The Pulse

Summer 2020

A Note from CEO, John Wendling

As healthcare providers throughout Texas continue to navigate the COVID-19 pandemic, we must provide more support than ever before to the medically underserved population in our region. We are making significant investments in staffing and technology for the health plan to better serve our members and provider partners – not only for the current crisis, but for many years into the future.

We will hire close to 100 new employees to fill a variety of clinical and non-clinical positions by the end of 2020. About half of the new staff will serve in community and provider outreach positions. We will hire 20 clinical employees to perform care management for members who need help navigating the healthcare insurance system and complying with physician instructions.

We also will upgrade our information technology platform so we can better manage health information and transactions among members and the more than 6,000 physicians and 40 hospitals in our network.

To bring our technology platform and operations services to the region in a more cost-effective manner, we are partnering with Cognizant, one of the world's leading professional services companies.

When we fully implement the Cognizant technology platform in early 2021, PCHP will manage all care management, member services, provider relations, quality

(continued on next page)

HEALTH SERVICES UPDATE

Physician Satisfaction Survey

The Be In Control Program Physician Satisfaction survey is now open and available through **August 14, 2020**. The purpose of this survey is to gather feedback from physicians with Parkland Community Health Plan members enrolled in the Be In Control Program. This program provides additional support to help members manage their asthma or diabetes. We would appreciate direct feedback from providers to understand what is perceived as successful and opportunities for improvement. The survey is available online, Parkland Physician Satisfaction Survey 2020, or via paper mailed to the physician's office.

AVA NORRIS, MBA, BSN, RN
VICE PRESIDENT HEALTH SERVICES

A Note from CEO, John Wendling *(continued from previous page)*

and data analytics in-house. We will use the system to move additional functions in-house in 2022 and 2023.

Expanding our workforce and technology supports the IHI Triple Aim of improving our members' healthcare experience and improving the quality of care and wellbeing for our members, while controlling the cost of care. With the launch of these and other new initiatives, we will improve the member experience and assure responsible stewardship of public funds.

The unique pressures of the pandemic will someday end. The expanded workforce and technology upgrades we are launching during this period will position us to grow over the next five years into a leading community health plan in Texas, renewing relationships across our community and our state.

John W. Wendling
CEO, Parkland Community Health Plan

QUALITY UPDATE

JENIFFER GONZALEZ, DIRECTOR OF QUALITY IMPROVEMENT

NCQA Accreditation

NCQA accreditation is a nationally recognized set of standardized guidelines that consumers, purchasers, and regulators can use to assess managed care plans. PCHP is applying for NCQA Health Plan accreditation in order to standardize their operation against the national standards. Parkland Community Health Plan will begin application for accreditation by Quarter 4, 2021. The focus areas of Health Plan Accreditation are: Policy, Utilization Management, Credentialing, Complaints & Appeals. Please note that providers could be required to participate in some of the accreditation activities.

Performance Improvement Projects (PIP) Status

Please see below PCHP 2019-2020 Performance Improvement status update:

Measure	Description	Status	Due Date
2021 PPV	Emergency department utilization that was potentially preventable	Approved	Jul 23
2018 PPC	Prenatal and postpartum care	In process	Oct 21
2018 WCC	Weight assessment and counseling for nutrition and physical activity for children and adolescents	In process	Oct 21
2019 MWCN	Member with complex needs	In process	Oct 22
2020 ADD	Follow-up care for children prescribed ADHD medication	In process	Oct 23

Provider Quality Forums

Starting in October 2020, PCHP will begin hosting Provider Quality Forums to address subjects like HEDIS, Performance Improvement Projects, Accreditation status, Clinical Practice Guidelines and other relevant subjects, for more information please contact Jeniffer Gonzalez, Director of Quality Improvement, at jeniffer.gonzalez@phhs.org.

HEDIS Season 2020

The HEDIS season 2020 closed on June 15, and our providers with the highest performance may be considered for future incentive payments. Thank you to all providers who participated and responded quickly to our requests.

Provider Recruitment

Would you like to participate in Parkland Community Health Plan Quality Committees? We are looking for the following sub-specialities: Neonatology, Behavioral Health, Surgery, Internist, OB/GYN.

Please note the providers will be paid for their participation. If you are interested please contact Jeniffer Gonzalez, Director of Quality Improvement, at jeniffer.gonzalez@phhs.org.

DR. NNEKA COS-OKPALLA, PHARMD, MBA, DIRECTOR OF PHARMACY

COVID-19

TDI Extends Emergency Rx Rule

On July 16, 2020, the Texas Department of Insurance (TDI) extended its April 1 emergency rule governing coverage of prescription drugs until September 27, 2020. The new rule, 28 TAC §35.2, requires TDI-regulated health plans to:

- Authorize payment for an additional one-time 90-day supply of any drug that is covered or required to be covered and as prescribed under the authority of a licensed health professional, regardless of the date on which the prescription has most recently been filled. This section does not affect laws limiting dispensation of certain drug classes.
- Extend established prior authorization (PA) approvals for 90 days. This applies only to drugs prescribed under the authority of a licensed health professional, excluding controlled substances as defined in the Texas Controlled Substances Act. The adoption order states that the intent of the rule is that plans would update their computer systems to reflect a 90-day extension of PA approvals for qualifying prescription drugs in advance of a refill request. "The provision ensures that enrollees' access to maintenance medications is not at risk due to decreased access to their prescribing health professionals or shortages of staff that may be experienced by plan administrators and cause prior authorization delays during the pandemic."
- Allow prescriptions to be filled at out-of-network pharmacies at no additional cost to the consumer ("copayments, coinsurance, or other cost sharing as if a prescription drug is dispensed in-network") when no reasonably available in-network pharmacy is able to timely dispense a drug. The health benefit plan may direct the enrollee to a particular mail-order pharmacy or an in-network pharmacy that can timely dispense the prescription drug but may not require the enrollee to travel more than 30 miles one-way or visit multiple pharmacies.
- Make alternative drugs available on-formulary or in the same preferred tier when an on formulary or preferred drug is unavailable due to shortage or lack of distribution. PA may not be required for the alternative drug if it has the same active ingredients and yields the same therapeutic effect as the originally-prescribed drug. The health plan may direct the enrollee to another pharmacy or a particular mail-order pharmacy that can timely dispense the prescription drug but may not require the enrollee to travel more than 30 miles one-way or visit multiple pharmacies.
- Waive any requirement for a consumer's signature unless specifically required by law. This does not prohibit a health plan from requiring a prescription drug to be delivered to and orally acknowledged by an adult.
- May not refuse or reduce payment for a prescription drug based solely on the grounds that it was delivered by a local pharmacy to the enrollee. This does not mandate coverage for delivery through UPS, FedEx, the USPS, or other such delivery company. The health plan is not responsible for any delivery fees.

Waiver for Telephonically Renewing Scheduled Drugs

The Texas Medical Board extended through September 2, a waiver allowing providers to telephonically renew scheduled drugs (such as opioids) for patients with chronic pain. The extended waiver continues to allow for telephone refills of a prescription for treatment of chronic pain by a physician with an established chronic pain patient. Ordinarily, there is a prohibition on telephonically renewing prescriptions for scheduled drugs for chronic pain. This is the fourth renewal of this waiver, the most recent of which expired July 5.

In lieu of this and in response to the pandemic, the DEA (Drug Enforcement Agency) adopted a policy on how to prescribe controlled substances to patients during the COVID-19 Public Health Emergency. These policies allow DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients. The decision tree see here only addresses prescribing controlled substances and does not address administering or direct dispensing of controlled substances, including by narcotic treatment programs (OTPs) or hospitals, and summarizes the policies for quick reference. The complete description of all requirements can be accessed at **www.deadiversion.usdoj.gov/coronavirus.html**, and codified in relevant law and regulations. These policies are effective beginning March 31, 2020, and will remain in effect for the duration of the public health emergency, unless DEA specifies an earlier date.

(continued on next page)

COVID-19 *(continued from previous page)*

Drug Shortages

Drug shortages represent an ongoing public health crisis that even predates COVID-19; and this has dramatically impacted all aspects of healthcare delivery. At the onset of the pandemic, there were drug shortage challenges all around the country. To get the most accurate list of these drug shortages, please visit various sites such as the FDA Drug Shortage page, ASHP Drug Shortage page, and Drugs.com Drug Shortage page. We are working very closely with our various partners, HHSC, Vendor drug program and our PBM; Navitus to navigate this world and to make sure our most vulnerable members are taken care of. We are also monitoring the status of medications on back order and have asked VDP to consider alternatives should the need arise. With this in mind, the focus is on those disease states where uncontrolled patients can become hospitalized. The FDA drug shortage website can be accessed here.

Proton Pump Inhibitors (PPIs): Guidelines

Some of the most common disorders encountered in clinical practice are stomach acid related disorders. These can range in severity from a minor inconvenience of heartburn, to life threatening gastrointestinal bleeding. The prevalence of gastroesophageal reflux diseases (GERD) are estimated at 10-20% of the Western population; and for the moderate to severe diseases (with symptoms more than twice weekly) is around 6%. To address these disorders, a variety of treatment strategies are available at a clinician's disposal – these include lifestyle modification, calcium antacids, H2 blockers, proton pump inhibitors (PPIs) and surgical management. Untreated GERD is a risk factor for other complications such as Barrett's Esophagus and esophageal cancer. Epigastric pain can be confused with cardiac chest pain, leading to expensive evaluation and anxiety. PPIs are generally considered safe and effective for the treatment of acid related disorders. There is confusion among patients and providers about the dosing and duration of treatment for various acid related disorders. Concerns have also been raised about the long-term safety and efficacy of these medications. Therefore, the lowest effective dose of the medication is recommended and should be administered for the shortest duration necessary as a rule. However, there are recommendations for dosing in certain clinical scenarios.

The most recent evidence-based guidelines for PPI dosing for several acid related gastrointestinal disorders, as well as some of the risks of prolonged acid suppression will be addressed in this write-up. Usually, the diagnosis of GERD is based on history and physical examination. Lifestyle modifications including weight loss, elevation of head of bed, tobacco and alcohol cessation, avoidance of eating at least three hours before bedtime, and avoidance of acidic foods such caffeine, coffee, chocolate, spicy food, fatty food, citrus and tomatoes, can be recommended under certain circumstances. Endoscopy is rarely indicated for the initial diagnosis. Empiric trial of PPI therapy is appropriate in the setting of typical symptoms, as response to the medication confirms the diagnosis. Counseling plays a huge role in addressing GERD, and advice as weight loss and tobacco cessation will have additional health benefits. However, while the studies generally support a positive benefit of weight loss on GERD symptoms, there is no evidence that trigger avoidance is helpful.

PPIs are the initial treatment of choice for GERD. Dosing should be started at standard dosing (e.g. omeprazole 20 mg or equivalent), once daily before meals in the morning for eight weeks. For patients with partial response, or predominant nighttime symptoms, the timing can be adjusted, or considered for twice a day dosing. Switching to a different PPI can also be considered. An H2 blocker can be added at bedtime, in addition to a PPI, to help with nighttime symptoms if applicable; however, the H2 blocker should not be given in close timing to the PPI, as it can inhibit absorption of the PPI. After eight weeks, the PPI should be discontinued, unless there is evidence of Barrett's esophagus. Long-term PPIa may be necessary for symptom management if other comorbidities are present. If symptoms recur after discontinuation, maintenance dosing with either an H2 blocker or PPI at the lowest effective dose can be pursued. If GERD symptoms cannot be managed with H2 blockers or PPIs, referral and endoscopic evaluation is appropriate. Response to an empiric trial of PPI can confirm the diagnosis. Response can take up to six weeks of daily use. If empiric trial is successful, therapy should be continued indefinitely. Patients with dyspepsia should be tested for H. pylori infection and treated if positive. Patients with dyspepsia who are negative for H. pylori or remain symptomatic after treatment should be treated with once daily dose PPI.

(continued on next page)

COVID-19 *(continued from previous page)*

Patients should be questioned about use of non-steroidal anti-inflammatory drugs (NSAIDS), and their use should be discontinued. If appropriate, cox-2 inhibitors can be substituted. There is no clinical benefit to higher PPI dosing; the medication should be discontinued if the patient does not respond to standard dose daily therapy in eight weeks. PPIs tend to be more effective in managing reflux symptoms than dyspepsia. An erosion of the lining of the either the stomach commonly known as peptic ulcer disease; the treatment will depend on the cause. In ulcers caused by H. pylori infection, two weeks of twice daily dosing of a PPI in conjunction with antibiotics is typical treatment. For treatment of NSAID induced ulcers, PPIs should be continued for at least 8-12 weeks. Long-term maintenance of PPIs should be considered for ulcers that are not attributed to H. pylori or NSAIDS, and these should be treated for 12 weeks. PPIs should also be continued when aspirin or NSAIDS cannot be discontinued. Once daily dosing is adequate for non-H. Pylori ulcers.

In summary, PPIs are some of the most commonly prescribed medications available on the market. They are safe, effective and inexpensive therapies for a variety of acid related conditions, and when used properly can prevent major, life-threatening bleeding complications. It is important to use the correct dose for the correct diagnosis.

In general, PPIs should be used at the lowest effective dose for the shortest period necessary to control symptoms. Periodic trials at dose reduction or elimination should be tried. However, many people do require long-term use of these medications. GERD and dyspepsia can have a major impact on quality of life. There is no reason why patients should suffer from these symptoms due to fears over long-term risk. Several of the conditions noted as potential long-term effects of PPIs are directly related to the acid suppression, rather than the medication itself. Therefore, as acid is more effectively suppressed, the risk will go up, and to an extent, there is some risk with other methods to attain acid suppression.

References

- Guidelines for the Diagnosis and Management of Gastroesophageal Reflux Disease. *The American Journal of Gastroenterology.* 108(2):308-328. March 2013.
- American College of Gastroenterology. Guidelines for Diagnosis and Management of Gastroesophageal Reflux Disease. *American Journal of Gastroenterology.* 108(3):308-328. March 2013.
- Vakil, NB (2019) Peptic ulcer disease: Management. Feldman, M, and Grover, S. Ed. UpToDate. Waltham, MA: UpToDate Inc. **https://www.uptodate.com**. Accessed July 13, 2020.

FWA Pharmacy Outreach

PCHP's PBM, Navitus routinely monitors pharmacy claims activity and dispensing patterns, and compares the claims data with known risk areas related to aberrant billing and fraud, waste, and abuse. If we identify outlier claims activity in comparison to other similarly situated participating pharmacies, we may request additional information in an FWA outlier letter. This letter allows an opportunity for the pharmacy to explain outlier claims. In addition to requesting an independent response to the specific claims patterns noted, we will also request supporting documentation such as:

- Policies
- Procedures
- Accreditations
- Ownership structure

Navitus reviews the above to ensure we have a full understanding of potential causes before considering further action. Pharmacies are encouraged to review the claims submitted and to construct replies addressing the areas of concern identified. Please provide all relevant information and respond to the letter in a timely manner.

The Prior Authorization (PA) Process and Dispensing 72-Hour Emergency Fills

Navitus processes Texas Medicaid pharmacy prior authorizations (PAs) for PCHP. Medications that require PA for these groups will undergo an automated review to determine if the PA criteria are met.

- If all criteria are met, the claim will be approved and paid, and the pharmacy will continue with the dispensing process.
- If the automated review determines that not all criteria are met, the claim will reject and the pharmacy will receive a message indicating that the drug requires prior authorization. The pharmacy should then contact the prescriber to initiate the PA process.

HHSC requires that a 72-hour emergency supply of a prescribed drug be provided only in cases where the following criteria are all met:

(1) PA is required

(2) The provider is not available to submit the PA request

(3) The medication is needed immediately

This requirement applies to non-preferred drugs on the Preferred Drug List (PDL) and/or any drugs subject to a clinical PA. This procedure should not be used for routine and continuous overrides, to circumvent step therapy requirements or for nonemergency medications. This override can be used more than once only if the provider remains unavailable to submit the PA request and reasonable good faith efforts have been made to contact the prescribing prescriber. Pharmacists should assist their patients by notifying and following up with the prescriber for such PA requests. Pharmacists should use their clinical discretion in determining when an emergency supply should be dispensed prior to the PA request. A 72-hour emergency supply is warranted when a medication is needed immediately, without delay (e.g., antibiotics, asthma, etc.). Medications that do not meet the 72-hour emergency supply may include those that do not have an immediate impact (e.g., acne, hepatitis C, and cholesterol treatments). Pharmacies may download 72-hour emergency override instructions from the download page at **www.txvendordrug.com/resources/downloads**.

Provider Relations Contact Information

Provider Relations Hotlines: Available Monday-Friday, 8 AM-5 PM CT

HEALTH*first* **1-888-672-2277** | KIDS*first* **1-888-814-2352**

Providers also have 24-hour service available by utilizing self-service tools such as our interactive voice response (IVR) system and provider portal for eligibility and benefit questions.

Effective July 1, 2020, PCHP Provider Relations territories and contacts transitioned to the following Provider Business Consultants:

Dallas County: Please email PCHP.ProviderRelations@phhs.org to determine assigned PBC

Sherron (Shon) Peace
Sherron.Peace@PHHS.org
214-266-2105

Addison, Allen, Carrolton, Coppell, Denton, Farmers Branch, Frisco, Irving, Lewisville, McKinney, Plano, Prosper, Richardson, Wylie

Teenu Maliyil
Teenu.Maliyil@phhs.org
214.266.2018

Anna, Commerce, Crandall, Farmersville, Forney, Garland, Greenville, Irving, Mesquite, Quinton, Rockwall, Rowlett, Royce City, Seagoville, Sunnyvale

Sabrina Lowery
Sabrina.Lowery@phhs.org
214.266.2126

Balch Springs, Cedar Hill, Corsicana, Desoto, Duncanville, Ennis, Gun Barrel City, Kaufman, Kerens, Lancaster, Mabank, Midlothian, Red Oak, Waxahachie

Provider Relations

As we have shared throughout the year, each quarter, our Provider Relations department will focus on identifying top trends that we would like our provider community to be aware of to promote provider satisfaction and minimize pain points. Please share this information with your staff in an effort to ensure your claims are handled correctly.

The following scenarios impact claim payment delays and/or denials:

- Offices submit claims/bills with different national provider identifier (NPI)/Texas provider identifier (TPI) numbers vs. what is listed on the state's master file causing claim denials.
- Attestation is not updated or completed (please contact Texas Medicaid Health Plans (TMHP) if you receive any correspondence and remember to act immediately).
- Diagnosis/procedure codes do not support modifiers billed – see your manual for additional guidance.
- Provider's address is listed incorrectly in our system resulting in payments being distributed to the incorrect address. Please send any address changes or demographic changes to: pchp.credentialing@phhs.org.

Remember, we are here to help, so please stay connected with your Provider Relations Representative as we focus on improving our communication, education and outreach. Thanks for all you do and we are so glad you are a part of our network.

Contact us:

Claim Inquiries/Claim Research: Customer service representatives and claim rework processors are available 8 AM-5 PM, (Monday-Friday) to assist in real-time. Our CICR department is knowledgeable and trained to assist with the following provider calls: claim status, pay denials/reconsiderations, billing and coding, check tracers, coordination of benefits (COB), voided claims, prior authorization, remittances, appeal status, etc.

HEALTH*first* **1-888-672-2277** | KIDS*first* **1-888-814-2352**

Important Phone Numbers

Provider Relations and Member Services

HEALTH*first*	**1-888-672-2277**
KIDS*first*	**1-888-814-2352**

Extensions

Member Services	5428 | 5432 (Spanish)
Pre-Certification	4021
Provider Relations	5430
Claims	5191
Nurse	4120

Nurse Line

HEALTH*first*	**1-888-667-7890**
KIDS*first*	**1-800-357-6162**

Pharmacy

Navitus	**1-877-908-6023**
Prior Authorization Fax	**1-920-735-5312**

BIN# **610591** | PCN **ADV** | GROUP# **RX8801**

Behavioral Health Benefits	**1-888-800-6799**

Dental

MCNA Dental	**1-855-691-6262**
Denta Quest (Medicaid)	**1-800-516-0165**
Denta Quest (CHIP)	**1-800-508-6775**

Prior Authorization Fax	**1-866-835-9589**
LogistiCare – Medical Transportation *for Medicaid members only*	**1-877-633-8747** (24/7) **1-855-687-3255** (M-F 8-5)
Superior Vision	**1-800-879-6901**
Report Fraud, Waste or Abuse	**1-800-436-6184**