B-Engrossed
Senate Bill 724

Ordered by the House May 31
Including Senate Amendments dated April 19 and House Amendments dated May 31

Sponsored by Senator BATES; Representatives CLEM, FREEMAN

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.

Requires Oregon Health Authority to establish method for accounting for coordinated care organization's costs in providing innovative, nontraditional health services. Requires authority and Department of Human Services to provide statement of costs when authority or department requires organization to assume responsibility for providing additional health services.

Specifies requirements for insurer or third party administrator's reimbursement of ambulatory surgical center costs.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to payments for health services; creating new provisions; amending ORS 414.065; and declaring an emergency.

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

SECTION 1. ORS 414.065, as amended by section 19, chapter 8, Oregon Laws 2012, is amended to read:

414.065. (1)(a) With respect to health care and services to be provided in medical assistance during any period, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and subject to legislative funding and paragraph (b) of this subsection:

(A) The types and extent of health care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards, including outcome and quality measures, to be observed in the provision of health care and services.

(C) The number of days of health care and services toward the cost of which public assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health care or services.

(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of health care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available

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.

therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of health care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all health care and services for which such payments of medical assistance were made.

(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

(5) In determining a global budget for a coordinated care organization:

(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization; [*and*]

(b) The authority shall consider the community health assessment conducted by the organization and reviewed annually, and the organization's health care costs[.]**; and**

(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

(6) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

(a) To support improved delivery of health care to recipients of medical assistance; and

(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

SECTION 2. In consultation with coordinated care organizations, the Oregon Health Authority shall, not later than August 1, 2013, develop a method for accounting for the provision of innovative, nontraditional health services in determining a global budget for a coordinated care organization.

SECTION 3. Section 4 of this 2013 Act is added to and made a part of ORS chapter 414.

SECTION 4. (1) If the Oregon Health Authority or the Department of Human Services requires a coordinated care organization to provide a service, paid for out of the organization's global budget, that was previously reimbursed by the authority or the department on a fee-for-service basis, the authority or the department must provide the organization with a statement of the costs incurred by the authority or the department in reimbursing the service during the three-year period prior to the organization's assumption of the cost of the service.

(2) If the authority or the department requires a coordinated care organization to assume the cost of a service as described in subsection (1) of this section, the authority or the department shall report to the Legislative Assembly, not later than February 1 of the following year, a statement of the increased cost to the coordinated care organization of providing the service, calculated as the average annual cost incurred by the authority or the department in reimbursing the service during the three-year period prior to the organization's assumption of the cost of the service.

SECTION 5. Section 6 of this 2013 Act is added to and made a part of the Insurance Code.

SECTION 6. (1) As used in this section, "ambulatory surgical center" has the meaning given that term in ORS 442.015.

(2) An insurer or a third party administrator for a self-insured plan shall reimburse an

out-of-network ambulatory surgical center for a service covered under a policy or certificate of health insurance by issuing a check made payable to both the center and to the insured or beneficiary who received the service or, if the insured or beneficiary who received the service is a dependent, to the policyholder or certificate holder. The insurer or administrator shall pay the center the reimbursement amount allowed under the terms of the policy or certificate.

SECTION 7. The amendments to ORS 414.065 by section 1 of this 2013 Act become operative July 1, 2013.

SECTION 8. Section 2 of this 2013 Act is repealed January 2, 2014.

SECTION 9. Section 6 of this 2013 Act applies to payments made on claims presented on or after January 1, 2014.

SECTION 10. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.