FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: SB 239**
Seventy-Sixth Oregon Legislative Assembly – 2011 Regular Session
Legislative Fiscal Office

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Measure Description:
Requires the Oregon Health Authority (OHA) to reimburse a hospital for the full cost of hospital services that are provided to a recipient of medical assistance if the hospital is designated by the Office of Rural Health as (1) a rural critical access hospital; (2) a type A or B hospital and the hospital had an overall net profit of less than five percent for the preceding year. Requires the Office of Rural Health to designate and reassess at least once every five years a hospital as a type A, type B, type C or rural critical access hospital.

Government Unit(s) Affected:
Oregon Health Authority (OHA), Oregon Health Science University (OHSU)

Expenditure Impact:
See Analysis

Local Government Mandate:
This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

Analysis:
SB 239 requires the Office of Rural Health to designate and reassess at least once every five years a hospital as a type A, type B, type C or rural critical access hospital. The bill directs the Oregon Health Authority (OHA) to reimburse a hospital for the full cost of hospital services that are provided to a recipient of medical assistance if the hospital is designated by the Office of Rural Health as (1) a rural critical access hospital; (2) a type A or B hospital and the hospital had an overall net profit of less than five percent for the preceding year.

Office of Rural Health, Oregon Health Science University (OHSU)
SB 239 requires the Office of Rural Health to designate and reassess at least once every five years a hospital as a type A, type B, type C or rural critical access hospital. A type A hospital is a small and remote hospital that has 50 or fewer beds and is more than 30 miles from another acute inpatient care facility. A type B hospital is a small and rural hospital that has 50 or fewer beds and is 30 miles or less from another acute inpatient care facility. A type C hospital is considered to be a rural hospital and has more than 50 beds, but is not a referral center. A rural critical access hospital is a facility that meets the criteria set forth in 42 U.S.C. 1395i-4 (c)(2)(B) and that has been designated a critical access hospital by the Office of Rural Health and the Oregon Health Authority. OHSU estimates the cost of this work to be minimal. Assuming the review of 25 existing rural facilities over the course of five years, the agency anticipates using existing staff and resources to perform these reviews.

Note that OHSU is a semi-independent agency not subject to the state’s budgetary process. Funds for OHSU are appropriated to the Department of Administrative Services to pass through to OHSU.

Oregon Health Authority (OHA)
SB 239 requires the Oregon Health Authority (OHA) to reimburse a hospital for the full cost of hospital services that are provided to a recipient of medical assistance if the hospital is designated by the Office

of Rural Health as (1) a rural critical access hospital; (2) a type A or B hospital and the hospital had an overall net profit of less than five percent for the preceding year. OHA is directed to adopt by rule a formula for determining overall net profit based on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services, excluding capital items. Hospital services administered by prepaid managed care health services organizations are exempt from the requirements of this bill.

With passage of this bill, if a qualifying type A or B Hospital has an overall net profit margin of five percent or greater, in the year prior to the review, the state would no longer be required to reimburse that hospital at the full cost of qualifying inpatient or outpatient services. Variable factors that make it difficult to estimate the potential cost savings include: (1) uncertainty in predicting profitability of affected hospitals; and (2) payment differential between 100% cost and Diagnosis Related Group (DRG) varies significantly by procedure and by hospital. Although a reliable estimate is not possible at this time due to the aforementioned factors, OHA cautiously anticipates between $1.5 and $8.8 million in potential savings.