Glossary of Program Integrity Terminology
2020

Term	Definition
Abuse	Provider practices that: • are inconsistent with sound fiscal, business, or medical practices and • result in an unnecessary cost to the OHA or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the OHA.
Affiliate	A person who controls, is controlled by, or is under common control with the person specified. Control can be direct or indirect (e.g., through one or more intermediaries).
Affiliation	In the context of program integrity and for the purposes of applying 42 CFR §455.107, Affiliation of an individual or entity can mean any of the following: (1) Direct or indirect ownership interest of 5 percent or greater in another organization. (2) A general or limited partnership interest (regardless of the percentage) in another organization. (3) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization. (4) An interest in which an individual is acting as an officer or director of a corporation. (5) Any payment assignment relationship under 42 CFR §447.10(g).
Agent	Any person who authorized to act on behalf of a provider.
Alternative Payment Methodology	As provided in ORS 414.025(1)(a-b): A payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services. This includes but is not limited to shared savings arrangements; bundled payments; and payments based on episodes.
Annual Fraud, Waste and Abuse (FWA) Assessment Report	The annual fraud, waste, and abuse report the Contractor must provide to OHA in accordance with Ex. B, Part 9 of the Contract.
Annual and Quarterly FWA Audit Reports	The annual and quarterly fraud, waste, and abuse audit reports the Contractor must provide to OHA in accordance with Ex. B, Part 9 of the Contract.

Administrative Performance (AP) Standard	The standard for accurate and timely submission, as described in OAR 410-141-3430 of: • all valid claims for a subject month within 45 days of the date of adjudication and • corrected encounter data within 63 days of the date that OHA notified the Contractor about data requiring correction.
AP Withhold or Administrative Performance Withhold (APW)	The dollar amount that OHA will withhold from the Contractor's capitation payments for the month that the Contractor did not meet the AP Standard (the subject month). This equals one percent (1%) of the Contractor's adjusted monthly and weekly capitation payments paid for the subject month as described in Exhibit C, Section 11.
Applicable Law(s)	All state and federal statutes, rules, regulations, and case law that apply to: • a particular issue that is referenced in the Contract, • the entire Contract
Centers for Medicare & Medicaid Services and CMS	The federal agency within the Department of Health and Human Services (DHHS) that administers Medicare and works in partnership with all fifty states to administer Medicaid.
Contract	CCO 2.0 inclusive of all exhibits, attachments, appendices, as set forth in sec. 4 of the general provisions awarded to Contractor as a result of RFA OHA-4690-19.
Contract Effective Date	The date CCO 2.0 became effective, was October 01, 2019, as identified in sec. 1 of the general provisions of the Contract.
Contract Year	The twelve-month period during the Term that commences on January 01 and runs through the end of the day on December 31 of each calendar year.
Control	The direct or indirect power to manage a Person or set the Person's policies, whether by: • owning voting securities, • contract other than a commercial contract for goods or non-management services, or • otherwise, unless the power is the result of an official position or corporate office the person holds. OHA shall presume that a person controls another person if the person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of the other person.
Conviction	Conviction for a criminal offense or assessed civil penalties related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs, or as described in sections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act.

Coordinated Care Organization (CCO)	A corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by OHA 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.
Corrective Action and Corrective Action Plan	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. This can be a request by OHA to an MCE or a request by an MCE to a subcontractor.
Credentialing and recredentialing	Contractor selection of providers using universal application and credentialing procedures and objective quality information. CCOs shall take steps to remove providers from their provider network if they fail to meet objective quality standards. Contractor shall ensure that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO and re-credentialed no less frequently than every three years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. Contractors shall screen their providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes; Contractor shall have written policies and procedures for collecting evidence of credentials, screening the credentials, reporting credential information and recredentialing of participating providers including acute, primary, dental, behavioral, substance use disorder providers and facilities used to deliver covered services, consistent with Patient the Protection and Affordable Care Act sec. 6402, 42 CFR§ 438.214, 42 CFR §455.400-455.470 (excluding §455.460), OAR 410-141-3120 and Exhibit G of the Contract, except as provided in para. b, of sec, 6, Ex. B, Part 4. These procedures shall also include collecting proof of professional liability insurance, whether by insurance or a program of self-insurance. When credentialing providers or provider types designated by Centers for Medicare and Medicaid Services (CMS) as “moderate or “high-risk,” Contractor shall, at the time of enrollment, provide to OHA with documentation, via administrative notice, that demonstrates the provider has undergone a fingerprint-based background check and site visit within the previous 5 years. For a provider who is actively enrolled in Medicare and has undergone a fingerprint-based background check as part of Medicare enrollment, this will be deemed to satisfy the requirement for OHA Provider Enrollment.

Credible allegation of fraud	An allegation that has indicators of reliability and has verified by the State through careful review of all allegations, facts and evidence. Allegations can come from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. The State Medicaid agency must review all allegations carefully and act judiciously on a case-by-case basis. A MCE (Managed Care Entity) must notify OHA's Program Integrity Audit Unit of any suspected cases of any fraud, waste, or abuse (FWA) immediately, prior to any internal vetting. OHA will work with other stakeholders to investigate any suspected cases of FWA and will determine the appropriate action to take.
Delegate	The act of Contractor assigning Work to: • a subcontractor under a subcontract, or • a governmental entity or agency pursuant to a memorandum of understanding (MOU).
Disclosable event	Event that a disclosing entity must disclose to OHA. For purposes of program integrity and §455.107 this means when the entity • Currently has an uncollected debt to Medicare, Medicaid, or CHIP, regardless of the amount of the debt; whether the debt is currently being repaid (for example, as part of a repayment plan); or whether the debt is currently being appealed; • Has been or is subject to a payment suspension under a federal health care program (as that latter term is defined in section 1128B(f) of the Act), regardless of when the payment suspension occurred or was imposed; • Has been or is excluded by the OIG from participation in Medicare, Medicaid, or CHIP, regardless of whether the exclusion is currently being appealed or when the exclusion occurred or was imposed; or • Has had its Medicare, Medicaid, or CHIP enrollment denied, revoked or terminated, regardless of the reason for the denial, revocation, or termination; whether the denial, revocation, or termination is currently being appealed; or when the denial, revocation, or termination occurred or was imposed.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Encounter data	Data that the Contractor must submit to OHA as described in OAR 410-141-3430. The data reports all services the Contractor provided to Members regardless of whether the services were: • Covered Services, non-covered services, or other Health-Related services, • not paid for, • paid for on a Fee-For-Service or capitated basis, • performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor, and (iv) were performed pursuant to Subcontractor agreement, special arrangement with a facility or program; or other arrangement.
Entity	A single legal entity capable of entering into a risk contract that covers coordinated care services with the state and conducting the business of a coordinated care organization.
Exhibit L	The required financial reporting found in Exhibit L of Contract with OHA. This includes: • Solvency Plan • Financial Reporting • Sustainable Rate of Growth OHA's Ex. L Financial Reporting Template on the CCO Contract Forms page contains definitions and instructions for completing and submitting each Report; and instructions and due dates for submitting supplemental reports.
False claim	A claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information that would result, or has resulted, in an overpayment. See also, Oregon False Claims Act as set forth in ORS 180.750-180.785 and federal False Claims Act as set forth in 31 USC 3729 through 3733.
Fee-for-Service (FFS)	A method in which doctors and other health care providers are paid for each service performed.
Fiscal agent	A contractor that processes or pays vendor claims on behalf of the Medicaid agency.
Fraud	The intentional deception or misrepresentation that a Person: • knows, or should know, to be false, or does not believe to be true, and • makes knowing the deception could result in some unauthorized benefit to themselves or some other Person(s).
FWA Prevention Handbook	The handbook of fraud, waste, and abuse policies and procedures that complies with the requirements set forth in Sec. 11 of Ex. B, Part 9 and any other applicable provisions of the Contract.

Governance Structure and Governing Board	The Contractor's governing body that meets the requirements of ORS 414.625.
Grievance	An 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 enrollee's rights regardless of whether remedial action is requested. The MCE Grievance process is further defined in OAR 410-141-3230.
Health Insurance Portability and Accountability Act (HIPAA)	The 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.
Healthcare Common Procedure Coding System (HCPCS)	A method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.
Indirect ownership interest	An ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity.
Managed Care Entity and MCE	An entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and coordinated care organizations (CCO).
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. This includes: • an officer or director of the disclosing entity, if the entity is organized as a corporation; • partner in the disclosing entity, if the entity is organized as a partnership.
Medicaid	A joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by OHA.

Medicare	A federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes: (a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; (b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies; (c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.
Member	A client who is enrolled with Contractor under the Contract. Also known as recipient and beneficiary.
Memorandum of Understanding (MOU)	An agreement between Contractor and a governmental agency or entity where the agency or entity performs Work under the Contract on behalf of or as otherwise requested by Contractor.
Monitor	To determine quality, progress and/or compliance through any or all of the following actions: • Annual compliance reviews • Quarterly reporting • Other contract deliverables
National Correct Coding Initiative (NCCI)	The Centers for Medicare & Medicaid Services (CMS) initiative to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.
Non-participating provider	A provider that does not have a contractual relationship with an MCE and is not on their panel of providers.
Oregon Health Authority (OHA or Authority)	The agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS Chapter 414. The agencies under OHA are the Public Health Division (PHD), Health Systems Division (HSD), External Relations (ER), Health Policy and Analytics (HPA), Fiscal and Operations (FO), Office of Equity and Inclusion (OEI), and the Oregon State Hospital (OSH).

Other disclosing entity	Any other Medicaid disclosing entity and Any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes: • any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII); • any Medicare intermediary or carrier; and • any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.
Overpayment	As set forth in 42 CFR §438.2, overpayment means any payment made to a network provider by an MCE to which the network provider is not entitled under Title XIX of the Act or any payment to an MCE by a state to which the MCE is not entitled to under Title XIX of the Act.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity. Includes interest in: • The capital, the stock, or the profits of the entity, or • Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
Ownership or control interest	A person or corporation who • Has a direct or an indirect ownership interest (or any combination thereof) of 5 percent or more in the entity; • Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, if such interest is equal to or exceeds 5 percent of the total property and assets of the entity; • Is an officer or a director of the entity; • Is a partner in the entity if the entity is organized as a partnership; • Is an agent of the entity; or • Is a managing employee of the entity.
Participating provider	A provider that has a contractual relationship with an MCE and is on their panel of providers.

Payment	The flow of funds from OHA to Contractor.
Provider	An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.
Provider Overpayment	A payment made by the OHA or Contractor to a provider in excess of the correct payment amount for a service.
Provider Termination	The termination of Provider's contract with Contractor, or a prohibition of provider's participation in OHA Health Services Division (HSD) programs as provided by OAR 410-120-0000. Termination means a sanction prohibiting a provider's participation in the Division's programs by canceling the provider's OHA-assigned billing number and agreement. No payments, Title XIX, or state funds will be made for services provided after the date of termination. Termination is permanent unless: (a) The exceptions cited in 42 CFR §1001.221 are met; or (b) Otherwise stated by the OHA at the time of termination.
Recoupment or Recovery	The withholding by OHA of all or a portion of one or more future payments that may be owing to Contractor or a third party to offset amounts that the party owes OHA.
Related Party	An entity that: • provides administrative services or financing to a CCO directly or through one or more unrelated parties; and • is associated with the CCO by any form of affiliation, control or investment.
Relationships to excluded, penalized, or convicted persons	The following relationships as defined in 42 CFR §1001.2: • Immediate family member: a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. • Member of household: any individual with whom a person share a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Risk Accepting Entity	An entity that: • enters into an arrangement or agreement with a coordinated care organization to provide health services to Members of the coordinated care organization; • assumes the financial risk of providing health services to medical assistance recipients; and • is compensated on a prepaid capitated basis for providing health services to Members of a coordinated care organization.
Sanction	An action taken by Contractor against a Provider or Subcontractor, or by the OHA against Contractor, in cases of Fraud, Waste, Abuse, or violation of contractual requirements.
Significant business transaction	Any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 and five percent of a provider’s total operating expenses.
State Medicaid Fraud Control Unit and Medicaid Fraud Control Unit	A unit certified by the HHS Secretary as meeting the criteria of 42 U.S.C. 1396b(q) and CFR 42 §1002.305. For Oregon, this is the Oregon Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU).
Subcontract	(i) a contract that obligates a Subcontractor to perform certain Work that is otherwise required to be performed by Contractor, or (ii) the act of delegating or otherwise assigning certain Work required to be performed by Contractor under this Contract to a Subcontractor.
Subcontractor	Any individual, entity, facility, or organization, other than a participating provider, that has entered into a subcontract with the Contractor or with any subcontractor for any portion of the Work under the Contract.
Suspected fraud, waste or abuse	An incident with any of the characteristics listed in sec. 16 of Ex. B, Part 9 of the Contract, regardless of the Contractor’s own suspicions or lack thereof. Contractor must report all suspected cases of fraud, waste, or abuse, including suspected fraud committed by its employees, providers, subcontractors, members, or any other third parties to OHA’s Program Integrity Audit Unit (PIAU) and MFCU.
Suspension	A sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's OHA-assigned billing number for a specified period of time. No payments, Title XIX, or State funds will be made for services provided during the suspension. The number shall be reactivated automatically after the suspension period has elapsed.

Termination	For a Medicaid or CHIP provider, a state Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For a Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For Medicaid, CHIP and Medicare programs: • there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. • The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. • The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include but is not limited to fraud; integrity; or quality.
Waste	The over-utilization or inappropriate utilization of services and misuse of resources.
Wholly owned supplier	A supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider. Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
Withhold	To designate a portion of a payment from OHA to Contractor to apply toward an amount owed by Contractor to OHA, or to delay all or part of a payment to Contractor under conditions authorized by the Contract.