SPH, Glossary

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**Acute care** —. Preventive care, primary care, and other medical care provided under the direction of a provider for a condition having a relatively short duration.

**Agency option (AO)** — A service delivery option under which the provider is responsible for managing the day-to-day activities of the attendant and all business details.

**Applicant** — A person who has applied for Medicaid benefits.

**Authorized Representative** —Any person or entity acting on behalf of the individual and with the individual’s written consent.

**Centers for Medicare and Medicaid Services (CMS)** — The federal agency that administers Medicare and Medicaid.

**Code of Federal Regulations (CFR)** — The codified federal regulatory law that governs most federal programs, including Medicaid.

**Community First Choice (CFC) option** — Personal assistance services; habilitation services focused on the acquisition, maintenance and enhancement of skills; emergency response services; and support management provided in a community setting for eligible Medicaid members in the STAR PLUS Home and Community Based Services program who have received an institutional Level of Care (LOC) determination.

**Community Living Assistance and Support Services (CLASS)** — A non-capitated 1915(c) waiver which provides home and community-based services to individuals with intellectual or developmental disabilities.

**Consumer Directed Services Employer** – A member or legally authorized representative (LAR), parent, or court appointed guardian who chooses to participate in the CDS option and therefore is responsible for hiring and retaining service providers to deliver program services.

**Consumer Directed Services (CDS) option** — A service delivery option in which a member or LAR employs and retains service providers and directs the delivery of eligible STAR+PLUS Home and Community Based Services (HCBS) program services. A member participating in the CDS option is required to use a financial management services agency (FMSA) chosen by the member or LAR to provide financial management services.

**Days —** A calendar day, unless otherwise specified in the text. A calendar day includes weekends and holidays.

**Deaf Blind with Multiple Disabilities (DBMD)** — A non-capitated 1915(c) waiver which provides home and community-based services to individuals who are deaf and blind and have a third disability.

**Denial —**Closure of an application with a finding of ineligibility.

**Designated Representative (DR)** — A willing adult appointed by the CDS employer to assist with or perform the employer's required responsibilities to the extent approved by the employer. A DR, usually a family member, is not a paid service provider and is at least age 18.

**Eligibility date** — The first date all eligibility criteria are met, as described in [Section 3240](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-and-services#3240), STAR+PLUS Home and Community Based Services Program Requirements.

**Employee (a.k.a. service provider)** — An individual who is hired, trained and managed by the employer to provide services authorized by the MCO.

**Enrollment broker** — A contracted entity that assists individuals in selecting and enrolling with a managed care organization (MCO). If requested, the enrollment broker also may assist the member in choosing a primary care physician (PCP).

**Family member** — A person who is related by blood, affinity or law to an individual.

**Financial Management Services (FMS)** — Assistance provided to members who manage funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

**Financial management services agency (FMSA)** — An agency that contracts with the MCO to provide FMS to members who choose the CDS option.

**Health maintenance activity (HMA)**— A task that may be exempt from delegation based on registered nurse assessment that enables the member to remain in an independent living environment, and goes beyond activities of daily living because of the higher skill level required to perform.

**Home and community-based services (HCS)** — A non-capitated 1915(c) waiver which provides home and community-based services to individuals with intellectual or developmental disabilities as cost-effective alternatives to institutional care.

**Individual service plan (ISP)** — An individualized and person-centered plan in which a member enrolled in the STAR+PLUS HCBS program operated by the MCO, with assistance as needed, identifies and documents his or her preferences, strengths, and health and wellness needs in order to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services The ISP is supported by the results of the member's program-specific assessment and must meet the requirements of 42 CFR §441.301.

**Individual Service Plan (ISP) Service Tracking Tool** — This tool is developed at least annually by the member, the MCO and family members to document necessary MDCP services determined by the member’s team and the budget associated with delivering the services. The total cost of the member’s budget provided on this tool must be below the determined cost ceiling. This is also known as Form 2604.

**Intellectual and developmental disability (IDD)** — A disability with onset during the developmental period that includes limitations in both intellectual and adaptive functioning, which covers many everyday conceptual, social, and practical skills. IDD can begin at any time, up to age 22. It usually lasts throughout a person's lifetime.

**Interdisciplinary team (IDT)** — All individuals/entities involved in planning the member’s plan of care (POC). This typically includes the member, the member’s authorized representative, the service coordinator, the primary care physician, etc.

**Legally authorized representative (LAR)**— A person authorized by law to act on behalf of a member, including a parent of a minor, guardian of a minor, managing conservator of a minor or the guardian of an adult, as defined by state or federal law, including Texas Occupations Code §151.002(6), Texas Health and Safety Code §166.164, and Texas Estates Code Chapter 752.

**Long-term Services and Supports (LTSS)** — Services, including Primary Home Care, Day Activity and Health Services, and the STAR+PLUS HCBS program, that assist members in living in the community.

**Managed Care Compliance & Operations (MCCO)** — A unit within the Medicaid/Children's Health Insurance Program (CHIP) Division of HHSC that is responsible for administrative and operational aspects of administering the Medicaid managed care programs.

**Managed care organization (MCO)** — An established health maintenance organization or Approved Non-Profit Health Corporation (ANHC) that arranges for the delivery of health care services. In accordance with Chapter 843 of the Texas Insurance Code, it is currently licensed as such in the state of Texas.

**Medicaid Estate Recovery Program (MERP)** — A program that requires Texas Health and Human Services (HHSC), as the State Medicaid agency, to recover the costs of Medicaid long-term care benefits received by certain Medicaid recipients. For further information, see the MERP website at [http://dadsview.dads.state.tx.us/merp/index.html (link is external)](http://dadsview.dads.state.tx.us/merp/index.html).

**Medical necessity (MN)** — The medical criteria a person must meet for admission to a Texas nursing facility (NF), as defined in Texas Administrative Code, Title 40 §19.2401.

**Member** — An individual who is enrolled in and receiving services through a STAR+PLUS MCO.

**Money Follows the Person (MFP)** — A process used when a member in a Medicaid-certified NF who requests to move to the community is Medicaid-eligible and approved for the STAR+PLUS HCBS program before leaving the NF.

**Mutually exclusive services** — Two or more services that may not be authorized for the same individual during the same time period.

**Plan of care (POC)** — A care plan the MCO develops for its members that includes acute care and LTSS. The POC is not the same as the ISP .

**Program Support Unit (PSU)**— An HHSC unit with staff who support and handle certain aspects of the STAR+PLUS HCBS program, as described in [Section 3300](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-and-services" \l "3300" \o "Section 3300, Administrative Procedures), Administrative Procedures.

**Provider**— An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the MCO for the delivery of covered services to the MCO’s members.

**Responsible party** — An individual who:

* assists and/or represents an applicant or member in the application or eligibility redetermination process; or
* is familiar with the applicant or member and his or her financial affairs and functional condition.

**Service coordinator** — The MCO staff person with primary responsibility for providing service coordination and care management to STAR+PLUS members.

**Service Responsibility Option (SRO)** — A service delivery option that empowers the member to manage most day-to-day activities. This includes supervision of the individual providing personal attendant services (PAS). The member decides how services are provided. It leaves the business details to a provider of the member's choosing.

**Social Security Administration (SSA)** — U.S. government agency created in 1935 by President Franklin D. Roosevelt, the **SSA** administers the social insurance programs in the U.S. The agency covers a wide range of Social Security services, such as disability, retirement and survivors benefits.

**STAR Kids** — Managed care program for recipients under the age of 21 who receive SSI, SSI-related Medicaid, and/or 1915(c) waiver services.

**STAR+PLUS Home and Community Based Services (HCBS)** program — Authority granted to the state of Texas to allow delivery of community-based LTSS that assist members to live in the community in lieu of an NF.

**STAR+PLUS program** — The State of Texas Access Reform Plus Medicaid managed care program in which HHSC contracts with MCOs to provide, arrange, and coordinate preventive, primary, acute and long term care covered services to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO program. Children under age 21, who qualify for Medicaid through the SSI program, may voluntarily participate in the STAR+PLUS program. The STAR+PLUS program is the umbrella designation that includes both the STAR+PLUS services and STAR+PLUS HCBS program.

**STAR+PLUS program specialist** — The staff person responsible, along with Managed Care Compliance & Operations, for STAR+PLUS policy development.

**STAR+PLUS Services** — Authority granted to the state of Texas to allow delivery of Medicaid State Plan acute care, Primary Home Care (PHC), and Day Activity and Health Services (DAHS) through a managed care delivery system statewide.

**Supplemental Security Income (SSI)** — Federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

**Support advisor** — An employee who provides support consultation to an employer, a DR, or a member receiving services through the CDS option.

**Support consultation** — An optional service that is provided by a support advisor and provides a level of assistance and training beyond that provided by the FMSA through FMS or CFC support management. Support consultation helps a CDS employer to meet the required employer responsibilities of the CDS option and to successfully manage the delivery of program services.

**Texas Administrative Code (TAC)** — A compilation of all the state rules in Texas.

**Termination —**Closure of an ongoing case due to a finding of ineligibility.

**Texas Health and Human Services Commission (HHSC)** — Administrative agency within the executive department of the state of Texas established under Texas Government Code Chapter 531. HHSC is the single state agency charged with administration and oversight of the Texas Medicaid program, including Medicaid managed care.

**Texas Medicaid & Healthcare Partnership (TMHP)** — The Texas contractor administering Medicaid provider enrollment and fee-for-service claims processing. TMHP is responsible for processing Medical Necessity and Level of Care (MN/LOC) Assessments for the waivers.

**Third-Party Resource (TPR)**— Any individual, entity or program that is, or may be, liable to pay for, or provide, any medical assistance or supports to a recipient under the approved state Medicaid plan, or as part of their caregiving arrangement without pay.

**TxMedCentral** — A secure Internet bulletin board the state and MCOs use to share information, as described in [Section 5110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-5000-automation-and-payment-issues-starplus" \l "5110" \o "5110), TxMedCentral Naming Convention and File Maintenance.

**Unlicensed Assistive Person (UAP)**— A paraprofessional who assists individuals with physical disabilities, mental impairments, and other health care needs with their activities of daily living (ADLs), and provides bedside care. A UAP may perform nursing tasks only in specific situations, as governed by the Texas Administrative Code (TAC) for the Texas Board of Nursing, Title 22, Part 11, Rules 224 and 225.

**Upgrade** — An existing STAR+PLUS member who requests STAR+PLUS HCBS program services or if the MCO determines the member would benefit from the STAR+PLUS HCBS program and is granted services after meeting waiver eligibility criteria.