Health and Human Services Commission
Stakeholder Input

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Please complete the information below.

1. Description of recommendation:

Require Medicaid MCOs to simultaneously process physician credentialing applications while the physician pursues Medicaid enrollment via TMHP. Currently, physicians must submit a Medicaid enrollment application then await receipt of a TPI number(s) before beginning the HMO credentialing process. TMA and TPS frequently receive complaints from physicians that the entire process takes 6 months or more to become enrolled in Medicaid, credentialed by the HMOs, and then begin seeing HMO patients. Some plans indicate they will initiate the credentialing process while awaiting a physician's TPI number, but this is not standard practice because some HMOs interpret the HHSC-HMO rules to preclude establishing a parallel process. Once TMHP finalizes a physician's Medicaid enrollment, the information should be expeditiously transmitted to the HMO to allow the plan to complete credentialing.

Further, HMO's should be required to honor the TMHP effective date regardless of whether the HMO has completed the credentialing process and pay claims retroactive to that date so that physicians can begin seeing patients more quickly.

By allowing physicians and other acute care providers to simultaneously pursue Medicaid enrollment and HMO credentials, the state will expedite physician enrollment into HMO networks.

Benefit: Allowing a concurrent Medicaid enrollment and HMO credentialing application processes, it will shorten the timeframe for new physicians to join HMO networks, thus allowing them to see patients more quickly.

2. Description of recommendation

Simplify and streamline the Medicaid Vendor Drug program, which is inordinately complex given that the management of the prescription drug benefit is split between HHSC and the MCOs. It is much too cumbersome for prescribers to determine which drugs or drug classes are subject to additional clinical edits and if there is an edit, which plans also have adopted it. Physicians should have a single location to look up this information rather having to go to each PBMs website to figure it out.

a) Within each drug class on the PDL, include a hotlink so that when a physician views the PDL he/she can immediately determine if there are any associated clinical edit(s) for the entire class of drugs or a particular drug within the class. The link should take the physician to each clinical edit and also name each individual HMO that also has opted to implement the identical HHSC edit or a less stringent version. Currently, physicians must search each individual HMO website to determine which plans have adopted particular clinical edits.

b) Limit changing drugs from preferred to non-preferred status on the PDL to annual revisions.

c) When a drug's status on the preferred list is changed – e.g. from preferred to non-preferred, provide the rationale for the change so that physicians understand HHSC's justification for the revision.

d) For physicians using Epocrates, establish electronic mechanism to convey whether a drug/drug class is subject to an additional clinical edit, provide a mechanism to easily and quickly access the edit, and indicate which HMOs use the same edit.

e) If there is a drug shortage, adopt an expedited communication plan so that HHSC and HMOs can quickly communicate with network physicians what product to use instead.
f) Revise requirements managing drug benefit to the package insert instead of indication. Legacy FDA reviews of drugs excluded pediatric, obstetric and geriatric patients, meaning many drugs do not have official FDA approval for treatment of those populations. This creates unnecessary hassles for physicians who may be required to obtain prior approval to use a drug for a non-label population even though there is clinical evidence supporting such usage.
g) When the Drug Utilization Review Board considers a clinical edit, publicize the justification for the proposal and the entity that recommended it.

Benefit: One of the most frequent complaints TMA and TPS receive about Medicaid is that the drug benefit is too complicated, frustrating and time consuming. No other payer has such a byzantine pharmacy benefit, thus fueling physicians' reluctance to participate in the program. Making the pharmacy benefit more transparent and easier to use will reduce program hassles for physician practices.

2. Description of recommendation: Eliminate use of Texas Provider Identifier and only use the NPI number.

Benefit: The legacy enrollment process is inefficient and confusing. Many physicians have multiple TPI numbers because they have multiple office locations or participate in multiple Medicaid programs, such as acute care Medicaid and Texas Health Steps. Relying on the physician's NPI number for enrollment and claims submission rather than multiple Medicaid TPI numbers will streamline both processes for physicians and the state.

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4. Description of recommendation: Increase payments to cover costs of physicians acquiring long-acting reversible contraceptives (LARCs), such as IUDs, to promote greater use of the devices and to help reduce Texas' rate of unplanned pregnancies.

Benefit To address the cost of physicians directly acquiring LARCs, HHSC gives physicians the option to obtain LARCs via a specialty pharmacy, whereby physicians submit an order on behalf of an individual patient seeking a LARC. The pharmacy then ships the device to the physician practice within a specified period of time. The physician bills Medicaid for the insertion fee only and does not bear the acquisition costs. While this approach relieves physicians of the costs of utilizing LARCs, it does not promote best clinical practice, which is to insert the device the same day as the initial office visit, rather than scheduling another appointment for the patient to return to obtain the device. Unfortunately, many women fail to return for the second appointment.

We ask HHSC to implement a process to establish a system to update LARC payment rates monthly so that physicians who wish to buy and bill for LARCs are not financially penalized for doing so.

5. Description of recommendation: Abide by Texas insurance requirements establishing that coordination of benefits is an insurance function, thus eliminating the need for costly Medicaid recoupments from physicians when a Medicaid health plan discovers a patient was erroneously enrolled in the plan.

Medicaid MCOs frequently recoup payments from physicians as much as two years after a service was provided. The recoupments are triggered by various reasons, such as after the MCO is informed the patient was retroactively enrolled in Medicaid fee-for-service or was mistakenly enrolled in two MCOs simultaneously. While the physician can subsequently bill Medicaid fee for service or the correct MCO for services, this process is time consuming and expensive for the practice. Since the patient did not lose Medicaid eligibility, the recoupment should be managed among the payers, which is how commercial carriers manage these types of recoupments.

Additionally, we have received an increase in calls from physicians reporting Medicaid is recouping payments when it identifies another insurer as the responsible party, such as an auto or home insurer. The recoupments often occur months to years after the service was provided and the family no longer carries insurance with that carrier, thus making it difficult for the physician to file a claim. These types of recoupments also should be handled between Medicaid and the insurer when a physician has provided the service in good faith and made reasonable attempt to determine if a party besides Medicaid was liable.

Benefit. Eliminating costly Medicaid recoupments related to coordination of benefits will help reduce Medicaid administrative costs, making the program more attractive to physicians.

6. Description of recommendation: Require MCOs to share meaningful and actionable data with network physicians, such as notification of patient emergency department usage and prescription data, as well as providing confidential comparative data on their practice's utilization and costs. Further, some health plans indicate they meet at least quarterly with network physicians to review performance data and practice issues. This promotes dialogue between the physicians and MCOs as well as opportunities for the MCO to be aware of hassles experienced by physicians and patients that might not otherwise be elevated.

MCOs also should be required to promptly notify physicians when the practice's assigned provider representative has changed. We frequently receive calls from physicians who have attempted to resolve complaints with a plan, but were stymied because their provider representative kept changing, often without notice, requiring the practice to start again with the resolution process.

Benefit. Improving communications between MCOs and network providers will facilitate collaboration and minimize physician frustration, a key reason practices limit or stop Medicaid participation.

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7. Description of recommendation: Promote adoption of innovative Medicaid delivery models, such as physician-led accountable care organizations or patient-centered medical homes, as well as value based purchasing initiatives, such as gain sharing, to reward physicians for improving Medicaid quality and reducing costs.

At the recent Texas Medicaid Congress facilitated by TMA, several physicians noted they were interested in partnering with health plans to test new models of care, but either had no interest from the MCO(s) in their region or were unsure how to initiate the discussion. HHSC should facilitate efforts by physicians and MCOs to test new delivery system and payment models.

Benefit. Testing new models of care and payment mechanisms that reward physicians' efforts to improve health outcomes and lower costs holds the potential to slow Medicaid cost growth while achieving our mutual goals of better care for Texas' low-income patients.

8. Description of recommendation: Collaborate with physicians and other stakeholders to develop an interconception care program for women at risk for low-birth weight babies or premature delivery.

Benefit. Our organizations strongly support HHSC's plan to automatically enroll women into the women's health program when they lose pregnancy Medicaid coverage 60 days postpartum (the new process will begin in July 2016). Providing women timely access to family planning and preventive health screenings will help women to better time and space their pregnancies and to detect chronic conditions earlier. However, if a physician determines the patient needs ongoing chronic care management or treatment, few resources exist. Women with a prior premature delivery or a chronic illness, such as hypertension or diabetes, are at greater risk of poor birth outcomes, thus jeopardizing not only the health of the mother and baby but also increasing Medicaid birth-related costs. A healthy pregnancy begins well before conception. Establishing an interconception care program that provides treatment of chronic conditions will help achieve our mutual goals of improving the health of women and their babies.

9. Description of recommendation: Implement a provider type and specialty code for urgent care. Many primary care physicians cover urgent care centers in addition to operating their own practices. Without a separate provider type, it wreaks havoc with PCP assignments and makes it difficult to differentiate physician after-hours clinics from other facilities.

Benefit. Improve ability of patient's to identify urgent care locations

10. Description of recommendation Add a feature to the TMHP and MCO fee schedules or policy manuals to determine any place of service or diagnosis restrictions (e.g., whether procedure can only be performed on an in-patient). Having a single place to look up such information will make it easier for physicians to abide by Medicaid utilization restrictions, which often vary from other payers.

Benefit. Making it easier for physicians to follow Medicaid rules prior to providing services will reduce practices' administrative costs, making the program more attractive to new providers.

11. Description of recommendation. Ensure Texas Medicaid recognizes all appropriate claims modifiers. If a modifier is not covered, the Medicaid fee-for-service or MCO provider manual should list any modifiers that are not recognized

Benefit. Reducing physician frustration and practice costs.

12. Description of recommendation. Eliminate prior approval for medical drug screens. Texas Medical Board rules regarding chronic pain specify physicians must conduct random drug screens. By requiring prior approval, physicians cannot fulfill that requirement for Medicaid patients. This limits physicians' ability to properly screen patients at high risk for opioid abuse.

Further, we have received information that when physicians do attempt to follow Medicaid requirements, the form requires individual authorization for each component of the drug test rather than allowing the entire panel to be completed. This is a non-standard approach -- physicians do not bill for individual components for these tests. Thus codes are not easily obtained.

Benefit. Eliminating the prior approval process for medical drug screens will help Texas physicians comply with TMB rules and the state's efforts to reduce opioid addiction.

13. Description of recommendation.

Revise the payment policy to reimburse physicians for venipuncture performed and analyzed in the physician's in-office lab. The Medicaid manual (section 9.2.41.2 Laboratory Handling Charge) states that a physician may bill a laboratory handling charge for obtaining a specimen via venipuncture or catheterization *and* sent to an outside lab. Many physicians have in-office, moderately complex labs and run many tests in house. The current policy does not reimburse them for the staff costs or supplies of obtaining the specimen.

Benefit. Revising the policy will ensure physicians are appropriately reimbursed for their staff time and supplies while also expediting receipt of lab results by facilitating in-office lab services when appropriate.

14. Description of recommendation

Improve understanding and effectiveness of care coordination within the Medicaid managed care model.

- Increase provider education on (1) populations that receive automatic care coordination, (2) how to best utilize this automatic care coordination and (2) how to request care coordination on behalf of a patient that does not automatically receive it.
- Include a patient's care coordinator name and phone number on the patient's Medicaid card and in the patient's electronic portal
- Care coordinators should be held responsible for helping a transition age youth find adult providers
- Billable care coordination by both the physician and a social worker/nurse coordinator in the provider setting should be streamlined and MCOs should clearly outline for all medical homes how to take advantage of this service
- Educate providers on the unique care coordination model STAR Kids MCOs will be responsible for implementing
- Encourage MCOs to provide a capitated care coordination PMPM to practices able to demonstrate high quality outcomes with internal care coordination efforts.

Benefit

- Improving the use and understanding of the care coordination benefit both at the MCO level and in the provider's office will help streamline continuity of care for patients and cut Medicaid costs by improving health outcomes.

15. Description of recommendation

HHSC should encourage MCOs to “gold star” provider practices that can show a history of proper utilization of medical services and waive certain prior authorization requirements.

- Prior authorizations can be replaced with retroactive reviews of a physician’s services provided followed by education when needed.

Benefit

Reducing administrative burden on providers that have a history of providing high quality, low cost care will encourage physicians to accept new Medicaid patients and stay enrolled in the program for longer. For large groups, reducing staff required to perform prior authorizations will allow for investment in other areas of the practice to improve health outcomes of patients.

16. Description of recommendation.

Eliminate pre-authorization for simple procedures in the office. Examples include performing an ear lavage when it is necessary to determine whether a patient has an ear infection, chemical cautery for umbilical granulomas, or treating molluscum contagiosum warts.

Benefit

Eliminating burdensome and unnecessary prior authorizations will reduce Medicaid physician practice costs, making the program more attractive to physicians.