5101:3-26-01 **Managed health care programs: Definitions.**

As used in Chapter 5101:3-26 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.

~~(A)~~(B) "Advance directive" means written ~~instruction~~ 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.

~~(B)~~(C) "Assignment" means ~~MCP enrollment of~~ the process by which the SSE, ODJFS, or other ODJFS-approved entity selects an MCP for eligible individuals in mandatory counties who fail to choose an MCP, or the MCP enrollment of eligible individuals in preferred option counties who fail to declare a choice between medicaid fee-for-service or MCP enrollment.

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

~~(D) "Auto-disenrollment" means the enrollee's MCP disenrollment as described in paragraph (S) of this rule.~~

~~(E) "Auto-reenrollment" means the enrollee's MCP enrollment as described in paragraph (B)(3)(i) of rule 5101:3-26-02 of the Administrative Code.~~

(E) "Automatic renewal" means the process by which an eligible individual automatically terminated from MCP membership has membership in the same MCP renewed without the individual having to contact the SSE or ODJFS.

(F) "Automatic termination" means the process by which a member's MCP membership is terminated not at the request of the member or the MCP, but for reasons described in paragraph (B)(2) of rule 5101:3-26-02.1 of the Administrative Code.

(G) "CAP" means corrective action plan.

~~(F)~~(H) "~~Capitation~~Premium rate" means the monthly payment amount per ~~enrollee~~ member for which the managed care plan (MCP) is entitled as compensation for performing its obligations in accordance with Chapter 5101:3-26 of the Administrative Code and/or the provider agreement between ODJFS and the MCP.

~~(G)~~(I) "Case" means one or more assistance groups living in the same household.

~~(H)~~(J) "Case management" means activities performed on behalf of ~~enrollees~~ members ~~to coordinate services among health care providers and across organizations and time~~ which include services described in paragraph (A)(8) of rule 5101:3-26-03.1 of the Administrative Code.

~~(I)~~(K) "CCR" means the consumer contact record. The CCR contains ~~consumer-specific information that is utilized by ODJFS and/or its designee to enroll consumers in managed care plans~~ demographic health-related information provided by an eligible individual, MCP member, or ODJFS that is utilized by the SSE to process MCP membership transactions.

~~(J)~~(L) "CDJFS" means a county department of job and family services.

~~(K)~~(M) "CFR" means the Code of Federal Regulations, as amended, unless otherwise specified.

(N) "CLIA" means the clinical laboratory improvement amendments regulated by the centers or medicare and medicaid services under 42 CFR part 493,laboratory requirements.

~~(L)~~(O) "CMS" means the centers for medicare and medicaid services.~~, formerly known as HCFA.~~

~~(M) "Contiguous service area," for the purpose of rule 5101:3-26-02 of the Administrative Code, means all adjoining counties covered by the medicaid-serving MCP's certificate of authority, which includes medicare and/or medicaid enrollment.~~

~~(N)~~(P) "Coordination of benefits (COB)" means a procedure establishing the order in which health care entities pay their claims. For the purpose of this rule, the ~~medicaid-serving~~ MCP is the payer of last resort.

~~(O) "Covered families and children medicaid" means a federal and state financed grant-in-aid program administered by the state providing medical coverage to low-income families, children and pregnant women who meet the eligibility criteria as specified in Chapters 5101:1-39 and 5101:1-40 of the Administrative Code.~~

~~(P)~~(Q) "Covered services" means those medical services set forth in rule 5101:3-26-03 of the Administrative Code or a subset of those medical services.

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

~~(R)~~(S) "DEA" means drug enforcement administration.

~~(S) "Disenrollment" means the process by which an eligible individual's MCP enrollment is terminated. Disenrollments may be automatic, enrollee-initiated, or MCP-initiated as described in rule 5101:3-26-02.1 of the Administrative Code.~~

(T) "Eligible individual" means any medicaid ~~recipient~~ consumer who is a legal resident of the MCP's ~~county of operation~~ service area~~. Categories of medicaid which are eligible for enrollment in MCPs are~~ and is in a medicaid assistance category specified in the MCP's provider agreement with ODJFS.

(U) "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.

(V) "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 defined in paragraph ~~(R)~~ (U) of this rule.

~~(W) "Enrollee," otherwise known as a member, means each eligible individual enrolled in an MCP.~~

~~(X) "Enrollment" means the process by which an eligible individual becomes a member of an MCP.~~

~~(Y)~~(W) "EQRO" means external quality review organization.

~~(Z) "ESE (Enrollment Services Entity)" means an organization or individual under contract with or designated by ODJFS to provide MCP enrollment information and assistance services to eligible individuals.~~

~~(AA)~~(X) "Family planning services" means those services and supplies provided in accordance with rule 5101:3-4-07 of the Administrative Code.

~~(BB)~~(Y) "FQHC (federally qualified health center)" means a health services entity determined by the U.S. secretary of health and human services to be an FQHC or having received a grant under section 329, 330, or 340 of the Public Health Service Act of 1999 as an FQHC and having contracted with ODJFS to provide

medicaid-covered services.

~~(CC) "Forgery" means a specific kind of fraud which involves an unauthorized imitation of a signature or document.~~

~~(DD)~~(Z) "Fraud" means any intentional deception or misrepresentation made ~~committed~~ by an ~~enrollee~~ individual or entity with the ~~intent of obtaining a medical service to which a person is not entitled or any false or misleading representation or statement by a provider concerning medical services rendered for use in obtaining reimbursement from the medical assistance program~~ knowledge that the deception could result in some unauthorized benefit to himself, 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 MCP identification card to obtain services or supplies.

~~(EE) "Grievance" means any complaint which an MCP enrollee or their authorized representative presents to an MCP regarding what the enrollee perceives to be an inappropriate action or lack of appropriate action by an MCP or any of its providers. For the purposes of Chapter 5101:3-26 of the Administrative Code, "appropriate action" is defined as the MCP's compliance with applicable program requirements and with any MCP operational procedure that has been conveyed in writing to the MCP's enrollees or ODJFS.~~

~~(FF) "HCFA" means the health care financing administration, now known as CMS.~~

~~(GG)~~(AA) "Healthchek," otherwise known as the early and periodic screening, diagnosis, and treatment (EPSDT) program, is a program of comprehensive preventive health services available to medicaid ~~recipients~~ consumers from birth through twenty years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems.

~~(HH) "Healthy start" is Ohio's name for the covered families and children medicaid eligibility program which provides medicaid services for pregnant women, infants, and children up to specified ages and income limits.~~

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

~~(JJ)~~(CC) "Hospital" means an institution located at a single site which 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 which is operated by the United States government or the Ohio department of mental health.

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

~~(LL) "Individual care plan (ICP)" means a plan of care which includes the enrollee's history, a clinical summary of current problems, short and long term treatment goals, and a treatment plan that includes a list of services required, their frequency, and a description of who will provide the services.~~

~~(MM)~~(EE) "Inpatient facility" means an acute or general hospital, rehabilitation facility, or nursing or ICF-MR facility.

~~(NN)~~(FF) "Intermediate care facility for the mentally retarded (ICF-MR)" means a long-term care facility, or part of a facility, for the mentally retarded/developmentally disabled, currently certified by the Ohio department of health as being in compliance with the ICF-MR standards and medicaid conditions of participation.

~~(OO) "JAC (joint advisory council)" means the group convened in counties and comprised of local entities to discuss issues related to the ODJFS managed care program.~~

~~(PP)~~(GG) "LEP" means ~~limited English proficiency~~ limited-English proficiency.

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

~~(QQ)~~(II) "MCP (managed care plan)" also referred to as plan, means ~~HICs~~ a HIC licensed in the state of Ohio ~~as well as~~ or an alternative qualified ~~arrangements~~ entity which enters into a provider agreement with ODJFS pursuant to rule 5101:3-26-04 of the Administrative Code. For the purpose of this chapter, MCP does not include entities approved to operate as a PACE site, as defined in paragraph ~~(EEE)~~ (AAA) of this rule.

(JJ) "MCP member" or "member" means a medicaid consumer who has selected MCP membership or has been assigned to an MCP for the purpose of receiving health care services.

~~(RR) "MCP non-contracting provider" means any provider with a medicaid provider agreement who does not contract with an MCP but delivers health care services to that MCP's enrollee(s).~~

~~(SS)~~(KK) "Medicaid" means medical assistance provided under a state plan approved

under Title XIX of the Social Security Act.

~~(TT)~~(LL) "~~Medical necessity" as used in this chapter is the same as defined in paragraph (A) of rule 5101:3-1-01 of the Administrative Code~~ "Medically necessary" otherwise known as medical necessity, as used in this chapter is the same as defined in paragraph (A) of rule 5101:3-1-01 of the Administrative Code.

~~(UU)~~(MM) "Medicare" is the federally financed medical assistance program determined under Title XVIII of the Social Security Act.

~~(VV)~~(NN) "MFCU (medicaid fraud control unit)" means ~~the~~ a state or federal governmental agency charged with the investigation and prosecution of fraud and related offenses within medicaid.

~~(WW)~~(OO) "MR/DD" means mental retardation or developmental disabilities.

~~(XX)~~(PP) "Nursing facility (NF)" means any long-term care facility (excluding intermediate care facilities for the mentally retarded/developmentally disabled), or part of a facility, currently certified by the Ohio department of health as being in compliance with the nursing facility standards and medicaid conditions of participation.

~~(YY)~~(QQ) "ODA" means the Ohio department of aging.

~~(ZZ)~~(RR) "ODADAS" means the Ohio department of alcohol and drug addiction services.

~~(AAA)~~(SS) "ODI" means the Ohio department of insurance.

~~(BBB)~~(TT) "ODJFS" means the Ohio department of job and family services.

~~(CCC)~~(UU) "ODJFS approval" means written approval by ODJFS and does not constitute approval by any other state or federal agency.

~~(DDD)~~(VV) "ODJFS-approved entity" means any entity other than the CDJFS which is under contract with or designated by ODJFS to perform the functions set forth in rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code.

~~(EEE)~~(WW) "ODMH" means the Ohio department of mental health.

~~(FFF)~~(XX) "ODMR/DD" means the Ohio department of mental retardation and

developmental disabilities.

(YY) "Oral interpretation services" means services provided to LRP consumers to ensure that they receive MCP information in a format and manner that is easily understood by those consumers.

(ZZ) "Oral translation services" means services provided to LEP consumers to ensure that they receive MCP information translated into the primary language of the consumer.

~~(GGG) "OWF" means the Ohio works first program as established under Chapter 5107. of the Revised Code.~~

~~(HHH)~~(AAA) "PACE" means the program of all inclusive care for the elderly. The PACE program integrates the provision of acute and long-term care across settings for frail older adults who have been determined to require at least an intermediate level of care as defined in rule 5101:3-3-06 of the Administrative Code.

~~(III) "Participating provider," otherwise known as provider, means a physician or other health care practitioner or health care facility under employment or contractual arrangement with an MCP for the purpose of providing covered services to enrollees. This definition does not include a provider engaged by a participating provider group on a consulting basis.~~

~~(JJJ) "Participating provider group" means the physicians or other health care practitioners who are members of, employed by or associated with a professional medical group, health center or clinic that has contracted with the MCP for the delivery of covered services to enrollees.~~

~~(KKK)~~(BBB) "PCP (primary care physician)" is an individual physician (M.D. or D.O.) or medical group practice contracting with the MCP to provide primary care and case management services to ~~enrollees~~ their members.

(CCC) "Provider" means a physician or other health care professional or health care facility under employment or contractual arrangement with an MCP for the purpose of providing covered services to their members.

(DDD) "Provider panel" also referred to as panel, means an MCP's providers as specified in paragraph (A)(3) of rule 5101:3-26-05 of the Administrative Code.

~~(LLL)~~(EEE) "Post-stabilization care services" means covered services related to an emergency medical condition that a treating physician 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 CFR 422.113 to improve or resolve the member's condition.

(FFF) "Protected health information (PHI)" is information received from or on behalf of ODJFS that meets the definition of PHI as defined by the Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated by the United States department of health and human services, specifically 45 CFR 164.501, and any amendments thereto.

~~(MMM)~~(GGG) "Provider agreement" means a formal agreement between ODJFS and an MCP for the provision of ~~comprehensive~~ medical services to medicaid consumers covered under the provider agreement ~~to medicaid beneficiaries for which the MCP assumes the risk as defined in paragraph (QQQ) of this rule.~~

(HHH) "QAPI" means a quality assessment and performance improvement program as described in rule 5101:3-26-07.1 of the Administrative Code.

~~(NNN)~~(III) "Qualified family planning provider (QFPP)" means any public or nonprofit health care provider that complies with federal Title X guidelines/standards, and receives either Title X funding or family planning funding from the Ohio department of health.

~~(OOO) "Quality program (QP)" means an ongoing program designed to objectively and systematically monitor and evaluate the quality and appropriateness of enrollees' care, pursue opportunities to improve enrollees' care, and resolve identified problems.~~

~~(PPP)~~(JJJ) "Quality indicators" means measurable variables relating to a specified clinical or health services delivery area which are reviewed over a period of time to monitor the process or outcome of care delivered in that area.

~~(QQQ)~~(KKK) "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 ODJFS to the contractor for services covered under the provider agreement.

~~(RRR) "Risk corridor" means a percentage of financial gain or loss, calculated on the medical services portion of the capitation payment only, for which the MCP and ODJFS agree to share liability.~~

~~(SSS)~~(LLL) "Rural health clinic" (RHC) means a clinic as defined in rule 5101:3-16-01 of the Administrative Code which is certified by the ODH as meeting the conditions of certification for rural health clinics under Title XVIII medicare and which has filed an agreement with the United States department of health and human services to provide rural health clinic services under medicare.

(MMM) "Selection services entity (SSE)" means an organization or individual under

contract with or designated by ODJFS to provide MCP information and selection services to eligible individuals.

~~(TTT)~~(NNN) "Self referral" is the process by which an MCP ~~enrollee~~ member may access certain services without the PCP's and/or MCP's prior approval.

(OOO) "Service area" is one or more counties specified in the MCP's provider agreement.

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

~~(VVV)~~(QQQ) "State cut-off" means the eighth state working day from the end of a calendar month.

~~(WWW) "Stop-loss" means the establishment of a dollar figure for expenditures related to an inpatient hospital stay per enrollee per state fiscal year at which the provisions of rule 5101:3-26-09 of the Administrative Code will become operative.~~

~~(XXX)~~(RRR) "Subcontract" means a written contract between an MCP and a third party or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the MCP's obligations under the provider agreement the MCP has with ODJFS.

(SSS) "Termination," formerly known as disenrollment, means the process by which an individual's MCP membership is terminated. Terminations may be automatic, member-initiated, or MCP-initiated as described in rule 5101:3-26-02.1 of the Administrative Code.

~~(YYY)~~(TTT) "Third party administrator (TPA)" means any entity utilized in accordance with the provisions of paragraph (A)~~(2)~~(3) of rule 5101:3-26-05 of the Administrative Code to manage or administer a portion of services in fulfillment of the MCP's provider agreement with ODJFS.

~~(ZZZ)~~(UUU) "Third party payor" means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical services furnished under a state plan.

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

~~(BBBB) "Urgent care services," otherwise known as "urgent nonemergency services," are services provided for conditions due to illness or injury which are not~~

~~life-threatening but require prompt attention and/or treatment to prevent complication to or deterioration of the enrollee's condition.~~

~~(CCCC) "Utilization management (UM)" means the evaluation and determination of the appropriateness of patient use of medical care resources, and provision of any needed assistance to clinician and/or enrollee, to ensure appropriate use of resources (may include prior authorization, concurrent review, discharge planning, and case management).~~

Effective: 07/01/2003

R.C. 119.032 review dates: 04/15/2003 and 07/01/2008

CERTIFIED ELECTRONICALLY

Certification

06/20/2003

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02, 5111.17
Rule Amplifies: 5111.01, 5111.02, 5111.17
Prior Effective Dates: 4/1/85, 2/1/89 (Emer.), 2/15/89 (Emer.), 4/23/89, 5/15/89 (Emer.), 5/1/92, 7/31/92 (Emer.), 10/25/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer.), 9/27/97, 5/14/99, 7/1/00, 7/1/01, 7/1/02