HEALTH POLICY AND ANALYTICS
Public Employees' Benefit Board
Oregon Educators Benefit Board
Kate Brown, Governor

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Public Employees' Benefit Board (PEBB) and
Oregon Educators Benefit Board (OEBB)
Rules Advisory Committee (RAC) Notification
September 29, 2020

PEBB and OEBB have scheduled the following Rules Advisory Committee (RAC):

Rule Sponsor: April Kelly and Margaret Smith-Isa

- **Meeting Description:** Discuss proposed rules amendments related to Hospital Payments
- **Meeting Date and Time:** September 29, 2020, 10:00am
- **Meeting location:** Call-in only (Following direction from the Gov/CDC public meetings are via conference call)
- **Meeting call-in number:** 888-398-2342
- **Call-in participant code:** 584090#
- **Seeking RAC members?** Yes

At the RAC, members will help us better understand the fiscal impact of the proposed rule changes and determine if Small Businesses will be impacted by the proposed Rule.

Please share this information with others who may be affected by, and interested in providing input about, the proposed rule changes.

To view PEBB and OEBB's current rules, go to:

https://www.oregon.gov/oha/PEBB/Pages/Admin-Rules.aspx

https://www.oregon.gov/OHA/OEBB/Pages/Admin-Rules.aspx

Proposed changes for the Rules Advisory Committee discussion

Rule(s)	Description of proposed changes
101-080-0010, 101-080-0020 (PEBB)	Senate Bill 1067 (2017) established a cap on PEBB and 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. This becomes effective for PEBB January 1, 2020. These proposed amendments clarify aspects of the payment cap implementation, including clarifying the

	distinction between "maximum" and "actual" payment amounts and exempting children's hospitals from the cap.
111-080-0065, 111-080-0070 (OEBB)	Senate Bill 1067 (2017) established a cap on PEBB and 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. This becomes effective for OEBB October 1, 2019. These proposed amendments clarify aspects of the payment cap implementation, including clarifying the distinction between "maximum" and "actual" payment amounts and exempting children's hospitals from the cap.

Rules Advisory Committee contact information

If you would like to be an PEBB or OEBB RAC member, and if you are likely to be affected by the changes described above, we invite you to join us as a RAC member. To do this, contact the PEBB/OEBB Rule Coordinator. Include the meeting date, time and Rule number.

- Rule Coordinator: April Kelly
- Phone: 503-378-6588
- Email: April.R.Kelly@state.or.us

If PEBB or OEBB is not seeking RAC members, or you are not chosen to join the RAC, you are welcome to observe the RAC and email your input to the Rule Coordinator following the RAC meeting.

Thank you in advance for your participation and continued interest.

About Rule Advisory Committees

Rule Advisory Committee meetings are held in accordance with Oregon Revised Statute 183.333 (Policy statement; public involvement in development of policy and drafting of rules).

The RAC will hold at least one meeting to discuss the proposed revisions, the fiscal impact statement, and summary for the Notice or Proposed Rulemaking that the Division will file for these changes.

101-080-0010
Hospital Payments

(1) **Except** as provided in section (~~8~~**10**), the maximum reimbursement amount for each claim subject to ORS 243.256 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 ~~carrier shall determine the PEBB member's cost sharing based upon the lower~~ **actual reimbursement amount for each claim subject to ORS 243.256 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** ~~of the amount allowed by~~ ORS 243.256 **and these rules.** ~~or the carrier's contracted rate for the provider.~~

(3) The carrier shall determine the PEBB member's cost sharing based on the 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 243.256(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

(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 243.256(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 PEBB. Moneys returned to PEBB under this rule will be deposited in the Public Employees' Revolving Fund for purposes consistent with ORS 243.167.

(~~5~~**7**) If a fully-insured carrier provides total fee-for-service payments to an in-network hospital under ORS 243.256(1) or (2) that exceed twice the total payments at the Medicare rate for the plan year, the fully-insured carrier will provide PEBB 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 243.256(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 PEBB. Moneys returned to PEBB under this rule will be deposited in the Public Employees' Revolving Fund for purposes consistent with ORS 243.167.

(~~7~~**9**) If a fully-insured carrier provides total fee-for-service payments to an out-of-network hospital under ORS 243.256(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 PEBB 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 243.256 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 reported to PEBB 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 243.256 the carrier or third-party administrator will return the difference to PEBB. Moneys returned to PEBB under this rule will be deposited in the Public Employees' Revolving Fund for purposes consistent with ORS 243.167.

(~~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, **calculation of the maximum reimbursement amount for** ~~the~~ outpatient **services** ~~reimbursements apply~~ **applies** the Medicare Ambulatory Payment Classification (APC) or Hospital Outpatient Prospective Payment System (OPPS), and ~~that~~ **calculation of the maximum reimbursement amount** for inpatient **services** ~~the reimbursements apply~~ **applies** 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 243.256 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 243.256 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 243.256 and this rule.**

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) 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) PEBB will annually review this calculation under section (2) of this rule using the most recent available twelve months of data in APAC.

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 ~~carrier shall determine the OEBB member's cost sharing based upon the lower~~ **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** ~~of the amount allowed by~~ ORS 243.879 **and these rules.** ~~or the carrier's contracted rate for the provider.~~

(3) The carrier shall determine the PEBB member's cost sharing based on the 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.

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(~~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:

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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.

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(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 this calculation under section (2) of this rule using the most recent available twelve months of data in APAC.