Simplify processes and enhance care with our Texas Provider Protection Plan

Texas | Medicaid

Our Texas Provider Protection Plan is designed to reduce administrative burdens and enhance care provider experience through streamlined processes, digital options, and comprehensive support. Our approach follows the Texas Health and Human Services Commission (HHSC) Provider Protection Plan. References and resources are provided at the end of this article.

Objectives

Our Texas Provider Protection Plan aims to:

- **Reduce administrative burdens:** streamline and simplify processes for network care providers and nonemergency medical transportation (NEMT) providers
- **Enhance care provider experience:** ensure a supportive environment for care providers interacting with us
- **Optimize enrollment and reimbursement:** facilitate efficient credentialing and claims processing

Plan components

1. **Non-retaliation policy:**
    - We guarantee that care providers can file appeals, complaints, or grievances without fear of retaliation from us.
    - We have established a precise and secure reporting mechanism for care providers to express their concerns safely.
    - Non-retaliation clauses are included in our provider agreements.
    - All our associates participate in comprehensive internal training focused on ethical conduct, emphasizing the importance of non-retaliation.

We offer information in our **Training academy** and the **Provider Manual** which guides reporting concerns or filing complaints, ensuring a streamlined and responsive process.

2. **Timely claims processing:**

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- We process claims according to the timelines and guidelines specified in the UMCM 2.0 Uniform Managed Care Claims Manual.
- Clean claims for Medicaid members are adjudicated within 30 days of the receipt date (10 days for nursing facility units and a percentage of the claims costs). Interest is applied to all claims paid outside the claim's turnaround time.
- We have a comprehensive **Claims Solution Resource Guide**. This valuable resource is used during care provider orientations and training sessions and is accessible 24/7 on our website. This guide educates care providers on avoiding claim issues and provides tips on filing accurate claims. It also includes information about filing and appeal deadlines, rejected versus denied claims, how to submit a claim payment dispute, and information on ERA and EFT.
- The Clear Claim Connection tool allows care providers to preapprove claims with procedure and diagnosis codes, effectively minimizing delays and the need for resubmissions.

3. **Care provider education and training:**
   - We provide new care provider orientations, practice-specific orientations, and monthly webinars on claims submission, preapprovals (PA), appeals, and grievance processes. These can be found on our **Training resources** page.
   - Our provider relationship management representatives conduct regular site visits and offer tailored care provider orientation and training sessions. These personalized services are available upon request to meet the specific needs of our partners.
   - We also have **Provider and facility digital guidelines** on our website, which provide information about our digital platforms and solutions. This includes resources like **https://Availity.com**, electronic data interchange, electronic medical records connections, and business-to-business desktop integration. The guide is available to both participating and non-participating care providers. To ensure easy access to information, the guide also directs care providers to further instructions on the **https://Availity.com**.
   - Comprehensive manuals and materials, aligned with UMCC Section 8.1.4.6, detail our policies and procedures and are accessible online 24/7 in our **resource library**.
   - Provider relationship management representatives lead the quarterly Medicaid Provider Advisory Committee (MPAC) to gather feedback from care providers on their priorities and challenges.

4. **Member access to care:**
   - We adhere to UMCC Section 8.1.3 Access to Care, ensuring timely access to essential healthcare services for all members.
   - We continuously monitor network adequacy and implement corrective actions as necessary.
   - Our Network Adequacy Task Force continuously evaluates our network to ensure members have timely access to medically necessary care. The task force holds monthly meetings with representatives from Provider Network Development, Quality Management, Service Coordination, and other key teams to identify network gaps and enhance access. We also

revise recruitment strategies and, when necessary, approve out-of-network authorizations or arrange transportation if there is a shortage of contracted care providers for the required services.

5. **Prompt credentialing process:**
   - **Digital care provider enrollment** (DPE) is available 24/7 for qualified new care providers. As providers complete the initial enrollment process, our contracting team sends electronic contracts for review and signature. Once credentialing is complete, care providers receive a welcome letter and a copy of their fully executed agreement within 45 days of contract execution.
   - We adhere to state standards for credentialing and re-credentialing according to Sections 8.1.4.4 (Provider Credentialing and Re-credentialing) and expedite credentialing when criteria are met.
   - Our care provider contracts delineate expectations, requirements, and reimbursement methodology according to provider-specific requirements and standards.

6. **Compliance with reapproval standards:**
   - We align with sections 8.1.8 Utilization Management and 8.1.21.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies to ensure preapprovals comply with state and federal standards.
   - Systems are in place to track and expedite routine/non-urgent authorization requests within [three] business days.
   - Care providers receive 30 days' notice before any policy changes, except in cases of suspected fraud, waste, or abuse (FWA).
   - Our UM program has written policies and procedures governing processes for adverse determinations, denials, and appeals according to state guidelines.
   - Standardized UM guidelines across Texas programs streamline the PA process, using technology like Epic Payer Platform for efficient approvals and feedback through the Medical Pre-Authorization Committee (MPAC).
   - We provide a **Prior authorization lookup tool** that allows care providers to look up and identify our preapproval requirements.

7. **Comprehensive care provider website — Availity Essentials:**
   - Our secure website, **https://Availity.com**, provides continuous access to tools designed to streamline care provider operations and minimize administrative burdens. It includes features such as electronic data interchange (EDI), preapproval requests, HIPAA transactions, digital care provider enrollment, demographic updates, and clinical data exchange, all supported by a live chat for immediate assistance.
   - Network care providers have 24/7 access to our Patient360 platform, a dashboard featuring HEDIS® care alerts, preapprovals, prescriptions, care gaps, and other patient information.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

8. **Incorporation of additional measures:**
    - We integrate any additional requirements or measures developed by the Health and Human Services Commission (HHSC) or care provider protection.

Monitoring and Evaluation

We use key performance indicators for ongoing monitoring to ensure the effective implementation of best practices. Care provider feedback is actively sought to refine and enhance our initiatives, ensuring a supportive and effective environment:

- **Proactive identification:** Our operations team identifies care providers experiencing above-average rates of claims not eligible for reimbursement, including coding-related recoveries.
- **Targeted support:** Provider relationship management representatives offer necessary reeducation and personalized support to affected care providers.
- **Weekly analytics reports:** We generate Top 10 Denial reports weekly to pinpoint high volumes of claims not eligible for reimbursement and analyze the underlying causes.
- **Intervention strategy:** Change in Denial reports detect significant increases in claims not eligible for reimbursement within specific periods, allowing for timely interventions.

We are dedicated to transparency, efficiency, and innovation, reinforcing our commitment to leading care provider support and delivering healthcare excellence.

References

Texas HHSC Uniform Managed Care Contract
Amended STAR+PLUS 4
Texas HHSC Uniform Managed Care Manual

Provider resource documents

Claim Solution Resource Guide
Provider and facility digital guidelines
2023 Provider Digital Engagement Supplement
Medicaid/CHIP Provider Manual
Medicaid/CHIP Provider Quick Reference Guide
Nursing Facility Provider Manual