House Bill 2832

Sponsored by Representative MAURER

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.**

Changes definition of type B hospital for purposes of reimbursement rates in medical assistance program. Requires hospital to have five-year average operating margin of five percent or less to be designated as type B hospital. Requires Department of Human Services in consultation with Office for Oregon Health Policy and Research to prescribe methodology by rule for determining five-year average operating margin.

A BILL FOR AN ACT

Relating to Medicaid reimbursement of type B hospitals; creating new provisions; and amending ORS 414.025, 414.727, 414.728 and 414.743.

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

SECTION 1. ORS 414.025, as amended by section 18a, chapter 861, Oregon Laws 2007, is amended to read:

414.025. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

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.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with mental retardation; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(L) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

(m) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(n) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(o) Is an individual or member of a group who, subject to the rules of the department and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(p) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(q) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(r) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

(s) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

(3) "Income" has the meaning given that term in ORS 411.704.

(4) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the Department of Human Services may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Department of Human Services according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical

care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;

(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(n) Other diagnostic, screening, preventive and rehabilitative services;

(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(p) Any other medical care, and any other type of remedial care recognized under state law;

(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and

(s) Hospice services.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

(9) "Rural critical access hospital" has the meaning given that term in ORS 315.613.

(10) "Type A hospital" has the meaning given that term in ORS 442.470.

(11) "Type B hospital" means a hospital that:

(a) Is small and rural according to standards established by the Office of Rural Health;

(b) Was not designated by the federal government as a rural referral hospital before January 1, 1989; and

(c) Has a five-year average operating margin of five percent or less according to meth-

odologies prescribed by the department by rule in consultation with the Office for Oregon Health Policy and Research.

SECTION 2. ORS 414.727 is amended to read:

414.727. (1) A prepaid managed care health services organization, as defined in ORS 414.736, that contracts with the Department of Human Services under ORS 414.725 (1) to provide prepaid managed care health services, including hospital services, shall reimburse Type A and Type B hospitals and rural critical access hospitals[*, as described in ORS 442.470 and identified by the Office of Rural Health as rural hospitals,*] fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the capitation rates paid to the prepaid managed care health services organization for the contract period.

(2) The department shall base the capitation rates described in subsection (1) of this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(3) This section may not be construed to prohibit a prepaid managed care health services organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in subsection (1) of this section.

(4) Hospitals reimbursed under subsection (1) of this section are not entitled to any additional reimbursement for services provided.

SECTION 3. ORS 414.728 is amended to read:

414.728. For services provided to persons who are entitled to receive medical assistance and whose medical assistance benefits are not administered by a prepaid managed care health services organization, as defined in ORS 414.736, the Department of Human Services shall reimburse Type A and Type B hospitals and rural critical access hospitals[*, as described in ORS 442.470 and identified by the Office of Rural Health as rural hospitals,*] fully for the cost of covered services based on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

SECTION 4. ORS 414.743 is amended to read:

414.743. (1) As used in this section, "fully capitated health plan" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that all health services described in ORS 414.705 are reasonably accessible to enrollees.

(2) A fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must pay for hospital services at 80 percent of the Medicare rate for the noncontracting hospital.

(3) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full the rates described in subsection (2) of this section.

(4) This section does not apply to type A and type B hospitals[*, as described in ORS 442.470,*] and rural critical access hospitals[*, as defined in ORS 315.613*].

(5) The Department of Human Services shall adopt rules to implement and administer this section.

SECTION 5. ORS 414.743, as amended by section 2, chapter 886, Oregon Laws 2007, is amended to read:

414.743. (1) As used in this section, "fully capitated health plan" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725

to provide an adequate network of providers to ensure that all health services described in ORS 414.705 are reasonably accessible to enrollees.

(2) A fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must pay for hospital services as follows:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(3) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full for hospital services, rates:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(4) This section does not apply to type A and type B hospitals[*, as described in ORS 442.470,*] and rural critical access hospitals[*, as defined in ORS 315.613*].

(5) The Department of Human Services shall adopt rules to implement and administer this section.

SECTION 6. The amendments to ORS 414.025, 414.727, 414.728 and 414.743 by sections 1 to 5 of this 2009 Act apply to contracts or agreements between the Department of Human Services and hospitals, that are entered into or renewed on or after the effective date of this 2009 Act.
