

A-Engrossed
Senate Bill 37

Ordered by the Senate April 20
Including Senate Amendments dated April 20

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Senior and Disabled Services)

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 Department of Human Services to ensure that rural health clinics receive full reimbursement within 45 days for health services provided to persons enrolled in prepaid managed care health services organizations.

[Declares emergency, effective on passage.]

A BILL FOR AN ACT

1
2 Relating to payment for health care services; creating new provisions; and amending ORS 414.725.

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

4 **SECTION 1.** ORS 414.725 is amended to read:

5 414.725. (1)(a) Pursuant to rules adopted by the Department of Human Services, the department
6 shall execute prepaid managed care health services contracts for health services funded by the
7 Legislative Assembly. The contract must require that all services are provided to the extent and
8 scope of the Health Services Commission's report for each service provided under the contract. The
9 contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and
10 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the department shall establish
11 timelines for executing the contracts described in this paragraph.

12 (b) It is the intent of ORS 414.705 to 414.750 that the state use, to the greatest extent possible,
13 prepaid managed care health services organizations to provide physical health, dental, mental health
14 and chemical dependency services under ORS 414.705 to 414.750.

15 (c) The department shall solicit qualified providers or plans to be reimbursed for providing the
16 covered services. The contracts may be with hospitals and medical organizations, health mainte-
17 nance organizations, managed health care plans and any other qualified public or private prepaid
18 managed care health services organization. The department may not discriminate against any con-
19 tractors that offer services within their providers' lawful scopes of practice.

20 (d) The department shall establish annual financial reporting requirements for prepaid managed
21 care health services organizations. The department shall prescribe a reporting procedure that elicits
22 sufficiently detailed information for the department to assess the financial condition of each prepaid
23 managed care health services organization and that includes information on the three highest
24 executive salary and benefit packages of each prepaid managed care health services organization.

25 (e) The department shall require compliance with the provisions of paragraph (d) of this sub-
26 section as a condition of entering into a contract with a prepaid managed care health services or-

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.

1 ganization.

2 **(f)(A) The department shall adopt rules and procedures to ensure that a rural health**
 3 **clinic that provides a health service to an enrollee of a prepaid managed care health services**
 4 **organization receives total aggregate payments from the organization, other payers on the**
 5 **claim and the department that are no less than the amount the rural health clinic would**
 6 **receive in the department's fee-for-service payment system. The department shall issue a**
 7 **payment to the rural health clinic in accordance with this subsection within 45 days of re-**
 8 **ceipt by the department of a completed billing form.**

9 **(B) "Rural health clinic," as used in this paragraph, shall be defined by the department**
 10 **by rule and shall conform, as far as practicable or applicable in this state, to the definition**
 11 **of that term in 42 U.S.C. 1395x(aa)(2).**

12 (2) The department may institute a fee-for-service case management system or a fee-for-service
 13 payment system for the same physical health, dental, mental health or chemical dependency services
 14 provided under the health services contracts for persons eligible for health services under ORS
 15 414.705 to 414.750 in designated areas of the state in which a prepaid managed care health services
 16 organization is not able to assign an enrollee to a person or entity that is primarily responsible for
 17 coordinating the physical health, dental, mental health or chemical dependency services provided to
 18 the enrollee. In addition, the department may make other special arrangements as necessary to in-
 19 crease the interest of providers in participation in the state's managed care system, including but
 20 not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk
 21 they wish to underwrite.

22 (3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the de-
 23 partment for health services provided pursuant to ORS 414.705 to 414.750 may not exceed the total
 24 dollars appropriated for health services under ORS 414.705 to 414.750.

25 (4) Actions taken by providers, potential providers, contractors and bidders in specific accord-
 26 ance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to
 27 provide health care services shall be performed pursuant to state supervision and shall be consid-
 28 ered to be conducted at the direction of this state, shall be considered to be lawful trade practices
 29 and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

30 (5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall
 31 advise a patient of any service, treatment or test that is medically necessary but not covered under
 32 the contract if an ordinarily careful practitioner in the same or similar community would do so un-
 33 der the same or similar circumstances.

34 (6) A prepaid managed care health services organization shall provide information on contacting
 35 available providers to an enrollee in writing within 30 days of assignment to the health services
 36 organization.

37 (7) Each prepaid managed care health services organization shall provide upon the request of
 38 an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

39 (a) Grievances and appeals; and

40 (b) Availability and accessibility of services provided to enrollees.

41 (8) A prepaid managed care health services organization may not limit enrollment in a desig-
 42 nated area based on the zip code of an enrollee or prospective enrollee.

43 **SECTION 2. The amendments to ORS 414.725 by section 1 of this 2009 Act apply to claims**
 44 **billed by a rural health clinic to a prepaid managed care health services organization on or**
 45 **after May 17, 2011.**

