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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 111
OREGON HEALTH AUTHORITY
OREGON EDUCATORS BENEFIT BOARD

FILED
07/19/2019 2:03 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Hospital Payment Rules

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 08/31/2019 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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Salem, OR 97301

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: 08/21/2019

TIME: 2:00 PM

OFFICER: OEBC Staff

ADDRESS: Health Licensing Office -
Boardroom

1430 Tandem Ave NE

Suite 180

Salem, OR 97301

SPECIAL INSTRUCTIONS:

The meeting location is accessible to
persons with disabilities.

NEED FOR THE RULE(S):

Senate Bill 1067 (2017 Regular Session) established a cap on OEBC 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.

These rules clarify aspects of the payment cap implementation.

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 video recording from the OEBC/PEBC Innovation Workgroup from Tuesday, May 21, 2019. This can be found online: <https://www.oregon.gov/oha/PEBC/Pages/Board-Meeting-Minutes.aspx>

Meeting video recording from the OEBC Board meeting from Tuesday, June 4, 2019. 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/OEBC/Pages/OEBC-Board-Meetings.aspx>

FISCAL AND ECONOMIC IMPACT:

The combined estimated fiscal impact of this provision in SB 1067 (2017 Regular Session) is a savings of \$81 million-dollar savings for both the Public Employees' Benefit Board (PEBC) and Oregon Educators Benefit Board (OEBC). These savings are for reduced hospital reimbursements over a plan year and does not include potential savings through Kaiser Permanente plans. Approximately 37% of PEBC and OEBC enrollments are in Kaiser Permanente plans.

The estimated adverse fiscal impacts to hospital systems in Oregon range from \$7 million dollars to \$16 million dollars.

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, because the rules will result in payments from insurers to hospitals below what they are currently receiving. From the information that was gathered, there is a variance among the adverse fiscal impact that these rules will cause. From smaller hospital systems, the impact range is \$7-9 million. For a larger hospital system, the impact is estimated at \$16 million.

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 this proposed rule.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

111-080-0065, 111-080-0070

ADOPT: 111-080-0065

RULE SUMMARY: Payment limits on inpatient and outpatient hospital services as required under ORS 243.879

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 886

Statutes/Other Implemented: ORS 243.879, ORS 243.864(1)(a)

ADOPT: 111-080-0070

RULE SUMMARY: Payment limits on inpatient and outpatient hospital services as required under ORS 243.879

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) OEBC will review this calculation annually using the most recent available twelve months of data in APAC.

Statutory/Other Authority: ORS 243.860 to ORS 243.886

Statutes/Other Implemented: ORS 243.879, ORS 243.864(1)(a)