TEXAS Health and Human Services

Coverage of Services Not in the Texas Medicaid State Plan

In some cases, Texas Medicaid Managed Care Organizations (MCOs) cover services that are not included in the Medicaid State Plan.

These services fall into specific categories: services covered due to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), in-lieu-of services, case-by-case services, value-added services, medically necessary Centers for Medicare and Medicaid Services (CMS)-covered outpatient drugs not yet on the Texas Medicaid formulary, and durable medical equipment (DME) covered under the Home Health DME and Supplies Exceptional Circumstances provision.

Below is an overview of these categories, followed by a chart with cited sources for this information.

Services covered due to EPSDT

- Section 1905(r) of the Social Security Act mandates that all Medicaid eligible beneficiaries age 20 and younger receive medically necessary services to treat, correct and ameliorate illnesses and conditions identified in an EPSDT screening, if the service is covered in the state's Medicaid plan or if the service is allowable as a Medicaid state plan benefit by CMS.
  - Exceptions include: experimental or investigational treatment, services or items not generally accepted as effective and/or not within the normal course and duration of treatment, and services for the caregiver or provider convenience.
- In Texas, this is known as the Texas Health Steps Comprehensive Care Program (CCP).
  - If a Medicaid member, age 20 or younger, is screened through THSteps and determined to have medical necessity for a service that is not included in the Texas Medicaid State Plan or goes beyond the limits of the State Plan or Texas Medicaid Provider Procedures Manual, but is allowable by CMS, then those services must be covered under EPSDT.
  - Providers must submit prior authorization and supporting documentation when requesting a medically necessary service if the service is not

addressed in the Texas Medicaid Provider Procedures Manual (TMPPM) and the client is 20 years of age or younger.
  - Services covered under EPSDT are included in the rate setting process.

In-lieu-of services

- In-lieu-of services are not covered in the Medicaid State Plan but are offered in lieu of a covered service or setting. In-lieu-of services must be approved by HHSC and are outlined in MCO contracts listed in the table below. In-lieu-of services are included in the rate setting process.
- Allowable in-lieu-of services in Texas are inpatient mental health care provided at an institution for mental disease (IMD) in lieu of an acute care hospital for members ages 21-64, certain services in chemical dependency treatment facilities for substance use disorder treatment in lieu of an acute care hospital.
  - As part of the implementation of SB 1177, 86th Legislature, Regular Session, 2019, HHSC is evaluating additional evidence-based behavioral health services for cost-effectiveness to be offered in-lieu-of existing state plan services when medically appropriate. HHSC anticipates corresponding contract amendments to be effective in state fiscal year 2021.

Case-by-case services

- MCOs may offer individual members additional benefits that are outside the scope of services. These services may be based on medical necessity, cost-effectiveness, the wishes of the member or the member's family, or the potential for improving the member's health status. For STAR+PLUS, STAR Kids, and STAR Health members, these case-by-case services may also be based on functional necessity.
- Case-by-case services are not included in the rate-setting process and do not require HHSC approval. MCOs may choose to offer case-by-case services in appropriate situations to any of their members but are not required to do so. MCOs often choose to provide case-by-case services for a variety of reasons such as improvement of health status or cost-effectiveness.
- MCOs may use current capitation to provide case-by-case services, but case-by-case services may not be included in encounter data for future rate setting processes. Case-by-case services and benefits cannot increase the cost borne or capitation rates paid by HHSC and cannot violate any other state or federal rule or regulation. The MCO must maintain documentation of each authorized case-by-case service provided to each member.

Value-added services

- Value-added services or benefits are additional services proposed by MCOs, within specified programs and service areas, and generally available to all members who meet the MCO's qualification criteria for the service.
  - Value-added services may be actual health care services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improved health outcomes among members. Best practice approaches to delivering covered services are not considered value-added services.
- These services and benefits must be approved by HHSC.
- Any value-added services that MCOs elect to provide must be provided at no additional cost to HHSC.
  - The costs of value-added services are not reportable as allowable medical or administrative expenses, and therefore are not factored into the rate setting process.
  - Value-added services must be included in encounter data and are designated with Financial Arrangement Code (FAC) '11'.
- In addition, MCOs may not pass on the cost of the value-added services to members or providers.

Medically necessary CMS-covered outpatient drugs not yet on the Texas Medicaid formulary

- MCOs must cover CMS-covered outpatient drugs not yet on the Vendor Drug Program formulary if the drugs are medically necessary and prescribed by a qualified provider. CMS-covered outpatient drugs not yet on the Vendor Drug Program formulary are included in the rate-setting process.
- Drugs that are not federally rebateable may be covered for members 20 years and younger under EPSDT. For members 21 years and older, MCOs may offer coverage to individual members as a case-by-case service.

DME covered under the Home Health DME and Supplies Exceptional Circumstances provision

- The Home Health DME and Supplies Exceptional Circumstances provision, a requirement for MCOs to deliver home healthcare services in accordance with 42 Code of Federal Regulations (CFR) §440.70, was added to the managed care contracts listed in the table below in September 2018. DME provided under this provision of the CFR are included in the rate setting process.
- Additional information about DME covered under the home health DME and supplies exceptional circumstances provision is available in the MCO Notice

titled, "Home Health Durable Medical Equipment and Supplies Exceptional Circumstances Provision" and delivered on December 10, 2020.

Federal Authority	State Authority	Description
Services covered due to EPSDT		
Section 1905(r)(5) of the Social Security Act	• Uniform Managed Care Contract (UMCC), STAR+PLUS Expansion, STAR+PLUS MRSA, STAR Health, and STAR Kids Contracts, Attachment A • TMPPM Children's Services Handbook, Section 2, "Medicaid Children's Services Comprehensive Care Program (CCP)"	Services that are not covered by the Texas Medicaid State Plan but are considered an allowable service by CMS may be covered due to EPSDT if medical necessity criteria are met. The only time a service for members under 21 would not be considered for coverage under EPSDT is if the service was not considered an allowable service by CMS.
In-lieu-of services		
42 CFR §438.3(e)(2)	• Texas Government Code § 533.005(g) • UMCC ▸ Attachment B-2, ▸ Attachment B-2.2 ▸ 8.1.15.7.1, "Psychiatric Services" • STAR+PLUS Expansion, STAR+PLUS MRSA, and STAR Health Contracts, ▸ Attachment B-2 ▸ 8.1.15.7.1, "Psychiatric Services" • STAR Kids Contract, Attachment B-2 • Section 1115 demonstration waiver, "Texas Healthcare Transformation and Quality Improvement Program"	A service or setting that is not covered in the state plan and offered in lieu of a covered service or setting. In Texas, allowable in lieu of services are services provided in Institutions of Mental Diseases (IMDs) in lieu of acute care hospitals, and certain services in chemical dependency treatment facilities for substance use disorder treatment in lieu of acute care hospitals.
Case-by-case services		
42 CFR §438.3(e)(1)	• 1 Texas Administrative Code (TAC) §353.409 • UMCC, STAR+PLUS Expansion, STAR+PLUS MRSA, and STAR Health Contracts, 8.1.2.2, "Case-by-Case Services"	A service that is not covered in the state plan or by EPSDT, does not have to be approved by HHSC, and does not have to be provided to all MCO members. Case-by-case

Federal Authority	State Authority	Description
	• STAR Kids Contract, §8.1.2.4, "Case-by-Case Services"	services may include services and benefits that are not otherwise covered by Texas Medicaid. Case-by-case services are not included in the capitation rate.
Value-added services		

42 CFR §438.3(e)(1)	• 1 TAC §353.409;
	• UMCC, STAR+PLUS Expansion
	• STAR+PLUS MRSA, and STAR Health Contracts
	  ▸ Attachment A
	  ▸ §8.1.2.1, "Value-added Services"
	• STAR Kids Contract,
	  ▸ Attachment A
	  ▸ §8.1.2.3, "Value-added Services"
		A service that is not covered in the state plan and offered by an MCO to all of their members who meet the eligibility criteria for the service in a specific MCO program and service area. Examples include car seats and bike helmets.

Medically necessary CMS covered outpatient drugs not yet on the Texas Medicaid formulary (pharmacy)		
42 USC §1396r-8(a)(1), (k)(2); 42 CFR §438.3(s)	• 1 TAC §353.905(a) • Uniform Managed Care Manual (UMCM) Chapter 2.2, Section I, "Medically Necessary Non-Formulary Drug" • UMCC §8.1.21, "Pharmacy Services" • STAR+PLUS Expansion Contract, §8.1.42, "Pharmacy Services" • STAR+PLUS MRSA Contract, §8.1.16, "Pharmacy Services" • STAR Kids Contract, §8.1.17, "Pharmacy Services" • STAR Health Contract, §8.1.20, "Pharmacy Services"	CMS-covered outpatient drugs not yet on the formulary must be approved by MCOs if medically necessary and prescribed by a qualified provider. These drugs are included in the rate-setting process because federal regulation requires HHSC to pay for them.
DME covered under the Home Health DME and Supplies Exceptional Circumstances provision		
42 CFR §440.70 (b)(3)(v)	• 1 TAC §354.1039(a)(4)(D) • UMCC	The Home Health DME and Supplies Exceptional

Federal Authority	State Authority	Description
	▸ Attachment B-2 ▸ Attachment B-2.2 ● STAR+PLUS Expansion, STAR+PLUS MRSA, STAR Health, and STAR Kids Contracts ▸ Attachment B-2 ● TMPPM, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, Section 2.2.3 "Home Health DME and Supplies Exceptional Circumstances Provision"	Circumstances provision is a requirement for MCOs to deliver home healthcare services in accordance with 42 CFR §440.70.

	Included in rate setting process?	Allowable cost/ expense?[i]	Offered to all plan members who meet eligibility criteria?	Set or approved by HHSC?
Services covered due to EPSDT	Yes	Yes	Yes	No
In-lieu-of services	Yes	Yes	No	Yes
Case-by-case services	No	No	No	No
Value-added services	No	No	Yes	Yes
Medically necessary CMS-covered outpatient drugs not yet on the Texas Medicaid formulary (pharmacy)	Yes	Yes	No	Yes
DME covered under the Home Health DME and Supplies Exceptional Circumstances provision	Yes	Yes	Yes	No

[i] Allowable cost: Chapter 6.1 of the UMCM: Allowable cost means a cost that is allocable to the Contract if: (a) the goods or services involved are specifically chargeable or assignable to the Contract in accordance with relative benefits received, (b) all activities which benefit from MCO's indirect cost will receive an appropriate allocation of indirect costs, (c) any cost allocable to the Contract under the principles provided for in this document may not be charged to other contracts to overcome deficiencies, to avoid restrictions imposed by law or terms of such contracts, or for other reasons.

Allowable expense: Attachment A of UMCC: Allowable Expenses means all expenses related to the Contract between HHSC and the MCO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with the Uniform Managed Care Manual's "Cost Principles for Expenses."
Allowable costs/expenses govern what can be included in the calculation of net income. Value-added and case-by-case services are included in the Financial Statistical Report but on an informational basis only.