

## **410-141-0000**

### **Definitions**

In addition to the definitions in OAR 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 or CCO to act within the timeframes provided in 42 CFR 438.408(b); or
  - (f) For a member who resides in a rural service area where the PHP or CCO is the only PHP or CCO, the denial of a request to obtain covered services outside of the PHP or CCO provider network under any of the following circumstances:
    - (A) From any other provider (in terms of training, experience, and specialization) not available within the network;
    - (B) From a provider not part of the network that is the main source of a service to the member as long as the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.
    - (C) Because the only plan or provider available does not provide the service due to moral or religious objections;
    - (D) Because the member’s provider determines the member needs related services that would subject the member to unnecessary risk if received separately, and not all related services are available within the network; or
    - (E) The Authority determines that other circumstances warrant out-of-network treatment for moral or religious objections.
- (2) “Adjudication” means the act of a court or entity in authority when issuing an order, judgment, or decree; as in a final CCO or MCO claims decision or OHA issuing a final hearings decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.
- (3) “Appeal” means a request for review of an action.
- (4) “Behavioral Health” means mental health conditions as well as substance use disorders.
- (5) “Behavioral Health Evaluation” means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

(6) “Capitated Services” mean those covered services that a PHP or Primary Care Manager (PCM) agrees to provide for a capitation payment under contract with the Authority.

(7) “Capitation Payment” means:

(a) Monthly prepayment to a PHP for health services the PHP provides to members;

(b) Monthly prepayment to a PCM to provide primary care management services for a member enrolled with the PCM.

(8) “CCO Payment” means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.

(9) “Certificate of Authority” means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.

(10) “Certified or Qualified Health Care Interpreter” means a trained person who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into spoken English and readily able to translate the written or oral statement of other persons into the spoken language of the person with limited English proficiency. A certified Health Care Interpreter has met Oregon training standards for certification, has received certification from a national certification body, and is listed in the Oregon Health Care Interpreter Registry; a qualified Health Care Interpreter has met Oregon training standards for qualification and has demonstrated language proficiency in English and a second language where certification is not possible using a standardized, nationally recognized language proficiency assessment and is listed in the Oregon Health Care Interpreter Registry.

(11) “Certified Traditional Health Worker” means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305.

(12) “Cold Call Marketing” means a PCP’s or CCO’s unsolicited personal contact with a potential member for the purpose of marketing.

(13) “Co-morbid Condition” means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

(14) “Community Advisory Council” means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625.

(15) “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) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;
- (f) Provides health education and information that is culturally appropriate to the individuals being served;
- (g) Assists community residents in receiving the care they need;
- (h) May give peer counseling and guidance on health behaviors; and
- (i) May provide direct services such as first aid or blood pressure screening.

(16) “Community Mental Health Program (CMHP)” means the organization of all services for individuals with mental or emotional disorders 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).

(17) “Community Standard” means typical expectations for access to the health care delivery system in the 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.

(18) “Condition/Treatment Pair” means diagnoses 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, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

(19) “Contract” means an agreement between the State of Oregon acting by and through the Authority and a PHP or CCO to provide health services to eligible members.

(20) “Converting MCO” means a CCO that:

- (a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;
- (b) Was formed by one or more MCOs that contracted with the Authority as of July 1, 2011.

(21) “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.

(22) “Coordinated Care Services” mean a CCO’s fully integrated physical health, behavioral health services pursuant to ORS 414.651, and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.

(23) “Corrective Action or Corrective Action Plan” means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(24) “Covered Services” mean medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the legislature funds based on the Prioritized List of Health Services.

(25) “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 honored when the individual is unable to make such decisions.

(26) “Dental Care Organization (DCO)” means a PHP that provides and coordinates dental services as capitated services under OHP.

(27) “Dental Case Management Services” mean services provided to ensure member receives dental services including a comprehensive, ongoing assessment of the member’s dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.

(28) “DCBS Reporting CCO” means for the purpose of OAR 410-141-3340 through 410-141-3395 a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.

(29) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection agency.

(30) “Diagnostic Services” mean 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.

(31) “Disenrollment” means the act of removing a member from enrollment with a PHP, PCM, or CCO.

(32) “Enrollment” means the assignment of a member to a PHP, PCM, or CCO for management and receipt of health services.

(33) “Free-Standing Mental Health Organization (MHO)” means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.

(34) “Fully-Capitated Health Plan (FCHP)” means PHPs that contract with the Authority to provide capitated health services including inpatient hospitalization.

(35) “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.

(36) “Grievance” means a member’s complaint to a PHP, CCO, or to a participating provider about any matter other than an action.

(37) “Grievance System” means the overall system that includes:

(a) 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 other matters for which the member is given the right to a hearing by rule or state statute.

(38) “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, behavioral health that includes mental health and substance use disorders, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;

(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, behavioral health, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.

(39) “Health System 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.

(40) “Holistic Care” means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, especially one considered outside the mainstream of scientific medicine as naturopathy or chiropractic and often involving nutritional measures.

(41) “Intensive Case Management (ICM)” means a specialized case management service provided by fully capitated health plans to members identified as aged, blind, or disabled who have complex medical needs including:

(a) Early identification of members eligible for ICM 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 necessary and appropriate linkage of community support and social service systems with medical care systems.

(42) “Licensed Health Entity” means a CCO that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(43) “Line Items” mean condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.

(44) “Marketing” means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(45) “Medical Case Management Services” means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.

(46) “Mental Health Assessment” means a qualified mental health professional’s determination of a member’s need for mental health services.

(47) “Mental Health Case Management” means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.

(48) “Mental Health Organization (MHO)” means a PHP that provides capitated behavioral services for clients.

(49) “National Association of Insurance Commissioners (NAIC)” means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

(50) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.

**(51) “Non-Participating Provider”** means a provider that does not have a contractual relationship with a PHP or CCO and is not on their panel of providers.

(52) “OHA or Authority Reporting CCO” means a CCO that reports its solvency plan and financial status to the Authority under these rules.

(53) “Other Non-Medical Services,” also referred to as flexible services, means health-related, non-state plan services intended to improve care delivery and member health. Flexible services are health related and cost-effective alternatives to more technical services. Flexible services are unable to be reported in the conventional manner using CPT or HCPCS codes and may effectively treat or prevent the physical or mental healthcare condition documented in the member’s health or clinical record. The Authority has revised the reporting framework so that CCOs also report qualified flexible services to the Authority in a grouping called “health related services” to be accounted for in the CCO’s medical or member service expenses. These expenditures are not counted as administrative costs when determining the medical loss ratio. Flexible services may include, but are not limited to:

(a) Training and education for health improvement or management (e.g., classes on healthy meal preparation, diabetes self-management curriculum);

(b) Self-help or support group activities (e.g., post-partum depression programs, Weight Watchers groups);

(c) Care coordination, navigation, or case management activities (not covered under state plan benefits, e.g., high utilizer intervention program);

(d) Home and living environment items or improvements (non-DME items to improve mobility, access, hygiene, or other improvements to address a particular health condition, e.g., air conditioner, athletic shoes, or other special clothing);

(e) Transportation not covered under State Plan benefits (e.g., other than transportation to a medical appointment);

(f) Programs to improve the general community health (e.g., farmers’ market in the “food desert”);

(g) Housing supports related to social determinates of health (e.g., shelter, utilities, or critical repairs);

(h) Assistance with food or social resources (e.g., supplemental food, referral to job training or social services);

(i) Other (describe).

**(54) “Participating Provider”** means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers.

(55) “PCM Member” means a client enrolled with a primary case manager.

(56) “Peer Wellness Specialist” means an individual who assists behavioral 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 behavioral health service and support needs through community outreach;

(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 behavioral health issues.

(57) “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.

(58) “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.

(59) “Physician Care Organization (PCO)” means a PHP that contracts with the Authority to provide partially-capitated health services under OHP exclusive of inpatient hospital services.

(60) “Potential Member” means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP or CCO.

(61) “Premium” means:

(a) CCO payment when the payment is made by the Authority to the CCO for purposes of OAR 410-141-3340 to 410-141-3395;

(b) Also includes any other revenue received by the CCO for the provision of healthcare services over a defined period of time.

(62) “Primary Care Management Services” means services that ensure PCM members obtain health services that are necessary to maintain physical and emotional development and health.

(63) “Primary Care Manager (PCM)” means a primary care provider who agrees to provide primary care management services to their members.

(64) “Prioritized List of Health Services” means the listing of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP health services.

(65) “Service Area” means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.

(66) “Substance Use Disorder (SUD) Services” means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the American Society of Addiction Medicine Patient Placement Criteria 2-Revision (ASAM PPC-2R). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

(67) “Treatment Plan” for behavioral health consists of the following three components:

(a) “Emergency Response System” means the coordinated method of triaging the mental health service needs of members and providing covered services when needed. The system operates 24-hours a day, 7-days a week and includes, but is not limited to: after hours on call staff, telephone and in person screening, outreach, and networking with hospital emergency rooms and police.

(b) “Emergency Services” means covered services furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency situation.

(c) “Services Coordination” means services provided to members who require access to and receive services from one or more Allied Agencies or program components according to the treatment plan. Services provided may include establishing pre-commitment service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements based on mental or emotional disability.

(68) “Treatment Plan” for physical and dental health consists of the following two components:

(a) “Emergency Services Related to Physical Health” means services from a qualified provider necessary to evaluate or stabilize an emergency medical condition including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the member’s condition is not likely to materially deteriorate from or during a member’s discharge from a facility or transfer to another facility.

(b) “Services Coordination” means services provided to members who require access to and receive covered services or long-term care services from one or more allied agencies or program components according to the treatment plan. Services provided may include establishing pre-commitment service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements based on mental or emotional disability;

(69) “Service Authorization Request” means a member’s initial or continuing request for the provision of a service including member requests made by their provider or the member’s authorized representative.

(70) “Valid Preauthorization” means a document the Authority, a PHP, or CCO receives requesting a health service for a member 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 the request or payment of the service including the appropriate billing codes.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 45-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 11-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14