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 recipient 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) "Adverse benefit determination" is a managed care entity's (MCE's):

(1) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(2) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCE;

(3) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code;

(4) Failure to act within the resolution time frames specified in rule 5160-26-08.4 of the Administrative Code;

(5) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities, if applicable; or

(6) Denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" as defined in 42 C.F.R. 447.45(b) (October 1, 2021) is not an adverse benefit determination.

(D) "Appeal" is the member's request for an MCE to review an adverse benefit determination.

~~(C)~~(E) "Authorized representative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(F) "Care management system" means the system established by the Ohio department of medicaid (ODM) in accordance with section 5167.03 of the Revised Code.

~~(D)~~(G) "Consumer contact record (CCR)" means the record containing demographic health-related information provided by an eligible individual, managed care member, or ~~the Ohio department of medicaid (ODM)~~ODM that is used by the Ohio medicaid consumer hotline to process membership transactions.

~~(E)~~(H) "Coordination of benefits (COB)" means a procedure establishing the order in which health care entities pay their claims as described in rule 5160-26-09.1 of the Administrative Code.

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

~~(G)~~(J) "Eligible individual" means any medicaid recipient who is a legal resident of the managed care service area and is in one of the categories specified in rule 5160-26-02 of the Administrative Code.~~the MCO's provider agreement with ODM.~~

~~(H)~~(K) "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.

~~(I)~~(L) "Emergency services" means covered inpatient services, outpatient services, or medical transportation services 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 MCO~~an MCE.

~~(J)~~(M) "Explanation of benefits (EOB)," otherwise known as "explanation of payment (EOP)," or "remittance advice (RA)," means the information sent to providers and/or members by any other third party payer, or ~~MCO~~MCE, to explain the adjudication of a claim.

~~(K)~~(N) "Federally qualified health center (FQHC)" has the same meaning as in rule 5160-28-01 of the Administrative Code.

~~(L)~~(O) "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.

(P) "Grievance" is the member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by an MCE to make an authorization decision.

~~(M)~~(Q) "Healthchek" services, otherwise known as early and periodic screening, diagnostic, and treatment (EPSDT) services, are comprehensive preventive health services available to individuals under twenty-one years of age who are enrolled in medicaid as those services are described in rule 5160-1-14 of the Administrative Code.

~~(N)~~(R) "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.

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

~~(P)~~(T) "Inpatient facility" means an acute or general hospital.

~~(Q)~~(U) "Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" has the same meaning as in section 5124.01 of the Revised Code.

~~(R)~~(V) "Managed care" means a health care delivery system operated by the state in accordance with 42 C.F.R. part 438 (October 1, ~~2019~~2021).

(W) "Managed care entity (MCE)" means a managed care organization, the single pharmacy benefit manager, a MyCare Ohio plan as defined in rule 5160-58-01 of the Administrative Code, and the OhioRISE plan as defined in rule 5160-59-01 of the Administrative Code.

~~(S)~~(X) "Managed care organization (MCO)" ~~or "managed care plan (MCP)"~~ has the same definition as in 42 C.F.R 438.2 (October 1, 2021) ~~means~~ and is a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM.

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

~~(U)~~(Z) "Medicaid fraud control unit (MCFU)" means an identifiable entity of state or federal government charged with the investigation and prosecution of fraud and related offenses within medicaid.

~~(V)~~(AA) "Medically necessary," or "medical necessity," has the same meaning as in rule 5160-1-01 of the Administrative Code.

~~(W)~~(BB) "Medicare" means the federally financed medical assistance program defined in 42 U.S.C. 1395 (as in effect ~~July 1, 2020~~July 1, 2022).

~~(X)~~(CC) "Member" ~~or "enrollee"~~ means a medicaid recipient who has selected or been assigned to ~~MCO membership or has been assigned to an MCO~~ an MCE for the purpose of receiving health care services.

(DD) "Network provider" means any provider, group of providers, or entity that has a network provider contract with the MCE in accordance with rule 5160-26-05 of the Administrative Code and receives medicaid funding directly or indirectly to order, refer, or render covered services as a result of the MCE's provider agreement or contract with ODM.

(EE) "Non-contracting provider" means any provider with an ODM provider agreement who does not contract with an MCE, but delivers health care services to an MCE's members.

(FF) "Non-contracting provider of emergency services" means any person, institution or entity that does not contract with an MCE, but provides emergency services to an MCE's members, regardless of whether that provider has an ODM provider agreement.

(GG) "Notice of action (NOA)" is the written notice an MCE provides to members when an adverse benefit determination has occurred or will occur.

~~(Y)~~(HH) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(Z)~~(II) "Ohio medicaid consumer hotline" means the managed care enrollment broker and customer service agent for individuals receiving Ohio medicaid services.

~~(AA)~~(JJ) "Oral interpretation services" means services provided to a limited-reading proficient eligible individual or member to ensure that he or she receives ~~MCO~~ MCE information in a format and manner that is easily understood by the eligible individual or member.

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

~~(CC)~~(LL) "Pending member"~~," or "pending enrollee,"~~ means an eligible individual who has selected or been assigned to ~~an MCO~~an MCE but whose ~~MCO~~ membership in the MCE is not yet effective.

~~(DD)~~(MM) "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, ~~2019~~2021) to improve or resolve the member's condition.

~~(EE)~~(NN) "Premium" means the monthly payment amount per member to which the MCO 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.

~~(FF)~~(OO) "Primary care provider (PCP)" 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 MCO 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).

~~(GG)~~(PP) "Protected health information (PHI)" 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, ~~2019~~2021).

~~(HH)~~(QQ) "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-related services rendered to ~~an MCO's~~an MCE's member.

~~(II)~~(RR) "Provider agreement" means a formal agreement between ODM and an MCO for the provision of medically necessary services to medicaid recipients who are enrolled in the MCO.

~~(JJ)~~(SS) "Provider ~~panel~~network"~~," otherwise known as "panel"~~ or "network," means ~~the MCO's~~ an MCE's contracted providers available to the ~~MCO's~~MCE's ~~general membership~~members.

~~(KK)~~(TT) "Qualified family planning provider (QFPP)" means any public or nonprofit health care provider that complies with guidelines/standards set forth in 42 U.S.C. 300 (as in effect ~~July 1, 2020~~July 1, 2022), and receives either Title X funding or family planning funding from the Ohio department of health.

(UU) "Respite services" are services that provide short-term, temporary relief to the informal unpaid caregiver of a managed care member in order to support and preserve the primary care giving relationship.

~~(LL)~~(VV) "Risk" or "underwriting risk" means the possibility that an MCO 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.

~~(MM)~~(WW) "Rural health clinic (RHC)" has the same meaning as in rule 5160-28-01 of the Administrative Code.

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

~~(OO)~~(YY) "Service area" means the geographic area specified in the MCO's provider agreement where the MCO agrees to provide Medicaid services to members residing in those areas.

(ZZ) "Single case agreement" means a contract with an out-of-network provider to provide services to an MCE's member on a one-time, individual, or limited basis.

(AAA) "Single pharmacy benefit manager (SPBM)" is a prepaid ambulatory health plan as defined in 42 C.F.R. 438.2 (October 1, 2021) and the state pharmacy benefit manager selected under section 5167.24 of the Revised code which is responsible for processing all pharmacy claims under the care management system. The SPBM service area is statewide.

(BBB) "SPBM contract" means a formal agreement between ODM and the SPBM for the provision of medically necessary pharmacy services to medicaid recipients who are enrolled in the SPBM.

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

(DDD) "State hearing" means the process set forth in 42 C.F.R 431, Subpart E (October 1, 2021) and division 5101:6 of the Administrative Code.

~~(QQ)~~(EEE) "Subcontract" means a written contract between ~~an MCO~~ an MCE and a third party, including the ~~MCO's~~ MCE's parent company or any subsidiary corporation owned by the ~~MCO's~~ MCE'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 MCO's provider agreement or the SPBM's contract with ODM.

~~(RR)~~(FFF) "Subcontractor" means an individual or entity ~~any party~~ that has entered into a subcontract with an MCE to perform a specific part of the obligations specified under the MCO's provider agreement or the SPBM's contract with ODM. A provider or network provider is not a subcontractor by virtue of the provider's contract with an MCE.

~~(SS)~~(GGG) "Third party" means the same as in section 5160.35 of the Revised Code.

~~(TT)~~(HHH) "Third party administrator" means any entity used in accordance with the provisions of this chapter to manage or administer a portion of services in fulfillment of the provider agreement with ODM.

~~(UU)~~(III) "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 third party payer (TPP) or in part the obligation of the member, the TPP, and/or the ~~MCO~~MCE.

~~(VV)~~(JJJ) "Third party claim" or "COB claim" means any claim submitted to ~~the MCO~~an MCE for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by ~~the MCO~~an MCE:

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

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

~~(WW)~~(KKK) "Third party liability (TPL)" 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 (~~UU~~EEE) of this rule.

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

~~(YY)~~(MMM) "Title X services" means services and supplies allowed under 42 U.S.C. 300 (as in effect ~~July 1, 2020~~July 1, 2022), and provided by a qualified family planning provider.

~~(ZZ)~~(NNN) "Tort action," or "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.

~~(AAA)~~(OOO) "Waste" means payment for or the attempt to obtain payment for items or services when there may be no intent to deceive or misrepresent, but poor or inefficient billing or treatment methods result in unnecessary costs.

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