OFFICE OF THE SECRETARY OF STATE
BEV CLARNO
SECRETARY OF STATE

JEFF MORGAN
INTERIM DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 111
OREGON HEALTH AUTHORITY
OREGON EDUCATORS BENEFIT BOARD

FILED
10/30/2020 3:46 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Amendments to Hospital Payment Rules

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/30/2020 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: April Kelly
503-378-6588
April.R.Kelly@state.or.us

500 Summer Street NE, E-88
Salem,OR 97301

Filed By:
April Kelly
Rules Coordinator

HEARING(S)

Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/19/2020
TIME: 11:00 AM
OFFICER: April Kelly
ADDRESS: CALL-IN ONLY
Following direction from Gov/CDC
public meetings are via conference call
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Due to COVID-19, public hearings are being held via conference call. To provide oral testimony during this hearing please dial 1-888-398-2342, access code 537268#

NEED FOR THE RULE(S):

Senate Bill 1067 (2017 Regular Session) established a cap on OEBB health benefit plan claims payments for inpatient and outpatient hospital services, with payment for in-network hospital services limited to 200% of the amount Medicare would pay for the services and payments to out-of-network hospitals limited to 185% of the amount Medicare would pay for the services.

The legislation included provisions specifying that certain hospitals are not subject to these payment caps as well as language requiring that a health plan carrier or third-party administrator that does not reimburse claims on a fee-for service basis take into account the limits established in SB 1067 when determining payments for hospital services. SB 1067 states that such non-fee-for-services, i.e. alternative payment methods, include, but are not limited to, value based

payments, capitation payments, and bundled payments.

The proposed revisions to OEBB's established rules are necessary to clarify aspects of the hospital reimbursement limit and provide for consistent implementation across OEBB's insurance carriers.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Senate Bill 1067 (2017 Regular Session), ORS 243.256 This statute can be found at oregonlegislature.gov

Meeting recording from the OEBB Board meeting from Tuesday, October 6, 2020. The proposed rules were reviewed and approved by the Board to give staff the authority to move these rules through the rulemaking process and open public comment. This can be found online: https://www.oregon.gov/oha/OEBB/Pages/OEBB-Board-Meetings.aspx

FISCAL AND ECONOMIC IMPACT:

The proposed revisions to the Oregon Educators Benefit Board (OEBB) and the Public Employees' Benefit Board's (PEBB) established rules are necessary to clarify aspects of the hospital reimbursement limit and provide for consistent implementation across OEBB/PEBB insurance carriers and self-insured third party administrators. These revisions serve to ensure that the estimated combined savings of $81 million for OEBB and PEBB under the original rule are fully realized. Without the revisions OEBB savings are estimated to fall short of this projection by approximately $11 million.

The estimated adverse fiscal impact to hospital systems varies based on the volume of services individual hospitals provide to OEBB and PEBB members, estimated ranging from $3.4 million to $5 million for larger hospitals providing significant volume of service for OEBB/PEBB members.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

There are no expected adverse fiscal impacts or costs to state agencies, local or tribal government associated with the proposed rule changes. There are expected adverse impacts to hospital systems in Oregon. The estimated adverse fiscal impact to hospital systems varies based on the volume of services individual hospitals provide to OEBB and PEBB members, estimated ranging from $3.4 million to $5 million for larger hospitals providing significant volume of service for OEBB/PEBB members.

The effect on small business is not likely. The hospitals subject to this limitation should have more than 50 employees, and so those impacted by the reimbursement limits would not be considered a “small business”. Additionally, hospitals are typically operated as non-profit corporations. Therefore, those entities would be excluded from the definition of small business, and so would not be part of the fiscal impact on a small business.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Not applicable. Since small businesses are not expected to be impacted by the proposed rules, none were invited to participate in the development of these proposed rule amendments.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
111-080-0065, 111-080-0070

AMEND: 111-080-0065

RULE SUMMARY: The proposed revisions to OAR 111-080-00165 clarify aspects of the hospital reimbursement limit and provide for consistent implementation across OEBB's insurance carriers.

CHANGES TO RULE:

111-080-0065
Hospital Payments
(1) Except as provided in section (~~8~~10), the maximum reimbursement amount for each claim subject to ORS 243.879 and these rules shall be determined by the carrier applying the applicable percentage of the Medicare rate, or the Medicare rate for similar services or supplies, as of the date of service of the claim. ¶
(2) The actual reimbursement amount for each claim subject to ORS 243.879 and these rules shall be based on the lesser of billed charges, the carrier's contracted rate for the provider, or the maximum reimbursement amount established in ORS 243.879 and these rules. ¶
(3) The carrier shall determine the OEBB member's cost sharing based ~~up~~on the ~~lower of the amount allowed by ORS 243.879 or the carrier's contracted rate for the provider.~~ actual reimbursement amount as determined in section (2) above.¶
(4) The actual reimbursement amount established for inpatient and outpatient hospital services and supplies shall not be subject to adjustments in the middle of a contract year should the maximum reimbursement amount change as a result of actions taken by the Centers for Medicare and Medicaid Services (CMS).¶
(~~3~~5) The following payments shall not be included under ORS 243.879(1) or these rules:¶
(a) services or supplies that are not covered by Medicare¶
(b) services or supplies provided at Ambulatory Surgery Centers¶
(c) professional services provided in a Hospital¶
(d) services or supplies provided at children's hospitals.¶
(~~4~~6) If a third-party administrator of a self-insured plan provides total fee-for-service payments to an in-network hospital under ORS 243.879(1) or (2) that exceed twice the total payments at the Medicare rate for the plan year, the self-insured plan third-party administrator will return the difference to OEBB. Moneys returned to OEBB under this rule will be deposited in the Oregon Educators Revolving Fund for purposes consistent with ORS 243.884.¶
(~~5~~7) If a fully-insured carrier provides total fee-for-service payments to an in-network hospital under ORS 243.879(1) or (2) that exceed twice the total payments at the Medicare rate for the plan year, the fully-insured carrier will provide OEBB a credit to fully-insured premium rates equivalent to this difference. ¶
(~~6~~8) If a third-party administrator of a self-insured plan provides total fee-for-service payments to an out-of-network hospital under ORS 243.879(1) or (2) that exceed 1.85 times the total payments at the Medicare rate for the plan year, the self-insured third-party administrator will return the difference to OEBB. Moneys returned to OEBB under this rule will be deposited in the Oregon Educators Revolving Fund for purposes consistent with ORS 243.884.¶
(~~7~~9) If a fully-insured carrier provides total fee-for-service payments to an out-of-network hospital under ORS 243.879(1) or (2) that exceed 1.85 times the total payments at the Medicare rate for the plan year, the fully-insured carrier will provide OEBB a credit to fully-insured premium rates equivalent to this difference.¶
(~~8~~10) If a carrier or third-party administrator does not reimburse hospitals on a fee-for-service basis, it may pursue an alternative payment method that maintains total payments while taking into account the limits established in ORS 243.879 and described in this rule, including, but not limited to: ¶
(a) value based payments, ¶

(b) capitation payments and¶
(c) bundled payments. A carrier or third-party administrator using alternative payment methods must provide actuarial calculations that show the payment methods used adhere to the limits specified in ORS 243.879. Such alternative payment methods must be reported to OEBB as part of its benefit plan agreement with the carrier or third-party administrator. If payments under the alternative payment arrangement exceed the limits specified in ORS 243.879 the carrier or third-party administrator will return the difference to OEBB. Moneys returned to OEBB under this rule will be deposited in the Oregon Educators Revolving Fund for purposes consistent with ORS 243.884.¶
(~~9~~11) For purposes of this rule, the "Medicare rate" is the amount of reimbursement for a claim that would be paid as if ~~Medicare~~The Centers for Medicare and Medicaid Services (CMS) reimbursed the claim. Therefore, ~~the outpatient reimbursement~~calculation of the maximum reimbursement amount for outpatient services appl~~y~~ies the Medicare Ambulatory Payment Classification (APC) or Hospital Outpatient Prospective Payment System (OPPS), and ~~that for inpatient the reimbursement~~calculation of the maximum reimbursement amount for inpatient services appl~~y~~ies Medicare Severity Diagnosis Related Groups (MS-DRG). All rebates, incentives, or adjustments that would have applied if reimbursed by Medicare would also apply. The "Medicare rate" as defined in this rule is used to determine the maximum reimbursement amount for each claim subject to ORS 243.879 and these rules and in no way prohibits a carrier or third-party administrator from establishing contracted claims reimbursement rates that are lower than the maximum reimbursement amount. This includes contracted claims reimbursement rates informed by Medicare Advantage rates, so long as contracted rates do not exceed the maximum reimbursement established in ORS 243.879 and this rule. Furthermore, this includes capturing data fields on claims for services or supplies that are necessary to determine the Medicare rate for the service or supply in order to ensure that the actual reimbursement amount does not exceed the maximum reimbursement amount established in ORS 243.879 and this rule.
Statutory/Other Authority: ORS 243.860 to 886
Statutes/Other Implemented: ORS 243.879, ORS 243.864(1)(a)

AMEND: 111-080-0070

RULE SUMMARY: Update to OAR 111-080-0070 changes the review of the calculation from annually to every three years.

CHANGES TO RULE:

111-080-0070
Exempt Hospitals
(1) As specified in ORS 243.879, these payment limits do not apply to reimbursements paid by a carrier or third-party administrator to: ¶
(a) Type A or type B hospitals (defined in ORS 442.470);¶
(b) Rural critical access hospitals (defined in ORS 315.613); or¶
(c) Hospitals that are located in a county with a population of less than 70,000 on August 15, 2017, classified as a sole community hospital by the Centers for Medicare and Medicaid Services, and have Medicare payments composing at least 40 percent of the hospital's total annual patient revenue. ¶
(2)(a) Total annual patient revenue for a hospital will be calculated using the Allowed Amount for all inpatient and outpatient claim records in the state's All Payer All Claims (APAC) database for that hospital in a calendar year, and ¶
(b) Total Medicare payments to a hospital will be calculated using the Allowed Amount for all inpatient and outpatient claim records paid by Medicare in the APAC for that hospital in a calendar year.¶
(3) OEBB will ~~annually~~ review th~~is~~e calculation under section (2) of this rule at least every three years using the most recent available ~~twelve months of~~ data in APAC.
Statutory/Other Authority: ORS 243.860 to 243.886
Statutes/Other Implemented: ORS 243.879, ORS 243.864(1)(a)