Final Rules Related to Hospital Payments

Overview

This attachment provides final Oregon Administrative Rules 101-080-0010 and 101-080-0020 which relate to payment for hospital services provided by PEBB benefit plans. These rules were developed to align with provisions included in Senate Bill 1067 (2017) that limit payments for inpatient and outpatient hospital services to 200 % of the amount paid by Medicare for in-network hospitals and 185% of the amount paid by Medicare for out-of-network hospitals.

.

The Board reviewed the initial draft of these rules at the July 16th meeting. During the course of rules development, both a Rules Advisory Committee meeting (June 27th) and a Public Hearing (August 21st) were held. The draft rules were posted for public comment through August 31st. During the public comment period written comments were received from the stakeholders listed below.

- AllCare Health
- Asante
- Kaiser Permanente
- Moda Health
- Oregon Association of Hospitals and Health Systems (OAHHS)
- Oregon Health Sciences University (OHSU)
- Portland Public Schools
- Providence Health Plan
- Salem Health
- Service Employees International Union Local 503 (SEIU)
- St. Charles Medical Center

All comments received were reviewed and considered. Significant edits made to the initial draft rules are included in the final rules below in underlined text. The two most significant changes include:

1. Added language to the rules to define "Medicare rate"

2. Additional language to differentiate between self-insured and fully-insured plans when verifying payments remain within the established limit

Final OARs 101-080-0010 and 101-080-0020 for Board approval are provided on the following pages.

Board Action

Board action is requested.

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) Except as provided in section (8), 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 amount allowed by ORS 243.256 and these rules.

(3) 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.

(4) 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) 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) 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) 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) 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) For purposes of this rule, the "Medicare rate" is the amount of reimbursement for a claim that would be paid as if Medicare reimbursed the claim. Therefore, the outpatient reimbursements apply the Medicare Ambulatory Payment Classification (APC) or Hospital Outpatient Prospective Payment System (OPPS), and that for inpatient the reimbursements apply Medicare Severity Diagnosis Related Groups (MS-DRG). All rebates or incentives that would have applied as if reimbursed by Medicare would also apply.

111-080-0070 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) 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
   a. 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.

Statutory/Other Authority: ORS 243.061 to 243.302
Statutes/Other Implemented: ORS 243.256