75th OREGON LEGISLATIVE ASSEMBLY - 2009 Regular Session **MEASURE: SB 37 A**
STAFF MEASURE SUMMARY **CARRIER: Sen. Morrisette**
Senate Committee on Human Services & Rural Health Policy **Sen. Kruse**

REVENUE: No revenue impact
FISCAL: Fiscal statement issued

Action:		Do Pass as Amended and Be Printed Engrossed
Vote:		4 - 1 - 0
	Yeas:	Kruse, Telfer, Verger, Morrisette
	Nays:	Monnes Anderson
	Exc.:	0
Prepared By:		Jennifer Kellar, Administrator
Meeting Dates:		1/21, 3/4, 4/8, 4/13

WHAT THE MEASURE DOES: Requires the Department of Human Services to adopt rules and procedures to ensure that payments made by the department to rural health clinics (RHCs) to cover the difference between what the clinic receives from the plan and from other insurers is not less than the amount that would be received under the department's fee-for-service payment system. Requires the agency to reimburse rural health clinics within 45 days of receiving a claim. Applies to claims billed by a rural health clinic to a prepaid managed health care services organization on or after May 17, 2011.

ISSUES DISCUSSED:

- Reimbursement payments to RHCs see a delay in payment up to a nine month period
- Division of Medical Assistance Programs (DMAP) would need procedures revised to comply with measure
- DMAP could pay estimated reconciliation payments to RHCs within 45 days to comply with measure and do a final reconciliation later, which could take up to one year
- Concern with estimate reimbursements leading to over or underpayments to RHCs
- Significant increase in noted expenditures from initial committee hearing by agency
- Impact if emergency clause in measure deleted

EFFECT OF COMMITTEE AMENDMENT: Removes emergency clause. Modifies date that the measure applies to claims billed by a rural health clinic to a prepaid managed care health services organization from on or before January 2, 2010 to on or before May 17, 2011.

BACKGROUND: The Division of Medical Assistance Programs (DMAP) is required by 42 USC 1396a(bb) to make supplemental payments to rural health clinics at least every four months for services they provide to managed care plan enrollees. The supplemental payments represent the difference, if any, between the payment received by the rural health clinic from the managed care plan, and all other payers, and the payment the clinic would have received through the division's fee-for-service payment system. Senate Bill 37-A requires the division to make those supplemental payments within 45 days of receiving a completed billing form.

Currently, DMAP processes supplemental payments quarterly and up to nine months in arrears. A clinic submits data no earlier than six months from the end of the reported quarter. The time lag is to ensure all other payers have reimbursed the rural health clinics before the division provides the final payment. It also complies with encounter submission requirements in the contracts with managed care plans. DMAP currently provides expedited reimbursements to six federally-qualified health centers and two rural health clinics. The division provides an interim payment by allowing these providers to submit their claims 60 days after the end of the month. The division then reimburses the clinics within 30 days.