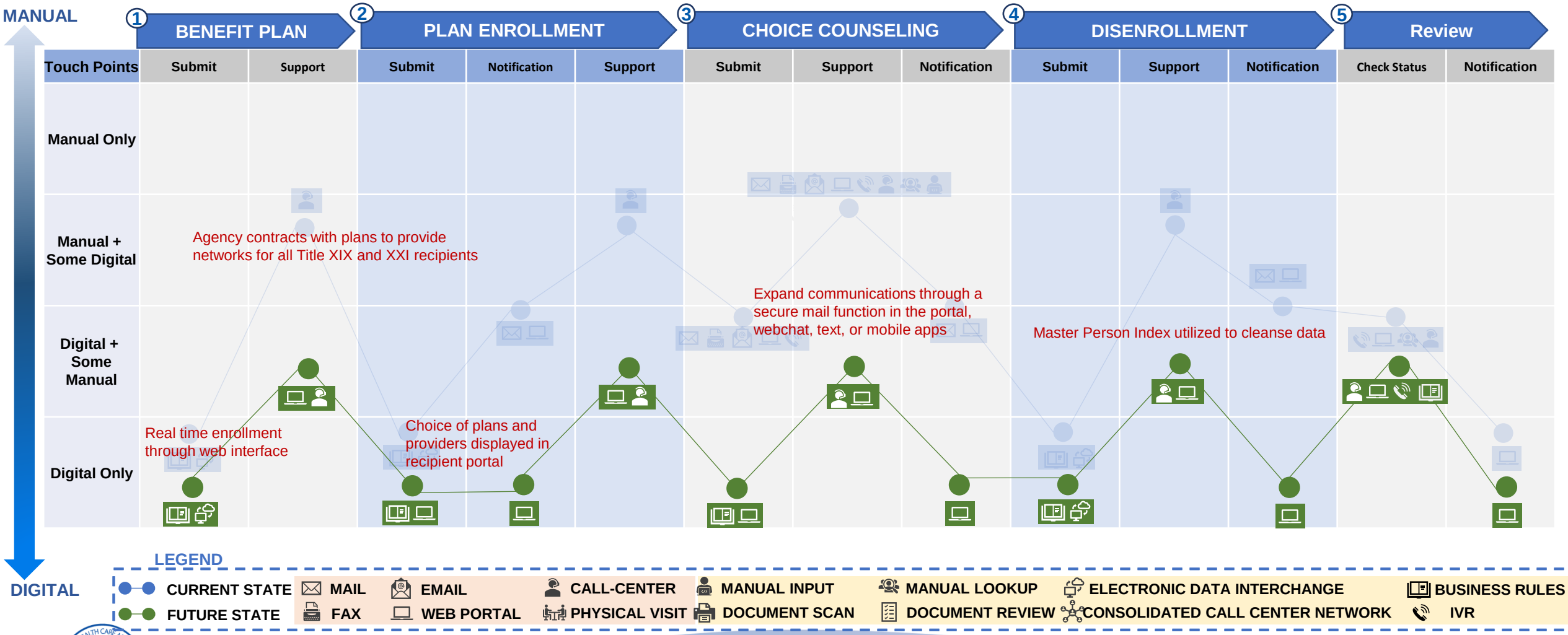
CONSOLIDATED CALL CENTER NETWORK
BUSINESS RULES
IVR

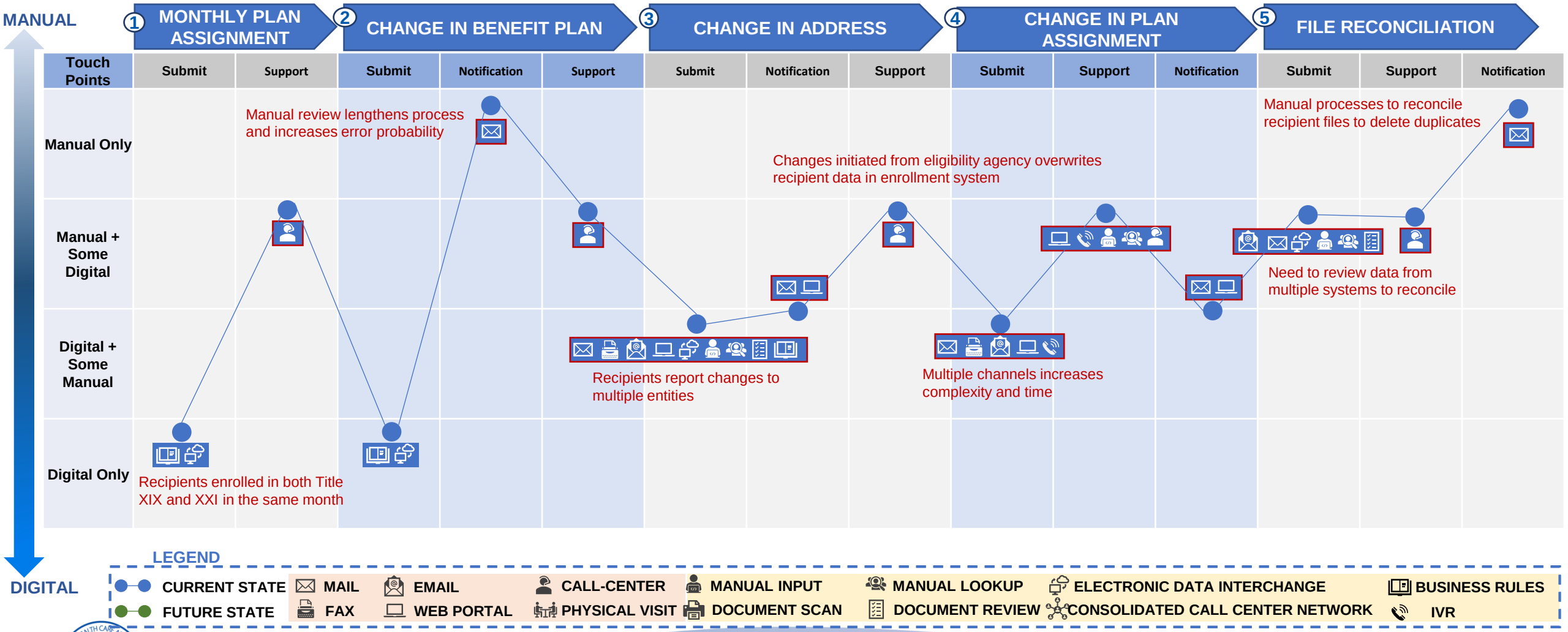
# RECIPIENT EXPERIENCE: RECIPIENT ENROLLMENT FUTURE STATE

## The current recipient experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints



# RECIPIENT EXPERIENCE: RECIPIENT MAINTENANCE CURRENT STATE

## The current recipient experience is poor and prone to errors driven primarily by multiple channels and manual touchpoints



# RECIPIENT EXPERIENCE: RECIPIENT MAINTENANCE FUTURE STATE

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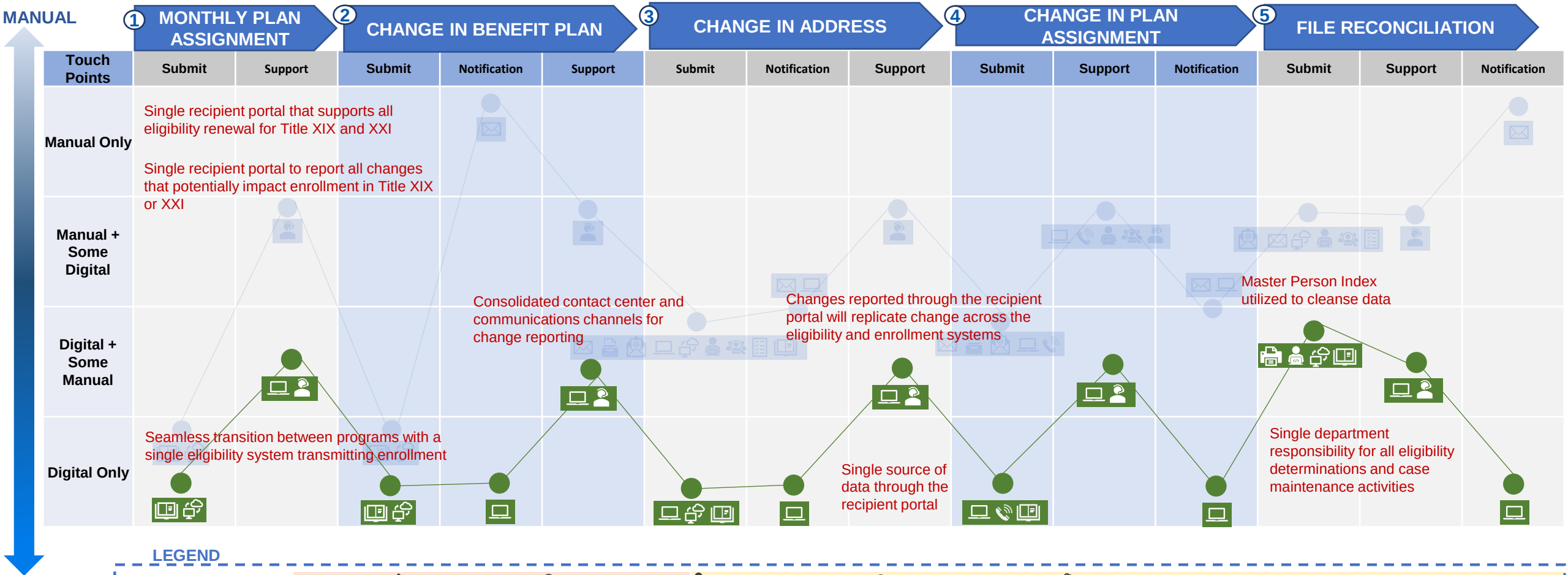


LEGEND

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ELECTRONIC DATA INTERCHANGE
CONSOLIDATED CALL CENTER NETWORK
BUSINESS RULES
IVR


# BACKGROUND RESEARCH

# BACKGROUND RESEARCH

## BACKGROUND RESEARCH

SEAS reviewed and collated key strategic inputs (background research) to serve as an initial guide to aid in the development of the strategic framework and to focus the work of updating the strategic plan. This includes summary documents of key insights on federal and state regulations, Medicaid Enterprise operational measurements, and more.


# BACKGROUND RESEARCH INDEX

# BACKGROUND RESEARCH INDEX

| Title | Purpose | Source |
|---|---|---|
| Medicaid Enterprise Certification Lifecycle (MECL) | Review CMS's certification approach | Centers for Medicare and Medicaid Services (CMS) |
| MECL Certification "At-a-Glance" | Review CMS's certification approach | Centers for Medicare and Medicaid Services (CMS) |
| Healthcare Effectiveness Data & Information Set (HEDIS) | Review healthcare performance measurements | CMS, National Committee for Quality Assurance (NCQA), and other sources |
| iConnect Research | Gain insight into Agency's interoperability opportunities | Florida Agency for Persons with Disabilities |
| Department of Children and Families (DCF) Enterprise Integrated System Implementation | Gain insight into Agency's interoperability opportunities | Florida Department of Children and Families |
| Department of Elder Affairs Enterprise Client Information and Registration Tracking System | Gain insight into Agency's interoperability opportunities | Florida Department of Elder Affairs |
| Department of Health (DOH) Centralized Online Reporting, Tracking, and Notification | Gain insight into Agency's interoperability opportunities | Florida Department of Health |
| FX Lessons Learned Summary (IS/IP & EDW Procurements) | Leverage lessons learned from FX to provide insights into future projects | SEAS |

# BACKGROUND RESEARCH INDEX

| Title | Purpose | Source |
|---|---|---|
| Florida Planning, Accounting, and Ledger Management (PALM) Project | Gain insight into Agency's interoperability opportunities | Florida Department of Financial Services |
| Florida State Statute 42, Agency for Healthcare Administration Chapter 409 Florida Statutes | Review AHCA's statutory requirements | Florida Senate www.leg.state.fl.us (Online Sunshine, legislative site) |
| Case Management Tracking (Legal) | Review Case Management Tracking (Legal) | SEAS |
| Provider Experience Project | Review Provider Experience Project to evaluate current state | SEAS |
| Provider Management Module | Review background information on Provider Management Module | SEAS |
| U.S. Census Bureau Quick Facts | State population by state | U.S. Census Bureau |
| Medicaid.gov Enrollment by the number | Medicaid population by state | CMS |
| Total Medicaid Spend by State | Medicaid spend by state | Kaiser Family Foundation |


# KEY S-3/S-4 MEETINGS

# MEETING LOG INVENTORY

| Participants | Meeting title | Date |
|---|---|---|
| FX Executive Governance/ Greg Pins | FX Executive Governance: Future State Design Approach Overview | December 5, 2019, 3:00 p.m. – 3:30 p.m. |
| FX Executive Governance/SEAS | FX Executive Governance: Future State Design: Strategic Priorities Review | December 12, 2019, 3:00 p.m. – 4:00 p.m. |
| FX Executive Governance/SEAS | FX Future State Design Session | December 13, 2019, 8:30 a.m.—4:30 p.m. |
| FX Executive Governance/SEAS | FX Future State Design: Sequencing Decisions Meeting #1 | December 18, 2019, 2:00 p.m.-4:00 p.m. |
| FX Executive Governance/SEAS | FX Future State Design: Sequencing Decisions Meeting #2 | January 9, 2020, 8:30 a.m.—4:30 p.m. |
| FX Executive Governance/SEAS | FX Transformation—Future State Design | January 16, 2020, 1:00 p.m. –3:00 p.m. |


# CASE STUDIES

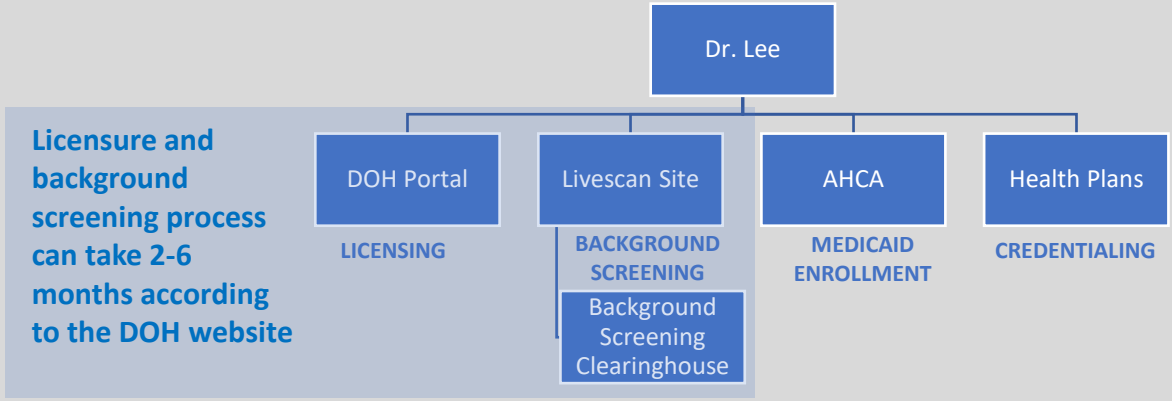
# CASE STUDY 1: PROVIDER LICENSURE AND CREDENTIALING

## CASE SCENARIO

Dr. Lee recently graduated from medical school and wants to start practicing Medicine in Florida. He applies through the Department of Health's (DOH) Florida Board of Medicine portal to obtain his license. Once licensed Dr. Lee decides that he also wants to participate in the Medicaid program. As part of his Medicaid enrollment, Dr. Lee decides he wants to participate in both fee for service and a health plan network.

## CURRENT STATE

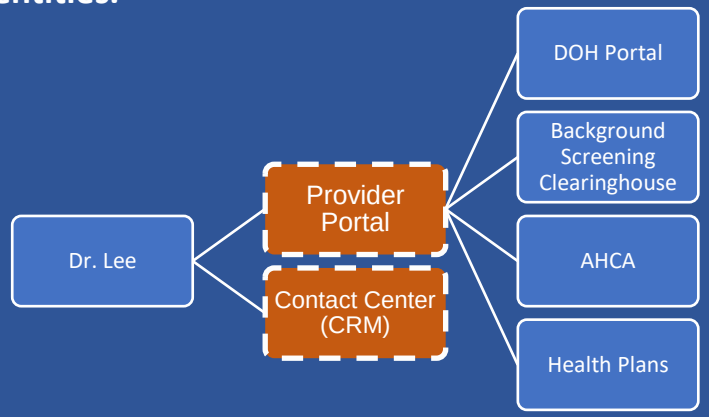
**Dr. Lee must submit the same documentation and background screening materials multiple times for licensure, Medicaid enrollment, and health plan credentialing, and has limited visibility.**




- Dr. Lee must interact with DOH through mail, email, or call center for licensure questions, the BSC call center for questions related to his background screening, and the Fiscal Agent's call center for Enrollment
- Due to limited visibility into the process and no real-time updates, Dr. Lee continuously calls the Fiscal Agent's enrollment call center
- He must provide duplicative information to each plan as part of their credentialing process

## FUTURE STATE

**Dr. Lee will apply for this license and Medicaid application simultaneously through a single portal that will collect all the necessary information and share data across the entities.**




- Dr. Lee can log onto the portal and have complete visibility into the process through status tracking, representative chatting, and self-help features
- The portal will integrate with the background screening clearing house and contain robust self-help features to minimize the need for interaction with a contact center
- Dr. Lee will only need to go through the credentialing process once regardless of the number of plans with which he contracts to be a provider

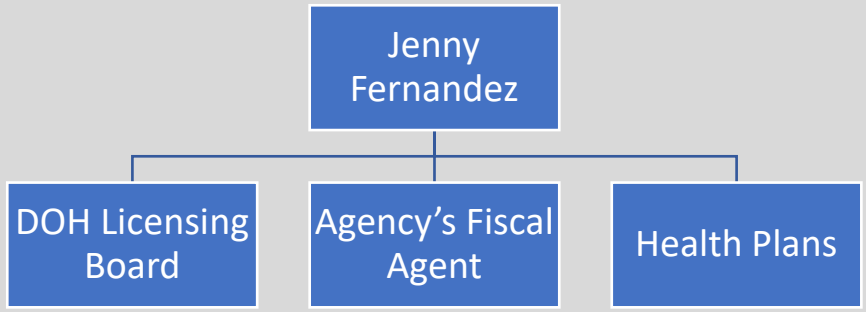
# CASE STUDY 2: PROFILE UPDATE

## CASE SCENARIO

Jenny Fernandez is a licensed Physical Therapist that is a participating provider in the Medicaid program and is contracted with three health plans. Jenny was recently married and has taken the name of her spouse. Jenny needs to change her name on her Physical Therapist license and with Medicaid.

## CURRENT STATE

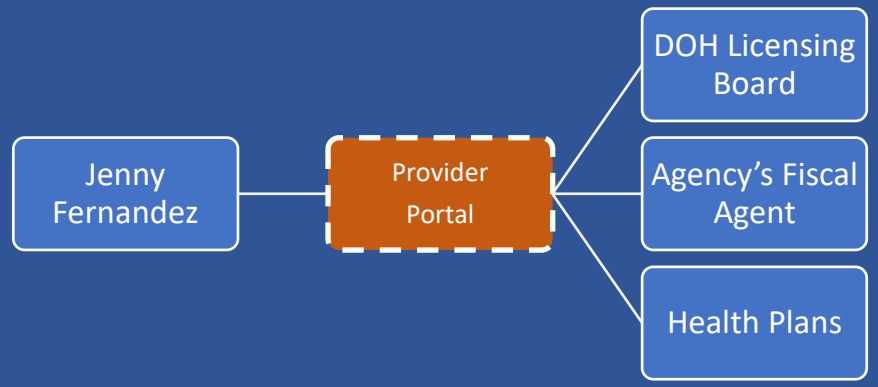
**Ms. Fernandez is required to contact the Department of Health's licensing board, the Agency's fiscal agent, and all three health plans.**




- Ms. Fernandez must provide documentation to each individual entity to have her name changed
- Each entity has its own submission requirements and processes

## FUTURE STATE

**Ms. Fernandez logs into the secure provider portal and uploads her marriage license which is distributed to all necessary entities.**




**Her provider profile and demographic information is automatically updated across all platforms**

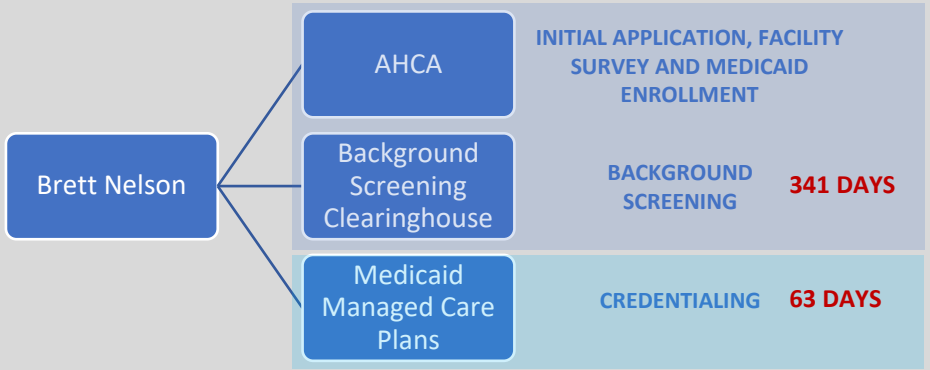
# CASE STUDY 3: FACILITY LICENSURE

## CASE SCENARIO

Brett Nelson spent millions of dollars to build and open a nursing home. He applied for the appropriate license through AHCA. The initial application was completed and submitted through the eleven-page paper process with numerous supporting documents. The licensure process took almost a full year, significantly delaying the start of operations and Brett's ability to recoup his initial investment.

## CURRENT STATE

**Mr. Nelson submits the same documentation and supporting documents multiple times for licensure, Medicaid enrollment, and Medicaid Managed Care Plan credentialing.**

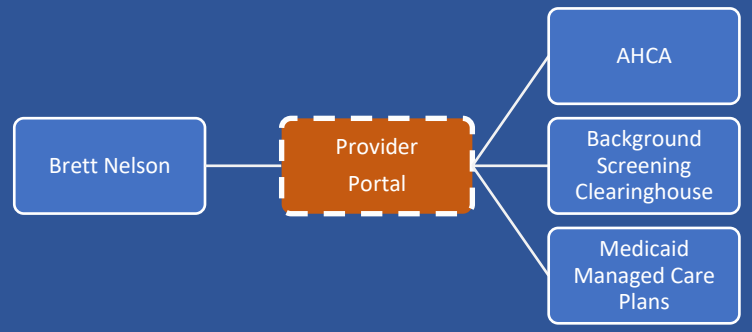



**From the initial submission of the application, it took 404 days to complete the process**

- **The facility was charged a non-refundable application fee based on the number of beds in the facility that was submitted with the application**
- **The license will not be processed until all supporting documents and fees are submitted**
- **The survey was scheduled through a manual process using Outlook to look for availability on staff's calendars to conduct the survey**

## FUTURE STATE

**Mr. Nelson will apply online for the facility license and Medicaid simultaneously through a single portal that will collect all the necessary information and share data across the entities.**




- **The portal will integrate with the BSC and contain robust self-help features to minimize the need for interaction with a contact center**
- **Field Survey staff will be notified for survey via automated workflow functionality and the results will be updated in real or near-real time**
- **The facility will only need to go through the credentialing process once regardless of the number of plans**

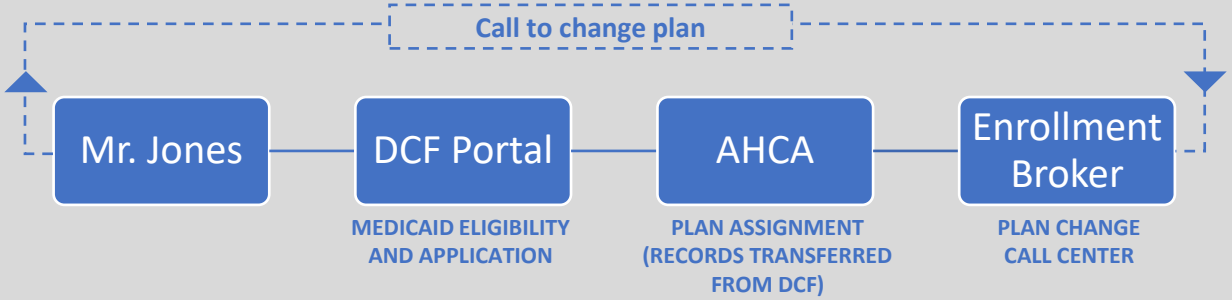
# CASE STUDY 4: RECIPIENT PLAN ENROLLMENT

## CASE SCENARIO

Mr. Jones recently lost his job and applies for public assistance through the DCF portal for himself, his wife, and their three children (ages 2, 6, and 10). Mr. Jones' sole source of income is through unemployment benefits. Mr. and Mrs. Jones are over-income for Medicaid and are only eligible for the Medically Needy program. Their three children are determined eligible for Medicaid. The three children are determined eligible for Medicaid and are auto assigned to a plan by the Agency. When Mrs. Jones logs into the plans' portal, she discovers that the children's pediatrician (Dr. Kid) does not participate in the auto-assigned plan.

## CURRENT STATE

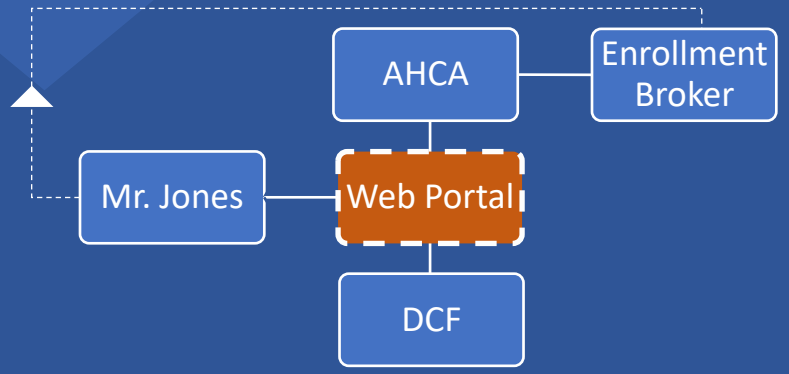
**Mr. Jones' children are auto assigned to a plan by the Agency without reviewing the available plans and providers with the family. The process to change is manual and time consuming.**




- **Mrs. Jones has no visibility or participation in the plan assignment as the kids are auto assigned to a plan and a letter is mailed to inform her**
- **Mrs. Jones must call the plan's recipient call center to change the plan as their preferred provider does not participate in the auto assigned plan**
- **The family may pay out of pocket for visits or find a different provider that does not have access to the children's medical history**

## FUTURE STATE

**Mr. and Mrs. Jones will be able to review the available plans and providers prior to a final eligibility determination and select the preferred plan prior to being auto assigned to another plan.**




- **The Agency and DCF integrate plan enrollment into the DCF web eligibility portal to make a real-time call to the Agency's Enrollment Broker**
- **Mrs. Jones has visibility into plan assignment and can call the Agency's Enrollment Broker real-time prior to final eligibility determination**
- **The process is digital with no need for mail as the applicants can access their real-time status on the web portal**


# PRIOR AND UPDATED STRATEGIC PRIORITIES MAPPING

# 2017 STRATEGIC PRIORITIES

## The original Strategic Priorities are mapped to high-level tactics that address how the roadmap would meet the Priorities

| Strategic Priority | How FX Addressed the Priority |
|---|---|
| Integration Platform | High-Level Tactics:<br>▪ Integration Services Platform module<br>○ 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<br>○ Specific integration components planned for the Integration module include:<br>• 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<br>▪ Enterprise Data Warehouse module<br>○ 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 |
| Provider | High-Level Tactics:<br>▪ Identity Reconciliation module<br>○ Creates a “single source of truth” for Provider Identity across the Agencies, Bureaus, and plans<br>▪ Streamlined Provider Enrollment module<br>○ Speeds of the process by which a previously unenrolled provider could provide care through the Medicaid program<br>○ Improves the user-interface and pulls information from across the State to prepopulate the application to the greatest degree appropriate<br>▪ Performance Management and Population Health<br>○ Better ties specific providers to health measures of their patients<br>○ Foundation of improving value-based care across the State of Florida |

# 2017 STRATEGIC PRIORITIES

## The original Strategic Priorities are mapped to high-level tactics that address how the roadmap would meet the Priorities

| Strategic Priority | How FX Addressed the Priority |
|---|---|
| Recipient | High-Level Tactics:<br>▪ User Interface / Recipient Portal<br>○ 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<br>○ 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<br>○ Information will be pulled into the portal as greater inter-agency collaboration occurs<br>▪ Streamlined Recipient Enrollment<br>○ Improves the recipient experience by improving and speeding the recipient enrollment process via new systems and collaborations with the Department of Children and Families<br>▪ Integrated and Accessible Data for the Recipient<br>○ Prepare existing data within the Agency and work with stakeholders (e.g., sister agencies, providers) to integrate currently disparate data that could improve the recipient experience, such as provider performance information<br>○ Data sets would be provided to recipients via the Recipient Portal |
| Program Integrity | High-Level Tactics:<br>▪ Automation and Analytics<br>○ Medicaid Program Integrity area is an excellent area for the Agency to create tangible results through a series of quick-wins<br>○ Leverage automation and analytics to improve the Agency's Medicaid fraud detection<br>▪ Develop Model for Managed Care and Fee for Service<br>○ Improves the recoupment models – the processes and supporting advanced analytics – to recoup Medicaid fraud dollars in both the Fee for Services and Managed Care areas.<br>○ Necessary for the Managed Care area as no single health plan has detailed information on fraud in other health plans<br>○ Could greatly assist in the recoupment of funds across the State of Florida |

# 2017 STRATEGIC PRIORITIES

## The original Strategic Priorities are mapped to high-level tactics that address how the roadmap would meet the Priorities

| Strategic Priority | How FX Addressed the Priority |
|---|---|
| Financials | High-Level Tactics:<br>▪ Enhance / Real-Time Reporting<br>○ Implement modular systems with the requisite templates and data feeds to make the reporting functions within Finance and Accounting as real-time as appropriate<br>○ Will lower the administrative burden currently experienced through the reporting process<br>▪ Reduce & Eliminate Manual Processes & Redundant Systems<br>○ Selection of new systems with automation components to lessen the manual functions existing within the Finance and Automation functions<br>○ Leverage current systems to reduce duplication<br>▪ Analytics & Dashboarding<br>○ AHCA will establish the analytical capabilities to implement dashboarding across the Finance and Accounting functions<br>○ Dashboards will create transparency around Key Performance Indicators |
| Value Based Care | High-Level Tactics:<br>▪ Health Plan Encounter Data<br>○ AHCA will implement the capability for health plans to report encounter data consistently and in real-time or near real-time<br>○ AHCA will be able to use advanced analytical capabilities conduct Value-Based Care<br>▪ Performance / Contract Management<br>○ AHCA will leverage advanced analytics and improved health plan encounter data (see above) to continually improve the measurement and management of provider and health plan performance |

# 2017 STRATEGIC PRIORITIES

## The original Strategic Priorities are mapped to high-level tactics that address how the roadmap would meet the Priorities

| Strategic Priority | How FX Addressed the Priority |
|---|---|
| Inter-Agency Focus | High-Level Tactics:<br>▪ Data Sharing<br>○ AHCA will leverage newly modular systems to share real-time data, as appropriate, with agency partners (sister agencies, academics, and vendors)<br>▪ Social Determinants of Health<br>○ AHCA will improve the use of data from across sister agencies to correlate appropriate social factors (e.g., criminal records, school absences) with health outcomes<br>▪ Shared Licensure & Credentialing<br>○ AHCA will coordinate with sister agencies to speed the provider credentialing process |

# UPDATED STRATEGIC PRIORITIES

## The updated Strategic Priorities are mapped to modules. Those modules, either in their scope or recommended steps to be taken, work towards satisfying the Strategic Priorities

| Strategic Priority | How FX Addressed the Priority |
|---|---|
| Reduce DXC costs and integration risk by accelerating contract resolution | ○ IS/IP<br>  ○ Sunset MEUPS (the DXC single sign-on)<br>▪ EDW<br>  ○ Sunset DSS and Onbase scope of the DXC contract ($2.2M and $705K annually, respectively)<br>▪ Provider<br>  ○ Sunset Provider Enrollment and Provider Field Services scope of the DXC contract ($4.3M and $1.4M annually, respectively)<br>▪ Core<br>  ○ Sunset EDI, Claims, Encounters, Banking, and all remaining scope of the DXC contract (representing about $44.5M annually)<br>▪ Recipient / Enrollment Broker<br>  ○ Sunset File Maintenance and Buy-In aspects of the DXC contract (representing about $2.5M annually)<br>▪ Pharmacy Benefits Management<br>  ○ Sunset PBM scope of the DXC MED037 contract ($12.1M) |
| Provider Experience: Streamline credentialing, licensing, improve provider data, and overall experience | ▪ Provider module scope: Licensure, Credentialing, Enrollment, Maintenance, Provider Network Verification |
| Prioritize ability to have high-quality, accessible data, analytics, and reporting | ▪ IS/IP, EDW, Provider<br>▪ Centralized Contact Center<br>▪ Core<br>▪ Recipient / Enrollment Broker<br>▪ Pharmacy Benefits Management<br>  ○ Integrate PBM claims data into EDW to improve real-time analytic capabilities<br>▪ Third Party Liability, Case MGMT, Plan / Contractor MGMT |
| Prioritize interoperability opportunities between agencies and within AHCA | ▪ IS/IP, EDW, Provider<br>▪ Recipient / Enrollment Broker<br>▪ Third Party Liability, Case MGMT, Plan / Contractor MGMT |

# UPDATED STRATEGIC PRIORITIES

## The updated Strategic Priorities are mapped to modules. Those modules, either in their scope or recommended steps to be taken, work towards satisfying the Strategic Priorities

| Strategic Priority | How FX Addressed the Priority |
|---|---|
| Strategically leverage efficient procurement vehicles where possible | ▪ Provider<br>  ○ Leverage NASPO for the Provider Module<br>  ○ Projected to reduce procurement and DDI timelines<br>▪ Centralized Contact Center<br>  ○ Procure a single vendor to provide the CRM, call center infrastructure, and resources to address communication and simple operating tasks for all business areas<br>▪ Core<br>  ▪ Initiate planning immediately, analyzing use of NASPO |
| Maximize staff efficiency | ▪ IS/IP, EDW, Provider<br>▪ Recipient / Enrollment Broker<br>▪ Pharmacy Benefits Management<br>▪ Third Party Liability, Case MGMT, Plan / Contractor MGMT |
| Prioritize renegotiating and improving functionality and technology for large (non-DXC) systems contracts | ▪ IS/IP<br>  ○ Sunset the Provider Data Management System. Additional annual hosting expenses for PDMS ($200K) will be avoided<br>▪ EDW<br>  ○ Sunset Laserfiche system ($230K annually)<br>▪ Provider<br>  ○ Sunset Versa Regulation system ($201K annually), and the Fraud and Abuse Case Tracking system<br>  ○ PNV scope from the AHS enrollment broker contract should be sunset which will result in a reduction in the $15M annual contract<br>▪ Recipient / Enrollment Broker<br>  ○ Resolve AHS enrollment broker contract (about $15M annually)<br>▪ Pharmacy Benefits Management<br>  ○ Depending on final PBM scope decisions during planning this module PBM may also resolve a separate DXC contract for the PRMIS system dealing with rebates ($1.3M annually) |

# UPDATED STRATEGIC PRIORITIES

## The updated Strategic Priorities are mapped to modules. Those modules, either in their scope or recommended steps to be taken, work towards satisfying the Strategic Priorities

| Strategic Priority | How FX Addressed the Priority |
|---|---|
| Minimize impacts of procurements on Agency staff | ○ IS/IP, EDW<br>  ○ Continue the current strategy for implementation for IS/IP & EDW<br>▪ Core<br>  ○ Review existing financial management functions to see if they meet needs for healthcare payment submission, processing, and payment activities for claim and encounter processing<br>  ○ Evaluate if Core vendor can also provide TPL scope<br>▪ Centralized Contact Center<br>  ○ Align procurement so vendor can go-live in support of Provider and Enrollment Broker implementations<br>  ○ Select vendor who specializes in similar call center and business process outsourcing, with ability to scale and healthcare experience<br>▪ Pharmacy Benefits Management<br>▪ Plan / Contractor MGMT<br>  ○ Evaluate if Plan Management and Contractor Management can leverage same procurement<br>▪ Case MGMT<br>  ○ Evaluate if Case Management can be built with an existing contracted platform |
| Improve visibility and experience through portal and Contact Center | ▪ Centralized Contact Center<br>  ○ Define shared SLA responsibilities with module vendors that drive contact center interactions<br>  ○ Phase transition to a unified communications strategy; Transition phases: Provider, Enrollment Broker, Pharmacy Benefit Management, and Core<br>▪ Recipient / Enrollment Broker<br>  ○ Modify scope of future Enrollment Broker contract to move communications to Centralized Contact Center vendor |
| Maximize accountability for vendor performance | ▪ Third Party Liability, Case MGMT, Plan / Contractor MGMT |
| Align to CMS modularity to streamline system transformation & modernization | ▪ Modules: IS/IP, EDW, Provider, Core, Recipient / Enrollment Broker, Pharmacy Benefits Management |
| Reduce impact to Agency and staff | ▪ Pharmacy Benefits Management<br>  ○ Implement new PBM capabilities after other modules but before Core to reduce resource demands and implementation risk |