House Bill 3420

Sponsored by Representative WEIDNER; Representatives THOMPSON, WHISNANT, Senator KNOPP

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.**

Requires Oregon Health Authority to investigate possibility of receiving federal approval to implement copayments or other mechanisms to encourage medical assistance recipients to take personal responsibility for their own health and health care. Requires authority to report conclusions from investigation to 2014 regular session of Legislative Assembly.

Requires authority to reimburse physicians who are paid on fee-for-service basis at rate equal to 110 percent of Medicare rate.

A BILL FOR AN ACT

Relating to medical assistance; creating new provisions; and amending ORS 414.065.

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

SECTION 1. (1) The Oregon Health Authority shall investigate the possibility of obtaining federal approval to impose copayments in the medical assistance program that exceed the nominal amounts adopted by the United States Secretary of Health and Human Services under 42 U.S.C. 1396o or to implement other financial mechanisms designed to encourage medical assistance recipients to take personal responsibility for their health and health care.

(2) The authority shall report to the 2014 regular session of the Legislative Assembly the conclusions from its investigation and shall recommend options that are likely to receive federal approval.

SECTION 2. 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) **Subject to subsection (7) of this section,** 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

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.

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 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.

(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.

(7) Fees for physician services shall be paid at a rate that is equal to 110 percent of the Medicare rate for the same services. This applies to physicians who are reimbursed on a fee-for-service basis.
