Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

March 27, 2024

Health and Human Services Commission,

As the statewide trade association representing health insurers, HMOs, Medicaid managed care, and other health plans that serve over 20 million Texans, the Texas Association of Health Plans (TAHP) is committed to ensuring that Texas families and employers have access to affordable, comprehensive, and high-quality coverage. We are writing today to express concern with the proposal from this agency that claims be denied for services rendered at servicing locations the provider did not correctly enter into PEMS/PEMS+, and that providers be denied entry into networks if their address is not entered per HHSC's specifications. While we are in agreement that providers should be required to provide all practice locations to the agency, doing so by denying claims and entry into MCO provider networks is unnecessarily punitive, and it would create significant provider abrasion and impede provider cash flow. The policy would also negatively impact MCO requirements related to network adequacy and access to care.

Federal regulations do not require the denial of a claim or bar entry into MCOs' networks when an address is incorrect. HHSC's reference in the document "Federal and State Regulations on Medicaid Provider Address Requirements," slides 4 and 5, reference to 42 CFR §455.104 (b)(1)(i). We are unclear how this applies. The regulation is specific to a "disclosing entity," which is defined as "a Medicaid provider (*other than an individual practitioner or group of practitioners*), or a fiscal agent."[1] Likewise, the slides reference 42 CFR 455.432(b) and .450, which mention specific practice locations, but do not relate to claims requirements or network adequacy, and certainly do not require the denial of claims for incorrect addresses or bar entry into MCO networks.

Assumedly because this is not a federal requirement, other states do not make addresses a fatal edit. In researching the procedures of other states, we have yet to find a single state that uses the threat of denied claims and denied participation in MCO networks to collect addresses from providers. For example, Florida requires MCOs to ensure that the zip code is registered with the state if a provider has more than one practice location, yet as a fixed data element, this is far easier than what this agency is proposing. Other states, such as Arkansas and Mississippi, require denials only if the billing provider NPI is not enrolled through the state agency. These

[1] 42 CFR §455.101.

TAHP
The Texas Association of Health Plans

Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

states have not required MCOs to compare addresses to provider records, nor outreach to providers for their addresses.

Matching claims addresses are currently impossible, and implementation would be extremely difficult. Currently, MCO systems validate provider information submitted on claims based on fixed data elements, such as NPI and tax identification number, to validate the provider's MCO contract and HHSC program enrollment. MCO claim systems do not have the ability to pick up addresses in claims to see if there is a match. Further, there are multiple addresses for any given provider (i.e. billing, financial, office location, etc.), and details of which address HHSC will apply the requirements to have not been shared with the MCOs. Even if those details were provided, addresses vary, and even standardized address systems have flaws. There are abbreviations, optional address lines, and so on. Programming and reconfiguration of claims systems to meet this requirement would take a significant amount of time and financial resources.

This policy would lead to significant provider abrasion, as it is also unworkable for the provider under many circumstances. There are numerous services that are not delivered in the provider's place of business, for example durable medical equipment, home health services, laboratory, and radiology professional component claims. Similarly, for office-based claims, the standardized claim form only includes the provider's billing address—in these cases providers do not have the ability to include the servicing location on the claim form. In addition, providers with non-matching addresses will not show up in MCOs' networks, since the master provider file will reject provider records that do not match. If the master file rejects the records, the provider will not show up in an MCO's network directory and members will not be able to choose those providers. This will cause member abrasion in addition to provider abrasion, and will negatively impact network adequacy and access to care. HHSC has proposed that the MCOs compare the provider addresses in PEMS to the provider addresses in the MCO provider database, and conduct ongoing mass outreach to providers to remediate discrepancies between the two systems. Providers who are in multiple networks would be receiving calls and letters from multiple MCOs, as there would not be a centralized system to coordinate the efforts.

In lieu of adopting this potentially detrimental policy, we ask that the agency reinstate the MCOs' ability to share provider address information with the HHSC subcontractor responsible for provider enrollment. This would allow HHSC to collect address information, complying with federal rules, without the significant provider abrasion and administrative burden

TAHP
The Texas Association of Health Plans

Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

that would result from making addresses a fatal claim edit. The subcontractor could then outreach to applicable providers or present the different addresses to the provider within PEMS for validation, rather than having numerous MCOs reaching out to providers simultaneously. We also ask that HHSC make incorrect provider addresses a warning edit instead of a fatal edit so claims do not reject, and to allow providers to render services until their address can be corrected. This solution would eliminate the anticipated provider abrasion and potential loss of participating Medicaid providers, eliminate unnecessary redundant efforts, and accomplish the goals of the agency.

Sincerely,

Jamie Dudensing, RN
CEO
Texas Association of Health Plans