

Glossary

A***Abuse***

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

Access-based Fee (ABF)

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

Activities of Daily Living (ADLs)

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

Acuity Risk Adjustment

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

Acute Care Services

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

Acute Care Utilization Review (ACUR)

Acute Care Utilization Reviews (ACUR) are one type of utilization review designed to monitor Managed Care Organizations (MCOs) and ensure they are authorizing, justifying, and providing appropriate, medically necessary services to Medicaid clients, without over-utilization or under-utilization. For this review, a team of nurses conducts a desk review of a targeted sample set of medical records selected based on complaints, the severity of frequency of non-compliance instances, and the volume or cost of particular services. Nurses from the ACUR team conduct an in-depth review of the sample cases' authorization process, medical necessity determination, timeliness, and accuracy in the resolution.

Administrative Expense Limits (Admin Cap)

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

Agency Option

The agency option refers to an option Medicaid clients have in determining how certain long-term services and supports (LTSS) may be delivered. This option is the traditional method of service delivery where services are delivered through a provider agency. The provider agency is the employer of attendants or other direct service workers, and is responsible for all of the employment and business operations-related activities. The service coordinator case management agency (for Community Living Assistance and Support Services (CLASS) waiver program only) or provider agency (for Deaf Blind with Multiple Disabilities (DBMD) only), coordinates with the individual or authorized representative to monitor and ensure clients are satisfied with their services. See Provider Agency.

Aging and Disability Resource Center (ADRC)

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

Alberto N. v. Smith

A federal lawsuit settled in May of 2005 that 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 age 20 and younger who are eligible for the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

All Patient Refined Diagnosis Related Group (APR-DRG)

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

Alternative Payment Model (APM)

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

Alternative Prospective Payment System (APPS)

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

Amount, Duration, and Scope

Amount, duration, and scope refers to 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.

Appointment Availability

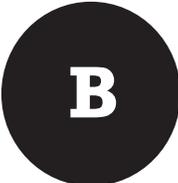
Appointment availability is a measurement used to assess client access to care within the managed care delivery system. It is measured by the time between when a member contacts a provider and the date of the first available appointment. Managed Care Organizations (MCOs) can reduce the use of emergent care by ensuring members have timely access to regular and preventive care. HHSC imposes MCO certain appointment availability standards for STAR, Children's Health Insurance Program (CHIP), STAR Kids, STAR Health, and STAR+PLUS based on the type of medical appointment requested. Texas' external quality review organization (EQRO) conducted secret shopper studies to evaluate MCO compliance with these availability standards.

Asset Test

Conducted as part of calculating financial eligibility, asset tests count the resources, such as savings or checking accounts, applicants may have access to. There is a limit on the amount of assets a household can have to be eligible. Those subject to the Modified Adjusted Gross Income (MAGI) methodology are typically not subject to asset tests. See Modified Adjusted Gross Income (MAGI).

Audits

An official inspection of performance or finances, audits are conducted by independent contractors or outside agencies, such as the Office of Inspector General (OIG). See Office of Inspector General (OIG).



B

Behavioral Health Integration

Behavioral Health Integration refers to the addition of mental health targeted case management and mental health rehabilitative services to the array of services provided under managed care. Managed Care Organizations (MCOs) are required to develop a network of public and private providers of mental health rehabilitation and mental health targeted case management, and to ensure adults with serious mental illness and children

with serious emotional disturbance have access to this comprehensive array of services. HHSC requirements also target effectively sharing information between care coordination and service authorization staff, including utilization management data; encouraging co-location of behavioral and physical healthcare coordination staff; requiring warm call transfers between physical and behavioral healthcare coordination staff; implementing effective means of clinical information sharing, such as clinical rounds that include both behavioral and physical health MCO staff; and further linking behavioral health and physical health provider portals for those MCOs that operate separate portals.

Behavioral Health Services

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

Benefits Program Integrity

A branch of investigation within the Office of Inspector General (OIG) that examines clients suspected of abusing HHSC programs, including Medicaid and CHIP, but also the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and the Women, Infants, and Children (WIC) program. See Office of Inspector General (OIG).

Better Birth Outcomes (BBO)

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

Blind Children's Vocational Discovery and Development Program

The Blind Children's Vocational Discovery and Development Program supports children and youth age 20 and younger, who have vision impairments. The program serves both

Medicaid and Children’s Health Insurance Program (CHIP) eligible children and coordinates case management services and payment with these programs to ensure that children have access to services. The clients, in partnership with the program, develop a pathway for a successful future through independent living skills, assistive therapy, and support services.

Breast and Cervical Cancer Services (BCCS)

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



Capitation Rate

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

Care Coordination

The value of managed care relies on care coordination provided by Managed Care Organizations (MCOs). Care coordination includes services performed by MCOs or by primary care providers, such as assistance with setting up appointments, locating specialty providers, and member health assessments. In particular, MCOs are required to identify and provide care coordination for members with special health care needs (MSHCN). The MCO is responsible for working with MSHCN, their healthcare providers, and their families to develop a seamless package of care in which all needs are met through a comprehensive service plan. This coordination is available to MSHCN including women with high-risk

pregnancies, members with high-cost catastrophic cases, and individuals with mental illness and co-occurring substance abuse. See Members with Special Health Care Needs (MSHCN).

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women is a component of Texas Health Steps (THSteps). This Medicaid benefit provides health-related case management services to children age 20 and younger or pregnant women who are eligible for Medicaid. Case managers assist eligible clients in gaining access to medically necessary medical, social, educational, and other services related to their health condition, health risk or high-risk condition. Services include assessing the needs of eligible clients, developing a service plan with clients and families, making referrals, problem-solving, advocacy, and follow-up regarding client and family needs. See Texas Health Steps (THSteps).

Centers for Medicare & Medicaid Services (CMS)

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

Certified Community Behavioral Health Clinic (CCBHC) Pilot

The Certified Community Behavioral Health Clinic (CCBHC) pilot program is a state-run project designed to shift the system towards an efficient and integrated care delivery system. The project runs eight pilot sites, including Bluebonnet Trails, Burke, Helen Farabee, Integral Care, Montrose Center, StarCare, Tarrant MHMR, and Tropical Texas. The pilots in Burke and Tropical Texas are Medicaid health home pilot programs for persons who are diagnosed with a serious mental illness and at least one other chronic health condition.

Chemical Dependency Treatment Facility (CDTF)

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

Children's Health Insurance Program (CHIP)

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

Children's Health Insurance Program (CHIP) Perinatal

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

Children's Hospital

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

Children's Medicaid

The majority of individuals receiving full Medicaid benefits are children, birth through age 20. Children with Medicaid coverage are generally eligible to receive a wider range of healthcare services than adults, including services like physical, occupational, and speech therapy, private duty nursing services, and hearing and nursing services. Most children are covered under one of the managed care programs in Texas, such as STAR, STAR Health, or STAR Kids. Children with Medicaid coverage also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program services, known in Texas as Texas Health Steps (THSteps). Children who are not eligible for Medicaid due to income may be eligible for Children's Health Insurance Program (CHIP). See Texas Health Steps (THSteps), STAR, STAR Health, STAR Kids, and Children's Health Insurance Program (CHIP).

Children's Medicaid Dental Services (CMDS) Program

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

Chronic Care Management

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

Client

A client is an individual who has applied for and is enrolled in Medicaid/CHIP. If enrolled into a health plan, they may also be referred to as a member.

Clinical Prior Authorizations

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

Community Attendant Services (CAS)

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

Community First Choice (CFC)

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

Community Living Assistance and Support Services (CLASS)

Community Living Assistance and Support Services (CLASS) is a 1915(c) waiver program that provides community-based services to people with developmental disabilities other than intellectual disability as an alternative to institutional care. See Home and Community-Based Services (HCBS) 1915(c) waivers.

Community Partner

Community Partners are members of our statewide network of nonprofit, faith-based, local, and community groups that help individuals apply for and manage benefits. These groups either participate in the program as self-service locations where they provide computers with internet connection or assistance sites where staff and volunteers help clients.

Complaints

HHSC monitors Managed Care Organization (MCO) complaints, grievances, and appeals processes, and uses data as a mechanism to flag for early warnings of potential systemic problems that warrant investigation, point to the need for policy clarifications, or signal larger operational issues.

Comprehensive Care Program (CCP)

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

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

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a nationally recognized and validated tool for collecting standardized information on members' experiences with health plans and services. This survey focuses on consumer perceptions of quality, such as the communication skills of providers and ease of access to healthcare services. See National Core Indicators - Aging and Disabilities (NCI-AD) Survey.

Consumer Directed Services (CDS) Option

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

Contractor

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

Corrective Action Plan (CAP)

In cases of contractual non-compliance, HHSC may use corrective action plans (CAPs) to hold Managed Care Organizations (MCOs) accountable. The CAP process requires MCOs to provide HHSC with a detailed explanation of the reasons for the deficiency, an assessment or diagnosis of the cause, actions taken to cure or resolve the deficiencies, including

short- and long-term solutions, and actions taken to prevent future occurrences. HHSC administers CAPs on a monthly basis, and reviews, approves, and closes CAPs once appropriate actions have been taken to address the non-compliance.

Cost-Sharing

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



Data and Technology Division (DAT)

A division within the Office of Inspector General (OIG), the Data and Technology (DAT) division supports OIG's role in helping to ensure Medicaid program integrity. DAT uses data research and analytics to identify, monitor, and assess trends and patterns of behavior of providers, clients and retailers participating in Medicaid and other health and human service programs.

Day Activity and Health Services (DAHS)

Day Activity and Health Services (DAHS) are state plan, community-based, long-term services and supports (LTSS). DAHS is offered during the day, Monday through Friday, to clients residing in the community. Services, 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 (DBMD)

Deaf Blind with Multiple Disabilities (DBMD) is a 1915(c) waiver program that provides community-based services to people who are deaf and blind and have a third disability (e.g., an intellectual disability) as an alternative to institutional care. See Home and Community-Based Services (HCBS) 1915(c) waivers.

Deferral

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

Delivery Supplemental Payment

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

Delivery System Reform Incentive Payment (DSRIP) Pool

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

Dental Maintenance Organization (DMO)

Dental Maintenance Organizations (DMOs) deliver and manage comprehensive dental services to eligible Medicaid/CHIP clients. For Medicaid/CHIP, there are two DMOs that operate statewide.

Dental Quality Alliance (DQA)

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

Diagnosis Related Group (DRG)

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

Disallowance

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

Disproportionate Share Hospital (DSH)

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

Disproportionate Share Hospital (DSH) Funding

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

Dual Demonstration

The Dual Eligible Integrated Care Demonstration Project, or the Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS program. Dual Demonstration is testing an innovative payment and service delivery model to alleviate fragmentation and improve coordination of services for dual eligibles, enhance quality of care, and reduce costs for both the state and the federal government. See Dual Eligible.

Dual Eligible

Dual eligibles are individuals who qualify for both Medicare and Medicaid benefits. Medicare is a federally-paid and administered health insurance program. Texas covers a different mix of Medicare cost-sharing depending on the individual's income.

Drug Utilization Review (DUR)

Drug Utilization Reviews (DURs), prospective and retrospective, are used by HHSC and Managed Care Organizations (MCOs) to evaluate client use of prescription drugs. See Prospective Drug Utilization Review (DUR), Retrospective Drug Utilization Review (DUR), and Texas Drug Utilization Review (DUR) Board.

E

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

This is a required Medicaid state plan benefit for eligible children and youth, birth through age 20. In Texas, this program is referred to as Texas Health Steps (THSteps). See Texas Health Steps (THSteps).

Early Childhood Intervention (ECI)

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

Electronic Health Record (EHR)

An electronic health record (EHR) contains 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 healthcare quality, and the ability to exchange electronic health information with, and integrate such information from other sources. See Electronic Health Record (EHR) Incentive Program.

Electronic Health Record (EHR) Incentive Program

Through the Electronic Health Record (EHR) incentive program, HHSC pays Medicaid providers for the meaningful use of EHRs. See Medicaid Provider Health Information Exchange (HIE) Connectivity Project and Health Information Exchange (HIE) Texas.

Electronic Visit Verification (EVV)

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

Emergency Medicaid

Emergency Medicaid is acute care coverage designed to meet a sudden, critical medical need. Most people realize, and apply for, this benefit only after an emergency occurs. If determined eligible, the individual is covered by Medicaid only from the start of a qualifying emergency medical condition to when the event is stabilized, as verified by a medical provider.

Encounter Data

Used in the calculation of Managed Care Organization (MCO) capitation rates, encounter data refers to the historical claims experience of MCOs for a particular base period of time. Encounter data includes the records of the healthcare services for which MCOs pay and the amounts MCOs pay to providers of those services. See Capitation Rates.

Enhanced Federal Medical Assistance Percentage (EFMAP)

The enhanced federal medical assistance percentage (EFMAP) is used to determine federal matching funds for Children's Health Insurance Program (CHIP). Derived from each state's average per capita income, the Centers for Medicare & Medicaid Services (CMS) updates this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The EFMAP for Texas in federal fiscal year 2019 is 70.73 percent and in state fiscal year 2019 is 70.65 percent. See Federal Medical Assistance Percentage (FMAP) and Matching Funds.

E-Prescribing (EPCS)

E-Prescribing (EPCS) refers to the computer-to-computer transfer of prescription, drug, benefit, and patient information among prescribers, pharmacies, and payers. Medicaid and Children's Health Insurance Program (CHIP) began implementing EPCS in 2010.

External Quality Review Organization (EQRO)

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



Family Planning Program (FPP)

The Family Planning Program (FPP) helps fund clinic sites across the state to provide quality, comprehensive, low-cost, accessible family planning and reproductive health-care services to eligible women and men. These services help individuals determine the number and spacing of their children, reduce unintended pregnancies, positively affect future pregnancy and birth outcomes, and improve general health.

Federal Poverty Level (FPL)

The federal poverty level (FPL) is an indicator established annually by the U.S. Department of Health and Human Services. Public assistance programs usually define income limits in relation to the FPL, and HHSC issues guidelines based on income and household size. For example, based on their relation to the FPL, larger households will have a higher income limit than smaller households. See [Income Limits](#).

Federal Medical Assistance Percentage (FMAP)

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

Federally Qualified Health Center (FQHC)

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

Fee-For-Service (FFS)

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

Fee-For-Service (FFS) Rates

Fee-for-service (FFS) rates are paid directly to providers—physicians, other medical practitioners, pharmacists, and hospitals. HHSC is responsible for establishing reimbursement methodologies. However, the commission consults with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are subject to a public hearing, and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process. Changes in FFS rates will often impact managed care capitation rates.

Financial Criteria

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

Financial Statistical Report (FSR)

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

Fraud

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

Freedom of Choice

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

Freedom of Choice 1915(b) Waivers

Section 1915(b) waivers allow states to use a central broker (e.g., enrollment broker) to assist people with choosing a Managed Care Organization (MCO), to use cost savings to provide additional services, or to limit clients’ choice of Medicaid providers by requiring Medicaid clients join MCOs. Texas has used these waivers to provide an enhanced benefit package (beyond what is available through the state plan) with cost savings from managed care.

Frew v. Smith

A class action lawsuit filed against Texas in 1993, 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 require-

ments on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services. Since 2007, HHSC and the Department of State Health Services (DSHS) have actively worked to meet the requirements of the corrective action orders.



Graduate Medical Education (GME) Payments

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



Health and Behavior Assessment and Intervention (HBAI)

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

Health and Human Services Commission (HHSC)

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

Health Information Exchange (HIE) Texas

Health Information Exchange (HIE) Texas is a project that enhances the state's HIE infrastructure to support connectivity, and assists local HIEs in implementing connections and facilitating the exchange of data for Medicaid and CHIP clients. HIE Texas builds off of the Medicaid Provider HIE Connectivity Project. See Medicaid Provider Health Information Exchange (HIE) Connectivity Project.

Health Insurance Premium Payment (HIPP) Program

The Health Insurance Premium Payment (HIPP) program reimburses eligible individuals for their share of an employer-sponsored health insurance premium payment when it is determined that the cost of the premium is less than the cost of projected Medicaid expenditures.

Health Maintenance Organization (HMO)

Health Maintenance Organizations (HMOs) are health insurance organizations, where individuals pay a predetermined fee in return for a range of medical services from healthcare providers registered with the organizations.

Health Plan

Managed Care Organizations (MCOs) are often referred to as health plans, a term which describes their function in providing medical coverage and coordinated care to Medicaid/CHIP clients. See Managed Care Organization (MCO).

Healthcare Effectiveness Data and Information Set (HEDIS)

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures for Managed Care Organizations (MCOs). HEDIS data for Texas Medicaid/CHIP managed care programs is posted and regularly updated on the Texas Healthcare Learning Collaborative (THLC) portal. See Texas Healthcare Learning Collaborative (THLC) Portal.

Healthcare Payment Learning and Action Network (HCP-LAN)

The Healthcare Payment Learning and Action Network (HCP-LAN) seeks to accelerate the healthcare system's transition to alternative payment models (APMs). HHSC is using HCP-LAN to help shift Managed Care Organizations (MCOs) in Texas Medicaid and Children's Health Insurance Program (CHIP) to APMs. See Alternative Payment Model (APM) and Pay-For-Quality (P4Q).

Healthy Families Project

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

Healthy Texas Women (HTW)

Healthy Texas Women (HTW) provides women’s health and family planning services at no cost to eligible, low-income Texas women age 15 through age 44. HTW helps women plan their families, whether it is to achieve, postpone, or prevent pregnancy.

Home and Community-based Services (HCS)

Home and Community-based Services (HCS) is a 1915(c) waiver program that provides community-based services to people with intellectual disabilities as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). See Home and Community-Based Services (HCBS) 1915(c) waivers.

Home and Community-Based Services—Adult Mental Health (HCBS-AMH)

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

Home and Community-Based Services (HCBS) 1915(c) Waivers

Home and Community-Based Services (HCBS) 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility criteria for care in an institution. See Home and Community-based Services (HCS), Community Living Assistance and Support Services (CLASS), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD), Medically Dependent Children Program (MDCP), and Youth Empowerment Services (YES).

Hospice

Hospice services are palliative care consisting of medical, social and support services to terminally ill individuals and their loved ones, when curative treatment is no longer desired or possible and a physician has indicated the individual has six months or less to live.

Hospital Quality-Based Payment Program

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

I***Income Disregards***

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

Income Limits

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

Inspections

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

Instrumental Activities of Daily Living (IADLs)

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

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

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

L***Legal Permanent Resident (LPR)***

A Legal Permanent Resident (LPR) is any person not a citizen of the U.S. who is residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant. LPRs may also be referred to as 'Green Card Holders.'

Liquidated Damages (LDs)

Liquidated damages (LDs) are compensation for contractual non-compliance. HHSC assesses LDs quarterly to address any harm incurred due to Managed Care Organization (MCO) contractual non-compliance.

Local Behavioral Health Authority (LBHA)

There are two local behavioral health authorities (LBHAs) across the state of Texas, serving in a similar capacity to the 37 local mental health authorities (LMHAs) also contracting with HHSC. See Local Mental Health Authority (LMHA).

Local Intellectual and Developmental Disability Authority (LIDDA)

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

Local Mental Health Authority (LMHA)

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

Long-Acting Reversible Contraceptive (LARC)

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

Long-Term Services and Supports (LTSS)

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

***Managed Care***

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

Managed Care Long-Term Services and Supports Utilization Review (MLTSS UR)

The Managed Care Long-Term Services and Supports Utilization Review (MLTSS UR) team conducts sampled reviews of STAR+PLUS Home and Community-Based Services (HCBS) to determine Managed Care Organizations' (MCOs') conduct of assessments, MCOs' procedures and related information used to determine appropriateness of member enrollment in the HCBS program. The review includes ensuring MCOs are providing services according to their assessment of service needs.

Managed Care Organization (MCO)

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

Mandatory Benefits

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

Matching Funds

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

Medicaid

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

Medicaid Breast and Cervical Cancer (MBCC) Program

The Medicaid Breast and Cervical Cancer (MBCC) program provides Medicaid to eligible women who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and are found to have breast or cervical cancer, including pre-cancerous conditions. Women found eligible receive full Medicaid benefits and are enrolled into STAR+PLUS. Women remain eligible for MBCC as long as they are receiving active treatment, such as chemotherapy or radiation, for breast or cervical cancer. See Breast and Cervical Cancer Services (BCCS).

Medicaid Buy-In for Children (MBIC)

The Medicaid Buy-In for Children (MBIC) program allows children age 18 and younger with disabilities to buy in to Medicaid. Children with family countable income at or below 300 percent of the federal poverty level (FPL) may qualify for the program, and households

at or below 10 percent of the FPL will not pay a premium. MBIC families make monthly payments according to a sliding scale that is based on family income.

Medicaid Buy-In (MBI) for Workers with Disabilities

The Medicaid Buy-In (MBI) program enables working persons with disabilities to buy in to Medicaid. Individuals with income below 250 percent of the federal poverty level (FPL) and resources at or below \$5,000 may qualify and may pay a monthly premium in order to receive Medicaid benefits.

Medicaid Estate Recovery Program (MERP)

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

Medicaid for Former Foster Care Children (FFCC)

Medicaid for Former Foster Care Children (FFCC) covers Medicaid clients who aged out of the foster care system in Texas at age 18 and older and who were receiving federally-funded Medicaid when they aged out of foster care. FFCC clients are automatically enrolled in STAR Health through the month of their 21st birthday. Individuals may opt out of STAR Health for STAR, which allows for a choice of health plans. After an individual attains age 21, coverage will transfer to STAR. FFCC clients may continue to be eligible up to the month of their 26th birthday. See Medicaid for Transitioning Foster Care Youth (MTFCY).

Medicaid for Pregnant Women

Texas elects to extend Medicaid eligibility to pregnant women with a household income at or below 198 percent of the federal poverty level (FPL), well above the federal requirement of 133 percent of the FPL. Pregnant women who qualify receive services through the STAR program, which include prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum care. Pregnant women who do not meet income requirements may qualify for Children's Health Insurance Program (CHIP) Perinatal, the Medically Needy with Spend Down program, or the Medically Needy with Spend Down Emergency program. See Children's Health Insurance Program (CHIP) Perinatal.

Medicaid for the Elderly and People with Disabilities (MEPD)

Medicaid for the Elderly and People with Disabilities (MEPD) is for people age 65 and older and those with disabilities who do not receive Supplemental Security Income (SSI). Individuals may qualify for this program through a facility, such as a nursing facility or an intermediate care facility for individuals with an intellectual disability or related condition

(ICF/IID). Examples of MEPD services and programs are: state plan long-term services and supports (LTSS); Home and Community-Based Services (HCBS) waiver programs, which provide community-based care as an alternative to institutional care; care in a Medicaid-certified long-term care facility; the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Buy-In programs; and Medicare Savings Programs. See Long-Term Services and Supports (LTSS).

Medicaid for Transitioning Foster Care Youth (MTFCY)

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

Medicaid Lock-In Program

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

Medicaid Provider Health Information Exchange (HIE) Connectivity Project

This project helps Medicaid service providers connect to local Health Information Exchanges (HIEs) to facilitate electronic reporting and data exchange between providers and Texas Medicaid. HIE is the secure electronic movement of health-related information from Electronic Health Records (EHRs) among treating physicians, other care providers, and organizations. Texas is served by several community-based and private HIEs. See the Electronic Health Records (EHR) Incentive Program.

Medical Transportation Program (MTP)

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

Medically Dependent Children's Program (MDCP)

Medically Dependent Children's Program (MDCP) is a 1915(c) waiver program that provides respite, minor home modifications, and adaptive aids to children and youth age 20 and younger as an alternative to nursing facility care. See Home and Community-Based Services (HCBS) 1915(c) waivers.

Medically Needy with Spend Down Program

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

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.

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

A Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals that are dually eligible for both programs.

Medicare Savings Program

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

Medication Assisted Therapy (MAT)

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

Members with Special Health Care Needs (MSHCN)

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

Mental Health Parity

Mental Health Parity policies seek to address differences in mental health coverage from physical health coverage. Federal law now prohibits differences in treatment limits, cost-sharing, and in- and out-of-network coverage between mental health and substance use disorder (SUD) benefits and medical and surgical benefits.

Modified Adjusted Gross Income (MAGI)

Modified Adjusted Gross Income (MAGI) is a tool used for financial eligibility determinations. The MAGI methodology uses federal income tax rules for determining income and household composition. It is calculated by taking household income, subtracting tax-deductible expenses (such as IRA contributions or alimony payments), and adding back a standard income disregard equivalent to five percent of the federal poverty level (FPL). Federal law requires most financial eligibility be determined with the MAGI methodology. However, Medicaid programs for people age 65 and older, the disabled, and those receiving Supplemental Security Income (SSI), do not use MAGI for eligibility determinations. Applicants subject to MAGI are typically not subject to asset tests. See Asset Tests and Income Disregards.



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

Similar to the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, HHSC participates in the National Core Indicators - Aging and Disabilities (NCI-AD) survey on a biennial basis. This allows the state to assess outcomes of services provided to members who participate in STAR+PLUS Home and Community-Based Services (HCBS) and the Program of All-Inclusive Care for the Elderly (PACE).

Network Adequacy

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

No Wrong Door (NWD)

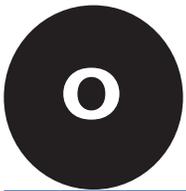
The No Wrong Door (NWD) system represents the effort to streamline access to long-term services and supports (LTSS) options for all populations and all payers. In NWD systems, multiple state and community agencies coordinate to ensure that regardless of which agency people contact for help, they can access one-to-one counseling and information about all of the agencies and services available in their communities.

Non-Financial Criteria

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

Nursing Facility

Nursing facilities provide services to meet the medical, nursing, and psychological needs of persons who have a level of medical necessity requiring nursing care on a regular basis.



Office of Inspector General (OIG)

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

Operational Reviews

Operational reviews allow HHSC to conduct an in-depth review of Managed Care Organization (MCO) operational compliance and performance across a number of areas to ensure policies and practice align with performance standards. HHSC conducts on-site biennial operational reviews of MCOs, which include review modules on claims processing, member and provider training, complaints/appeals, encounter data, utilization management, and website critical elements.

Optional Benefits

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



Pay-For-Quality (P4Q)

Pay-For-Quality (P4Q) refers to programs that seek to reward the use of evidence-based practices and promote healthcare coordination and efficacy among Managed Care Organizations (MCOs). HHSC implements medical P4Q programs for STAR, STAR+PLUS, and Children’s Health Insurance Program (CHIP), and a dental P4Q program. Strong P4Q programs incentivize MCOs to pursue quality-based alternative payment models (APMs) with providers to help them achieve higher performance on P4Q measures.

Pediatric Quality Indicator (PDI)

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

Per Member Per Month (PMPM)

Per Member Per Month (PMPM) rates are calculated for each risk group within each of the state’s service areas, based on encounter data, and form the basis for the capitation rates paid to Managed Care Organizations (MCOs) for the delivery of contractually required Medicaid and Children’s Health Insurance Program (CHIP) services. See Capitation Rate and Encounter Data.

Performance Improvement Project (PIP)

Performance improvement projects (PIPs) are an integral part of Texas’ Managed Care Quality Improvement Strategy. Federal regulations require all states with Medicaid managed care programs to ensure health plans conduct PIPs. PIPs must use ongoing measurements and interventions to achieve significant improvement over time in health outcomes and enrollee satisfaction. Health plans conduct PIPs to improve areas of care identified by HHSC, in consultation with Texas’ EQRO, as needing improvement.

Perinatal Advisory Council

This council, part of Better Birth Outcomes (BBO), recommends criteria for designating levels of neonatal and maternal care and ways to improve neonatal and maternal outcomes. Levels of care designations are anticipated to improve health outcomes by promoting care in the most appropriate setting. See Better Birth Outcomes (BBO).

Personal Assistance Services (PAS)

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

Personal Care Services (PCS)

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

Potentially Preventable Admissions (PPA)

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

Potentially Preventable Complication (PPC)

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

Potentially Preventable Emergency Department Visit (PPV)

A potentially preventable event (PPE) in which emergency treatment for a condition that could have been treated or prevented by a physician or other healthcare provider in a nonemergency setting. See Potentially Preventable Event (PPE).

Potentially Preventable Event (PPE)

Potentially preventable events (PPEs) are encounters, which could be prevented, that lead to unnecessary services or contribute to poor quality of care. PPEs are used to measure

care quality. See Potentially Preventable Hospital Admissions (PPA), Potentially Preventable Complication (PPC), Potentially Preventable Hospital Readmission (PPR), Potentially Preventable Emergency Department Visit (PPV).

Potentially Preventable Readmission (PPR)

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

Preferred Drug List (PDL)

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

Prescribed Pediatric Extended Care Center (PPECC)

Prescribed Pediatric Extended Care Centers (PPECCs) provide non-residential, facility-based care during the day as an alternative to private duty nursing (PDN) for individuals age 20 and younger who are medically or technologically dependent.

Prescription Drugs

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

Prevention Quality Indicator (PQI)

Prevention Quality Indicators (PQIs) use hospital discharge data to measure quality of care for ambulatory care sensitive conditions, which are conditions where good outpatient care or early intervention can prevent hospitalization, complications, or more severe disease.

Primary Care Provider (PCP)

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

Primary Home Care (PHC)

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

Profit Limit

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

Program of All-Inclusive Care for the Elderly (PACE)

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

Promoting Independence (PI) Initiative

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

Prospective Drug Utilization Review (DUR)

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

Prospective Payment System (PPS)

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

Provider Agency

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

Provider Enrollment Screening

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

Provider Field Investigations (PFI)

The Office of Inspector General's (OIG) Provider Field Investigations (PFI) look into allegations of fraud, waste, and abuse by healthcare providers. The results of an investigation may lead to recoupment of overpayments, imposition of sanctions or administrative actions, referrals to licensing boards, and referrals to the Office of Attorney General's Medicaid Fraud Control Unit. See Office of Inspector General (OIG).

Psychiatric Hospital

A psychiatric hospital is an institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons. The provisions for certification

apply only where the entire institution is primarily for the treatment of mental illness. A psychiatric wing of a general hospital may not be certified.



Qualified Aliens

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

Quality Assessment and Performance Improvement (QAPI) Projects

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

Quality Incentive Payment Program (QIPP)

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



Readiness Reviews

HHSC conducts readiness reviews to determine if a Managed Care Organization (MCO) is capable of providing the services that they are being contracted to provide. Readiness reviews are completed at least 90 days prior to the operational start of a contract to provide enough time to identify and remedy operational issues prior to contract start date.

Regional Healthcare Partnership (RHP)

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

Regional Healthcare Partnership (RHP) Planning Protocols

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

Research and Demonstration 1115 Waivers

Research and Demonstration 1115 waivers allow flexibility for states to test new ideas for operating their Medicaid programs, including implementing statewide health system reforms, providing services not typically covered by Medicaid, or allowing innovative service delivery systems to improve care, increase efficiencies, and reduce costs.

Resource-based Fee (RBF)

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

Retrospective Drug Utilization Review (DUR)

Retrospective Drug Utilization Reviews (DURs) examine the drug therapy after the person has received the medication. Retrospective DURs evaluates claims data to analyze prescribing practices, a person's medication use, and pharmacy dispensing practices. HHSC and Managed Care Organizations (MCOs) conduct multiple reviews each calendar year on topics such as identifying patterns of drug misuse, medically unnecessary prescribing, or inappropriate prescribing. Intervention letters are sent to physicians to

help better manage a person's drug therapy. The Texas Drug Utilization Review (DUR) Board also reviews and approves the retrospective DURs for fee-for-service (FFS). See Texas Drug Utilization Review (DUR).

Risk Margin

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

Rural Health Clinics (RHC)

A rural health clinic (RHC) is a clinic located in a rural area designated by the U.S. Health Resources and Services Administration as a shortage area. To qualify as an RHC, the clinic must be located in a non-urbanized and medically underserved area and have a nurse practitioner or physician'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.

Rural Hospital

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



School Health and Related Services (SHARS)

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

Screening, Brief Intervention and Referral to Treatment (SBRIT)

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive public health approach to the delivery of early intervention and treatment services for clients

who are age 10 and older and who have alcohol or substance use disorder, or who are at risk of developing such disorders.

Secret Shopper Studies

Secret shopper studies, which are conducted by the state's external quality review organization (EQRO), evaluate whether providers met appointment availability standards, also helped quantify the extent of provider directory issues. Secret shoppers contact network providers, using contact information provided by Managed Care Organizations (MCOs), to see how quickly they can get appointments across all Medicaid programs.

Service Area (SA)

Also called Service Delivery Areas (SDAs), service areas (SAs) are the geographic locations within the state where services are delivered by certain health plans and their providers.

Service Comparability

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

Service Responsibility Option (SRO)

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

Single State Agency

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

STAR

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

STAR Health

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

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

STAR Kids

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

STAR+PLUS

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

STAR+PLUS Home and Community-Based Services (HCBS) Program

The STAR+PLUS Home and Community-Based Services (HCBS) program provides a cost-effective alternative to living in a nursing facility to clients who are elderly or who have disabilities. Services included are nursing, Personal Assistance Services (PAS), adaptive aids, medical supplies, and minor home modifications to make members' homes more accessible.

State-Owned Teaching Hospital

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

State Plan

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

State Supported Living Center (SSLC)

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

Statewide Availability

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

Substance Use Disorder (SUD)

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

Sufficient Coverage

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

Supplemental Hospital Funding

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

Supplemental Nutrition Assistance Program (SNAP)

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

Supplemental Security Income (SSI)

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

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

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

Texas Alliance for Innovation on Maternal Health Bundle Implementation (TexasAIM)

Part of Better Birth Outcomes (BBO), the Texas Alliance for Innovation on Maternal Health Bundle Implementation (TexasAIM) are maternal safety initiatives Texas seeks to implement in hospitals and other settings. The Department of State Health Services (DSHS) has assembled a multi-disciplinary team to facilitate these initiatives throughout the state. Texas will first work to implement the Obstetric Hemorrhage Bundle, followed by the Obstetric Care for Women with Opioid Use Disorder Bundle, and the Severe Hypertension in Pregnancy Bundle. See Better Birth Outcomes (BBO).

Texas Department of Family and Protective Services (DFPS)

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

Texas Department of Insurance (TDI)

The Texas Department of Insurance (TDI) regulates both commercial and state-funded health insurance plans because Managed Care Organizations (MCOs) are licensed as Health Maintenance Organizations (HMOs) in Texas. TDI requires MCOs to file an annual network adequacy report.

Texas Drug Utilization Review (DUR) Board

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

Texas Health Steps (THSteps)

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

Texas Healthcare Learning Collaborative (THLC)

This website serves as a public reporting platform, contract oversight tool, and a tool for Managed Care Organization (MCO) quality improvement efforts. The website was developed for use by HHSC, MCOs, providers, and the general public to obtain up-to-date MCO and hospital performance data on key quality of care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality of care information.

Texas Home Living (TxHmL)

Texas Home Living (TxHmL) is a 1915(c) waiver program that provides community-based services to current Medicaid recipients with intellectual disabilities or related conditions as an alternative to an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID).

Texas Integrated Eligibility Redesign System (TIERS)

HHSC uses an integrated system to determine eligibility for Medicaid, Children's Health Insurance Program (CHIP), and other programs. The eligibility system offers convenient access to applications for services and information about programs and services available in Texas. This system has multiple channels, including a smartphone app, a self-service website (yourtexasbenefits.com), a network of local eligibility offices and community partners, and the 2-1-1 phone service. See Community Partners.

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

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

Third Party Liability (TPL)

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

Time and Distance Standards

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

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

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

Uniform Hospital Rate Increase Program (UHRIP)

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

Urban Hospital

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

**V**

Value-Added Services

Value-added services are additional healthcare benefits not paid for by Medicaid, but that may be offered by Managed Care Organizations to their members.

Vendor Drug Program (VDP)

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

**W**

Waivers

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

Waste

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

**Y**

Your Texas Benefits Website

A self-service website (yourtexasbenefits.com) where individuals can apply for Medicaid and other Texas HHSC programs. Clients can also view benefit information, edit and manage personal information, select their health plan, print temporary Medicaid cards or order replacement cards, set up and view their Texas Health Steps (THSteps) alerts, and

view services provided by Medicaid. Individuals may also manage, but not apply for, their benefits, view alerts, and find local offices or community partners through the Your Texas Benefits smartphone application. See Texas Integrated Eligibility Redesign System (TIERS) and Medicaid Eligibility.

Youth Empowerment Services (YES)

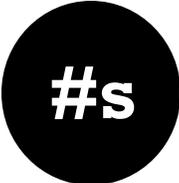
The Youth Empowerment Services (YES) is a 1915(c) waiver program that provides community-based services to children and adolescents age 3 through age 18 with serious emotional disturbances and their families.



Z

Zika Prevention

Zika Prevention is an ongoing Better Birth Outcomes (BBO) project to reduce and eliminate the spread of the Zika virus, which has been linked to serious birth defects in infants whose mothers were infected during pregnancy. Zika is spread primarily through mosquito bites. Efforts to reduce transmission, particularly among expectant mothers, include a regular updated public information website to educate the public: hhs.texas.gov/services/health/prevention/zika-medicaid-benefit, and improving provider capacity around Zika. Additionally, Texas covers certain mosquito repellent products as a benefit in Medicaid, Children's Health Insurance Program (CHIP), and other state programs. See Better Birth Outcomes (BBO).



#s

1115 Transformation Waiver

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

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The book underwent a complete redesign to more accurately reflect how we serve millions of Texans today. This required a full team effort.

Staff from within MCS Change Management, MCS Results Management, and staff from the Chief Program & Services Office led the redesign and coordination across HHS. The following areas provided critical program, financial, and enrollment data:

- All MCS units
- HHSC Financial Services
- Access & Eligibility Services
- Center for Analytics & Decision Support
- Health, Developmental & Independence Services
- Health & Specialty Care System
- IDD & Behavioral Health Services
- Office of the Inspector General
- DSHS Vital Statistics

Every attempt has been made to ensure the accuracy of the material reported in this book at the time of publication in December 2018.