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DEFINITIONS

- Action – 1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension or termination of a previously authorized service; 3) the denial, in whole or in part, of payment for a service; 4) the failure to provide services in a timely manner, as defined in Section 7.12.1 of this Contract; 5) the failure to act within the timeframes for resolving grievances and appeals, as described in Section 6.12 of this Contract; 6) for an enrollee of a rural area, the denial of the enrollee’s request to exercise his or her right under 42 CFR §438.52(b)(2)(ii) to obtain services outside the network.
- Active NorthSTAR User – An Enrollee who has received, in the four months prior to the first day of the month for which a premium is paid, at least one covered service, other than a clinical assessment, that was paid for by the Contractor. Or is a client with current active Medicaid.
- Adjudicate – to pay or to deny a claim.
- Adverse Determination - a determination by the Contractor or Contractor’s utilization review agent that the behavioral health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate.
- Adult - A person age 21 or over.
- Annual Enrollee months – The total Enrollee months in a given State fiscal year.
- Appeal – a request for review of an action or adverse determination.
- Assertive Community Treatment (ACT) – A team-based, self-contained program merging treatment, rehabilitation and support services in a mobile service delivery system for enrollees with serious mental illness who have a history of multiple hospitalizations or involvement with the judicial system, or who stay in homeless shelters or community residential homes.
- Behavioral Health Services – Services provided to diagnose or treat mental health disorders or chemical dependency disorders.
- Chemical dependency – The abuse of, or the psychological or physical dependence on, or the addiction to, alcohol or a controlled substance, corresponding to the DSM IV criteria for the various substance abuse and substance dependency disorders.
- Chemical dependency counselor (LCDC) – A person licensed by DSHS (see definitions under rules of counselor licensure 40 TAC §150.3) to provide counseling to chemically dependent

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individuals.

- Child – See Youth.
- Claim – a covered service delivered by a health care provider pursuant to the requirements of this Contract to a covered life or to an enrollee.
- Clean Claim – –For non-electronic claims, a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy that includes:
 - A. The required data elements set forth in Title 28, TAC, Chapter 21, §21.2803(b) or (c) of this title (relating to Elements of a Clean Claim); and
 - B. If applicable, the amount paid by the primary plan or other valid coverage pursuant to Title 28, TAC, Chapter 21, §21.2803(d) of this title (relating to Elements of a Clean Claim)

For electronic claims, a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

- Community Resource Coordination Groups (CRCGs) – A statewide system of local interagency groups, including both public and private providers, which coordinate services for "multi-need" youth. CRCGs develop individual service plans for youth whose needs can be met only through interagency cooperation. CRCGs address complex needs in a model that promotes local decision-making and that ensures youth receive the integrated combination of social, medical and other services needed to address their individual problems.
- Complaint - Any dissatisfaction expressed by a complainant orally or in writing to the Contractor with any aspect of the Contractor's operation, including but not limited to: 1) dissatisfaction with plan administration; 2) procedures related to the review or appeal of an adverse determination; 3) the denial, reduction, or termination of a service for reasons not related to medical necessity; 4) the manner in which a service is provided; or 5) a disenrollment decision. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the complainant or a provider's or enrollee's oral or written dissatisfaction or disagreement with an adverse determination. A complaint includes a grievance.

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- Continuity of Care – The coordination of services that ensures a consumer an efficient entrance into the managed care network, appropriate transitioning or adjustment of services to meet enrollees’ changing needs during the episode of care that is inclusive of a multidisciplinary team approach or communication between physical and behavioral health care providers, and smooth transitions out of the network in the event the enrollee loses membership eligibility or elects to enroll in a different managed behavioral healthcare plan. This may involve the sharing of documentation, necessary verbal information exchanges and follow-up by the incumbent care provider.
- Covered Lives – Individuals residing in the Service Area who are eligible for NorthSTAR, as defined in §6.1 of the Contract.
- Covered Services – All behavioral health services authorized or required to be provided under the Contract.
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, revised (DSM-IV-TR) – The American Psychiatric Association’s official classification of mental disorders.
- Direct Service Claims Target (DSCT) – The percentage of total premium dollars paid to a Contractor that they propose to spend on direct service costs.
- Direct Service Cost– The cost of covered services that are provided to NorthSTAR enrollees directly by the Contractor, a subcontractor, or non-contracted provider and paid for by the Contractor. (Note: this would include covered emergency services provided by a non-contracted provider if the Contractor paid for the service.) Specifically, Direct Services Costs will be calculated using the methodology described in 4.16 of this contract.
- COPSD – A co-occurring mental illness and chemical dependency disorder.
- Emergency behavioral health condition – Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent lay person possessing an average knowledge of medicine and health, requires immediate intervention and/or medical attention without which an individual would present a danger to themselves or others or which renders individuals incapable of controlling, knowing or understanding the consequences of their actions.
- Emergency behavioral health services – Inpatient or outpatient behavioral health services needed to evaluate or stabilize an emergency behavioral health condition.
- Encounter – An electronic or paper form used to record and report a service delivered by a provider to an enrollee. Normally an encounter will include all the information recorded in a

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standard claim, with the exception of financial information.

- Enrollee – A covered life who is enrolled in NorthSTAR.
- Enrollment Broker – An entity contracting with the State to carry out specific functions related to Medicaid enrollee services under NorthSTAR. The enrollment broker assists Medicaid eligible individuals enroll in Medicaid managed care and select managed care plans. The enrollment broker’s responsibilities include: Receiving a list of Medicaid clients from NorthSTAR who are mandated or otherwise eligible to enroll in a managed care plan;
 - a. Providing education and enrollment activities to assist clients select a managed care plan.
 - b. Providing enrollment materials through the mail
 - c. Operating the information interfaces required to record enrollment decisions in NorthSTAR and in SAVERR, the State’s Medicaid eligibility system, and to inform managed care plans of their enrolled beneficiaries.
 - d. Providing services with respect to ongoing enrollment, disenrollment and re-enrollment activity of clients.
 - e. Maintaining client help line that responds to client inquiries regarding the administration of managed care programs.
- Episode of Chemical Dependency Care or Episode of Care– A planned, structured, and organized program to promote a chemical-free status that may include different facilities or modalities lasting up to a year. An episode of care is complete when the individual is discharged on medical advice from a level of care or a series of levels without a lapse in treatment. An episode of care is determined by the treating professional who is a psychiatrist, a physician with experience in addiction medicine, or the primary counselor (e.g., qualified credentialed counselor). In the medical and social-medical a program, an episode of care is physician-determined, whereas, counselors may determine the episode of care in social model programs.
- Grievance – an expression of dissatisfaction about any matter other than an action or adverse action. The term is also used to refer to the overall system that includes grievances and appeals handled at the Contractor level and access to the State’s fair hearing process.
- ICHP- The Institute for Child Health Policy (ICHP), contracted in August 2002, provides external reviews to assess Medicaid clients' access to care and the quality of care provided by the

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Primary Care Case Management (PCCM) network, Medicaid HMOs and CHIP health plans. The quality monitor also collects encounter data and health care claims paid by the HMOs

- Licensed Clinical Social Worker - Advanced Clinical Practitioner (LCSW) – An individual licensed by the State Board of Social Work Examiners as a Licensed Clinical Social Worker - Advanced Clinical Practitioner.
- Licensed Professional Counselor (LPC) – An individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors.
- Local Behavioral Health Authority (LBHA) – The term for the entity designated by the State to be responsible for planning, policy development, coordination and oversight of covered services.
- Marketing Materials – materials that are produced in any medium, by or on behalf of Contractor, which can reasonably be interpreted to market to potential enrollees.
- Medicaid Eligible – A person who is determined to be eligible for Medicaid services by DHS.
- Medically Necessary Service – A behavioral health service that:
 - a. Is reasonably necessary for the diagnosis or treatment of a mental health or chemical dependency disorder to improve or maintain an individual’s level of functioning resulting from such a disorder;
 - b. Is in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
 - c. Is furnished in the most appropriate and least restrictive setting in which services can be safely provided;
 - d. Is the most appropriate level or supply of service which can safely be provided; and
 - e. Could not be omitted without adversely affecting the individual’s mental and/or physical health or the quality of care rendered.
- NorthSTAR Program – Behavioral Health State of Texas Access Reform Program covering publicly funded mental health and chemical dependency treatment services for Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall Counties managed jointly by the TDSHS.
- Pharmaceutical Assistance Program (PAP) – Acquisition of free medications from pharmaceutical companies for indigent clients.

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- Physician – An individual who is licensed by the Texas State Board of Medical Examiners.
- Post-stabilization care services – covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the enrollee’s condition.
- Potential enrollee - a Medicaid recipient who is subject to mandatory enrollment in the NorthSTAR program but is not yet an enrollee of the Contractor.
- Primary Care Physician or Primary Care Provider – A physician or provider who has agreed with TDH or a STAR HMO to provide a medical home to Medicaid Enrollees and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.
- Provider – A person or entity that directly delivers covered services to a covered life or to an enrollee.
- Psychiatrist – An individual who is licensed by Texas State Board of Medical Examiners to practice medicine in Texas and who specializes in diagnosis, treatment, and prevention of mental illnesses and chemical dependency.
- Psychologist – An individual licensed as a psychologist by the Texas State Board of Examiners of Psychologists.
- Qualified Credentialed Counselor- An Individual responsible for planning, directing, or supervising treatment programs. The clinical program director (QCC) must have at least two years of post-licensure experience providing chemical dependency treatment.
- Readiness Review – A pre-implementation review process conducted by the State or its agent to assess the Contractor’s capacity and capability to perform the duties and responsibilities required under the Contract.
- Resiliency & Disease Management - DSHS initiative utilizing quantifiable measures to guide assessment and level of care recommendations for community mental health services.
- Risk – The possibility the Contractor may incur a loss because the cost of providing services may exceed the payments made by the State to the Contractor.
- Savings – The positive difference, if any, between (a) the contractor’s DSCT times total

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premiums paid to the contract and (b) the contractor's actual total Direct Services cost.

- Service Area - Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties.
- State Hospital – Any one of eight hospitals owned and operated by DSHS providing both short-term and long-term residential inpatient services to persons in the mental health priority populations. These hospitals are listed in Sec. 532.001, Texas Health and Safety Code.
- STAR Program – The State of Texas Access Reform Program, the name of the State of Texas Medicaid managed care program. In the service area, STAR provides primarily physical health services.
- Subcontractor – Any entity having an agreement with the Contractor, and/or another party, to fulfill the requirements that are allowed in the contract awarded by the State.
- Texas Health Steps (THSteps) – The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It includes the state's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 United States Code §1396, and defined and codified at 42 Code of Federal Regulations §440.40 and §441.56-62.
- Texas Recommended Assessment Guidelines - Systematic assessment process for measuring mental health service needs and recommending levels of care among adult and child/adolescent consumers based on their most recent principal diagnosis and nine assessment domains.
- TMHP- Texas Medicaid & Healthcare Partnership provides administration of Medicaid claims processing and the Medicaid primary care case management services program.
- Uniform Assessment - Standardized assessment instruments used by the DSHS for determining RDM eligibility.
- UTMB-340B Drug Pricing Program- The U.S. Public Health Service 340B discounted drug program offers significant cost savings on outpatient drugs to covered entities, which include community health centers, migrant health centers, public housing facilities, homeless centers, federally qualified health center look-alikes, Title X family planning facilities, HIV grantees, sexually transmitted diseases (STD) and tuberculosis (TB) programs, and publicly-supported disproportionate share hospitals. This program provides substantial savings on covered outpatient drugs purchased by specified federally funded entities serving the most vulnerable patient populations. For an additional description see Appendix 20.

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- Urgent care: Behavioral health services provided to a covered life or to an enrollee to prevent serious deterioration of the individual's mental or physical health.
- Utilization review (UR) – A system for concurrent and/or retrospective review of the appropriateness of behavioral health care services being provided.
- Youth – A person under the age of 21, also referred to as a "child" or collectively as "children" in the Contract.