TMA Recommendations for Administrative Simplification in Medicaid HMOs

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1.a. Category for Administrative Requirement	1.b. Administrative Requirement	* 1.c. Proposed Solution	* 1.d. Benefit
Network Adequacy	Medicaid HMOs are contractually required to maintain a comprehensive network of physicians and providers and to ensure their enrollees are able to obtain medically necessary services timely. However, the most common physician complaint regarding the HMO model is network inadequacy, particularly for subspecialty care. The current standard is based on the needs of a commercial population and may be inadequate for Medicaid. Inadequate networks frequently result in patients resorting to the ER to obtain care.	Evaluate whether Texas Medicaid should adopt an alternate network adequacy standard. Require HMOs to clearly communicate to physicians and patients the process for obtaining services when an in-network physician/provider cannot be found. Require the HMOs to establish a dedicated contact person for a physician to call to request assistance in arranging services not available in network. Establish an HHSC ombudsman tasked with overseeing network adequacy, responding to patient and physician complaints, and enacting physician recruitment initiatives. Establish a division within HHSC or TMHP dedicated to recruiting new physicians to participate in Medicaid and/or allow the HMOs to recruit physicians who are not enrolled in	Improve patient and physician satisfaction with the HMO model Reduce ER utilization.

		Medicaid but whose specialty is needed within the network. Implement more stringent monitoring of HMO network adequacy, including surveying patients and physician regarding their experiences with the health plan networks. Apply stiffer penalties for plans that fail to maintain adequate networks. Publish in-network and out-of-network utilization trends and patient/physician complaints. Foster innovative alternative solutions to providing care, such as promoting use of telemedicine	
Credentialing	Physicians/providers must complete the credentialing process with each HMO. If the physician also is applying to participate in Medicaid, the physician must also separately enroll via TMHP before applying to the HMOs. Much of the credentialing paperwork and documentation is duplicative.	Establish a centralized credentialing portal to allow physicians/providers to simultaneously apply to participate in all the HMOs participating in the service area. Require the HMOs to use the standardized credentialing form. Consider ways to integrate Medicaid/Medicaid HMO application and credentialing processes for physicians newly applying.	Centralizing the credentialing process will reduce redundant and wasteful paperwork.

Claims	HMOs frequently recoup claims from physicians for services provided to patients enrolled in the HMO at the time of service, but who were subsequently determined ineligible for HMO enrollment. The recoupments are often 2 years or more after the date of service. While the physician can subsequently file an appeal to TMHP, the appeal process is cumbersome, time consuming, and frustrating.	Coordination of benefits is an insurance function. Rather than recoup funds from a physician who provided services in good faith based on the patient's eligibility at the time of service, the state should require TMHP and the HMOs to coordinate recoupments between each other without seeking funds from the physician.	Reduce administrative hassles and frustration.
Vendor Drug Program	Texas tasked the HMOs with administering the Medicaid prescription drug benefit, but the HHSC Vendor Drug Program establishes the Medicaid preferred drug list and clinical edits. There is considerable confusion among physicians regarding who is responsible for developing the PDL and clinical edits and when/how changes are made. The state and plans do not clearly publicize that a preferred drug may also be subject to additional clinical edits.	Establish a more robust system on Epocrates and on the HHSC and HMO websites, respectively, to allow physicians to easily see when a preferred drug is subject to additional clinical edits, which clinical edits are in use by which plans, to provide "pop up" alerts when a change to the PDL has occurred, and to list plan specific requirements, such as day supply limits.	Reduce administrative hassles, frustration and costs
Claims	Medicaid fee-for-service maintains outdated policy regarding reimbursement for after-hours care, which discourages physicians from establishing office hours on nights and weekends. Some HMOs, on the other hand, provide physicians	Revise the Medicaid FFS policy to promote development of after-hours clinics by physicians. Encourage HMOs to foster the development of after-hours services by	Patients will have access to physician services at more convenient times, thus potentially reducing reliance on ERs for

	incentives to establish after-hours clinics. However, because the FFS and HMO standards are inconsistent, a physician who provides after-hours services to HMO patients often will run afoul of the FFS requirements. The Texas legislature expects Medicaid to implement measures to reduce inappropriate ER usage, but not all HMOs provide incentives for PCPs to provide after- hours care, which can be costly for practices to establish and maintain.	physician offices by adopting innovative payment incentive models	non-emergency conditions.