



TAHP
The Texas Association of Health Plans

PEMS and IT Projects

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Overview

- PEMS is one example of how earlier communication and collaboration will help all of us be more successful with timely implementation of IT projects
- Ongoing and new IT challenges
 - Will now be dealing with multiple and new vendors, which means even more communication and collaboration is needed
 - History of TMHP vendors prioritizing FFS and what is easiest for them to build vs what will work in a predominately Medicaid managed care program
 - Lack of upfront or early communication or collaboration with vendors - vendors tend to plan without any conversations about MCO processes or systems
 - Project overlap - lack of recognition that MCOs can only make so many changes to IT systems at a time and then must be scheduled out. Additionally, high-level timeline planning could would be beneficial for HHSC staff needs and success
 - Feasible implementation timelines
 - Clear, consistent communication on project updates and outcomes

PEMS and Provider Addresses

Concern: Over-reliance on provider addresses in PEMS system

- **Why this is an issue:** claims denials, does not work with MCO or DMO systems, data integrity problems, provider abrasion, downstream issues with provider directories and network adequacy
- **Update:** Has not been addressed
- **Ask:** Lessen (or eliminate) over-reliance on provider addresses.
 - Do not make addresses a fatal error. Allow the plans to override address discrepancies so claims are not denied.
 - Prioritize data points that are less prone to change than addresses and supported by managed care contracting and credentialing policies, such as: NPI and Tax ID.
 - MCOs and DMOs believe that providers will not reliably update their addresses, regardless of their requiring such.
 - The policies HHSC points towards don't explicitly require the primary use of provider addresses to inform enrollment.

PEMS and Data Integrity

Concern: Data integrity issues between the **legacy Master Provider File (MPF) (C21)** and PEMS MPF – Plans negotiated the use of legacy MPF until there were not data issues

- **Why this is an issue:** Claims denials, does not work with MCO system, data integrity problems, provider abrasion, will cause provider directory and network adequacy issues
- **Update:** Has not been addressed – Inconsistent on if its being used or not
- **Ask:** Fix ongoing data issues between the legacy and PEMS MPFs before progressing the project.
 - Do not use the PEMS MPF as the source of truth until data issues are fully resolved.
 - Consult with the plans on the timeline for the PEMS MPF as a source of truth in any capacity (**HHSC agreed to this at the 6/22 HHSC PEMS meeting with plans**)
 - Roll back the use of the PEMS MPF to validate encounters.
 - **This change went into effect 6/30, after HHSC agreed to consult with the plans on the timeline for use of the PEMS MPF as the source of truth, in any capacity.**
 - If this change cannot be reverted, we ask that HHSC works with the plans to fully assess impacts and coordinates with applicable HHSC/TMHP areas to ensure providers, members, MCOs, and DMOs do not experience unintended consequences of the PEMS MPF's premature use as the source of truth.
 - **MCOs told about it July 13** after it was already in effect

PEMS and Communication

Concern: Plans need their questions answered and need a reliable method to submit questions.

- **Why this is an issue:** The plans will ask questions during HHSC IT meetings and the appropriate state staff is not always available for a resolution, or HHSC states that issue was resolved via the issue log (without providing a response on the call). Multiple plans report their questions not being included in the issue log, or partially answered or not answered, or not being able to locate the issue log. This creates confusion. Some questions have been asked by multiple plans repeatedly over months.
- **Update:** Has been partially addressed
 - Improvements noted over the past month with the addition of an HHSC managed care project specialist to assist in communications around PEMS.
 - An increase in HHSC staff the last few PEMS meetings, in lieu of solely relying on the project leads and TMHP.
 - PEMS project leads have been more engaged with TAHP in the last month, and allow TAHP to inform on agenda topics and on the plans' concerns. Every technical conversation should involve plan experts.
- **Ask:** Review the issue log with plans, ensure issues are adequately addressed before being noted as resolved, add questions from MCO meetings to ensure the issue log captures all concerns, ensure appropriate state staff attend PEMS meetings (including Deloitte).

PEMS and Provider Registration Delays

Concern: Providers receive their letter from the state which says their enrollment is successful, but they are not permitted to render services through their MCO/DMO because:

- The legacy file states the provider is not enrolled
- The PEMS file does not display a TPI. In order to add providers to network, they have to have TPI.
- Business rules changed with the PEMS rollout to disallow retroactive billing for providers, so a provider cannot render services until their provider billing effective date (upon signature of the agreements and require all screenings to be completed and become the date in which the provider may begin to bill for services)
- **Why this is an issue:** Multiple plans have noted the delay can be up to 3-4 months. Not allowing providers to render services as soon as they should be able to results in provider abrasion and network adequacy issues. This is a concern with access to care, especially in rural areas. TMHP has stated multiple times over several months that issuance of a TPI only takes 4 days which is not the case.
- **Update:** Has not been addressed
- **Ask:** Allow retro billing for providers up to a year, consistent with [federal policy](#).

PEMS and Product Design

Concern: TMHP continue to prioritize and make changes based on FFS, and continue to fail to coordinate with MCO/DMO technical experts. For example, FFS policies are established without consideration for managed care, then applied to managed care. Plan input is not solicited or incorporated into the PEMS project.

- **Why this is an issue:** Managed care is 97% of the market. Project solutions and next steps are not always feasible for the plans, or will create negative downstream impacts such as denied claims and provider abrasion. TMHP regularly outlines next steps for the PEMS project without checking with the plans on feasibility. For example: address remediation for providers.
- **Update:** Has not been addressed
- **Ask:** HHSC and TMHP should proactively collaborate and communicate with the plans at regular intervals and as issues arise with the PEMS project, and should readily incorporate the plans' input where feasible.

IT Project Challenges

- PEMS concerns echo several concerns the plans have around state-required IT projects as a whole:
 - Lack of opportunity for the MCOs and DMOs to provide input
 - Input not being readily accepted when the plans do provide it
 - Systems not being designed with managed care in mind, instead prioritizing FFS or vendor convenience
 - Nonfeasible implementation timelines
 - For example, HHSC states testing is coming but MCOs haven't been given an opportunity to build out their systems, and therefore have nothing to test.
 - Communication on project updates is not always cohesive or predictable
- Additional concerns not specific to PEMS:
 - Project overlap causes a drain on the plans' resources (limited IT staff, cost of building and rebuilding systems). This may be exacerbated for smaller plans.
 - The plans are not given information they need to build out their systems prior to testing: detailed technical specifications and 60-90 days to make any needed system updates.

Timelines

- We must have realistic timelines for us to all be successful.
- Timelines should:
 - Be acknowledged from the beginning of implementation to clearly outline expectations, so all parties can strive for adherence.
 - Account for every piece of project implementation such as: collaboration with the plans on design/method of the system, meetings to collaborate on specs, meetings with vendors, testing, etc.
 - Vary by project.
 - Have plan input to ensure feasibility as each MCO and DMO has different system configurations.
- Note: Some timelines are static, such as plans needing 60–90 days to build out IT systems prior to testing, or to make any needed updates after testing concludes.

Resolutions for IT Projects

- IT Consortium – **to open and establish reliable lines of communication** between HHSC and the plans on IT Project Implementations.
 - Set the standard of HHSC checking in with MCOs at various checkpoints throughout the design and implementation of projects:
 - Prior to initiation (to inform on scope)
 - At set intervals throughout implementation (frequency set per project)
 - As issues arise (either side could call a Consortium meeting)
 - HHSC and TAHP would designate contact, and either entity could call an IT Consortium meeting
 - Head off issues with IT project SMEs to be addressed succinctly and minimize negative downstream impacts to plans and providers.
 - [Link to IT Consortium Project Charter](#) – please provide TAHP with feedback.
- HHSC will **incorporate the plans' feedback** into projects where feasible.
- A single point of contact/ email address for each IT project that the plans can direct all of their questions and concerns to.
- Feasible timelines for implementation, agreed upon by HHSC and managed care plans.
- It is imperative that TMHP prioritizes IT planning and implementation for the majority of the Medicaid/CHIP market: managed care (97% of Medicaid)

Questions?

