77th OREGON LEGISLATIVE ASSEMBLY – 2013 Regular Session **MEASURE: SB 724 C**
STAFF MEASURE SUMMARY **CARRIER: Rep. Clem**
House Committee on Rules

REVENUE: No revenue impact
FISCAL: Minimal fiscal impact, no statement issued

Action:		Do Pass as Amended and Be Printed Engrossed
Vote:		8 - 0 - 1
	Yeas:	Barnhart, Berger, Dembrow, Hicks, Holvey, Jenson, Kennemer, Garrett
	Nays:	0
	Exc.:	Hoyle
Prepared By:		Erin Seiler, Administrator
Meeting Dates:		6/6

WHAT THE MEASURE DOES: Requires Oregon Health Authority (OHA) develop account method for innovative, nontraditional services by August 1, 2013. Directs OHA or Department of Human Services (DHS) provide Coordinated Care Organizations (CCOs) statement of their costs when transferring those service responsibilities to CCOs. If CCOs assume cost of service, OHA or DHS shall report to Legislative Assembly no later than February 1 of following year. Requires payments from insurers to pay ambulatory surgical centers directly, or to patient with dual-issued check, made jointly to both ASC and patient. Applies to payments on or after January 1, 2014. Declares emergency, effective on passage.

ISSUES DISCUSSED:
- Amendments

EFFECT OF COMMITTEE AMENDMENT: Allows insurers to pay ambulatory surgical centers directly, or to patient with dual-issued check.

BACKGROUND: Under the current Coordinated Care Organizations (CCOs) model, each CCO is paid a per member lump sum to account for physical and mental health care for Oregon's Medicaid population. The current Centers for Medicare and Medicaid Services (CMS) waiver does not allow moneys to be spent on "non-medical" services or supplies. With this restriction, the CCOs are responsible for paying for flexible services out of their "other funds." Senate Bill 724-C creates a method to pay CCOs for non-medical, innovative health services that are not currently covered by Medicaid dollars.

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures in independent facilities apart from hospitals. Proponents assert that certain insurers will not pay out of network ASCs directly, but rather send a check directly to the patient which is also made out solely to that patient. This practice allows patients to retain funds which should have been remitted to the ASCs as payment for services provided. Senate Bill 724-C requires reimbursement checks to pay ASCs directly, or to patient with dual issued check, made jointly to both the ASC and the patient.