DOCUMENT HISTORY LOG

| **STATUS1** | **DOCUMENT REVISION2** | **EFFECTIVE DATE** | **DESCRIPTION3** |
| --- | --- | --- | --- |
| Baseline | 2.0 | December 1, 2013 | Initial version Uniform Managed Care Manual Chapter 5.15, “Special Exception Request Template for Variance from Mileage or Out-of-Network Utilization Standards.”  Chapter 5.15 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, and 529-12-0003. |
| Revision | 2.1 | August 15, 2014 | Instructions are modified to add additional considerations for determining whether to grant a special exception.  Template Header is modified to add Program(s), Plan Code(s), and Service Area.  Exceptions Requested is modified to include MCO performance and to clarify the examples.  Justification for Exception is modified to update a cross-reference.  Plan for Ensuring Access to Covered Services #4 is modified to require supporting documentation and a description of other non-financial contract terms the MCO offered the providers/facilities.  Plan for Ensuring Access to Covered Services #5 is added and subsequent items renumbered.  Plan for Ensuring Access to Covered Services #8 is modified to change “additional information” to “additional documentation.”  Chapter 5.15 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042. |
| Revision | 2.2 | October 15, 2014 | Revision 2.2 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.  “Applicability of Chapter 5.15” is modified to add the Medicare-Medicaid Dual Demonstration. |
| Revision | 2.3 | January 15, 2016 | Revision 2.3 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.  “Applicability of Chapter 5.15” is modified to add STAR Kids.  Template is modified to add a row for “Date Submitted”. |
| Revision | 2.4 | May 30, 2019 | Revision to 2.4 is modified to remove mileage variance. |
| Revision | 2.4.1 | October 15, 2019 | Accessibility approved version. |
| Revision | 2.5 | September 18, 2020 | Template is modified to add the exception request option for Out-of-Network SUD Residential Services variances from the utilization standard. |

**1** Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

2  Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.

# Applicability of Chapter 5.15

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS (including the Medicare-Medicaid Dual Demonstration), STAR Health, STAR Kids, CHIP, Children’s Medicaid Dental Services, or CHIP Dental Services. In this chapter, references to “CHIP” or the “CHIP Managed Care Program(s)” apply to the CHIP and CHIP Dental Services. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Health, STAR Kids, and Children’s Medicaid Dental Services Programs. For purposes of this Chapter, the term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), Dental Contractors, insurers, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all Programs, except where noted.

## Instructions

An MCO must complete this form each time it requests a variance from the Medicaid or CHIP out-of-network utilization standards for each service area. The MCO must submit this form for each special exception request.

The MCO must submit this form no later than 30 Days after the end of the State Fiscal Quarter (SFQ) for which it requests a variance. With the request, the MCO can also request a special exception for up to three subsequent SFQs. For example, to request a special exception for the SFQ1 and SFQ2, the MCO must submit this form no later than 30 Days after the end of SFQ1. HHSC will determine the number of requested SFQs for which to grant an approval.

In addition to reviewing the information and documentation submitted with the request, HHSC will also consider the following information when determining whether to grant a special exception (1 Tex. Admin. Code § 353.4 (for Medicaid) and 1 Tex. Admin. Code § 370.604 (for CHIP)):

* The MCO's 24-month history of claims payment timeliness
* The MCO's 24-month history of Provider Complaints
* The MCO's solvency status

If HHSC approves the MCO’s request for special exception, the MCO must submit, within five Business Days, a second report to exclude the data for which the special exception was approved. For example, the MCO must submit the OON Utilization Report required in UMCM Chapter 5.3.8 to exclude the specific Out-of-Network (OON) provider for which the special exception was approved. Refer to UMCM Chapters 5.0 and 5.1 for reporting submission requirements.

|  |  |
| --- | --- |
| **MCO:** |  |
| **Requested SFQ(s):** |  |
| **Service Area(s):** |  |
| **Program(s):** |  |
| **Plan Code(s):** |  |
| **Date Submitted:** |  |

|  |  |
| --- | --- |
| **Exception Requested:**  **(Select one)** | Out-of-Network (OON) Hospital Admissions variance from utilization standard  Out-of-Network (OON) Emergency Room Visits variance from utilization standard  Out-of-Network (OON) Other Outpatient Services variance from utilization standard  Out-of-Network (OON) SUD Residential Services variance from utilization standard |
| Identify the Performance Standard and include the MCO performance for which the MCO is requesting a variance and provider types.  **Example:**  **Performance Standard:** No more than 15% of total hospital admissions may occur in OON facilities.  **MCO Performance:** The MCO performance for the quarter is 23%.  **Provider Type(s):** Acute care hospital | |
| **Performance Standard:**  **MCO Performance:** | |

|  |  |
| --- | --- |
| **Justification for Exception:**  **(Select all that apply)** | Lack of Providers in Service Area  Unsuccessful Contracting Efforts  Other (explain in Question #8 below) |

|  |  |
| --- | --- |
| **Plan for Ensuring Access to Covered Services:**  **(Complete this section for each exception requested. Attach additional pages if necessary.)** | 1. Are there providers/facilities located within the Service Area with which the MCO has not contracted? Provide their names and addresses (and telephone numbers, if available). Identify whether the providers are enrolled with Texas Medicaid. |
| 1. If the MCO answered yes to Question 1, what sources of information did it rely on to identify the providers/facilities (or lack thereof)? HHSC must be able to verify the sources. Provide the full citation of the sources and the location of the specific information. |
| 1. If the MCO answered yes to Question 1, explain why it has not contracted with the providers/facilities within the Service Area. |
| 1. If the MCO answered yes to Question 1, explain all efforts the MCO has made in the preceding 12 months to contract with providers/facilities within the Service Area, and provide supporting documentation. Include dates, the number of contracting attempts, rates offered, and a description of why contracting efforts were not successful. Describe other, non-financial contract terms the MCO offered the providers/facilities, including those relating to prior authorization and utilization management. The MCO does not need to include contracting efforts with providers who are not enrolled with Texas Medicaid. If the MCO has encouraged providers to enroll in Texas Medicaid, the MCO should describe these efforts. |
| 1. Include the MCO's history of overturned claims denials for the OON exception request within the last 24 months in the Service Area. |
| 1. Explain how the MCO will provide access to Covered Services within the Service Area. |
| 1. Is the MCO proposing to use “alternate” providers/facilities to provide the Covered Services? If yes, include written assurance that the alternate provider/facility: (a) is currently providing Covered Services to Medicaid/CHIP beneficiaries and (b) is willing to provide these Covered Services to the MCO’s Members. Provide documentation that the alternate provider/facility meets all license, education, and experience requirements to meet MCO’s credentialing policies and procedures and meets all state and federal laws and requirements that apply to the identified services. List the contracted alternate providers/facilities below, as well as the next nearest providers/facilities. |
| 1. Provide any additional documentation to support the MCO’s justification for requesting a special exception or plan for ensuring access to care. For example, did an unusual number of Members receive emergency services from OON providers outside of the MCO’s Service Area? |