UNIFORM MANAGED CARE MANUAL 4.7
Value-Added Services Template Instructions Version 2.3

Document History Log

STATUS [1]	DOCUMENT REVISION [2]	EFFECTIVE DATE	DESCRIPTION [3]
Baseline	2.0	March 15, 2015	Initial version Uniform Managed Care Manual Chapter 4.7 "Physical and Behavioral Health Value-Added Services Instructions." Version 2.0 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.
Revision	2.1	April 1, 2015	Section I "Applicability of Chapter" is revised to remove applicability to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. Revision 2.1 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	September 1, 2015	Section I "Applicability of Chapter" is revised to add applicability to STAR Kids. Revision 2.2 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, and 529-13-0071.
Revision	2.3	April 1, 2023	Section IV is modified to remove the requirement to enter "N/A" if the MCO does not offer a Value-added Service from the General Category list. Section V "Data Entry Instructions" is modified to prohibit submission of a proposed Value-added Service under more than one category, require additional information for a proposed Value-added service under the Gift Program General Category, and promote accessibility. Appendix A is modified to update the categories. The title of Appendix A is modified for clarity.

Revision	2.4	January 30, 2024	Section V “Data Entry Instructions” is revised to include instructions on how to complete the value-added services table for the general category, applicable programs and whether a value-added service was previously approved.

[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represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.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.

I. Applicability of Chapter

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, CHIP, and STAR Kids programs, and Dental Contractors providing Children's Medicaid and CHIP Dental Services to Members through dental health plans. In this chapter, references to "CHIP" or the "CHIP Managed Care Program(s)" apply to the CHIP Program and the CHIP Dental Contractors. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS, and STAR Kids Programs, and the Medicaid Dental Contractors. The term "MCO" includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Dental Contractors, 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.

II. Objective

Managed Care Organizations (MCOs) contracting with the State of Texas to provide comprehensive health care services to qualified Program recipients must submit the Value-Added Services (VAS) Template in accordance with the Contract for services between HHSC and the MCO, and in accordance with the instructions below. HHSC will use the data in the VAS templates for comparison charts for managed care Members. Ad Hoc reports may be requested by HHSC as needed.

III. General

Value-added Services is defined in Attachment A to the applicable MCO Contract.

IV. VAS Template

The Value-Added Services Templates (UMCM Chapters 4.5 "Physical and Behavioral Health Value-added Services Template" and 4.4 "Dental Value-added Services Template") must be completed according to the instructions provided by HHSC. Chapter 4.4 is for Dental Contractors' use and Chapter 4.5 is for all other MCOs.

HHSC will provide the VAS Template to the MCOs in Word format. Document integrity is critical to the automated compilation of this data.

MCOs must follow the instructions in the bullets below:

- Only one template is required for each MCO. MCOs should not submit individual templates for each program or Service Area.
- The MCO must fill out a VAS table of the correct type (i.e. Physical Health, Behavioral Health, Medicaid Dental, or CHIP Dental) for each VAS they are offering.
- MCOs will copy one table for each VAS submitted for that particular type (Physical Health, Behavioral Health, Medicaid Dental, or CHIP Dental).
- The MCO may copy and paste additional VAS tables as needed, but the integrity of the table must not be changed.
- MCOs must add additional tables for general categories with more than one VAS item.
- MCOs must enter "N/A" if it does not offer the VAS for a specific program.
- MCOs may not add additional general category descriptions.

V. Data Entry Instructions

Please follow the instructions for each section listed below. The data should be submitted at the Program level.

1) MCO Information

MCOs must fill in the blank spaces under page 2

MCO/Dental Contractor*:* MCO Name

Period Covered: Date the VAS is applicable. Please note whether the period applies to the beginning of the state fiscal year (SFY) or midyear.

MCOs may propose to either add new value-added services or to enhance its approved value-added services during midyear submissions. MCOs may not propose to delete, limit, or restrict any of its SFY approved value-added services during midyear submissions.

MCO/Dental Contractor Contact: MCO contact that can respond to any questions regarding information included in the VAS template.

MCO/Dental Contractor Contact Email*:* Email address for MCO contact

MCO/Dental Contractor Contact Phone Number: Office number for MCO contact

Fill in the MCO/Dental Contractor Name and Period covered in the footer of the Word document. MCOs will submit one Word document for all Programs to HHSC staff for

approval. MCOs can submit any number of VAS proposals--to do so, copy the applicable VAS tables as many times as needed in each document.

2) VAS Tables

Please follow the instructions below for the following tables.

- **VAS Summary – Physical and Behavioral Health Services**
- **VAS Summary – Medicaid/CHIP Dental Services**

Note: The Medicaid/CHIP Dental table has the same elements as the Physical/Behavioral Health tables with the exception of “Applicable Service Areas”.

a) General Category

The General Category column describes general categories used in the Program comparison charts for managed care clients. MCOs must fit their proposed VAS into one of the general categories in Appendix A. A proposed VAS may not be submitted under more than one category. MCOs may submit multiple VAS submissions for each general category as long as a new table is created for each VAS. If a new table is created, the MCOs must include the General Category to which it belongs. This row will repeat at the top of each table for identification purposes.

The Brief Title section describes the proposed VAS in each section. MCOs should provide a short title for each proposed VAS in addition to the general category.

b) Description of Value-added Services and Members Eligible to Receive the Services

The Description column includes a detailed description of the VAS offered. If the proposed VAS is submitted with Gift Programs as the General Category in section (a), the MCO must include a description of how the proposed VAS will promote healthy lifestyles and improve health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific health goals or other programs approved by HHSC, such as support for Members to increase independence and maintain success in home and community-based settings.

c) Applicable Programs

Identify which applicable Programs/Comparison Charts for the VAS. MCOs will be required to provide a response to whether or not a VAS item applies for each Program/Comparison Chart listed by inserting “yes”, “no”, or “N/A”.

- CHIP
- STAR
- STAR+PLUS Medicaid Only
- STAR+PLUS Dual Eligibles
- STAR+PLUS Nursing Facility Medicaid Only
- STAR+PLUS Nursing Facility Dual Eligibles
- Medicare-Medicaid Plan – Members in a Nursing Facility
- Medicare-Medicaid Plan – Members in the Community

For items d) – h) and j) – k), please provide responses for all programs or type in "N/A" if not applicable.

d) Applicable Service Areas

List all service areas the VAS applies to for each program/subtype.

e) Limitations or Restrictions

Please list any limitations/restrictions for each program including but not limited to:

- Age, for ages please specify whether it applies to a specific age group. If the VAS applies to a range, please specify if it is up to a certain age by using this format, "age x through y". HHSC will interpret this to mean that the VAS applies to Members until the last month of their y birthday. Do not use the terms "under" or "over" in your age limitations.
- Gender;
- Dollar amounts;
- Time limits;
- Visits;
- Program level restrictions including but not limited to:
  - CHIP Perinate newborns versus unborn child
  - STAR+PLUS waiver and STAR+PLUS non-waiver Members

f) Proposed Comparison Chart Language

Provide proposed comparison chart language that includes a description of the Value-added service as well as limitations. The proposed language should be written at a sixth- grade reading level and should not exceed 170 characters including spaces.

g) Is this a new VAS or previously approved VAS?

The MCO should describe whether or not the proposed was previously approved. If not,

please insert “new”. If previously approved, please note whether or not there have been any changes made. If no changes have been made, please insert “previously approved unchanged”. If changes have been made, please insert “previously approved changed” and describe changes.

h) Date initially approved

If this VAS was previously approved, state the period (SFY or midyear SFY) it was approved by HHSC staff. Please use the date the MCO received the approval email from HHSC staff.

i) Describe how the MCO will identify the Value-added Service in administrative data (Encounter Data). (if there is a difference by Program, make sure it is noted)

The Encounter Data column should include information on how the MCO will identify the VAS in administrative data (encounter data), as well as the applicable financial arrangement code and description. The information should include Healthcare Procedure Coding System Codes (HCPCS) if applicable. If the VAS is not identified in in encounter data, please submit a description of how it will be accounted for in the financial statistical report (FSR). Only one response is needed for all Programs, unless there is a difference at the Program level.

j) Are any of these codes in the Texas Medicaid Provider Procedures Manual (TMPPM) or CHIP Explanation of Coverage (EOC)?

Describe whether or not the VAS is included as a Medicaid/CHIP covered service or is similar to a Medicaid/CHIP covered service or benefit. Refer to the managed care contracts, Texas Medicaid Provider Procedures Manual, and the CHIP Explanation of Coverage for covered services. MCOs should respond “yes” if the VAS is the same or similar to a service in one of the above mentioned locations. Otherwise mark “no”.

k) If so, how is the VAS different than the covered benefit?

If a MCO responded “yes” to j), describe how the VAS goes above and beyond what is already covered, or if there are different prior authorization requirements that apply.

l) Entity Responsible for Providing this Service (if there is a difference by Program, make sure it is noted)

Describe which entity is responsible for providing this service including any subcontractors.

m) How and when will Providers be notified about the availability of VAS (if there is a difference by Program, make sure it is noted)

Describe how and when providers will be notified about the availability of the VAS.

n) How and when will Members be notified about the availability of VAS (if there is a difference by Program, make sure it is noted)

Describe how and when Members will be notified about the availability of the VAS.

o) How may a Member obtain or access the VAS? (if there is a difference by Program, make sure it is noted)

Describe how a Member may obtain or access the VAS. The MCO should consider how the proposed VAS can be made available to members who may have accessibility challenges including age, literacy, language, visual or hearing limitations, or difficulty with technology. Provide responses to the following questions:

- Is there a trigger (e.g. claim filed, Member referral, or encounter data) that notifies the MCO that a VAS needs to be provided to a Member?
- Describe when the Member will receive the VAS.
    - Does the Member need to submit a voucher to obtain the VAS?
- How long after the request will a Member receive a VAS?
    - Can the Member receive a VAS if they meet all conditions in one month, but are disenrolled from the plan the next month?

APPENDIX A: General Categories

Physical and Behavioral Health Categories

- 24-Hour Nurse Line
- Alzheimer's Care
- Behavioral Health
- Behavioral Health – Inpatient Follow-up Incentive Program
- Behavioral Health – Online Mental Health Resources
- Behavioral Health – Off-site Services
- Disease Management
- Drug Store Services/Over-the-Counter Benefits
- Emergency Response Services (ERS)
- Extra Dental Services for Adults (age 21 and older) and Pregnant Women
- Extra Foot Doctor (Podiatry) Services
- Extra Help for Individuals with Intellectual or Developmental Disabilities
- Extra Help for Pregnant Women
- Extra Help Getting a Ride (when state services are not available)
- Extra Vision Services
- Gift Programs
- Health and Wellness Services
- Healthy Play and Exercise Programs
- Help for Members with Asthma
- Home Visits
- Pest Control
- Short-term Phone Help
- Sports and School Physicals

Dental Categories

- Dental care kit
- Gift Programs