TO BE RESCINDED

5160-26-01 **Managed health care programs: definitions.**

As used in Chapter 5160-26 of the Administrative Code:

(A) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes consumer practices that result in unnecessary cost to the medicaid program.

(B) "Advance directive" means written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.

(C) "Assistance group" means a group of consumers receiving benefits together under a specific category of assistance.

(D) "Authorized representative" has the same meaning as in rule 5160:1-1-55.1 of the Administrative Code.

(E) "Care plan" means a written document developed by the managed care plan for a member receiving care management services. The care plan is based on the assessment and includes measureable goals, interventions and outcomes with completion timeframes that address the member's clinical and non-clinical needs.

(F) "Care management" means activities performed on behalf of members that include services described in rule 5160-26-03.1 of the Administrative Code.

(G) "CCR" means the consumer contact record. The CCR contains demographic health-related information provided by an eligible individual, managed care member, or ODM that is utilized by the medicaid consumer hotline to process membership transactions.

(H) "CDJFS" means a county department of job and family services.

(I) "C.F.R." means the Code of Federal Regulations, as amended, unless otherwise specified.

(J) "CLIA" means the clinical laboratory improvement amendments regulated by CMS under 42 C.F.R. part 493 (October 1, 2013), laboratory requirements.

(K) "CMS" means the centers for medicare and medicaid services.

(L) "COB (coordination of benefits)" means a procedure establishing the order in which health care entities pay their claims.

(M) "COB claim" means any claim that meets the definition of a third party claim as established in this rule.

(N) "Covered services" means those medical services set forth in rule 5160-26-03 of the Administrative Code or a subset of those medical services.

(O) "CSP" means coordinated services program as defined in rule 5160-20-01 of the Administrative Code.

(P) "DBA" means doing business as, in accordance with ODI's designation.

(Q) "DEA" means drug enforcement administration.

(R) "Eligible individual" means any medicaid consumer who is a legal resident of the managed care service area and is in one of the categories specified in the MCP's provider agreement with ODM.

(S) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

(T) "Emergency services" means covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. As used in this chapter, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCP.

(U) "EOB (explanation of benefits)," otherwise known as "EOP (explanation of payment)," or "RA (remittance advice)," means the information sent to providers and/or members by any other third party payer, or managed care plan (MCP), to explain the adjudication of a claim.

(V) "FQHC" means a federally qualified health center as defined in rule 5160-28-01 of the Administrative Code.

(W) "Fraud" means any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes fraud under applicable federal or state law. Member fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's identification card to obtain services or supplies.

(X) "Healthchek," services otherwise known as early and periodic screening, diagnosis, and treatment (EPSDT) services, are comprehensive preventive health services available to medicaid consumers from birth through twenty years of age.

(Y) "HIC" means a "health insuring corporation" as defined in section 1751.01 of the Revised Code.

(Z) "Hospital" means an institution located at a single site that is engaged primarily in providing to inpatients, by or under the supervision of an organized medical staff of physicians licensed under Chapter 4731. of the Revised Code, diagnostic services and therapeutic services for medical diagnosis and treatment or rehabilitation of injured, disabled, or sick persons. "Hospital" does not mean an institution that is operated by the United States government or the Ohio department of mental health and addiction services.

(AA) "Hospital services" means those inpatient and outpatient services that are generally and customarily provided by hospitals.

(BB) "Inpatient facility" means an acute or general hospital.

(CC) "Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" has the same meaning as in rule 5123:2-7-01 of the Administrative Code.

(DD) "LEP" means limited-English proficiency.

(EE) "LRP" means limited-reading proficiency.

(FF) "Medicaid consumer hotline" means an organization or individual under contract with or designated by ODM to provide medicaid managed care information and enrollment services to eligible individuals.

(GG) "MCP (managed care plan)," otherwise known as "plan," means a HIC licensed in the state of Ohio that enters into a provider agreement with ODM in the managed health care program. For the purpose of this chapter, MCP does not include entities approved to operate as a PACE site, as defined in paragraph (VV) of this rule.

(HH) "Medicaid" means medical assistance as defined in section 5162.01 of the Revised Code.

(II) "Medically necessary," otherwise known as "medical necessity," as used in this chapter is the same as defined in rule 5160-1-01 of the Administrative Code.

(JJ) "Medicare" means the federally financed medical assistance program defined in 42 U.S.C. 1395 (as in effect December 1, 2014).

(KK) "Member," otherwise known as "enrollee," means a medicaid consumer who has selected MCP membership or has been assigned to an MCP for the purpose of receiving health care services.

(LL) "MFCU (medicaid fraud control unit)" means an identifiable entity of state or federal government charged with the investigation and prosecution of fraud and related offenses within medicaid.

(MM) "MHAS" means the Ohio department of mental health and addiction services.

(NN) "NF (nursing facility)" has the same meaning as in section 5165.01 of the Revised Code.

(OO) "ODA" means the Ohio department of aging.

(PP) "ODI" means the Ohio department of insurance.

(QQ) "ODM" means the Ohio department of medicaid or its designee.

(RR) "ODM approval" means written approval by ODM and does not constitute approval by any other state or federal agency.

(SS) "ODODD" means the Ohio department of developmental disabilities.

(TT) "Oral interpretation services" means services provided to a limited-reading proficient eligible individual or member to ensure that he or she receives MCP

information in a format and manner that is easily understood by the eligible individual or member

(UU) "Oral translation services" means services provided to a limited-English proficient eligible individual or member to ensure that he or she receives MCP information translated into the primary language of the eligible individual or member.

(VV) "PACE" has the same meaning as in rule 5160-36-01 of the Administrative Code.

(WW) "PCP (primary care provider)" means an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Administrative Code contracting with an MCP to provide services as specified in rule 5160-26-03.1 of the Administrative Code. Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).

(XX) "Pending member," otherwise known as "pending enrollee," means an eligible individual who has selected or been assigned to an MCP but whose MCP membership is not yet effective.

(YY) "PHI (protected health information)" means information received from or on behalf of ODM that meets the definition of PHI as defined by 45 C.F.R. 160.103 (October 1, 2013).

(ZZ) "Post-stabilization care services" means covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (October 1, 2013) to improve or resolve the member's condition.

(AAA) "Premium" means the monthly payment amount per member to which the MCP is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM.

(BBB) "Provider" means a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care services rendered to an MCP's member.

(CCC) "Provider agreement" means a formal agreement between ODM and an MCP for

the provision of medically necessary services to medicaid consumers who are enrolled in the MCP.

(DDD) "Provider panel," otherwise known as "panel," means the MCP's contracted providers available to the MCP's general membership.

(EEE) "QFPP (qualified family planning provider)" means any public or nonprofit health care provider that complies with guidelines/standards set forth in 42 U.S.C. 300 (as in effect December 1, 2014), and receives either Title X funding or family planning funding from the Ohio department of health.

(FFF) "Risk" or "underwriting risk" means the possibility that an MCP may incur a loss because the cost of providing services may exceed the payments made by ODM to the contractor for services covered under the provider agreement.

(GGG) "RHC" means a rural health clinic as defined in rule 5160-16-01 of the Administrative Code.

(HHH) "Self-referral" means the process by which an MCP member may access certain services without prior approval from the PCP or the MCP.

(III) "Service area" means the geographic area specified in the MCP's provider agreement.

(JJJ) "SFY (state fiscal year)" means the period July first through June thirtieth, corresponding to the state of Ohio's fiscal year.

(KKK) "State cut-off" means the eighth state working day prior to the end of a calendar month.

(LLL) "Subcontract" means a written contract between an MCP and a third party, including the MCP's parent company or any subsidiary corporation owned by the MCP's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the MCP's provider agreement with ODM.

(MMM) "Subcontractor" means any party that has entered into a subcontract to perform a specific part of the obligations specified under the MCP's provider agreement with ODM.

(NNN) "Third party benefit" means any health care service(s) available to members

through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the TPP or in part the obligation of the member, the TPP, and/or the MCP.

(OOO) "Third party claim" means any claim submitted to the MCP for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by the MCP:

(1) Any claim received by the MCP that shows no prior payment by a TPP, but the MCP's records indicate that the member has third party benefits.

(2) Any claim received by the MCP that shows no prior payment by a TPP, but the provider's records indicate that the member has third party benefits.

(PPP) "TP (third party)" is as defined in section 5160.35 of the Revised Code.

(QQQ) "TPA (third party administrator)" means any entity utilized in accordance with the provisions of this chapter to manage or administer a portion of services in fulfillment of the provider agreement with ODM.

(RRR) "TPL (third party liability)" means the payment obligations of the TPP for health care services rendered to a member when the member also has third party benefits as described in paragraph (NNN) of this rule.

(SSS) "TPP (third party payer)" means an individual, an entity, or a program responsible for adjudicating and paying claims for third party benefits rendered to an eligible member.

(TTT) "Title V," otherwise known as the "program for medically handicapped children," means the program established under sections 3701.021 to 3701.0210 of the Revised Code.

(UUU) "Title X services" means services and supplies allowed under 42 U.S.C. 300 (as in effect December 1, 2014), and provided by a qualified family planning provider.

(VVV) "Tort action," otherwise known as "subrogation," means the right of ODM to recover payment received from a third party payer who may be liable for the cost of medical services and care arising out of an injury, disease, or disability to the member.

(WWW) "United States" means the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

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