2022 STRATEGY UPDATE

STRATEGY UPDATE TABLE OF CONTENTS

Section A

Executive Summary

FX'S VISION SUPPORTS THE AGENCY'S VISION

The FX vision guides the MES modular transformation, supported by the Guiding Principles.

AGENCY 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 health care."

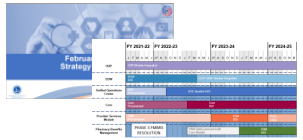
FX GUIDING PRINCIPLES

The “Guardrails” to guide the decision-making process to achieve the vision

- **Enable High-Quality and Accessible Data**
- **Improve Health 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**

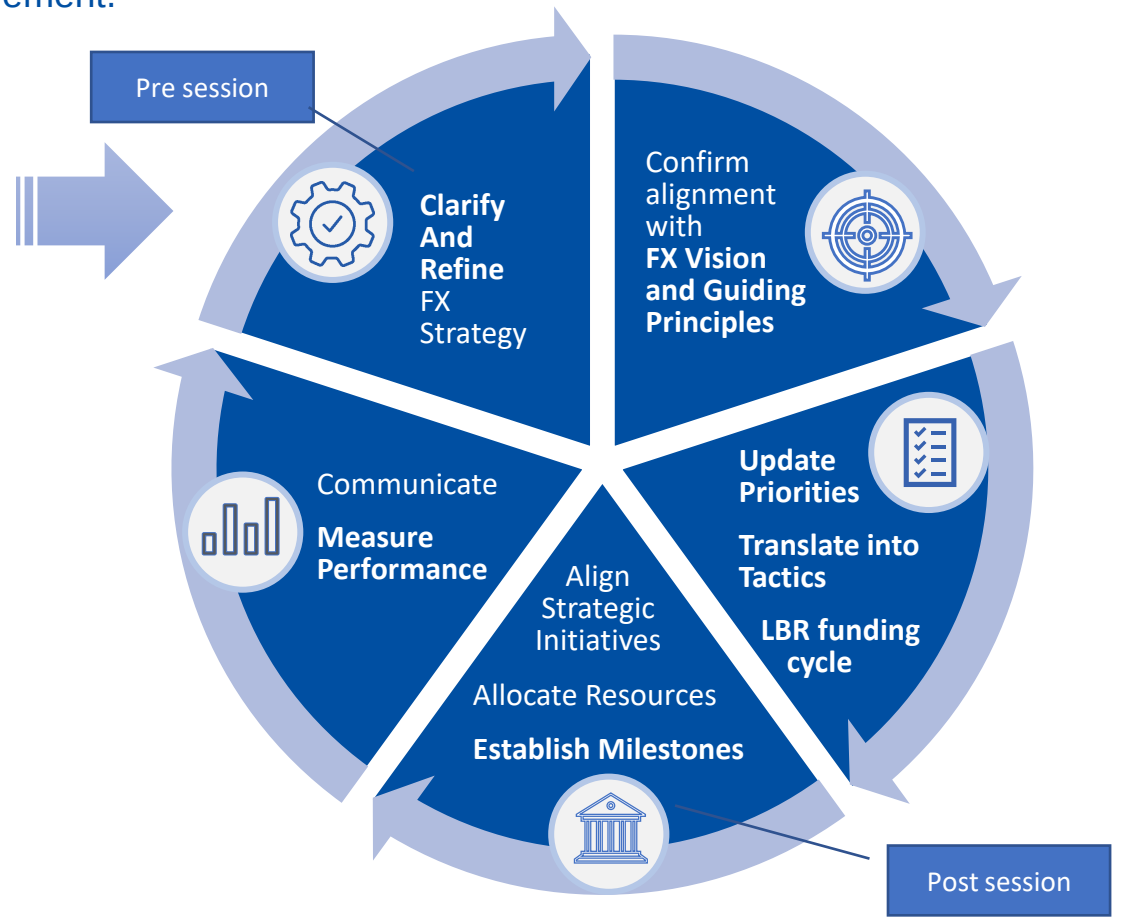
FX ENTERPRISE STRATEGY ELABORATION PROCESS

Aligning Priorities and Enabling a Culture of Continuous Improvement.



FX Vision and Guiding Principles
FX Enterprise Strategic Plan (S-3)
FX Strategic Roadmap

The FX Enterprise Strategic Plan is reviewed and elaborated annually to conform to the Florida budget cycle, ensure alignment with FX Vision and Guiding Principles, update priorities based on Legislative direction and transformation progress, strategic initiatives, resource capacity and set new tactics, milestones and performance measures



FX ENTERPRISE STRATEGIC PLAN UPDATE

The SEAS Vendor updated the FX Enterprise Strategic Plan in 2022 to incorporate progress to date, include new priorities, align strategic initiatives, capture future implementation milestones and dependencies and adjust for resource constraints.

ADDITIONAL ANALYSIS

- Core module and Unified Operations Center module planning and analysis
- Analysis of unified credentialing and necessary policy/rule/statute changes
- Inventoried all existing technology systems, including an in-depth contract analysis
- Developed a Business Process Inventory aligned to MITA business processes
- Strategy elaboration analysis of information related to the implementation, testing, legacy decommissioning, certification, OCM/training coordination of each FX module, applicable legacy systems, integration and interdependencies across the enterprise
- Review of Agency staffing capacity and support alternatives
- Analysis of module interdependencies, sequence and roadmap updates to accommodate resource and other constraints

LESSONS LEARNED

- A holistic understanding of the Agency and its program constraints (including timelines and resources) is critical for strategic planning
- Standardized contracts across modules can simplify vendor coordination and oversight
- Align module certification approach to CMS shift toward an outcomes-based certification model
- Multi-vendor coordination requires thoughtful and inclusive planning
- Fiscal agent contract turnover language should specify access to legacy systems, data, procedures and information during the planning process
- Vendor planning and coordination must include impacted legacy system vendors
- Task order process takes longer than anticipated and has multi-vendor impacts
- Greater clarity needed on complexity of integration requirements with module vendors

WHAT HAS CHANGED

- Agency staff turnover and key leadership / sponsorship changes, including Commissioner, continue to impact the FX program
- Interoperability mandate from CMS (Interoperability Application Programming Interfaces (APIs))
- Unified Operations Center solution vendor awarded, includes customer and business operations services
- Recipient functionality absorbed into the EDW, UOC, and Core functionality
- Re-alignment of the Legislative Budget Request (LBR) to include only FX Phase 3 activities
- Option to combine Pharmacy Benefits Management functionality into Core contract rather than procure separately
- Remaining Fiscal Agent functions not transitioned by 12/31/2024 can be covered by awarded Core vendor contract

FX STRATEGIC PRIORITIES AND TACTICS

TOP 5 STRATEGIC PRIORITIES 2020

- **Unify communications and business operations** through a Unified Operations Center
- **Reduce risk of integration and cost** to fiscal agent by accelerating contract resolution
- **Provider Experience**: Streamline credentialing, improve provider data, and overall experience
- Prioritize ability to have **high-quality, accessible data**, analytics, and reporting
- Prioritize **interoperability opportunities** between agencies and within the Agency

TACTICS

- Implement a module integration strategy that prioritizes data quality, accessibility, analytics and reporting. Coordinate strategy across modules to insure consistency in delivery.
- Prioritize Fiscal Agent contract resolution (FX Strategic Roadmap Phase 3 Activities) by transitioning and sunsetting key FMMIS functions iteratively to FX Modules (IS/IP, EDW, PSM, UOC and Core)
- Procure a Unified Operations Center solution that centralizes Recipient and Provider customer service and enterprise business support services
- Procure a Provider Services solution that includes streamlined credentialing, enrollment, maintenance, improved provider data and overall provider customer experience
- Develop and initiate CMS Interoperability (CMSI) strategy between and within the Agency

PROGRESS ON FX STRATEGIC PRIORITIES

The Agency continues to advance the FX Transformation, focusing on strategic priorities defined in the FX Strategic Plan.

2020 Strategic Priorities	2022 Progress to Date
Unify communications and business operations through a **Unified Operations Center (UOC)**	✓ Executed UOC contract with Automated Health Systems 10/2022. DDI in progress. Solution centralizes Recipient and Provider customer service and enterprise business support services
Reduce risk of integration and cost to fiscal agent by **accelerating contract resolution**	✓ Prioritized LBR to focus only on Phase 3 (FMMIS resolution) activities. FX Strategic Roadmap revised accordingly ✓ Established FX integration platform (IS/IP); Interface design and Module Integration planning and design in progress. ✓ EDW solution DDI in progress ✓ Core contract executed 12/2022. Option to include PBM and ability to absorb FMMIS Core functions not transitioned by 2025 ✓ PSM module procurement in process (intent to award expected 2/2023) ✓ UOC contract awarded 10/2022. DDI in progress
Provider Experience- Streamline credentialing, improve provider data, and overall experience	✓ PSM module solution procurement in process. Solution to include streamlined credentialing, enhanced data access, and improved provider experience
Prioritize ability to have **high-quality, accessible data**, analytics, and reporting	✓ EDW module solution DDI in process. ✓ Established and initiated a module integration plan that prioritizes data quality, accessibility, real-time analytics and reporting capabilities
Prioritize **interoperability opportunities** between agencies and within the Agency	✓ Initiated the CMS Interoperability (CMSI) Patient Access Rule Planning Project (CPAR) to produce the patient access and provider directory functions required by rule CMS-9115-F. Involves Agency partners, IS/IP and EDW vendors.

RECOMMENDATIONS

STRATEGIC PRIORITIES

- **Unify communications and business operations** through a Unified Operations Center
- **Reduce risk of integration and cost** to fiscal agent by prioritizing contract resolution
- **Provider Experience**: Streamline credentialing, improve provider data, and overall experience
- Prioritize ability to have **high-quality, accessible data**, analytics, and reporting
- Prioritize **interoperability opportunities** between agencies and within the Agency

2022 RECOMMENDATIONS

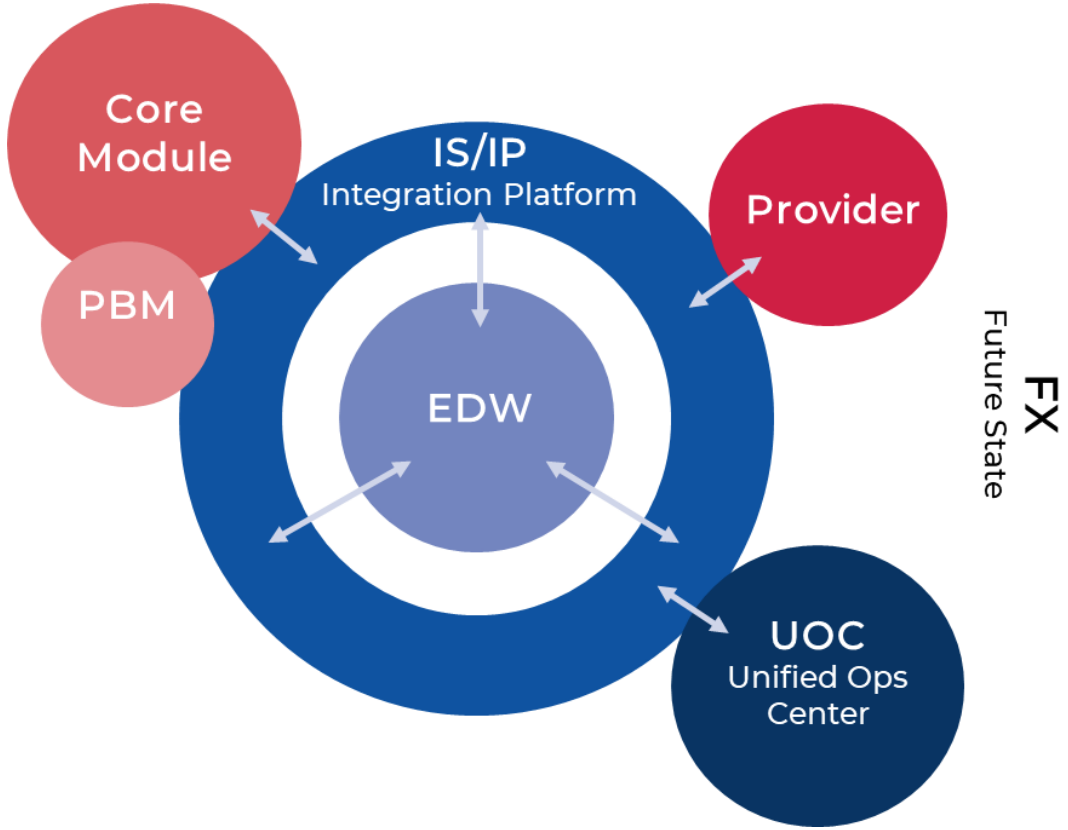
- Fully engage leadership and stakeholders in **Module Integration** activities to ensure adoption and enable the planning, identification and development of integration services across modules/legacy systems, interfaces, and enable increased interoperability between agencies
- Continue to prioritize LBR funding on FX Phase 3 activities to **expedite Fiscal Agent transition.** Exercise the option to include PBM in the Core vendor contract and establish a **Testing Center of Excellence (TCOE)** to enable and operationalize end-to-end functional testing across the program
- Proceed with PSM contract execution according to FX Strategic Roadmap to achieve expected **provider experience benefits**
- Prioritize the implementation of the enterprise **Certification Management** plan, including Agency staffing support, to achieve CMS and State outcomes and optimize Federal Financial Participation (FFP)
- Establish a **workforce transition model** and align staffing with FX transformation and exercise organizational change management activities to support implementation

THE BENEFITS OF FX INVESTMENT

PROVIDERS	• Faster enrollment process for Medicaid participation • Streamlined central source credentialing process • Reduced claims denial error rate
RECIPIENTS	• Unified customer experience • Self service portal and tools • More communication options • Health care data access and portability
EXTERNAL STAKEHOLDERS	• Better data for decision-making • Data available more quickly and near-real time • Stronger data integration with the Health Plans • Flexibility for policy changes and enhancements
AGENCIES	• Real-time data sharing • Reuse and interoperability • Cross program integration • Added security through federation

MODULE INTEGRATION IS ESSENTIAL TO FX TRANSFORMATION

- Module Integration activities on FX are complex and center around the planning, identification, and development of the green integration services connections depicted on the graphic between the platform and EDW and between the platform and the modular systems – as well sister agency systems.
- <u>Module Integration has been difficult to communicate with the Legislature about because of its complexity and cost.</u>



FX STRATEGIC ROADMAP – OVERVIEW

ROADMAP GUIDELINES

1. **Prioritize Fiscal Agent resolution activities (Phase 3)**
2. **Ensure continuity of operations**
3. **Promote interoperability** among Health and Human Services (HHS) agencies and within the Agency
4. **Pursue transformational improvements** if they do not distract from Roadmap Guideline #1 and #2

KEY OUTCOMES

- **Fiscal Agent contract resolution**
- Includes a plan to ensure **continuity of operations**
- **Enables interoperability** through technology and best value
- **Provides transformational benefits**
- **Minimizes Agency resource needs**
- **Lowest risk alternative** to Agency with least financial impact

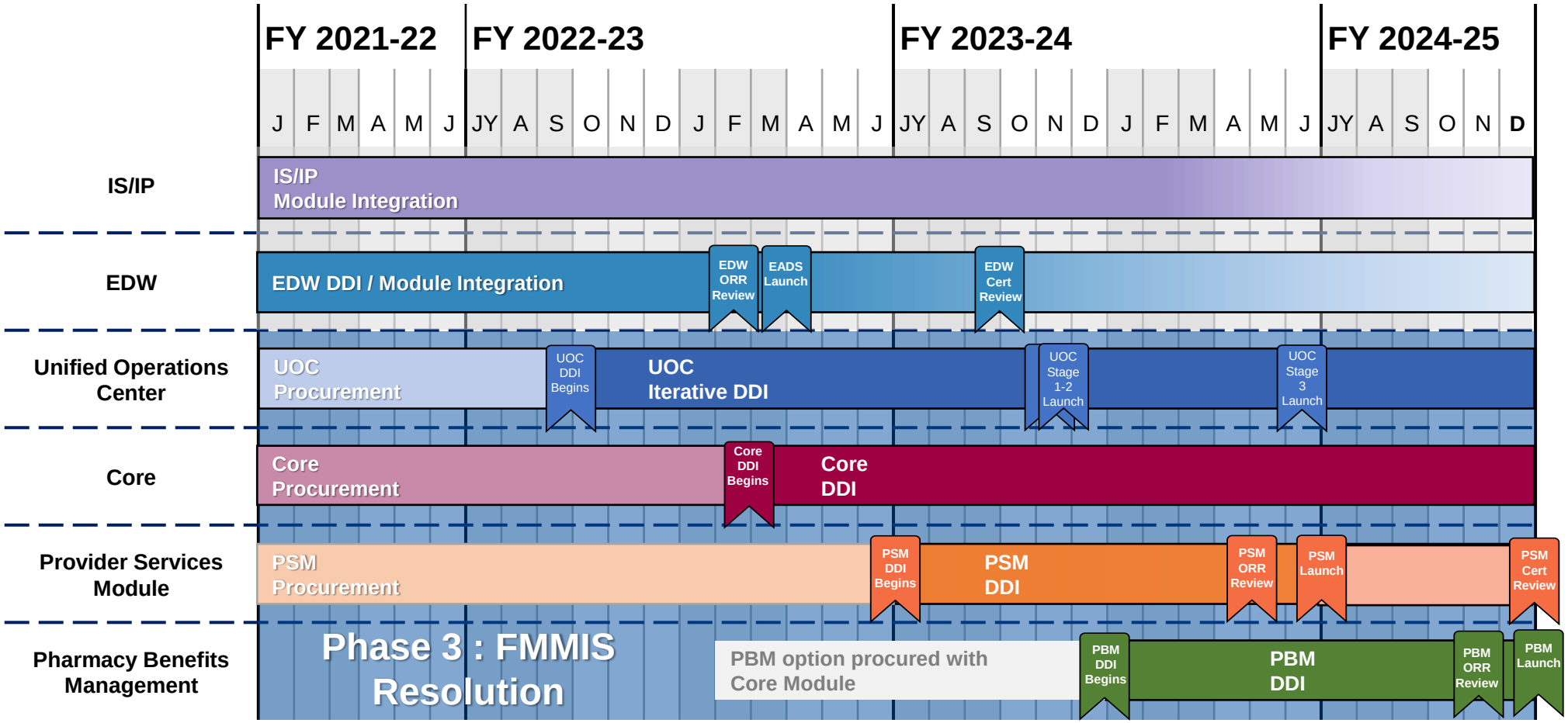
The Roadmap meets updated Guidelines and Outcomes

PHASE III – FX STRATEGIC ROADMAP INFLUENCERS

The initial phase of the roadmap development was influenced by several variables and factors linked to the expiration of the Fiscal Agent Contract on December 31, 2024.

- **Do not impact or modify existing in-flight projects**
- **Focus on top Strategic Priorities**
- **Identify modules necessary to resolve the Fiscal Agent Contract**
- **Consider contract expiration dates and extension options as constraints (Enrollment Broker, Pharmacy Benefits 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 incrementally**
- **Consolidate operational and phone-based personnel into a Unified Operations Center to improve stakeholder experience and reduce operational cost**

PHASE 3: PRIORITIZE FMMIS RESOLUTION



FX COSTS AND BENEFITS THROUGH PHASE 3

FX is a multi-year program with costs and benefits estimated throughout the life of the program. Estimates are replaced with actual expenditure amounts as the program advances.

The FX Program strategy and roadmap are assessed continually, with estimates being fine-tuned to incorporate new information. As such, cost and benefit amounts may change year-over-year as the FX strategy evolves and planned activities are conducted.

The following slides present the cost and benefits information that reflect the types of year over year changes that can occur.

AGENCY COST IMPACTS THROUGH PHASE 3

Year	FY 2022-23 IV-B[1]	FY 2023-24 IV-B[2]	Variance	Why?
FY 2019-20	$32.0 M	$32.0 M	$0.0 M	• Historical amounts - NO change
FY 2020-21	$38.6 M	$38.6 M	$0.0 M	• Historical amounts - NO change
FY 2021-22	$67.1 M	$45.8 M	($21.3 M)	• Decreased expenditures for IS/IP Task Orders • Decreased expenditures for FMMIS Support Services • No expenditures for the PSM, Core, and UOC Implementations • No expenditures for Data Services and Content Management
FY 2022-23	$117.8 M	$100.5 M	($17.3 M)	• Overall reduction in Appropriated funding • Reduction in SEAS funding • Reduction in funding for UOC implementation
FY 2023-24	$120.2 M	$175.8 M	$55.6 M	• Majority of increase due to inclusion of Module Integration estimates • Increased funding for FMMIS Support Services • Increased funding for PSM Implementation
FY 2024-25	$125.0 M	$158.4 M	$33.4 M	• Increase largely due to inclusion of Module Integration estimates • Increased funding for FMMIS Support Services • Increased funding for Core Implementation
FX Total	**$500.7 M**	**$556.2 M**	**$55.5** M	

[1]These cost amounts are per the Cost Benefit Analysis contained in the FY 2022-23 IV-B submitted to the Florida Legislature.
[2]These cost amounts are per the Cost Benefit Analysis contained in the FY 2023-24 IV-B submitted to the Florida Legislature.

December 2022

AGENCY BENEFITS IMPACTS THROUGH PHASE 3

Year	FY 2022-23 IV-B[1]	FY 2023-24 IV-B[2]	Variance	Why?
FY 2022-23	$6.9M	$0.0M	($6.9M)	• No realization of benefits expected during the Fiscal Year due to FX Strategic Roadmap modifications
FY 2023-24	$25.5M	$9.7M	($15.8M)	• A decrease in realized benefits for the PSM module due to FX Strategic Roadmap modifications
FY 2024-25	$63.4M	$40.3M	($23.2M)	• Removal of realized benefits in the Fiscal Year for the Core module due to FX Strategic Roadmap modifications
FY 2025-26	$145.4M	$150.6M	$5.2M	• An increase in realized EDW, PSM, and UOC module benefits due to FX Strategic Roadmap modifications • A decrease in realized benefits for the Core module due to FX Strategic Roadmap modifications
FY 2026-27	$219.8M	$289.4M	$69.6M	• An increase in realized PSM, UOC, and Core module benefits due to FX Strategic Roadmap modifications
FY 2027-28	$294.9M	$289.6M	($5.3M)	• Removal of benefits for Phase 4 modules
FX Total	**$755.9M**	**$779.6M**	**$23.6M**	

[1]These benefits amounts are per the Cost Benefit Analysis contained in the FY 2022-23 IV-B submitted to the Florida Legislature.
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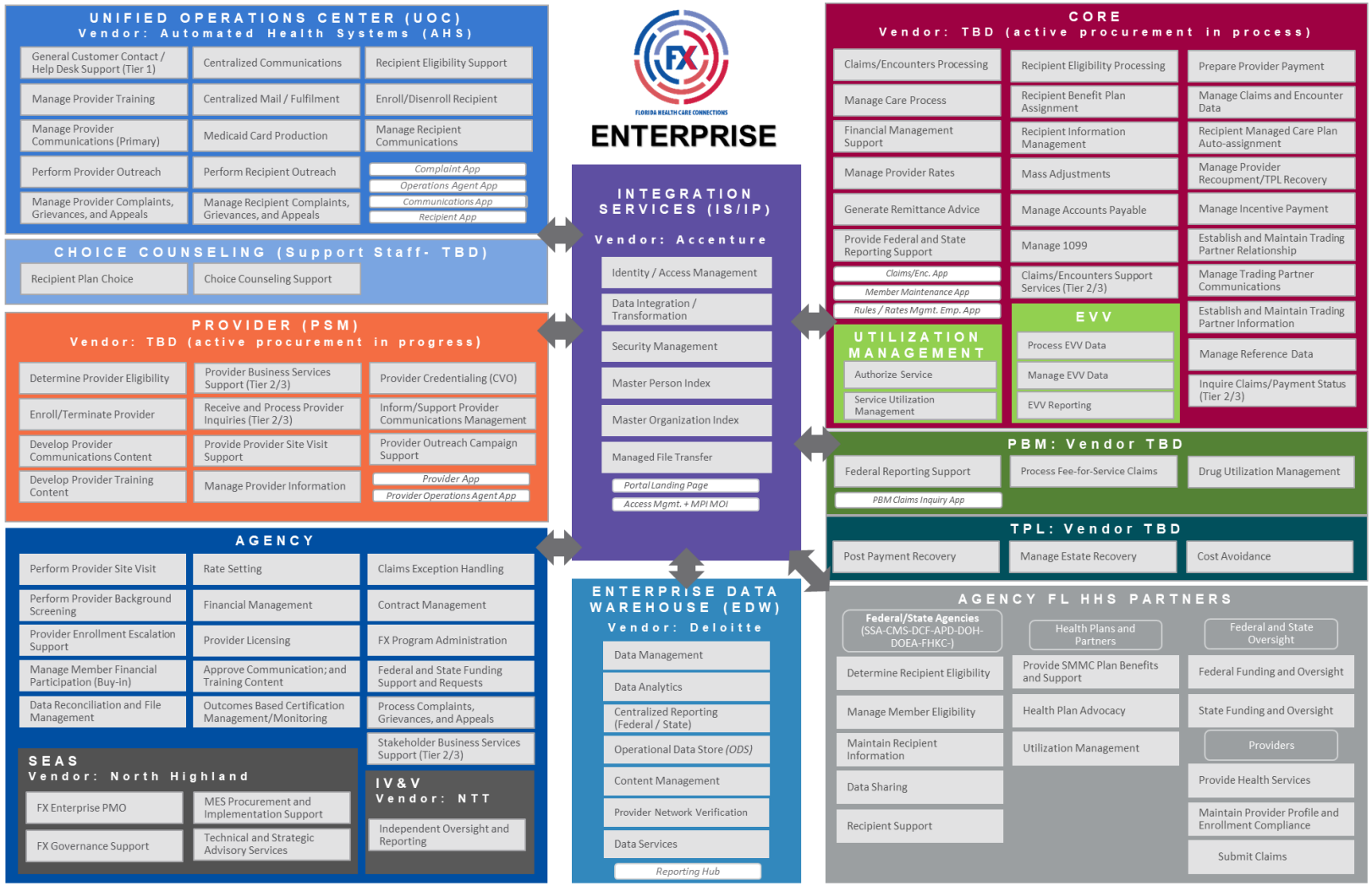
December 2022

FUTURE STATE BUSINESS PROCESS CONTEXT

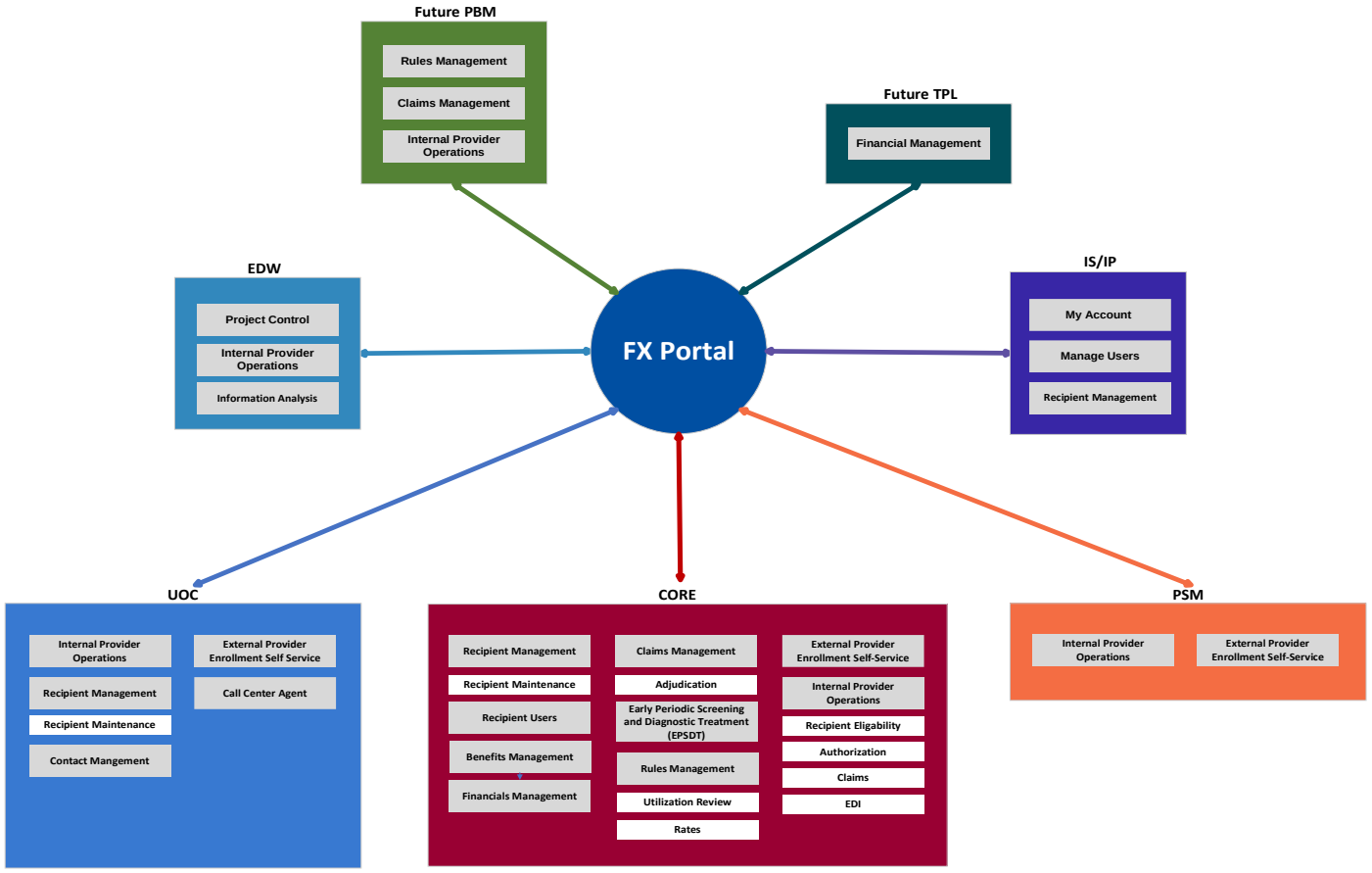


[Link to full diagram]

Note: This is not representative of all business processes and impacts, instead it is intended to inform a framework of FX Module functions based on analysis completed to date. Each FX module will be further elaborated during each project activities to meet AHCA's business needs.

FUTURE STATE PORTAL

- FX Portal provides users a secure gateway to all FX modules and infrastructure tools based on user profile attributes
- Internal users access the systems and tools to support customer service and business operations
- Customers (Recipients, Providers) access relevant information and self-service support



Section B

FX History

AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) OVERVIEW

The Agency is the chief health policy and planning entity for the State of Florida.

Its ~$32B annual budget is the largest in the state.

- Principal function is providing $32B in Medicaid services to 4.5M recipients, 4th highest in US*
- FL Medicaid pays for:**
  - 48% of all children
  - 56% of birth deliveries
  - 63% nursing home days
- Responsible for licensing ~50,000 healthcare facilities

*** 20/21**
****20/21**

The Agency 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 ~~A~~gencies and 18 health plans

Services

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

Data Processes

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

THE AGENCY FACES MULTIPLE CHALLENGES

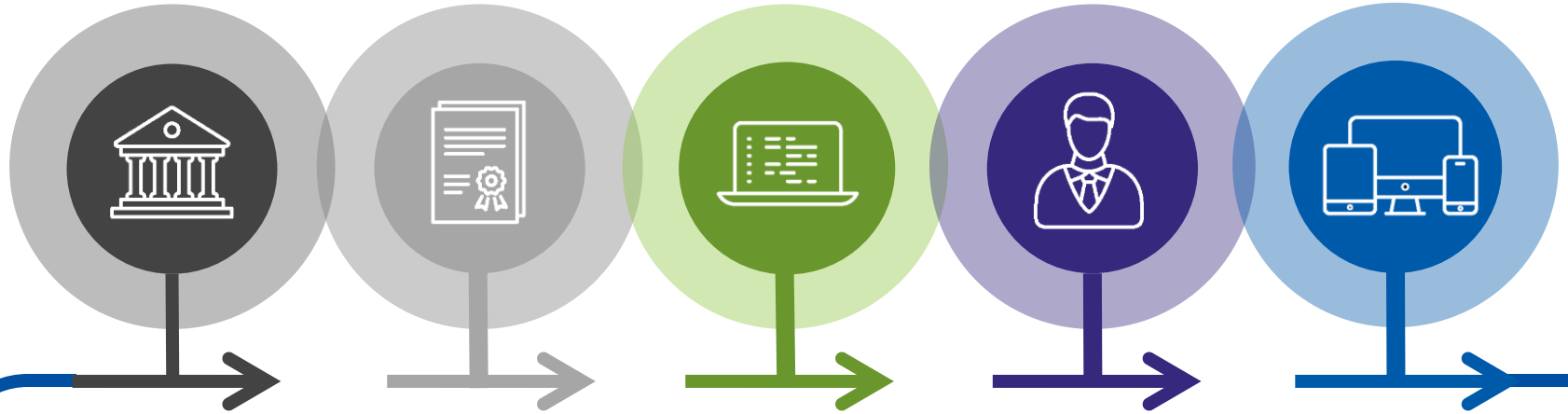
The Agency has several opportunities to enhance technologies and streamline operations, further enabling the Agency to meet its mission.

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**

The Florida Health Care 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 HHS
- Supports interoperability through flexible solutions and seamless integrations

Federal Compliance

- Advances Medicaid Information Technology Architecture (MITA) maturity through enabling modularity
- Certification focused on module outcomes
- Promotes interoperability through APIs

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 enrollment and credentialing processes
- Unified Operations 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 THE AGENCY'S TRANSFORMATION

The previous strategic plan laid the groundwork for a focused transformation guided by the Centers for Medicare & Medicaid Services (CMS) mandates and the Agency's Guiding Principles to improve service and health 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 health care 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 Health Care requires more and better data*** to leverage Artificial Intelligence (AI) and algorithms
- ***Telemedicine*** is eliminating state and national geographic boundaries of healthcare regulation and service delivery

Navigate National CMS MMIS Experiences

- ***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***
- ***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

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
- Program 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) Vendor procurement

2017-2019

FX Project Execution

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

2020 - 2022

Roadmap Update

- UOC, PSM, and Core procurements and implementation in process
- Updated and refined FX Strategic Roadmap
- Refreshed staffing and budget

KEY ANALYSIS AND CHANGES FROM PREVIOUS PLAN

Update Analysis That Influenced Strategic Plan

- Executive alignment on **Strategic Priorities, FX Module scope, and sequencing**
- **Updated system inventory** to align contract costs and termination dates
- Inventory of future state processes impacts and interactions
- Assigned **cost and benefits** to each module based on refined scope
- UOC **rollout readiness** to consume business functions
- Milestones and key dependencies
- **Timing for implementation** of single source credentialing, around SMMC procurement

Key Changes from 2021-22 LBR to Recommended Solution

- FX Strategic Roadmap is separated into four Phases:
  - **Phase 3** – Modules that are critical to **Fiscal Agent Contract Resolution**
  - **Phase 4** – Non-critical modules to complete the transformation
- **Unified Operations 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 and implementation dependencies**
- Provider scope limited to enrollment and credentialing

Additional analysis informed a more detailed and comprehensive roadmap

Section C

S-3 Methodology, Vision, and Guiding Principles

STRATEGY UPDATE OVERVIEW

The 2020 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

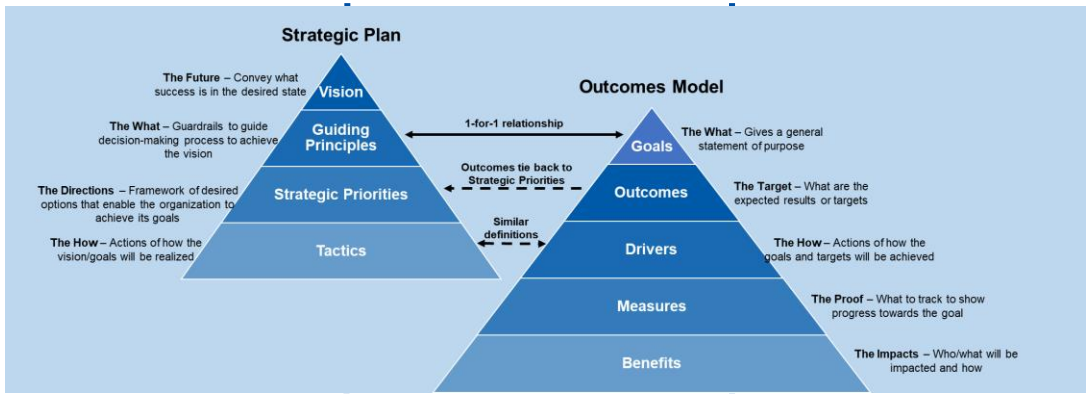
1 ASSESS CURRENT STATE

*Identified **Pain Points, Gaps, and Opportunities***

- Identified Agency & 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 S-3** plan*



3 UPDATE STRATEGIC PRIORITIES

***Identified, validated, and prioritized** Strategic Priorities*

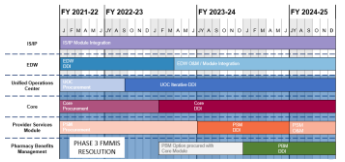
4 TRANSLATE PRIORITIES INTO TACTICS

*Leveraged **Strategic Priorities** and Executive Decisions to prioritize projects*

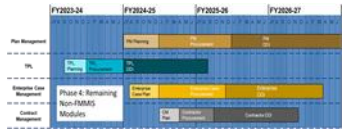
5 DEVELOP FUTURE STATE ROADMAP

*Generated **draft roadmap** and **validated with the Agency***

Phase 3



Phase 4



REFINE & ITERATE

STRATEGY REFRESH OVERVIEW – METHODOLOGY DETAILS

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

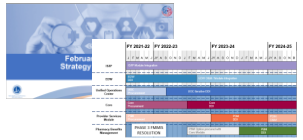
METHODOLOGY

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	6 REFINE AND ITERATE
Identified ***Pain Points, Gaps and Opportunities***	*Gathered from* ***Original S-3*** *plan*	***Identified, validated, and prioritized*** *Strategic Priorities*	*Leveraged* ***Strategic Priorities*** *and Executive Decisions to prioritize projects*	*Generated* ***draft roadmap*** *and* ***validated with Agency***	***Analysis*** *of* ***milestones, dependencies, and processes***
▪ Identified and assessed Agency and HHS opportunities ▪ Documented current state processes using process mapping, and documented pain points ▪ Completed market scan of Medicaid transformations in other states ▪ Created a comprehensive sys-tems inventory ▪ Documented all existing contract details, expiration dates, and extension options ▪ Assessed all existing CBAs and associated benefits ▪ Analyzed organization maps, impacts, and resources	▪ Reviewed and confirmed the Agency's vision and FX guiding principles with Agency leadership ▪ Updated the FX vision with input from Agency leadership	▪ Generated list of recommended Strategic Priorities from industry and Agency SMEs ▪ Agency leadership built on and refined list ▪ Agency leadership ranked the new drafted Strategic Priorities ▪ 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 ▪ Developed an inventory of decisions requiring Agency leadership input ▪ Conducted multiple tactical decisions evaluating each approach ▪ Strategic Priorities helped provide guardrails when making sequencing decisions ▪ Translated decisions made into key tactics	▪ Based on agreed-upon sequencing decisions and tactics, the SEAS Vendor developed a new future state roadmap and presented the draft future state roadmap to the Agency and incorporated suggestions	▪ Granular review and elaboration of dependencies within and across modules ▪ Targeted roadmap milestones that impact the success of modular implementation and FX transformation ▪ Created a business process inventory to catalog future state module dependencies across MITA business processes ▪ Realigned roadmap based revised budget. staffing, and Agency priorities

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

FX ENTERPRISE STRATEGY ELABORATION PROCESS

Aligning Priorities and Enabling a Culture of Continuous Improvement.



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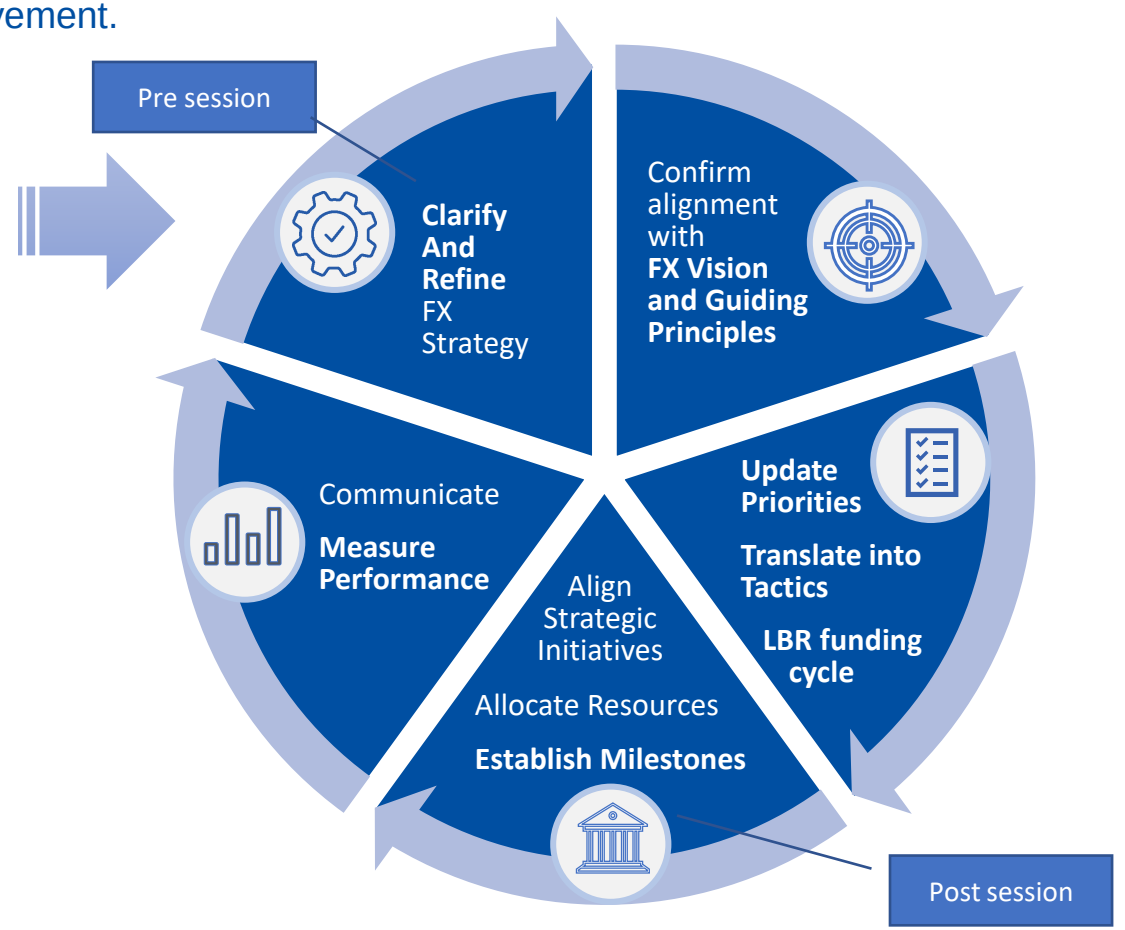


FX'S VISION SUPPORTS THE AGENCY'S VISION

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

AGENCY 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 health care."

FX GUIDING PRINCIPLES

The “Guardrails” to guide the decision-making process to achieve the vision

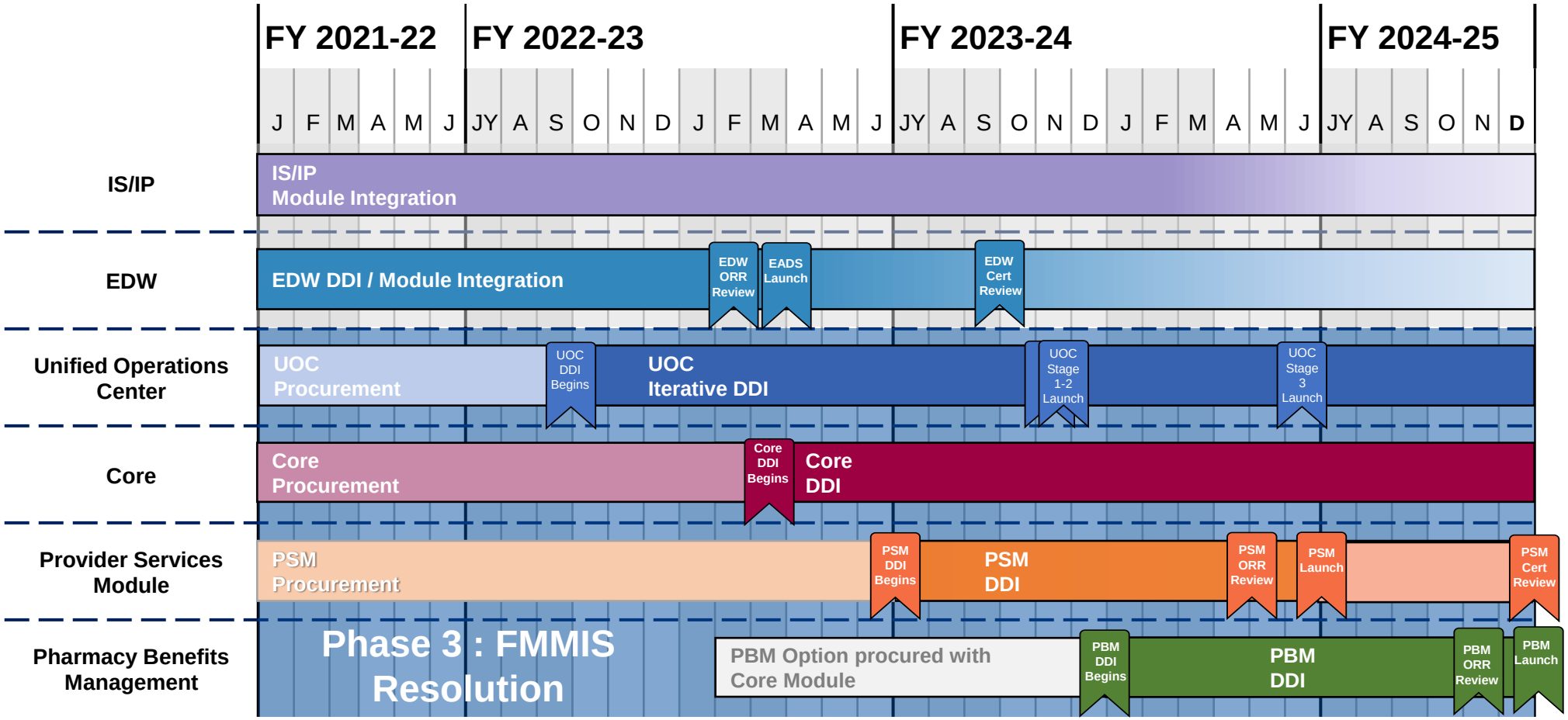
- **Enable High-Quality and Accessible Data**
- **Improve Health Outcomes**
- **Reduce Complexity**
- **Use Evidence-Based Decision-Making**
- **Improve Integration with Partners**
- **Improve Provider and Recipient Experience**
- **Enable Good Stewardship of Medicaid Funds**
- **Enable Holistic Decision-Making Rather Than Short-Term Focus**

PHASE III – FX STRATEGIC ROADMAP INFLUENCERS

The initial phase of the roadmap development was influenced by several variables and factors linked to the expiration of the Fiscal Agent Contract on December 31, 2024.

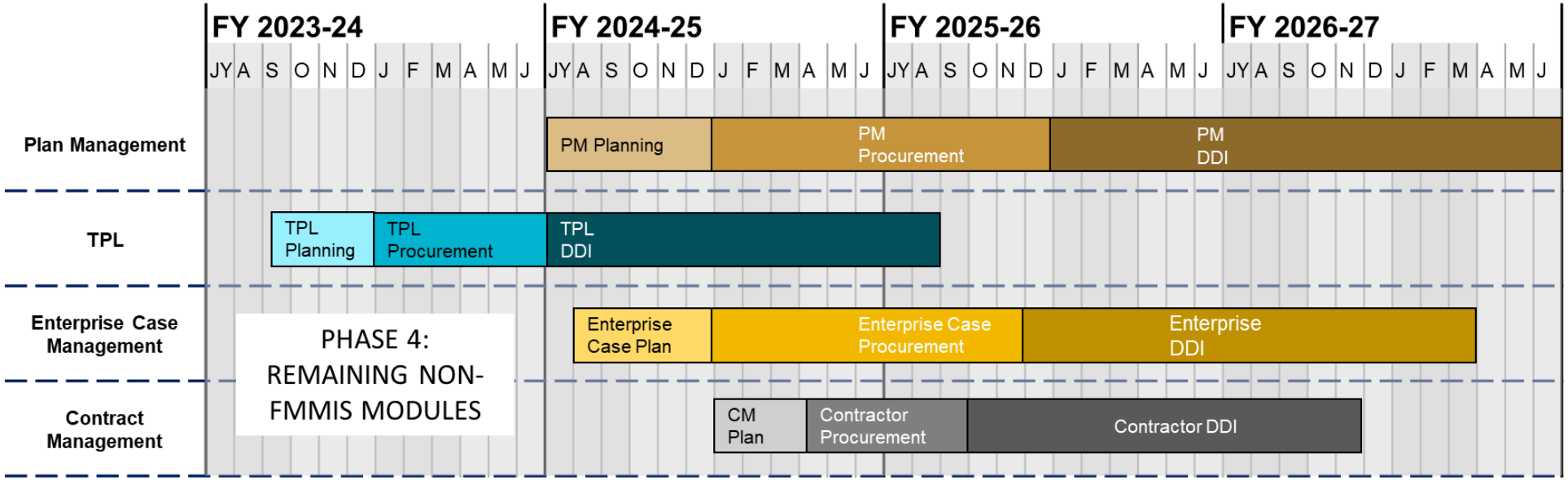
- **Do not impact or modify existing in-flight projects**
- **Focus on top Strategic Priorities**
- **Identify modules necessary to resolve the Fiscal Agent Contract**
- **Consider contract expiration dates and extension options as constraints (Enrollment Broker, Pharmacy Benefits Manager)**
- **Recognize 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 incrementally**
- **Consolidate operational and phone-based personnel into a Unified Operations Center to improve stakeholder experience and reduce operational cost**

PHASE 3: PRIORITIZE FMMIS RESOLUTION



PHASE 4 – FX STRATEGIC 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

Section D

Strategy Elaboration & Next Steps

STRATEGY ELABORATION EXERCISE

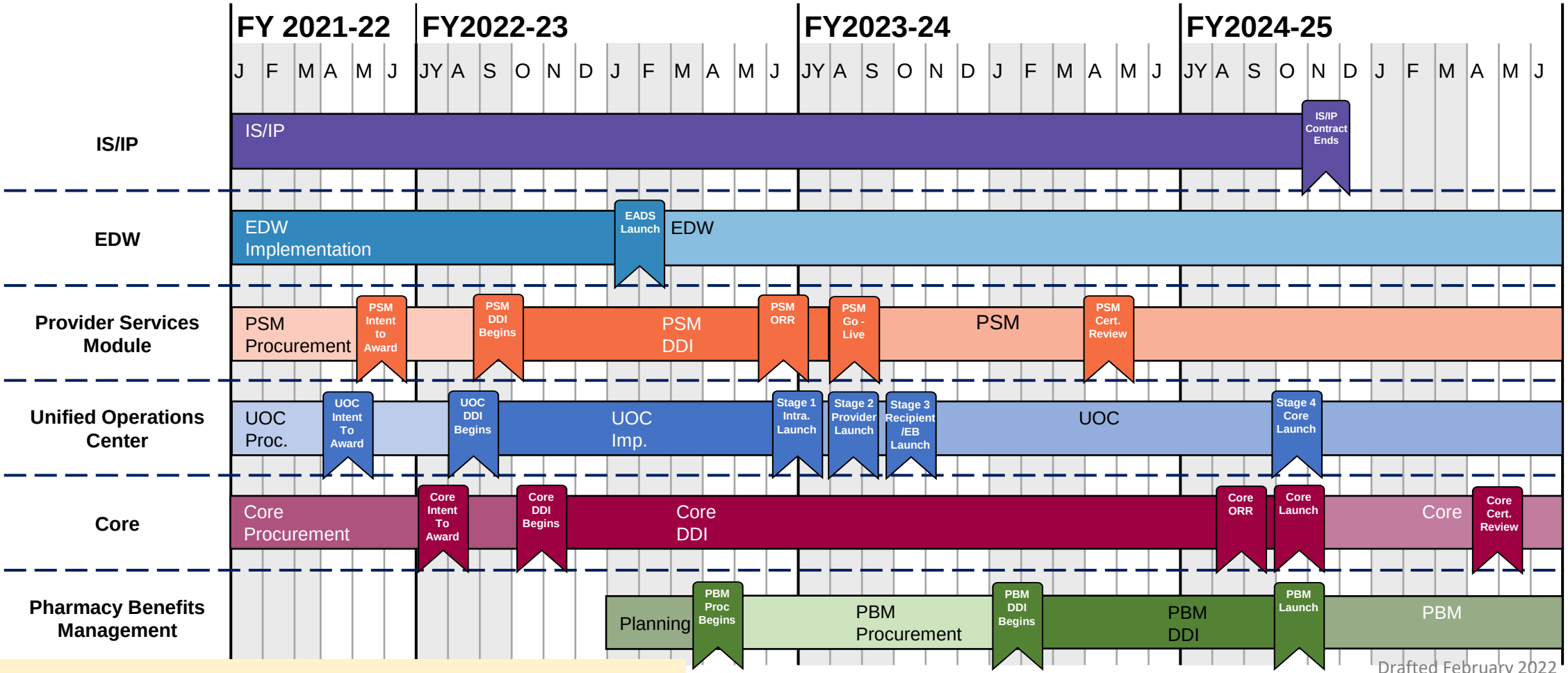
Strategy Elaboration

SEAS conducted strategy elaboration sessions with the Agency, IS/IP, EDW, and SEAS teams in February 2022 to gather in depth information related to the implementation, testing, legacy decommissioning, certification, OCM/training coordination of each FX module and applicable legacy systems. The output of these sessions served as inputs to the FX Strategic Plan, Master Program Schedule and FX Strategic Roadmap. This section includes a **point-in-time summary of the elaboration sessions**.

Note: This section aligns with the FX Strategic Roadmap Timeline from February 2022

February 2022 FX Strategic Roadmap Elaboration Snapshot

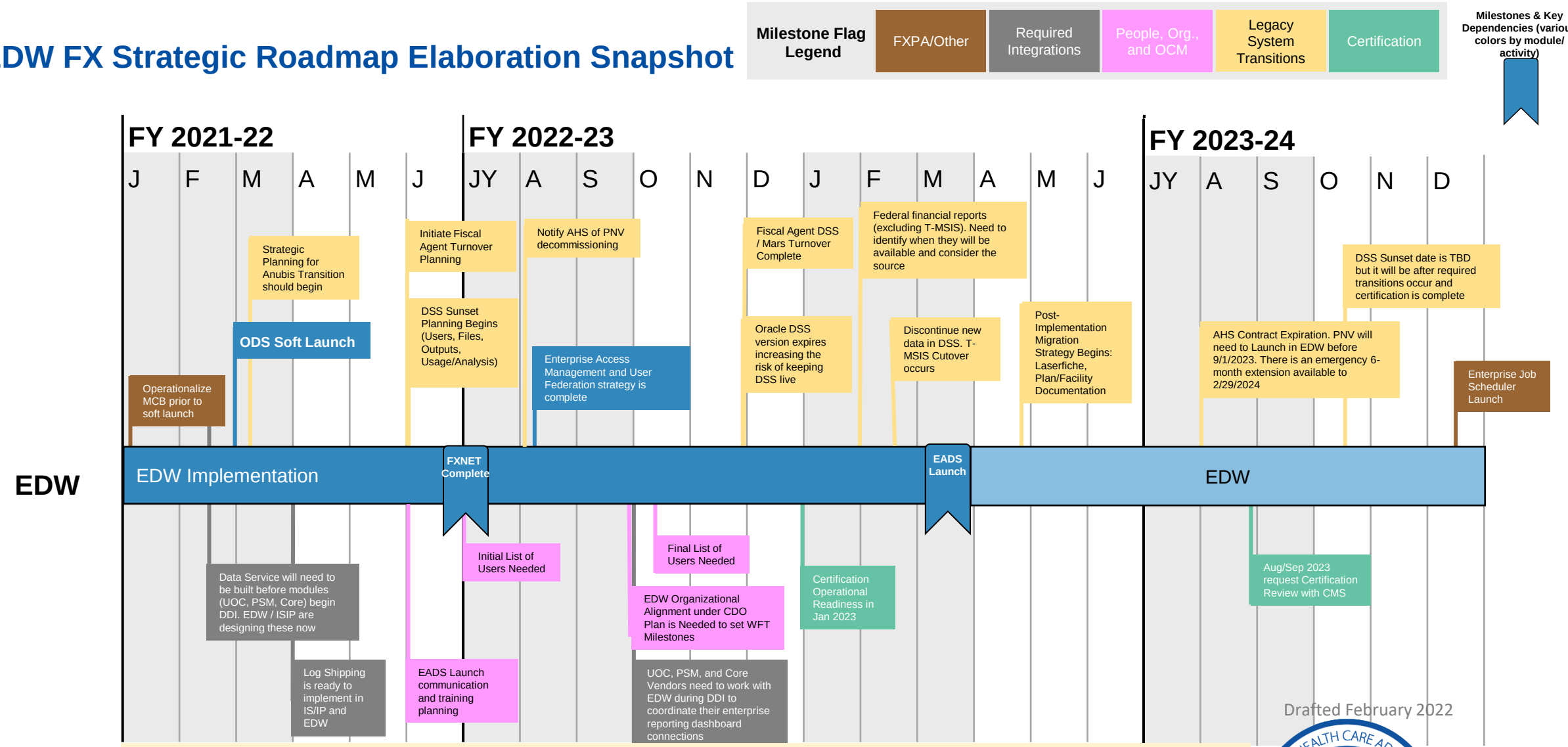
IS/IP
EDW
UOC
PSM
CORE
PBM



Drafted February 2022

Note: The timeline and milestones above were captured 2/2022 and may not reflect current state. This exercise informed the Master Program Schedule which is updated weekly.

EDW FX Strategic Roadmap Elaboration Snapshot



Drafted February 2022

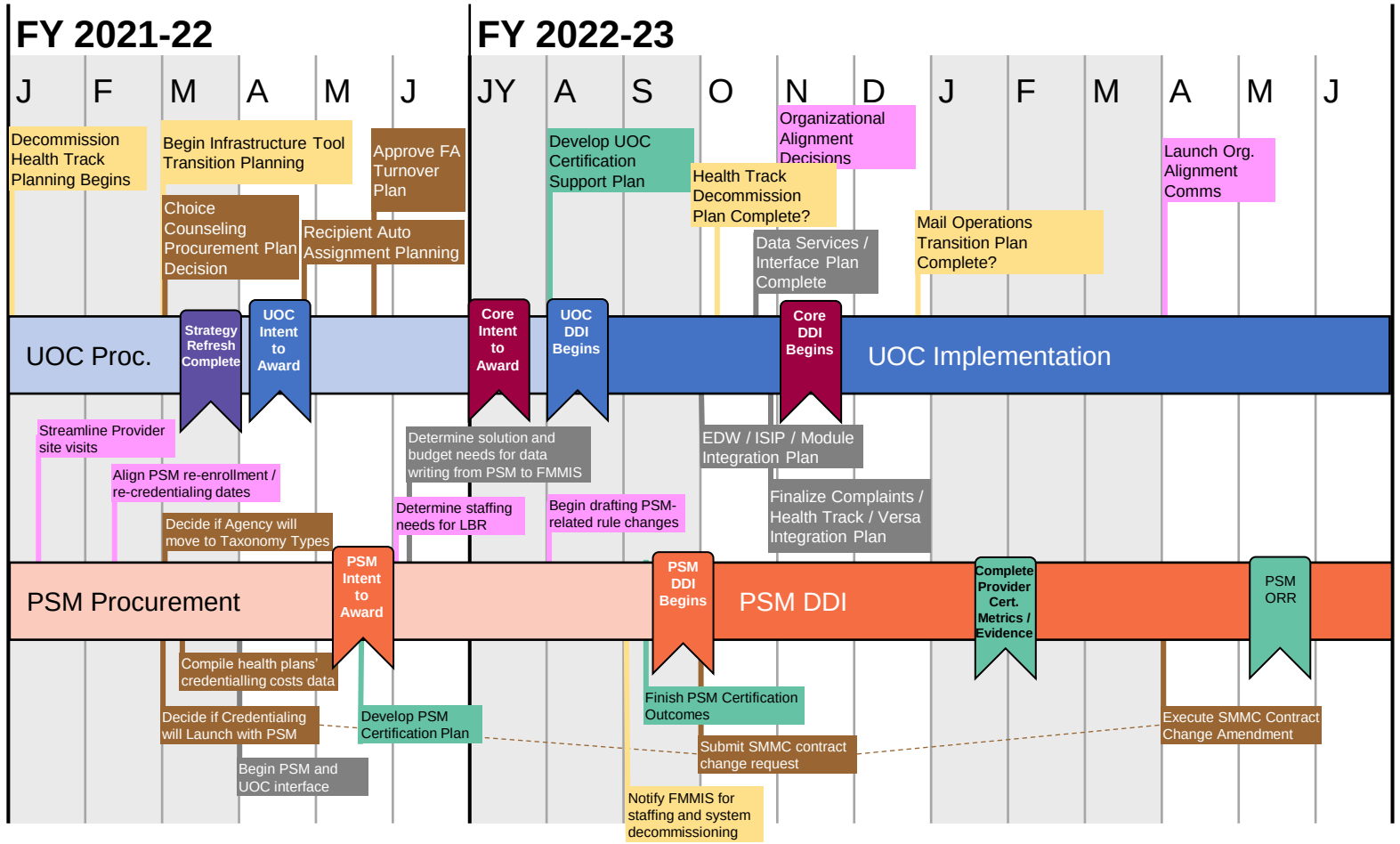
Note: The timeline and milestones above were captured 2/2022 and may not reflect current state. This exercise informed the Master Program Schedule which is updated weekly.

UOC/PSM FX Strategic Roadmap Elaboration Snapshot

Milestone Flag Legend

FXPA/Other	Required Integrations	People, Org., and OCM	Legacy System Transitions	Certification

Milestones & Key Dependencies (various colors by module/ activity)

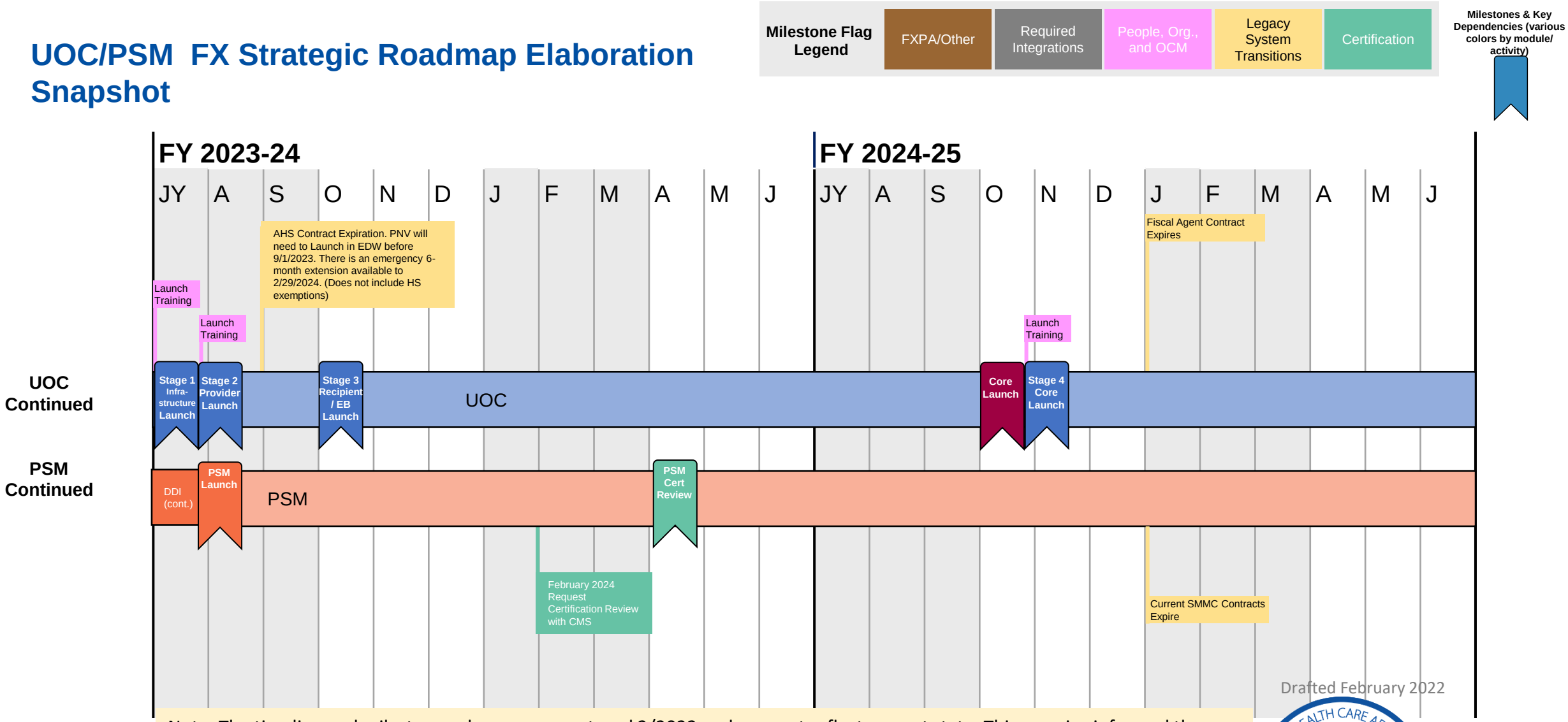


UOC Continues on Next Slide

PSM Continues on Next Slide

Note: The timeline and milestones above were captured 2/2022 and may not reflect current state. This exercise informed the Master Program Schedule which is updated weekly.

UOC/PSM FX Strategic Roadmap Elaboration Snapshot



Drafted February 2022

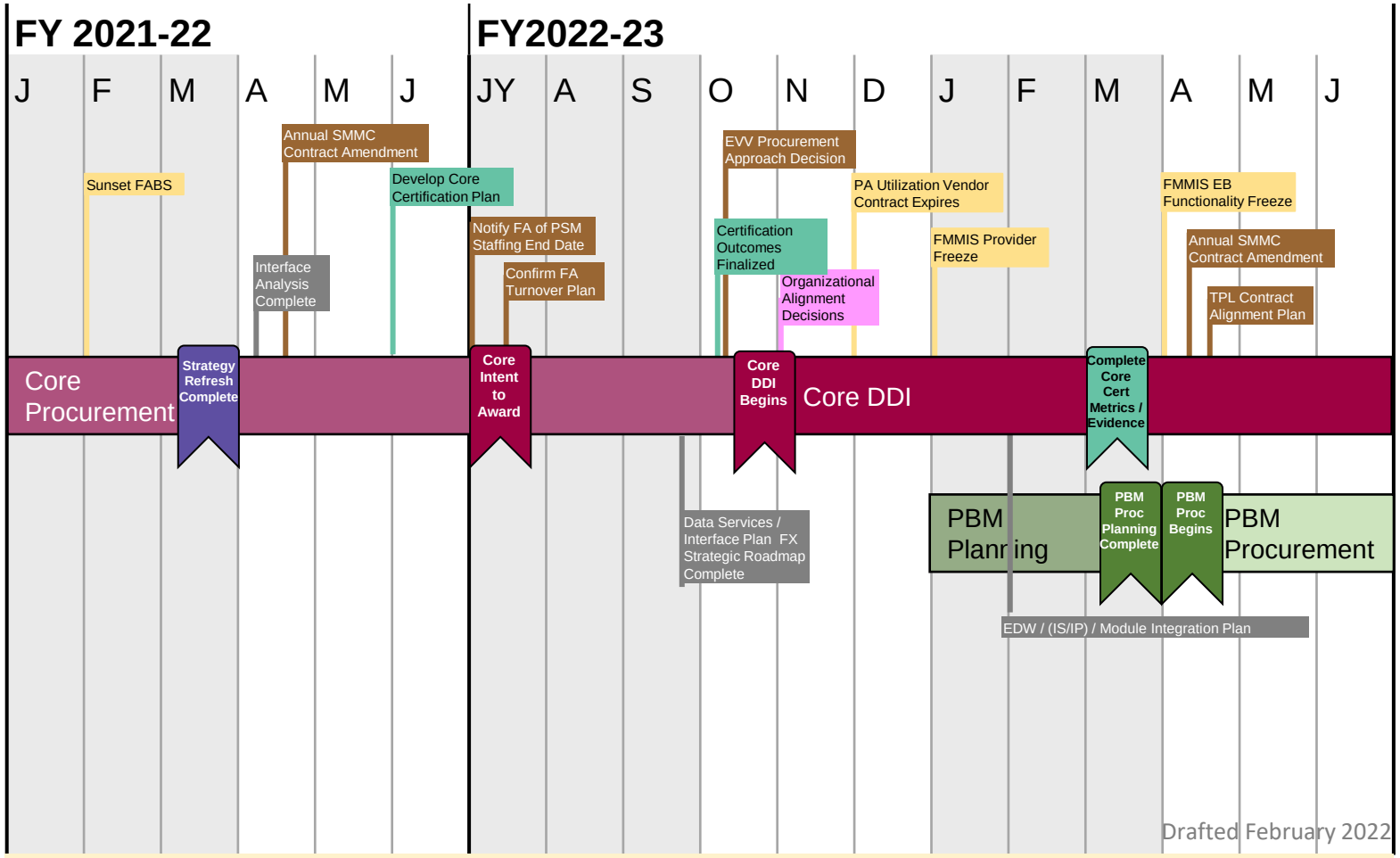
Note: The timeline and milestones above were captured 2/2022 and may not reflect current state. This exercise informed the Master Program Schedule which is updated weekly.

Core / PBM FX Strategic Roadmap Elaboration Snapshot

Milestone Flag Legend

- FXPA/Other
- Required Integrations
- People, Org., and OCM
- Legacy System Transitions
- Certification

Milestones & Key Dependencies (various colors by module/ activity)

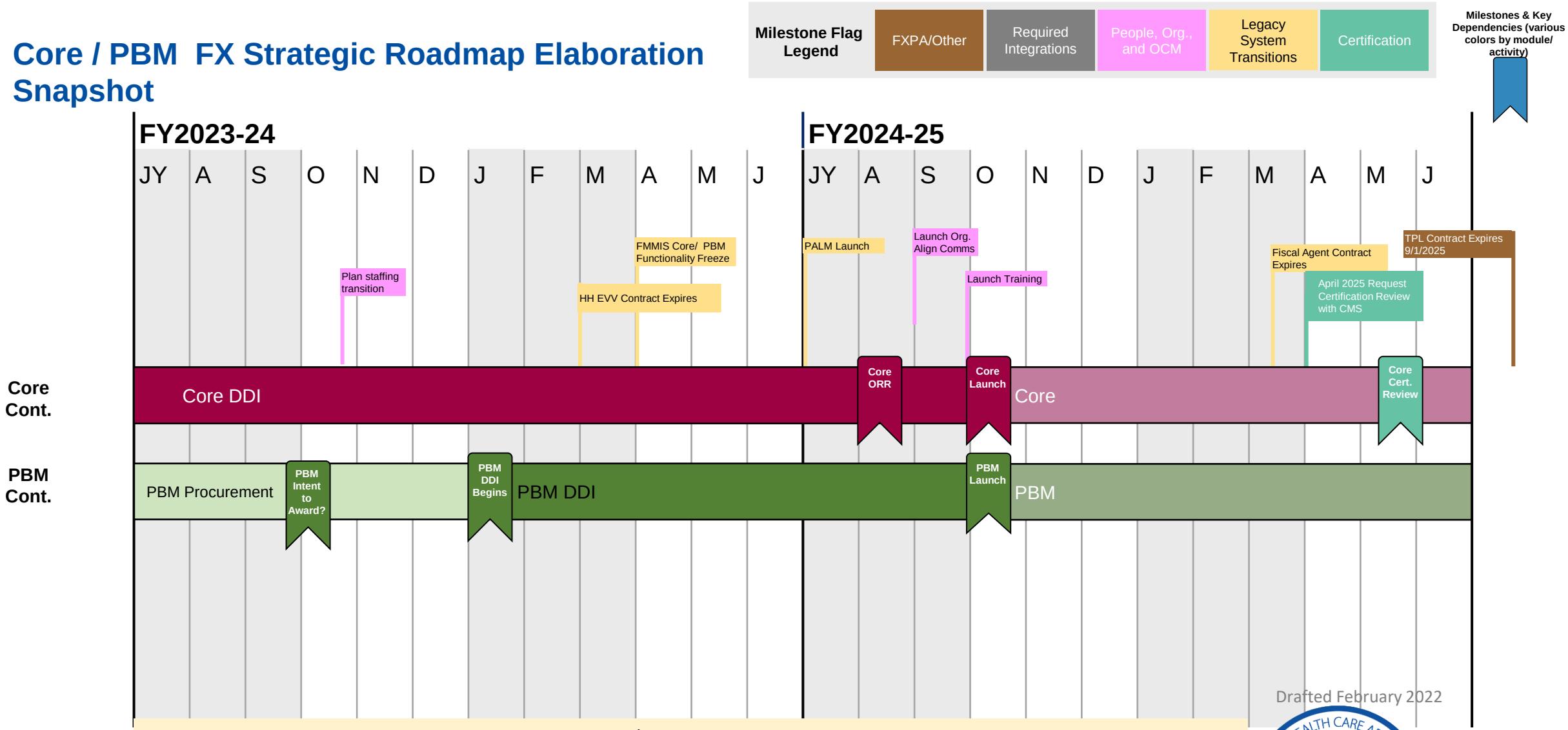


Core Continues on Next Slide

PBM Continues on Next Slide

Note: The timeline and milestones above were captured 2/2022 and may not reflect current state. This exercise informed the Master Program Schedule which is updated weekly.

Core / PBM FX Strategic Roadmap Elaboration Snapshot



Drafted February 2022

Note: The timeline and milestones above were captured 2/2022 and may not reflect current state. This exercise informed the Master Program Schedule which is updated weekly.

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 FX Program modules that represent existing business areas and operations. These are critical items to resolve the Fiscal Agent contract:

- ***Module timeline*** for all modules ***related to Fiscal Agent.*** Includes each module's planning, procurement implementation, Launch, 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 the Agency's business processes. It includes the following*:*

- ***Module timeline*** for all modules ***not related to Fiscal Agent.*** Includes each module's planning, implementation, Launch, 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***
- ***Unified Operations Center Work group***
- ***Sunset Plans***

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 12/31/2021, which has options for five 1-year renewals. Agency should extend renewals to extend the contract beyond July 2023. Contract includes three 1-year renewal options.
- Phase 1 of Unified Operations Center goes live November 2023, including Recipient /Enrollment Broker functionality. Enrollment Broker contract expires September 2023 (with one 6-month extension option available)
- Fiscal Agent contract expires December 2024. Turnover planning begins 2022.

Stakeholder Engagement/Legislative Discussions

- Statewide Medicaid Managed Care contracts expire December 2024. SMMC ITN Posting February 2023.

Sunset Plan

- Plan sunset functionality affected by EDW Launch that occurs March 2023.

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. The Agency will need a new purchase order to continue FACTS throughout module implementation.

Sunset Plan

- Approve Fiscal Agent turnover plan.
- Approve turnover plan for Enrollment Broker decommissioning including system functionality sunsetting associated with the UOC module, including enrollment broker.

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

- Enrollment Broker contract with AHS expires September 2023 (with one remaining 6-month extension option). Transition plan should be completed prior to UOC contract execution.
- Electronic Visit Verification (EVV) contract expires 2024. The Agency should begin procurement process at beginning of the fiscal year.

7/1/2025 – 6/30/2026

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

- IS/IP Operations and Maintenance (including enhancements) contract with Accenture renewed through 10/31/2025.

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 the Fiscal Agent and Magellan. These contracts expire January 2025.
- Core module completes 2024, so the Agency can then resolve the Fiscal Agent contract.

Contract Extensions/Negotiations

- SMMC Contracts expire December 2024.

7/1/2026 – 6/30/2027

- The new Contractor module is planned for Launch in December 2026. Beginning in July 2026, the Agency should begin planning for the sunset of the Contract Administration Tracking System (CATS).
- EDW contract with Deloitte expires December 2027.

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 module definitions inform the module procurement process and helps the Agency, SEAS Vendor, and future vendors conduct activities that are within scope of the project.

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 that 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 can find services and 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.

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 (FX). 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.
PROVIDER NETWORK VERIFICATION	Each health plan provider network must include certain types and 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.

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

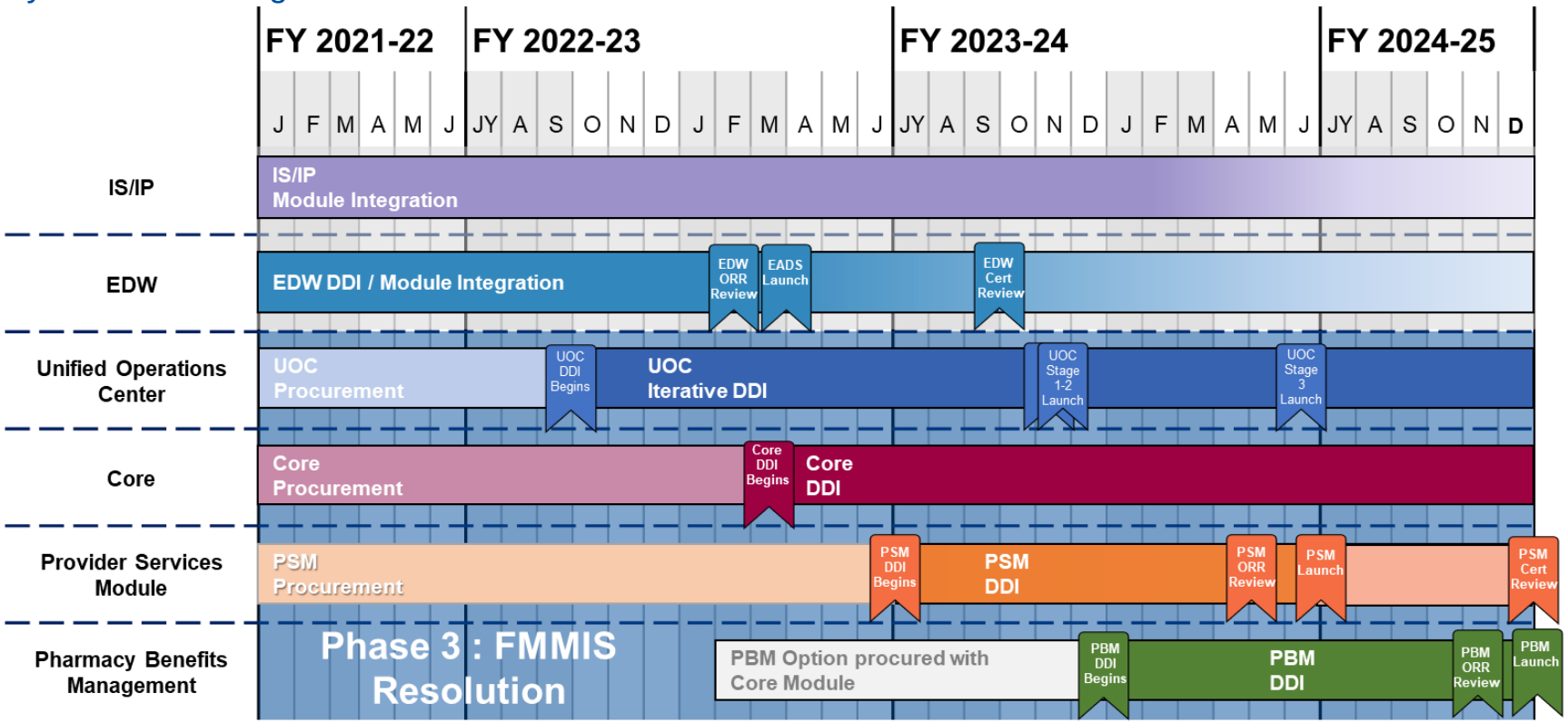
Benefits figure represents total validated benefits through FY2028-29

- 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

$83M

PHASE 3: FMMIS RESOLUTION

The current Fiscal Agent contract with Gainwell Technologies expires 12/31/2024. The functions currently performed in the Fiscal Agent contract, FMMIS, or DSS will be replaced with a robust, modern group of healthcare modules, incorporating 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 to replace the FMMIS. These modules include Provider, Core, Unified Operations Center, and Pharmacy Benefits Management.



CORE – 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 shall 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 (Cont.) – 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 the to-be-paid amount. The module will also capture the health plan paid amount.

CORE (Cont.)- Recipient: SCOPE OF SERVICES AND DEFINITIONS

RECIPIENT MANDATORY ASSIGNMENT	Business logic to determine if new recipients meet the statutory criteria to be assigned as a mandatory member into a managed care plan. Process also includes the identification of voluntary recipients that may select a managed care option.
PLAN ASSIGNMENT	Algorithm to assign mandatory members to the appropriate health, dental, or Long-Term Care (LTC) plan specified by Agency defined business rules.

UNIFIED OPERATIONS CENTER: SCOPE OF SERVICES AND DEFINITIONS

RECIPIENT MANAGEMENT	Recipient Management and file maintenance includes business functions to manage and reconcile recipient information, grievances, appeals, communication, and interactions. Recipient communication will be generated by modules but will leverage the UOC.
ENROLLMENT BROKER	The Enrollment Broker is the systems, contact center, platform, and operations that allow a recipient to select a health plan. The UOC will improve a recipient's ability to perform self-service plan selection. Enrollment Broker Choice Counseling call center will use the UOC platform.
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.).

UNIFIED OPERATIONS 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
- Multiple mail and fulfillment operations

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
- Across Agency access to integrated contact data
- Centralized entry and tracking of complaints, grievances, and appeals
- Centralized mail and fulfillment operations

BENEFITS

Benefits figure represents total validated benefits through FY 28-29

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

$188M

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.

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 Lifecycle 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 Agency 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 the overall organization and timely processing of all case management related documentation. This includes intake and tracking of public records requests.
REDACTION	Automates a process that 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

State MMIS Research 2019

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 not needed 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., Fiscal Agent)
- **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

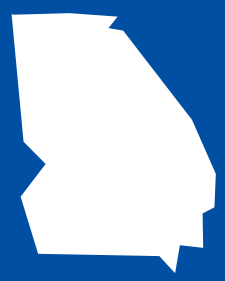
Some states have transitioned from incremental modular to a *modular single-cutover* approach due to risks and challenges integrating with their legacy system, similar risk exists for FL

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

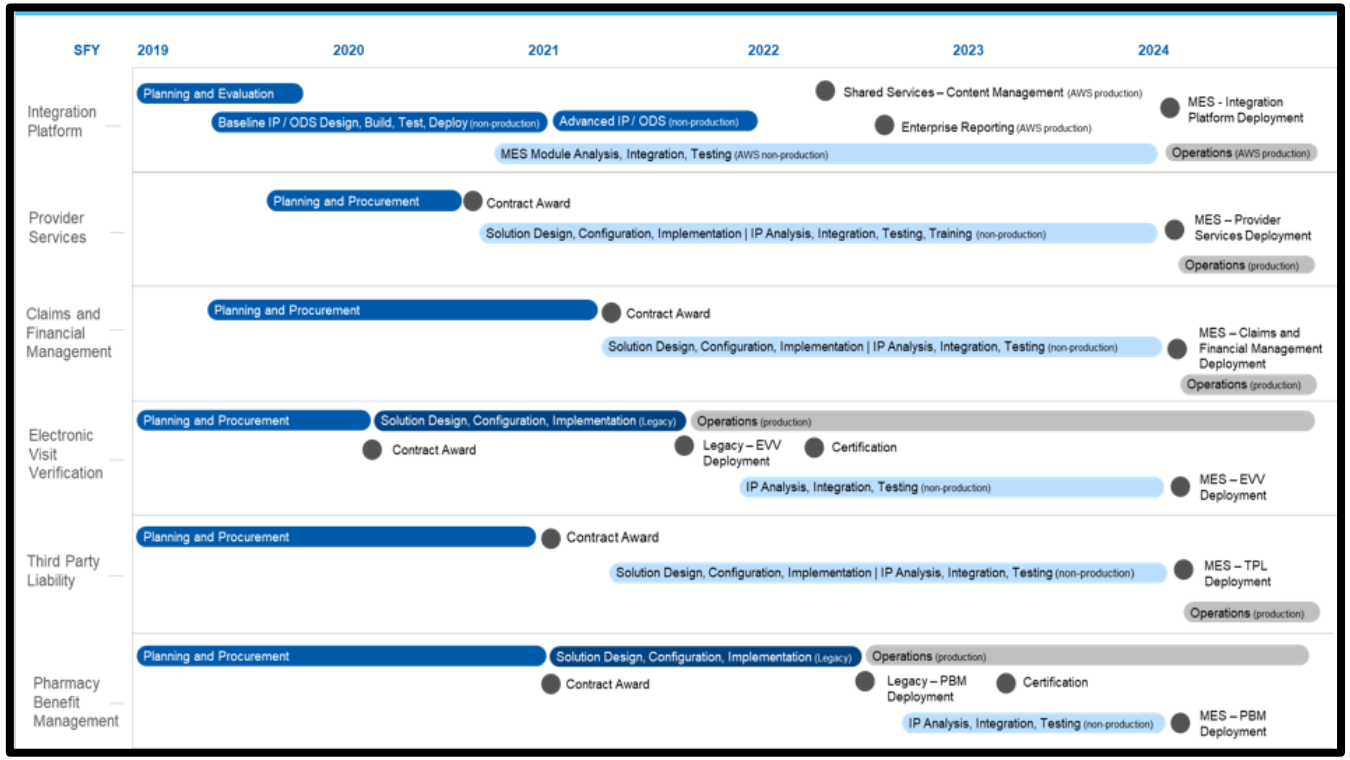
12/4/2019 Interview with Matt Jarrard, DCH Chief Information Officer



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 the 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

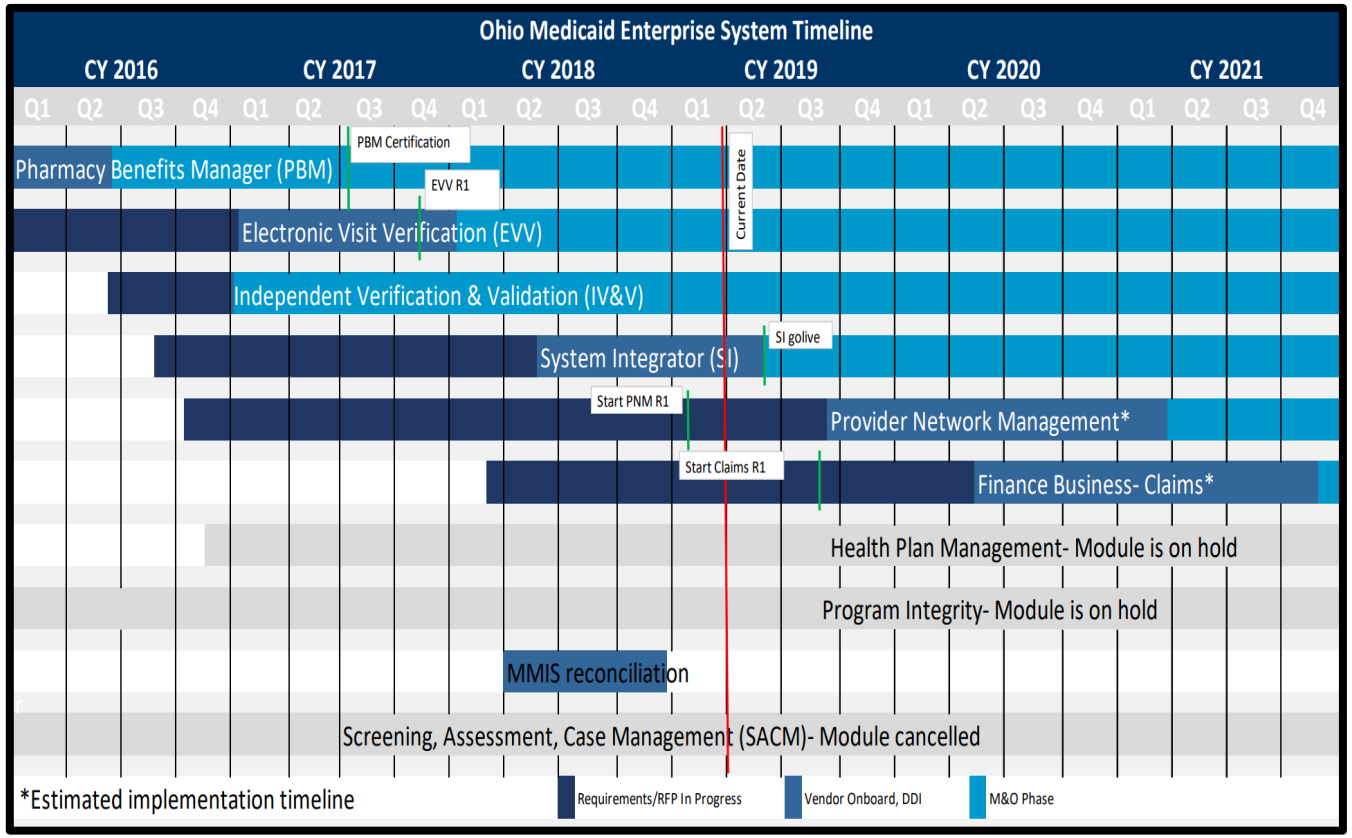
EXECUTIVE SUMMARY—OHIO DEPARTMENT OF MEDICAID

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 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 Fiscal Agent and to define module requirements for future procurements as clearly and specifically as possible



Source: Ohio Department of Medicaid Enterprise System Timeline

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

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)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES Healthy Connections MEDICAID

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Source: SC DHHS Replacement MMIS Timeline

AGENCY FOR HEALTH CARE ADMINISTRATION STATE OF FLORIDA

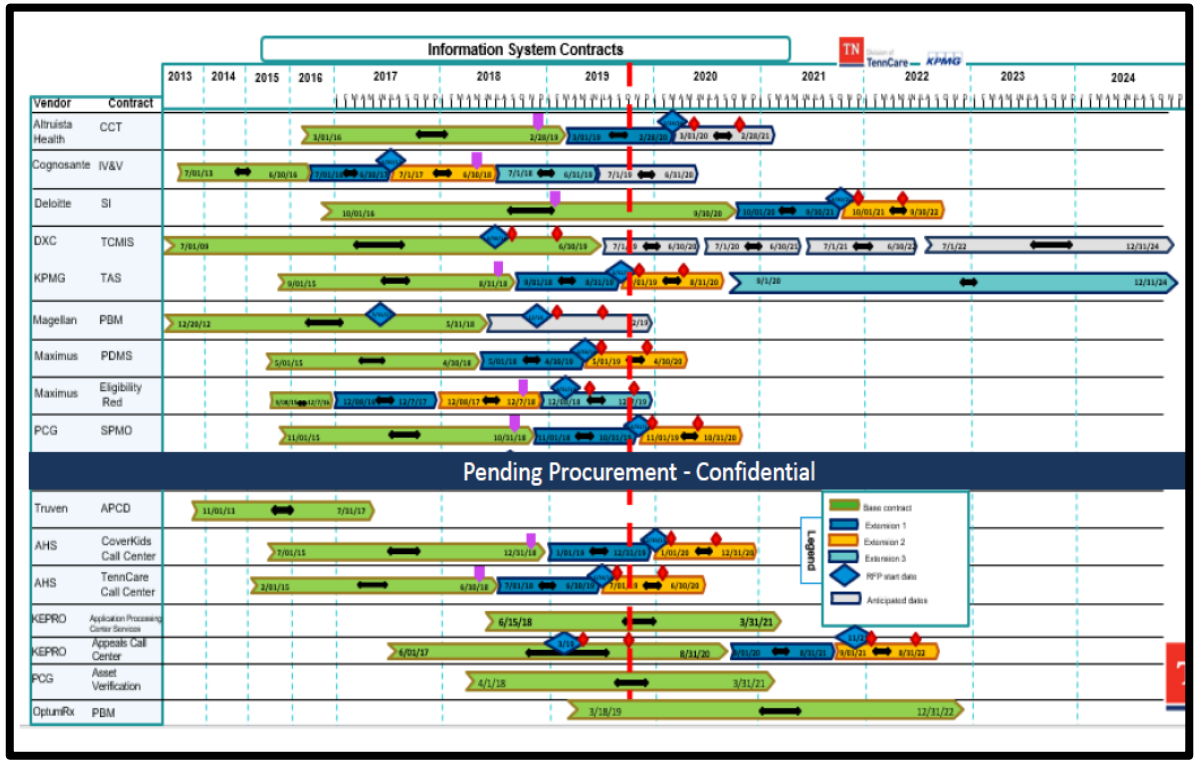
EXECUTIVE SUMMARY—TENNCARE (TENNESSEE MEDICAID)

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

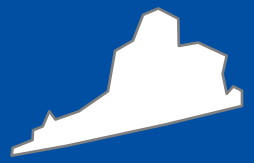
- Hired the Strategic EPMO vendor and decentralized technical executive decision-making to IT SMEs (Technical Advisory Review Board)
- Has developed an Advanced Planning Document (APD) Dashboard
  - ✓ APD dashboard has been shared with 16 other states and CMS
- TennCare will be procuring modules as cohorts 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

EXECUTIVE SUMMARY—VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

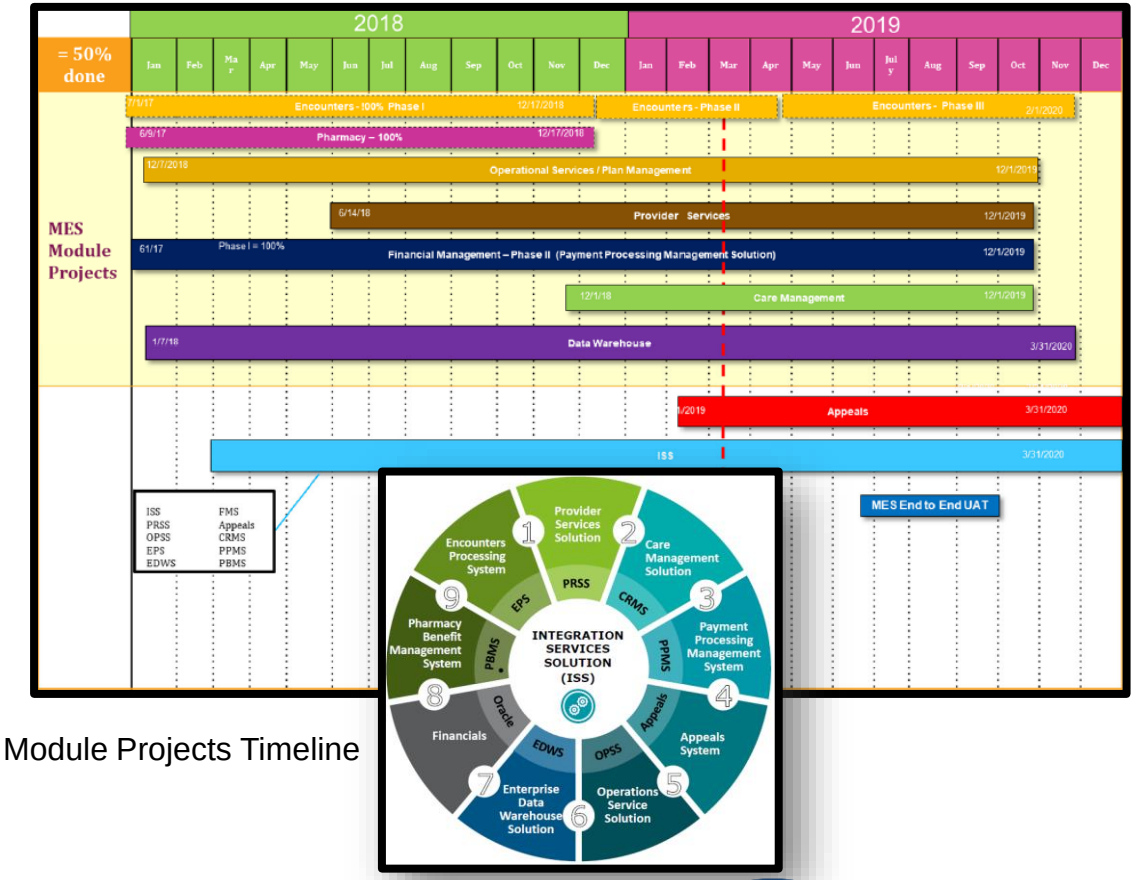
11/22/2019 Interview with Frank Guinan, Virginia DMAS Information Technology Program Manager



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

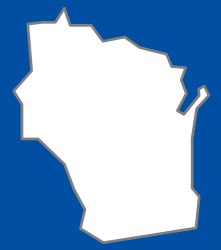
- EPS:
  - ✓ Developed an in-house module for Encounters Processing: Encounters Processing Solution (EPS)
  - ✓ Is reusing the EPS module with North Carolina (NC), reducing NC's speed and reducing its costs
- Experienced two failed procurement (Claims and Financial) due to splitting the Core module.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



Source: Virginia DMAS MES Module Projects Timeline

EXECUTIVE SUMMARY—WISCONSIN DEPARTMENT OF HEALTH SERVICES

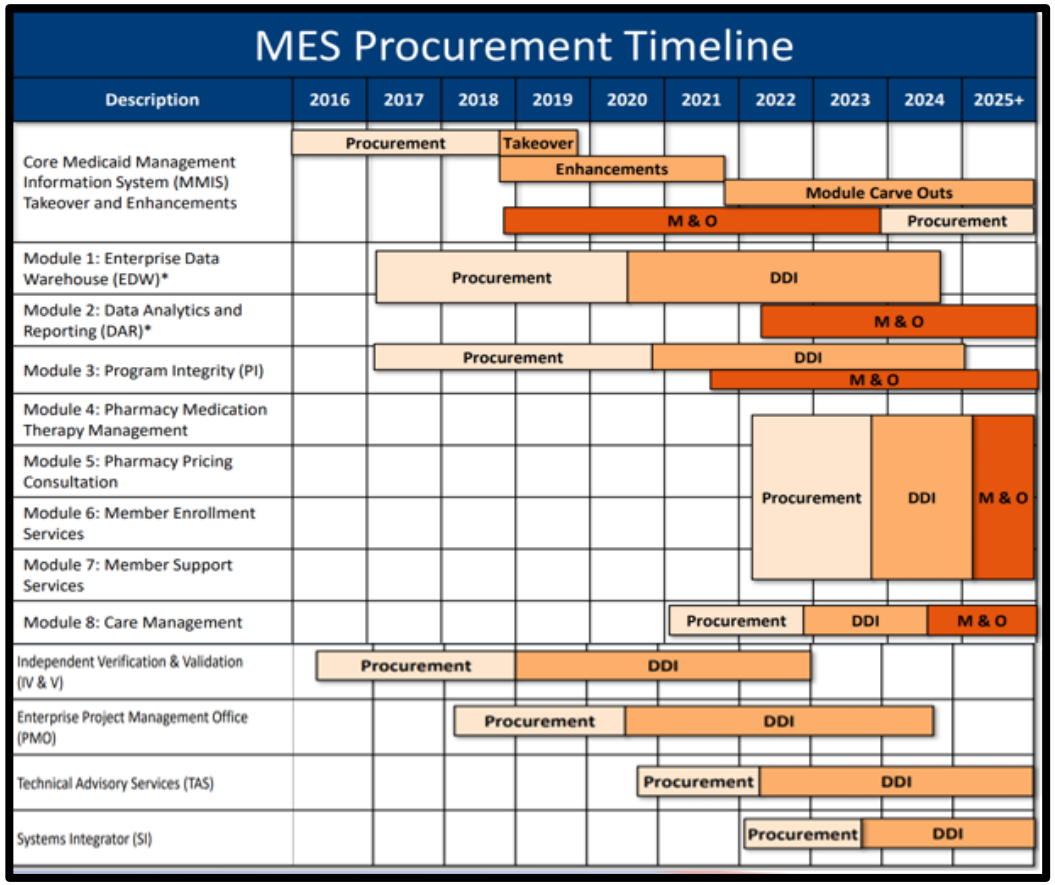
11/12/2019 Interview with Nick Havens, Wisconsin Department of Health Services (DHS) Data and Vendor Management Section Chief, Leads MMIS Transformation



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 (Fiscal Agent)
  - ✓ Pursued a *takeover* procurement and only the incumbent bid
  - ✓ Fiscal Agent awarded takeover in Nov 2018 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

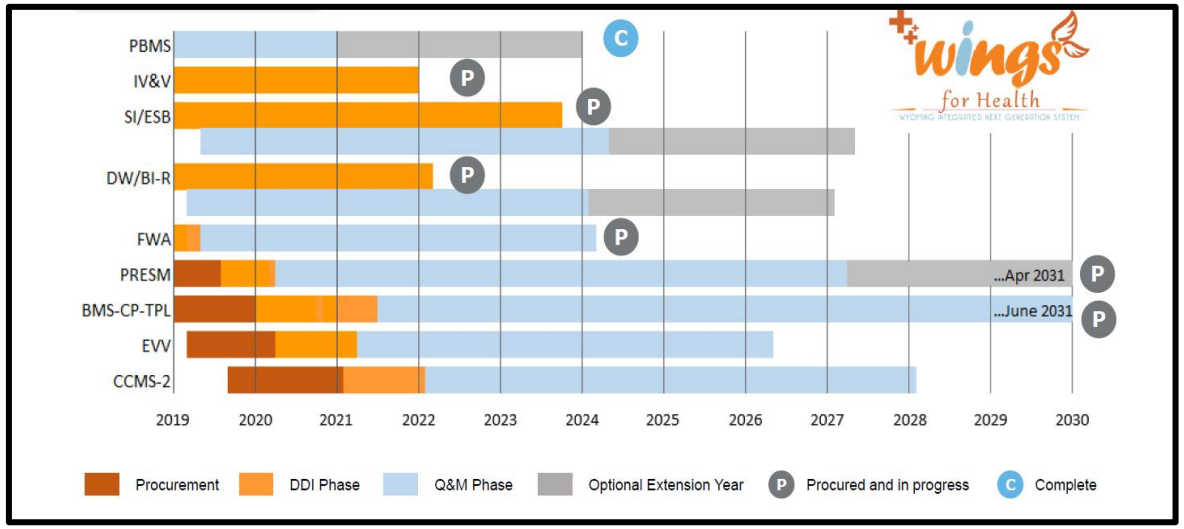
EXECUTIVE SUMMARY—WYOMING DEPARTMENT OF HEALTH

11/29/2019 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 Benefits 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 G

Appendix

STRATEGY METHODOLOGY - 2019

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

PROCESS AND ORGANI-ZATION	**Organizational Scan**	Map the functions and modules to Agency 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 the Agency's interactions with other agencies to identify opportunities to reuse 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

2017 EXECUTIVE VISIONING SESSION STRATEGIC PRIORITIES

The SEAS Vendor interviewed Agency 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 RESEARCH

STATE MMIS RESEARCH 2019

INTERVIEW DETAILS

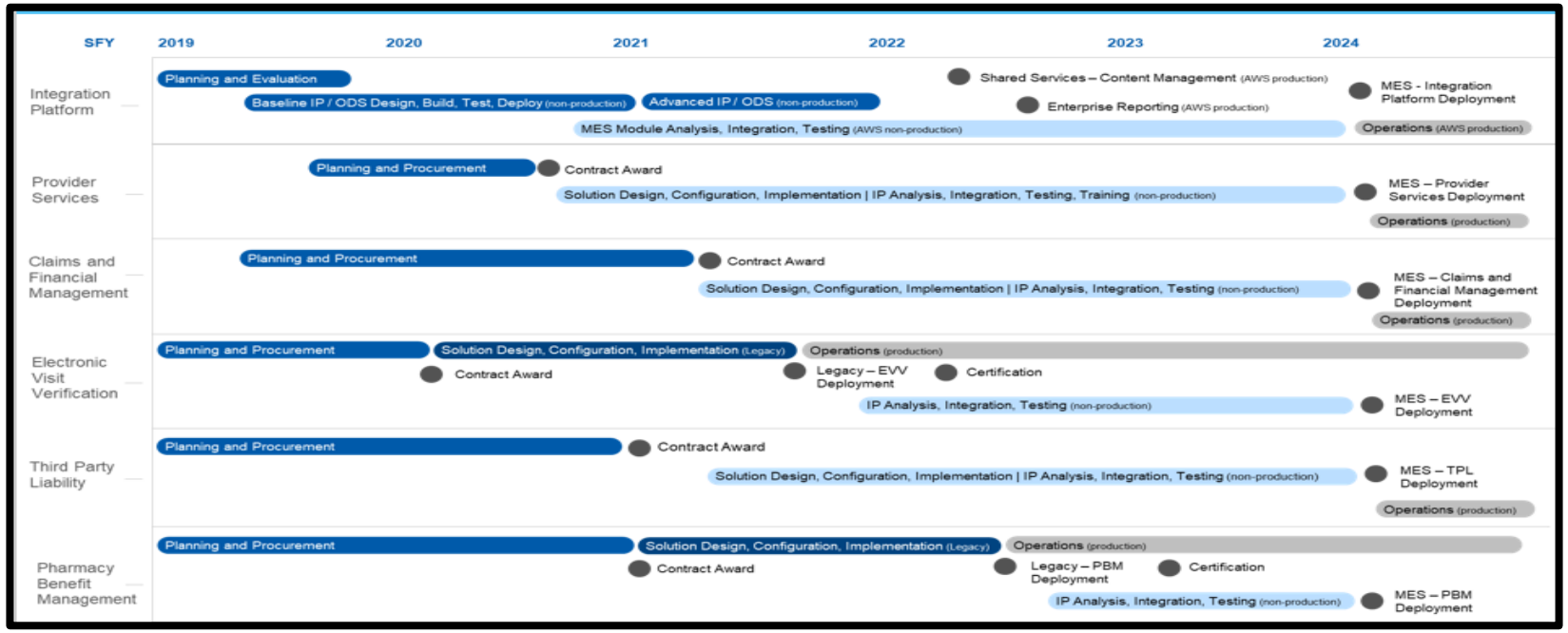
STATE MMIS TRANSFORMATION STAKEHOLDER INTERVIEWS - 2019

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.

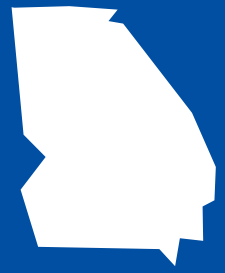
Georgia

Georgia Medicaid Management Information System (GAMMIS) includes claims processing for the Department of Community Health (DCH) managed programs. GAMMIS began operations with Fiscal Agent as the legacy system vendor in 2010. GA canceled their contract with their EDW/EDS solution in September 2019. The system integrator 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)



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Medicaid Spend (#, and as a % of FL)	
$10.9B	47%

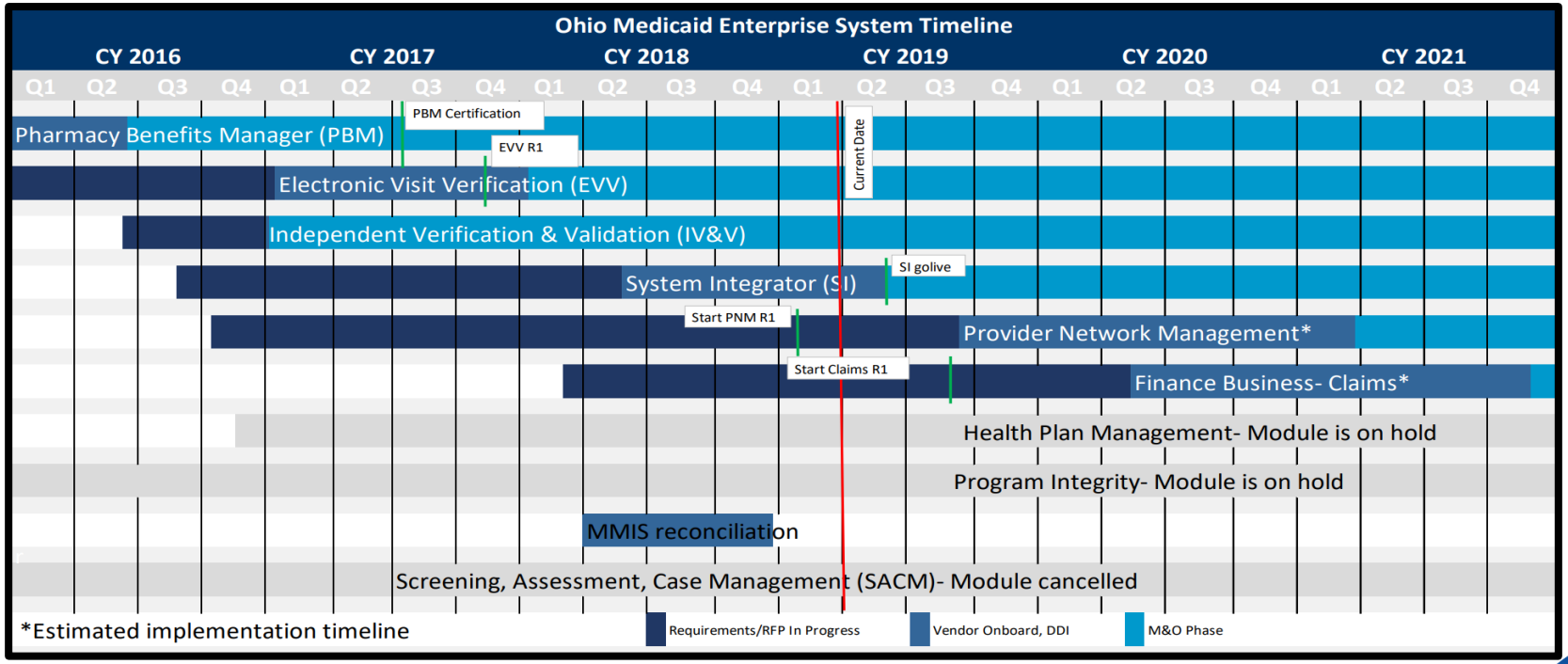
Key Strategic Inputs Driving GA Transformation	• **Expedite sunset of the legacy system** • **Control costs by minimizing throw-away integration** into the legacy system and resulting layers of integration testing • **Minimize risk** of transformation through incremental development of interface standards and integrations in a collaborative manner with modular vendors • **Show progress** through incremental build of business functions and execution of use cases • **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. The system 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 Operations 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. • 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. • 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) • Learn from unique project lessons, reflect on them, and pivot when necessary • Use all resources available to ensure a collaborative effort amongst all stakeholders • Ensure the right decision makers are collaborative ✓ (i.e., PMO, Strategy/Planning, S/I Vendor)

OHIO – MODULAR SINGLE-CUTOVER

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

Ohio

Replaced PBM before 2017. Began procurement for an 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. Provider Management was awarded in September 2019. Working on an RFP for Finance/Claims/Core.



OHIO – MODULAR SINGLE-CUTOVER

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11, 689, 442	55%
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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** • **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. • **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. • **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. • **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. • 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 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 SII when handling business (i.e., meetings) to ensure you are having the right conversations with the right people in the room. Sunsetting the Fiscal Agent system has been difficult to manage. State recommends starting direct conversations earlier about plans to sunset.

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 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

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES Healthy Connections MEDICAID

29

AGENCY FOR HEALTH CARE ADMINISTRATION STATE OF FLORIDA

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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 • South Carolina considers its transformation using a *lean approach* starting with modules with **upcoming expiration dates** and evaluated the overall performance of each vendor • **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 • South Carolina's transformation initiative is constantly evolving taking into consideration their organization's structure • Transformation work is divided into two Design, Develop, and Implement (DDI) programs. Components include: Replacement of MMIS Program, the Medicaid Enterprise System Program (Data Program), and Member Management Replacement Plan (MMRP) • 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 • Do diligent capacity planning for Subject Matter Experts within the Agency • 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"

TENNESSEE – MODULAR INCREMENTAL-CUTOVER

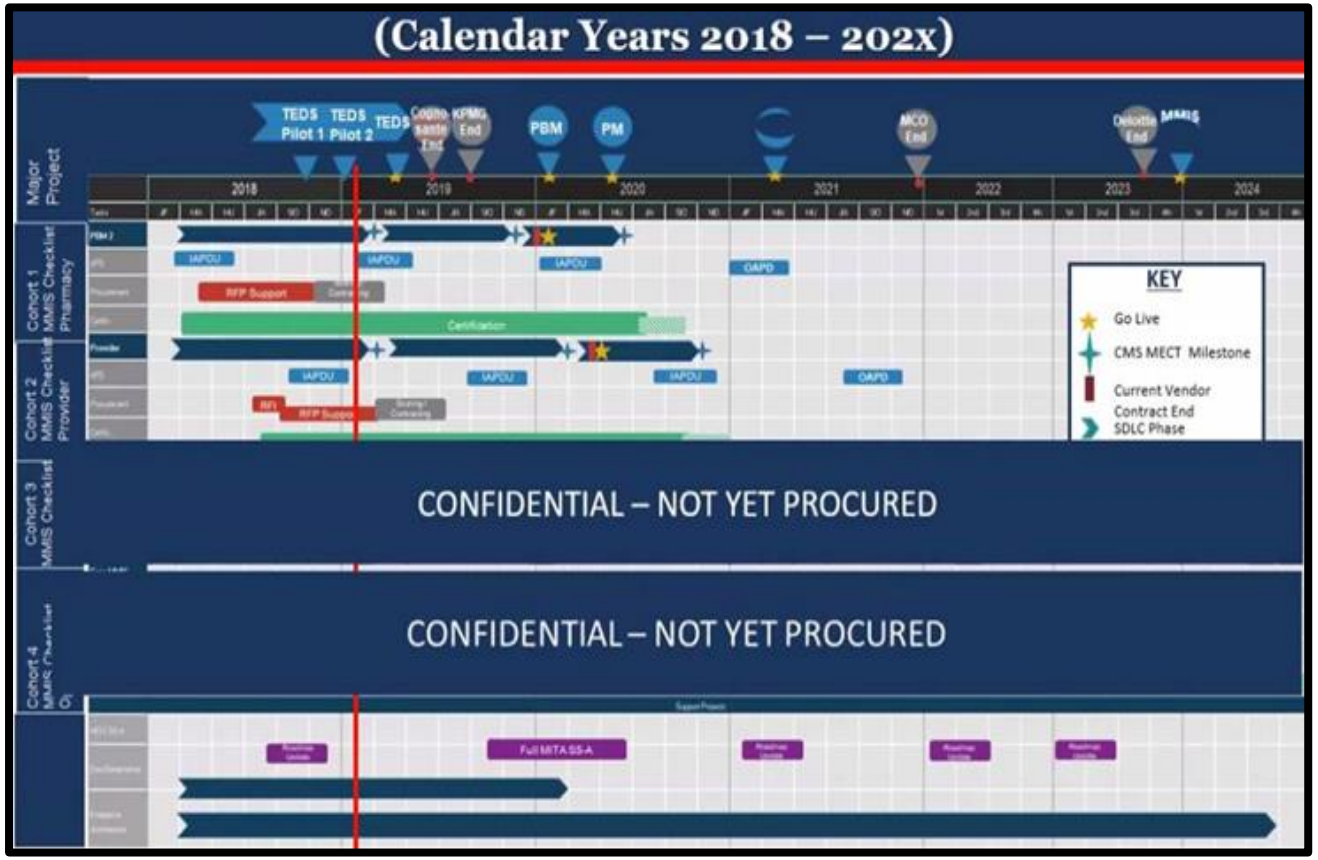
Tennessee has been on the modular journey longer than other states and have built robust program and project management standards within their organization

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 Fiscal Agent 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; e-Prescribing; 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



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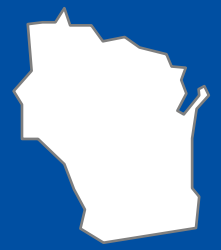
$9.7B	42%

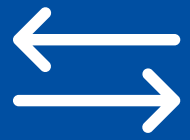
Key Strategic Inputs Driving TN Transformation	• Maintain and operate the MMIS and plan for an **Enterprise Data Governance solution** • **Improve security and governance of data** for improved decision-making and better program outcomes • **Meet federal qualifications** for 90/10 match and MITA certification • **Improve quality of care** • **Reduce cost of care** • Take advantage of **marketplace innovations** • **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 • TennCare operates as “one team” the Strategic Program Management Office, Technical Advisory Services, IV&V, and Fiscal Agent as the legacy system vendor • 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 • Considering leveraging a Utah NASPO cloud-based solution
Lessons Learned	• Ensure program and project management governance structure are consistent • Do not underestimate the power of organizational change management (OCM) services • 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) • Establish *health checks* of contractual deliverables throughout the life cycle of the project to help identify potential risks earlier on

WISCONSIN – "TAKEOVER" (FISCAL AGENT → FISCAL AGENT) TO MODULAR

Strategy was takeover; only one vendor bid, so state selected Fiscal Agent



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%

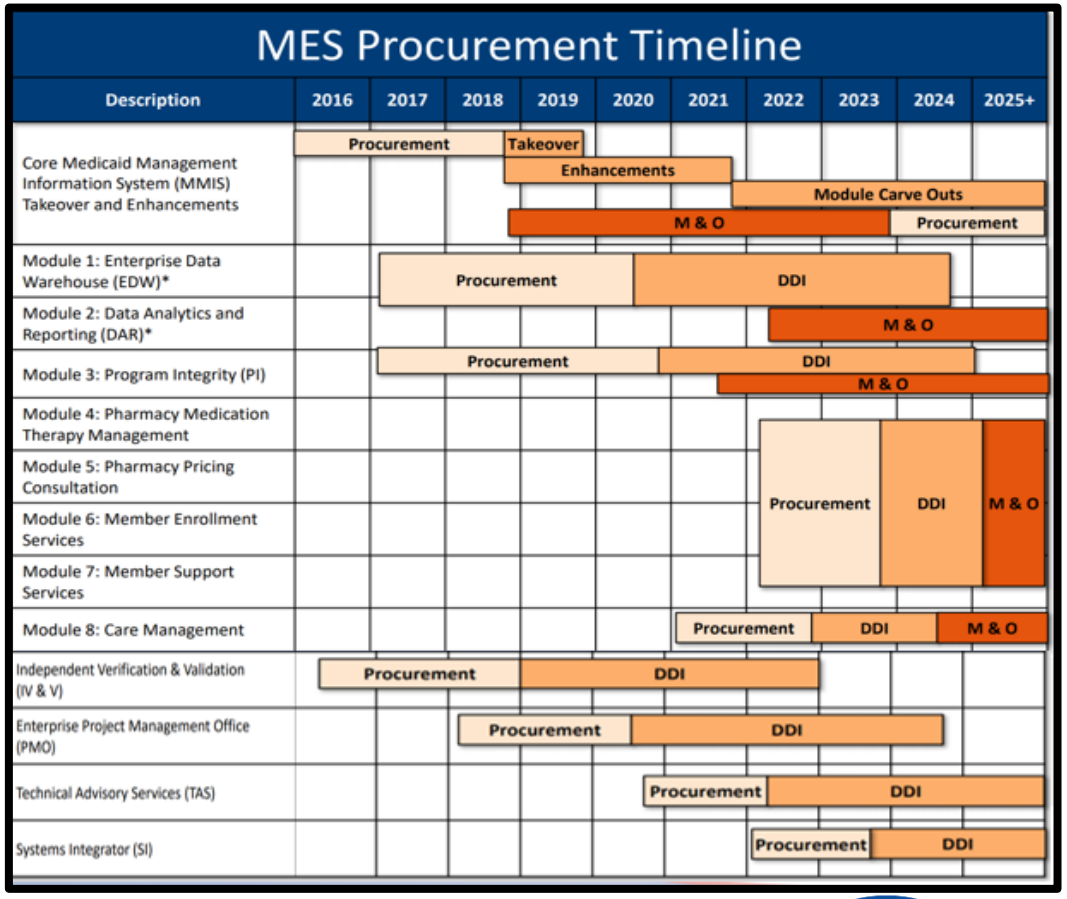


Wisconsin

Wisconsin's strategy can be summarized in three phases:

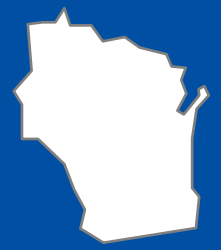
- Procure a takeover of the legacy system (Fiscal Agent) with required enhancements (integrate LTC) that will allow them to eventually retain their legacy core processing as their core module.
- Build the infrastructure (Enterprise Data Warehouse (EDW)), Data & Analytics (D&A), and find strategic partners (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. **Fiscal Agent 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.



WISCONSIN – "TAKEOVER" (FISCAL AGENT → FISCAL AGENT) TO MODULAR

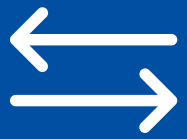
11/12/2019 Interview with Nick Havens, Wisconsin Department of Health Services (DHS) Data and Vendor Management Section Chief, *Leads MMIS Transformation*



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 t*akeover* 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. • **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. • **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. • 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. • 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. • Now accelerating a System Integrator (SI) procurement because WI is **concerned that legacy vendors will have too much strategic influence** over the integration process. • Poor documentation of the existing system has cased problems with vendor onboarding. • Budget will drive tradeoffs. After seeing the cost responses on some of their procurements they scaled back requirements to focus on needs vs. wants.

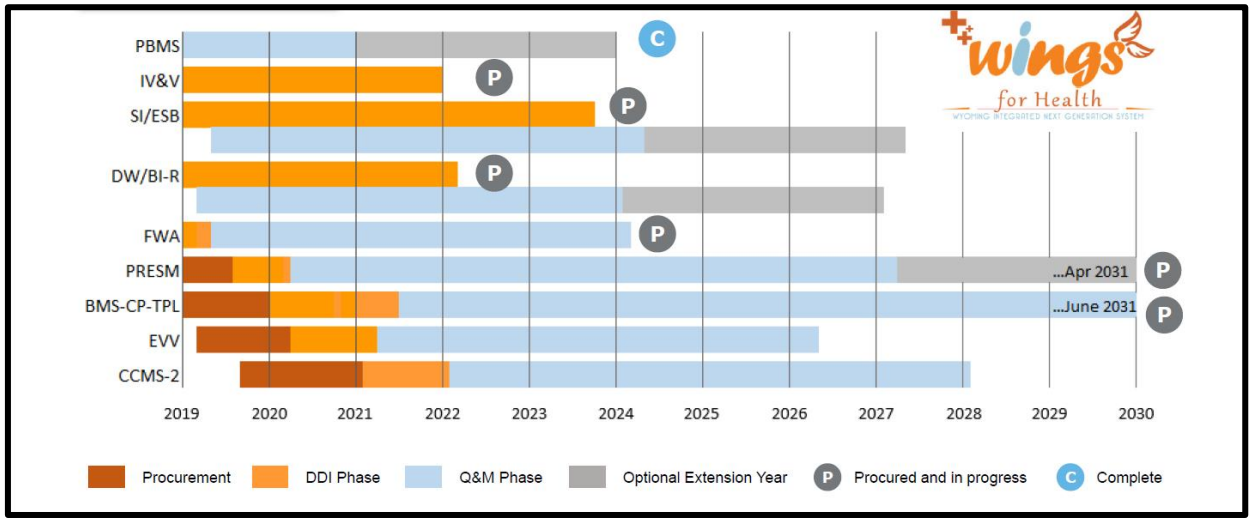
WYOMING – MODULAR INCREMENTAL-CUTOVER

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 Benefits 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

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

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

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

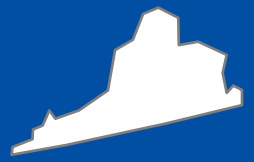
Medicaid Spend (#, and as a % of FL)	
$602.6MM	2.6%

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). • **Short, incremental module implementations.** Not doing too many modules at one time to limit disruption to stakeholders.
Transformation Organization and Ownership Within DOH	• The Wyoming Integrated Next Generation System (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. • 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 • 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.
	• Ensure that your team is clear on your expectations for the SI in their early months.
	• Begin documenting all interfaces ASAP.
	• Do not be afraid to change from initial direction:
	  • 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).
	  • 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.

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

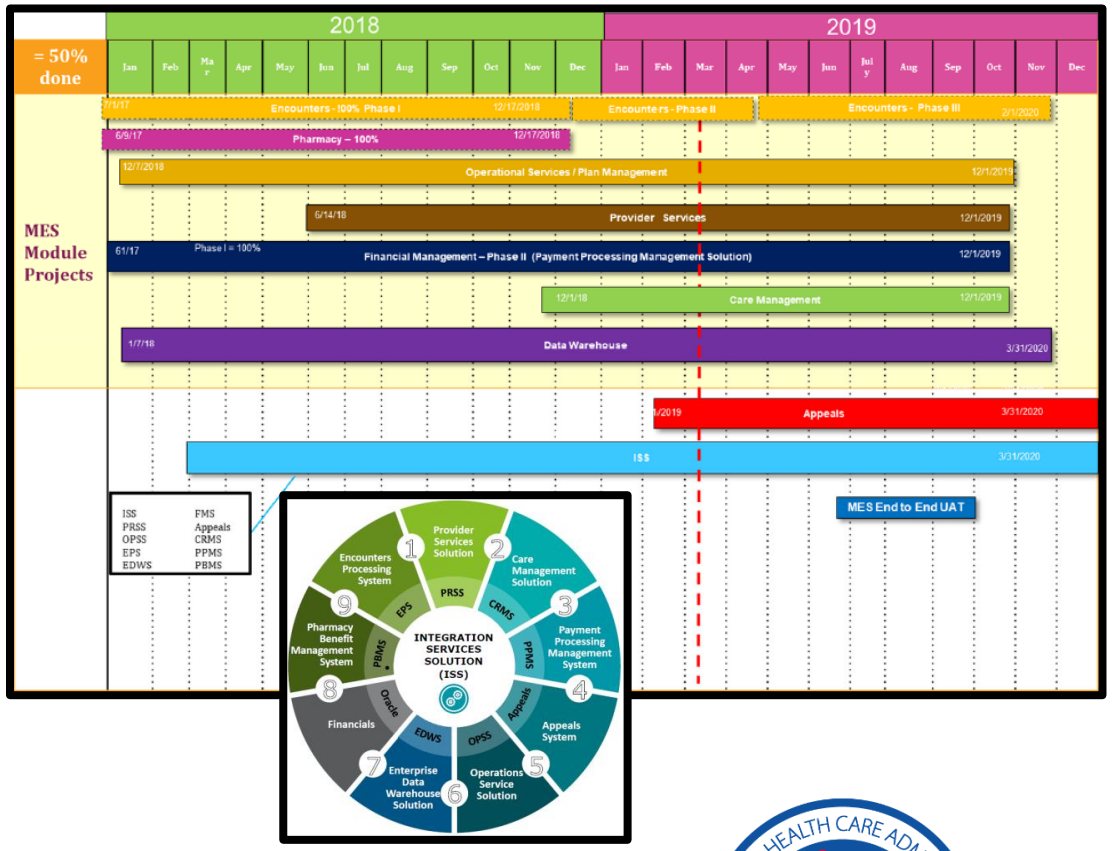


Virginia

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.

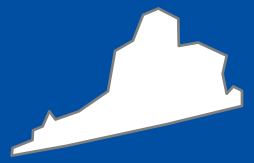
The FMS procurement was eventually canceled.

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 • Customer-centric services environment • Ability to measure performance of Medicaid programs • **Nimble speed-to-market** environment responsive to change • Creating environments that can be monitored for fraud and abuse incidents through algorithms and analytics • 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 • 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 • Recommend states do not split Claims/Financial (Core) module • Find the commonalities between data interfaces prior to implementation • Recommend all vendors are on their own clouds and their own servers while integrating (VA is currently experiencing latency issues)