

**410-141-0000 Acronyms and Definitions**

In addition to the definitions in 410-120-0000, the following definitions apply.

(1) "Action" means, in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

- (a) The denial or limited authorization of a requested service, including the type or level of service;
- (b) The reduction, suspension or termination of a previously authorized service;
- (c) The denial in whole or in part, of payment for a service;
- (d) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (Division);
- (e) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or
- (f) For a ~~Division~~ member in a single Fully Capitated Health Plan (FCHP) or Mental Health Organization (MHO) PHP or CCO service area, the denial of a request to obtain services outside of the FCHP or MHO's participating provider panel pursuant to OAR 410-141-0160 and 410-141-0220 or OAR 410-141-3320, as applicable.

~~(2) Addictions and Mental Health Division (AMH) — The Oregon Health Authority (Authority) office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.~~

~~(3) Administrative Hearing — An Authority hearing related to an action, including a denial, reduction or termination of benefits that is held when requested by the Oregon Health Plan (OHP) client or Division member. A hearing may also be held when requested by an OHP client or Division member that believes a claim for services was not acted upon with reasonable promptness or believes the payer took an action erroneously.~~

~~(4) Advance Directive — A form that allows a person to have another person make health care decisions when he/she cannot make decisions and tells a doctor if the person does not want any life sustaining help if he/she is near death.~~

~~(5) Aged — Individuals who meet eligibility criteria established by the Department Seniors and People with Disabilities Division (SPD) for receipt of medical assistance because of age.~~

~~(6) Americans with Disabilities Act (ADA) — Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service, delivery and facility accessibility.~~

~~(7) Alternative Care Settings — Sites or groups of practitioners that provide care to Division members under contract with the Division member's PHP. Alternative care settings include but are not limited to urgent care centers, hospice, birthing centers, out-~~

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~~placed medical teams in community or mobile health care facilities, and outpatient surgicenters.~~

~~(8) Ancillary Services — Those medical services under the OHP not identified in the definition of a condition/treatment pair, but medically appropriate to support a service covered under the OHP benefit package. Ancillary services and limitations are referenced in the General Rules OAR s 410-120-1210, Benefit Packages and 410-120-1200, Exclusions and applicable individual program rules.~~

~~(92) "Appeal" — means a request for review of an action as defined in this rule.~~

~~(10) Automated Voice Response (AVR) — An Authority computer system that provides information on the current eligibility status of OHP clients and Division members by phone or by Web access.~~

~~(11) Blind — Individuals who meet eligibility criteria established by the Department' SPD for receipt of medical assistance because of a condition or disease that causes or has caused blindness.~~

~~(XX3) "Coordinated Care Services" means a CCO's fully integrated physical health, chemical dependency and mental health services pursuant to ORS 414.725 and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.~~

~~(124) "Capitated Services" — mean T those covered services that a PHP or Primary Care Manager (PCM) agrees to provide for a capitation payment under the Division OHP contract or agreement with the Authority.~~

~~(135) "Capitation Payment" means:~~

~~(a) Monthly prepayment to a PHP for the provision of all capitated health services needed by OHP the PHP provides to members clients enrolled with the PHP;~~

~~(b) Monthly prepayment to a PCM to provide primary care management services for an OHP a client enrolled with the PCM. Payment is made on a per OHP client, per month basis.~~

~~(XX6) "CCO Payment" means the monthly prepayment to a CCO for services the CCO provides to members in accordance with the global budget.~~

~~(167) "Chemical Dependency Organization (CDO)" — means a PHP that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as capitated services under the OHP.~~

~~All chemical dependency services covered under the OHP are covered as capitated services by the CDO.~~

~~(178) "Chemical Dependency Services" — means A assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others.,~~

consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

~~(18) Children's Health Insurance Program (CHIP) — A Federal and State funded portion of the Division established by Title XXI of the Social Security Act and administered in Oregon by the Authority.~~

~~(19) "Children Receiving Children, Adults and Families (CAF) Child Welfare or Oregon Youth Authority (OYA) Services" — mean individuals who are receiving medical assistance under ORS 414.025(2)(f), (i), (j), (k) and (e), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of CAF, the Authority, or OYA who are in placement outside of their homes.~~

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~~(20) Claim — (1) a bill for services; (2) a line item of a service; or (3) all services for one client within a bill.~~

~~(21) Client Enrollment Services (CES) — The Division unit responsible for adjustments to enrollments, retroactive disenrollment and enrollment of newborns.~~

~~(22) Clinical Record — The clinical record includes means the medical, dental or mental health records of an OHP client or Division member. These records include the PCP's record, the inpatient and outpatient hospital records and the Exceptional Needs Care Coordinator (ENCC), complaint and disenrollment for cause records that may reside in the PHP's administrative offices.~~

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~~(239) "Cold Call Marketing" — means a PCP's or CCO's — Any unsolicited personal contact by a PHP with a potential member for marketing purposes as defined in this rule.~~

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~~(24) Comfort Care — The provision of medical services or items that give comfort and/or pain relief to an individual who has a terminal illness. Comfort care includes the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness. Comfort care includes but is not limited to care provided through a hospice program (see Hospice rules), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort care includes nutrition, hydration and medication for disabled infants with life-threatening conditions not covered under condition/treatment pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable comfort care is provided consistent with Section 4751 OBRA 1990 — Patient Self Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness with the intent to prolong life.~~

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~~(x10) "Community Advisory Council" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members consumer's and the community, consistent with ORS 414.625's health~~

~~services needs. The council's membership includes representatives of the community and of county government, with consumers making up a majority of the membership.~~

~~(11)~~ "Community Health Worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

~~(2512)~~ "Community Mental Health Program (CMHP)" —means Tthe organization of all services for ~~persons~~ individuals with mental or emotional disorders ~~and developmental disabilities~~ operated by, or contractually affiliated with, a local Mental Health Authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority's Addictions and Mental Health Division (AMH).

~~(2613)~~ "Co-morbid Condition" —means a medical condition or /diagnosis ~~(i.e., illness, disease and/or disability)~~ coexisting with one or more other current and existing conditions or /diagnoses in the same patient.

~~(2714)~~ "Community Standard" —means Ttypical expectations for access to the health care delivery system in the ~~Division client's member's or PCM member's~~ community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in PHPs and to PCM members take into consideration the community standard and be adequate to meet the needs of the Division and PCM members.

~~(2815)~~ "Condition/Treatment Pair" —means Ddiagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9-CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or the Authority AMH Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health ~~Services Evidence~~ Review Commission, constitute the line items in the Prioritized List of Health Services.

Condition/treatment pairs may contain many diagnoses and treatments. ~~The condition/treatment pairs are referred to in OAR 410-141-0520.~~

~~(20) Continuing Treatment Benefit—A benefit for OHP clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to an OHP benefit package that doesn't cover the treatment.~~

~~(30) Co-payment—The portion of a covered service that a Division member must pay to a provider or a facility. This is usually a fixed amount that is paid at the time one or more services are rendered.~~

~~(34)16) "Contract" —means The contract an agreement between the State of Oregon, acting by and through its the Authority, the Division and an FCHP, dental care organization (DCO), physician care organization (PCO), or a CDO, or between AMH and an PHP or CCO-MHO for the provision of to provide covered health services to eligible Division members, for a capitation payment. A contract may also be referred to as a service agreement.~~

~~(17) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.~~

~~32(18) "Corrective Action or Corrective Action Plan" —means a A Division- initiated request for a contractor or a contractor- initiated request for a subcontractor to develop and implement a time specific plan, that is acceptable to the Division, for the correction of Division-identified areas of noncompliance, as described in Exhibit H, Encounter Data Minimum Data Set Requirements and Corrective Action, Schedule 4, Pharmacy Data Requirements and Corrective Action, and in Exhibit B, Part VI, Section 2, Sanctions.~~

~~(33)19) "Covered Services" —A means re medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that are funded by the the Legislature funds, based on the Prioritized List of Health Services, and described in ORS 414.705 to 414.750; OAR 410-120-1210; 410-141-0120; 410-141-0520; and 410-141-0480; except as excluded or limited under OAR 410-141-0500 and rules in chapter 410, division 120.~~

~~(20) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. -The individual makes the declaration when they are able to understand and make decisions related to treatment, which is and honored when the individual is unable to make such decisions.~~

~~(34) Dentally Appropriate— Services that are required for prevention, diagnosis or treatment of a dental condition and that are:~~

~~(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;~~

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~~(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;~~

~~(c) Not solely for the convenience of the OHP member or a provider of the service;~~

~~(d) The most cost effective of the alternative levels of dental services that can be safely provided to a Division member.~~

~~(3521) "Dental Care Organization (DCO)" — means a PHP that provides and coordinates capitated dental services as capitated services under OHP. All dental services covered under the OHP are covered as capitated services by the DCO; no dental services are paid by the Division on a fee-for-service (FFS) basis for OHP clients enrolled with a DCO provider.~~

~~(3622) "Dental Case Management Services" — Smean services provided to ensure that eligible a Division a members obtain receives dental services, including a a comprehensive, ongoing assessment of the member's dental and medical needs related to dental care of the Division member, plus and the development and implementation of a plan to ensure that eligible Division the members obtain capitated receives those services.~~

~~(37) Dental Emergency Services — Dental services may include, but are not limited to the treatment of severe tooth pain, unusual swelling of the face or gums, and avulsed tooth consistent with OAR 410-123-1060.~~

~~(38) Dental Practitioner — A practitioner who provides dental services to Division members under an agreement with a DCO, or is a FFS practitioner. Dental practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.~~

~~(39) Department — The Department of Human Services or any of its programs or offices established in ORS chapter 407, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs (OMAP) is used in contract or in administrative rule, it shall mean the Division of Medical Assistance Programs (Division). Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in contract or in rule, it shall mean the Addictions and Mental Health Division (AMH). Wherever the former Seniors and People with Disabilities or SPD is used in contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Wherever the former Children Adults and Families or CAF is used in contract or rule, it shall mean the Children, Adults and Families Division (CAF). Wherever the former Health Division is used in contract or in rule, it shall mean the Public Health Division (PHD).~~

~~(4023) "Diagnostic Services" — Tmeans those services required to diagnose a condition, including but not limited to radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.~~

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~~(41) Disabled—Individuals who meet eligibility criteria established by DHS SPD for receipt of medical assistance because of a disability.~~

~~(4224) "Disenrollment" —means the act of removing or discharging an OHP client from enrollment with a PHP, or PCM, or CCO's responsibility. After the effective date of disenrollment an OHP client is no longer required to obtain capitated services from the PHP or PCM, nor be referred by the PHP for medical case managed services or by the PCM for PCM case managed services.~~

~~(43) Division—The Division of Medical Assistance Programs or Division of the Authority responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and CHIP. The Division writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of client eligibility and processes and pays Division providers.~~

~~(44) DMAP Member—An OHP client enrolled with a PHP.~~

~~(45) Emergency Medical Condition—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 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. An "emergency medical condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210 (3) (f) (B))~~

~~(46) Emergency Services—covered services furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency medical condition. Emergency services include all inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the Division member or transfer of the Division member to another facility.~~

~~(4725) "Enrollment" —means the assignment of a OHP client s, subject to OAR 410-141-0060, become Division members of a to a PHP, or PCM or CCO for management and receipt of health services. PCM members of a PCM that contracts with the Division to provide capitated services. An OHP client's enrollment with a PHP indicates that the Division member must obtain or be referred by the PHP for all capitated services and referred by the PHP for all medical case managed services subsequent to the effective date of enrollment. An OHP client's enrollment with a PCM indicates that the PCM member must obtain or be referred by the PCM for preventive and primary care and referred by the PCM for all PCM case managed services subsequent to the effective date of enrollment.~~

~~(48) Enrollment Area — Client enrollment is based on the client's residential address and zip code. The address is automatically assigned a county code or Federal Information Processing Standard (FIPS) code by the system, which indicates to the Authority worker that PHPs are in the area.~~

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~~(49) Enrollment Year — A twelve-month period beginning the first day of the month of enrollment of the OHP client in a PHP and, for any subsequent year(s) of continuous enrollment, beginning that same day in each such year(s). The enrollment year of OHP clients who re-enroll within a calendar month of disenrollment shall be counted as if there were no break in enrollment.~~

~~(50) End Stage Renal Disease (ESRD) — End stage renal disease is defined as that stage of kidney impairment that appears irreversible and requires a regular course of dialysis or kidney transplantation to maintain life. In general, 5% or less of normal kidney function remains. If the person is 36 or more months post-transplant, the individual is no longer considered to have ESRD.~~

~~(5426) "Exceptional Needs Care Coordination (ENCC)" — means aA specialized case management service provided by FCHPs fully capitated health plans to Division members identified as aged, blind or disabled who have complex medical needs, consistent with OAR 410-141-0405. ENCC includes-, including:~~

~~(a) Early identification of those Division members who are aged, blind, disabled or who have complex medical needs eligible for ENCC services-;~~

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of capitated services and discharge planning; and

~~(e) Aid with coordinating coordinating necessary and appropriate linkage of community support and social service systems linkage with medical care systems, as necessary and appropriate.~~

~~(52) Family Health Insurance Assistance Program (FHIAP) — A program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 185% of the Federal Poverty Level (FPL). FHIAP is funded with federal and states funds through Title XIX, XXI or both.~~

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~~(53) Family Planning Services — Services for clients of childbearing age (including minors who can be considered sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.~~

~~(54) Fee-for-Service (FFS) Health Care Providers — Health care providers who bill for each service provided and are paid by the Division for services as described in the Division provider rules. Certain services are covered but are not provided by PHPs or by PCMs. The client may seek such services from an appropriate FFS provider. PCMs~~

~~provide primary care services on a FFS basis and may refer PGM members to specialists and other providers for FFS care. In some parts of the state, the State may not enter into contracts with any managed care providers. OHP clients in these areas will receive all services from FFS providers.~~

~~(55) FPL — Federal Poverty Level~~

~~(56)(27) “Free-Standing Mental Health Organization (MHO)” —means Tthe single MHO in each county that provides only mental health services and is not affiliated with an a fully capitated health plan for FCHP for that service area. In most cases this “carve-out” MHO is a county CMHP or a consortium of CMHPs, but may be a private behavioral health care company.~~

~~(57)(28) “Fully-Capitated Health Plan (FCHP)” —means PHPs that contract with the Division Authority to provide capitated health services, including inpatient hospitalization under the OHP. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.~~

~~(58) Fully Dual Eligible — For the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Division for full medical assistance coverage. The covered categories include Qualified Medicare Beneficiary (QMB) plus OHP with limited drug benefit package (system identifier BMM) and OHP with limited drug benefit package (system identifier BMD). The covered categories do not include OHP Plus benefit package; OHP Standard benefit package; QMB only; Specified Limited Medicare Beneficiary (SLMB/SMB) and SLMB with a Federal match aka Qualified Individual (SMF)~~

~~(xx29) Global Budget means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members, including providing access to and ensuring the quality of those services.~~

~~(59)(30) “Grievance” —means aA Division member's or representative's expression of dissatisfactioncomplaint to contractor a PHP, CCO or to a participating provider about any matter other than an action.~~

~~(60)(31) “Grievance System” —means Tthe overall system that includes:~~

~~(a) complaints Grievances to a PHP or CCO on matters other than actions;~~

~~(b) Appeals to a PHP or CCO on actions; and~~

~~(c) Contested case hearings through the state on actions, and appeals handled at the PHP level and access to the State fair hearing process. Possible subjects for grievances 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 Division member's rights.~~

~~(61) Health Care Professionals — Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: medical doctors (including psychiatrists), osteopathic physicians, pharmacists, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physicians assistants (PA), qualified mental health professionals (QMHPs), and qualified mental health associates (QMHAS), dentists, dental hygienists, limited access permit (LAP), denturists, and certified dental assistants. These professionals may conduct health, mental health or dental assessments of Division members and provide screening services to OHP clients within their scope of practice, licensure or certification.~~

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~~(62) Health Insurance Portability and Accountability Act (HIPAA) of 1996 — HIPAA is a federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.~~

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~~(63) Health Plan New/noncategorical client (HPN) — A person who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an OHP client.~~

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~~(64) Health Services Commission — An eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be served.~~

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~~(xx32) “Health Services” means:~~

~~(a) For purposes of CCOs, the integrated services authorized to be provided within the medical assistance program as defined in ORS 414.025, for the physical medical, mental health, chemical dependency and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;~~

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~~(b) For all other purposes, the services authorized to be provided within the medical assistance program as defined in ORS 414.025, for the physical medical, mental health, chemical dependency and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.~~

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~~(xx33) “Health Systems Transformation (HST)” means the transformation of health care delivery in medical assistance programs as prescribed by 2011 House Bill 3650, Chapter 602, Oregon Laws 2011 and 2012 Enrolled Senate Bill 1580, Chapter 8, Oregon Laws 2012; and including the CCO Implementation Proposal from the Oregon Health Policy Board (January 24, 2012) approved by Section 2 of 2012 Enrolled Senate Bill 1580.~~

~~(65) Hospice Services — A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for~~

Medicare and/or accredited by the Oregon Hospice Association, is listed in the Hospice Program Registry, and has a valid provider agreement.

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~~(66) Hospital Hold — A hospital hold is a process that allows a hospital to assist an individual admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the OHP due to inpatient hospitalization. OHP clients shall be exempted from mandatory enrollment with an FCHP if clients become eligible through a hospital hold process and are placed in the adults/couples category.~~

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~~(67) Indian Health Care Provider — An Indian health program or an urban Indian organization.~~

~~(68) Indian Health Program — An Indian health service facility, any federally recognized tribe or tribal organization or any tribe 638 FQHC enrolled with the Authority as an American Indian/Alaska Native (AI/AN) provider.~~

~~(6934) "Line Items" — means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services, developed by the Health Services Commission for the OHP Medicaid Demonstration Project.~~

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~~(70) Local and Regional Allied Agencies include the following: local Mental Health Authority; CMHPs; local DHS offices; Commission on Children and Families; OYA; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.~~

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~~(7135) "Marketing" — A means any communication from a PHP or a CCO to an OHPa client who is not enrolled in that the PHP or CCO, and which the communication can reasonably be interpreted as to be an attempt to influence the OHP client;:~~

(a) To enroll in that particular PHP or CCO;

(b) To either disenroll or not to enroll with another PHP or CCO.

~~(72) Marketing Materials — Any medium produced by, or on behalf of, a PHP that can reasonably be interpreted as intended for marketing as defined in this rule.~~

~~(73) Medicaid — A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by DHS.~~

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~~(74) Medical Assistance Program — A program for payment of health care provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and CHIP. The Medical Assistance Program is administered and coordinated by the Authority.~~

~~(75) Medical Care Identification — The preferred term for what is commonly called the "medical card" That is the size of a business card and issued to Medical Assistance Program clients.~~

~~(7636)~~ "Medical Case Management Services" — ~~means~~ Services provided to ensure ~~that Division~~ members obtain health ~~care~~ services necessary to maintain physical and emotional development and health. ~~Medical case management services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are capitated services or non-capitated services, and follow-up, as appropriate, to assess the impact of care.~~

~~(77) Medically Appropriate~~ — ~~Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:~~

~~(a) Consistent with the symptoms of a health condition or treatment of a health condition;~~

~~(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;~~

~~(c) Not solely for the convenience of an OHP client or a provider of the service or medical supplies; and~~

~~(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a Division member or PCM member in the PHP's or PCM's judgment.~~

~~(78) Medicare~~ — ~~The federal health insurance program for the aged and disabled administered by CMS under Title XVIII of the Social Security Act.~~

~~(79) "Medicare Advantage"~~ — ~~An organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.~~

~~(8037)~~ "Mental Health Assessment" — ~~means~~ The a qualified mental health professional's determination of a Division member's need for mental health services. A Qualified Mental Health Professional collects and evaluates data pertinent to a member's mental status, psychosocial history and current problems through interview, observation and testing.

~~(8438)~~ "Mental Health Case Management" — ~~S~~means services provided to Division member's members who require-need assistance to ensure access to mental health benefits and services from local, regional or state allied agencies or other service providers. ~~Services provided may include: advocating for the Division member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring Division member's to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services. ENCC Services are separate and distinct from Mental Health Case Management.~~

~~(8239)~~ "Mental Health Organization (MHO)" — ~~means~~ A a PHP under contract with AMH that provides capitated mental health services ~~as capitated services under~~for the

OHP clients. MHOs can be FCHPs, CMHPs or private behavioral organizations or combinations thereof.

~~(83) "National Drug Code or (NDC)" — means A universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display less than 11 digits, but leading zeroes can be assumed and need to be used when billing~~

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~~(84) National Provider Identifier (NPI) — A federally directed provider number mandated for use on Health Insurance Portability and Accountability Act (HIPAA) transactions; individuals, provider organizations and subparts of provider organizations that meet the definition of health care providers (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI. (85) Non-Capitated Services — Those OHP covered services paid for on a FFS basis and for which a capitation payment has not been made to a PHP.~~

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~~(86) Non-Covered Services — Services or items for which the Division is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered under the OHP. Non-covered services for the OHP are identified in:~~

~~(a) OAR 410-141-0500;~~

~~(b) Exclusions and limitations described in OAR 410-120-1200; and~~

~~(c) Individual provider administrative rules.~~

~~(8740) "Non-Participating Provider" — A means a provider that does not have a contractual relationship with the a PHP or CCO and, i.e. is not on their panel of providers.~~

~~(88) "Ombudsman Services" — Ombudsman Services — Services mean services provided by the Authority to OHP client's who are aged, blind or disabled who have complex medical needs. Ombudsman staff may serve as the OHP client's advocate whenever the OHP client (a representative, a physician or other medical personnel, or other personal advocate serving the OHP client) is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the OHP. Ombudsman services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about OHP systems.~~

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~~(89) "Oregon Health Plan (OHP)" — means, Tthe Medicaid and Children's Health Insurance (CHIP) Demonstration Project which expands Medicaid and CHIP eligibility to eligible OHP clients. The OHP relies substantially upon prioritization of health services~~

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and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

~~(90) Oregon Health Plan (OHP) Plus Benefit Package—A benefit package available to eligible OHP clients as described in OAR 410-120-1210.~~

~~(91) Oregon Health Plan (OHP) Standard Benefit Package—A benefit package available to eligible OHP clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210.~~

~~(92) Oregon Health Plan (OHP) client—An individual found eligible by the Authority to receive services under the OHP. The OHP categories eligible for enrollment are defined as follows:~~

~~(a) Temporary Assistance to Needy Families (TANF)—OHP clients categorically eligible with income under current eligibility rules;~~

~~(b) CHIP—Children under one year of age who have income under 185% FPL and do not meet one of the other eligibility classifications;~~

~~(c) Poverty Level Medical (PLM) Adults under 100% of the FPL are OHP clients who are pregnant women with income under 100% of FPL;~~

~~(d) PLM Adults over 100% of the FPL are OHP clients who are pregnant women with income between 100% and 185% of the FPL;~~

~~(e) PLM children under one year of age have family income under 133% of the FPL or were born to mothers who were eligible as PLM Adults at the time of the child's birth;~~

~~(f) PLM or CHIP children one through five years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;~~

~~(g) PLM or CHIP children six through eighteen years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;~~

~~(h) OHP adults and couples are OHP clients aged 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;~~

~~(i) OHP families are OHP clients, aged 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;~~

~~(j) General Assistance (GA) recipients are OHP clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;~~

~~(k) Assistance to Blind and Disabled (AB/AD) with Medicare eligibles are OHP clients with concurrent Medicare eligibility with income under current eligibility rules;~~

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~~(l) AB/AD without Medicare eligibles are OHP clients without Medicare with income under current eligibility rules;~~

~~(m) Old Age Assistance (OAA) with Medicare eligibles are OHP clients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;~~

~~(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;~~

~~(o) OAA without Medicare eligibles are OHP clients without Medicare with income under current eligibility rules;~~

~~(p) CAF Children are OHP clients who are children with medical eligibility determined by CAF or OYA receiving OHP under ORS 414.025(2)(f), (l), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of CAF or OYA who are in placement outside of their homes.~~

~~(93) Oregon Youth Authority (OYA) — The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.~~

~~(9441) "Participating Provider" — means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers. An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to Division members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.~~

~~(95) "PCM Case Managed Services" include the following: Preventive services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, rural health clinics (RHC), migrant and community health clinics, federally qualified health centers (FQHC), county health departments, Indian health service clinics and Tribal health clinics, CMHPs, MHOs; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.~~

~~(9642) "PCM Member" — means An OHPa client enrolled with a PGM primary case manager.~~

~~(97) PHP Coordinator — the Division employee designated by the Division as the liaison between the Division and the PHP.~~

~~xx(43) "Peer Wellness Specialist" means an individual who assists mental health services consumers to reduce stigmas and discrimination and to provide direct services to assist individuals to create and maintain recovery, health and wellness by:~~

~~(a) -Assessing the individual's mental health service and support needs through community outreach;~~

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(b) Assisting individuals with access to available services and resources; and

(c) Addressing barriers to services and providing education and information about available resources and mental health issues.

(xx44) "Person Centered Care" means care that reflects the individual patient's strengths and preferences; reflects the clinical needs of the patient as identified through an individualized assessment; is based upon the patient's goals; and will assist the patient in achieving the goals.

(xx45) "Personal Health Navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

~~(9846) "Physician Care Organization (PCO)" —means a PHP that contracts with the Division Authority to provide partially-capitated health services under the OHP, exclusive. The distinguishing characteristic of a PCO is the exclusion of inpatient hospital services.~~

~~(99) Post Hospital Extended Care Benefit — A 20-day benefit for non-Medicare Division members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.~~

~~(100) Post Stabilization Services — covered services, related to an emergency medical condition that is provided after a Division member is stabilized in order to maintain the stabilized condition or to improve or resolve the Division member's condition.~~

~~(101) Potential Division member — An OHP client who is subject to mandatory enrollment in managed care, or may voluntarily elect to enroll in a managed care program, but is not yet enrolled with a specific PHP.~~

~~(102) Practitioner — A person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.~~

~~(103) Prepaid Health Plan (PHP) — A managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with the Division and/or AMH on a case managed, prepaid, capitated basis under the OHP. PHPs may be DCOs, FCHPs, MHOs, PCOs or CDOs.~~

~~(104) Preventive Services — Those services as defined under expanded definition of preventive services for OHP clients in OAR 410-141-0480, and OAR 410-141-0520.~~

~~(10547) "Primary Care Management Services" —mean sPrimary care management services are services provided tothat ensure PCM-members obtain health care services~~

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~~that are necessary to maintain physical and emotional development and health. Primary care management services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that are preventive or primary care services or PCM case managed services and follow-up, as appropriate, to assess the impact of care.~~

~~(10648) "Primary Care Manager (PCM)" — means Aa physician (MD or DO), nurse practitioner, physician assistant, or naturopath with physician backups, primary care provider who agrees to provide primary care management services as defined in rule to PCM their members. PCMs may also be hospital primary care clinics, RHCs, migrant and community health clinics, FQHCs, county health departments, Indian health service clinics or Tribal health clinics. The PCM provides Primary Care Management Services to PCM members for a capitation payment. The PCM provides preventive and primary care services on a FFS basis.~~

~~(107) Primary Care Dentist (PCD) — A Dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for Division members. PCDs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.~~

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~~(108) Primary Care Provider (PCP) — A practitioner who has responsibility for supervising and coordinating initial and primary care within their scope of practice for Division members. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.~~

~~(10949) "Prioritized List of Health Services" — means Tthe listing of condition and treatment pairs developed by the Health Services Evidence Review Commission for the purpose of implementing the administering OHP Demonstration Project health services. See OAR 410-141-0520, for the listing of condition and treatment pairs.~~

~~(110) Professional Liability Insurance — Coverage under the Federal Tort Claims Act (the "FTCA") if contractor is deemed covered under the FTCA, and to the extent the FTCA covers contractor's professional liability under this contract~~

~~(111) Proof of Indian Heritage — Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service — services provided by Indian health service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.~~

~~(112) Provider — An individual, facility, institution, corporate entity or other organization which supplies medical, dental or mental health services or medical and dental items.~~

~~(113) Provider Taxonomy Codes: is a standard administrative code set, as defined under HIPAA in federal regulations at 45 CFR 162, for identifying the provider type and area of specialization for all providers.~~

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~~(114) Quality Improvement — Quality improvement is the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement (as used in these rules) includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."~~

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~~(115) Representative — A person who can make OHP related decisions for OHP clients who are not able to make such decisions themselves. A representative may be, in the following order of priority, a person who is designated as the OHP client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the OHP client, the Individual Service Plan Team (for developmentally disabled clients), a Department case manager or other Department designee.~~

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~~(116) Rural — A geographic area is 10 or more map miles from a population center of 30,000 people or less.~~

~~(117) Seniors and People with Disabilities Division (SPD) — The division within the Authority responsible for providing services such as:~~

~~(a) Assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program;~~

~~(b) Cash assistance grants for persons with long-term disabilities through GA and the Oregon Supplemental Income Program (OSIP); and~~

~~(c) Administration of the Federal Older Americans Act.~~

~~(41850) "Service Area" — Tmeans the geographic area within which the PHP or CCO has identified in their agreed under Ccontract or Agreement with the Authority, to provide health services under the OHP.~~

~~(119) Stabilize — No material deterioration of the emergency medical condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.~~

~~(120) Terminal Illness — An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.~~

~~(121) Triage—Evaluations conducted to determine whether or not an emergency condition exists, and to direct the Division member to the most appropriate setting for medically appropriate care.~~

~~(122) "Urban"—A means a geographic area is less than 10 map miles from a population center of 30,000 people or more.~~

~~(123) "Urgent Care Services" mean c— Covered services that are medically appropriate and immediately required to prevent serious deterioration of a Division member's health that is a result of unforeseen illness or injury. Services that can be foreseen by the individual are not considered urgent services.~~

~~(124) Valid Claim:~~

~~(a) An invoice received by the PHP for payment of covered health care services rendered to an eligible client that:~~

~~(A) Can be processed without obtaining additional information from the provider of the service or from a third party; and~~

~~(B) Has been received within the time limitations prescribed in these rules.~~

~~(b) A valid claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical appropriateness. A valid claim is synonymous with the federal definition of a clean claim as defined in 42 CFR 447.45(b).~~

~~(12551) "Valid Pre-Authorization" means a document the Authority, a PHP or CCO receives requesting a health service for a client who would be eligible for the service at the time of the service, and the document contains:~~

~~(a) A beginning and ending date not exceeding twelve months; and~~

~~(b) All data fields required for processing of the request or payment of the service, including the appropriate billing codes.~~

~~— A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:~~

~~(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and~~

~~(b) Has been received within the time limitations prescribed in these rules.~~

~~-[Publications: Publications referenced are available from the agency.]~~

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

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