Senate Bill 1065

Sponsored by Senator MORRISETTE (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires prepaid managed care health services organization that contracts with Department of Human Services to report to department all claims paid to rural health clinics for services provided to Medicaid-eligible enrollees in organization. Requires department to pay clinics difference between rate paid by organization and clinic rate prescribed by department by rule.

Permits exchange of Oregon Health Plan patient's protected health information between state health plan, prepaid managed care health services organization and rural health clinic when organization or clinic is providing health care services to patient.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care services; creating new provisions; amending ORS 192.527 and 414.725; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 414.725 is amended to read:

414.725. (1)(a) Pursuant to rules adopted by the Department of Human Services, the department shall execute prepaid managed care health services contracts for health services funded by the Legislative Assembly. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the department shall establish timelines for executing the contracts described in this paragraph.

(b) It is the intent of ORS 414.705 to 414.750 that the state use, to the greatest extent possible, prepaid managed care health services organizations to provide physical health, dental, mental health and chemical dependency services under ORS 414.705 to 414.750.

(c) The department shall solicit qualified providers or plans to be reimbursed for providing the covered services. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private prepaid managed care health services organization. The department may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.

(d) The department shall establish annual financial reporting requirements for prepaid managed care health services organizations. The department shall prescribe a reporting procedure that elicits sufficiently detailed information for the department to assess the financial condition of each prepaid managed care health services organization and that includes information on the three highest executive salary and benefit packages of each prepaid managed care health services organization.

(e) The department shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with a prepaid managed care health services organization.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(f)(A) A prepaid managed care health services organization that contracts with the department must report, within 30 days, all claims that the prepaid managed care health services organization has paid to a rural health clinic for services provided to a person eligible for health services under ORS 414.705 to 414.750. The department shall by rule prescribe the form of the report. Within 45 days of the department's receipt of a report, the department shall pay to a clinic identified in the report the difference between the rate paid to the clinic by the prepaid managed care health services organization and the rate adopted by the department by rule for the service when provided by a clinic.

(B) If the department is unable to calculate the amount of the payment due to the clinic within 45 days of receiving the report from the prepaid managed care health services organization, the department shall pay the full amount of the clinic's claim. The department shall offset one or more subsequent payments to the clinic by the amount of any overpayment or underpayment resulting from the application of this subparagraph.

(C) "Rural health clinic," as used in this paragraph, shall be defined by the department by rule and shall be consistent with the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The department may institute a fee-for-service case management system or a fee-for-service payment system for the same physical health, dental, mental health or chemical dependency services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state in which a prepaid managed care health services organization is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee. In addition, the department may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the department for health services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for health services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A prepaid managed care health services organization shall provide information on contacting available providers to an enrollee in writing within 30 days of assignment to the health services organization.

(7) Each prepaid managed care health services organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to enrollees.

(8) A prepaid managed care health services organization may not limit enrollment in a desig-

nated area based on the zip code of an enrollee or prospective enrollee.

SECTION 2. ORS 192.527 is amended to read:

192.527. (1) Notwithstanding ORS 179.505, a state health plan**, a rural health clinic** or a prepaid managed care health services organization may [*disclose*] **exchange** the protected health information of an individual listed in subsection (2) of this section, without obtaining an authorization from the individual or a personal representative of the individual, [*to another prepaid managed care health services organization*] for treatment activities of a prepaid managed care health services organization **or rural health clinic** when the prepaid managed care health services organization **or rural health clinic** is providing behavioral or physical health care services to the individual.

(2) The protected health information that may be [*disclosed*] **exchanged** pursuant to subsection (1) of this section includes the following, as defined by the Department of Human Services by rule:

(a) Oregon Health Plan member name;

(b) Medicaid recipient number;

(c) Performing provider number;

(d) Hospital provider name;

(e) Attending physician;

(f) Diagnosis;

(g) Date or dates of service;

(h) Procedure code;

(i) Revenue code;

(j) Quantity of units of service provided; or

(k) Medication prescription and monitoring.

(3) As used in this section[,]**:**

(a) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.736.

(b) "Rural health clinic" has the meaning given that term in ORS 414.725.

SECTION 3. The amendments to ORS 414.725 by section 1 of this 2008 Act apply to claims billed by a rural health clinic to a prepaid managed care health services organization on or after the effective date of this 2008 Act.

SECTION 4. This 2008 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2008 Act takes effect on its passage.