Glossary of Program Integrity Terminology
2022

Term	Reference	Definition
Abuse	42 CFR § 455.2 OAR 410-120-0000	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	Contract Ex A 42 CFR § 455.101	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	42 CFR §455.102	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	42 CFR § 455.101	Any person who authorized to act on behalf of a provider.
Alternative Payment Methodology	Contract Ex A ORS 414.025	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	Contract Ex A	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	Contract Ex A	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	Contract Ex A	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.
Administrative Performance Penalty or AP Penalty (APP)	Contract Ex A	The dollar amount equal to one percent (1%) of Contractor's adjusted Capitation Payment paid for the Subject Month (including monthly and weekly payments combined for the Subject Month) as described in Exhibit C, Section 8 that will be withheld during the Withhold Month.
Applicable Law(s)	Contract Ex A	All state and federal statutes, rules, regulations, and case law, as may be amended from time to time, applicable to: • a particular issue that is referenced in the Contract, or • the Contract.
Centers for Medicare & Medicaid Services and CMS	Contract Ex A	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	Contract Ex A	The General Provisions together with all Exhibits, Exhibit Attachments, and Referenced Documents as set forth in Sec. 4 of the General Provisions, and any amendments (including restatements) (Contract awarded as a result of RFA OHA-4690-19).
Contract Effective Date	Contract Ex A	The date CCO 2.0 became effective, was October 01, 2019, and as identified in sec. 1 of the General Provisions of the Contract.
Contract Year	Contract Ex A	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	Contract Ex A	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	Contract Ex B, Part 4(6)(g)	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)	Contract Ex A OAR 410-141-3500	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 (CAP)	Contract Ex A OAR 410-141-3500	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	Contract Ex B, Part 4 OAR 410-141-3510	MCE selection of providers using universal application and credentialing procedures and objective quality information. MCEs must accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application. MCEs must take steps to remove providers from their provider network if they fail to meet objective quality standards. MCE must ensure that all participating providers providing coordinated care services to Members are credentialed upon initial contract with the MCE and re-credentialed no less frequently than every three years. • The credentialing and re-credentialing process must include review of any information in the National Practitioners Databank.

		• MCE must 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. • MCE must 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 (PPACA) sec. 6402, 42 CFR§ 438.214, 42 CFR §455.400-455.470 (excluding §455.460), OAR 410-141-3510 and Exhibit G of the Contract, except as provided in para. b, of sec, 5, 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, the MCE must not execute any contract with such Providers unless the Provider has been approved for enrollment by OHA. OHA is responsible for performing site visits for such "moderate" or "high" risk Providers and for ensuring that such "high" risk Providers have undergone a fingerprint-based background checks. For a Provider who is actively enrolled in Medicare and has undergone a fingerprint-based background check as part of Medicare enrollment, OHA deems this Provider to have satisfied the same background check requirement for OHA Provider Enrollment.
Credible allegation of fraud	42 CFR § 455.2	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: • Fraud hotline complaints. • Claims data mining. • 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 must notify OHA's Office of Program Integrity (OPI) or MFCU of any suspected cases of fraud, waste, or abuse (FWA) within 7-days of identification of the issue. OHA will work with other stakeholders to investigate any allegations and will determine, in coordination with MFCU, the appropriate action to take.
Delegate	Contract Ex A	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	42 CFR §455.101	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	42 CFR § 455.101	A Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.
Encounter data	Contract Ex A OAR 410-141-3570	Information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a Managed Care Entity (MCE) that is subject to the requirements of 438.242 and 438.818. The information that the Contractor must submit to OHA under OAR 410-141-3570 and related to services that were provided to Members regardless of whether the services provided: • were Covered Services or non-covered services, (excluding Health-Related services); • were not paid for;

		• paid for on a Fee-For-Service (FFS) or capitated basis; • were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor; and • were performed pursuant to Subcontractor agreement, special arrangement with a facility or program; or other arrangement.
Entity	OAR 410-141-3500	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	Contract Ex A	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.
Excluded Providers	42 CFR § 455.2 Contract Ex B, Part 4	MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. This means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.
False claim	Contract Ex A OAR 410-120-0000	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)	Contract Ex A	A method in which doctors and other health care providers are paid for each service performed.
Fiscal agent	42 CFR § 455.101	A contractor that processes or pays vendor claims on behalf of the Medicaid agency.
Fraud	Contract Ex A	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	Contract Ex A	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	Contract Ex A ORS 414.572	The Contractor's governing body that meets the requirements of ORS 414.572.
Grievance	42 CFR § 438.400 OAR 410-141-3875	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 410-141-3875.
Health Insurance Portability and Accountability Act (HIPAA)	OAR 410-120-0000	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)	OAR 410-120-0000	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	42 CFR § 455.101	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	OAR 410-141-3500	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	42 CFR § 455.101	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	OAR 410-120-0000	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	OAR 410-120-0000	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	Contract Ex A	A client who is enrolled with Contractor under the Contract.
Memorandum of Understanding (MOU)	Contract Ex A	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	Contract Ex A	• to observe and check the progress or quality of something, • to undertake some acts over a period of time, • to otherwise engage in activities, or • any combination, or all, of the foregoing, which enables the party or persons undertaking such observations, acts, or activities to determine the quality, progress, or compliance (or

		any and all combination thereof) of the activities that are subject to observation, acts, or activities.
National Correct Coding Initiative (NCCI)	Contract Ex A OAR 410-120-0000	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	OAR 410-141-3500	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)	OAR 410-120-0000	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	42 CFR § 455.101	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	42 CFR §438.2	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	42 CFR § 455.101	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	42 CFR § 455.101	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	OAR 410-141-3500	A provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.
Payment	Contract Ex A	The flow of funds from OHA to Contractor.
Program Integrity Audit (PI Audit)	Contract Ex A	The review of Medicaid claims for suspicious aberrancies to establish evidence that fraud, waste, or abuse has occurred, is likely to occur, or whether actions of individuals or entities have the potential for resulting in an expenditure of Medicaid funds which is not intended under the provisions of this Contract, State or Federal Medicaid regulations, and whether improper payment has occurred.
Prohibited Affiliations	42 CFR § 438.610	As provided in 42 CFR § 438.610, an MCE may not knowingly have a relationship of the type described in paragraph (c) of this section with the following: (1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

		(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section. (b) An MCE may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act. (c) The relationships described in paragraph (a) of this section, are as follows: (1) A director, officer, or partner of the MCE. (2) A subcontractor of the MCE, as governed by 42 CFR § 438.230. (3) A person with beneficial ownership of 5 percent or more of the MCE's equity. (4) A network provider or person with an employment, consulting or other arrangement with the MCE for the provision of items and services that are significant and material to the MCE's obligations under its contract with the State.
Provider	OAR 410-141-3500 Contract Ex A	An individual, facility, institution, corporate entity, or other organization that: • Is engaged in the delivery of services or items or ordering or referring for those services or items; • Bills, obligates, and receives reimbursement from the Authority's Health Systems Division on behalf of a Provider, (also termed a "Billing Provider); or • Supplies health services or items (also termed a "Rendering Provider").
Provider Overpayment	Contract Ex A	A payment made by the OHA or Contractor to a provider in excess of the correct payment amount for a service.
Provider Termination	OAR 410-120-0000	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	Contract Ex A	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	Contract Ex A	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	42 CFR §455.3 42 CFR §1002 42 CFR §1001.2	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	Contract Ex A	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	Contract Ex A	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	42 CFR §455.101	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	42 CFR §1002.3	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	Contract Ex A	(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	Contract Ex A OAR 410-141-3500	An individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.
Suspected fraud, waste or abuse	Contract Ex B, Part 9 (17)	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 Office of Program Integrity (OPI) and MFCU.
Suspension	OAR 410-120-0000	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	OAR 410-120-0000	For a Medicaid or CHIP provider, a state Medicaid agency 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	Contract Ex A	The over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.
Wholly owned supplier	42 CFR § 455.101	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	Contract Ex A	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.