Oregon's Health Care Cost Growth Target Program

Q&A for Data Submitters

Version 3.0

May 8, 2023

About

This document accompanies the initial Cost Growth Target Data Submission Template and Data Submission Manual (CGT-1 and CGT-2) and provides answers to questions that data submitters and stakeholders have asked during the development of the Template and Manual, during data submission training, and office hours.

Please contact HealthCare.CostTarget@oha.oregon.gov with any questions.

Contents

FAQs

Cost Growth Target Program

1. What are the requirements of the Cost Growth Target Program?

Data submission: All payers and third-party administrators with at least 1,000 covered Oregon lives across all lines of business must submit cost growth target data (OAR 409-065). OHA will identify payers and TPAs using enrollment data and provide annual notification to mandatory data submitters for each reporting year. Provider organizations do not have any data submission requirements.

Taking action to meet the cost growth target: payer and provider organization cost growth will be measured relative to the cost growth target each year and reported on, and there are accountability mechanisms for payers and provider organizations who fail to meet the cost growth target without good reason (see below), but payers and provider organizations are not required to take any specific action to meet the cost growth target.

Performance Improvement Plans: payer and provider organizations who fail to meet the cost growth target with statistical certainty and without a good reason in a given year for one or more markets may be subject to a Performance Improvement Plan (PIP). OHA will notify any payers or provider organizations that they are required to submit a performance improvement plan for a given year, and will provide the performance improvement plan template, guidelines, and timeframe for submission. Payers and provider organizations subject to a PIP will also be required to report progress on their PIPs according to OHA guidance.

Financial Penalties: payer and provider organizations who fail to meet the cost growth target with statistical certainty and without a good reason in three out of five years may be subject to a financial penalty. Payers and provider organizations subject to financial penalties would be required to make the payment.

Civil Penalties: payers may be subject to fines for late or incomplete submission of data. Payers and provider organizations may be subject to fines for late or incomplete performance improvement plans.

2. How will OHA use the annual cost growth target data submission files from payers?

The annual cost growth target data submission (CGT-1) will be used to calculate performance relative to the cost growth target at the state, market, payer, and provider organization level.

3. Does each data reporter submit one CGT-1 file?

Yes, each data reporter should submit one file. One parent entity may be responsible for building multiple data reporters' CGT-1 files, this is OK as long as each is submitted individually[1].

For a list of data reporters, visit the CGT Data Submission webpage:
https://www.oregon.gov/oha/HPA/HP/Pages/cost-growth-target-data.aspx

If data reporters have questions or concerns about reporting various business entities or lines of business as indicated by OHA on the list of data reporters, please contact the program directly to discuss: HealthCare.CostTarget@oha.oregon.gov

[1] An exception can be made if the parent entity is responsible for multiple data reporting entities whose membership across markets (Medicare, Medicaid, Commercial) is mutually exclusive. Example: Parent Entity X is the parent entity of Payer A (Medicare Advantage only) and Payer B (Commercial only), two CGT data reporters. Since the cost growth target applies at the market level, Parent Entity X can coordinate with OHA to submit one CGT-1 file with combined Payer A & B data as the data template will differentiate spending by market and thus, the two payers.

Performance Relative to the Cost Growth Target

4. How will OHA handle conversations with payers and providers about their cost growth target performance, including addressing extraordinary events, such as the COVID-19 pandemic and changes in benefits?

OHA received multiple questions about potential reasons that the cost growth target may not be met in a given year, and how OHA will handle conversations with payers and providers, including addressing extraordinary events, such as the COVID-19 pandemic and changes in benefits. The response below is from the Implementation Committee Recommendation Report (January 2021).

Following the calculation of performance relative to the cost growth target and applying statistical testing, OHA will have 1:1 conversations with any payer and provider organization that was found to have exceeded the cost growth target with statistical confidence. OHA will coordinate with DCBS for commercial payer conversations. At the 1:1 conversation:

- OHA will share its findings and any interpretations, including identification of key factors that may have caused cost growth to exceed the target that year based on its independent analysis which may utilize additional data sources like claims data from the All Payer All Claims Program (APAC).
- Payers and provider organizations will share any supplemental data that sheds light on factors that influenced cost growth performance, and potential interpretations, including key factors that may have caused cost growth to exceed the target that year.

The purpose of these meetings is to identify key factors that caused cost growth to exceed the target that year. After identifying the key factors that caused cost growth to exceed the target in a given year, OHA will determine if exceeding the cost growth target was or was not reasonable based on consideration of potentially substantiating factors, with consideration of the payer or provider organization's perspective.

This determination will inform whether the payer or provider organization should be held accountable for that year's performance. A mix of factors may be the cause of cost growth, including factors that cannot be anticipated (e.g., COVID-19).

Some of the potential factors that may cause an organization to reasonably exceed the target in a given year include, but are not limited to:

- Changes in mandated benefits
- New pharmaceuticals or treatments / procedures entering the market
- Changes in taxes or other administrative factors
- “Acts of God” – natural disasters, pandemics, other
- Changes in federal or state law
- Investments to improve population health and/or address health equity

The isolated impact of the identified factor, or the combination of identified factors must be significant enough to have caused the payer or provider organization’s cost growth to exceed the target. Factors should be completely outside of the control of the payer or provider organization and may be environmental, market-based, or governmental in nature. However, not all factors can be predicted, so this will not be a fixed list of criteria, but rather an opportunity to understand what has happened during the year.

If a payer or provider organization disagrees with OHA’s determination, the payer or provider organization will be able to appeal. The appeal process and additional documentation for these 1:1 conversations will be developed later in 2023 and incorporated in rulemaking.

5. Are payers and provider organizations accountable for all lines of business included in the data submission?

No, market accountability at the payer and provider organization level aligns with the following lines of business (LOB) reported in the CGT data submission template: Medicare (Advantage) – LOB 1, Medicaid – LOB 2, and commercial (full claims) – LOB 3. Other LOBs (4-6) are included in data reporting but are not considered for an entity’s cost growth performance.

6. How will hospital community benefit spending be taken into consideration for cost growth target performance?

Investments to improve population health and/or address health equity are potential factors that may cause an organization to reasonably exceed the target in a given year and will be taken into consideration in determining whether a provider organization should be held accountable for their cost growth; see above.

7. How will OHA use the Supplemental Health Care Exhibit (SHCE) and Medical Loss Ratio (MLR) data to obtain NCPHI relevant to just Oregon residents?

The Net Cost of Private Health Insurance (NCPHI) is calculated separately for the different segments of Oregon's health insurance markets. To get NCPHI applicable to Oregon residents, NCPHI PMPM must first be calculated using in-situ information from a payer's premium, claims, and member month data from either the SHCE or MLR. Next, this NCPHI PMPM will be multiplied by each payer's member months reported in their CGT-1 submission to get NCPHI for Oregon residents within each market segment. By using member months reported in the CGT-1 data, OHA will assume the cost of administering private health insurance for Oregon residents is the same for the payer as it is for their non-Oregon members.

Benefits

8. How will changes in legislative requirements and/or mandated benefits be reflected in the cost growth target data submission and/or analysis?

See above.

9. How will OHA ensure comparability across payers and provider organizations and comparability over time if offered benefits are different?

The purpose of the cost growth target program is to measure each payer and provider organization's own cost growth, relative to themselves, rather than comparing against each other. Benefits will vary across different lines of business (Medicaid, Medicare, Commercial: full claims, Commercial: partial claims, etc.) and markets (Medicaid, Medicare, Commercial); and the market is the level at which cost growth target performance will be compared year-over-year.

If benefits within a given line of business change significant year-over-year, the process for understanding drivers of cost growth, which includes holding 1:1 conversations with payers and provider organizations, will provide opportunity to surface these changes and understand their impacts on performance relative to the cost growth target. Benefit changes may be a "reasonable" explanation for why a payer has exceeded the cost growth target in a given year.

10. Benefits are not consistent across all members. How should payers handle optional, non-essential health benefit claims and benefits such as infertility or bariatric surgery?

Benefits will vary across different lines of business and markets (Medicaid, Medicare, Commercial), the latter being the level at which cost growth target performance will be compared year-over-year. There is no expectation that payers try to standardize benefits across members for the purpose of cost growth target reporting.

If benefits within a given line of business change significantly year-over-year, the process for understanding drivers of cost growth, which includes holding 1:1 conversations with payers and provider organizations, will provide opportunity to surface these changes and understand their impacts on performance relative to the cost growth target. Benefit changes may be a "reasonable" explanation for why a payer has exceeded the cost growth target in a given year.

Services such as infertility or bariatric surgery should be included if they are a covered benefit for a given line of business.

Data Submission Inclusion Criteria

11. Is the data submission limited to providers in Oregon?

No. Data reporters should submit data limited to Oregon *residents*, but all services for Oregon residents should be included, whether the provider is inside or outside of Oregon.

See page 9 of the Data Specification Manual: "Total Health Care Expenditures is inclusive of spending on behalf of Oregon residents who are insured by Medicare, Medicaid, or commercial insurance, and receive care from any provider in or outside of Oregon.

12. Who is providing Medicaid data for the Cost Growth Target Program?

Oregon's Coordinated Care Organizations are required to submit data for their enrolled Medicaid members. OHA will provide Medicaid data for the Medicaid Fee-For-Service population.

13. Should payers use paid amounts or allowed amounts?

Payers must calculate claims payments using allowed amounts, which include payer paid amount to providers as well as patient liability for cost-sharing like co-payments, deductibles, co-insurance. However, starting with the 2022 data submission onward, when reporting claims payment for **LOB code 5** (Medicare Expenses for Medicare/Medicaid Dual Eligible) and **LOB 6** (Medicaid Expenses for Medicare/Medicaid Dual Eligible) – payments should be reported using **Paid Amounts** regardless of whether the payer is the primary or secondary payer.

14. If payers are reporting Medicare / Medicaid dual eligible expenses separately, on a paid amount basis, would that double count member months?

Yes, this is expected for a payer that covers, and thus reports for, a dual eligible person's Medicare (LOB5) and Medicaid (LOB 6) expenses. A payer that reports costs for one member in both lines of business should report the appropriate member months in each LOB row.

15. How should payers handle coordination of benefit (COB) claims?

Coordination of benefit claims should be included if the data submitter is the primary payer of those claims for members. Data submitters should exclude claims for members for which they are the secondary or tertiary payer.

16. What payments are excluded (e.g., Medicare Part D settlements, reinsurance recoveries, ACA risk transfer amounts, etc.)?

Payers should only report claims and non-claims payments **made to providers**. Reporters shall not submit data for any excluded lines of business. See section 'Which Lines of Business are Included' in the Data Specification Manual.

17. How should payers report carved-out services (e.g., behavioral health, lab, etc.…)?

OHA has provided general parameters for payers to follow in accounting for carved-out services and vendor costs, but reporting will depend on payers' ability to identify and allocate these costs. See this guidance in section 'How Spending is Categorized' in the Data Specification Manual:

- Spending for covered benefits should be included, regardless of how the payer is delivering the benefits. If a payer is unable to determine the total spending by service category for carved-out benefits, and…
    - …has encounter data, the payer should estimate payments and include them in the calculation allocated to the appropriate service category.
    - …does not have access to claims or encounter data for carved out services, the payer should apply a reasonable estimate of spending per member per service category and describe how they calculated the estimate in Tab 1 of the Data Submission Template.
- Spending on the administrative fees of carved-out vendor contracts should be included or excluded in accordance with payer reporting on federal financial forms such as the NAIC Medical Loss Ratio form.
- Spending for contracts and vendors that provide strictly administrative functions for health plan operations should not be included in the calculation.

18. Should payers include end-stage-renal-disease (ESRD) member spending?

Yes. Payers should include ESRD member data in their submission and apply risk adjustment where appropriate.

19. Should CCOs include 711 drug spending?

Yes, CCOs should report any 711 costs *they* are paying. CCOs should not estimate costs for 711 drug spending for CCO members that are "carved out" and paid by Medicaid Fee-For-Service.

Demographic Adjustment

20. How is the Demographic Score (TMEALL04) defined in the TME_ALL tab?

The demographic adjustment score reported in TME_ALL tab is the weighted average of demographic adjustment scores reported in TME_PROV and TME_UNATTR tabs by line of business, that is, the product of the member months times the risk adjustment scores divided by the sum of member months in a given year-line of business.

Example of TMEALL04 calculation (for one year-line of business):

- TME_PROV tab

Provider Organization Name	Member Months	Demographic Score
Main St Provider Group	720,000	1.15234
Hospital System Z	480,000	1.14254

- TME_UNATTR tab

Provider Organization Name	Member Months	Demographic Score
N/A	100,000	1.16475

- TME_ALL tab, Demographic Score field (TMEALL04) =

$$\frac{(720{,}000*1.15234) + (480{,}000*1.14254) + (100{,}000*1.16475)}{(720{,}000 + 480{,}000 + 100{,}000)}$$

$$= 1.14968$$

Data submitters should confirm in Table 2 of tab TME Validation that for each combination of year & line of business, the demographic adjustment score reported in TME_ALL tab is equal to the weighted average of demographic adjustment scores reported in TME_PROV and TME_UNATTR tabs.

See CGT-1 with mock data for an example:
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/CGT-1-Data-Submission-Template-training-mock-data.xlsx

21. What sex factor should be used for a member that is not classified as Male (M) or Female (F)?

If the sex of a member is not categorized as male or female, please use the male demographic factors that OHA provided for the relevant market and member age.

Attribution

22. Should payers use their own definitions to identify primary care providers, or should they follow the provider taxonomy and procedure codes included in the Manual?

The Data Specification Manual talks about primary care providers in two different ways: (1) defining primary care providers for the primary care-based member attribution, and (2) defining primary care services for categorizing claims spending.

When identifying primary care providers for the purposes of member attribution: payers can use their own attribution methodologies (Tier 3), but if they are using taxonomy codes to identify primary care providers, they should use the taxonomy codes in Table 3 to identify the primary care providers that members are being attributed to.

If payers need additional guidance in identifying primary care services to help with attribution, OHA has also provided a set of procedure codes from the Primary Care Spending Report Program in Appendix B. Payers can also use their own internal processes for identifying primary care services.

When identifying primary care services for categorizing claims spending: payers can also choose to use the taxonomy and procedure codes provided in Appendix B to identify primary care spending for the claims professional: primary care category, or they can use their own internal methodology to match the description of the provider taxonomy codes provided.

Standard Deviation and Statistical Testing

23. How will OHA use standard deviation in the analysis?

Standard deviation will be used to calculate confidence intervals for year-to-year cost growth for each payer and provider organization subject to the target. See standard deviation details under section 'Tabs 2-4 – Total Medical Expenses (TME)' in the Data Specification Manual and the supplemental Statistical Analysis document posted online.

24. Should the standard deviation calculation include members with no utilization?

Yes. When calculating the standard deviation, payers should include **all** members attributed to that entity, or in the case of the unattributed cohort, all unattributed members. The standard deviation reflects the distribution of costs regardless of utilization. See the Supplemental SD Calculation document posted online.

25. For commercial partial claims rows (Line of Business code = 4), should payers calculate the standard deviation PMPM *after* partial claims adjustment?

Yes, payers should calculate the standard deviation PMPM *after* partial claims adjustment for rows where Line of Business code is 4, Commercial: partial claims.

Pharmacy Rebates

26. OHA collects the majority of pharmacy rebates for Medicaid – where will this be recorded and noted?

OHA will be reporting pharmacy rebates that it captures for the Oregon Health Plan and will apply these rebates at the Medicaid market level. OHA does not intend to report pharmacy rebates for the Oregon Health Plan at the CCO level or provider organization level.

27. Pharmacy rebates may take many months to complete due to complex contracts with manufacturers and will not be complete after 180 days runout. How should payers handle this?

OHA recognizes that payers may not have complete pharmacy rebate data for a measurement period prior to the annual cost growth target data submission. Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the reporting period; see section 'Tab 6 – Pharmacy Rebates' in the Data Specification Manual.

If payers estimate any pharmacy rebate data, they will be asked to describe the methods in Tab 1 of the Data Submission Template.

28. How should payers report rebates that are passed along to self-funded customers, or used to support their overall benefits program?

Payers should report any rebates they receive, regardless of whether they are passed along to self-funded customers or not. I.e., payers should report total rebates, not net retained rebates; see section 'Tab 6 – Pharmacy Rebates' in the Data Specification Manual.

Non-Claims Payments

29. Not all incentive payments may be complete after 180 days runout. How should payers handle this?

Payers should apply reasonable and appropriate estimations of non-claims liability for each provider organization (including payments expected to be made to organizations not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period (see section 'Data Completeness' in the Data Specification Manual). OHA may request additional detail from payers about their estimations.

30. Some payers use vendors to manage provider incentive payments; how should this be reported?

If a payer has a vendor manage performance incentive payments to providers on its behalf, these dollars should still be included and reported in the Non-Claims: Performance Incentive Payments category. Excerpt from Non-Claims Payments in section 'Tabs 2-4 – Total Medical Expenses (TME)' of the Data Specification Manual:

- If the payer has detailed data from the vendor about how much the incentive payments made to providers were, allocate directly to the provider organization.
- If the payer does not have data from the vendor about incentive payments, follow the guidance for administrative costs and reasonable estimates in the Data Specification Manual.

31. How should payers report non-claims payments if they cannot split out payments to only report for OR residents?

Total medical expenditure (TME) is the sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Oregon residents for all health care services (see full definition in Data Specification Manual). If payers cannot split out non-claims payments for just OR residents, payers can use their own estimation to report these payments and summarize their methodology in Table 1.3 "Does TME data include Oregon residents only?" (for more estimation guidance see section Data Completeness).