Payment for Hospital Services

Rules Proposed:

101-080-0010, 101-080-0020

Rule Summary: Payment limits on inpatient and outpatient hospital services as required under ORS 243.256

101-080-0010 Hospital Payments

(1) The following payments shall not be included under ORS 243.256(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 243.256(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 PEBB.

(3) If total fee-for-service payments made to an out-of-network hospital under ORS 243.256(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 PEBB.

(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 243.256 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 243.256. Such alternative payment methods must be agreed to by PEBB 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 243.256 the carrier or third party administrator will return the difference to PEBB.

101-080-0020 Exempt Hospitals

(1) As specified in ORS 243.256, 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.

i. 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.

ii. 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.

iii. The percent of a hospital's total annual patient revenue derived from Medicare will be determined using (i) and (ii).

(2) PEBB will review this calculation annually using the most recent available calendar year of data in APAC.