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

July 13, 2026

Health and Human Services Commission,

Texas Association of Health Plans appreciates the opportunity to comment on the proposed UMCM Chapter 3.36. Several aspects of the draft are welcome and reflect good practice: the built-in opportunity to cure a data deficiency before liquidated damages attach, the commitment to publish future data quality requirements through an update to this chapter with corresponding MCO Hub notice, and the 120-day compliance window following any new requirement. We support these provisions as drafted. Our comments below are narrower, and focus on ensuring that this chapter operates as an enforcement mechanism for existing HHSC data standards rather than as an independent, and potentially conflicting, source of new requirements.

1. HHSC's Existing Encounter Data and Claims Requirements Should Control

Section VI provides that federal or state statute or rule supersedes the Chapter in the event of a conflict, but says nothing about conflicts between the Chapter and HHSC's own existing encounter data infrastructure, such as the Encounter Data Companion Guides, the HHSC SCAN Call process, and related edit determinations. Those processes already establish which fields are required on encounter data and claims, and MCOs' systems and edits are built around them. We recommend adding a parallel provision stating that where a data quality requirement or field designation in this Chapter conflicts with HHSC's Companion Guides or other HHSC-established encounter or claims requirements, HHSC's requirements control unless and until HHSC itself amends them.

We also object to Section VI's conflict-notification process and recommend that it be struck entirely. If this Chapter faithfully implements HHSC's existing requirements, as Section II states it is intended to do, there should be no conflicts to identify in the first place. A conflict arises only where OIG has, intentionally or not, imposed a data standard HHSC has not adopted. It is not appropriate to place the burden of surfacing that discrepancy on the MCO, nor to make the existence of a conflict turn on the OIG's own written agreement that one exists. The language requiring MCO notification and OIG validation of a conflict should be removed, and replaced with the provision proposed above: HHSC's existing requirements control automatically in the event of any conflict, without any MCO notification obligation or HHS OIG sign-off.

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

2. Clarify Coordination Between HHS OIG and HHSC Oversight of the Same Data

We appreciate that Section V already commits the OIG to coordinating with HHSC before assessing IG-13, to confirm HHSC is not separately pursuing ED-1 for the same noncompliance. We ask that this coordination be extended beyond liquidated-damages deconfliction to the underlying data quality determination itself. In other words, before HHS OIG treats a field as deficient under this Chapter, it should confirm with HHSC whether that field is, in fact, a current HHSC requirement (including current edit status, e.g., warning vs. fatal). This avoids a scenario where OIG holds an MCO to a standard HHSC has not yet adopted or enforced.

3. The Rendering Provider NPI Requirement 1 Needs a Carve-Out

Table 1 states the rendering provider field "may not be left blank or populated with the billing provider's NPI or name" when rendering provider information is required. Both examples given (critical care in an ED, speech therapy) involve professional claims where a distinct rendering individual clearly exists. The requirement as written doesn't account for the many circumstances, such as FQHCs, RHCs, and other ancillary or facility billing arrangements (e.g., DME), where HHSC's own Companion Guides and current encounter edit logic recognize that there is no separate rendering provider distinct from the billing provider, and where the billing provider's NPI is the accepted entry. We request that Table 1 be revised to expressly exclude scenarios where HHSC's own edits currently permit billing provider information in this field

TAHP supports HHS OIG's goal of ensuring accurate encounter and claims data for fraud, waste, and abuse detection. Our concern is that this chapter should enforce HHSC's existing data standards, not create a second, independently defined one that MCOs must reconcile on their own. Adopting the changes proposed above would resolve this without limiting HHS OIG's ability to identify and correct genuine data deficiencies. We welcome the opportunity to discuss these comments further before the chapter is finalized.

Sincerely,

Jamie Dudensing, RN
CEO, Texas Association of Health Plans