DRAFT

Division 65
SUSTAINABLE HEALTH CARE COST GROWTH TARGET PROGRAM

409-065-0000 Purpose

Senate Bill 889 (2019 Legislature) established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority and House Bill 2081 (2021 Legislature) authorized accountability mechanisms to achieve a sustainable rate of health care cost growth. ~~-~~ These rules (OAR 409-065-0000 to 409-065-0055~~0030~~) define reporting and accountability requirements to the Oregon Health Authority. Submitted~~The~~ data will inform the work of the Sustainable Health Care Cost Growth Target Program as it reports on health care cost drivers and trends.

Statutory/Other Authority: -ORS 442.386
Statutes/Other Implemented: -ORS 442.386 & ORS 442.385

History:
OHP 5-2021, adopt filed 11/19/2021, effective 11/19/2021
OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

409-065-0005 Definitions

The following definitions apply to OAR 409-065-0000 to 409-065-0055: ~~0030:~~

(1) "Accident policy" means an insurance policy that provides benefits only for a loss due to accidental bodily injury.

(2) -"Authority" means the Oregon Health Authority.

(3) -"DCBS" means the Oregon Department of Consumer and Business Services.

(4) -"Dental-only insurance" means an insurance policy that provides benefits only for dental services.

(5) -"Disability policy" means an insurance policy that provides benefits for losses due to a covered illness or disability.

(6) "Frontline worker" means any worker whose total annual compensation is less than $200,000, adjusted annually to reflect any percentage changes in the Consumer Price Index for All Urban Consumers, West Region (All Items), as published by the Bureau of Labor Statistics of the United States Department of Labor, excluding executive managers and salaried managers.

(7) ~~(6)~~ "Health benefit plan" has the meaning provided in ORS 743B.005.

(8) ~~7)~~ "Health care" has the meaning provided in ORS 442.385.

(9) ~~8)~~ "Health insurance" has the meaning provided in ORS 731.162.

(10) ~~9)~~ "Hospital indemnity policy" means an insurance policy that provides benefits only for covered hospital stays.

(11) ~~10)~~ "Long-term care insurance" has the meaning provided in ORS 743.652.

(12) "Mandatory reporter" means any reporting entity determined to be a mandatory reporter in OAR 409-065-0010.

~~(13) (11) "Mandatory Reporter" means any payer or licensed third party administrator with a mean total lives of 1,000 or more across all lines of business, as calculated by the Authority.~~

~~(12)~~ "Medicare supplemental insurance" means a group or individual insurance policy or a subscriber contract, other than a policy issued pursuant to a contract under Section 1876 of the ~~federal~~ Social Security Act (42 U.S.C. ~~section~~ 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. 1395~~section 1395ss~~(g)(1) that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(14) ~~13)~~ "Payer" has the meaning provided in ORS 442.385.

(15) "Performance improvement plan" (PIP) has the meaning provided in OAR 409-065-0040.

(16) "Provider Organization" means an entity including but not limited to a clinic, health system, hospitals with primary care, medical group, accountable care organization, or independent practice association that employs physicians or other health care personnel who render health care services to patients.

(17) ~~(14)~~ "Specific disease policy" means an insurance policy that provides benefits only for a loss due to a covered disease.

(18) ~~15)~~ "Stand-alone prescription drug plan" means an insurance policy that provides benefits only for prescription drugs.

(19) ~~16)~~ "Stop-loss plan" means insurance against the risk of economic loss assumed under a less than fully-insured employee health benefit plan as provided in ORS 742.065.

(20) ~~17)~~ "Third-party administrator (TPA)" means any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of Oregon or residents of another state from offices in Oregon, in connection with life insurance or health insurance coverage; or any person or entity who must otherwise be licensed under ORS 744.702.

(21~~18~~) "Vision policy" means a health benefits plan covering only vision health care.

(2219) "Voluntary reporter" means a payer or third-party administrator that does not meet the requirements to be considered a Mandatory reporterReporter and elects to submit cost growth target data on a voluntary basis.

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385

History:
OHP 5-2021, adopt filed 11/19/2021, effective 11/19/2021
OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

409-065-0010 General Reporting Requirements

(1) Determination of a mandatory reporter.

(a) For payers or licensed third-party administrators, the Authority shall identify mandatory reporters using health insurance enrollment data from DCBS and Medicaid enrollment reports from the Authority.

(A) The Authority shall aggregate the most recent four (4) quarters of data.

(B) The Authority shall calculate the mean total lives for each payer and licensed third-party administrator for each reporting year.

(b) All payers or licensed third-party administrators with calculated mean total lives of 1,000 or more across all lines of business shall be mandatory reporters.

(c)The Authority shall make annual mandatory reporter determinations ~~on an annual basis~~ and provide written notification no later than April 30 of each year to all mandatory reporters subject to the reporting requirements of OAR 409-065-0010 to 409-065-0030 for the current year.

(~~.~~

~~(~~2) ~~-~~All Mandatory reportersReporters must submit data files in a manner and form as prescribed by 409-065-0015.

(3) The Authority will identify voluntary reporters that have calculated mean total lives of 1,000 or higher across all lines of business and invite them to participate in the annual data submission.

(4) If a payer or licensed third-party administrator~~an entity~~ believes a determination by the Authority of its mandatory reporter status to be in error, the entity~~organization~~ must follow~~contact~~ the procedure outlined in OAR 409-065-0027~~Authority to contest the determination no later than 30 calendar days after receipt of notification~~.

(5) New mandatory reporters submitting for the first time, or mandatory reporters that did not submit data in the previous year, must attend a data submission training session prior to their first submission of data, as provided by the Authority.

(6) A mandatory reporter may submit a waiver of reporting in compliance with OAR 409-065-0020.

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385

History:
OHP 5-2021, adopt filed 11/19/2021, effective 11/19/2021
OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

409-065-0015 Data Submission Requirements

(1) Annual data submission dates are provided in the Cost Growth Target Data Specification Manual (CGT-2); the data submission dates must not be before September 1st of each year.

(2) CGT-1 must be submitted in accordance with instructions published by the Authority in the Cost Growth Target Data Specification Manual (CGT-2).

(3) Mandatory and voluntary reporters must submit data files for all required lines of business as defined in the Cost Growth Target Data Specification Manual (CGT-2). They may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business.

(a) Required lines of business include:
(A) Commercial;
(B) Medicare; and
(C) Medicaid.

(b) Excluded lines of business include:
(A) Accident policy;
(B) Disability policy;
(C) Hospital indemnity policy;
(D) Long-term care insurance;
(E) Medicare supplemental insurance;
(F) Stand-alone prescription drug plans;
(G) Specific disease policy;
(H) Stop-loss plans;
(I) Supplemental insurance that pays deductibles, copays or coinsurance;
(J) Vision-only insurance;
(K) Workers compensation; and
(L) Dental-only insurance.

(c) A mandatory reporter that contracts with another entity remains responsible for reporting all required lines of business. If the mandatory reporter elects to have the data reported by a contracted entity, the mandatory reporter must notify the Authority and provide contact information for the contracted entity.

(4) The Authority has 90 calendar days to review and request clarification or corrections to the annual data submission (CGT-1). If the Authority finds errors through edit checks or validation, mandatory reporters must make corrections and resubmit data or submit a waiver request within 30 calendar days of notification by the Authority of the error(s). The Authority may make multiple requests for corrections or resubmissions. The annual data submission is only considered complete when all corrections and resubmissions have been submitted and approved by the Authority.

~~(5) If a mandatory reporter changes its health risk adjustment method or software (including version updates), it must re-submit at least one prior year of data using the updated adjustment method in order to ensure comparability between years.~~

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385

History:
OHP 5-2021, adopt filed 11/19/2021, effective 11/19/2021
OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

409-065-0020 Data Submission Waivers

(1) The Authority may grant a waiver or deadline extension to the data submission requirements.

(2) If a mandatory reporter believes they are eligible for a waiver of all or part of the data submission requirements they may request a waiver of reporting requirements by submitting a Cost Growth Target Data Submission Waiver/Extension Request (CGT-3).

(a) Mandatory reporters may submit a CGT-3 form as follows~~for the following reasons~~:

(A) To request a partial waiver to the data submission requirements, mandatory reporters~~. The request~~ must submit a completed CGT-3 form to the Authority~~be submitted~~ no later than 14 calendar days prior to the annual reporting deadline; or

(B) To request a waiver of all data submission or validation requirements, mandatory reporters must submit a completed CGT-3 form to the Authority~~. The request must be submitted~~ no later than 60 calendar days prior to the applicable deadline.

(b) The Authority must approve or deny the waiver request and provide written notification to the requestor within 14 calendar days of receipt of the request.

~~(c(c) If the Authority denies the request, the requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 calendar days of the denial. The appeal process is conducted pursuant to ORS Chapter 183 and the Attorney General's Uniform and Model rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove a compelling need for the waiver.~~

~~(d~~) The Authority shall only grant waivers for one data submission cycle at a time.

(3) If a mandatory reporter believes they require a deadline extension they must notify the Authority by submitting a CGT-3 form.~~Cost Growth Target Data Submission Waiver/Extension Request (CGT-3).~~

(a) Mandatory reporters may submit a CGT-3 form as follows~~for the following reasons~~:

(A) To request a deadline extension for the data submission, mandatory reporters~~. The request~~ must submit a completed CGT-3 form to the Authority~~be submitted~~ no later than 14 calendar days prior to the annual reporting deadline; or

(B) To request a deadline extension for data correction, resubmission, or validation requirements, mandatory reporters must submit a completed CGT-3 form to the Authority ~~. The request must be submitted~~ no later than 7 calendar days after the Authority requests the data correction, resubmission, or validation requirement.

(b) The Authority must approve or deny the deadline extension request and provide written notification to the requestor within 14 calendar days of receipt of the request.

(4~~c~~) If the Authority denies a~~the~~ request for waiver or deadline extension, the requestor may appeal the denial pursuant to the procedure outlined in OAR 409-065-0027~~by requesting a contested case hearing. The appeal must be filed within 30 calendar days of the denial. The appeal process is conducted pursuant to ORS Chapter 183 and the Attorney General's Uniform and Model rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove a compelling need for the exception~~.

(5~~d~~) The Authority shall only grant waivers or deadline extensions for one data submission cycle at a time.

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385

History:
OHP 5-2021, adopt filed 11/19/2021, effective 11/19/2021
OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

409-065-0025 Data Submission Compliance and Enforcement

(1) Unless approved by a waiver or exception, a failure to comply with general data submission requirements exists when a mandatory reporter:
(a) Fails~~includes but is not limited to:~~

~~(a) Failure~~ to submit data files by the specified submission date, or
~~;~~

(b) Fails~~Failure~~ to submit data files for a required line of business.

(2) Unless approved by a waiver or exception, a failure to comply with data file requirements exists when a mandatory reporter:
(a) Submits~~includes but is not limited to:~~

~~(a) Submitting~~ a data file in an unapproved layout;

(b) Submits~~Submitting~~ a data element in an unapproved format;

(c) Submits~~Submitting~~ a data element with unapproved coding;

(d) Fails~~Failure~~ to submit a required data element; or

(e) Fails~~Failure~~ to comply with validation and quality control efforts, including resubmitting or correcting data in a timely fashion as requested by the Authority.

(3) The Authority shall~~must~~ provide mandatory reporters written notification of each failure to comply with data submission or data filing requirements prior to imposing a civil penalty. Mandatory reporters will have 30 calendar days from notification to come into compliance.

(4) The Authority may impose a civil penalty on a mandatory provider for a violation of these rules if the mandatory reporter ~~penalties against mandatory reporters for each failure to comply that is not resolved within 30 calendar days of written notification. If a mandatory reporter~~ does not come into compliance 30 days~~within 30 calendar days of written notification, penalties may be assessed starting~~ from the notification described in (3). A~~date the mandatory reporter was notified of non-compliance. Pursuant to ORS 442.993, the Authority may adopt a schedule of~~ civil penalty may~~penalties~~ not ~~to~~ exceed $500 per day for each ~~of violation, determined by the severity of the~~ violation of OAR 409-065-0025(1) or OAR 409-065-0025(2).~~for any mandatory reporter that fails to report cost growth data.~~

(5) Civil penalties will be imposed in the manner provided in ORS 183.745~~If a mandatory reporter has made documented efforts to comply with these rules, the Authority may consider this a mitigating factor before imposing civil penalties against the mandatory reporter~~.

Statutory/Other Authority: ORS 442.386 & 442.993
Statutes/Other Implemented: ORS 442.386, ORS 442.385 & 442.993

History:
OHP 5-2021, adopt filed 11/19/2021, effective 11/19/2021
OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

409-065-0027 Mandatory Reporter Data Submission Informal Conference and Contested Case Hearings

[placeholder for rule language re: process for appealing / contesting OHA's determination of:

Mandatory reporter status

Denial of waiver or extension request

Civil penalty

409-065-0030 Data Access and Disclosure

(1) The Authority may use and disclose data submitted to it under these rules in accordance with ORS 442.386 and any applicable Authority policies and state and federal rules, regulations, and statutes.
(2) The Authority may disclose data to payers or provider organizations in the administration of the program, excluding any confidential information provided to the Authority by a payer or provider organization regarding the determination of a reasonable cause of cost growth.
(3

~~(2~~) The Authority may provide a public use data set in compliance with applicable Authority policies and state and federal rules and~~,~~ regulations~~, and statutes~~.

Statutory/Other Authority: ~~-~~ORS 442.386
Statutes/Other Implemented: ~~-~~ORS 442.386 & ORS 442.385

History:
OHP 5-2021, adopt filed 11/19/2021, effective 11/19/2021
OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

OAR 409-065-0035 Reasonable Causes of Cost Growth

(1) The Authority shall not impose a performance improvement plan or financial penalty on an entity that exceeded the cost growth target due solely to unforeseen market conditions or other equitable factors, as enumerated in (2) of this rule. The Authority shall determine, on a case-by-case basis, when such a condition or factor suffices as a reasonable cause for an entity to exceed the cost growth target.

(2) Reasonable cause for exceeding the cost growth target includes but is not limited to:

(a) Changes in law including changes in mandated benefits codified in Oregon Revised Statute, Oregon Administrative Rule, Federal law, or Federal Regulations;

(b) New pharmaceuticals or medical treatments entering the market, including new medical procedures;

(c) Changes in taxes related to health care or other administrative requirements including but

not limited to changes in medical loss ratio rebate requirements pursuant to state or federal regulations;

(d) Acts of God such as natural disasters or pandemics;

(e) Entity investments to improve population health or address health equity including but not limited to investments in primary care or behavioral health;

(f) Macro-economic factors such as periods of significant inflation, supply chain shortages, or labor shortages;

(g) A provider organization's total compensation, defined as wages, benefits, salaries, bonuses, and incentive payments, paid to frontline workers, defined as any worker whose total annual compensation is less than $200,000 adjusted annually to reflect any percentage changes in the Consumer Price Index for All Urban Consumers, West Region (All Items), as published by the Bureau of Labor Statistics of the United States Department of Labor;

(h) High-cost outliers; and

(i) Any other reasonable cause specified in writing by the Authority and published on the program's website.

(3) The Authority shall notify an entity in writing if the entity's cost growth for that measurement period exceeded the cost growth target with statistical significance and if the entity needs to participate in the determining reasonableness process as specified in writing by the Authority and published on the program's website.

(4) Entities are responsible for participating in conversations regarding the determination of reasonableness with the Authority. If an entity does not participate in conversations regarding the determination of reasonableness, the Authority will not be able to determine that the cost growth was reasonable and the entity will be subject to any applicable accountability mechanisms, including performance improvement plans and financial penalties, and civil penalties as outlined in OAR 409-065-0025.

(5) An entity that exceeds the cost growth target with statistical significance may submit analyses and supporting documentation to the Authority as discussion items during the conversations regarding the determination of reasonableness for the measurement period. Such analyses and supporting documentation may include but are not limited to:

(a) the quantified impact of the reasonable cause on the entity's cost growth with detailed

explanation of how the entity calculated the impact;

(b) what the entity's cost growth would have been had it not been for the reasonable cause, including a detailed explanation of how the entity calculated the cost growth;

(c) sufficient documentation to support the claim of a reasonable cause; and

(d) the aggregate amount of total compensation using a methodology specified by the Authority in sub-regulatory documentation, if a provider organization claims total compensation paid to frontline workers as a reasonable cause, as specified in (2)(g).

(6) The Authority may request information from the entity claiming a reasonable cause.

(7) After reviewing information submitted by the entity, the Authority shall determine whether the entity's claim of reasonable cost growth for the measurement period is accepted. The Authority shall notify the entity of the Authority's determination in writing. The Authority may publish the results of conversations regarding the determination of reasonableness, while redacting any confidential information.

(8) A payer or provider organization may request that the Authority reconsider its reasonableness determination. A request for reconsideration must be submitted in writing to the Authority within 30 days of the date of the Authority's written notice of determination and must include a detailed explanation of why the payer or provider organization believes the Authority's decision is in error along with any supporting documentation. The Authority reserves the right to request additional information from the entity.

(a) After receiving a request for reconsideration, the Authority will inform the payer or provider organization in writing whether it has reconsidered its decision.

(b) After receiving the Authority's decision, the payer or provider organization may appeal the Authority's decision in accordance with OAR 409-065-0050

409-065-0040 Performance Improvement Plans (PIP)

(1) A payer or provider organization that exceeds the cost growth target with statistical significance, as defined by the Authority in Data Submission Statistical Analysis document, and without reasonable cause, as defined in 409-065-0035, during a measurement year for Medicaid, Medicare Advantage, or the commercial insurance market, shall complete the PIP template enumerated in (2).

(2) The Authority shall develop and publish on the program website a performance improvement plan (PIP) template, titled CGT-XX.

(a) This PIP is a document written by a payer or provider organization and approved by the Authority that
(A) identifies key cost growth drivers and the specific actions a payer or provider organization will take to address those key cost growth drivers;
(B) identifies an appropriate timeframe or timeframes by which the payer or provider organization will reduce the cost growth; and
(C) includes clear metrics for success to be used for evaluating progress and completeness.

(b) A payer or provider organization shall use the document titled CGT-XX, to describe:

(A) the root cause(s)of cost growth including, but not limited to, any causes identified during discussions with the Authority regarding the determination of a reasonable cause for cost growth;

(B) strategies developed by the payer or provider organization to address the root cause or causes of cost growth in a specified timeframe, but no more than 24 consecutive months from the date the Authority approves the submitted PIP, unless extended by the Authority as per (9) of this rule;

(C) specific and achievable outcome measures to track progress;

(D) the strategy developed by the payer or provider organization to avoid negative effects on health care service availability, quality, and health equity;

(E) the plan for adjusting the strategy during the duration of the PIP in response to unmet savings or measures, and any negative effects on quality, access, and health equity; and

(F) the payer or provider organization's plan for how to pass generated savings on to consumers.

(3) The Authority shall collaborate with a payer or provider organization required to develop and undertake a performance improvement plan by providing technical assistance, which may include sub-regulatory guidance, office hours, a webinar published on the program website, and consultation with the payer or provider organization at their request.

(4) The Authority may, at its sole discretion, agree to a payer or provider organization combining required PIPs for multiple markets or to a payer and provider organization submitting a PIP jointly developed in the event that the strategies to address the root cause or causes of cost growth would benefit from a collaborative PIP.

(5) The payer or provider organization must submit its PIP to the Authority no later than 90 calendar days from the date the Authority notifies the payer or provider organization in writing that a PIP is required. The payer or provider organization is responsible for completing and submitting the PIP template to the Authority.

(6) The notified payer or provider organization may request an extension to complete and submit a PIP. The Authority may grant, at its sole discretion, an extension of up to 45 calendar days for the payer or provider organization to submit a complete PIP. The payer or provider organization must request an extension no later than 30 calendar days prior to the PIP submission deadline.

(7) Within 30 calendar days of receipt, the Authority shall assess the submitted PIP to ensure it is complete and either approve the PIP or, if the PIP is incomplete, return it to the submitting payer or provider organization for revision with a specified deadline for the revised PIP, as determined by the

Authority on a case-by-case basis. In accordance with ORS 442.386(8) and in order for the Authority to deem a submitted PIP template complete, the PIP must address the factors outlined in (2)(a).

(8) After the Authority's approval of the PIP, the payer or provider organization shall submit progress reports every 6 months, from the date the Authority approved the submitted PIP, regarding all progress made in advancing the purpose of the PIP, including qualitative and quantitative data as specified in the PIP.

(9) PIPs, progress reports, and any relevant documents will be published on the program website with confidential information redacted pursuant to (12) of this rule.

(10) At the request of the payer or provider organization, the Authority may grant one or multiple extensions to a payer or provider organization with an approved PIP to achieve the activities outlined in the PIP. The Authority shall publish on the program website all granted extensions and any new applicable deadlines for activities and milestones in each PIP.

(11) At the full discretion of the Authority, the Authority may waive an approved PIP that a payer or provider organization has implemented or is in the process of implementing. If waived by the Authority, the payer or provider organization is no longer required to submit progress reports or other required documentation pertaining to the waived PIP.

(a) In contemplating a waiver of an approved PIP, the Authority may take the following into consideration:

(A) the payer or provider organization's achievement of PIP goals ahead of the schedule specified in the PIP;

(B) unforeseen market circumstances;

(C) the payer or provider organization's performance related to the cost growth target; or

(E) the payer or provider organization is required to develop a subsequent PIP.

(12) A payer or provider organization required to submit a PIP may designate portions of the PIP, and any reports or documents pertaining to a PIP, as confidential. The applicant shall submit two versions of such materials to the Authority. One shall be marked as "CONFIDENTIAL" and shall contain the full unredacted version of the PIP and any reports or documents and shall be maintained as such by the Authority. The second shall be marked as "PUBLIC" and shall contain a redacted version of the PIP and any reports or documents pertaining to the PIP (from which the confidential portions have been removed or obscured) and shall be made available to the public by the Authority. A payer or provider organization claiming confidentiality in respect of portions of a PIP and any reports or documents shall include a redaction log that provides a reasonably detailed statement of the grounds on which confidentiality is claimed, citing the applicable statutory basis for confidentiality of each portion.