DRAFT – Cost Growth Target Program rules
April 2024 Version

Redlines signify changes made since the previously posted versions of the draft rules. Previous redlines were accepted; the redlines below are the new changes.

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) define reporting and accountability requirements to the Oregon Health Authority. Submitted 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
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409-065-0005 Definitions

The following definitions apply to OAR 409-065-0000 to 409-065-0055:
(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) "CGT-1" means the Data Submission Template as set forth on the website of the Authority.

(4) "CGT-2" means the Cost Growth Target Data Specification Manual as set forth on the website of the Authority.

(5) "CGT-3" means the Cost Growth Target Data Submission Waiver/Extension Request as set forth on the website of the Authority.

(6) "CGT-4" means the Cost Growth Target Frontline Worker Data Submission Template as set forth on the website of the Authority.

(7) "CGT-5" means the Cost Growth Target Performance Improvement Plan Template as set forth on the website of the Authority.

(8~~6~~) "DCBS" means the Oregon Department of Consumer and Business Services.

(97) “Dental-only insurance” means an insurance policy that provides benefits only for dental services.

(108) “Disability policy” means an insurance policy that provides benefits for losses due to a covered illness or disability.

(119) “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.

(1210) “Health benefit plan” has the meaning provided in ORS 743B.005.

(1311) “Health care” has the meaning provided in ORS 442.385.

(1412) “Health insurance” has the meaning provided in ORS 731.162.

(1513) “Hospital indemnity policy” means an insurance policy that provides benefits only for covered hospital stays.

(1614) “Long-term care insurance” has the meaning provided in ORS 743.652.

(1715) “Mandatory reporter” means any reporting entity determined to be a mandatory reporter in OAR 409-065-0010.

(1816) “Medicare supplemental insurance” or “Medicare supplemental policy” has the meaning provided in OAR 836-052-0119.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 Social Security Act (42 U.S.C. 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. 1395(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.

(1974) “Payer” has the meaning provided in ORS 442.385.

(2018) “Performance improvement plan” (PIP) has the meaning provided in OAR 409-065-0040.

(2119) “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.

(220) “Specific disease policy” means an insurance policy that provides benefits only for a loss due to a covered disease.

(2318) “Stand-alone prescription drug plan” means an insurance policy that provides benefits only for prescription drugs.

(2419) “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.

(250) “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.

(264) "Vision policy" means a health benefits plan covering only vision health care.

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

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409-065-0010 General Reporting Requirements for Mandatory Reporters

(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 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 reporters 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 believes a determination by the Authority of its mandatory reporter status to be in error, the entity must follow the procedure outlined in OAR 409-065-0027.

(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.

(7) An entity may appeal the Authority's determination of mandatory reporter status pursuant to the procedure outlined in OAR 409-065-005027.

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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) Annual data submissions must be submitted on the 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 will validate the submitted data in accordance with CGT-2.

(54) The Authority ~~has~~ will review a submitted CGT-1 within 90 calendar days after confirming receipt~~to review and request clarification or corrections to the annual data submission (CGT-1)~~. If the Authority finds errors during its review through edit checks or validation, the Authority will issue a notice of the error(s). ~~m~~Mandatory reporters must ~~make corrections~~correct and resubmit data (or submit a waiver request pursuant to OAR 409-065-0020) within 30 calendar days ~~of~~ after ~~notification by~~ the date the Authority issues notice of the error(s). ~~The Authority may make multiple requests for corrections or resubmissions. The~~The Authority will consider the annual data submission ~~is only considered~~ complete after the mandatory reporter submits ~~when~~ all necessary corrections and resubmissions, as determined ~~have been submitted and approved~~ by the Authority. Voluntary reporters may correct and resubmit data, as applicable.

Statutory/Other Authority: ORS 442.386
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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~~ must submit a CGT-3 form to request a waiver as follows:

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

(B) To request a waiver of all data submission or validation requirements as specified in CGT-2 and OAR 409-065-0015(4), mandatory reporters must submit a completed CGT-3 form to the Authority no later than 60 calendar days ~~prior to~~before 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~~ following receipt of the request.

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

(3) If a mandatory reporter believes they ~~require~~ need a deadline extension they must ~~notify the~~submit a CGT-3 form requesting one. ~~Authority by submitting a CGT-3 form.~~

(a) Mandatory reporters may submit a CGT-3 form to request a deadline extension as follows:

(A) To request a deadline extension for ~~the~~ data submission, mandatory reporters must submit a completed CGT-3 form to the Authority no later than 14 calendar days ~~prior to~~before 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 ~~-~~no later than seven~~7~~ calendar days after the Authority requests the data correction, resubmission, or validation requirement.

(b) The Authority must issue its determination on a mandatory reporter's ~~approve or deny the~~ CGT-3 deadline extension request ~~and provide written notification to the requestor~~ within 14 calendar days ~~of~~ after the date ~~receipt~~ of the request.

(4) If the Authority denies a ~~request for waiver or deadline extension~~CGT-3 request, the ~~requestor~~ mandatory reporter may appeal the denial pursuant to the procedure outlined in OAR 409-065-00502~~7~~.

(5) The Authority ~~shall~~ will 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
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409-065-0025 Data Submission Compliance and Enforcement

(1) Unless the Authority approves~~ed by~~ a waiver ~~or exception~~ submitted pursuant to OAR 409-065-0020, a mandatory reporter fail~~sure~~ to comply with general data submission requirements ~~exists~~ when a mandatory reporter:

(a) Fails to submit data files by the specified submission date, or
(b) Fails to submit data files for a required line of business.

(2) Unless the Authority approves~~approved by~~ a waiver ~~or exception~~submitted pursuant to OAR 409-065-0020, a mandatory reporter fails ~~failure~~ to comply with data file requirements ~~exists~~ when a mandatory reporter:

(a) Submits a data file in an unapproved layout;
(b) Submits a data element in an unapproved format;
(c) Submits a data element with unapproved coding;
(d) Fails to submit a required data element; or
(e) Fails 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~~ will ~~provide~~ issue a notice of noncompliance to mandatory reporters ~~written notification of each failure to comply with data submission or data filing requirements prior to~~before imposing a civil penalty under OAR 409-065-0027.~~.~~ Mandatory reporters ~~will~~ must come into compliance within~~have~~ 30 calendar days ~~from~~ from the date the Authority issues its ~~notification to~~ notice of noncompliance~~come into compliance~~.

(4) The Authority may impose a civil penalty on a mandatory provider for a violation of ~~these rules~~this rule if the mandatory reporter does not come into compliance as required under (3)~~30 days from the notification described in (3)~~. Pursuant to ORS 442.993, the Authority adopts the following schedule of civil penalties:

(a) Up to $500 per day for each violation of OAR 409-065-0025(1)(a) through (b);

~~(b) Up to $500 per day for each violation of OAR 409-065-0025(2)(d) (e);~~

(b~~c~~) Up to $400 per day for each violation of OAR 409-065-0025(2)(a) through (e).

~~A civil penalty may not exceed $500 per day for each violation of OAR 409-065-0025(1) or OAR 409-065-0025(2).~~

(5) Civil penalties will be imposed in the manner provided in ORS 183.745.

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

[Note: Appeal and contested case details are now in -0050]

409-065-0028 General Reporting Requirements for Provider Organizations

[Placeholder for CGT-4 and the frontline workforce data submission.]

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

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385
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OAR 409-065-0035
Reasonable Causes of Cost Growth

(1) The Authority shall not impose a performance improvement plan outlined in OAR 409-065-0040 or financial penalty outlined in OAR 409-065-0045 on an entity that exceeded the cost growth target due to unforeseen market conditions or other equitable factors, as enumerated in section (2) of this rule. The Authority shall conduct ~~an~~ analyse~~i~~s to understand potential systematic causes, market conditions, or other factors that might result in entities exceeding the cost growth target. The Authority shall determine, on a case-by-case basis, when such a condition or factor or a combination of such conditions or factors suffices as a reasonable cause for an entity to exceed the cost growth target ("determination of reasonableness").

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

(a) Changes in mandated benefits codified in Oregon Revised Statute, Oregon Administrative Rule, Federal law, or Federal Regulations, to the extent that the mandated benefits are not defrayed under applicable law;

(b) Changes in federal, state, or local law that increases costs, including, but not limited to workforce and labor requirements and compliance requirements.

(c) New pharmaceuticals, and new uses of existing pharmaceuticals, or new medical treatments entering the market, including new medical procedures and devices;

(d) 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;

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

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

(g) Macro-economic factors wholly outside of the ability of the entity to influence or mitigate, such as periods of significant inflation, supply chain shortages, or labor shortages;

(h) 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~~;

(i) High-cost patient or member outliers; and

(j) Any other reasonable cause specified in writing by the Authority and published as guidance 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 confidence and if the entity must participate in the Authority's determination of ~~ing~~ 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 process with the Authority. Participation may include but is not limited to the entity or its delegate or representative:

(a) ~~to the entity or its delegate or representative~~ attending meetings with the Authority,

(b) ~~,~~ responding to Authority questions, or

(c) providing supplemental documentation, analysis or data as requested to support claims of reasonable cost growth.

(5) ~~If~~ Failure of an entity ~~does not~~to participate in conversations regarding the determination of reasonableness process upon request by the Authority may result in the Authority being unable to determine that the cost growth was reasonable. As a result, the entity may be subject to any applicable accountability mechanisms~~, including performance improvement plans and financial penalties, and civil penalties as outlined in OAR 409-065-0025~~.

~~, the Authority may not be able to determine that the cost growth was reasonable and the entity may be subject to any applicable accountability mechanisms, including performance improvement plans and financial penalties, and civil penalties as outlined in OAR 409-065-0025.~~

(6~~5~~) An entity that exceeds the cost growth target with statistical confidence may submit analyses and supporting documentation to the Authority for any and all potentially acceptable reason~~s~~s for cost

growth as the entity may identifyies. 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) of this rule and OAR 409-065-0028.

(76) The Authority may request additional information, documents and analyses as the Authority may require in order to evaluate the an entity's assertation of reasonable cause for exceeding the cost growth target.

(87) No person shall file or cause to be filed with the Authority any statement, report, or other information required or permitted to be file and known to such person to be false or misleading in any material aspect.

(98) 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 acceptableed. The Authority shall issue a Notice of Intent notice of intent to impose one of three possible determinations: cost growth is due to an acceptable reason(s), cost growth is not due to an acceptable reason(s), or the reason(s) for cost growth cannot be determined. The Authority shall notify the entity of the Authority's Notice of Intent to impose a certain determination in writing. The Authority may, subject to OAR 409-065-xxxx 0030 publish the results of conversations regarding the determination of reasonableness process. The Authority will notify the payer or provider organization if a Performance Improvement Plan is required, as per OAR 409-065-0040.

(109) A payer or provider organization may request a contested case hearing pursuant to the procedure outlined in 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-5XX.

(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-5~~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.

409-065-0045 Cost Growth Target Financial Penalties

[Edits pending discussions at RAC #4 meeting]

409-065-0050
Cost Growth Target Accountability Contested Case Hearings

(1) A payer or provider organization is entitled to an informal conference and contested case hearing as provided in this rule regarding determinations made under OAR 409-065-0000 through 409-065-0055.

(2) This rule applies to informal conferences and contested case hearings requested on determinations made under OAR 409-065-0010 through 409-065-0030.

(a) An entity that wishes to contest a notice of determination of mandatory reporter status must request a hearing within 20 calendar days after the Authority issues the determination of mandatory reporter status outlined in OAR 409-065-0010.

(b) A mandatory reporter that wishes to appeal a denial of waiver or extension request must request a hearing within 20 calendar days after the Authority issues its determination pursuant to OAR 409-065-0020.

(c) A mandatory reporter that wishes to contest a civil penalty issued by the Authority regarding data submission or data filing requirements must request a hearing within 20 calendar days after the Authority issues a Notice of Intent to Impose Civil Penalties pursuant to OAR 409-065-0025.

(3) This rule applies to informal conferences and contested case hearings requested on determinations made under OAR 409-065-0035 through 409-065-0045.

(a) A payer or provider organization that wishes to contest a notice of intent to impose the Authority's determination that cost growth is due to an acceptable reason(s), cost growth is not due to an acceptable reason(s), or the reason(s) for cost growth cannot be determined, within 20 calendar days after the Authority issues the determination.

(b) A payer or provider organization that wishes to contest a financial penalty issued by the Authority must request a hearing within 30 days after the Authority issues a Notice of Intent to Impose Financial Penalties pursuant to OAR 409-065-0045.

(4) Informal Conference Request.

(a) Upon receipt of a determination outlined in (2) or (3) of this rule, a payer or provider organization may request via email an informal conference with the Authority.

(b) The Authority will schedule an informal conference with the payer or provider organization. The purposes of this informal conference are:

(A) To provide an opportunity to settle the matter;

(B) To give the parties and the Authority an opportunity to review the information which is the basis for the action; and

(C) To give the parties and the Authority the chance to correct any misunderstandings of the facts.

(c) If the payer or provider organization request a contested case hearing, the payer or provider organization may, at any time prior to the hearing date, request an additional informal conference with the Authority, which may be granted if the Authority finds at its sole discretion that the additional informal conference will facilitate the resolution of disputed issues.

(d) At the conclusion of the informal conference, the Authority may reissue the determination and issue a final order.

(5) Contested Case Hearing.

(a) In a contested case conducted pursuant to this rule, an Administrative Law Judge (ALJ) assigned by the Office of Administrative Hearings will conduct the contested case hearing pursuant to ORS 183.411 through 183.497, the Attorney General's Model Rules at OAR 137-003-0501 to 137-003-0700, and the provisions of these rules.

(b) The Authority's contested case hearings governed by this rule may be open to the public.

(c) The issues to be considered in a contested case conducted pursuant to this rule shall be limited in scope to the facts and conclusions contained in the order or determination.

(d) In a contested case conducted pursuant to this rule, the party requesting the contested case hearing shall have the burden of proof.

(6) Proposed and Final Orders. The ALJ is authorized to serve a proposed order on all parties and the Authority unless prior to the hearing, the Authority notifies the ALJ that a final order may be served by the ALJ.

(a) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file written exceptions to the proposed order to be considered by the Authority, or the ALJ when the ALJ is authorized to issue the final order. The exceptions must be in writing and received by the Authority, or the ALJ when the ALJ is authorized to issue the final order, not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may be submitted without prior approval of the Authority.

(b) The Authority shall issue a final order within 30 days of receipt of the proposed order, which may adopt some or all of the proposed order, as the Authority shall determine in its sole discretion. The final order is effective immediately upon being signed or as otherwise provided in the order.

(c) After receiving the exceptions or argument, if any, the Authority may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority may issue an amended proposed order.

(7) The time limits established in this rule may be waived or shortened by agreement among the parties and the Authority.

(8) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.

~~(1) The Authority shall hold a contested case hearing upon a written request for a hearing within the time specified in paragraph (3) of this rule by a person aggrieved by any act, threatened act or failure of the Authority to act under ORS 442.385 and 442.386 or OAR 409-065-0030 to OAR 409-065-0055.~~

~~(2) The Authority's contested case hearings governed by this rule are not open to the public and are closed to nonparticipants, except nonparticipants may attend subject to the parties' consent and applicable confidentiality laws~~

~~(3) Contested case hearings shall be conducted pursuant to ORS 183.411 through ORS 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 through OAR 137-003-0700, and the provisions of this rule.~~

~~(4) A payer or provider organization that wishes to contest a determination issued by the Authority must request a hearing within 15 calendar days from the date of notice.~~

~~(5) In a contested case conducted pursuant to this rule, the party requesting the contested case hearing shall have the burden of proof.~~

~~(6) In a contested case conducted pursuant to this rule, an administrative law judge assigned by the Office of Administrative Hearings shall serve a proposed order on all parties and the Authority, unless prior to the hearing the Authority notifies the administrative law judge that a final order may be served, within 30 calendar days of the close of the evidentiary record in the contested case.~~

~~(7) The Authority shall issue a final order within 30 days of receipt of the proposed order, which may adopt some or all of the proposed order, as the Authority shall determine in its sole discretion. The final order is effective immediately upon being signed or as otherwise provided in the order.~~

~~(8) The time limits established in paragraphs (5) and (6) of this rule may be waived or shortened by agreement among the parties and the Authority.~~

~~(9) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.~~

409-065-0055
Annual Public Hearings

(1) The program shall hold an annual public hearing regarding the growth in total health expenditures in relation to the health care cost growth in the previous calendar year. The director of the Authority may require any payer or provider organization to participate in a conference that is found to be a significant contributor to health care cost growth in the state or exceeds the cost growth target with statistical confidence, as defined by the Authority, and without reasonable cause, as defined in 409-065-0035, during the performance year. The Authority shall notify the payer or provider organization of the requirement to participate. Each such payer or provider organization that is required to participate in such hearing shall provide testimony on issues identified by the director of the Authority and provide additional information on actions taken to reduce such payer's or provider organization's contribution to state-wide and market-level health care costs and expenditures.

(2) The director of the Authority may require that any other entity, including but not limited to a drug manufacturer or pharmacy benefit manager, that is found to be a significant contributor to health care cost growth in this state during the performance year participate in such hearing. Any other entity that is required to participate in such hearing shall provide testimony on issues identified by the director of the Authority and provide additional information on actions taken to reduce such other entity's contribution to state-wide health care costs.

***Note: Cite to ORS 413.037 as authority for this OAR.