

Glossary

A

ACTIVITIES OF DAILY LIVING

(ADLs) – Activities that are essential to daily personal care including bathing or showering, dressing, getting in or out of bed or a chair, using a toilet, and eating.

ADOPTION ASSISTANCE (AA)

AA is a program designed to facilitate the adoption of children with special needs by providing Medicaid health coverage for the child, monthly payments to assist in meeting the child's needs, and reimbursement for some adoption fees up to a certain amount.

AGENCY OPTION (AO)

AO is the traditional method of service delivery in which services are delivered through a provider agency. The provider agency is the employer, therefore it is responsible for duties such as: hiring, training, managing, and dismissing employees; employee payroll and taxes; liability (e.g., on-the-job injuries); and providing back-up services. See also **CONSUMER DIRECTED SERVICES; SERVICE RESPONSIBILITY OPTION.**

AGING AND DISABILITY

RESOURCE CENTER (ADRC)

An initiative supported by a grant

from the Administration on Aging to improve access to long-term services and supports. Texas has ADRCs in nine areas of the state.

ALBERTO N. V. TRAYLOR

– A federal lawsuit that was settled in May 2005 and requires 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 under 21 years of age that are eligible for the Medicaid Early and Periodic Screening, Diagnosis and Treatment program. See also **TEXAS HEALTH STEPS.**

ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS

(APR-DRG) – A system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications. This system of classification is used as a financing mechanism to reimburse hospitals and other providers for services rendered.

AMOUNT, DURATION, AND

SCOPE – How a Medicaid benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state

Medicaid plans vary in what they cover.

APPLICANT – A person who has applied for Medicaid or CHIP benefits.

THE AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) – A federal law passed in February 2009 providing economic stimulus funding through a multitude of new and existing programs and providing a temporary increase in the Federal Medical Assistance Percentage (FMAP) rate during the 27-month recession adjustment period from October 2008 through December 2010.

AVERAGE RECIPIENT (CLIENT) MONTHS PER MONTH – The arithmetic average of the number of Medicaid recipient months (the number of certified, unduplicated Medicaid clients in a given month). In most Medicaid-related reports, this average is generally cited in reference to a state or federal fiscal year. See also **CLIENT**.

B

BALANCED BUDGET ACT (BBA) – A federal law (P.L. 105-33) passed in 1997 designed to achieve substantial reductions in spending to balance the federal budget by the year 2002. The law made several changes to Medicaid and Medicare, and created

the State Children’s Health Insurance Program. See also **CHILDREN’S HEALTH INSURANCE PROGRAM**.

BALANCED BUDGET REFINEMENT ACT (BBRA) – A federal law (P.L. 106-113) passed in 1999 that included payment reforms and other technical changes intended to address the reduction in payments experienced by Medicare providers under the Balanced Budget Act. See also **BALANCED BUDGET ACT**.

BALANCING INCENTIVE PROGRAM (BIP) – The federal BIP authorized \$3 billion for states through September 2015 to increase access to community-based long term services and supports using a No Wrong Door system, statewide standardized assessment instruments, and administrative separation of eligibility and case management from service provision to reduce or eliminate conflict in case management. See also **LONG-TERM SERVICES AND SUPPORTS; NO WRONG DOOR**.

BEHAVIORAL HEALTH CARE – Assessment and treatment of mental or emotional disorders and substance use disorders. See also **SUBSTANCE USE DISORDER**.

BEHAVIORAL HEALTH ORGANIZATION (BHO) – A managed care organization that provides or contracts for behavioral health services.

BENEFICIARY – One who benefits from a publicly-funded program. Most commonly used to refer to people enrolled in the Medicare program.

BENEFIT IMPROVEMENT AND PROTECTION ACT (BIPA) – A federal law (P.L.106-554) passed in 2000 that increased disproportionate share hospital payments, modified the upper payment limit for governmental facilities, and allowed federal State Children’s Health Insurance Program allocations to be carried forward. See also **CHILDREN’S HEALTH INSURANCE PROGRAM; DISPROPORTIONATE SHARE HOSPITAL; UPPER PAYMENT LIMIT.**

BENEFIT PACKAGE – Services an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

BETTER BIRTH OUTCOMES (BBO) – A collaboration between HHSC and the Department of State Health Services to improve access to women’s preventive, interconception, prenatal, and perinatal health care. The collaboration focuses on meeting a client’s health care needs impacting her ability to have a healthier pregnancy.

BREAST AND CERVICAL CANCER SERVICES (BCCS) – BCCS helps fund clinic sites across the state to provide quality, low-cost, and

accessible breast and cervical cancer screening and diagnostic services to women who reside in Texas, are over the age of 18, do not have health insurance and meet income limits. See also **MEDICAID FOR BREAST AND CERVICAL CANCER.**

C

CAPITATION – A prospective payment method that pays a managed care organization a uniform amount on a monthly basis for each enrolled member for the provision of covered services.

CARE COORDINATION – A service available to recipients of Medicaid Managed Care, including STAR, STAR+PLUS, STAR Health, and the Children’s Health Insurance Program. (This service is called Service Management in STAR and CHIP and Service Coordination in STAR Health). Care coordination includes working with individuals and families to develop a plan of care to meet the needs of the individual and to coordinate the services of the managed care organization.

CARVE-IN – Refers to the transition of a Medicaid service or population from fee-for-service to managed care delivery.

CARVE-OUT – A decision to purchase separately a service that is typically part of a managed care organization plan.

CASE MANAGEMENT – Services that assist individuals receiving Medicaid to gain access to needed medical, social, educational, and other services. Case management includes assessing an individual’s needs and strengths and developing, implementing, and monitoring the implementation of a care plan. Case management is available through such resources as the Case Management for Children and Pregnant Women program; the Early Childhood Intervention program; local mental health authorities; Medicaid home and community-based services waiver programs such as Community Living Assistance and Support Services and Home and Community-based Services; and through services for the visually or hearing impaired. See also **LOCAL MENTAL HEALTH AUTHORITY**.

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN SERVICES – Health-related case management services to eligible children (birth through age 20) and pregnant women. Case managers are approved through the Texas Department of State Health Services and enrolled with the Texas Medicaid & Healthcare Partnership (TMHP) as Medicaid providers. See also **CASE MANAGEMENT; CASE MANAGER**.

CASE MANAGER – An experienced professional (typically a nurse, social worker, qualified mental

health professional, qualified mental health professional, or parent case manager) who works with individuals, service providers, and others to develop and implement a care plan to coordinate all services needed to meet an individual’s medical, social, educational, and other needs.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) – The federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) – CSHCN are defined in the Uniform Managed Care Contract for Medicaid and the Children’s Health Insurance Program as children from birth up to age 19 who meet all of the following criteria:

- Have a serious ongoing illness, complex chronic condition, or disability that has lasted or is anticipated to last at least twelve continuous months or more.
- Have an illness, condition, or disability that results (or without treatment would be expected to result) in limited function, activities, or social roles compared to the accepted pediatric age-related milestones.
- Require regular, ongoing therapeutic intervention and evaluation.

- Have a need for health or health-related services at a level significantly above the usual for the child's age.

These children are provided special protections under Medicaid managed care. Protections include efforts to identify CSHCN and ensure that the state has appropriate quality and care coordination guidelines in place for CSHCN.

The CSHCN Services program is the name of a non-Medicaid, Title V and state-funded program at HHSC. The definition of CSHCN for the HHSC program differs from that of the Uniform Managed Care Contract and aligns with the definition in Title V legislation.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) – The Balanced Budget Act of 1997 enacted on August 5, 1997, established a new state children's health insurance program by adding Title XXI to the Social Security Act and amending the Medicaid statute. The purpose of this program is to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION (CHIPRA) – Passed by Congress in February 2009, CHIPRA extended federal Children's Health Insurance

Program funding to states through September 2013. CHIPRA includes multiple provisions that allow states new options for their programs. See also **CHILDREN'S HEALTH INSURANCE PROGRAM**.

CHILDREN'S HOSPITAL – A hospital within the state which is recognized under Medicare as a children's hospital and which is exempted by Medicare from the Medicare prospective payment system. See also **MEDICARE**.

CHIP PERINATAL PROGRAM (CHIP-P) – The CHIP Perinatal program provides prenatal care to the unborn children of pregnant women up to 202 percent of the federal poverty level who are not eligible for other Medicaid programs or traditional CHIP.

CLAIMS ADMINISTRATOR – Processes and adjudicates all claims for the Medicaid services outside the scope of capitated arrangements between health plans and HHSC. See also **TEXAS MEDICAID & HEALTHCARE PARTNERSHIP**.

CLAIMS PROCESSING SYSTEM – A system that enters, tracks, and processes claims from providers for payment.

"CLAWBACK" PAYMENTS – Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare

providing drug coverage to dual eligibles.

CLIENT – A person who has applied for or is enrolled in the Medicaid program. See also **RECIPIENT; APPLICANT**.

COMMUNITY ATTENDANT SERVICES (CAS) – An optional state plan benefit that allows states to provide home and community-based services to individuals with functional disabilities. In Texas, this optional benefit provides personal care services to people who have income in excess of Supplemental Security Income limitations, but who would financially qualify to be in an institution. See also **PRIMARY HOME CARE; 1929**.

COMMUNITY FIRST CHOICE (CFC) – Senate Bill 7, 83rd Legislature, Regular Session, 2013, directed HHSC to implement the most cost-effective option for delivering basic attendant care and habilitation to Medicaid-eligible individuals. CFC is a federal option that allows states to provide home and community-based attendant services to Medicaid recipients with disabilities. 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 WAIVER PROGRAM (CLASS) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to people with developmental disabilities other than intellectual disability as an alternative to ICF/IID institutional care. See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; WAIVER; 1915(c)**.

COMPARABILITY – In general, the state must ensure that the same Medicaid benefits are available to all people who are eligible. Exceptions include benefits approved under Medicaid waiver programs for special subpopulations of Medicaid eligibles and benefits available to children through Early and Periodic Screening, Diagnosis, and Treatment/THSteps that may not be available to adults.

COMPREHENSIVE CARE PROGRAM (CCP) – Texas' name for the expanded portion of the Early and Periodic Screening, Diagnosis, and Treatment program/THSteps. THSteps-CCP covers services for children (until age 21) that are not usually allowed or are more limited under the Texas Medicaid state plan. CCP is a result of a Congressional

mandate, which became effective in 1990. See also **TEXAS HEALTH STEPS**.

CONSUMER DIRECTED SERVICES (CDS) – A service delivery model that allows the consumer or his/her representative to hire, fire, train, and supervise personal attendants, as well as to directly purchase services. Texas was one of the first states to receive approval from the Centers for Medicare & Medicaid Services to implement the CDS delivery model in multiple Medicaid home and community-based waiver programs and in the Medicaid state plan. See also **AGENCY OPTION; SERVICE RESPONSIBILITY OPTION; WAIVER; 1915(c)**.

CONTINUITY OF CARE – The degree to which the care of a patient is not interrupted.

CONTRACTOR – Person or organization with which the state has successfully negotiated an agreement for the provision of required tasks.

CO-PAYMENT OR CO-PAY – A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the health care service is rendered.

CURRENT POPULATION SURVEY – A U.S. Census Bureau-sponsored

survey. Results from this survey are used in many states to estimate the size and composition of populations that are potentially eligible for Medicaid and the number of persons without health insurance.

D

DAY ACTIVITY AND HEALTH SERVICES (DAHS) – Long-term services and supports offered during the day, Monday through Friday, to clients residing in the community. Services, which are provided at a licensed day activity and health services center, include nursing and personal care, meals, transportation, and social and recreational activities.

DEAF-BLIND WITH MULTIPLE DISABILITIES WAIVER (DBMD) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to people who are deaf and blind and have a third disability (e.g., intellectual disability) as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition. See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; WAIVER; 1915(c)**.

DEFICIT REDUCTION ACT (DRA)

OF 2005 – Federal legislation that is estimated to reduce direct federal spending by \$39 billion for the five-year period of 2006-2010 due to changes in drug reimbursements and policies, cost-sharing, benefit flexibility, and in asset policy for long-term care eligibility.

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) POOL

– One of two payment pools available from the 1115 Transformation Waiver. 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 access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and health of the patients and families served. See also **TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER; UNCOMPENSATED CARE POOL; REGIONAL HEALTHCARE PARTNERSHIPS (RHPs)**.

DEVELOPMENTAL DISABILITY – A severe, chronic disability manifested before age 22, which results in impaired intellectual functioning or deficiencies in essential skills. See also **INTELLECTUAL DISABILITY; RELATED CONDITION**.

DIAGNOSIS –

- The art of distinguishing one disease from another.
- Determination of the nature of a cause of a disease.
- A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem.
- A code for the above.

DISPROPORTIONATE SHARE – A program that provides additional reimbursement to hospitals that serve a disproportionate share of low-income patients to compensate for revenues lost by serving needy Texans. See also **DISPROPORTIONATE SHARE HOSPITAL**.

DISPROPORTIONATE SHARE HOSPITAL (DSH) – A hospital designation that describes hospitals that serve a higher than average number of Medicaid and other low-income patients.

DRUG FORMULARY – A listing of prescription medications, which are available to Medicaid and Children’s Health Insurance Program clients. The Medicaid drug formulary is an open formulary that includes preferred and non-preferred drugs. Non-preferred drugs require prior authorization before dispensing while preferred drugs do not require prior authorization. The CHIP formulary

does not require prior authorization for non-preferred drugs.

DRUG UTILIZATION REVIEW

(DUR) – Evaluation of client’s drug history before medication is dispensed to ensure appropriate and medically-necessary utilization. Review of drug therapy after client has received the medication, examines claims data to analyze prescribing practices, medication use by clients and pharmacy dispensing practices.

DRUG UTILIZATION REVIEW

(DUR) BOARD – The DUR Board is an HHSC advisory board composed of physicians and pharmacists who review and approve the therapeutic criteria for DUR and clinical authorization criteria. See also **DRUG UTILIZATION REVIEW (DUR)**.

DUAL ELIGIBLE – Individual who qualifies for both Medicare benefits and Medicaid assistance. Texas covers a different mix of Medicare cost-sharing depending on the individual’s/couple’s income. See also **MEDICAID QUALIFIED MEDICARE BENEFICIARIES; QUALIFIED DISABLED WORKING INDIVIDUALS; QUALIFIED INDIVIDUALS; QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES**.

DURABLE MEDICAL EQUIPMENT (DME) – Equipment which can

stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs, and oxygen equipment.

E

E-PRESCRIBING – The computer-to-computer transfer of prescription, drug, benefit, and patient information among prescribers, pharmacies, and payers. Medicaid and the Children’s Health Insurance Program began implementing e-prescribing in 2010.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) – See also **COMPREHENSIVE CARE PROGRAM; TEXAS HEALTH STEPS**.

ELECTRONIC HEALTH RECORD (EHR) – An electronic record

of an individual’s health-related information that includes patient demographic and clinical health information, such as medical histories and problem lists, and that has a variety of capabilities, including clinical decision support; physician order entry; capture and query of information relevant to health care quality; and the ability to exchange electronic health information with,

and integrate such information from, other sources.

ELECTRONIC VISIT

VERIFICATION (EVV) – EVV is a telephone and computer-based system that electronically verifies service visits occur and documents the precise time service begins and ends. EVV is used to verify that individuals/ members receive the services authorized for their support and for which the state is being billed.

ELIGIBILITY SUPPORT SERVICES, ENROLLMENT, AND OUTREACH AND INFORMING CONTRACTOR

– Entities with which the state contracts to provide business services that support the state’s determination of client eligibility for Medicaid, CHIP, SNAP, and TANF programs; assist in educating clients who are enrolling in Medicaid managed care and CHIP about their health plan and primary care provider choices; enroll clients into Medicaid managed care and CHIP; process health plan changes, and provide outreach and informing services to Texas Health Steps program recipients.

ELIGIBLE CLIENT – An individual who has been determined to meet the eligibility criteria for a public program such as Medicaid.

EMERGENCY MEDICAL CONDITION – A medical condition with acute symptoms of sufficient

severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the patient’s health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

ENCOUNTER DATA – Information derived from a contact or service delivered by a health care provider for any capitated service provided to an eligible member.

ENHANCED MATCH RATE – Federal matching rate that is higher than the regular federal medical assistance percentage. See also **CHILDREN’S HEALTH INSURANCE PROGRAM; FEDERAL MEDICAL ASSISTANCE PERCENTAGE.**

ENROLLEE – An individual who is enrolled in and eligible for services from a health plan either as a subscriber or as a dependent.

EXPERIENCE REBATE – Medicaid and CHIP managed care organizations are required to pay HHSC experience rebates, which

are a form of profit sharing. The amount paid to the state (the experience rebate) is calculated using a graduated rebate method based on the excess of allowable MCO Medicaid or CHIP revenues over allowable MCO Medicaid or CHIP expenses. The rebate amount is based on pre-tax income and varies based on the amount of pre-tax profit and the variable percentage applied.

EXTERNAL QUALITY REVIEW ORGANIZATION – See **QUALITY MONITOR**.

F

FEDERAL BENEFIT RATE (FBR) – The Supplemental Security Income limit.

FEDERAL DRUG REBATES – Payments to the state from drug manufacturers and pricing rules mandated by the federal Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L.101-508). The payment is dependent on the state's expenditures for each specific drug product. See also **OMNIBUS BUDGET RECONCILIATION ACTS**.

FEDERAL FISCAL YEAR (FFY) – The federal fiscal year is a 12-month period beginning October 1 and ending September 30.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) – The

percentage of federal dollars available to a state to provide Medicaid services. The FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.

FEDERAL POVERTY LEVEL (FPL) – Income guideline established annually by the federal government. Public assistance programs usually define income limits in relation to the FPL.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) – A center receiving a grant under the Public Health Services Act or an entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless programs. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.

FEE-FOR-SERVICE REIMBURSEMENT (FFS) – The traditional Medicaid health care payment system, under which providers receive a payment for each unit of service they provide.

FREEDOM OF CHOICE – In general, a state must ensure that Medicaid beneficiaries are free to obtain services from any qualified

provider. Exceptions are possible through Medicaid waivers and special contract options. Texas Health Steps clients have freedom of choice with regard to a medical checkup provider, even if that provider is not the child's primary care provider.

FREW V. SMITH – A class action lawsuit that was filed against Texas in 1993 and 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.

G

GENERIC DRUG – A chemically-equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or “generic” name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.

GRADUATE MEDICAL EDUCATION (GME) – Payments that cover the costs of residents' and teaching

physicians' salaries and fringe benefits, program administrative staff, and allocated facility overhead costs for hospitals that operate medical residency training programs.

H

HEALTH AND HUMAN SERVICES COMMISSION (HHSC) – The oversight agency for health and human services in Texas. HHSC is the single state Medicaid and CHIP agency for Texas.

HHSC PHARMACY BENEFIT MANAGEMENT (PBM) – A Texas Medicaid program that administers the Medicaid outpatient prescription drug benefit in both traditional Medicaid and managed care. Pharmacy Benefit pays for up to three prescriptions a month per adult in FFS programs. Nursing facility residents, 1915(c) waiver participants, adults enrolled in managed care, and children under age 21 are not subject to the three-prescription limitation. Pharmacy Benefit manages formularies, the preferred drug list, prior authorization criteria, and rebates; defines and manages pharmacy benefit policies for both FFS and MCO clients; and performs prospective and retrospective drug utilization reviews for FFS clients.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

– Federal legislation (P.L. 104-191) that prohibits insurers from excluding individuals because of health problems or disabilities; limits insurers’ ability to exclude treatment for pre-existing conditions; requires standardized electronic exchange of administrative and financial health services information for all health plans, including Medicaid; protects the security of electronically transmitted or stored information and the privacy of individuals covered by Medicaid; and implements the new National Provider Identifier to be used in all electronic transactions between providers and health plans in May 2007. In April 2007, the Centers for Medicare & Medicaid Services announced a contingency period for any covered entity showing a good faith effort to become compliant. The contingency period allowed covered entities to continue using legacy identifiers until May 23, 2008, without penalty.

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

– A Medicaid program that pays for employer or private health insurance premiums for persons who are Medicaid-eligible when the premiums are less expensive than providing regular Medicaid coverage for those persons.

HEALTH PASSPORT – A web-based repository of medical information for each child enrolled in the STAR Health program. The Health Passport allows authorized users immediate access to a child’s basic claim-based health record through a secure, password-protected website. The Health Passport includes available claims information, immunization records, behavioral health assessments, Texas Health Steps exam forms, lab results, and other health care information. See also **STAR HEALTH**.

HEALTH PLAN – See **MANAGED CARE ORGANIZATION**.

HEALTH EFFECTIVENESS DATA INFORMATION SET (HEDIS) – A core set of performance measures developed for employers to use in assessing health plans. It was established and is promoted by the National Committee for Quality Assurance (NCQA).

HEALTHY TEXAS WOMEN (HTW) – A state-funded program that provides women’s health and family planning services at no cost to eligible, low-income Texas women.

HOME AND COMMUNITY-BASED SERVICES (HCS) WAIVER – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Texas to provide 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.

See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; WAIVER; 1915(c)**.

HOME AND COMMUNITY-BASED (HCBS) SETTINGS – Settings that provide access to the full benefits of community living. CMS promulgated regulations prohibiting services from being provided in a setting that is institutional in nature or has the effect of isolating individuals from the greater community. All HCBS settings must comply with the new rule by March 2019.

HOSPICE – A treatment approach that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care. The goal of hospice is to help terminally ill individuals continue life with minimal disruption of normal activities while remaining primarily in the home environment. Hospice uses an interdisciplinary approach to deliver medical, social, psychological, emotional, and spiritual services through a broad spectrum of professional and other caregivers with the goal of making the individual as physically and emotionally comfortable as possible.

I

INDEPENDENT ASSESSMENT – Assessments of access, quality, and cost of Medicaid managed care programs operated under a 1915(b) waiver. These assessments are required by the federal government and performed by an entity external to the state agencies that oversee and operate the Medicaid program.

INFANT – Children from birth to one year of age.

INSTITUTION FOR MENTAL DISEASE (IMD) – A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) – Activities that are essential to independent daily living including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone.

INTEGRATED ELIGIBILITY DETERMINATION – HHSC uses an integrated system to determine eligibility for Medicaid, CHIP, Supplemental Nutrition Assistance Program (formerly Food Stamps), and Temporary Assistance for Needy Families. The eligibility system offers convenient access to eligibility

services through multiple channels, including a self-service website (www.YourTexasBenefits.com), a smartphone app, a network of local eligibility offices and community-based organizations, and the 2-1-1 phone service. See also **TEXAS INTEGRATED ELIGIBILITY REDESIGN SYSTEM**.

INTELLECTUAL DISABILITY – A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

INTEREST LIST – A list of individuals who are interested in receiving 1915(c) waiver services, but for whom waiver slots are not available due to the waiver being at maximum enrollment. See also **WAIVER; 1915(c)**.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION (ICF/ IID) – Optional Medicaid state plan service which provides residential care and services for individuals with developmental disabilities based on their functional needs. See also **INTELLECTUAL DISABILITY; RELATED CONDITION**.

J

K

KATIE BECKETT OPTION – See **TEFRA 134(a)**.

L

LEGISLATIVE BUDGET BOARD (LBB) - The Legislative Budget Board is a permanent joint committee of the Texas Legislature that develops budget and policy recommendations for legislative appropriations for all agencies of state government, as well as completes fiscal analyses for proposed legislation. The LBB also conducts evaluations and reviews for the purpose of identifying and recommending changes that improve the efficiency and performance of state and local operations and finances.

LOCAL MENTAL HEALTH AUTHORITY (LMHA) – The local component of the mental health system designated to carry out the legislative mandate for planning, policy development, coordination, and resource development/allocation, and to supervise and ensure the provision of services to persons with mental illness or intellectual disability in one or more local service areas. See also **COMMUNITY MENTAL HEALTH CENTERS**.

LONG-TERM SERVICES AND SUPPORTS (LTSS) – Assistance for persons who are over age 65

and those with chronic disabilities. The goal of LTSS is to help such individuals be as independent as possible. See also **ACTIVITIES OF DAILY LIVING**.

M

MANAGED CARE – A system in which the overall care of a patient is coordinated by a single provider or organization. Many state Medicaid and CHIP programs include managed care components as a way to improve quality and control costs. See also **MANAGED CARE ORGANIZATION; STATE OF TEXAS ACCESS REFORM; STAR+PLUS PROGRAM; STAR HEALTH; STAR KIDS; CHIP**.

MANAGED CARE ORGANIZATION (MCO) – An organization that delivers and manages health services under a risk-based arrangement. The MCO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the MCO may suffer losses. If enrollees cost less, the MCO profits. This gives the MCO an incentive to control costs. See also **1903(m); 1915(b)**.

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 BUY-IN PROGRAM FOR WORKERS WITH DISABILITIES (MBI)

– More commonly known as Medicaid Buy-In, this program enables working persons with disabilities to receive Medicaid services. MBI clients may be required to pay a monthly premium depending on their earned and unearned income. The program is available to individuals with countable earned income less than 250 percent of the federal poverty level and \$3,000 in resources. Texas implemented MBI in 2006.

MEDICAID BUY-IN FOR

CHILDREN (MBIC) – A program that allows children up to age 19 with disabilities to “buy-in” to Medicaid. Children with family income less than or equal to 150 percent of the federal poverty level may qualify for the program and pay a monthly premium in order to receive Medicaid benefits. Texas implemented MBIC in 2011.

MEDICAID ELIGIBLE – In Texas, this term refers to persons who, after going through a certification process, become eligible to receive services and other assistance under the Medicaid program. The term does not include persons who could be eligible for Medicaid (e.g., meet all income and asset criteria tied to

eligibility) that are not enrolled in the program.

MEDICAID ELIGIBILITY AND HEALTH INFORMATION SERVICES SYSTEM (MEHIS) –

MEHIS replaced the paper Medicaid identification form with a permanent plastic card, automated eligibility verification, and provided an electronic health record for all Medicaid clients

MEDICAID ESTATE RECOVERY PROGRAM (MERP) –

MERP is required by federal and state law to recover, after the time of death, certain long-term care and associated Medicaid costs of services provided to recipients age 55 and over.

MEDICAID FOR BREAST AND CERVICAL CANCER (MBCC) –

MBCC provides full Medicaid coverage for eligible uninsured women ages 18 to 64 who have been diagnosed with a qualifying breast or cervical cancer. Women may receive a qualifying diagnosis from any provider but must apply for MBCC through the Breast and Cervical Cancer Services program administered by the Department of State Health Services. Clients receive Medicaid benefits as long as they meet the eligibility criteria and are receiving active treatment for breast or cervical cancer.

MEDICAID QUALIFIED MEDICARE BENEFICIARIES –

Medicare

beneficiaries who are eligible for full Medicaid benefits. Medicaid pays the deductible and co-insurance for Medicare services and covers all other Medicaid services not covered by Medicare.

MEDICAID RECIPIENT – A Medicaid client or enrollee who has received a service paid for with Medicaid program funds.

MEDICAID REIMBURSEMENT –

Amount of money the Medicaid program reimburses or pays to a health care organization or other provider for services or other forms of assistance provided to Medicaid clients.

MEDICAID RURAL SERVICE AREA (MRSA) –

On March 1, 2012, STAR managed care expanded to serve Texas Medicaid clients in 164 rural counties. The MRSA STAR program serves clients who were previously covered by the Primary Care Case Management program—if they had Medicaid only (e.g., pregnant women and children with limited income, TANF clients, and adults receiving Supplemental Social Security Income (SSI)). Children age 20 and younger with SSI may choose between managed care and traditional Medicaid. SSI children age birth through 20 years of age may volunteer to participate in STAR in the Medicaid RSA.

See also **PRIMARY CARE CASE MANAGEMENT; STAR.**

MEDICAID STATE PLAN – The document that serves as the contract between the state and the Centers for Medicare & Medicaid Services for the Texas Medicaid program and that gives HHSC authority to administer the Medicaid program in Texas. It describes the nature and scope of the state’s Medicaid program including Medicaid administration, client eligibility, benefits, and provider reimbursement. CMS must approve the plan and any amendments to the plan. Texas also has a CMS-approved Children’s Health Insurance Program state plan.

MEDICAID WELLNESS PROGRAM FOR CHILDREN WITH DISABILITIES

– The Texas Medicaid Wellness Program is a community-based care management program that enrolls fee-for-service high-risk clients with complex, chronic, or co-morbid conditions. Extensive case management focuses on the whole person (rather than the disease) through telephonic and face-to-face interventions that aim to improve health outcomes.

MEDICAL CARE ADVISORY COMMITTEE (MCAC)

– Mandated by federal Medicaid law, the MCAC reviews and makes recommendations to the State Medicaid Director on proposed Medicaid rules.

MEDICAL NECESSITY – Health services that are:

- Reasonably necessary to prevent illness or medical conditions, or to provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, physical deformity or limitations in function, illness or infirmity of a recipient, threaten to cause or worsen a handicap, or endanger life;
- Provided at appropriate locations and at the appropriate levels of care for the treatment of clients’ conditions;
- Consistent with health care practice guidelines and standards that are issued by professionally-recognized health care organizations or governmental agencies;
- Consistent with the diagnoses of the conditions; and
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

MEDICAL TRANSPORTATION PROGRAM (MTP)

– MTP arranges non-emergency transportation to and from medically necessary, Medicaid-allowable health care services for persons enrolled in Medicaid who have no other means of transportation.

MEDICALLY DEPENDENT CHILDREN PROGRAM (MDCP)

– A 1915(c) Medicaid waiver program that provides respite, minor home modifications, and adaptive aids to

children as an alternative to nursing facility care. See also **1915(c); WAIVER.**

MEDICALLY NEEDY WITH SPEND DOWN PROGRAM

– A program for pregnant women and children who are ineligible for regular Medicaid coverage due to excess income, but who meet Medicaid income eligibility limits after accounting for their medical expenses (a process called “spend down”). Clients are not required to pay their medical expenses in order to qualify for the medically needy program.

MEDICARE – The nation’s largest health insurance program financed by the federal government. Medicare provides insurance to people who are age 65 and older and to those with disabilities or permanent kidney failure. See also **MEDICARE PART A; MEDICARE PART B; MEDICARE PART C; MEDICARE PART D.**

MEDICARE EQUALIZATION – Limited payments for most Medicare Part A and B services provided to individuals dually eligible for both Medicaid and Medicare of no more than the Medicaid payment amount for the same service. See also **MEDICARE PART A; MEDICARE PART B.**

MEDICARE PART A – Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled

nursing facility, for home care by a home health agency, or hospice care by a licensed and certified hospice agency. See also **MEDICARE.**

MEDICARE PART B – Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also **MEDICARE.**

MEDICARE PART C – Previously called Medicare+Choice, Medicare Part C was renamed Medicare Advantage and modified by the Medicare Prescription Drug Improvement and Modernization Act of 2003. It provides for certain managed care coverage options in Medicare, under which managed care organizations receive a capitated monthly payment per covered beneficiary. Additional benefits and cost-sharing arrangements may be offered by Medicare managed care organizations. See also **MEDICARE; MANAGED CARE ORGANIZATION; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003.**

MEDICARE PART D – A voluntary Medicare prescription drug benefit created by the Medicare Prescription Drug Improvement

and Modernization Act of 2003 that began January 1, 2006. Beneficiaries who remain in traditional Medicare may choose a private drug-only plan; those who choose to enroll in a managed care organization may choose a plan that offers a drug benefit. See also **MEDICARE; MANAGED CARE ORGANIZATION; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)**.

MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT (MMA) OF 2003 – A federal law (P.L. 108-173) that created a new Medicare prescription drug benefit (Part D) and made other program and payment changes.

MEMBER – Medicaid client who is enrolled in a managed care organization plan. See also **ENROLLEE**.

MENTAL ILLNESS (as defined in the Texas Medicaid state plan) – A single severe mental disorder, excluding intellectual disability, or a combination of severe mental disorders as defined in the latest edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

MODIFIED ADJUSTED GROSS INCOME (MAGI) – Federal law requires states to determine financial

eligibility for most individuals in Medicaid and CHIP based on the modified adjusted gross income (MAGI) methodology. The MAGI methodology uses federal income tax rules for determining income and household composition. The Affordable Care Act applies a five percentage point income disregard to individuals that are subject to the MAGI methodology. The MAGI methodology applies to the Medicaid eligibility groups for children, pregnant women, and parents and caretaker relatives. The ACA provides exceptions to the use of MAGI and to the elimination of assets tests and income disregards. In Texas, the exceptions primarily apply to emergency Medicaid, foster care children, medically needy, individuals receiving Supplemental Security Income, and Medicaid programs for people age 65 and over and people with disabilities.

MONEY FOLLOWS THE PERSON – The 2002-03 General Appropriations Act, Senate Bill 1, 77th Legislature, Regular Session, 2001 (Article II, HHSC, Rider 37), stipulates that as clients relocate from nursing facilities to community care services, the nursing facility funds will be transferred to the community care budget to cover the cost of their services. Also known as the “Money Follows the Person” rider. The rider language was codified by House Bill 1867, 79th Legislature, Regular Session, 2005.

N

NETWORK ADEQUACY – Medicaid MCO provider networks must be adequate to ensure individuals enrolled with the MCO are able to access all medically necessary covered services. Provider networks must establish additional minimum provider access standards including: minimum distance, travel time, and appointment wait times for member access to providers; expedited credentialing to expand the list of provider types; and provider directories published online with provider information updated at least weekly.

NEWBORNS – Children up to age one whose family income and resources are above the current requirements for Temporary Assistance for Needy Families, but not above 198 percent of the federal poverty level. The Children’s Health Insurance Program covers newborns up to 201 percent of the federal poverty level.

NO WRONG DOOR (NWD) – The NWD system represents the effort to streamline access to LTSS options for all populations and all payers. In NWD systems, multiple state and community agencies coordinate to ensure that regardless of which agency people contact for help, they can access one-to-one counseling and information about all of the agencies and services available in

their communities. See also **LONG-TERM SERVICES AND SUPPORTS**.

NURSING FACILITY CARVE-IN – Effective March 1, 2015, nursing facility services became a statewide covered benefit under the STAR+PLUS managed care program for individuals aged 21 years and older. See also **CARVE-IN; NURSING FACILITIES; STAR+PLUS PROGRAM**.

NURSING FACILITIES (NF) – Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) long-term care program. See also **LONG-TERM SERVICES AND SUPPORTS**.

O

OFFICE OF INSPECTOR GENERAL (OIG) – The 78th Legislature created the Office of Inspector General in 2003 to strengthen HHSC’s authority and ability to combat fraud, waste, and abuse in health and human services programs. OIG is divided into seven divisions: Investigations, Audits, Inspections, Medical Services, Data and Technology, Operations, and Chief Counsel.

OMNIBUS BUDGET RECONCILIATION ACTS (OBRA) – Federal laws that

direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.

OPERATING DEPARTMENT – State agencies with day-to-day operational responsibility for various Medicaid-funded programs. As a result of the HHS system transformation on September 1, 2016, the Texas Medicaid program’s functions are administered solely by HHSC, ending its use of operating departments. See also **TRANSFORMATION; HEALTH AND HUMAN SERVICES COMMISSION.**

OPTIONAL SERVICES OR BENEFITS – Over 30 different services that a state can elect to cover under a Medicaid state plan. Examples include personal care, rehabilitative services, prescription drugs, therapies, diagnostic services, intermediate care facilities for individuals with an intellectual disability or related condition, targeted case management, etc.

OUTLIER – An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.

P

PATIENT PROTECTION AND AFFORDABLE CARE ACT – The Patient Protection and Affordable Care Act (PPACA) was signed into

law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA). The ACA includes provisions to expand health insurance coverage, including an individual mandate, sliding-scale health insurance subsidies for individuals and families up to 400 percent of the federal poverty level (FPL); tax incentives for small employers to offer health insurance to their employees, an optional expansion of Medicaid up to 133 percent of the FPL and measures to improve quality, reduce fraud and abuse, and reform payment methodologies.

PER MEMBER PER MONTH (PMPM) – The unit of measure related to each member for each month the member was enrolled in a managed care plan.

PERSON-CENTERED PLANNING – Person-centered service plans document service options that take into account an individual’s strengths, goals and preferences as well as needs.

PERSONAL ASSISTANCE SERVICES (PAS) – Medicaid community-based entitlement benefit delivered through several programs, including STAR+PLUS and traditional Medicaid, where it is known as Primary Home Care. PAS are non-technical, non-skilled services that offer attendant care

for individuals who need assistance with activities of daily living (e.g. bathing, dressing, eating, grooming) or instrumental activities of daily living (e.g. shopping, light house work, preparing meals). See also **PRIMARY HOME CARE**.

PERSONAL CARE SERVICES (PCS) – Medicaid community-based entitlement benefit that provides attendant services to assist individuals from birth through age 20 with disabilities in performing activities of daily living (e.g. bathing, dressing, eating, grooming) and instrumental activities of daily living (e.g. shopping, light house work, preparing meals).

PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 (PRWORA) – Federal legislation P.L. 104-193 that eliminated Aid to Families with Dependent Children and created Temporary Assistance for Needy Families, a block grant for states to provide time-limited cash assistance for needy families, with work requirements for most clients. See also **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES**.

PHARMACY BENEFITS MANAGER (PBM) – Each Medicaid and CHIP managed care organization (MCO) contracts with PBM to process prescription claims. The PBMs contract and work with pharmacies

that actually dispense medications to CHIP and Medicaid managed care clients. MCOs must allow any pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO's network.

PHARMACY CLAIMS AND REBATE ADMINISTRATOR – Processes and adjudicates all claims for Medicaid and CHIP fee-for-service out-patient prescription drugs. The pharmacy claims administrator performs all rebate administration functions including invoicing and reconciliation of federal, state, and supplemental rebates. This vendor also stores managed care organization encounter data to support program oversight of prescription drug benefits in managed care.

PHARMACY PRIOR AUTHORIZATION VENDOR – Evaluates prior authorization requests submitted through a call center and from the pharmacy point-of-sale system for drugs that are not on the preferred drug list or have been selected for clinical edits.

PHYSICIAN EXTENDER – A physician extender is a health care provider who is not a physician, but who performs medical activities typically performed by a physician. Physician extenders are most commonly nurse practitioners or physician assistants.

POTENTIALLY PREVENTABLE EVENTS (PPEs) – One of, or any combination of, the following:

- An admission of a person to a hospital or long-term care facility that may reasonably have been prevented with adequate access to ambulatory care or health care coordination.
- A health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory test, therapy service, or radiology service, that may not reasonably be necessary for the provision of quality health care or treatment.
- A harmful event or negative outcome with respect to a person, including an infection or surgical complication, that occurs after the person’s admission to a hospital or long-term care facility; and may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) – Screening to identify persons with mental illness, intellectual disability, or related conditions in nursing facilities.

PREFERRED DRUG LIST (PDL) – A cost-control measure used by Texas and other states to manage increasing drug costs. The PDL is a list of preferred drugs that are safe, clinically effective and cost-effective compared to other drugs on the market. Drugs on the PDL do not require prior approval in order to be reimbursed. Medicaid also covers drugs not on the PDL, but a physician’s office must call to obtain prior approval before a non-preferred drug can be reimbursed.

PREFERRED DRUG LIST VENDOR – The contracted vendor that provides information to the Drug Utilization Review (DUR) Board on the clinical efficacy, safety, and cost-effectiveness of drug products; negotiates supplemental drug manufacturer rebates on behalf of the state; and assists HHSC and the board with the development and maintenance of the preferred drug list. See also **DRUG UTILIZATION REVIEW BOARD**.

PREMIUMS PAYABLE SYSTEM (PPS) – A group of applications that generate capitation payments for individuals enrolled in a managed care program and supports managed care organizations’ deliverables tracking and performance monitoring.

PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS (PPECC) – Provides non-residential, facility-based care as an alternative

to private duty nursing for individuals under the age of 21 with complex medical needs.

PRESCRIPTION DRUG – A drug which has been approved by the Food and Drug Administration which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.

PREVENTIVE CARE – Comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well-person care.

PRIMARY CARE – Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine providers.

PRIMARY CARE CASE MANAGEMENT (PCCM) – Former managed care option in which each participant was assigned to a single primary care provider who authorized most other services. The PCCM program was terminated in March 2012.

PRIMARY CARE PHYSICIAN (PCP) – A physician or provider who has agreed to provide a medical home to Medicaid clients and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

PRIMARY HOME CARE (PHC) – The name of Personal Assistance Services delivered through traditional fee-for-service Medicaid. See also **PERSONAL ASSISTANCE SERVICES**.

PRIOR AUTHORIZATION – An authorization from the Medicaid program for the delivery of certain services. It must be obtained prior to providing the service. Examples of such services are goal-directed therapy and transplants.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) – A waiver of the Medicaid state plan granted under Section 1115(a) of the Social Security Act. This waiver allows Texas to provide comprehensive medical and community-based services under a capitated, risk-based system to frail elderly individuals (age 55 and older) as a cost-effective alternative to institutional care. The waiver is part of a national demonstration project. PACE is available in El Paso, Amarillo, and Lubbock. See also **WAIVER; 1115(a)**.

PROMOTING INDEPENDENCE – The Promoting Independence Plan and Initiative is the Texas response to the U.S. Supreme Court Olmstead decision regarding Title II of the Americans with Disabilities Act. The Court ruled that states must provide community-based services for persons with disabilities who would otherwise be entitled to

institutional services when certain conditions are met, or have a comprehensive, effective plan to provide community services. The Promoting Independence Plan and Initiative have been expanded to respond to two Governor's Executive Orders which seek to improve the service delivery system for persons who have disabilities and/or who are aging.

PROVIDER – A person, group, or agency that provides a covered Medicaid service to a Medicaid client.

PROVIDER CREDENTIALING – The process through which managed care organizations ensure that each health care provider meets all professional standards, including licensure.

PROVIDER NETWORKS – Organizations of health care providers that provide services within managed care plans. Network providers are selected with the expectation that they will deliver care inexpensively, and enrollees are channeled to network providers to control costs.

Q

QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI) – Medicare beneficiaries with income less than or equal to 200 percent of the federal poverty level who do not qualify for full Medicaid benefits. The Texas

Medicaid program pays Medicare Part A premiums for disabled working individuals. However, the number of QDWI eligible for this benefit in Texas is small. See also **MEDICARE PART A**.

QUALIFIED INDIVIDUALS (QI) – Medicare beneficiaries with income between 120 and 135 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays a portion of the Medicare Part B premium. See also **MEDICARE PART B**.

QUALIFIED MEDICARE BENEFICIARY (QMB) – Medicare beneficiaries with income less than or equal to 100 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays all Medicare Part A and B premiums, deductibles, and coinsurance. See also **MEDICARE PART A; MEDICARE PART B**.

QUALITY MONITOR – Provides external review of the access and the quality of care provided to Medicaid and CHIP clients enrolled in Medicaid/CHIP managed care. Also known as the External Quality Review Organization.

R

RECIPIENT – A person who received a Medicaid service while eligible for the Medicaid program. People may be Medicaid eligible without being Medicaid recipients.

See also **CLIENT; MEDICAID ELIGIBLE**.

RECIPIENT (CLIENT) MONTHS –

This term reflects a complete count (could be actual or estimated) of all certified Medicaid clients for a given month. The count reflects all Medicaid clients, regardless of whether or not they received services during that month. For any given month, the number of recipient months is equal to the number of unduplicated clients for that month. Recipient months and unduplicated clients differ on an annualized basis. See also **CLIENT**.

REGIONAL HEALTH CARE

PARTNERSHIPS (RHPs) – Under the 1115 Transformation Waiver, eligibility to receive Uncompensated Care or Delivery System Reform Incentive Payment requires participation in one of 20 RHPs, which reflect existing delivery systems and geographic proximity. The RHPs include public hospitals, public health care districts, health providers, and/or other stakeholders in a given region. The activities of each RHP are coordinated by an “anchoring entity,” which is a public hospital or other local governmental entity with the authority to make intergovernmental transfers, such as a hospital district, a hospital authority, a health science center, or a county. See also **UNCOMPENSATED CARE; DELIVERY SYSTEM REFORM**

INCENTIVE PAYMENT; 1115 TRANSFORMATION WAIVER.

REHABILITATIVE SERVICES FOR MENTAL ILLNESS –

Specialized services provided to people age 18 and over with severe and persistent mental illness and people under 18 with serious emotional disturbance. Mental health rehabilitation includes:

- Crisis intervention services.
- Medication training and support services.
- Psychosocial rehabilitation services.
- Skills training and development services.
- Day programs for acute needs.

See also **MENTAL ILLNESS**.

REINSURANCE – Insurance purchased by a managed care organization, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the unusually high claims of its participating providers, policyholders, or employees and covered dependents. Also called risk control insurance or stop-loss insurance.

RELATED CONDITION – A disability other than an intellectual disability that manifests itself before age 22 and results in substantial functional limitations in three of six major life activities (e.g., self-care,

expressive/receptive language, learning, mobility, self-direction and or capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other disabilities are said to be “related to” intellectual disability in their effect on the individual’s functioning.

REQUIRED SERVICES – Services that a state is required to offer to categorically needy clients under the Medicaid state plan. (Medically Needy clients may be offered a more restrictive service package.)

RETROSPECTIVE DRUG UTILIZATION REVIEW

VENDOR – Performs drug use review (DUR) retrospective interventions to assist health care providers in delivering appropriate prescription pharmaceutical drugs to Texas Medicaid Pharmacy Benefit Management clients.

RISK CONTRACT – An agreement with a managed care organization to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also **MANAGED CARE ORGANIZATION**.

RURAL HEALTH CLINICS (RHCs) – 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’s 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.

S

SCHOOL HEALTH AND RELATED SERVICES (SHARS)

– Medicaid optional benefit that provides services related to a child’s Individual Education Plan. Services are provided in a school setting and include audiology, physician services, occupational therapy, physical therapy, speech therapy, psychological services, nursing services, counseling, personal care services, and transportation.

SELECTIVE CONTRACTING – Option under section 1915(b) of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.

SERVICE DELIVERY AREA

(SDA) – Regions of the state in which clients receive Medicaid services through an MCO, and that are treated as a unit in terms of planning and implementation of managed care strategies.

SERVICE RESPONSIBILITY

OPTION (SRO) – Under the SRO, the traditional agency remains the employer of record, but the consumer participates in selecting and managing the

attendant staff. The option allows consumers to select and manage their care staff but without the responsibility of being an employer. See also **AGENCY OPTION (AO); CONSUMER DIRECTED SERVICES (CDS)**.

SETTINGS – See **HOME AND COMMUNITY-BASED SETTINGS**

SIGNIFICANT TRADITIONAL PROVIDER (STP) – Under Texas Medicaid law, managed care organizations (MCOs) must include in their provider networks, for at least three years, each health care provider who:

- Previously provided care to Medicaid and charity care patients at a significant level (as defined by HHSC).
- Agrees to accept the standard provider reimbursement rate of the MCO.
- Meets the credentialing requirements of the MCO.
- Complies with all of the terms and conditions of the standard provider agreement of the MCO.

SINGLE STATE AGENCY – The Social Security Act requires that the state designate a single agency to administer or supervise administration of the state’s Medicaid plan. In Texas, HHSC fulfills this function. See also **HEALTH AND HUMAN SERVICES COMMISSION; MEDICAID STATE PLAN**.

SKILLED NURSING FACILITY (SNF) – A nursing facility that is certified to treat Medicare patients.

SOCIAL SECURITY ADMINISTRATION (SSA) – Federal agency responsible for determining eligibility for Supplemental Security Income benefits in Texas and most other states.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB) – Medicare beneficiaries with income less than 120 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays the Medicare Part B premium. See also **PART B**.

SPELL OF ILLNESS – A continuous period of hospital confinement. Successive periods of hospital confinement shall be considered to be continuous unless the last date of discharge and the date of readmission are separated by at least 60 consecutive days of care.

STAR (STATE OF TEXAS ACCESS REFORM) – A statewide managed care program primarily for pregnant women and low-income children and caretakers. Most people in Texas Medicaid get their coverage through STAR.

STAR HEALTH – 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). The program was implemented on April 1, 2008. See also **HEALTH PASSPORT**.

STAR KIDS – A statewide managed care program for children with disabilities, including children who are receiving benefits under the Medically Dependent Children Program waiver. STAR Kids was implemented on November 1, 2016. See also **MEDICALLY DEPENDENT CHILDREN PROGRAM (MDCP)**.

STAR+PLUS – A statewide managed care program for adults with disabilities or those age 65 and older.

STATE FISCAL YEAR (SFY) – The Texas state fiscal year runs from September 1 through August 31 of each year.

STATE SUPPORTED LIVING CENTERS (SSLCs) – SSLCs provide campus-based direct services and supports to people with intellectual and developmental disabilities who are medically fragile or who have behavioral problems.

STATEWIDENESS – 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. See also **1902(a)(1)**.

SUBSTANCE ABUSE – The taking of alcohol or other drugs at dosages that place a person’s social, economic, psychological, and physical welfare in potential hazard, or endanger the public health, safety, or welfare, or a combination thereof. Also called chemical dependency.

SUBSTANCE USE DISORDER – A pattern of substance use that meets the diagnostic criteria for Substance Abuse or Substance Dependence as set forth in the latest edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

SUPPLEMENTAL DRUG MANUFACTURER REBATES – Payments to the state from drug manufacturers for drug products included on the Medicaid Preferred Drug List, based on claims for each specific drug product.

SUPPLEMENTAL SECURITY INCOME (SSI) – SSI is a federal cash assistance program for low-income older people and people of all ages with disabilities. It is administered by the Social Security Administration. In Texas, SSI recipients are automatically eligible to receive Medicaid.

SYSTEM FOR APPLICATION VERIFICATION, ELIGIBILITY, REFERRALS, AND REPORTING (SAVERR) – The state’s past eligibility information system that was replaced by the Texas Integrated Eligibility and Redesign System (TIERS). See also **TEXAS INTEGRATED ELIGIBILITY AND REDESIGN SYSTEM**.

T

TARGETED CASE MANAGEMENT (TCM) – An optional Medicaid state plan service. In Texas, TCM is provided for people with chronic mental illness, women with high-risk pregnancies, infants with a high risk of getting health problems, persons with intellectual disabilities and related conditions, and blind or visually impaired adolescents. TCM encompasses activities that assist the target population in gaining access to medical, social, educational, and other services. Such activities include assessment, case planning, service coordination or monitoring, and case plan reassessment.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) – The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and

secondary coverage responsibilities of the Medicare program.

TEFRA 134(a) – Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain children with disabilities. This option is not offered in Texas.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

(TANF) – Formerly Aid to Families with Dependent Children, TANF provides financial assistance to needy, dependent children and the parents or relatives with whom they are living. Eligible TANF households receive monthly cash and Medicaid benefits if they apply for Medicaid.

TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES

(DADS) – DADS is an agency that works with Texas Medicaid by operating Texas’ state supported living centers and its regulatory programs for providers of long-term care services. DADS’ functions will transfer to HHSC on September 1, 2017. See also **STATE SUPPORTED LIVING CENTERS**.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

(DFPS) – DFPS is charged with protecting children and adults who are older or have disabilities living at home or in state facilities, and licensing group day-care homes, day-care centers, and registered family homes. The agency is also

charged with managing community-based programs that prevent delinquency, abuse, neglect and exploitation of Texas children, adults age 65 and older and those adults with disabilities.

TEXAS DEPARTMENT OF INSURANCE (TDI) – TDI is mandated by the Legislature to regulate the insurance industry and protect the people and businesses that are served by insurance. Functions of the agency include: resolving insurance-related complaints; conducting windstorm inspections; licensing insurance agents/agencies and adjusters; licensing insurance companies and managed care organizations; certifying utilization review agents, independent review organizations (IROs), workers' compensation networks and assigning requests to IROs; registering life settlement entities; assuring fair and efficient regulation; enforcing insurance laws; combating insurance fraud; fire prevention, fire safety, and fire industry regulation; and regulating and administering the Texas workers' compensation system.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS) – DSHS is an agency that works with Texas Medicaid by operating Texas' state hospitals and certain regulatory programs for acute care and public health providers. On September 1, 2017, these regulatory programs and

the operation of state hospitals will transfer to HHSC, after which DSHS' remaining programs will focus on its core public health mission.

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER – Known as the 1115 Transformation Waiver, the waiver is a demonstration running through December 31, 2017, that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Limit payments. The 1115 Transformation Waiver, approved in December 2011, provides new means, through regional collaboration and coordination, for local entities to access additional federal matching funds. See also **UNCOMPENSATED CARE POOL; DELIVERY SERVICES REFORM INCENTIVE PAYMENT POOL; REGIONAL HEALTHCARE PARTNERSHIPS.**

TEXAS EDUCATION AGENCY (TEA) – Provider agency for School Health and Related Services (SHARS). See also **SCHOOL HEALTH AND RELATED SERVICES (SHARS).**

TEXAS HEALTH STEPS (THSteps) – The name in Texas for the Medicaid program for children that provides services under the required state plan service known as the Early and Periodic Screening,

Diagnosis, and Treatment Program. THSteps provides medical and dental prevention and treatment services for children of low-income families from birth to age 21. The program offers comprehensive and periodic evaluation of a child's health, development, and nutritional status, as well as vision, dental, and hearing care. See also **COMPREHENSIVE CARE PROGRAM**.

TEXAS HOME LIVING WAIVER (TxHmL) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide 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. See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; WAIVER; 1915(c)**.

TEXAS INTEGRATED ELIGIBILITY AND REDESIGN SYSTEM (TIERS) – The technology and automated systems that support eligibility services for programs administered by HHSC. TIERS replaced several outdated technology and automation systems with a modernized eligibility system that supports the business processes and improves service delivery.

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP (TMHP) – Entity that serves as the Medicaid claims administrator. As claims administrator, TMHP processes and adjudicates claims for Medicaid services provided in the traditional, fee-for-service system. TMHP does not process or adjudicate claims for services provided by Medicaid managed care organizations (MCOs) but does collect encounter data from the MCOs for use in evaluation of quality and utilization of managed care services. See also **CLAIMS ADMINISTRATOR; ENCOUNTER DATA**.

TEXAS MEDICAID MANAGEMENT INFORMATION SYSTEM (TMMIS) – The claims processing and information retrieval system that states are required to have to operate Medicaid programs. The MMIS is an integrated group of procedures and computer processing operations (subsystems) that enable management of administrative costs; services to clients and providers; inquiries; claims control; and management reporting. The capabilities needed to operate under managed care differ somewhat from those required under traditional Medicaid. See also **MEDICAID ELIGIBILITY AND HEALTH INFORMATION SERVICES SYSTEM (MEHIS)**.

TEXAS WOMEN’S HEALTH PROGRAM (TWHP) – A state-funded program that provided eligible Texas women with preventive health care, screenings, contraceptives and treatment for certain sexually transmitted diseases. This program ended on December 31, 2013, and was replaced by the Healthy Texas Women program. See also **HEALTHY TEXAS WOMEN**.

TITLES OF THE 1965 SOCIAL SECURITY ACT –

- II Old-Age, Survivors, and Disability Insurance Benefits
- IV-A Temporary Assistance for Needy Families
- IV-B Child Welfare
- IV-D Child Support
- IV-E Foster Care and Adoption
- IV-F Job Opportunities and Basic Skills Training
- V Maternal and Child Health Services
- XVI Supplemental Security Income
- XVIII Medicare
- XIX Medicaid
- XX Social Services
- XXI Children’s Health Insurance Program

TRADITIONAL MEDICAID – The traditional Medicaid health care payment system, also known as fee-for-service reimbursement, under which providers receive a payment for each unit of service they provide. See also **FEE-FOR-SERVICE REIMBURSEMENT; MANAGED CARE; MANAGED CARE ORGANIZATION**.

TRANSFORMATION – Senate Bill 200, 84th Legislature, Regular Session, 2015, moves programs and administrative functions to HHSC in two phases – transferring all client services and most administrative support services in phase one, and transferring regulatory programs and state-operated facilities in phase two. As a result of transformation, a new Medical and Social Services division was created to promote and improve the health and welfare of individuals through streamlined access to and delivery of medical and social services. This new centralized structure connects similar programs to make it easier for individuals to locate and access a full array of services, and for the HHS system to better meet the needs of the whole person. The Medical and Social Services division is comprised of four departments, including the Medicaid & CHIP Services department, which operates all Medicaid programs for the HHS system.

TRANSFORMED MEDICAID STATISTICAL INFORMATION SYSTEM (T-MSIS) – The monthly reporting system used to report all Texas Medicaid claims and eligibility data to the Centers for Medicare & Medicaid Services.

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT) – A conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life experiences.

U

UNCOMPENSATED CARE (UC) POOL – One of two payment pools available from the 1115 Transformation Waiver. UC Pool payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC payments will be based on each provider's UC costs as reported on a UC application. See also **TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER; DELIVERY SYSTEM REFORM INCENTIVE PAYMENT POOL**.

UNDUPLICATED COUNT OF MEDICAID ELIGIBLES PER YEAR – In a given year, some persons may enter and exit the

Medicaid program on more than one occasion. Under this concept, persons certified eligible for one or more months during the year are counted only one time for the year to avoid multiple counts per eligible. See also **RECIPIENT (CLIENT) COUNTS**.

UPPER PAYMENT LIMIT (UPL) – Federal limits on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPL do not qualify for federal Medicaid matching funds. See also **TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER**.

UTILIZATION – The extent to which the members of a covered group use a program or obtain a particular service or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.

UTILIZATION MANAGEMENT (UM) – A process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.

UTILIZATION REVIEW (UR) – A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care

services and treatment plans on a prospective, concurrent, or retrospective basis.

V

VENDOR DRUG PROGRAM

(VDP) – The Texas Medicaid program that administers the outpatient prescription drug benefit in for traditional Medicaid (fee-for-service, (FFS) and Medicaid managed care. VDP pays for up to three prescriptions a month per adult in FFS programs. Nursing facility residents, 1915(c) waiver participants, adults enrolled in managed care, and children under age 21 are not subject to the three-prescription limitation. VDP manages the formulary, the preferred drug list, clinical prior authorization criteria, and drug manufacture rebates; defines and manages pharmacy benefit policies for Medicaid members; monitors MCO pharmacy compliance, performs prospective and retrospective drug utilization reviews for FFS clients, and enforces the use of rebate-eligible drugs on outpatient medical claims for both FFS and Medicaid managed care members

W

WAIVER – An exception to the usual Medicaid requirements granted to a state by the Centers for Medicare

& Medicaid Services. See also **1115(a); 1915(b); 1915(c)**.

WOMEN'S HEALTH PROGRAM

(WHP) – A Medicaid waiver program that provided family planning services and related health screenings to eligible uninsured women ages 18 to 44 with net family incomes at or below 185 percent of the federal poverty level. The Centers for Medicare & Medicaid Services approved a five-year waiver for WHP with an implementation date of January 1, 2007. The Medicaid waiver was not renewed, and WHP ended on December 31, 2013. See also **TEXAS WOMEN'S HEALTH PROGRAM; HEALTHY TEXAS WOMEN**.

X

Y

YOUTH EMPOWERMENT

SERVICES (YES) WAIVER – A Home and Community-Based Services waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, YES allows for more flexibility in the funding of intensive community-based services for children and adolescents age 3 to 18 with serious emotional disturbances and their families. See also **1915(c); WAIVER**.

Z

NUMBERED TERMS

1115(a) – Section of the Social Security Act which allows states to waive provisions of Medicaid law to test new concepts which are consistent with the goals of the Medicaid program. System-wide changes are possible under this provision. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY; WAIVER**.

1902(a)(1) – Section of the Social Security Act which requires that state Medicaid programs be in effect “in all political subdivisions of the state.” See also **STATEWIDENESS; WAIVER; 1915(b); 1915(c)**.

1902(a)(10) – Section of the Social Security Act which requires that state Medicaid programs provide services to people that are comparable in amount, duration, and scope. See also **COMPARABILITY; WAIVER; 1915(b)**.

1902(a)(23) – Section of the Social Security Act which requires that state Medicaid programs ensure that clients have the freedom to choose any qualified provider to deliver a covered service. See also **FREEDOM OF CHOICE; WAIVER; 1915(b)**.

1902(r)(2) – Section of the Social Security Act which allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income eligibility for determining Medicaid eligibility. See also **SUPPLEMENTAL SECURITY INCOME**.

1903(m) – Section of the Social Security Act which allows state Medicaid programs to develop risk contracts with managed care organizations or comparable entities. See also **RISK CONTRACT**.

1915(b) – Section of the Social Security Act which allows states to waive freedom of choice. States may require that beneficiaries enroll in managed care organizations or other programs. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; WAIVER**.

1915(c) – Section of the Social Security Act which allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an intermediate care facility for individuals with an intellectual disability or related condition, nursing facility, institution for mental disease, or inpatient hospital. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS**

FOR MEDICARE & MEDICAID SERVICES; COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES WAIVER PROGRAM; DEAF-BLIND WITH MULTIPLE DISABILITIES WAIVER; HOME AND COMMUNITY-BASED SERVICES WAIVER; MEDICALLY DEPENDENT CHILDREN PROGRAM; NURSING FACILITIES; STAR+PLUS; TEXAS HOME LIVING WAIVER; YOUTH EMPOWERMENT SERVICES WAIVER; WAIVER.

1915(c)(7)(b) – Section of the Social Security Act which allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; HOME AND COMMUNITY-BASED SERVICES WAIVER; WAIVER.**

1929 – Section of the Social Security Act which allows states to provide a broad range of home and community-based care to individuals with functional disabilities as an optional state plan benefit. In all states but Texas, the option can serve only people over 65. In Texas, individuals of any age may qualify to receive personal care services

through section 1929 if they meet the state’s functional disability test and financial eligibility criteria. See also **COMMUNITY ATTENDANT SERVICES.**