HHSC Uniform Managed Care Manual
HHSC RESPONSE TO COMMENTS

UMCM Chapter 5.28.1 Access to Network Providers Performance Standards

#	Page #	Issue/Concern	Proposed Solution or Language Change	HHSC Response
1.	Lines 118-137	Performance standards and specifications related to Pharmacy, 24 hour Pharmacy, and Mail Order Pharmacy listed in draft UMCM Ch. 5.28.1 (i.e. Performance Standard, Travel Time in Minutes, Distance in miles, etc.) are not consistent with the draft UMCC v2.31 changes	Align the performance standards and specifications related to Pharmacy, 24 hour Pharmacy, and Mail Order Pharmacy in UMCM Ch. 5.28.1 to the UMCC v2.31 changes for Pharmacy Access.	HHSC made changes to the amendment as a result of this comment. HHSC aligned the UMCM Pharmacy portion with each program contract in column B for provider category "Pharmacy" and "24 hour Pharmacy."
2.		LTSS Providers with choice of (2) in each county. How will this be measured if counties are provided without an address on LTSS NCR?		HHSC provides the following information: The county served is captured on the N&C report on line 32. Out-of-state counties are captured on line 33.
3.		Seeking clarification for Nursing Facility. 47-Nursing Home is the provider type listed, but 80-Nursing Home is not included. Should 80-Nursing Home be included as a valid provider type as this is included in the JIP v6.13?		Thank you for your input. HHSC provides the following information: No changes were made to the chapter at this time; however, HHSC will review the provider types included in the provider crosswalk and will make updates as necessary.
4.		For the Therapies - OT PT ST category should the A0 – Speech Therapy provider specialty be pulled in as this category includes OT, PT, S individual therapists?	Recommendation to include this specialty.	Please see response to comment #3.
5.		Provider Specialties are not specifically outlined consistently in the crosswalk.	Recommendation to define supporting provider specialty types that should be included for each provider type to ensure these are all being reported accurately.	Please see response to comment #3.

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6.		Are we including pediatric PCPs in the Pediatric sub-specialty category?		HHSC provides the following information: HHSC will monitor access to pediatricians as a pediatric sub-specialty by capturing Provider Specialty (PS) 37 Pediatrics without limiting the Provider Type (PT) to PT 19 - Physician (D.O.) or PT 20 - Physician (M.D.) because the pediatrician access requirement is found in the specialist section of the contract. Therefore, all providers with the provider specialty (PS) 37-Pediatrics will be included for the pediatric sub-specialty category.
7.		Should 46 Case Management - Mental Retardation 'MR' be included in the Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR) category?		Please see response to comment #3.
8.		Pharmacy Provider standards does not align with the September 1, 2020 Redline UMCC requirements, Section 8.1.3.2 Access to Network Providers. "At the minimum, the MCO must ensure that all m Members have Pharmacy access. The MCO must ensure that access is consistent with 1 Tex. Admin. Code § 353.915."	Update Pharmacy Provider section to be consistent with UMCC requirements.	Please see response to comment #1.

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9.	PCP and Main Dentist Open Panel	Primary Care Provider (PCP) and Main Dentist access standards are indicated as a percentage of membership requiring access to two providers with open panels within the time and distance standards. Superior respectfully disagrees with the exclusion of closed panel providers in the adequacy measurement. Closed panel providers also afford access to membership; therefore, we would expect to also be able to count PCPs and Main Dentists with closed panels towards network adequacy.	Superior requests clarification on whether closed panel PCPs and Main Dentists will be counted towards overall time and distance adequacy standards. If they will not be, Superior recommends including providers with closed panels into time and distance adequacy standards and develop a separate and distinct measure for overall count to include two providers with open panels.	Closed panel PCPs and Main Dentists will not be counted towards overall time and distance network adequacy standards. HHSC respectfully declines to make the suggested change. The UMCM chapter 5.28.1 "Access to Network Providers Performance Standards" stating the 'Provider Count' for Main Dentist and PCP are 'Two (2) with Open Panel,' aligns with the UMCC 8.1.3.2 "Access to Network Providers" and 8.1.4.3 "Access to Network Providers" in the dental contract.
10.	Telehealth / Telemedicine	Telemedicine / telehealth access is not incorporated into overall adequacy measure. In accordance with SMMCAC recommendation and due to the current COVID-19 situation, the use of telemedicine/telehealth is increasing and affords significant access to care. Network adequacy requirements are meant to measure and ensure clients access to health care and telemedicine/telehealth is a modality of service delivery that should count when measuring MCO networks. Telemedicine/telehealth will remain a viable option for clients to access services after regular health care practices resume. Incorporation of these measures would follow suit with the final rule issued by CMS	Superior recommends allowing telemedicine/ telehealth providers in the network to count towards overall adequacy for the service they provide.	HHSC is working on telemedicine/telehealth standards for future use; however, at this time, HHSC respectfully declines to make the suggested change. HHSC provides the following information: The current process is to issue a Corrective Action Plan (CAP) request when performance is not met. The MCO /DMO may request an exception by demonstrating in the CAP Template and through supporting documentation how it provides access to care through Telemedicine.

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		in May 2020 CMS will afford a credit of 10% towards overall adequacy for the provider specialty offering the telehealth service. This provides support for member access to care in rural areas and encourages and accounts for telehealth providers in contracted networks.		
11.	Substance Use Disorder (SUD) - Outpatient	The provider service and type for Substance Use Disorder (SUD) – Outpatient is limiting and will not allow for adequacy to be met due to the provider landscape. It is our understanding that there are under 50 OTP providers identified as providing a Medicaid service and as of early May 2020, there is only one OTP provider that has completed both Medicare and Medicaid enrollment.	Given the progress related to provider enrollment and the existing landscape, Superior's recommendation is to measure Substance Use Disorder (SUD) – Outpatient access using Out-Of-Network Utilization. This would also align with the proposed change to measurement of access for Out-Of-Network SUD Residential Services in Chapter 5.15.	HHSC respectfully declines to make the suggested change.
12.	Attendant Care	Only one Attendant Care provider type is listed towards STAR+PLUS, STAR Kids, and STAR Health access. We believe the second provider type was omitted in error and the standard should also include the provider type 'XN'.	Superior Health Plan recommends updates to include both X2 and XN towards STAR+PLUS, STAR Kids, and STAR Health access.	As a result of this comment, HHSC made the following changes to the provider types for Attendant Care: XN was added to Row 106 and Column L as a provider type for STAR+PLUS, STAR Kids, and STAR Health.
13.	Data Source	Superior Health Plan is seeking clarification regarding which data files will be used to capture access. While data sources are captured in Column X, it is unclear the timing of the files that will be used to measure results.	Superior Health Plan recommends updates to include added detail for both Network & Capacity Report, P file, and membership file to be used– i.e. SFY 2021 Q1 Network & Capacity Report submitted for will be used with membership as of August 31, 2020 to	HHSC respectfully declines to make the suggested change. The MCOs/DMOs should refer to the Deliverables matrix and Enrollment Broker JIP for the frequency of submission.

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			capture access results.	
14.		Moving to a choice of two (2) providers in certain categories is favorable for members, and we understand HHSC's goal in proposing this. However, in any specialty that is scarce, difficult to find in Medicaid, or in a geographic area that is under-served or "Rural" - the plan will be out of compliance on a regular and possible permanent basis and always under CAP.	TCHP proposes that HHSC consider physicians that have telemedicine capabilities to be counted toward 2 provider measurement, in addition to reducing the number of specialties requiring 2 providers.	HHSC respectfully declines to make the suggested change. HHSC provides the following information: The current process is to issue a Corrective Action Plan (CAP) request when performance is not met. The MCO /DMO may request an exception by demonstrating in the CAP Template and through supporting documentation how it provides access to care through telemedicine. In addition, the provider count is in alignment with Tex. Admin. Code § 353.411.
15.	2	We have provided feedback and examples to HHSC and MAXIMUS regarding the long-standing issue of the MPF taxonomies not matching what is listed in NPPES. We performed a comparison on 3/24/2020 and shared the results of the unmatched records with HHSC. Since taxonomies directly affect our provider file processes and now the performance standards, we are requesting guidance on how to align the two sources, so that all taxonomies are up to date and accurate.	Solution taxonomy alignment issue before enforcing performance standard.	Please see response to comment #3.