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**NOTICE OF PROPOSED RULEMAKING**  
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 111  
OREGON HEALTH AUTHORITY  
OREGON EDUCATORS BENEFIT BOARD

**FILED**  
06/10/2019 11:48 AM  
ARCHIVES DIVISION  
SECRETARY OF STATE

FILING CAPTION: Hospital Payment Rules

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 07/31/2019 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.*

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Filed By:  
April Kelly  
Rules Coordinator

HEARING(S)

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

DATE: 07/23/2019

TIME: 10:00 AM

OFFICER: OEBC Staff

ADDRESS: Barbara Roberts DHS

Building - Room 137D

500 Summer Street NE

Salem, OR 97301

NEED FOR THE RULE(S):

Senate Bill 1067 (2017) established a cap on OEBC health benefit plan claims payments for inpatient and outpatient hospital services. These rules clarify aspects of the payment cap implementation.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Senate Bill 1067 (2017), ORS 243.879 This statute can be found at [oregonlegislature.gov](http://oregonlegislature.gov).

FISCAL AND ECONOMIC IMPACT:

The combined fiscal impact of this particular provision in SB 1067 (2017) was a combined savings of \$81 million for the Public Employees Benefit Board (PEBB) or Oregon Educators Benefit Board (OEBC).

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).

No fiscal impact was identified.

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

Not applicable. Since small businesses are not impacted by the proposed rule changes, none were invited to participate in the development of this proposed rule.

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WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

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RULES PROPOSED:

111-080-0065, 111-080-0070

ADOPT: 111-080-0065

RULE SUMMARY: Senate Bill 1067 (2017) established a cap on OEGB health benefit plan claims payments for inpatient and outpatient hospital services. These rules clarify aspects of the payment cap implementation.

CHANGES TO RULE:

111-080-0065

Hospital Payments

(1) 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.¶

(2) If total fee-for-service payments made to an in-network hospital under ORS 243.879(1) or (2) exceed twice the total payments at the Medicare fee-for-service base rate, the carrier or third party administrator will return the difference to OEGB. Moneys returned to OEGB under this rule will be deposited in the Oregon Educators Revolving Fund for purposes consistent with ORS 243.884.¶

(3) If total fee-for-service payments made to an out-of-network hospital under ORS 243.879(1) or (2) exceed 1.85 times the total payments at the Medicare fee-for-service base rate, the carrier or third-party administrator will return the difference to OEGB. Moneys returned to OEGB under this rule will be deposited in the Oregon Educators Revolving Fund for purposes consistent with ORS 243.884.¶

(4) 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 agreed to by OEGB as part of its benefit plan agreement with the carrier or third-party administrator. If actuarial calculations show 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 OEGB. Moneys returned to OEGB under this rule will be deposited in the Oregon Educators Revolving Fund for purposes consistent with ORS 243.884.

Statutory/Other Authority: ORS 243.860 to 243.886

Statutes/Other Implemented: ORS 243.879

ADOPT: 111-080-0070

RULE SUMMARY: Senate Bill 1067 (2017) established a cap on OEGB health benefit plan claims payments for inpatient and outpatient hospital services. These rules clarify aspects of the payment cap implementation, specifically related to hospitals that are exempt from the cap.

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) (A) 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 with Medicare payments composing at least 40 percent of the hospital's total annual patient revenue. 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. ¶

(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. ¶

(C) The percent of a hospital's total annual patient revenue derived from Medicare will be determined using (A) and (B). ¶

(2) OEGB will review this calculation annually 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