Senate Bill 430

Sponsored by Senator MANNING JR (at the request of Dan Cushing - Coalition for Healthy Oregon) (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.

Caps at Medicaid fee-for-service rates reimbursement paid by coordinated care organizations to noncontracted health care providers for health services provided to coordinated care organization members.

A BILL FOR AN ACT

Relating to health services provided to members of coordinated care organizations; amending ORS 414.743.

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

SECTION 1. ORS 414.743 is amended to read:

414.743. (1) Except as provided in subsection (2) of this section, a coordinated care organization that does not have a contract with a hospital to provide inpatient or outpatient hospital services under [ORS 414.591, 414.631 and 414.688 to 414.745] this chapter must, using Medicare payment methodology, reimburse the noncontracting hospital for services provided to a member of the organization at a rate no less than a percentage of the Medicare reimbursement rate for those services. The percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under this subsection is equal to four percentage points less than the percentage of Medicare cost used by the Oregon Health Authority in calculating the base hospital capitation payment to the organization, excluding any supplemental payments.

(2)(a) If a coordinated care organization does not have a contract with a hospital, and the hospital provides less than 10 percent of the hospital admissions and outpatient hospital services to members of the organization, the percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under subsection (1) of this section is equal to two percentage points less than the percentage of Medicare cost used by the Oregon Health Authority in calculating the base hospital capitation payment to the organization, excluding any supplemental payments.

(b) This subsection is not intended to discourage a coordinated care organization and a hospital from entering into a contract and is intended to apply to hospitals that provide primarily, but not exclusively, specialty and emergency care to members of the organization.

(3) Except as provided in subsections (1) and (2) of this section:

(a) A health care provider that does not have a contract with a coordinated care organization may not bill the coordinated care organization for a health service provided to a member of the coordinated care organization in an amount that exceeds the fee-for-service rate for the service established by the authority under ORS 414.065.

(b) A coordinated care organization that does not have a contract with a health care provider may not reimburse the provider for a health service provided to a member of the

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.

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coordinated care organization in an amount that exceeds the fee-for-service rate for the
service established by the authority under ORS 414.065.

(3) A hospital or health care provider that does not have a contract with a coordinated
care organization to provide inpatient or outpatient hospital services under ORS 414.591, 414.631 and
414.688 to 414.745 health services must accept as payment in full for hospital the services the
rates described in subsections (1) and (2) to (3) 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 442.470.

(5) The Oregon Health Authority shall adopt rules to implement and administer this section.