Hospital Association of Oregon

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Ms. Bartelmann and Mr. Goldman:

Thank you for the opportunity to participate in the Rules Advisory Committee (RAC) process regarding health care cost growth target accountability. On behalf of our 61 member hospitals, the Hospital Association of Oregon appreciates the work the Oregon Health Authority (OHA) has done so far to integrate the broad range of stakeholder feedback into the draft rules. We support many of the changes proposed at the fourth RAC meeting on April 17, 2024. We offer the following comments to build on our prior input.

Note, all references to the draft rules are from the April 2024 Version shared with RAC members on April 10, 2024.[1]

Draft OAR 409-065-0028: General Reporting Requirements for Provider Organizations

OHA proposes to populate this placeholder rule in accordance with the following concepts:[2]

- "Require large and mid-sized provider organizations to report frontline worker compensation.
- Allow small provider organizations to opt-in to data reporting.
- Such data can be referenced when discussing cost growth reasonableness but cannot be subtracted from an entity's cost growth. **No provider will be held accountable if the reason for exceeding the target was frontline worker compensation." (emphasis in original)**

While we appreciate that OHA has responded to our feedback on this topic, the proposal is still inconsistent with the language and intent of HB 2045 (2023).[3] Public reporting is a form of accountability under the cost growth target program. Therefore, it is inaccurate to state that, "No provider will be held accountable if the reason for

[1] Posted here.
[2] Oregon Health Authority, Sustainable Health Care Cost Growth Target Program: Rules Advisory Committee (RAC) Meeting #4 (slide deck), April 17, 2024, slide 19.
[3] *See also* ORS 442.386.

exceeding the target was frontline worker compensation," if the provider organization's cost growth is not adjusted to account for frontline worker compensation before being published in a public report.

We acknowledge that frontline worker compensation, which is a subset of operating costs, is not a direct input into a provider organization's Total Medical Expenditures (TME), which is intended to reflect amounts paid for care received by patients attributed to the provider organization.[4] Still, frontline worker compensation and other operating costs are key drivers of TME, and understanding the extent to which these operating costs contribute to cost growth in our health care system is an essential aspect of the cost growth target program. OHA would have to find some way to evaluate the relationship between these numbers to determine whether a provider organization's cost growth above the target was reasonable. If OHA believes it can conduct this analysis at the point of determining reasonableness, as it currently proposes to do, it seems possible for OHA to use the same methodology earlier in the process. The provider organization's cost growth should be adjusted to account for frontline worker compensation before being published in a public report and before determining reasonableness.

Draft OAR 409-065-0045: Cost Growth Target Financial Penalties

Calculating penalties

We support the following OHA proposals discussed at the April 17 RAC meeting:[5]

- Remove "restitution" language.
- Remove the BHP Fund component of the penalty and only have the penalty that directly benefits consumers, patients, or community.
- Instead of referencing only the years in which the entity exceeded the target, the penalty calculation would include the net overage/underage.
- A given year's performance (above or below the target) only counts once. No double penalizing for a given year's performance.

Regarding the latter two bullet points, our understanding is that if an entity is penalized more than once within a five-year period, the subsequent penalty amount(s) would be calculated based on the net overage/underage since the most recent penalty.

In addition to the above, we propose the following modifications to financial penalty calculations:

- If the net overage/underage compared to the target is zero or below, a financial penalty should not be imposed. Financial penalties should be a last resort when a payer or provider organization has failed to act in good faith to address cost drivers that are within its control. Cumulative cost growth at or below the target over five years is not consistent with such a failure.
- Subtract any amount of cost growth above the target that was determined to have a reasonable cause.
- For a provider organization, subtract from the adjusted PMPM any expenditures paid to outside providers for services provided to patients attributed to the provider organization.

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[4] Because TME does not account for charity care or patient non-payment, and because a provider organization's attributed TME also includes care provided to attributed patients by other providers, it does not reflect actual payment to the provider organization.

[5] Oregon Health Authority, Sustainable Health Care Cost Growth Target Program: Rules Advisory Committee (RAC) Meeting #4 (slide deck), April 17, 2024, slides 11-14.

- Exclude penalties more than five years old for the purpose of calculating penalties for repeated offenses within the same market. The statute does not provide for penalties outside of the five-year lookback window.[6]

Penalty cap

Regardless of how penalties are calculated, it remains critically important to cap them at a level that does not limit investments in the workforce, reduce access to care, or increase costs. All these things are likely to occur well before a payer or provider organization's solvency is threatened.

A reasonable penalty cap should reflect the newness of the program. Far from being a primary lever to contain cost growth, accountability mechanisms including financial penalties are intended as a "last resort only after transparency and collaborative efforts to contain costs do not have an impact."[7] We have no evidence from other states that financial penalties can slow the growth of consumer health care costs as part of a program like this. On the contrary, a financial penalty that makes it considerably more expensive for a payer or provider organization to operate is likely to translate to higher health care costs and/or undesirable tradeoffs affecting access to care. If evidence emerges that the financial penalty amounts are to blame for the state's inability to meet cost containment goals and evidence suggests higher financial penalties would reduce cost growth without unintended consequences, the state could revisit the conversation in the future as the program matures.

Overall limitation on imposing financial penalties

As we recommended previously, a payer or provider organization should be subject to a financial penalty only if the payer or provider organization has not made a good faith effort to comply with a performance improvement plan (PIP) or has refused to participate in the PIP process. This is consistent with the discussions by Cost Growth Target Advisory Committee members that, "Financial penalties should be rare, and only imposed after careful consideration of whether the entity had the opportunity to control costs and whether the entity has demonstrated good faith efforts in working to control costs and to implement a performance improvement plan."[8] One of the Advisory Committee Co-Chairs further described the "level of flagrancy" that would warrant a financial penalty as a payer or provider organization having to "still be outside the cost growth target, be on a performance improvement plan, and then still be ignoring your performance improvement plan to get to a financial penalty."[9]

Penalty timeline

OHA proposes to delay the potential imposition of financial penalties by one year, so that "instead of 2020-2021 performance as Year 1 of the 5-year penalty window, 2021-2022 would be Year 1 of the 5-year window."[10] This

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[6] *See* ORS 442.386.

[7] Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations Final Report to the Oregon Legislature, January 2021, p. 46. The full sentence reads, "OHA intends for any accountability mechanisms to apply as a last resort only after transparency and collaborative efforts to contain costs do not have an impact."

[8] Cost Growth Target Advisory Committee, Draft Principles for Financial Penalty Development, November 15, 2023, p. 3.

[9] Cost Growth Target Advisory Committee Meeting, November 15, 2023, recording starting at 1:18:32.

[10] Oregon Health Authority, Sustainable Health Care Cost Growth Target Program: Rules Advisory Committee (RAC) Meeting #4 (slide deck), April 17, 2024, slide 16.

approach is an improvement, but we maintain that Year 1 should be 2024-2025 to provide payers and provider organizations with adequate notice of the final standards to which they will be held accountable.

Draft OAR 409-065-0055: Annual Public Hearings

Based on the language OHA added to the draft guidance document before RAC #3,[11] and contrary to the language in the most recent version of this rule, our understanding is that the determination of reasonableness process will not have been completed at the time of the annual public hearing. We request that this rule be revised to describe:

- The inclusion of OHA's analysis in the Annual Report;
- The role of the public comment period and public hearing in determining which payers or provider organizations must participate in determining reasonableness process; and
- The publication of the supplemental report.

Testimony of individual entities at the annual public hearing could be for a variety of purposes, including but not limited to identifying systemic cost drivers and better understanding overall cost growth trends. The rule should also be revised to reflect this broader scope.

Conclusion

Thank you for the continued opportunity to provide feedback on the draft rules. We look forward to further discussion.

Sincerely,

Andrea Seykora
Director of Public Policy and Legal Affairs
Hospital Association of Oregon

About the Hospital Association of Oregon

Founded in 1934, the Hospital Association of Oregon (HAO) is a mission-driven, nonprofit trade association representing Oregon's 61 hospitals. Together, hospitals are the sixth largest private employer statewide, employing more than 70,000 employees. Committed to fostering a stronger, safer, more equitable Oregon where all people have access to the high-quality care they need, the hospital association supports Oregon's hospitals so they can support their communities; educates government officials and the public on the state's health landscape and works collaboratively with policymakers, community based organizations and the health care community to build consensus on and advance health care policy benefiting the state's 4 million residents.

[11] Oregon Health Authority, Sub-regulatory Guidance: Determining Reasonableness, draft for RAC discussion, March 2024, p. 21.