§ 243.256. Reimbursement methodology for payment to hospitals: Public Employee Rights and Benefits -- Benefit Plans (Generally)

(1) A hospital that provides services or supplies under a benefit plan offered by the Public Employees’ Benefit Board shall be reimbursed using the methodology prescribed by the Oregon Health Authority under ORS 442.392 and may not be reimbursed for each service or supply provided.

(2) This section applies to hospital payments made by a carrier under a contract with the board and to hospital payments made under a self-insurance program administered by a third party administrator on behalf of the board.

(3) This section does not apply to reimbursements paid by a carrier or third party administrator to a hospital that is not subject to the methodology prescribed by the authority under ORS 442.392. [2011 c.418 §6]

Note: The amendments to 243.256 by section 29, chapter 746, Oregon Laws 2017, apply to health benefit plans offered by the Public Employees’ Benefit Board for plan years beginning after July 1, 2019. See section 34, chapter 746, Oregon Laws 2017. The text that applies to plan years beginning after July 1, 2019, is set forth for the user’s convenience.

(1) A carrier that contracts with the Public Employees’ Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

   (a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or
   
   (b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

   (a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or
   
   (b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.
(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

(a) Value-based payments;
(b) Capitation payments; and
(c) Bundled payments.

(5) This section does not apply to reimbursements paid by a carrier or third party administrator to:

(a) A type A or type B hospital as described in ORS 442.470;
(b) A rural critical access hospital as defined in ORS 315.613; or
(c) A hospital:
   (A) Located in a county with a population of less than 70,000 on August 15, 2017;
   (B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services; and
   (C) With Medicare payments composing at least 40 percent of the hospital’s total annual patient revenue.

(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.