Oregon's Health Care Cost Growth Target Program

Determining Reasonableness

August 29, 2023

About

This document describes OHA's proposed process and documentation to determine whether payer cost growth that exceeded the target with statistical confidence was for a good reason. This document addresses questions that payers have raised to date about the determining reasonableness process.

This document will be expanded to include more information on the proposed process for provider organizations later this fall.

This document accompanies the Cost Growth Target Data Submission manual (CGT-2) and FAQs. **This process is not final and is subject to change pending input from the Cost Growth Target Advisory Committee, Technical Advisory Group, consultation with the Department of Justice, and the upcoming rulemaking process.** See Accountability Update (Aug 2023) document for additional information about the rulemaking process and timeline.

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

Contents

Version number	Date released	Description of change(s)
1.0	Aug 29, 2023	

Key Points

- OHA will treat 'determining reasonableness' as a separate process, following completion of the data validation process.

- Once a payer's data submission has been validated and determined to be complete and final, OHA will determine whether an entity needs to have a determining reasonableness conversation.

- **Only payers who exceed the cost growth target with statistical confidence for a given market will need to complete the determining reasonableness process.**

- Determining reasonableness conversations will be scheduled and held individually with each entity as needed. Each payer can determine who will participate in this conversation.

- When the determining reasonableness conversations are complete, OHA will provide written documentation, summarizing conversation participants and key themes, factors driving cost growth, and ultimately, whether the cost growth is considered reasonable or not.

- While no payer will be placed on a Performance Improvement Plan for the 2023 data submission cycle (cost growth between 2021-2022), in future years, determining reasonableness conversations may lead into consideration and development of Performance Improvement Plans.

Acceptable Reasons for Exceeding the Cost Growth Target

Oregon's Cost Growth Target Implementation Committee identified an initial list of potential factors that may cause a payer or provider organization to reasonably exceed the cost growth target. The Cost Growth Target Advisory Committee agreed in January 2023 that "macroeconomic factors" should be added to the list. And HB 2045 in the 2023 legislative session specified that a provider [organization] shall not be accountable for cost growth resulting from total compensation provided to frontline workers.

Reasonable factors 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
- Macroeconomic factors
- Total compensation for frontline workers

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[1] and may be environmental, market-based, or governmental in nature.

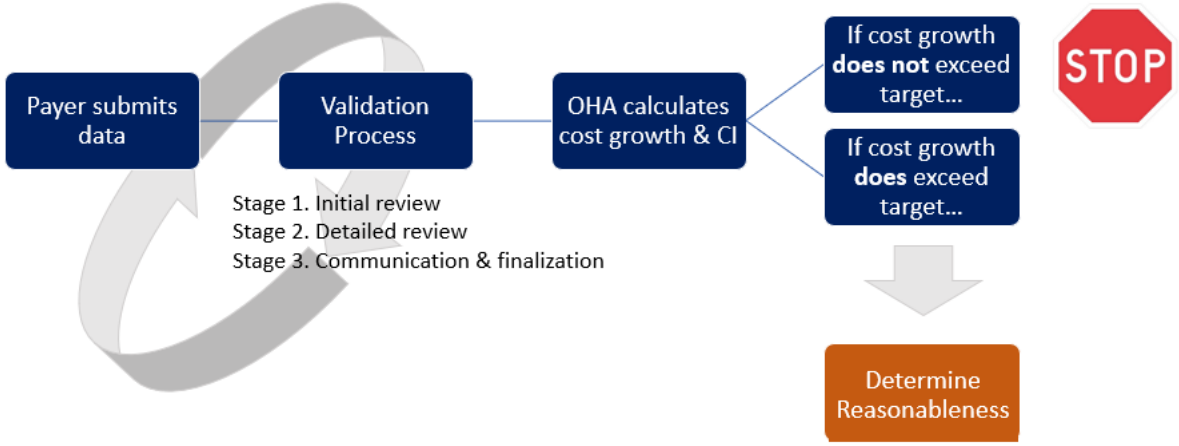
In November 2022, OHA shared a draft document with more detailed descriptions and examples of potential drivers of cost growth for discussion with the Advisory Committee, the Technical Advisory Group, and partners. The document included potential acceptable reasons for exceeding the cost growth target and was not intended to be a finite list of acceptable reasons. The list of acceptable reasons for exceeding the cost growth target will be included in the rulemaking process later in 2023 / early 2024.

[1] Excepting investments to improve population health and/or address health equity, which would be directly under the control of the payer or provider organization.

Determining Reasonableness for Payers

OHA will determine reasonableness as a separate process, following the completion of the established, three stage data validation process. See illustration below.

Data validation and determination of reasonableness for payers



Which payers must participate in the determining reasonableness process?

Not all payers will be required to complete the determining reasonableness process. Only payers who have exceeded the cost growth target with statistical confidence for a given market will need to complete the determining reasonableness process.

If this process had been in place for the 2022 data submission cycle (as reported in the May 2023 Health Care Cost Trends report), how many payers would have needed to complete the determining reasonableness process?

Commercial	7 of 8 payers
Medicare Advantage	8 of 10 payers
Medicaid	0 of 16 payers

How will payers know if they need to participate in determining reasonableness?

Following completion of the validation process, OHA will notify payers whether they need to participate in determining reasonableness conversations. This may come up in stage 3 validation conversations (see below), but OHA will provide written notice of the need for a determining reasonableness conversation.

Who should attend determining reasonableness conversations?

As with data validation conversations, each payer will have discretion over who attends determining reasonableness conversations with OHA. For example, payers may wish to have the same participants in validation conversations and determining reasonableness conversations or may wish to include other leadership or executives in the determining reasonableness conversation, but not validation.

For payers that are included in the cost growth target program for multiple markets, and who exceed the cost growth target with statistical confidence in multiple markets, OHA will defer to the payer's preference to have determining reasonableness conversations separately for each market or combined.

How will determining reasonableness conversations be different from validation conversations?

In the 2022 data cycle, OHA discussed potential reasons for cost growth and cost growth drivers with payers as part of the validation conversations. As no accountability mechanisms were in place for that measurement period and given the impacts of the COVID-19 pandemic on the health system, there was no need for an official determination.

For the 2023 data cycle, OHA intends to create more separation between the questions asked in data validation conversations and the determining reasonableness process. However, it is unlikely that OHA can create a complete separation between the two processes, and this may be more of an art than a science.

What happens in each of the validation stages?

The table below describes how OHA thinks about the validation process.

Validation Stage	Meeting?
Stage 1: Initial Review In this stage, OHA runs validation checks and identifies any obvious errors in the data submission. The focus of this stage is on data completeness and formatting. What OHA is looking for in stage 1: • *Is any data missing? E.g. payer only submitted for one of their commercial plans but not both.* • *Is the data for the correct measurement period?* • *Did the payer allow adequate claims run-out?* • *Are any fields in the template incomplete?* • *Do all tabs reconcile with each other? E.g. all of the providers who have attributed costs for the year under review also have a TIN listed in the submission*	No. OHA communicates with payer over email.
Stage 2: Detailed Review In this stage, OHA focuses on more detailed validation, such as identifying outliers and unexpected variations in trend. The focus of this stage is on anything unusual or concerning about the data and ensuring that there are not any underlying data issues influencing trend. What OHA is looking for in stage 2: • *Are there any big changes in year over year growth between this year and last year's submission?* • *Are there any validity concerns with any data? E.g. values that don't pass a 'sniff test'?* • *Are there any potential data issues that might require resubmission?*	Maybe – if needed to resolve any major questions or resubmission requests. If only minor issues, questions may be combined with stage 3

Validation Stage	Meeting?
Stage 3: Communication and Finalization of Data In this stage, OHA shares the data output summary with payer and discusses trends seen in the data. Stage 3 asks about cost drivers and helps provide context for trend reporting. Stage 3 will likely identify questions for additional analyses that a payer may wish to conduct in-house – see example questions below. The goal is to leave the stage 3 meeting with validated data. A payer may need to resubmit data before stage 3 is complete.	Yes

Sample Stage 3 Questions

- How has retail pharmacy spending changed in the measurement period?
  - A more detailed look at generic vs brand vs specialty?
  - Has place of service shifted?
- In Year 3 of the COVID-19 pandemic, how have the impacts continued to evolve when it comes to spending?
  - Has length of stay increased / decreased?
  - Which is the bigger driver – price or utilization?
  - Are shifting care sites still a factor?
- What is happening with behavioral health spending?
- Is there any health equity-focused spending occurring and where might that be showing up in the non-claims categories?
- Are there any known high-cost members / high-cost outliers?

Other topics such as the impact of inflation, the impact of Medicaid redeterminations, workforce shortages, solvency concerns, etc… may come up as part of validation conversations. However, OHA does not intend to talk about these potential cost drivers in stage 3 conversations**, as they are not required to ensure a valid and final data file**. OHA will engage with payers about these topics in determining reasonableness conversations if applicable.

How should payers prepare for determining reasonableness conversations?
OHA will develop the agenda and potential questions for discussion for the determining reasonableness conversation and share with the payer in advance.

OHA expects that some of the agenda and any requests for additional information or analyses will arise in the Stage 3 validation conversation (see above). To prepare, payers may wish to do some combination of the following:

- Review the data output provided by OHA for the measurement period and information surfaced during the validation process.
- Identify cost growth drivers and factors influencing cost growth from the payer's perspective (especially if different from OHA's perspective)
- Conduct additional analyses using in-house or supplemental data to better understand potential cost growth drivers and factors influencing cost growth. For example, if a new benefit was mandated during the measurement period, can the payer quantify how many members utilized the benefit and the total cost?
- Compile materials to provide insight from the payer's perspective. For example, if the payer believes they exceeded the cost growth target due to investments in population health or health equity, what were the investments made? How did these investments show up in the total cost of care as measured by the cost growth target program (i.e. are they reflected in a non-claims payment to provider organizations?)

OHA expects that determining reasonableness conversations may happen over several meetings, with time for iteration of analyses or to prepare any requested materials.

Will information shared in the determining reasonableness conversations be kept confidential?

Pending discussion with Department of Justice and rulemaking. OHA intends to publicly share the result of the determining reasonableness process for each payer – but specific details or materials shared with OHA during this process may be subject to confidentiality protections. OHA intends to develop a process for a payer to request that certain documents or materials be kept confidential.

How will the determining reasonableness process be documented?

When the determining reasonableness conversations are complete, OHA will provide written documentation for each payer, summarizing who participated, key themes from the conversation, factors driving cost growth, and ultimately, OHA's determination whether the cost growth is considered reasonable or not. This will likely take the form of a formal letter or memo from OHA to the payer.

OHA intends to share the results determination for each payer publicly. The letter/memo may be posted online, or OHA may explore a different option for presenting this information as part of the Annual Health Care Cost Trends reports.

Over time, this documentation may include a summary of the payer's cost growth in multiple measurement periods, whether they exceeded the target with statistical confidence for that period, and the results of the determining reasonableness process for that period. This will provide a running summary of payer performance relative to the target over time.

Potential example of what would be included in this running documentation for a payer for each measurement period, for each applicable market:

- *Measurement period*
- *Cost growth rate*
- *Confidence intervals*
- *Whether target was exceeded with statistical confidence*
- *Whether determining reasonableness process occurred*
- *Result of determining reasonableness process*

Who makes the final decision whether a payer's cost growth is reasonable?

OHA determines if exceeding the cost growth target was or was not reasonable based on consideration of potentially substantiating factors, the payer's perspective and any additional information shared during the determining reasonableness process.

Can a payer appeal OHA's decision in the determining reasonableness process?

If a payer disagrees with OHA's determination, the payer will be able to appeal. The appeal process and additional documentation will be developed as part of rulemaking.

Determining Reasonableness for Provider Organizations

OHA describes its process to hold 1:1 conversations with provider organizations that exceeded the cost growth target with statistical confidence in the Provider FAQ (March 2023, see question 13).

OHA will expand this document to further clarify the data validation process and determining reasonableness process for provider organizations.

Other Related Questions

OHA previously provided answers to questions from payers and provider organizations about issues related to determining reasonableness. These responses are included here for reference.

Questions from the Provider Organization FAQ

How is OHA taking the current high rate of inflation and the COVID-19 pandemic into account when reviewing cost growth?

OHA is taking the current economic landscape, including recent changes in inflation and the impact of the COVID-19 pandemic, into account when reviewing and interpreting cost growth performance. While none of these events could have been predicted when the CGT program was being designed, many are aligned with what the program would consider as reasonable factors for being over the target (see the previous question).

If a provider organization exceeds the cost growth target with statistical [confidence] in a given year, OHA will work with the organization to discuss the contributing factors and understand what was within or beyond the control of the organization. This will be taken into account before any accountability mechanisms are applied.

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.

How will OHA ensure comparability over time if services differ?

If services within a given market change significantly year-over-year, OHA and the provider organization will surface these changes through the process for understanding drivers of cost growth. Through conversations, OHA will seek to understand these changes and their impacts on performance relative to the cost growth target. Service changes may be a “reasonable” explanation for why a provider organization has exceeded the cost growth target in a given year.

Questions from the Data Submission FAQ

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

See above.

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.