oppaga

Special Report

May 2004 Report No. 04-30

Medicaid Field Offices Can Improve Efficiency and Effectiveness; State Could Outsource Some Activities

at a glance

Florida's Medicaid field offices provide a variety of services to Medicaid recipients and providers. The field offices could improve their efficiency and effectiveness by re-credentialing MediPass providers every three years instead of every two years, and taking steps to reduce exceptional claims. The Agency for Health Care Administration should clarify field office roles and periodically review their staffing to ensure wise use of resources.

The state could outsource some field office activities, namely processing exceptional claims, training providers, and managing the MediPass network. Outsourcing these services could provide savings by consolidating activities now shared by the field offices and either the Medicaid fiscal agent or the central office. The agency plans to begin developing specifications for a new fiscal agent contract in spring 2004. The new contract should clearly delineate fiscal agent responsibilities and include performance expectations along with incentives and penalties to ensure contract compliance and achievement of expected performance.

Scope

Pursuant to a legislative request, OPPAGA reviewed the Medicaid field offices to answer three questions.

- What are the major functions and activities of the Medicaid field offices?
- Could the Medicaid field offices perform their functions more efficiently and effectively?
- What Medicaid field office functions could be considered for outsourcing?

Background

The Agency for Health Care Administration (AHCA) is designated as the single state agency authorized to administer the Medicaid program.[1] In fulfilling its responsibilities, the agency develops and implements Medicaid policies and reimburses health care providers for medical services provided to clients.[2] The agency contracts with Affiliated Computer Services, Inc., the Medicaid fiscal agent, to enroll providers, process Medicaid claims, and distribute Medicaid forms and publications.

As seen in Exhibit 1, AHCA has designated 11 Medicaid service areas. While most areas have one field office, areas 2 and 3 each have a satellite office as well as a main field office. The field offices carry out a number of activities related to implementing and administering the Medicaid program and assisting Medicaid providers and recipients. The central office in Tallahassee directs field office activities.

[1] Chapter 409.902, *F.S.*

[2] See Appendix A for a brief overview of the Medicaid program including MediPass and other managed care alternatives.

Exhibit 1
Florida Medicaid's 11 Service Areas

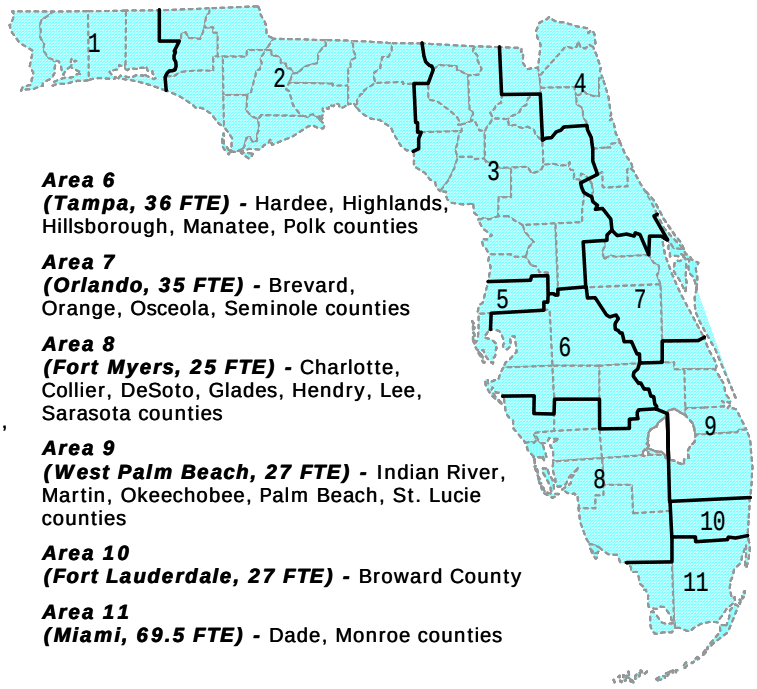
Area 1
(Pensacola, 23 FTE)
Escambia, Santa Rosa, Okaloosa, Walton counties

Area 2
(Tallahassee, 17.5 FTE) - Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla counties
(Panama City, 10.5 FTE) [1] - Bay, Franklin, Gulf, Holmes, Jackson, Washington counties

Area 3
(Alachua, 21.5 FTE) - Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union counties
(Ocala, 13 FTE) [1] - Citrus, Hernando, Lake, Marion, Sumter counties

Area 4
(Jacksonville, 34.5 FTE) - Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia counties

Area 5
(St. Petersburg, 27 FTE) - Pasco, Pinellas counties



Area 6
(Tampa, 36 FTE) - Hardee, Highlands, Hillsborough, Manatee, Polk counties

Area 7
(Orlando, 35 FTE) - Brevard, Orange, Osceola, Seminole counties

Area 8
(Fort Myers, 25 FTE) - Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota counties

Area 9
(West Palm Beach, 27 FTE) - Indian River, Martin, Okeechobee, Palm Beach, St. Lucie counties

Area 10
(Fort Lauderdale, 27 FTE) - Broward County

Area 11
(Miami, 69.5 FTE) - Dade, Monroe counties

[1] These are satellite offices.
Source: Agency for Health Care Administration.

For Fiscal Year 2003-04, the agency allotted $19,989,563 and 366.5 FTEs to support field office operations. The majority of the field offices' allotment (79%) is for salaries and benefits. The number of FTEs per service area varies, ranging from 23 in Area 1 to 71.5 in Area 11. [3]

Questions and Answers —

Question 1: What are the major functions and activities of the Medicaid field offices?

Field office functions and responsibilities fall into two major categories: beneficiary and network management and compliance and quality management. [4] Field offices also assist the central office in conducting pilot and demonstration projects and in obtaining other needed information.

Beneficiary and network management

This function provides support, as needed, to Medicaid recipients and providers.

Recipient support services. The field offices provide a variety of services to help Medicaid recipients understand program benefits and responsibilities. Medicaid recipients may contact field office staff for information related to eligibility, benefits, and provider availability. The field offices respond to these contacts, and sometimes refer callers to other entities such as the local economic self-sufficiency office, the nearest Social Security Administration office, or the HMO call center. Field offices also help

[3] The agency bases field staff FTEs largely on the proportion of recipients in the service area; it also considers other factors such as historic need, population demographics, and other existing infrastructure.

[4] The responsibilities of the Medicaid field offices are not outlined in statute or contained in a single agency policy. Instead, field office activities are authorized or required in part in various documents, such as the MediPass procedures manual and policies describing claims processing responsibilities.

Medicaid recipients enroll and dis-enroll in MediPass pilot projects, change their primary care physicians, and find specialty providers.

Recipient support services also include outreach activities to inform and educate recipients and encourage healthy behaviors. Field office staff participate in local health fairs, giving people an opportunity to meet the field office staff and learn about Medicaid. Field offices also participate in faith-based initiatives, such as Diabetes Sunday, in an effort to inform church members about diabetes and distribute literature describing symptoms and available services.

Provider support services. These field office services are intended to help retain an adequate network of Medicaid providers. Activities include

- responding to provider requests for help with enrolling in Medicaid, understanding Medicaid policy, and explaining why claims have been denied;
- training providers on Medicaid policies and billing as well as providing specialized training for MediPass primary care case managers and specialty providers; [5] and
- recruiting providers in areas where access is problematic by attending health care professional association meetings to explain the program and encourage providers to participate.

Field offices also process exceptional claims for providers. Exceptional claims are those that have been rejected by the fiscal agent or submitted more than 12 months after services were rendered. Field office staff review these claims and, when appropriate, either authorize the fiscal agent to pay the claim, send it back to the provider for additional information, or deny the claim.

Compliance and quality management

This field office function is intended to help ensure that Medicaid providers comply with state and federal rules and regulations and Medicaid recipients receive medically necessary services.

Medicaid policy requires field offices to conduct both mandatory and random site visits of providers. Before certain providers such as community mental health and durable medical equipment (DME) providers can be enrolled in Medicaid, field office staff must visit their offices and report site visit information to the central office. [6] Field offices also conduct random site visits to 10% of the providers in their service areas that have recently applied to enroll as Medicaid providers. Site visits generally include verifying that provider offices have inventory and are operational.

Field offices assist the central office to credential new MediPass providers and to re-credential MediPass providers every two years. Prior to being approved, MediPass primary care case managers must demonstrate their ability to provide 24-hour access to medical care including primary care and authorization for specialty and hospital care and meet AHCA's credentialing standards. [7] Field offices review credentialing applications and conduct site visits to review record-keeping practices and verify the provider's ability to provide the required services. [8] Field offices send completed applications, site visit reports, and other relevant information such as complaints and utilization reports to the central office for final processing and approval.

Field offices conduct annual reviews of Medicaid services provided in public schools and periodic reviews of specialty providers. [9] They also assist the Department of Children and Families in credentialing behavioral health providers and the Department of Health in overseeing early intervention services.

[5] For example, in 2003 the field offices conducted training for Medicaid providers serving people with developmental disabilities.

[6] The agency does not require site visits of DME providers associated with rural health clinics or pharmacies if co-located.

[7] For example, to be credentialed, these providers must have hospital privileges, current curriculum vitae that includes both educational and work history, active case loads of no more than 3,000 patients (including MediPass recipients and patients with other types of health care coverage), and a satisfactory site visit report from their local Medicaid field office. In addition, these providers must not be under Medicaid or Medicare sanction, have paid three or more malpractice claims over the past five years, or be under investigation for fraud or abuse.

[8] This includes examining the quality of the provider's record-keeping practices and reviewing patient records to assure that services rendered were medically necessary.

[9] In 2003, for example, the field offices conducted monitoring reviews of community programs and services provided for people with AIDS.

In addition, field offices authorize, in whole or in part, payment for certain services such as behavioral health, nursing, and transportation services. They also conduct periodic reviews to determine if services provided clients were medically necessary and billed according to Medicaid policy.

Special projects

Field offices participate in Medicaid pilot and demonstration projects and other special one-time projects as directed by the central office. In Fiscal Year 2002-03, the field offices participated in nine pilot and demonstration projects, including the Minority Physician Networks and the Prepaid Behavioral Health project. [10] Since pilot projects generally are implemented in only one or two service areas, all field offices are not necessarily affected. Other special projects, however, affect all field offices. Such projects are generally one-time requests from the central office. During 2002-03, field office staff participated in six of these projects, including a review of Medicaid non-emergency transportation expenses for the prior five fiscal years. [11]

Question 2: Could the Medicaid field offices perform their functions more efficiently and effectively?

Medicaid field offices could improve their efficiency and effectiveness by re-credentialing MediPass providers every three years, targeting strategies to reduce workload associated with processing exceptional claims, and clarifying field office, central office, and fiscal agent roles to ensure wise use of resources.

Re-credential MediPass providers every three years rather than every two years

MediPass policy currently requires that MediPass primary care case managers be re-credentialed every two years. According to AHCA officials, nearly all primary care case managers are re-credentialed without problems. National quality assurance organizations require managed care organizations to be re-credentialed every three years. [12] By re-credentialing every three years, AHCA could reduce field office FTEs or shift these resources to other activities.

AHCA officials indicate that field office staff take an average of 8.5 hours to complete each re-credentialing review. This includes reviewing the application and other supporting materials, traveling to the provider's office, and reviewing medical records while on-site. Currently, nearly 5,400 Medicaid providers are acting as MediPass primary care case managers. By re-credentialing MediPass providers every three years instead of biennially, the annual number of these reviews would decrease by one-third. This would free up over 7,600 staff hours for field offices to either cut costs by approximately $234,000 or shift these resources to other monitoring or quality assurance activities. [13]

Develop strategies to reduce the workload associated with exceptional claims

Although exceptional claims represent less than 1% of all provider claims, 13% of FTEs, the equivalent of 50 positions, are devoted to reviewing and resolving these claims. [14] Some of this workload can be avoided by developing strategies to reduce the number of claims that providers submit to field offices erroneously. Strategies could include improving provider training related to billing policies and

[10] Staff involvement in pilot and demonstration projects is generally limited to administrative functions, such as enrolling and dis-enrolling recipients.

[11] Field offices also conduct projects in response to local needs or problems. The area 10 field office, responding to judicial concerns, developed medical passports for all foster children in the service area that contain complete medical histories and follow foster children when they change placements.

[12] See National Committee For Quality Assurance's Managed Care Organization Accreditation. http://www.ncqa.org/Programs/Accreditation/MCO/images/1228_MCO%20Insert.pdf

[13] For example, the field offices could work with the central office to develop a quality improvement initiative to assist MediPass providers to improve their practices. A recent report (*Evaluation of the Florida Medicaid MediPass Program*, Florida Center for Medicaid Issues, College of Health Professions, University of Florida, January 2002) suggests that the agency could improve its ability to monitor quality of care and utilization of services by enhancing the way it compares physicians to their peers (physician profiling). Field offices could discuss current profiling with physicians and recommend changes to the central office; field offices could then use improved profile reports to identify providers whose practices depart from their peers and work with them to improve their practices.

[14] We estimated the number of exceptional claims staff based on information provided in a staffing study conducted by the agency in the fall of 2000 that showed 49.8 FTEs used for these activities. The 13 % is derived by dividing 49.8 by 366.5 total FTEs for Fiscal Year 2002-03.

recommending new claims processing edits to the fiscal agent.

The current field office claims tracking system is outdated and cumbersome. As a result, field offices do not systematically track and analyze the reasons for returning claims to providers or to the fiscal agent; they also do not analyze claims authorized for payment by the type of exception or override required. While Exhibit 2 shows that field offices returned to providers 41% of the exceptional claims processed in Fiscal Year 2002-03, the field offices do not track how many were returned for simple errors. Field office staff said many of these claims were returned because they had missing information or should have been sent to the fiscal agent for processing. Better provider education could reduce the number of claims submitted in error and the field office staff time used to process them.

Exhibit 2
Field Offices Processed More Than 123,000 Exceptional Claims in 2002-03

Field Office	Returned to Provider	Returned to Fiscal Agent[1]	Payment Authorized	TOTAL	% Returned to Provider
Area 1	2,432	515	4,166	7,113	34%
Area 2	1,590	111	4,120	5,821	27%
Area 3	3,485	270	4,253	8,008	44%
Area 4	5,467	10	4,428	9,905	55%
Area 5	4,484	0	6,582	11,066	41%
Area 6	6,672	274	8,149	15,095	44%
Area 7	4,685	0	4,927	9,612	49%
Area 8	4,051	528	4,827	9,406	43%
Area 9	4,130	61	7,062	11,253	37%
Area 10	5,168	2	7,611	12,781	40%
Area 11	9,200	19	14,574	23,793	39%
Total	**51,364**	**1,790**	**70,699**	**123,853**	**41%**

[1]These are claims field offices determined were denied in error by the Medicaid fiscal agent and subsequently returned to the fiscal agent for processing.
Source: *Fiscal Year 2002-03 Field Office Manager Summary Report.*

Exhibit 2 also shows the number of exceptional claims that field offices authorized for payment in Fiscal Year 2002-03. Field office staff indicated that many of the exceptional claims they received from providers exceeded 12 months from the date services were rendered or were claims for patients that receive both Medicare and Medicaid (dual eligibles). Field offices review each claim to determine whether it is a valid exception to Medicaid policy. [15] If valid, staff authorize the fiscal agent to override the edits that caused the fiscal agent to deny the claim. In Fiscal Year 2002-03, the field offices authorized payment for 57% of all exceptional claims.

To improve efficiency, AHCA should either enhance the existing exceptional claims tracking system or develop a new system that contains detailed information related to claims disposition and query capabilities. Individual field offices could use this information to identify training needs within their service areas and develop goals to reduce the number of exceptional claims. Field offices also can use these data to identify new edits for the fiscal agent to implement. The central office can use the new information to monitor field office performance and assist them as needed to meet their claims reduction goals.

Clarify roles of field offices, the central office, and the fiscal agent to ensure efficient use of field office resources

A 2002 evaluation of the MediPass program reported that many MediPass activities shared by field offices and the central office, including credentialing, were fragmented and potentially duplicative. [16] Our review also found that other Medicaid activities shared by the field offices and the central office or the fiscal agent are fragmented and potentially duplicative. By clarifying roles, the agency can better ensure that field office resources are used wisely.

For example, provider training is conducted by both the field offices and the fiscal agent. However, the extent of fiscal agent involvement in training varies by field office. A recent review conducted by the agency's internal audit unit reported that field office provider training is not coordinated to ensure consistency or evaluated to ensure quality. [17]

[15] Claims that exceed 12 months may be paid, for example, if there was a delay in determining recipient eligibility or if another program such as Medicare delayed paying a portion of the cost of service.

[16] *Evaluation of the Florida Medicaid MediPass Program*, Florida Center for Medicaid Issues, College of Health Professions, University of Florida, January 2002.

[17] *Review of the Medicaid Claims Denial Rate,* Office of Inspector General, Internal Audit Unit, Project No. 03-13, June 2003. .

Field offices and the fiscal agent also receive calls from providers related to claims status, enrollment status, and recipient eligibility. The fiscal agent has a call center with 45 call associates to respond to provider questions, as well as 18 field representatives who answer provider questions. However, instead of contacting the fiscal agent, some providers call their local field office. Some of these calls should be handled by the fiscal agent as they relate to claims or enrollment status or to recipient eligibility.

In addition to clarifying field office roles, AHCA should require that field offices report activity data that the central office can use to ensure that field offices do not carry out activities that should be handled by the fiscal agent or the central office. For example, the central office should direct field offices to track telephone calls from providers and recipients separately to identify field offices with high proportions of provider calls that the fiscal agent should handle. The field offices handled nearly 790,000 calls in Fiscal Year 2002-03; however, they currently do not track the source of calls on a regular basis.

AHCA should periodically review field office staffing to ensure that field offices spend time on critical activities. AHCA also should consider whether consolidating field offices would increase the efficiency and effectiveness of Medicaid operations. [18]

Question 3: What Medicaid field office activities could be outsourced?

The state could outsource some activities that are currently provided by the field offices. These include processing exceptional claims, training providers, and managing the MediPass provider network. Outsourcing these activities could provide savings by consolidating activities now shared by the field offices and the Medicaid fiscal agent or the central office. [19] Outsourcing these activities would allow the agency to reduce field office staff by around 55%. [20]

While the potential savings from outsourcing Medicaid field office activities in Florida is dependent on several factors and difficult to estimate, consolidation could improve operations. For example, having one entity responsible for designing and delivering provider training would better ensure that providers across Florida receive consistent information related to Medicaid policy and billing.

Florida's Medicaid program is among the largest in the country and bundling these field office services with current fiscal agent responsibilities should be attractive to potential vendors. AHCA's current contract with its Medicaid fiscal agent extends through June 2007. AHCA officials told us they plan to begin developing a Request for Proposals (RFP) to rebid the fiscal agent contract during the spring of 2004. This gives the agency ample time to include a broader array of vendor services and specifications in the RFP.

Prior to developing the RFP, however, AHCA should prepare a business case that includes the rationale for additional privatization, a cost-benefit analysis, a description of how the agency will monitor the contract, and a contingency plan specifying the actions the agency will take if it encounters problems with the contractor. AHCA should submit this business plan to the Legislature for review and approval. [21]

Regardless of whether the Legislature decides to outsource some or all of these additional activities, AHCA should take steps to ensure its contract with the next fiscal agent clearly delineates the required responsibilities. The new contract also should include performance expectations along with incentives and penalties to ensure contract compliance and achievement of expected performance.

[18] The Department of Children and Families is taking steps to consolidate administrative functions by region in order to attain substantial cost savings.

[19] Texas, for example, has outsourced claims administration, including all claims processing and provider training, and management of its primary care case management system since 1996.

[20] We estimated reduction in field staff based on information provided in a staffing study conducted by the agency in the fall of 2000 that showed 202 FTEs used for these activities. The 55% reduction is derived by dividing 202 by 366.5 total FTEs for Fiscal Year 2002-03.

[21] See *Information Brief: The Legislature Could Strengthen State's Privatization Accountability Requirements*, Report No. 04-02, January 2004, for further discussion of how to better ensure vendor accountability.

Conclusions and Recommendations

Medicaid field offices provide a number of services related to beneficiary and network management and quality control. The Agency for Health Care Administration could improve the efficiency and effectiveness of the field offices in three ways. We recommend that the Legislature direct AHCA to take the actions described below.

- Re-credential MediPass providers every three years rather than every two years. By re-credentialing every three years as recommended by national quality assurance organizations, AHCA could reduce the workload of field offices and cut costs by approximately $234,000 or free up over 7,500 hours for other activities.
- Enhance the tracking of exceptional claims and develop strategies to reduce the number of exceptional claims. Field offices need better information about the reasons for exceptional claims so that they can identify mechanisms, such as provider training or claims processing system edits, that could reduce the number of these claims. The central office can use better information to identify field offices that need assistance reducing the number of exceptional claims they receive. Reducing the number of exceptional claims would enable AHCA to reduce field office workload and costs.
- Clarify field office, central office, and fiscal agent roles to ensure efficient and effective use of resources. Several program activities, including training and MediPass provider credentialing are divided between the field offices, and the central office or the Medicaid fiscal agent. AHCA should clarify these roles to reduce fragmentation and duplication. In addition, the agency should require that field offices report activity data that the central office can use to ensure that field offices do not carry out activities that should be handled by the fiscal agent or the central office.

The Legislature also could consider outsourcing certain field office activities, namely exceptional claims processing, provider training, and/or MediPass network management. AHCA plans to begin developing an RFP for a new Medicaid fiscal agent in spring 2004. This RFP could include one or more of these additional activities. The Legislature should direct the agency to submit an outsourcing business plan for its review and approval. However, regardless of whether the Legislature decides to outsource any of these activities, it should direct AHCA to

- clearly specify the role and responsibilities of the fiscal agent in the new contract. The new fiscal agent contract should clearly delineate fiscal agent, central office, and field office responsibilities. It also should include performance expectations along with incentives and penalties to ensure contract compliance and achievement of expected performance.

Agency Response

In accordance with the provisions of s. 11.51, *Florida Statutes,* a draft of our report was submitted to the Agency for Health Care Administration for its review and response. The agency's written response is reproduced in Appendix B.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

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Appendix A

Overview of Florida's Medicaid System

Purpose. The Florida Medicaid program, authorized by Title XIX of the United States Social Security Act as amended in 1965, is among the largest in the country. [22] Its purpose is to improve the health of persons including children who might otherwise go without medical care. Medicaid provides health care services to low-income persons who meet federal and state eligibility requirements, mainly low-income families and children, elderly persons who need long-term care services, and persons with disabilities. In Fiscal Year 2003-04, Florida will serve an estimated 2.1 million Medicaid beneficiaries.

Service Delivery. Florida law requires that, to the extent possible, Medicaid clients enroll in a managed care delivery system. Depending on geographic availability, recipients have several managed care arrangements from which to choose.

- Medicaid Provider Access System (MediPass). The MediPass system is available statewide and is a primary care case management program. MediPass clients select or are assigned a primary care physician (PCP) who is responsible for providing primary care and referring patients for specialized services. The state pays PCPs a $3 monthly case management fee for each client in addition to fee-for-service reimbursement for each service they provide to clients. The state is currently implementing two MediPass pilot projects, Children's Provider Networks (also known as the Pediatric ER Diversion Program) and Minority Physician Networks. These pilot projects target specific utilization and cost concerns related to children and minorities and have the flexibility to develop their own networks and to outsource many administrative functions.
- Medicaid Health Maintenance Organizations (HMOs). Medicaid HMOs, available in 34 of the state's 67 counties, provide medical services to Medicaid clients on a prepaid basis. For each enrolled recipient, the state pays HMOs a monthly fee that is set at 92% of the expected cost to provide services to equivalent groups of fee-for-service recipients. Besides the approved Medicaid services, HMOs are required to provide additional services, including smoking cessation, pregnancy prevention, and domestic violence intervention services.
- Provider Service Networks (PSNs). PSNs are currently available in only two counties, Broward and Miami-Dade. PSNs provide medical services through an integrated health care delivery system owned and operated by Florida hospitals and physician groups.

As of March 2004, 1.4 million or 71% of the state's Medicaid clients were enrolled in one of these managed care options, including 706,426 clients enrolled in MediPass, 705,873 in Medicaid HMOs, and 17,910 in PSNs. Non-managed care clients are considered fee-for-service. This group includes Medicare dual eligibles (individuals who are eligible for both Medicare and Medicaid), institutionalized and hospice recipients, new recipients, recipients for whom Medicaid is supplemental insurance, and the medically needy.

[22] Florida ranks fourth nationally in the number of Medicaid clients served.

Appendix B

JEB BUSH, GOVERNOR **MARY PAT MOORE, INTERIM SECRETARY**

April 14, 2004

Mr. Gary R. VanLandingham, Interim Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, FL 32399-1475

Dear Mr. VanLandingham:

Thank you for the opportunity to respond to your office's preliminary and tentative report entitled *Medicaid Field Offices Can Improve Efficiency and Effectiveness; State Could Out source Some Activities.*

In your report you recommend that the Legislature direct the Agency for Health Care Administration to re-credential MediPass providers every three years; enhance the tracking of exceptional claims; develop strategies to reduce exceptional claims; and clarify the roles of the field offices, central office, and fiscal agent. You also recommend that the Legislature consider outsourcing certain field office activities, direct AHCA to submit an outsourcing business plan for review and approval, and direct AHCA to clarify the role and responsibilities of the fiscal agent within the new contract.

We appreciate the analyses performed by your staff and have included our response to these recommendations. The Agency is in agreement with many of the findings and recommendations expressed in your report. AHCA continuously looks for opportunities to improve operations and assess outsourcing opportunities. The Agency is committed to providing cost effective and efficient health care services to the State.

If you have any questions regarding this response please contact Michael Bennett at 414-5419.

Sincerely,

/s/
Mary Pat Moore
Interim Secretary

MPM/mb
Enclosure

Agency for Health Care Administration
Response to OPPAGA's Special Report
Medicaid Field Offices Can Improve Efficiency and Effectiveness; State Could Outsource Some Activities

Agency Response to OPPAGA Conclusions and Recommendations:

Recommendation to the Legislature:
Re-credential MediPass providers every three years rather than every two years. *By re-credentialing every three years as recommended by national quality assurance organizations, AHCA could reduce the workload of field offices and cut costs by approximately $234,000 or free up over 7,600 hours for other activities.*

Agency Response:
The Agency believes that this recommendation has merit and can be implemented as suggested.

Recommendation to the Legislature:
Enhance the tracking of exceptional claims and develop strategies to reduce the number of exceptional claims. *Field offices need better information about the reasons for exceptional claims so that they can identify mechanisms, such as provider training or claims processing system edits, that could reduce the number of these claims. The central office can use better information to identify field offices that need assistance reducing the number of exceptional claims they receive. Reducing the number of exceptional claims would enable AHCA to reduce field office workloads and costs.*

Agency Response:
Exceptional claims resolution by the field offices is an evolving process, requiring field office staff to work closely with both the fiscal agent and the central office in implementation. The field offices already have in place a training process for those providers that seem to need additional training on claims issues. As well, the field offices frequently engage in discussions and communications with the fiscal agent regarding "edit" problems, and suggestions for improvement of the overall system. The Agency designated exceptional claims work to be done by the field offices as a cost saving measure. The fiscal agent had indicated a price two to three times higher than that estimated for the field offices.

Recommendation to the Legislature:
Clarify field offices, central office, and fiscal agent roles to ensure efficient and effective use of resource. *Several program activities, including training and MediPass provider credentialing are divided between field offices, and the central office or the Medicaid fiscal agent. AHCA should clarify these roles to reduce fragmentation and duplication. In addition, the agency should require that field offices report activity data that the central office can use to ensure that field offices do not carry out activities that should be handled by the fiscal agent or the central office.*

Agency Response:
The Agency believes that for certain program activities this recommendation may have merit and that further refinement of the respective roles of the central office, field offices, and fiscal agent would serve to improve the program. Provider training activities, and MediPass credentialing efforts, while cited as examples of duplicated service areas, are not believed to be particularly problematic at the present time. Both the field offices and central office, and the fiscal agent have clearly defined and separate roles in the credentialing process. Provider training, while conducted by both field office staff and fiscal agent staff, is differentiated along areas of expertise and complexity of problem. It too, is not felt to be problematic, but will be reviewed along with other potential areas of duplicate effort to insure cost effectiveness and efficiency. The Agency will further explore existing activity data provided to the central office by the field offices and modify as needed to clarify the existing roles of the field offices, fiscal agent and central office.

Recommendation to the Legislature:
The Legislature could also consider outsourcing certain field office activities, namely exceptional claims processing, provider training, and/or MediPass network management. AHCA plans to begin developing an RFP for a new Medicaid fiscal agent in spring 2004. This RFP could include one or more of these additional activities. The Legislature should direct the agency to submit an outsourcing business plan for its review and approval.

Agency Response:
The Agency agrees that the areas outlined above are all potential candidates for inclusion in the upcoming fiscal agent RFP. The present fiscal agent contract expires in 2007. The Agency will soon commence discussion and drafting of this RFP in preparation for the procurement.

Recommendation to the Legislature:
Clearly specify the role and responsibilities of the fiscal agent in the new contract. *The new fiscal agent contract should clearly delineate fiscal agent, central office, and field office responsibilities. It should also include performance expectations along with incentives and penalties to ensure contract compliance and achievement of expected performance.*

Agency Response:
The fiscal agent contract contains clear delineation of responsibilities, and includes incentive and penalty provisions. Discussion and drafting of the RFP shall commence shortly, in preparation for procurement. The present fiscal agent contract expires in 2007.

> ***OPPAGA Comments.*** ***OPPAGA's review of the fiscal contract found several areas in which responsibilities should be more clearly delineated. For example, the current contract requires the fiscal agent to "present training seminars to providers requesting such training in conjunction with the area Medicaid staff." The contract does not specify whether the fiscal agent or area staff are to train providers together or separately and does not specify which would be responsible for particular areas of training. As a result, staff may conduct training that should be the responsibility of the fiscal agent. In addition, the agency's current system of providing incentives and penalties for fiscal agent performance can enable the fiscal agent to earn substantial incentive dollars despite poor performance in several areas.***

AGENCY SUMMARY

OPPAGA's Special Report: Medicaid Field Offices Can Improve Efficiency and Effectiveness; State Could Outsource Some Activities

The Agency is in agreement with many of the findings and recommendations expressed by OPPAGA. AHCA continuously looks for opportunities to improve operations and assess outsourcing opportunities. It is committed to providing cost effective and efficient health care services to the State.