PEMS and MCO Hub Concerns

Feb. 3. 2023

An outline of concerns and requests is compiled below for the PEMS and TexMed Modernization projects. Feedback was driven by the health and dental plans that TAHP represents, and issues are listed by priority.

PEMS

Provider addresses*[1]

- It is unclear why address discrepancies (in street nomenclature, etc.) are treated as fatal errors.
    - MCOs cannot require providers to make the update on PEMS.
- If plans begin editing claims based on the new PEMS file, they will be denying a *very high* percentage of claims based on address discrepancies.
- The default address methodology for PEMS involves associating the group address for performing providers in the group, and not using the servicing location of the provider.
- Previously, MCOs could submit multiple addresses on the provider file as alternate addresses, but they are now getting rejected and are not seen in PEMS.
- Ultimately, providers are going to blame the plans for denying claims associated with address discrepancies and significant abrasion will occur.
    - TMHP should prepare for the volume of provider complaints when providers are informed that claims are being denied because of this policy.

Old and new files not matching*

- Plans are still experiencing differences in data between the legacy file (COMBMPF) and new (PEMS) file, which indicates issues with how the state manages provider data.
- Current provider databases are using the legacy file to validate demographic data.

[1] * denotes items that should be fully addressed prior to end-to-end testing and the decommissioning of the legacy MPF

- If the legacy and PEMS files are not aligned, plans would experience thousands of demographic changes by moving from legacy to PEMS which would result in many claim edits on provider demographics.

Process mapping*

- The plans have had to do some crosswalking and making assumptions. Given the inconsistency between the legacy MPF and PEMS files, plans would benefit from understanding what assumptions were made when HHSC/TMHP tied them together; there's a lot that's not linked.
- Crosswalk between the legacy and the new file needs to be reviewed to head off network adequacy issues. How is the decision made to default providers to the main group location?
    - If the legacy file is decommissioned without addressing this then providers will drop out of networks they should otherwise be a part of.

CLIA

- HHSC committed to incorporating the applicable CLIA Laboratory Code (LC codes) in PEMS; however, the PEMS layout includes only the LC code, not the applicable effective dates (start and end date of certification) for each LC code, which are required to comply with CMS requirements.
    - The OIG published findings for all MCOs last year, relating that no MCO is administering the CLIA requirements appropriately.
    - There's no way for the plans to comply with HHSC policy that requires them to deny claims for labs that aren't certified when they don't know what the certification date is.

Downstream impacts

- Network adequacy and access to care
    - Rejected addresses due to discrepancies between old and new files will have a negative impact on network adequacy.
    - Associating the group address for performing providers and not using the service location of the provider will cause access to care issues for Maximus

assignment of PCPs since the servicing provider's address is not available for PCP assignments. It will also result in inaccurate network adequacy analysis that is utilized to measure MCO network access.
    - Delays to enrollment and credentialing mean providers are not available to provide service in their service delivery area(s) as soon as they would otherwise be.

HHSC communication

- HHSC seems to support a delay in testing until major issues are addressed, per communication in PEMS meetings and presentations, but no notices have been received to date.
    - On the 1/30/23 call, TMHP said PEMS is in readiness state until Feb. 6, when end to end testing begins. If TMHP was unable to match between legacy and new files, or if there are new clarifications from TMHP, then they'd move testing. But as of Jan. 30, it's still in the readiness phase and they don't think they're ready.
        - No more information has been received regarding this comment. While meetings were canceled this week due to weather and rescheduled to next week, no explanation of outcome or next steps were included.
    - HHSC indicated its success criteria was:
        - MCOs should be able to process the new MPF file end-to-end.
        - MCOs to confirm "all functions consuming new MPF are operating successfully."
- The first "no go" decision occurred Nov. 4, 2022, because question logs/issues were not entirely addressed or remediated by TMHP/HHSC.

MCO Hub

File structure and mapping

- Plans need:
    - Updated docs and JIPs for TPT in order to update to proper locations.

    - A complete inventory of the files themselves, to capture 2-way file sharing.
        - There are many things the plans send that are one-way files that plans just send to HHSC. Files just sent one way to HHSC that aren't listed on the crosswalk HHSC released. There's no clear mapping 1:1 to which folder. The mapping doc is very simple and vague, and plans need more detail.
    - Regression and production credentials to update connections and jobs.
- While folder content is helpful, it would be more helpful to be aligned on what exact files will live in the folder destinations and the way the folders will be structured. Commonly within TexMed and SFTP site, folders are designated as "inbound v outbound".
- The 15 calendar day file retention period is much shorter than current policy. Plans have raised concerns several times that this period is too short and have not been given an explanation.

Decommissioning of TexMedCentral

- TXMedCentral will be decommissioned once all users have successfully transitioned to the new MCOHub SFTP site with a tentative decommission date of May 2023, if not before.
- Plans have expressed concern at the 15 calendar day file retention period and overlapping testing periods of conflicting IT projects. Overlapping projects cause resource constraints and confusion. It would alleviate some of that concern to delay decommissioning of TexMedCentral and adjust timelines so projects do not overlap and MCOs have time to make system/programming updates.

Communication on project updates

- Timely communication on project updates, such as if the JIP is updated.
- Cohesive communication for project updates: MCO notices with similar titles, a standing meeting to discuss TexMedModernization/MCO Hub (this was suggested at the January scan call, HHSC took that item back)

Project scope

- Testing
    - What exactly will the plans be expected to test (ex: multiple rounds of automation, picking up and dropping files to multiple destinations)?
- Overall
    - Multiple plans expressed concern that HHSC/TMHP doesn't seem to have a grasp on what all this project entails on the plans' end. Complexities will vary from plan to plan as their systems are set up differently.
        - Just saying "here's the old and new folder" doesn't do much.
        - Multiple roles are automated, which helps to keep cost down. One MCO noted as they're going through teams to establish a complete inventory of what needs to be updated, they're finding that the scope of the work to do this keeps increasing.
        - A lot is connected to TexMed, they may have set it up years ago but now have to go back and adjust. This project is turning out to be bigger than they initially thought.
            - Some plans are looking at converting hundreds of automated jobs and processes.
    - A few MCOs offered to supply an inventory to HHSC/TMHP of what this effort will look like on their end, if it will help to inform a more feasible project timeline. The work, effort, and resources required to update their systems needs to be considered.

Solutions

1. Delay PEMS end-to-end testing and decommissioning of the legacy MPF until issues are resolved by HHSC/TMHP.
2. Don't categorize address discrepancies in PEMS as a fatal error.
3. Allow MCOs to validate provider information in PEMS by communicating correct provider information with TMHP (in addition to providers being able to correct their own information).
4. Allow MCOs/DMOs the standard 90 days to program their systems prior to testing for TexMed Modernization.

5. Do not decommission TexMedCentral in May– decommission as late as possible.
6. Expand the MCOHub 15 calendar day file retention policy.