



ADMINISTRATIVE RULES OF MONTANA



37.86.5001 HEALTH MAINTENANCE ORGANIZATIONS: DEFINITIONS

- (1) "Administrative contractor for managed care" means the entity the department contracts with to perform certain administrative functions of the managed health care programs.
- (2) "Basic medicaid" means the program of medicaid services for adults receiving medical assistance through the FAIM program who are 21 years and older and not pregnant. Basic medicaid excludes coverage for dental services, most durable medical equipment and supplies, eye examinations, eyeglasses, hearing aids, audiology services, and personal care services.
- (3) "Capitation rate" means the fee the department pays monthly to an HMO for the provision of covered medical and health services to each enrolled recipient. The fee is reimbursed whether or not the enrolled recipient received services during the month for which the fee is intended. The fee may vary by age, eligibility category and region.
- (4) "Community-based organizations" means local governmental and nonprofit organizations providing programs of preventive and other health related services. Community-based organizations include but are not limited to: local family planning services; local women, infants and children (WIC) projects; local projects of Montana initiative for the abatement of mortality of infants (MIAMI) ; HIV testing, partner notification and early intervention; childhood lead poisoning prevention services; cherish our Indian children; follow me programs for special needs children.
- (5) "Complaint" means an informal, verbal communication which an enrollee or their authorized representative presents regarding what the enrollee or their authorized representative perceives to be an inappropriate or lack of appropriate action by the HMO or any of its providers.
- (6) "Contract" means a contract between the department and an HMO for the provision of medical and health services to medicaid recipients.
- (7) "County office" means the location people go to apply for medicaid benefits that is either the department's local office of human services or the human services or welfare office of a county.
- (8) "Covered services" means all or a part of the medical and health services set forth in ARM 37.86.5007 that an HMO is responsible for delivering to enrolled recipients under a contract with the department.
- (9) "Day" means calendar days, except where the term working days or business days is expressly used.
- (10) "Department" means the Montana department of public health and human services.
- (11) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an

average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (a) 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;
 - (b) serious impairment to bodily functions; or
 - (c) serious dysfunction of any bodily organ or part.
- (12) "Emergency room screens" means a medical screening examination within the capacity of the hospital's emergency department, including stabilization when necessary, to determine whether an emergency medical condition exists.
- (13) "Emergency services" means, as defined at ARM 37.82.102, inpatient and outpatient hospital services that are necessary to treat an emergency medical condition.
- (14) "Enrollee" means a medicaid recipient who has been certified by the department as eligible to enroll with an HMO, and whose name appears on the HMO's enrollment information that the administrative contractor for managed care transmits to the HMO every month as specified in the contract.
- (15) "Enrollment area" means the county or counties that an HMO's certificate of authority from the state of Montana permits it to serve and in which the HMO has service capability as required by the department and set forth in the contract. If a proposed enrollment area is other than an entire county or counties, the proposed enrollment area should correspond to the normal service delivery area.
- (16) "Exempt" means medicaid recipients who are not ineligible for managed care and who can prove it would be a hardship to participate in a managed care program. The department has the discretion to determine hardship and to place time limits on all exemptions on a case by case basis.
- (17) "Families achieving independence in Montana (FAIM) " is a comprehensive welfare reform package. Participation in FAIM affects medicaid coverage for able-bodied adults 21 years and older. FAIM participants who are 21 years and older and not pregnant:
- (a) are only eligible for basic medicaid;
 - (b) are required to enroll in an HMO if one is available in their area. If there is no HMO available, they must enroll in the passport to health program. If there is neither a passport to health program nor an HMO available, recipients stay on regular fee-for-service medicaid.
- (18) "Federally qualified HMO" means an HMO qualified under section 1315(a) of the Public Health Service Act as determined by the U.S. public health service.
- (19) "Full medicaid" means the full scope of medicaid benefits as defined in ARM 37.85.206.
- (20) "Grievance" means a formal, written communication which an enrollee or their authorized representative presents regarding what the enrollee or their authorized representative perceives to be an inappropriate action or lack of appropriate action by the HMO or its providers.
- (21) "Health maintenance organization (HMO) " means a health maintenance organization or its parent corporation with a certificate of authority issued in accordance with 33-31-201 , et seq., MCA.

- (22) "Ineligible" means medicaid recipients who are not allowed by the department to be under managed care and who must stay on regular medicaid. The following categories of recipients are ineligible:
- (a) recipients with a spend down (medically needy) ;
 - (b) recipients living in a nursing home or institutional setting;
 - (c) recipients receiving medicaid for less than 3 months;
 - (d) recipients on the medicaid restricted card program;
 - (e) recipients who have medicare;
 - (f) recipients who live in an area without medicaid managed care;
 - (g) recipients in the medicaid eligibility subgroup of subsidized adoption;
 - (h) recipients whose eligibility period is only retroactive;
 - (i) recipients who cannot find a primary care provider who is willing to provide case management;
 - (j) recipients who are receiving medicaid home and community services for persons who are aged or disabled; and
 - (k) recipients who reside in a county in which there are not enough primary care providers to serve the medicaid population required to participate in the program.
- (23) "Managed health care provider" means any one of the alternative systems for delivery of regular fee-for-service medicaid services. Managed health care provider includes health maintenance organizations (HMOs) and primary care case management programs.
- (24) "Participating provider" means any person or entity that has entered into a contract with an HMO to provide medical care.
- (25) "Primary care provider" means a physician, clinic, or mid-level practitioner other than a certified registered nurse anesthetist that is responsible by contract to serve an HMO's enrollees that has been designated by an enrollee as the provider through whom the enrollee obtains health care benefits provided by the HMO. A primary care provider attends to an enrollee's routine medical care, supervises and coordinates all of the enrollee's health care, determines the need for and initiates all referrals, determines the provider of medical services and determines the medical necessity of the medical services to be performed. Obstetrician or gynecologist means a physician who is board eligible or board certified by the American board of obstetrics and gynecology.
- (26) "Recipient" means a person who is eligible for medicaid in accordance with the legal authorities governing eligibility.
- (27) "Regular medicaid" means the program of medicaid services for medicaid recipients that would have been available to an enrollee if the enrollee were not enrolled in an HMO.
- (28) "Routine care" means medical care for a condition that is not likely to substantially worsen in the absence of immediate medical intervention and is not an urgent condition or an emergency. Routine care can be provided through regularly scheduled appointments without risk of permanent damage to the person's health status.
- (29) "School based provider" means a provider that provides services in a school setting.

- (30) "Upper payment limit" means the cost to the department of providing the same services to an actuarially equivalent non-enrolled population.
- (31) "Urgent care" means medical care necessary for a condition that is not life threatening but which requires treatment that cannot wait for a regularly scheduled clinical appointment because of the prospect of the condition worsening without timely medical intervention.
- (32) "Usual manner" means obtaining medicaid benefits in the manner that medicaid recipients obtain them through the regular medicaid program.

Authorizing statute(s): Sec. 53-2-201 and 53-6-113, MCA

Implementing statute(s): Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

History: NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.