

# Glossary



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***Abuse***

Provider or client practices that result in unnecessary costs to Medicaid—including reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care and actions that are inconsistent with sound fiscal, business or medical practices.

***Accelerated Monitoring***

A contractual non-compliance remedy that utilizes more frequent or extensive monitoring than standard monitoring practices. Examples of accelerated monitoring practices include additional reporting requirements, escalated corrective action plans (CAPs) and onsite reviews.

***Access-based Fee (ABF)***

Under the fee-for-service (FFS) delivery model, access-based fees (ABFs) are a type of Medicaid rate used to pay physicians and other practitioners for services. Rates for physicians and other practitioners are uniform statewide and are categorized as either resource-based fees (RBFs) or ABFs. ABFs are calculated based on the following: historical charges, the current Medicare FFS rates, reviews of Medicaid fees paid by other states, surveys of providers' costs to deliver a service, and Medicaid fees for similar services. ABFs account for deficiencies in RBF methodology to adequately ensure access to health care services for Medicaid clients. Reimbursement rates for services outlined above are evaluated at least once every two years as a part of a biennial fee review process. See also Fee-for-Service (FFS) Rates and Resource-based Fee (RBF).

***Activities of Daily Living (ADLs)***

Activities of Daily Living (ADLs) are activities essential to daily personal care—including bathing or showering, dressing, getting in or out of a bed or a chair, using a toilet, and eating. Assistance with ADLs is a service offered through state plan long-term services and supports (LTSS) programs, including Primary Care Services (PCS), Community Attendant Services (CAS), Personal Assistance Services (PAS), Primary Home Care (PHC), and Day Activity and Health Services (DAHS). See also Long-term Services and Supports (LTSS).

### ***Acuity Risk Adjustment***

Before capitation rates for managed care organizations (MCOs) are finalized, an acuity risk adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. This adjustment recognizes the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. See also Capitation Rates.

### ***Acute Care Services***

Acute care services focus on preventive care, diagnostics and treatments. Acute care services covered by Medicaid include but are not limited to: inpatient and outpatient hospital services, laboratory and x-ray services, and physician services. Medicaid covers acute care services for all clients. See also Appendix B, page 130, for a full list of acute care services offered in Texas.

### ***Acute Care Utilization Review (ACUR)***

Acute Care Utilization Reviews (ACUR) are one type of review designed to monitor managed care organizations (MCOs) and ensure they are authorizing, justifying and providing appropriate, medically necessary services to Medicaid clients. For this review, a team of nurses conducts a desk review of a targeted sample set of medical records. This sample set is selected based on complaints, the severity and frequency of non-compliance instances, and the volume or cost of particular services. Nurses from the ACUR team conduct an in-depth review of the sample cases—including their authorization process, medical necessity determination, timeliness and accuracy of the resolution.

### ***Administrative Expense Limits (Admin Cap)***

The amount of allowable Medicaid administrative expenses by managed care organizations (MCOs) are limited by administrative expense limits (Admin Cap). The Admin Cap is compared to reported administrative expenses by the MCO. Any amounts over the Admin Cap become disallowed expenses and are added to the MCO's net income. MCOs are not prevented from incurring expenses that they consider necessary to the successful operation of their business. The Admin Cap only pertains to their ability to record those expenses on their financial statistical reports (FSRs). See also Financial Statistical Report (FSR).

### ***Agency Option***

The agency option refers to one option Medicaid clients have in determining how they receive certain long-term services and supports (LTSS), where services are delivered through a provider agency. The provider agency is the employer of attendants or other direct service workers and is responsible for all employment and business operations.

Either the service coordinator case management agency (for the Community Living Assistance and Support Services [CLASS] waiver program) or provider agency (for Deaf Blind with Multiple Disabilities [DBMD]) coordinates with the individual or authorized representative to monitor and ensure clients are satisfied with their services. See also Provider Agency.

### ***Aging and Disability Resource Center (ADRC)***

Aging and Disability Resource Centers (ADRCs) provide older adults, people with disabilities, and their family members with educational information about long-term services and supports (LTSS) and serve as a point of access for LTSS programs. Each ADRC partners with a network of local service agencies to coordinate information and referrals for individuals needing access to both private and public LTSS programs and benefits, including Medicaid. There are 22 ADRCs operating throughout Texas.

### ***Alberto N. v. Young***

A federal lawsuit settled in May 2005 that requires Health and Human Services Commission (HHSC) to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children age 20 and younger who are eligible for the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

### ***All Patient Refined Diagnosis Related Group (APR-DRG)***

All Patient Refined Diagnosis Related Group (APR-DRG) comes from the Diagnosis Related Group (DRG) classification system, which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. APR-DRGs are an expansion of the basic DRGs to be more representative of non-Medicare patients and to incorporate severity of illness subclasses. See also Diagnosis Related Group (DRG).

### ***Alternative Payment Model (APM)***

An alternative payment model (APM) is a payment approach that rewards providers for delivering high-quality, cost-efficient care. APMs link a percentage of the provider's overall payment to a measure of either quality or quality and cost. As part of building a strong pay-for-quality (P4Q) program that incentivizes managed care organizations (MCOs) to achieve better performance, the Health and Human Services Commission (HHSC) developed contractual requirements for MCOs to have minimum thresholds of their overall payments to health care providers be in the form of an APM. For a certain percentage of these payments, the provider must have some degree of risk, called the risk threshold. See also Pay-for-Quality (P4Q).

### ***Alternative Prospective Payment System (APPS)***

Like prospective payment systems (PPSs), alternative prospective payment systems (APPSs) are methods of reimbursement in which payment is made based on a predetermined, fixed amount—which is, in turn, based on the classification system of that service. However, where PPS rates are inflated annually for primary care using the Medicare Economic Index (MEI), APPS rates are inflated annually using 100.5 percent of the MEI. APPSs may be used by Federally Qualified Health Centers (FQHCs). If an FQHC chooses the APPS method, rates may be prospectively reduced to better reflect the reasonable costs or the PPS rates.

### ***Amount, Duration and Scope***

Amount, duration and scope refer to how a Medicaid benefit is defined and limited in a state Medicaid plan. Each state defines these parameters, so state Medicaid plans vary in what they cover.

### ***Appointment Availability***

Appointment availability is a measurement used to assess client access to care within the managed care delivery system. It is measured by the time between when a member contacts a provider and the date of the first available appointment. Managed care organizations (MCOs) can reduce the use of emergent care by ensuring members have timely access to regular and preventive care. The Health and Human Services Commission (HHSC) contractually requires MCOs to follow appointment availability standards—for STAR, Children’s Health Insurance Program (CHIP), STAR Kids, STAR Health, and STAR+PLUS—based on the type of medical appointment requested. Texas’ external quality review organization (EQRO) conducts secret shopper studies to evaluate MCO compliance with these availability standards. See also Mystery Shopper Method.

### ***Audits***

An audit is an official inspection of performance or finances that is conducted by independent contractors or outside agencies, such as the Office of Inspector General (OIG). See also Office of Inspector General (OIG).



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***Behavioral Health Services***

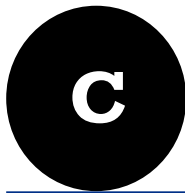
Behavioral health services generally refer to the treatment of mental health conditions and substance use disorders (SUDs). These services may be provided by the following: therapists in private practice, physicians, private and public psychiatric hospitals, community mental health centers, comprehensive provider agencies, and substance use treatment facilities. Screening services include Health and Behavioral Assessment and Intervention (HBAI) and Screening, Brief Intervention and Referral to Treatment (SBIRT). Treatment services include but are not limited to: psychiatric diagnostic evaluation and psychotherapy, psychological and neuropsychological testing, mental health targeted case management, psychotropic medications, and medication assisted therapy for SUDs. See also Health and Behavioral Assessment and Intervention (HBAI); Screening, Brief Intervention and Referral to Treatment (SBIRT); and Substance Use Disorder (SUD).

***Better Birth Outcomes***

Better Birth Outcomes (BBO) is a collaborative effort between the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS). BBO aims to improve access to women's preventive, interconception, prenatal and perinatal health care. There are currently more than 30 BBO initiatives. See also Healthy Families Project, Long-acting Reversible Contraception (LARC), Perinatal Advisory Council, Texas Alliance for Innovation on Maternal Bundle Implementation (TexasAIM), and Texas Neonatal Intensive Care Unit (NICU) Project (TNP).

***Breast and Cervical Cancer Services (BCCS)***

Breast and Cervical Cancer Services (BCCS) clinic sites provide quality, low-cost, and accessible breast and cervical cancer screening and diagnostic services to women. These clinic sites are the point of access for women applying to the Medicaid Breast and Cervical Cancer (MBCC) program. See also the Medicaid Breast and Cervical Cancer (MBCC) program.



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### ***Capitation Rate***

Through actuarially sound methodologies, Texas develops a per member per month (PMPM) rate, or capitation rate, for each risk group within all state service areas for its various Medicaid and Children’s Health Insurance Program (CHIP) managed care programs. These capitation rates differ across risk groups and service areas, but they are the same for each managed care organization (MCO) within a service area. The managed care rate-setting process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. Capitation rates are derived primarily from MCO historical claims experience, also called encounter data. In case of possible fluctuations in claims cost, a risk margin is typically added. While the calculation method remains largely the same, how capitation rates are determined varies by program. Capitation rates, paid monthly to MCOs, constitute the primary way the state pays for services. See also Encounter Data and Per Member Per Month (PMPM).

### ***Care Coordination***

The value of managed care relies on care coordination provided by managed care organizations (MCOs). Care coordination includes services performed by MCOs or by primary care providers—such as assistance with setting up appointments, locating specialty providers and member health assessments. In particular, MCOs are required to identify and provide care coordination for members with special health care needs (MSHCN). The MCO is responsible for working with MSHCN and their families, as well as their health care providers, to develop a seamless package of care in which all needs are met through a comprehensive service plan. This coordination is available to MSHCN, including women with high-risk pregnancies, members with high-cost catastrophic cases, and individuals with mental illness and co-occurring substance abuse. See also Members with Special Health Care Needs (MSHCN).

### ***Case Management for Children and Pregnant Women***

Case Management for Children and Pregnant Women is a component of Texas Health Steps. This Medicaid benefit provides health-related case management services to children age 20 and younger or pregnant women who are eligible for Medicaid. Case managers assist eligible clients in gaining access to medically necessary medical, social and educational services—as well as other services related to their health condition, health risk or high-risk condition. Services include assessing the needs of eligible clients, developing a

service plan with clients and families, making referrals, problem-solving, advocacy, and follow-up regarding client and family needs. See also Texas Health Steps.

### ***Centers for Medicare and Medicaid Services (CMS)***

The Centers for Medicare and Medicaid Services (CMS) is the federal agency within the U.S. Health and Human Services responsible for administering Medicare and overseeing state administration of Medicaid. States submit a Medicaid state plan that serves as the contract between the state and CMS. CMS must approve the plan and any amendments to the plan. CMS also approves any waivers for which states can apply. See also State Plan.

### ***Chemical Dependency Treatment Facility (CDTF)***

Chemical dependency treatment facilities (CDTFs) are any facilities that offer treatment for persons with a substance use disorder (SUD). CDTFs must be licensed and regulated by the state, except for Medication Assisted Therapy (MAT) services.

### ***Children's Health Insurance Program (CHIP)***

The Children's Health Insurance Program (CHIP) provides acute care, behavioral health care, dental services and pharmacy services for children in families with too much income to qualify for Medicaid but cannot afford to buy private health insurance. Children covered through CHIP generally receive similar services as children covered through Medicaid. See also Children's Health Insurance Program (CHIP) Perinatal.

### ***Children's Health Insurance Program (CHIP) Perinatal***

Children's Health Insurance Program (CHIP) Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid. Services include prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum care.

### ***Children's Hospital***

According to the Centers of Medicare and Medicaid Services (CMS), a certified children's hospital is a freestanding or hospital-within-hospital that predominantly treats individuals age 20 and younger.

### ***Children's Medicaid***

Children's Medicaid serves children age 18 and younger who meet the program's household income limits. Children's Medicaid provides acute care, behavioral health services, dental services, prescription drug benefits, and long-term services and supports. Children in the program are typically enrolled in the STAR managed care program, although some children with disabilities may be enrolled in STAR Kids. Children's Medicaid recipients also



receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services, known in Texas as Texas Health Steps. See also Early and Periodic Screening, Diagnosis and Treatment (EPSDT); STAR; STAR Kids; and Texas Health Steps.

### ***Children’s Medicaid Dental Services (CMDS) Program***

The Children’s Medicaid Dental Services (CMDS) program is a managed care program that provides dental benefits for children and youth on Medicaid, birth through age 20. There are two dental maintenance organizations (DMOs) operating statewide. See also Dental Maintenance Organization (DMO).

### ***Chronic Care Management***

Under managed care, managed care organizations (MCOs) must provide chronic care management programs and services. These programs and services must be part of a person-centered approach and address the needs of high-risk members with complex chronic or co-morbid conditions. See also Care Coordination.

### ***Client***

A client is an individual who has applied for and is enrolled in Medicaid, Children’s Health Insurance Program (CHIP), or both. If enrolled into a health plan, they may also be referred to as a member.

### ***Clinical Prior Authorization***

Clinical prior authorizations are evidence-based reviews designed to ensure the clinical appropriateness of a drug or drug class based on factors such as age, availability of alternative medications, or possible drug interactions. They may apply to an individual drug or a drug class that is included on federal formulary and may have preferred or non-preferred status on the Preferred Drug List (PDL). With the assistance of the Texas Drug Utilization Review Board, the Vendor Drug Program develops, manages and reviews clinical prior authorizations across both fee-for-service (FFS) and the managed care programs. Participating managed care organization (MCOs) are required to perform certain clinical prior authorizations and may perform others at their discretion. See also Non-preferred Prior Authorization, Preferred Drug List (PDL), Prior Authorization, Texas Formulary, and Vendor Drug Program (VDP).

### ***Community Attendant Services (CAS)***

Community Attendant Services (CAS) are state plan, home and community-based, long-term services and supports (LTSS) that include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These services are available to eligible adults and children.

***Community First Choice (CFC)***

Community First Choice (CFC) is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. To be eligible, an individual must require an institutional level of care. Individuals can receive CFC services and keep their spot on an interest list or continue to receive services in a waiver program. CFC services must be provided in community-based settings.

***Community Living Assistance and Support Services (CLASS)***

Community Living Assistance and Support Services (CLASS) is a 1915(c) waiver program that provides home and community-based services to people who have a related condition diagnosis qualifying them for placement in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). A related condition is a disability other than an intellectual or developmental disability, which originates before age 22 and which substantially limits life activity. See also Appendix B, page 133, for a full list of services offered through CLASS. Eligibility determinations for CLASS are based on level of care (LOC) criteria outlined in the Texas Administrative Code. CLASS has an interest list. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID) and Interest List.

***Complaints***

The Health and Human Services Commission (HHSC) monitors managed care organization (MCO) complaints, grievances and appeals processes for both members and providers. Data is used as a mechanism to flag for early warning of potential systemic problems that warrant investigation, point to the need for policy clarifications, or signal larger operational issues.

***Comprehensive Care Program (CCP)***

Federal law expanded the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, known in Texas as Texas Health Steps, to cover any medically necessary and appropriate health care services used for treating all physical and mental illnesses or conditions found in a screening. These benefits are included in Texas Health Steps but are referred to in Texas as the Comprehensive Care Program (CCP). See also Texas Health Steps.

***Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey***

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a nationally recognized and validated tool for collecting standardized information on member

experiences with health plans and services. This survey focuses on consumer perceptions of quality, such as the communication skills of providers and ease of access to health care services. See also National Core Indicators-Aging and Disabilities (NCI-AD) Survey.

### ***Consumer Directed Services (CDS) Option***

Consumer Directed Services (CDS) is a service delivery option for some individuals receiving long-term services and supports (LTSS) that allows the individual or the individual's legally authorized representative to be the employer of record for the direct care workers providing services—giving greater choice and control over the delivery of services. The individual or legally authorized representative can hire, train, supervise and dismiss the employee when necessary. Individuals may appoint a designated representative to assist with some employer responsibilities, like approving time sheets.

### ***Contractor***

A person or organization with which the state has successfully negotiated an agreement for the provision of required tasks.

### ***Corrective Action Plan (CAP)***

In cases of contractual non-compliance, the Health and Human Services Commission (HHSC) may use corrective action plans (CAPs) to hold managed care organizations (MCOs) accountable. The CAP process requires MCOs to provide HHSC with the following: a detailed explanation of the reasons for the deficiency; an assessment or diagnosis of the cause; actions taken to cure or resolve the deficiencies, including short- and long-term solutions; and actions taken to prevent future occurrences. HHSC administers CAPs monthly, and reviews, approves and closes CAPs once appropriate actions have been taken to address the non-compliance.

### ***Cost-sharing***

Cost-sharing refers to a co-paying arrangement, in which the state shares the cost of care with another party. Most families participating in Children's Health Insurance Program (CHIP), for example, pay an annual enrollment fee and pay co-payments for doctor visits, prescription drugs, inpatient hospital care and non-emergent care provided in an emergency room setting. See also Children's Health Insurance Program (CHIP).

### ***Crisis Diversion***

Crisis Diversion is a reserved capacity group for the Home and Community-based Services (HCS) program. Individuals qualify as members of this reserved capacity group if they have an intellectual or developmental disability and are at imminent risk of being

admitted or re-admitted to an institution. See also Home and Community-based Services (HCS) and Reserved Capacity Group.



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### ***Day Activity and Health Services (DAHS)***

Day Activity and Health Services (DAHS) are state plan, community-based, long-term services and supports (LTSS). DAHS is offered during the day, Monday through Friday, to clients residing in the community. Services provided at licensed day activity and health services centers include nursing and personal care, meals, transportation, and social and recreational activities.

### ***Deaf Blind with Multiple Disabilities (DBMD)***

Deaf Blind with Multiple Disabilities (DBMD) is a 1915(c) waiver program that provides community-based services to people who are deaf and blind and also have a third disability (e.g., an intellectual disability), as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). See also Appendix B, page 134, for a full list of services offered through DBMD. Eligibility determinations for DBMD are based on level of care (LOC) criteria outlined in the Texas Administrative Code. DBMD has an interest list. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID).

### ***Default Enrollment***

Default enrollment occurs when clients do not exercise their right to choose a managed care organization (MCO) and are automatically assigned to a health plan.

### ***Deferral***

A deferral refers to the withholding of federal funding, if the Texas Medicaid or Children's Health Insurance Program (CHIP) is determined to be out of compliance with federal regulations by the Centers of Medicare and Medicaid Services (CMS).

### ***Delivery Supplemental Payment***

Delivery supplemental payments are separate lump sums paid to managed care organizations (MCOs), as part of their capitation payments, to cover newborn delivery expenses. This payment is computed for each service area.

### ***Delivery System Reform Incentive Payment (DSRIP) Pool***

The Delivery System Reform Incentive Payment (DSRIP) pool is one of two hospital funding pools under the 1115 Transformation waiver along with Uncompensated Care (UC) pool. DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies and investments to enhance the following: access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and the health of the patients and families served. To earn DSRIP funds, providers must undertake projects from a menu of projects agreed upon by Centers for Medicare and Medicaid Services (CMS) and Health and Human Services Commission (HHSC) within the Regional Healthcare Partnership (RHP) planning protocol. See also Regional Healthcare Partnership (RHP).

### ***Dental Maintenance Organization (DMO)***

Dental maintenance organizations (DMOs) deliver and manage comprehensive dental services to eligible Medicaid and Children's Health Insurance Program (CHIP) clients. For Medicaid and Children's Health Insurance Program (CHIP) there are two DMOs that operate throughout Texas.

### ***Dental Quality Alliance (DQA)***

The Dental Quality Alliance (DQA) is an organization convened by the American Dental Association at the request of Centers for Medicare and Medicaid Services (CMS). The DQA has developed national evidence-based oral health care performance measures that have been tested for feasibility, validity, reliability and usability.

### ***Diagnosis Related Group (DRG)***

The Diagnosis Related Groups (DRGs) are a patient classification system that provide a means of relating the type of patients a hospital treats to the costs incurred by the hospital. The system was originally used by the Centers for Medicare and Medicaid Services (CMS) for hospital payment for Medicare clients, and it has been expanded to be more inclusive of non-Medicare clients. Under this system, each patient is classified into a DRG on the basis of clinical information. Hospitals are paid a pre-determined rate for each DRG admission. For fee-for-service (FFS) clients receiving inpatient or outpatient care, the rate is calculated using a standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG.

### ***Disallowance***

A disallowance refers to the recoument of federal funds by the Centers for Medicare and Medicaid Services (CMS), should CMS allege that certain claims are not allowable.

***Disproportionate Share Hospital (DSH)***

Disproportionate Share Hospital (DSH) is a designation for hospitals that serve a higher than average number of Medicaid and other low-income patients. See also Disproportionate Share Hospital (DSH) Funding.

***Disproportionate Share Hospital (DSH) Funding***

Disproportionate Share Hospital (DSH) funding is special funding for hospitals that serve a disproportionately large number of Medicaid and low-income patients. DSH funds are not tied to specific services for Medicaid-eligible patients. There are no federal or state restrictions on how disproportionate share hospitals may use their funds. They may use the payments to cover the uncompensated costs of care for low-income patients, including Medicaid patients. DSH payments have been an important source of revenue by helping hospitals expand health care services to the uninsured, defray the cost of treating low-income patients, and recruit physicians and other health care professionals to treat patients.

***Drug Utilization Review (DUR)***

Drug utilization reviews (DURs), prospective and retrospective, are used by the Health and Human Services Commission (HHSC) and managed care organizations (MCOs) to evaluate client use of prescription drugs. See also Prospective Drug Utilization Review (DUR), Retrospective Drug Utilization Review (DUR), and Texas Drug Utilization Review (DUR) Board.

***Dually Eligible***

Individuals who are dually eligible qualify for both Medicare and Medicaid benefits. Medicare is a federally paid and administered health insurance program. Medicaid is a state-administered health care and long-term care program jointly funded by the state and the federal government. Dually eligible individuals or couples may get partial or full Medicaid benefits. If only getting partial Medicaid benefits, an individual or couple will be enrolled into the Medicare Savings Program. Dually eligible individuals typically qualify for Medicaid for the Elderly and People with Disabilities (MEPD) and receive benefits through the STAR+PLUS managed care program. Dually eligible MEPD recipients may also be enrolled into a Medicaid-Medicare Plan (MMP) or a Dual-Eligible Special Needs Plans (D-SNP). See also Dual-Eligible Special Needs Plan (D-SNP), Medicaid for the Elderly and People with Disabilities (MEPD), Medicaid-Medicare Plan (MMP), Medicare Savings Program, and STAR+PLUS.



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***Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program***

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a required Medicaid state plan benefit for eligible children and youth, birth through age 20. In Texas, this program is referred to as Texas Health Steps. See also Texas Health Steps.

***Early Childhood Intervention (ECI)***

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children age 3 and younger who have developmental delays or disabilities.

***Electronic Visit Verification (EVV)***

Electronic Visit Verification (EVV) is a computer-based tracking system that electronically verifies the occurrence of personal attendant service visits by documenting the precise time a service delivery begins and ends. EVV helps prevent fraud, waste and abuse with the goal of ensuring Medicaid recipients receive care that is authorized.

***Emergency Medicaid***

The Emergency Medicaid program provides medical coverage designed to meet a sudden, critical health condition. Most covered individuals apply for this benefit only after an emergency occurs. If determined eligible, the individual is covered by Medicaid only from the start of a qualifying emergency medical condition to when the event is stabilized, as verified by a medical provider.

***Encounter Data***

Used in the calculation of managed care organization (MCO) capitation rates, encounter data refers to the historical claims experience of MCOs for a base period of time. Encounter data includes the records of the health care services for which MCOs pay and the amounts MCOs pay to providers of those services. See also Capitation Rates.

***Enhanced Federal Medical Assistance Percentage (EFMAP)***

The enhanced federal medical assistance percentage (EFMAP) is used to determine federal matching funds for Children's Health Insurance Program (CHIP). Derived from each state's average per capita income, the Centers for Medicare and Medicaid Services (CMS) updates

this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The EFMAP for Texas in federal fiscal year 2019 was 70.73 percent and in state fiscal year 2019 was 70.65 percent. See also Federal Medical Assistance Percentage (FMAP) and Matching Funds.

### ***Experience Rebate***

Experience rebate is the process of determining the amount of profit earned through the Medicaid managed care program that a managed care organization (MCO) must share with the state of Texas.

### ***External Medical Review (EMR)***

Medicaid clients who are denied services or program eligibility can appeal directly to the Health and Human Services Commission (HHSC) by requesting a fair hearing. As part of that request, they have the option to ask for an external medical review (EMR) before their fair hearing. During an EMR, an independent review organization (IRO) examines the client's case and can uphold or change the service denial or eligibility determination. Unlike a fair hearing, EMRs are privately conducted and additional evidence cannot be submitted by the member, the MCO or HHSC. EMRs must occur after a health plan appeal if a managed care organization (MCO) made the original decision to deny services or eligibility. See also Fair Hearing and Independent Review Organization (IRO).

### ***External Quality Review Organization (EQRO)***

An external quality review organization (EQRO) assesses managed care organization (MCO) performance on several metrics—access to care, utilization of care and quality of care—for all MCOs participating in Medicaid and Children's Health Insurance Program (CHIP) medical and dental managed care programs. The Institute for Child Health Policy at the University of Florida has been the EQRO for Texas since 2002.



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### ***Fair Hearing***

Medicaid clients who are denied services or program eligibility can appeal directly to the Health and Human Services Commission (HHSC) by requesting a fair hearing. During a fair hearing, an HHSC fair hearings officer publicly reviews evidence submitted by the client, the MCO, or HHSC program staff—and can uphold or change the original eligibility decision. While additional evidence may be submitted by either party, evidence submitted



by the MCO or HHSC must be presented to the client before the hearing. Fair hearings must occur after a health plan appeal if a managed care organization (MCO) made the original decision to deny services or eligibility. See also External Medical Review (EMR) and Health Plan Appeal.

### ***Federal Medical Assistance Percentage (FMAP)***

The federal medical assistance percentage (FMAP) determines the amount of federal matching funds Texas receives for Medicaid. Derived from each state's average per capita income, the Centers for Medicare and Medicaid Services (CMS) updates the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. As the state's per capita income increases in relation to the national per capita income, the FMAP rate decreases. For federal fiscal year 2019, Texas' Medicaid FMAP was 58.19 percent. See also Enhanced Federal Medical Assistance Percentage (EFMAP) and Matching Funds.

### ***Federal Poverty Level (FPL)***

The Federal Poverty Level (FPL) is a measure of income set by the U.S. Department of Health and Human Services used to determine eligibility for government programs and services, like Medicaid and Children's Health Insurance Program (CHIP). The FPL is updated yearly.

### ***Federally Qualified Health Center (FQHC)***

Federally Qualified Health Centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs serve underserved areas or populations, offer a sliding-scale fee, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

### ***Fee-for-Service (FFS)***

Fee-for-service (FFS) is a healthcare payment system under which providers receive a payment for each unit of service they provide. Under FFS, clients can go to any Medicaid provider, and the provider will submit claims directly for Medicaid covered services. Currently, only eight percent of Medicaid clients in Texas still receive services through FFS. The remaining 92 percent of clients are enrolled into one of the managed care programs. See also Managed Care.

### ***Fee-for-Service (FFS) Rates***

Fee-for-service (FFS) rates are paid directly to providers—physicians, other medical practitioners, pharmacists and hospitals. The Health and Human Services Commission (HHSC)

is responsible for establishing reimbursement methodologies. However, the commission consults with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are subject to a public hearing, and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process. Changes in FFS rates will often impact managed care capitation rates.

### ***Financial Criteria***

Texans who apply for Medicaid or the Children’s Health Insurance Program (CHIP) must meet certain financial criteria to be eligible for services. Generally, financial eligibility is measured by comparing an applicant’s income to the U.S. Department of Health and Human Services definition of the federal poverty level (FPL) for annual household incomes. Federal law currently requires that Modified Adjusted Gross Income (MAGI) be the primary measurement tool used to calculate financial eligibility for most Medicaid applicants. See also Federal Poverty Level (FPL) and Modified Adjusted Gross Income (MAGI).

### ***Financial Statistical Report (FSR)***

Managed care organizations (MCOs) are required to submit quarterly financial statistical reports (FSRs). FSRs include information on medical and administrative expenses and are one source for establishing capitation rates in future years. Validation of these reports is an important component of contract oversight, and FSRs are audited yearly.

### ***Fraud***

Fraud refers to an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. This term does not include unintentional technical, clerical or administrative errors.

### ***Freedom of Choice***

In general, a state must ensure that Medicaid clients are free to obtain services from any qualified provider. Exceptions are possible through Medicaid waivers and special contract options.

### ***Freedom of Choice 1915(b) Waivers***

Section 1915(b) waivers allow states to use a central broker (e.g., enrollment broker) to assist people with choosing a managed care organization (MCO), to use cost savings to provide additional services, or to limit client choice of Medicaid providers by requiring Medicaid clients join MCOs. Texas has used these waivers to provide an enhanced benefit

package—beyond what is available through the state plan—with cost savings from managed care.

### ***Frew v. Young***

A class action lawsuit filed against Texas in 1993, which alleged that the state did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. In 1995, the state negotiated a consent decree that imposed certain requirements on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services. Since 2007, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) have actively worked to meet the requirements of the corrective action orders.



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### ***Graduate Medical Education (GME) Payments***

Graduate medical education (GME) payments to state-owned teaching hospitals cover the costs of program administrative staff, allocated facility overhead, and salaries and fringe benefits for residents and teaching physicians. See also State-owned Teaching Hospitals.



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### ***Health and Behavior Assessment and Intervention (HBAI)***

Health and Behavior Assessment and Intervention (HBAI) services are designed to identify the psychological, behavioral, emotional, cognitive and social factors that are important to prevent, treat or manage physical health symptoms for children and youth, age 20 and younger. HBAI services help promote physical and behavioral health integration. See also Behavioral Health Integration.

### ***Health and Human Services Commission (HHSC)***

The Health and Human Services Commission (HHSC) is the single state agency implementing and overseeing Medicaid and the Children's Health Insurance Program (CHIP) for Texas. See also Single State Agency.

***Health Insurance Premium Payment (HIPP) Program***

The Health Insurance Premium Payment (HIPP) program reimburses people for their share of an employer-sponsored health insurance premium when it is determined that the cost of the premium is less than the cost of projected Medicaid expenditures. To be eligible for HIPP, an individual must be eligible for Medicaid or have a family member who is eligible or already receives Medicaid. The employer-sponsored health insurance must provide comparable coverage to Medicaid.

***Health Plan***

Managed care organizations (MCOs) are often referred to as health plans—a term which describes their function in providing medical coverage and coordinated care to Medicaid and Children’s Health Insurance Program (CHIP) clients. See also Managed Care Organization (MCO).

***Health Plan Appeal***

Medicaid members who are denied services or eligibility by their managed care organization (MCO) can ask for a health plan appeal. During a health plan appeal, the MCO reconsiders their original decision and can change or uphold it. If the member disagrees with the outcome of their health plan appeal, they have the right to appeal directly to the Health and Human Services Commission (HHSC) through a fair hearing. See also Fair Hearing.

***Healthcare Effectiveness Data and Information Set (HEDIS)***

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures for managed care organizations (MCOs). HEDIS data for Texas Medicaid and Children’s Health Insurance Program (CHIP) managed care programs is posted and regularly updated on the Texas Healthcare Learning Collaborative (THLC) portal. See also Texas Healthcare Learning Collaborative (THLC) Portal.

***Healthcare Payment Learning and Action Network (HCP-LAN)***

The Health and Human Services Commission (HHSC) is using the Healthcare Payment Learning and Action Network (HCP-LAN) to accelerate the transition to alternative payment models (APMs) within managed care organizations (MCOs) in Texas Medicaid and the Children’s Health Insurance Program (CHIP). See also Alternative Payment Model (APM) and Pay-for-Quality (P4Q).

### ***Healthy Families Project***

The Healthy Families Project is a Better Birth Outcome (BBO) initiative focused on women’s health disparities and infant mortality risk reduction. The program seeks to increase access to family planning services and decrease the risk for infant mortality among African American/Black and Hispanic women. This project provides communities with flexible resources that they can use to implement customized healthcare interventions. See also Better Birth Outcomes (BBO).

### ***Healthy Texas Women (HTW)***

Healthy Texas Women (HTW) is a women’s health and family planning program for low-income women age 15 through 44. To ensure continuity of care, HTW auto-enrolls women into the program when their Medicaid for Pregnant Women coverage ends. Women can still apply for HTW like they would for other Health and Human Services Commission (HHSC) programs. HTW was previously a state-administered, state-funded program. Through an 1115 Demonstration Waiver, HTW is now a Medicaid program that receives federal matching funds. HTW also offers an enhanced postpartum services for eligible HTW clients called HTW Plus. HTW Plus services include treatment for mental health conditions, including postpartum depression and substance use disorders (SUDs), and cardiovascular conditions.

### ***Home and Community-based Services (HCS)***

Home and Community-based Services (HCS) is a 1915(c) waiver program that provides community-based services to people with intellectual disabilities, as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). See also Appendix B, page 134, for a full list of services offered through HCS. Eligibility determinations for HCS are based on level of care (LOC) criteria outlined in the Texas Administrative Code. HCS has an interest list. See also Interest List and Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID).

### ***Home and Community-based Services–Adult Mental Health (HCBS-AMH)***

The Home and Community-based Services–Adult Mental Health (HCBS-AMH) program helps individuals with serious mental illness remain in the community. The HCBS-AMH program provides an array of intensive HCBS tailored to an individual’s assessed needs, preferences and goals.

### ***Home and Community-based Services (HCBS) 1915(c) Waivers***

Home and Community-based Services (HCBS) 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility

criteria for care in an institution. See also Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), Medically Dependent Children Program (MDCP), Texas Home Living (TxHmL), and Youth Empowerment Services (YES).

### ***Hospital Quality-based Payment Program***

The Hospital Quality-based Payment Program is an incentive/disincentive program that pays or recoups funds from hospitals according to their performance with fee-for-service (FFS) and managed care Medicaid patients—with the goal of improving quality and lowering costs. Through the program, hospitals and managed care organizations (MCOs) are financially accountable for certain potentially preventable events (PPEs) and can receive bonus payments for achieving low PPE rates. See also Potentially Preventable Event (PPE).



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### ***Income Disregards***

An income disregard refers to an income source or amount that is deducted or disregarded in a financial eligibility determination. For applicants subject to the Modified Adjusted Gross Income (MAGI) methodology, a standard income disregard of five percent of the federal poverty level (FPL) is granted. For applicants not subject to MAGI, there are program-specific income disregards. See also Federal Poverty Level (FPL) and Modified Adjusted Gross Income (MAGI).

### ***Income Limits***

Income limits are used in financial eligibility determinations. They are calculated based on household size and a certain percentage of the federal poverty level (FPL), which varies by program. Medicaid and Children's Health Insurance Program (CHIP) applicants must meet income limits in order to be eligible for services. See also Federal Poverty Level (FPL).

### ***Independent Review Organization (IRO)***

An independent review organization (IRO) is a group of medical experts, who are unaffiliated with a managed care organization (MCO) or the Health and Human Services Commission (HHSC), contracted to conduct external medical reviews (EMRs). During an EMR, an IRO can uphold or change an MCO's or HHSC's decision to deny services or program eligibility. See also External Medical Review (EMR).

### ***Inspection***

Inspections, such as those conducted by the Office of Inspector General (OIG), are targeted examinations into specific areas of Health and Human Services Commission (HHSC) programs, systems or functions that may identify systemic trends of fraud, waste and abuse.

### ***Instrumental Activities of Daily Living (IADLs)***

Instrumental activities of daily living (IADLs) are activities essential to independent daily living—including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone. Assistance with IADLs is a service offered through state plan long-term services and supports (LTSS) programs—including Personal Care Services (PCS), Community Attendant Services (CAS), Personal Assistance Services (PAS), Primary Home Care (PHC), and Day Activity and Health Services (DAHS). See also Long-Term Services and Supports (LTSS).

### ***Interest List***

Demand for 1915(c) waiver programs, like Home and Community-based Services (HCS) and Community Living Assistance and Support Services (CLASS), often exceed capacity. Many Medicaid waiver programs maintain interest lists, which individuals can join at any time. When a program slot becomes available, the next person on the interest list may undergo an eligibility determination for the program. If they are found eligible, they may take the open slot. An individual can be on multiple interest lists at the same time and may stay on a program's interest list while enrolled in a different Medicaid program.

### ***Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID)***

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) provide ongoing evaluation and individual program planning—as well as 24-hour supervision, coordination, and integration of health or rehabilitative services—to help individuals with an intellectual disability or related condition function to their greatest ability.

### ***Interstate Compact on the Placement of Children (ICPC)***

The Interstate Compact on the Placement of Children (ICPC) is an agreement between all 50 states, the District of Columbia, and the U.S. Virgin Islands, authorizing them to work together to ensure children placed across state lines for foster care or adoption receive adequate protection and support services. It establishes procedures for the placement of children across state lines and responsibilities for the agencies and individuals involved.



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***Lawful Permanent Resident (LPR)***

Legal permanent residents (LPRs) are non-citizens who are lawfully authorized to live permanently within the U.S. They are often called “green card holders.”

***Level of Care (LOC)***

Level of care (LOC) refers to the type and amount of care required by a resident of either a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). It is determined by evaluating the resident’s medical, nursing care and personal-care needs. See also Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID) and Nursing Facility.

***Liquidated Damages (LDs)***

Liquidated damages (LDs) are compensation for contractual non-compliance. The Health and Human Services Commission (HHSC) assesses LDs quarterly to address any harm incurred due to managed care organization (MCO) contractual non-compliance.

***Local Intellectual and Developmental Disability Authority (LIDDA)***

Local intellectual and developmental disability authorities (LIDDAs) serve as the point of entry for publicly funded intellectual and developmental disability (IDD) programs, whether the program is provided by a public or private entity. LIDDAs provide or contract to provide an array of services and supports for persons with IDD and enroll eligible individuals into Medicaid programs, such as intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID), Home and Community-based Services (HCS), and Texas Home Living (TxHmL). They are also responsible for Permanency Planning for eligible clients seeking to move from an institutional setting to a community-based setting.

***Local Mental Health Authority (LMHA)***

Local mental health authorities (LMHAs), along with local behavioral health authorities (LBHAs), evaluate the mental health needs of the communities in their areas and plan, develop policy, and coordinate services and resources to address those needs. LMHAs



provide information, recommendations and referrals to individuals seeking mental health services.

### ***Long-acting Reversible Contraception (LARC)***

Through this Better Birth Outcome (BBO) initiative, Texas is working to increase access to this method of contraception to avert unintended pregnancies. Long-acting reversible contraception (LARC) devices are highly effective for preventing pregnancy, are easy to use, and last for several years. The Health and Human Services Commission (HHSC) has established an add-on reimbursement to incentivize utilization of immediate postpartum (IP) LARC for women enrolled in Medicaid for Pregnant Women. See also Better Birth Outcomes (BBO).

### ***Long-term Services and Supports (LTSS)***

Rather than treat or cure a disease or condition, long-term services and supports (LTSS) provide an individual support with ongoing, day-to-day activities. Clients typically eligible for LTSS include adults age 65 and older and those with physical or intellectual disabilities. LTSS may be delivered through managed care or fee-for-service (FFS) and in conjunction with a waiver program.




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### ***Managed Care***

Managed care is a service delivery model where the Health and Human Services Commission (HHSC) contracts with managed care organizations (MCOs) to provide Medicaid and Children's Health Insurance Program (CHIP) services to clients. Overall care of patients under managed care is coordinated by the MCOs as a way to improve quality and control costs. Ninety-two percent of Medicaid clients in Texas are enrolled in managed care—where they select a health plan from the ones available in their service area and a primary care provider that coordinates their care. See also Health Plan, managed care organization (MCO), and Service Area and Primary Care Provider (PCP).

### ***Managed Care Long-term Services and Supports Utilization Review (MLTSS UR)***

The Managed Care Long-term Services and Supports Utilization Review (MLTSS UR) team conducts sampled reviews of STAR+PLUS Home and Community-based Services (HCBS) to determine how they, as managed care organizations (MCOs), conduct assessments and

use procedures and related information to determine appropriateness of member enrollment. The review includes ensuring MCOs are providing services according to their assessment of service needs.

### ***Managed Care Organization (MCO)***

A managed care organization (MCO) delivers and manages health services under a risk-based arrangement. The Health and Human Services Commission (HHSC) contracts with MCOs and pays them a per member per month (PMPM) rate, or capitation payment. MCOs are required to provide all covered, medically necessary services to their members, and are incentivized to control costs. Generally, Medicaid clients have a choice between at least two MCOs, or health plans, operating in their service area. See also Capitation Rate and Per Member Per Month (PMPM).

### ***Managed Care Report Card***

A managed care report card evaluates a managed care organization's (MCO's) performance using a one- through five-star rating system. Ratings are developed by surveying current members and analyzing claims data, and are updated yearly. Report cards are available on the Health and Human Services Commission (HHSC) website and are provided in all Medicaid and Children's Health Insurance Program (CHIP) enrollment packets.

### ***Mandatory Benefits***

The Social Security Act specifies a set of benefits state Medicaid programs must provide, or mandatory benefits. The state may also choose to provide some, all or no optional services specified under federal law. See also Appendix B, page 130, for a complete list of mandatory and optional benefits. See also Optional Benefits.

### ***Matching Funds***

Federal funds are a critical component of health care financing for the state of Texas. The amount of federal Medicaid funds that Texas receives is based primarily on the federal medical assistance percentage (FMAP), or Medicaid matching rate. The federal Children's Health Insurance Program (CHIP) funds that Texas receives are based on the enhanced federal medical assistance percentage (EFMAP).

### ***Maternal Opioid Misuse (MOM) Model***

The Maternal Opioid Misuse (MOM) model is a five-year project that seeks to facilitate better integration of prenatal care, addiction medicine and psychiatric care for pregnant women with an opioid use disorder (OUD) who are enrolled in Medicaid.

## ***Medicaid***

A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted federally in 1965 under Title XIX of the Social Security Act. Texas participation in Medicaid began September 1, 1967.

### ***Medicaid Breast and Cervical Cancer (MBCC) Program***

The Medicaid Breast and Cervical Cancer (MBCC) program provides Medicaid to eligible women diagnosed with breast or cervical cancer, including pre-cancerous conditions. To get MBCC, a woman must receive a screening at a Breast and Cervical Cancer Services (BCCS) clinic and apply for the program through the clinic. Women who have MBCC are enrolled into STAR+PLUS. Women remain eligible for MBCC if they are receiving active treatment, such as chemotherapy or radiation for breast or cervical cancer. See also Breast and Cervical Cancer Services (BCCS).

### ***Medicaid Buy-In for Children (MBIC)***

The Medicaid Buy-In for Children (MBIC) program offers low-cost Medicaid services to children with disabilities in families that make too much money to get Medicaid. Children with family countable income at or below 300 percent of the federal poverty level (FPL) may qualify for the program, and households at or below 10 percent of the FPL will not pay a premium. MBIC families make monthly payments according to a sliding scale that is based on family income.

### ***Medicaid Buy-In (MBI) for Workers with Disabilities***

The Medicaid Buy-In (MBI) for Workers with Disabilities program offers low-cost Medicaid services to adults with disabilities who work. Individuals with income below 250 percent of the federal poverty level (FPL) and resources at or below \$5,000 may qualify and may pay a monthly premium to receive Medicaid benefits.

### ***Medicaid Estate Recovery Program (MERP)***

The Medicaid Estate Recovery Program (MERP) is required by federal and state law to recover—after time of death—certain long-term care and associated Medicaid costs of services provided to recipients age 55 and older.

### ***Medicaid for Former Foster Care Children (FFCC)***

Medicaid for Former Foster Care Children (FFCC) covers Medicaid clients who aged out of the foster care system in Texas at age 18 and who were receiving federally funded Medicaid when they aged out of foster care. FFCC clients are automatically enrolled in STAR Health through the month of their 21st birthday. Individuals may opt out of STAR

Health for STAR, which allows for a choice of health plans. After an individual attains age 21, coverage will transfer to STAR. FFCC clients may continue to be eligible up to the month of their 26th birthday. See also Medicaid for Transitioning Foster Care Youth (MTFCY).

### ***Medicaid for Parents and Caretaker Relatives***

Medicaid for Parents and Caretaker Relatives is a program for adults who are a related caretaker for a child who already has Medicaid and who meet the program's income limits.

### ***Medicaid for Pregnant Women***

Medicaid for Pregnant Women provides health coverage to low-income pregnant women—including acute care services, like prenatal care, labor and delivery, and postpartum care. Texas elects to extend Medicaid eligibility to pregnant women with a household income at or below 198 percent of the federal poverty level (FPL)—well above the federal requirement of 133 percent of the FPL. Pregnant women who qualify receive services through the STAR program. Newborns, whose mothers qualified for Medicaid for Pregnant Women or Emergency Medicaid for their labor and delivery, are enrolled into Children's Medicaid and receive 12 months of continuous coverage from their date of birth.

### ***Medicaid for the Elderly and People with Disabilities (MEPD)***

Medicaid for the Elderly and People with Disabilities (MEPD) serves people age 65 and older and individuals with disabilities who do not receive Supplemental Security Income (SSI). Individuals may qualify for this program through a facility, such as a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). MEPD covers long-term services and supports (LTSS), including long-term care facilities and state plan home and community-based services. See also Long-term Services and Supports (LTSS).

### ***Medicaid for Transitioning Foster Care Youth (MTFCY)***

Medicaid for Transitioning Foster Care Youth (MTFCY) covers former foster care youth who were not receiving Medicaid when they aged out of foster care at age 18. Such individuals are eligible through the month of their 21st birthday to receive services through the fee-for-service or managed care models. See also Medicaid for Former Foster Care Children (FFCC).

### ***Medicaid Hospice Services***

Medicaid hospice services are palliative care consisting of medical, social and support services to terminally ill individuals and their loved ones—when curative treatment is no

longer desired or possible and a physician has indicated the individual has six months or less to live.

### ***Medicaid Lock-in Program***

The Medicaid Lock-in Program is an Office of Inspector General (OIG) oversight, prescription drug program that operates by limiting clients to receiving or purchasing their prescriptions to one provider or pharmacy—in order to prevent the abuse or overuse of controlled substances. Individuals enrolled can only purchase their prescriptions from the pharmacy to which they are “locked in.”

### ***Medicaid-Medicare Plan (MMP)***

Medicaid-Medicare Plans (MMPs) are designed to provide a fully integrated managed care model for individuals age 21 and older, who are dually eligible for Medicare and Medicaid. The model involves a three-party contract—between an MMP, the Health and Human Services Commission (HHSC), and the Centers for Medicare and Medicaid Services (CMS)—for the provision of the full array of Medicaid and Medicare services. All covered services, including acute care and long-term services and supports (LTSS), are provided by a single health plan. Participating individuals are required to be enrolled in STAR+PLUS. If eligible, individuals are passively enrolled into the program, but may choose to opt-out. MMPs operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties.

### ***Medical Home***

A medical home consists of a patient’s primary care provider (PCP) who delivers comprehensive preventive and primary care and provides referrals for specialty care and other covered services. See also Primary Care Provider (PCP).

### ***Medical Necessity***

Medical necessity is a measure used to determine an individual’s eligibility for a program or service. Authorized providers assess whether a program or service is reasonable, appropriate and consistent with health care practice guidelines. The Health and Human Services Commission (HHSC) uses medical necessity to determine eligibility for programs and services delivered through fee-for-service. Managed care organizations (MCOs) also use medical necessity to make eligibility determinations for the programs and services they deliver. HHSC monitors the medical necessity determination for all MCOs through utilization reviews (URs). See also Utilization Reviews (URs).

***Medical Transportation Program (MTP)***

The Medical Transportation Program (MTP) is responsible for ensuring consistent, appropriate, reasonably prompt and cost-effective non-emergency medical transportation services to eligible Medicaid clients who need transportation to covered health care services.

***Medically Dependent Children Program (MDCP)***

The Medically Dependent Children Program (MDCP) is a 1915(c) waiver program delivered through the STAR Kids managed care program. MDCP provides a cost-effective alternative to living in a nursing facility to children with disabilities. Eligibility determinations for MDCP are based on medical necessity criteria outlined in the Texas Administrative Code. Managed care organizations (MCOs) provide medical necessity assessments, which are used by the Health and Human Services Commission (HHSC) to help determine whether an individual qualifies for MDCP. MDCP has an interest list. See also Appendix B, page 135, for a full list of MDCP services. See also STAR Kids.

***Medically Needy with Spend Down Program***

Through the Medically Needy with Spend Down Program, Medicaid pays for unpaid medical expenses for medical services provided to children age 18 and younger and pregnant women who meet the required Spend Down limits. Spend Down is the difference between an applicant's household income and the Medically Needy income limit. Applicants must have unpaid medical bills that exceed the Spend Down amount to receive benefits under the program. See also Medicaid for Pregnant Women.

***Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)***

A Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals who are dually eligible for both programs. D-SNPs can serve both full and partial benefit dual eligibles. D-SNPs can operate within or without the STAR+PLUS program. If in STAR+PLUS, a D-SNP must deliver Medicaid services through STAR+PLUS. D-SNPs that do not operate in STAR+PLUS are only responsible for covering member cost-sharing payments.

***Medicare Savings Program***

Through the Medicare Savings Program, Medicaid provides limited assistance to certain Medicare beneficiaries, known as partial dual eligibles, who do not qualify for full Medicaid benefits. Individuals in this program receive assistance with all or a portion of Medicare premiums, deductibles and coinsurance payments through Medicaid.

***Medication Assisted Therapy (MAT)***

Medication Assisted Therapy (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders (SUDs), which can help some people sustain recovery. An example is the use of methadone for opioid use disorder (OUD).

***Members with Special Health Care Needs (MSHCN)***

Members with special health care needs (MSHCN) refers to managed care clients who either (a) require regular, ongoing therapeutic intervention and evaluation by appropriately trained personnel, or (b) have a serious, ongoing illness; a chronic or complex condition; or a disability that has lasted or is anticipated to last for a significant period of time. MSHCN may include women with high-risk pregnancies, members with high-cost catastrophic cases, and individuals with mental illness and co-occurring substance abuse. All members in STAR+PLUS and STAR Kids are considered MSHCN.

***Modified Adjusted Gross Income (MAGI)***

Modified Adjusted Gross Income (MAGI) is a tool used for financial eligibility determinations. MAGI uses federal income tax rules for determining income and household composition. Federal law requires financial eligibility for programs like Medicaid be determined using MAGI, except for people age 65 and older, individuals with disability, and those receiving Supplemental Security Income (SSI).

***Mystery Shopper Method***

The state's external quality review organization (EQRO) uses the mystery shopper method to evaluate whether providers meet appointment availability standards and to quantify the extent of provider directory issues. Using contact information provided by managed care organizations (MCOs), mystery shoppers contact network providers to see how quickly they can get appointments across all Medicaid programs.

***National Core Indicators-Aging and Disabilities (NCI-AD) Survey***

On a biennial basis, the Health and Human Services Commission (HHSC) participates in the National Core Indicators-Aging and Disabilities (NCI-AD) survey, which is similar to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This

allows the state to assess outcomes of services provided to members who participate in STAR+PLUS Home and Community-based Services (HCBS) and the Program of All-Inclusive Care for the Elderly (PACE).

### ***Network Adequacy***

Network adequacy refers to access to care standards that the provider networks of managed care organizations (MCOs) must meet in order to ensure clients are able to access all medically necessary covered services. Provider networks must establish minimum provider access standards—including minimum distance, travel time and appointment availability for member access to providers; expedited credentialing for certain provider types as specified by the Health and Human Services Commission (HHSC); and online publication of provider directories, with provider information updated at least weekly.

### ***Non-financial Criteria***

In addition to meeting financial eligibility criteria, applicants must meet non-financial criteria—including that they meet program-specific age limits, reside and intend to remain in Texas, provide a Social Security number (SSN) or apply for one, and meet citizenship or alien status program requirements. See also Qualified Aliens.

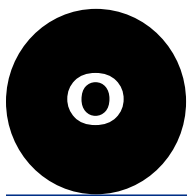
### ***Non-preferred Prior Authorization***

Non-preferred prior authorization may occur when prescribers choose medications listed on the Preferred Drug List (PDL) as “non-preferred” for their Medicaid patients. To prescribe the medication, the provider must obtain prior authorization from the Health and Human Services Commission (HHSC) or the patient’s managed care organization (MCO) before the drug is dispensed. See also Clinical Prior Authorization, Preferred Drug List (PDL) and Prior Authorization.

### ***Nursing Facility***

Nursing facilities are long-term care facilities that provide services to meet the medical, nursing and psychological needs of people who have a level of medical necessity requiring nursing care on a regular basis.





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### ***Office of Inspector General (OIG)***

The Office of Inspector General (OIG) is charged with safeguarding state health and human services by detecting and preventing fraud, waste and abuse and by ensuring the health and safety of Texans. The OIG engages in variety of activities related to Medicaid program integrity, including investigations, audits, inspections and reviews.

### ***Operational Review***

An operational review allows the Health and Human Services Commission (HHSC) to conduct an in-depth review of a managed care organization's (MCO's) operational compliance and performance across a number of areas to ensure policies and practices align with performance standards. HHSC conducts on-site biennial operational reviews of MCOs—including review modules on claims processing, member and provider training, complaints/appeals, encounter data, utilization management, and website critical elements.

### ***Optional Benefits***

The Social Security Act specifies a set of benefits state Medicaid programs must provide and a set of optional benefits states may choose to provide. The state may choose to provide some, all, or no optional services specified under federal law. See also Mandatory Benefits.



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### ***Pay-for-Quality (P4Q)***

Pay-for-quality (P4Q) refers to programs that seek to reward the use of evidence-based practices and promote health care coordination and efficacy among managed care organizations (MCOs). The Health and Human Services Commission (HHSC) implements medical P4Q programs for STAR, STAR+PLUS, Children's Health Insurance Program (CHIP), and a dental P4Q program. Strong P4Q programs incentivize MCOs to pursue quality-based alternative payment models (APMs) with providers to help them achieve higher performance on P4Q measures. See also Alternative Payment Model (APM).

***Pediatric Quality Indicator (PDI)***

Pediatric quality indicators (PDIs), which are similar to prevention quality indicators (PQIs), use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where effective outpatient care or early intervention can prevent hospitalization, complications or more severe disease. PDIs specifically screen for problems that children and youth may experience. See also Prevention Quality Indicators (PQIs).

***Performance Improvement Project (PIP)***

Performance improvement projects (PIPs) are an integral part of Texas' Managed Care Quality Improvement Strategy. Federal regulations require all states with Medicaid managed care programs to ensure health plans conduct PIPs. PIPs must use ongoing measurements and interventions to achieve significant improvement, over time, in health outcomes and enrollee satisfaction. Health plans conduct PIPs to improve areas of care identified by the Health and Human Services Commission (HHSC), in consultation with Texas' external quality review organization (EQRO), as needing improvement. See also External Quality Review Organization (EQRO).

***Per Member Per Month (PMPM)***

Per member per month (PMPM) rates are calculated for each risk group within each of the service areas in Texas—based on encounter data—and form the basis for the capitation rates paid to managed care organizations (MCOs) for the delivery of contractually required Medicaid and Children's Health Insurance Program (CHIP) services. See also Capitation Rate and Encounter Data.

***Personal Assistance Services (PAS)***

Personal Assistance Services (PAS) are state plan, community-based, long-term services and supports (LTSS) benefits for children and adults. PAS includes assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). In managed care, PAS can be delivered as an entitlement service, through the STAR+PLUS home and community-based services component, or through Community First Choice (CFC).

***Personal Care Services (PCS)***

Personal Care Services (PCS) are state plan, community-based, long-term services and supports (LTSS) benefits for children that include assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

***Pharmacy Benefits Manager***

Each Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO) contracts with a pharmacy benefits manager (PBM) to process prescription claims. The PBMs contract and work with pharmacies that dispense medications to Medicaid and CHIP managed care clients. MCOs must allow any pharmacy provider that is willing to accept the financial terms and conditions of the contract to enroll in the MCO's network.

***Postpartum Depression***

Postpartum depression is a mental health disorder that women may experience after giving birth. Symptoms must meet the diagnostic criteria set forth in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

***Potentially Preventable Admission (PPA)***

A potentially preventable admission (PPA) is a hospital admission or long-term care facility stay that might have been reasonably prevented with adequate access to ambulatory care or health care coordination. See also Potentially Preventable Event (PPE).

***Potentially Preventable Complication (PPC)***

A potentially preventable complication (PPC) is a harmful event or negative outcome, such as an infection or surgical complication, that occurs after a hospital admission or a long-term care facility stay and that might have resulted from care, lack of care or treatment during the admission or stay. See also Potentially Preventable Event (PPE).

***Potentially Preventable Emergency Department Visit (PPV)***

A potentially preventable emergency department visit (PPV) is emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a non-emergency setting. See also Potentially Preventable Event (PPE).

***Potentially Preventable Event (PPE)***

Potentially preventable events (PPEs) are encounters, which could be prevented, that lead to unnecessary services or contribute to poor quality of care. PPEs are used to measure care quality. See also Potentially Preventable Hospital Admission (PPA), Potentially Preventable Complication (PPC), Potentially Preventable Readmission (PPR), and Potentially Preventable Emergency Department Visit (PPV).

***Potentially Preventable Readmission (PPR)***

A potentially preventable readmission (PPR) is a return hospitalization, within a set time, that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow up. See also Potentially Preventable Event (PPE).

***Preadmission Screening and Resident Review (PASRR)***

A Preadmission Screening and Resident Review (PASRR) supports individuals with a mental illness, intellectual disability or developmental disability—who are at higher risk for moving into a nursing facility—to live independently in the community or most integrated setting of their choice. The PASRR process identifies the goals, wishes, and needed services and supports for these individuals to live a person-centered life—safely, and integrated within their community. If an individual is at risk of moving into a nursing facility and needs higher level supports and services to remain with their family or in the community, then these individuals are PASRR positive and are eligible for these enhanced levels of care.

***Preferred Drug List***

The Preferred Drug List (PDL) is a tool used to control growing Medicaid drug costs, while also ensuring program recipients are able to obtain medically necessary medicines. The PDL in Texas classifies drugs as preferred or non-preferred based on safety, efficacy and cost-effectiveness. Prescribers who choose non-preferred medications for their patients must obtain prior authorization. The Vendor Drug Program (VDP) and its vendors perform supplemental rebate negotiation with manufacturers and manage the PDL centrally across all Medicaid programs. Participating MCOs must use the PDL in administering pharmacy benefits to their members. See also Texas Drug Utilization Review (DUR) Board and Vendor Drug Program (VDP).

***Prescription Drugs***

Prescription drugs are pharmaceuticals that require a medical prescription from a provider to be dispensed. Outpatient prescription drugs are a benefit of Children's Health Insurance Program (CHIP) and all managed care programs. For those enrolled in fee-for-service (FFS) Medicaid, Texas pays for all outpatient drug coverage through the Vendor Drug Program (VDP). See also Vendor Drug Program (VDP).

***Prevention Quality Indicator (PQI)***

Prevention quality indicators (PQIs) use hospital discharge data to measure quality of care for ambulatory care sensitive conditions—which are conditions where effective outpa-

tient care or early intervention can prevent hospitalization, complications or more severe disease.

### ***Primary Care Provider (PCP)***

In managed care, primary care providers (PCPs) coordinate the care of Medicaid and CHIP clients and are responsible for providing initial and primary care to patients, maintaining continuity of care, and making referrals to specialists. PCPs tend to be general practitioners, family practice doctors, pediatricians, OB/GYNs, specialty trained nurses, or health clinics. Once enrolled into one of the managed care programs, clients pick a health plan, which includes a directory of PCPs contracting with that plan.

### ***Primary Home Care (PHC)***

Primary Home Care (PHC) services are state plan, community-based, long-term services and supports (LTSS) benefits for children and adults that include assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

### ***Prior Authorization***

A prior authorization is issued by a member's physician to document the medical necessity of a medication or medical service in certain situations before a managed care organization (MCO) can approve that medication or service. See also Clinical Prior Authorization and Non-clinical Prior Authorization.

### ***Profit Limit***

Managed care organizations (MCOs) are paid on a per member per month (PMPM) basis, also called a capitation rate. This rate includes a risk margin to account for fluctuations in predicted claims cost. This risk margin may result in profit for the plan. However, MCO profits are contractually limited and any profits earned over three percent are considered excessive profit and recovered by the Health and Human Services Commission (HHSC) through a tiered-experience rebate system. See also Per Member Per Month (PMPM) and Risk Margin.

### ***Program of All-inclusive Care for the Elderly (PACE)***

Program of All-inclusive Care for the Elderly (PACE) is a comprehensive care approach providing an array of services for a capitated monthly fee that is below the cost of comparable institutional care. PACE participants must be age 55 and older, live in a PACE service area, qualify for nursing facility level of care, and be able to live safely in the community at the time of enrollment. PACE participants receive all medical and social services needed through their PACE provider. PACE is available in Amarillo/Canyon, El Paso and Lubbock.

***Promoting Independence (PI) Initiative***

The Promoting Independence (PI) Initiative, also called Money Follows the Person (MFP) policy, provides the opportunity for individuals in need of long-term services and supports (LTSS) to move from facilities to community-based services. This better allows individuals to choose how and where they receive their LTSS. Other support services have since been developed to help identify individuals who want to leave an institutional setting and to assist them in relocating back to the community. PI is considered a reserve capacity group. See also Reserve Capacity Group.

***Prospective Drug Utilization Review (DUR)***

Prospective Drug Utilization Reviews (DURs) evaluate each client's drug history before medication is dispensed to ensure appropriate and medically necessary utilization. Therapeutic criteria for prospective DURs is determined by the Texas Drug Utilization Review (DUR) Board. See also Texas Drug Utilization Review (DUR) Board.

***Prospective Payment System (PPS)***

A prospective payment system (PPS) is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service. PPSs are used for inpatient and outpatient hospital reimbursement and rural health clinics (RHCs) reimbursement. Federally Qualified Health Centers (FQHCs) may be reimbursed using a PPS system or an alternative prospective payment system (APPS). PPS rates are inflated annually using the Medicare Economic Index (MEI) for primary care. See also Alternative Prospective Payment System (APPS).

***Provider Agency***

Provider agencies are the employers of attendants or other direct service workers, who provide long-term services and supports (LTSS), and are responsible for all of the employment and business operations-related activities. Provider agencies are licensed or certified by the Health and Human Services Commission (HHSC) and must comply with HHSC licensure and program rules.

***Provider Credentialing***

The process through which managed care organizations (MCOs) ensure that each health care provider meets all professional standards, including licensure.

### ***Provider Enrollment Screening***

The Office of Inspector General (OIG), in close collaboration with the Health and Human Services Commission (HHSC), completes the required state and federal disclosure and screening activities for high-risk providers seeking to enroll, re-enroll or revalidate their enrollment in Medicaid and other HHSC programs. See Office of Inspector General (OIG).

### ***Psychiatric Hospital***

A psychiatric hospital is an institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill people. The provisions for certification apply only where the entire institution is primarily for the treatment of mental illness. A psychiatric wing of a general hospital may not be certified.



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### ***Qualified Aliens***

Qualified aliens are non-citizen, Texas residents who are potentially eligible for certain programs like Medicaid. Qualified aliens may be subject to different requirements, such as waiting periods and time-based eligibility limitations. There are several categories, including but not limited to: Legal Permanent Residents (LPRs), asylees and refugees, and victims of human trafficking. See also Legal Permanent Resident (LPR).

### ***Qualified Disabled Working Individuals***

Qualified Disabled Working Individuals are dually eligible individuals who can receive partial, but not full, Medicaid benefits. Their income must be less than or equal to 200 percent of the federal poverty level (FPL). The Texas Medicaid program pays Medicare Part A premiums for disabled working individuals.

### ***Quality Assessment and Performance Improvement (QAPI) Projects***

Federal regulations require Medicaid health plans to develop, maintain and operate quality assessment and performance improvement (QAPI) programs. QAPI programs are ongoing, comprehensive quality assessment and performance improvement programs for all the services that the managed care organization (MCO) provides.

### ***Quality Incentive Payment Program (QIPP)***

The Quality Incentive Payment Program (QIPP) seeks to improve quality and innovation in the provision of nursing facility services. Both public and private nursing facilities can participate in the program. Payments are made quarterly by the STAR+PLUS managed care organizations (MCOs) to the nursing facilities, based on their completion of required quality improvement activities and their performance on agreed-upon quality measures.



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### ***Readiness Reviews***

The Health and Human Services Commission (HHSC) conducts readiness reviews to determine if a managed care organization (MCO) can provide the services that they are being contracted to provide. Readiness reviews are completed at least 90 days prior to the operational start of a contract to provide enough time to identify and remedy operational issues prior to contract start date.

### ***Regional Healthcare Partnership (RHP)***

Under the 1115 Transformation waiver, eligibility to receive Uncompensated Care (UC) or Delivery System Reform Incentive Payment (DSRIP) payments requires participation in one of the 20 Regional Healthcare Partnerships (RHPs) across Texas. RHPs collaborate to develop meaningful delivery system reforms and improve patient care for low-income populations. RHP plans include projects outlined in the RHP planning protocols. See also Regional Healthcare Partnership (RHP) Planning Protocols.

### ***Regional Healthcare Partnership (RHP) Planning Protocols***

Funds for the Delivery System Reform Incentive Payment (DSRIP) pool are divided into four categories, according to the Regional Healthcare Partnership (RHP) planning protocols: infrastructure development projects, program innovation and redesign projects, quality improvements, and population-focused improvements. Each of these four categories allow for the testing and piloting of new delivery system reforms, and assessments of their impact. See also Delivery System Reform Incentive Payment (DSRIP) Pool.

### ***Research and Demonstration 1115 Waivers***

Research and Demonstration 1115 waivers allow flexibility for states to test new ideas for operating their Medicaid programs—including implementing statewide health system



reforms; providing services not typically covered by Medicaid; or allowing innovative service delivery systems to improve care, increase efficiencies and reduce costs.

### ***Reserved Capacity Group***

A portion of 1915(c) waiver program slots are set aside for individuals in reserve capacity groups. When a waiver program slot opens, an individual from a reserve capacity group bypasses the general interest list and is given an eligibility determination for the program. Examples of reserved capacity groups are: Crisis Diversion and the Promoting Independence (PI) Initiative. See also Crisis Diversion.

### ***Resource-based Fee (RBF)***

Under the fee-for-service (FFS) delivery model, resource-based fees (RBFs) are a type of Medicaid rate used to pay physicians and other practitioners for services. Rates are uniform statewide and are categorized as either RBFs or access-based fees (ABFs). RBFs are calculated based on the actual resources required by an economically efficient provider to deliver a service. Reimbursement rates for services outlined above are evaluated at least once every two years as a part of a biennial fee review process. See also Access-based Fee (ABF) and Fee-for-Service (FFS) Rates.

### ***Retrospective Drug Utilization Review (DUR)***

Retrospective Drug Utilization Reviews (DURs) examine drug therapy after the person has received the medication. Retrospective DURs evaluates claims data to analyze prescribing practices, a person's medication use and pharmacy dispensing practices. The Health and Human Services Commission (HHSC) and managed care organizations (MCOs) conduct multiple reviews each calendar year on topics—such as identifying patterns of drug misuse, medically unnecessary prescribing or inappropriate prescribing. Intervention letters are sent to physicians to help better manage a person's drug therapy. The Texas Drug Utilization Review (DUR) Board also reviews and approves the retrospective DURs for fee-for-service (FFS). See also Texas Drug Utilization Review (DUR).

### ***Risk Margin***

In capitation rate setting, a risk margin is added in case of possible fluctuations in predicted claims cost. This margin is calculated as a percentage of the initial capitation rate. To the extent that a managed care organization (MCO) successfully manages member care and keeps medical costs and administrative costs on target, the risk margin may result in profit for the health plan. The Health and Human Services Commission (HHSC) has reduced the risk margin for most programs, and this new lower risk margin could potentially translate to additional profit limits. See also Capitation Rates and Profit Limits.

***Rural Health Clinics (RHC)***

A rural health clinic (RHC) is a clinic located in a rural area, designated by the U.S. Health Resources and Services Administration as a “shortage area.” To qualify as an RHC, the clinic must be located in a non-urbanized and medically underserved area and have a nurse practitioner or physician assistant in the clinic 50 percent of the time. An RHC may not exist as a rehabilitation agency or serve primarily as a treatment facility for mental diseases.

***Rural Hospital***

A rural hospital is typically categorized by its location outside of a city or metropolitan area and by its size and caseload, which are usually considerably smaller than urban hospitals.

***School Health and Related Services (SHARS)***

The School Health and Related Services (SHARS) program reimburses independent school districts, including public charter schools, for providing Medicaid services to children with disabilities. This program covers certain health-related services documented in a student’s Individualized Education Program or, for audiology services only, a student’s 504 plan. Services include audiology services; counseling; physician and nursing services; physical, speech, and occupational therapies; personal care services; and psychological services, such as assessments and transportation in a school setting.

***Service Area (SA)***

Service areas (SAs) are the geographic locations within the state where services are delivered by certain health plans and their providers. SAs may also be referred to as Service Delivery Areas (SDAs).

***Service Comparability***

In general, the state is required to provide the same level of services to all clients, except where federal law specifically requires a broader range of services or allows a reduced package of services.

### ***Service Coordination***

Managed care organizations (MCOs) are required to provide service coordination to STAR Health, STAR Kids and STAR+PLUS members who meet the eligibility criteria. Service coordination, as well as eligibility for the service, may be defined differently by program. For example, children in STAR Kids are automatically eligible for this service, while adults in STAR+PLUS must have complex health needs to receive service coordination. See also Service Management. See also A Closer Look, page 43.

### ***Service Management***

Managed care organizations (MCOs) are required to provide service management for STAR, STAR Health, and Children's Health Insurance Program (CHIP) members who meet the eligibility criteria. Like service coordination, the definition and eligibility criteria for service management may be defined differently by program. See also Service Coordination. See also A Closer Look, page 43.

### ***Service Responsibility Option***

Service Responsibility Option (SRO) is available in Medicaid managed care programs, Community Attendant Services (CAS), and Primary Home Care (PHC). SRO is a hybrid of the agency option and Consumer Directed Services (CDS) option—in which an individual, the provider agency, and when applicable the managed care organization (MCO) work together to provide the individual with increased control over the delivery of their services. In Medicaid managed care, services with the CDS option also have SRO. See also Consumer Directed Services (CDS) Option.

### ***Single State Agency***

As required by federal law, a single agency must be designated by each state to administer and supervise the administration of the Medicaid state plan. In Texas, the Health and Human Services Commission (HHSC) fulfills this function. See also Health and Human Services Commission (HHSC).

### ***STAR***

STAR is a statewide managed care program primarily for pregnant women, low-income children and their caretakers. Most people in Texas Medicaid get their coverage through STAR.

### ***STAR Health***

STAR Health is a statewide managed care program that provides coordinated health services to children and youth in foster care and kinship care. STAR Health benefits

include medical, dental and behavioral health services—as well as service coordination and a web-based electronic medical record, known as the Health Passport.

### ***STAR Kids***

STAR Kids is a statewide managed care program for children and youth age 20 and younger with disabilities, including children and youth receiving benefits under the Medically Dependent Children Program (MDCP) waiver.

### ***STAR+PLUS***

STAR+PLUS is a statewide managed care program for adults with disabilities and those age 65 and older.

### ***STAR+PLUS Home and Community-based Services (HCBS) Program***

STAR+PLUS Home and Community-based Services (HCBS) is a waiver program delivered through managed care that provides a cost-effective alternative to living in a nursing facility for individuals who are elderly or have disabilities. STAR+PLUS HCBS is delivered through the Texas 1115 Healthcare Transformation Waiver. Eligibility determinations for STAR+PLUS HCBS are based on medical necessity criteria outlined in the Texas Administrative Code. Managed care organizations (MCOs) provide medical necessity assessments, which are used by the Health and Human Services Commission (HHSC) to help determine whether an individual qualifies for STAR+PLUS HCBS. STAR+PLUS HCBS has an interest list. See also Appendix B, page 135, for a full list of STAR+PLUS HCBS services. See also STAR+PLUS.

### ***State-owned Teaching Hospital***

Teaching hospitals provide medical education, including post-graduate residency training programs, which incur higher expenses than hospitals without these programs. The portion of these costs attributable to serving Medicaid patients may be covered by Graduate Medical Education (GME) payments. See also Graduate Medical Education (GME) payments.

### ***State Plan***

State plans describe the nature and scope of the Medicaid program, including administration, client eligibility, benefits and provider reimbursement. All state plans must be approved by the Centers for Medicare and Medicaid Services (CMS). The state plan in Texas gives the Health and Human Services Commission (HHSC), as the single state agency, the authority to administer the Medicaid program. See also Single State Agency.

### ***State Supported Living Center (SSLC)***

State Supported Living Centers (SSLCs) are certified intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) that serve individuals with an intellectual disability who have medical or behavioral health needs. SSLCs provide 24-hour residential services, comprehensive behavioral treatment, health care, and other services in a campus setting.

### ***Statewide Availability***

In general, a state must offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options.

### ***Substance Use Disorder (SUD)***

A substance use disorder (SUD) occurs when an individual's use of a substance, such as alcohol or opioids, leads to health issues or problems in everyday life—work, school or home. The pattern must meet the diagnostic criteria set forth in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). The benefits of Medicaid SUD treatment include assessment, outpatient treatment, medication assisted therapy (MAT), and residential and ambulatory detoxification. Services must be provided by a chemical dependency treatment facility (CDTF). See also Medication Assisted Therapy (MAT).

### ***Sufficient Coverage***

Federal law allows states to determine what constitutes "reasonably sufficient" coverage in terms of the amount, duration and scope of services. Each state defines these parameters; thus, state Medicaid plans vary in what and how much they cover.

### ***Supplemental Hospital Funding***

The Health and Human Services Commission (HHSC) administers supplemental hospital payment programs that help cover the cost of uncompensated care, incentivize improvements to care quality and fund graduate medical education. Examples include the Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP) pools created under the 1115 Transformation waiver. See also Delivery System Reform Incentive Payment (DSRIP) Pool, Uncompensated Care (UC) Pool, and 1115 Transformation Waiver.

### ***Supplemental Nutrition Assistance Program (SNAP)***

The Supplemental Nutrition Assistance Program (SNAP), also known as food stamps, helps people buy the food they need for good health.

### ***Supplemental Security Income (SSI)***

Supplemental Security Income (SSI) is a federal cash assistance program for low-income individuals with disabilities and those age 65 and older. In Texas, all people eligible for SSI are automatically eligible for Medicaid.

### ***Suspension of Default Enrollment***

Suspension of default enrollment is a contractual non-compliance remedy that temporarily stops a managed care organization (MCO) from receiving clients through the default enrollment process. See also Default Enrollment.



### ***Targeted Review***

The Health and Human Services Commission (HHSC) conducts a targeted review of a managed care organization (MCO) when a significant or recurring problem occurs. The scope, entity and focus of targeted reviews vary based on the topics raised by complaints received and past instances of non-compliance.

### ***Temporary Assistance for Needy Families (TANF)***

The Temporary Assistance for Needy Families (TANF) program is a cash-assistance program that helps families pay for basic living needs.

### ***Texas Department of Family and Protective Services (DFPS)***

The Texas Department of Family and Protective Services (DFPS) is responsible for investigating charges of abuse, neglect or exploitation of children, elderly adults and adults with disabilities. DFPS also manages children in state conservatorship or foster care.

### ***Texas Department of Insurance (TDI)***

The Texas Department of Insurance (TDI) regulates both commercial and state-funded health insurance plans because managed care organizations (MCOs) are licensed as Health Maintenance Organizations (HMOs) in Texas. TDI requires MCOs to file a network adequacy report once a year. See also Network Adequacy.

### ***Texas Drug Utilization Review (DUR) Board***

The Texas Drug Utilization Review (DUR) Board is a Health and Human Services Commission (HHSC) advisory board whose members are appointed by the HHSC Executive Commissioner. The duties of the Texas DUR Board include developing and submitting recommendations to HHSC for the Preferred Drug List (PDL), suggesting restrictions or prior authorizations for certain prescription drugs, developing and reviewing educational interventions for Medicaid providers, and reviewing drug utilization across the Medicaid program. See also Clinical Prior Authorization and Preferred Drug List (PDL).

### ***Texas Formulary***

The Texas Formulary is a list of all the drugs covered by Texas Medicaid and the Children's Health Insurance Program (CHIP).

### ***Texas Healthcare Learning Collaborative (THLC)***

Texas Healthcare Learning Collaborative (THLC) is a website that serves as a public reporting platform, contract oversight tool, and a tool for managed care organization (MCO) quality improvement efforts. It was developed for use by the Health and Human Services Commission (HHSC), MCOs, providers, and the general public to obtain up-to-date MCO and hospital performance data on key quality-of-care measures—including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality-of-care information.

### ***Texas Health Steps***

Texas Health Steps is a required program, known in federal law as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Texas Health Steps provides medical and dental prevention and treatment services for children of low-income families, who are age 20 and younger and are enrolled in Medicaid. The program offers comprehensive and periodic evaluation of a child's health—including growth and development; nutritional status; and vision, dental and hearing care. See also Comprehensive Care Program (CCP).

### ***Texas Home Living (TxHmL)***

Texas Home Living (TxHmL) is a 1915(c) waiver program that provides community-based services to current Medicaid recipients with intellectual disabilities or related conditions, as an alternative to an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). Eligibility determinations for TxHmL are based on level of care (LOC) criteria outlined in the Texas Administrative Code. TxHmL has an interest list. See also Appendix B, page 136, for a full list of TxHmL services.

### ***Texas Neonatal Intensive Care Unit (NICU) Project (TNP)***

The Texas Neonatal Intensive Care Unit (NICU) Project (TNP), a Better Birth Outcomes (BBO) initiative, is a research collaborative involving Texas Medicaid, the Texas Department of State Health Services (DSHS), the Dartmouth Institute for Health Policy and Clinical Practice, The University of Texas Health Science Center at Houston - School of Public Health, and the University of Florida - Institute for Child Health Policy. This study analyzes linked Medicaid, birth certificate and death certificate data for all Medicaid-paid births in Texas for calendar years 2010-2014 to better understand recent growth in Texas' NICU capacity and payments. See also Better Birth Outcomes (BBO).

### ***Third-party Liability (TPL)***

Third-party liability (TPL) is a requirement of federal law for Medicaid to be the payer of last resort. This means that other sources of coverage a client or Medicaid-eligible patient may have, such as private health insurance, may be required to pay claims before Medicaid. Medicaid is also required to take reasonable measures to identify liable third parties and process claims accordingly.

### ***Time and Distance Standards***

Time and distance standards are metrics used to ensure managed care organization (MCO) provider networks can and are sufficiently capable of providing their members access to medically necessary services.



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### ***Uncompensated Care (UC) Pool***

The Uncompensated Care (UC) pool is one of two hospital funding pools under the 1115 Transformation waiver, along with the Delivery System Reform Incentive Payment (DSRIP) pool. UC payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other health care providers. Though previously defined as either unreimbursed costs for Medicaid or uninsured patients incurred by hospitals, uncompensated care costs are currently defined as unreimbursed charity care costs. The pool has historically been smaller than the reported total uncompensated care costs. See also Delivery System Reform Incentive Payment (DSRIP) Pool and 1115 Transformation Waiver.



### ***Uniform Hospital Rate Increase Program (UHRIP)***

The Uniform Hospital Rate Increase Program (UHRIP) is designed to reduce hospitals' uncompensated care costs through enhanced payments to hospitals for medically necessary covered services provided to Medicaid managed care members.

### ***Uniform Managed Care Contract***

The uniform managed care contract is a legal document that establishes the requirements that all managed care organizations (MCOs) must follow.

### ***Urban Hospital***

An urban hospital is typically categorized by its location within a city or metropolitan area and its size and caseload, which are usually considerably larger than rural hospitals.



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### ***Vendor Drug Program***

The Vendor Drug Program (VDP) provides outpatient drug coverage for individuals enrolled in fee-for-service (FFS). In addition, the VDP maintains control of certain aspects of the pharmacy administration for both FFS and managed care—including managing federal and supplemental drug rebates, the Preferred Drug List (PDL), and clinical prior authorizations. See also Clinical Prior Authorization, Fee-for-Service (FFS) and Preferred Drug List (PDL).



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### ***Waivers***

Federal law allows states to apply to the Centers for Medicare and Medicaid Services (CMS) for permission to depart from certain Medicaid requirements. Federal law allows three types of waivers: Research and Demonstration 1115 waivers, Freedom of Choice 1915(b) waivers, and Home and Community-based Services (HCBS) 1915(c) waivers.

## **Waste**

Waste refers to any practice that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items or services.



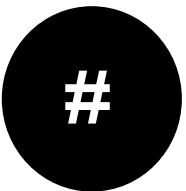
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### ***Your Texas Benefits Website***

A self-service website ([YourTexasBenefits.com](https://YourTexasBenefits.com)) where individuals can apply for Medicaid and other Texas Health and Human Services Commission (HHSC) programs. Clients can also accomplish the following online: view benefit information, edit and manage personal information, select their health plan, print temporary Medicaid cards or order replacement cards, set up and view their Texas Health Steps alerts, and view services provided by Medicaid.

### ***Youth Empowerment Services (YES)***

The Youth Empowerment Services (YES) is a 1915(c) waiver program that provides community-based services to children and adolescents age 3 through age 18 who have severe mental, emotional or behavioral disturbances—and their families.



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### ***1115 Healthcare Transformation Waiver***

The expansion of managed care has resulted in the end of the Upper Payment Limit (UPL) program, as federal regulations prohibit supplemental payments to providers in a managed care context. To preserve federal hospital funding, the Health and Human Services Commission (HHSC) submitted—and the Centers for Medicare and Medicaid Services (CMS) approved—a proposal for a five-year Section 1115 Demonstration waiver, called the 1115 Healthcare Transformation waiver. The 1115 Healthcare Transformation waiver contains hospital funding pools, including the Uncompensated Care (UC) pool and the Delivery System Reform Incentive Payment (DSRIP) pool.

# Acknowledgments

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The Health and Human Services Commission's (HHSC's) Medicaid and CHIP Services (MCS) Department sincerely thanks the dozens of hard-working individuals throughout the organization who contributed to the 13th edition of the Texas Medicaid and CHIP Reference Guide, also endearingly referred to as the "Pink Book".

Creating each edition of this guide requires a full team effort. Publishing this year's edition, while also responding to an unprecedented public health emergency, is an example of the commitment of the individuals who work at HHSC.

Staff from MCS Change Management led the book's updates and continued evolution with support from the MCS Project Advisory and Coordination Team. The following areas provided critical program, financial and enrollment data:

- All MCS units
- HHSC Financial Services
- Access and Eligibility Services
- Center for Analytics and Decision Support
- Health, Developmental and Independence Services
- Health and Specialty Care System
- Intellectual and Developmental Disabilities (IDD) and Behavioral Health Services
- Office of the Inspector General
- Department of State Health Services (DSHS) Vital Statistics

Every attempt has been made to ensure the accuracy of the material reported in this book at the time of publication in December 2020.