Oregon’s Health Care Cost Growth Target Program

Q&A for Provider Organizations

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About this Document

This document provides answers to questions that provider organizations may have about Oregon's Sustainable Health Care Cost Growth Target Program.

This document will be updated as needed to reflect additional questions and answers. New questions and answers are indicated in each update by an asterisk (*) and a highlight to make it easier for readers to identify updates.

Please contact HealthCare.CostTarget@dhsoha.state.or.us with any questions.

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Cost Growth Target Program

1. Why is there a cost growth target?

The cost of health care in Oregon has grown and is projected to grow faster than both the state economy and Oregonians' wages. Oregon's Cost Growth Target program was established in 2019 (Senate Bill 889; ORS 442.385, 442.386) as a vital tool to monitor and contain rising health care costs across the state.

2. What is a cost growth target?

The health care cost growth target sets an annual rate of growth for health care spending in Oregon. An important distinction must be made between cost growth targets and spending caps. Cost growth targets do not evaluate and limit/cap spending *amounts*, they aim to achieve a *sustainable rate of growth*. Cost growth trends of health insurance companies and health care provider organizations will be compared to the growth target each year. The cost growth target is set using economic data, such as historic and projected gross state product, wages, and income. Oregon's cost growth target is 3.4% for the first five years, and 3.0% for the second five years (2026-2030).

3. Who sets the cost growth target?

The statewide cost growth target has been set for 10 years (2021-2030) by the Cost Growth Target Implementation Committee. This Committee was established in 2019 (SB 889) and charged with setting the target and developing recommendations to guide program implementation. Committee members included provider organizations (hospitals, health systems, independent providers) as well as payers, employers, consumer advocates, researchers, and health economists.

The cost growth target will be set in future years by the Cost Growth Target Advisory Committee.

4. When will the cost growth target be revisited?

The Cost Growth Target Advisory Committee will review economic data, including historic and projected gross state product, wages, income, and inflation, as well as actual and projected health care cost growth trends for Oregon and nationally, and state performance relative to the cost growth target in 2024-25 and determine if the cost growth target should remain at 3.0% for 2026-2030 or if another target value is more appropriate.

5. What are the requirements for provider organizations?

For provider organizations who have been identified for inclusion in the Cost Growth Target Program, OHA will calculate year-over-year growth in their Total Medical Expenditures (TME) and compare their performance to the cost growth target.

Program requirements include:

- Data submission: not applicable. Provider organizations are not required to submit data.

- Taking action to meet the cost growth target: Beginning with cost growth from 2020 to 2021, provider organization trends will be measured relative to the cost growth target and publicly reported annually. Beginning with cost growth from 2022-2023 (see accountability timeline in question #6), provider organizations who exceed the cost growth target with statistical certainty and without good reason may face accountability mechanisms. It is up to provider organizations to determine what actions, if any, they will take to meet the cost growth target.

- Performance Improvement Plans: Beginning with cost growth from 2022 to 2023 (data submitted in fall 2024; see accountability timeline in question #6), provider organizations may be subject to a Performance Improvement Plan (PIP) if, in a given performance year, they:

    - exceed the cost growth target with statistical certainty; and
    - do not have a reasonable basis for not meeting the cost growth target.

  OHA will notify any provider organizations if they are required to submit PIP for a given year, and will provide the PIP template, guidelines, and timeframe for submission. Provider organizations subject to a PIP will also be required to report progress on their PIPs according to OHA guidance.

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

- Civil Penalties: provider organizations may be subject to fines for late or incomplete PIPs.

6. What is the first year a provider organization will be accountable for their year-to-year cost growth?

Cost Growth Target Program implementation is phased in over the next several years. See Fig 1.

- Beginning with the September 2022 data submission, provider organization performance relative to the cost growth target will be publicly reported.
- Beginning with the 2024[1] data submission, provider organizations who exceed the cost growth target in a given year **with statistical certainty and without good reason** may be subject to accountability measures such as Performance Improvement Plans (PIPs).

For the data submitted in 2021, OHA will not publicly report performance relative to the cost growth target for individual provider organizations, nor will any accountability measures apply.

Figure 1. Accountability timeline

		We are here				
CGT Year	**0**	**1**	**2**	**3**	**4**	**5**
Cost growth between	2018 – 20	2020 – 21	2021 – 22	2022 – 23	2023 –24	2024 – 25
Data submitted in	2021	2022	2023	2024	2025	2026
Report published in	2022	2023	2024	2025	2026	2027
Are payers/providers publicly identified?	No	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Do PIPs apply?	No	No	No	**Yes**	**Yes**	**Yes**
Does $ penalty apply?	No	No	No	No	No	**Yes**

7. Where can I find information for provider organizations?

OHA presented a virtual Orientation for Provider Organizations in May 2022. The orientation recording and slide deck are available online at the CGT Provider Organization webpage: https://www.oregon.gov/oha/HPA/HP/Pages/Cost-Growth-Target-for-Provider-Orgs.aspx

For general program information, visit the Oregon CGT main page: https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

[1] Decision to delay performance improvement plans for one year approved 1/18/23 by CGT Advisory Committee

Identifying Provider Organizations

8. Which provider organizations are subject to the cost growth target program?

Senate Bill 889 established a cost growth target that applies to "all providers and payers in the health care system in this state." In developing their recommendations for the Cost Growth Target Program, the Implementation Committee clarified that health care cost growth is measured for provider organizations, not individual clinicians. The Committee provided several parameters for determining which provider organizations should be held responsible for their performance relative to the cost growth target:

Provider organizations that can be held accountable for Total Medical Expenditures (TME)
Provider organizations that can be held accountable for TME include only those organizations that could in theory take on contracts where they are responsible for the total cost of care because they:

(1) include primary care providers who direct a patient's care, and/or
(2) can influence where a patient receives care to promote high value providers and care.

These types of provider organizations include health systems, hospitals with primary care providers, medical groups with primary care providers, and a subset of specialists that provide care coordination (e.g., some oncologists) or provide a majority of primary care-like services.

TME is the sum of the allowed amount of total claims and total non-claims spending paid to providers for all health care services delivered to Oregon residents. The allowed amount includes both the amount paid by the insurer to the provider and the patient liability owed directly to the provider, regardless of whether the patient actually paid the owed amount; this is also known as the negotiated rate, or the contract rate.

Provider organizations that have sufficient patient volume
Provider organizations must have sufficient patient volume to be able to detect accurate and reliable changes in annual per capita Total Medical Expenditures, and to help prevent situations where smaller provider organizations may exceed the health care cost growth target due to a few unusually complex and expensive cases.

Sufficient patient volume is defined as provider organizations with at least 10,000 unique all-payer attributed lives, or at least 5,000 attributed lives within any one market (Medicaid, Medicare, Commercial). To align with cost growth target data submissions, these thresholds were converted to attributed member months: at least 120,000 member months across all markets or at least 60,000 member months within one market. See examples in Fig. 2 below.

Figure 2. Provider organization examples with attributed member months

Provider organization #1
Provider organization is included in the Cost Growth Target Program due to >120,000 member months across all markets.

Market	Commercial	Medicare	Medicaid	Total
# of Attributed Member Months	80,000	15,000	70,000	165,000
Cost Growth Measured?	YES	NO	YES	
Cost Growth Publicly Reported?	YES	NO	YES	

Provider organization #2
Provider organization is included in the Cost Growth Target Program due to >60,000 member months in one market.

Market	Commercial	Medicare	Medicaid	Total
# of Attributed Member Months	80,000	5,000	0	85,000
Cost Growth Measured?	YES	NO	NO	
Cost Growth Publicly Reported?	YES	NO	NO	

9. How was my organization identified for inclusion?

Health insurance plans (aka CGT data reporters) have identified their members who live in Oregon and attributed them (where possible) to a primary care provider. All spending incurred by that member is attributed to the primary care provider and spending is then rolled up to the provider organization level based on primary care provider to organization affiliation.

Your organization was identified for inclusion in the Cost Growth Target Program from the most recent payer-reported cost growth target data submissions submitted each September. The list of current payers (data submitters) is available on the CGT Data Submission website: https://www.oregon.gov/oha/HPA/HP/Pages/cost-growth-target-data.aspx

Approximately 50 provider organizations were identified for inclusion in the Cost Growth Target Program from the initial 2018-2020 data. In the most recent data cycle, 2022 data collected on

2020-2021 spending, one provider organization dropped off the list and one provider organization entered the list. The full list and more details about the attribution and organizational affiliation is available online: https://www.oregon.gov/oha/HPA/HP/Pages/Cost-Growth-Target-for-Provider-Orgs.aspx.

If provider organizations have questions about how a payer attributed any members to their organization, OHA can help facilitate a meeting.

10. How are people attributed to provider organizations?

Payers are instructed to use a primary care-based attribution method to attribute their enrolled Oregon resident members to specific provider organizations. Not all members are attributed.

Payers use one of three attribution tiers below, in hierarchical order:

1) **Member selection**: Members who were required to select a primary care provider or a primary care home by plan design should be assigned to that primary care provider's organization.

2) **Contract arrangement**: Members not included in #1 who were attributed to a primary care provider or a primary care home during the measurement period pursuant to a contract between the payer and provider, should be attributed to that primary care provider's organization. For example, if a provider is engaged in a total cost of care arrangement, then the payer may use its attribution model for that contract to attribute members.

3) **Utilization**: Members not included in #1 or #2 who can be attributed to a primary care provider or a primary care home based on the member's utilization, using the payer's own attribution methodology.

One person's attribution (and expenses) can be split if they switch provider organizations or disenroll from the health plan during the year.

Performance Relative to the Cost Growth Target

11. Is cost growth data risk adjusted at the provider organization level?

At the provider organization and payer level, spending trends will be adjusted, however, the program is changing its adjustment methodology for the second year of data collection due to multiple reasons listed below.

Risk adjustment in 2021 data (spending in 2018 to 2020)

In the initial cost growth target data submission, payers could apply their own risk adjustment tool, however, this *prevents adjustment at the provider organization level.* Without a consistent risk tool applied in each payer file, combining risk scores and adjusted dollars at the provider level is impossible due to the incompatible nature of the various risk tools.

Relying on various payer-provided risk adjustment tools results in other issues as well:

- Risk adjustment tools are not Oregon specific
- Risk score growth due to inappropriate tool use confounds results
- Misalignment with other states moving to demographic adjustment or none at all

Demographic adjustment in 2022 data (spending in 2020 to 2021) and onward

Starting with the 2022 data submission, Oregon is adjusting spending data using OHA-provided demographic factors that payers will apply to their membership.

Demographic tables were created using data from Oregon's All Payer All Claims (APAC) database. Using five years of pre-COVID claims data which is specific to Oregon residents, the tables contain market specific factors that adjust only for the sex and age of each cohort.

Using these factors, year over year spending trends are adjusted at the provider organization and payer level but not at the market or statewide levels, since these populations are large enough to be stable over time.

12. How is year-to-year cost growth calculated for provider organizations?

The year-to-year cost growth for provider organizations is calculated using the data submitted from the payers by the steps below.

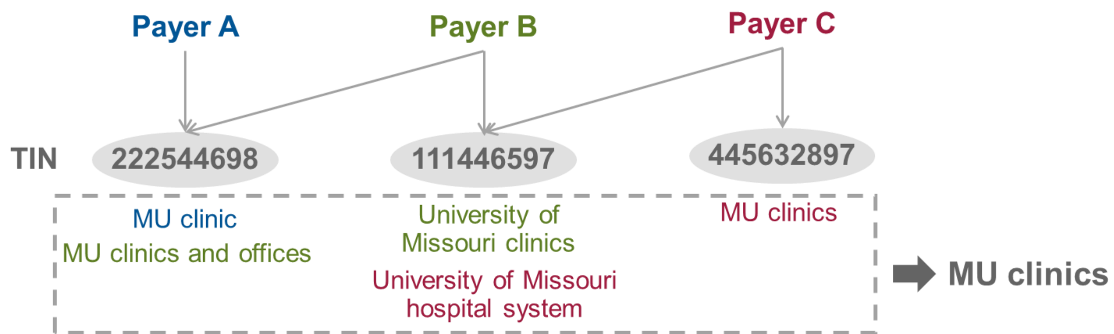
Note: the initial 2021 data did not adjust spending at the provider organization level in calculating Step 3 (see previous question) and thus confidence intervals (Step 4) were not produced.

Step 1: Identify the list of Taxpayer Identification Numbers (TINs) for each provider organization

Payers submit cost data attributed to provider organizations and their associated TINs. OHA uses the TIN information to conduct identify and link provider organizations across all of the payer data submissions.

The Figure below illustrates how OHA links provider organizations together from multiple payers' data files.

Figure 3. Illustrative example of rolling up TINs to Provider Organization Level



Notes:

- One TIN can be associated with different provider organization names across payers' files. If the TIN is the same, OHA considers the organization to be the same across multiple payers' files. For example, the name for TIN 222544698 is "MU clinic" in Payer A's file but is "MU clinics and offices" in Payer B's file. Since both names share the same TIN, they are considered the same provider organization.

- Multiple TINs with names that appear to be the same organization are rolled up into one single provider organization and assigned a single name. For example, "MU clinics" in the Figure above. OHA uses the list of TINs for a specific provider organization to pull the member month data and calculate the TME for that provider organization. OHA will share the TINs with the provider organizations to ensure the list of TINs is correct.

Step 2: Calculate the member months by market for each provider organization.

Only provider organizations that have sufficient volume are subject to the Oregon Cost Growth Target Program. Sufficient volume means a provider organization has at least 120,000 attributed member months across all markets or at least 60,000 attributed member months within one market. See Question 8 for more details on the sufficient volume.

Step 3: For provider organizations that have sufficient volume, calculate the demographic adjusted TME per member per month (PMPM) in Year 1 and in Year 2, and the year-to-year cost growth

Payers submit the spending attributed to a provider organization along with member months, the demographic score, and the demographic adjusted standard deviation. OHA will use these data elements to calculate the cost trend for that provider organization on a demographically adjusted PMPM basis.

The example below uses mock data to illustrate how this step works.

In 2020 and 2021, MU clinics have 3 payers that attributed commercial lives to their organization:

In 2020:

Payer	Market	Member Month	Demographic Score	Claims Expenses (Unadjusted)	Non-Claims Expenses (Unadjusted)	Demographic Adjusted Standard Deviation PMPM
Payer A	Commercial	30,000	1.2	$15,000,000	$3,000,000	$2,000
Payer B	Commercial	35,000	1.4	$17,000,000	$2,000,000	$3,000
Payer C	Commercial	40,000	1.5	$24,000,000	$4,000,000	$4,000

In 2021:

Payer	Market	Member Month	Demographic Score	Claims Expenses (Unadjusted)	Non-Claims Expenses (Unadjusted)	Demographic Adjusted Standard Deviation PMPM
Payer A	Commercial	33,000	1.3	$18,000,000	$2,000,000	$3,000
Payer B	Commercial	37,000	1.5	$22,000,000	$3,000,000	$4,000
Payer C	Commercial	45,000	1.6	$33,000,000	$2,000,000	$5,000

From the payer-submitted data, OHA can calculate MU clinics' weighted demographic score for each market and each year.

In 2020, MU clinics' weighted demographic score:

$$\frac{1.2\times30{,}000 + 1.4\times35{,}000 + 1.5\times40{,}000}{30{,}000 + 35{,}000 + 40{,}000} = \mathbf{1.38095}$$

For 2021, MU clinics' weighted demographic score:

$$\frac{1.3\times 33{,}000 + 1.5\times 37{,}000 + 1.6\times 45{,}000}{33{,}000 + 37{,}000 + 45{,}000} = \mathbf{1.48174}$$

The weighted demographic scores are then used to calculate the demographic adjusted TME PMPM in Year 2020 and 2021.

In 2020, the demographic adjusted TME PMPM is

$$\frac{(\$15{,}000{,}000+\$17{,}000{,}000+\$24{,}000{,}000)}{\mathbf{1.38095}\times 105{,}000} + \frac{(\$3{,}000{,}000+\$2{,}000{,}000+\$4{,}000{,}000)}{105{,}000} = \mathbf{\$471.92}$$

Note that only the claims expenses are demographic adjusted.
Non-claims expenses are not adjusted.

Similarly, in 2021, the demographic adjusted TME PMPM is $489.27.

The demographic adjusted cost growth from year 2020 to 2021 is

$$\frac{\$489.27 - \$471.92}{\$471.92} = \mathbf{3.68\%}$$

The cost growth rate exceeds the cost growth target of 3.4%.

Step 4: Calculate the confidence intervals for cost growth

The next step is to apply statistical testing and calculate the confidence interval to determine if the cost growth exceeds the target or not at a certain level of statistical confidence.

OHA uses the standard deviation values to calculate the confidence intervals which can tell us if the cost growth rate is over the target with 95% or 80% confidence. Below are the confidence interval calculations using the mock data in Step 3.

First, the demographic adjusted TME PMPM for each row are calculated as highlighted in yellow.

In 2020:

Payer	Market	Member Month	Demographic Score	Claims Expenses (Unadjusted)	Non-Claims Expenses (Unadjusted)	TME PMPM adjusted	Demographic Adjusted Standard Deviation PMPM
Payer A	Commercial	30,000	1.2	$15,000,000	$3,000,000	$516.67	$2,000
Payer B	Commercial	35,000	1.4	$17,000,000	$2,000,000	$404.08	$3,000
Payer C	Commercial	40,000	1.5	$24,000,000	$4,000,000	$500.00	$4,000

In 2021:

Year	Market	Member Month	Demographic Score	Claims Expenses (Unadjusted)	Non-Claims Expenses (Unadjusted)	TME PMPM adjusted	Demographic Adjusted Standard Deviation PMPM
Payer A	Commercial	33,000	1.3	$18,000,000	$2,000,000	$480.19	$3,000
Payer B	Commercial	37,000	1.5	$22,000,000	$3,000,000	$477.48	$4,000
Payer C	Commercial	45,000	1.6	$33,000,000	$2,000,000	$502.78	$5,000

Then, OHA calculates the pooled standard deviation across payers using the formula below, which is from the Statistical Analysis (PDF) document.

$$\sigma_{pool} = \sqrt{\underbrace{\frac{\sum_i N_{X_i}\sigma_{X_i}^2}{\sum_i N_{X_i}}}_{\text{section 1}} + \underbrace{\frac{\sum_{i<j} N_{X_i}N_{X_j}\left(\bar{X}_i - \bar{X}_j\right)^2}{\left(\sum_i N_{X_i}\right)^2}}_{\text{section 2}}}$$

In 2020, the value in section 1 is

$$\frac{30{,}000\times\$2{,}000^2 + 35{,}000\times\$3{,}000^2 + 40{,}000\times\$4{,}000^2}{30{,}000 + 35{,}000 + 40{,}000} = 10{,}238{,}095.24$$

And the value in section 2 is

$$\frac{30{,}000\times35{,}000\times(\$516.67-\$404.08)^2 + 35{,}000\times40{,}000\times(\$404.08-\$500)^2 + 30{,}000\times40{,}000\times(\$516.67-\$500)^2}{(30{,}000 + 35{,}000 + 40{,}000)^2}$$

= 2,405.71

For 2020, the pooled standard deviation PMPM is $\sqrt{10{,}238{,}095.24+2405.71}$ = **$3,200.08**

Similarly, for 2021, the pooled standard deviation PMPM is $4,184.88.

The last step is to calculate the 95% and 80% confidence intervals for the cost growth using the formula below.

$$CI = \frac{\bar{X}_1\bar{X}_2 \pm \sqrt{\bar{X}_1^2\bar{X}_2^2 - \left(\bar{X}_1^2 - t_{\text{df},\alpha}^2\frac{V_1}{n_1}\right)\left(\bar{X}_2^2 - t_{\text{df},\alpha}^2\frac{V_2}{n_2}\right)}}{\bar{X}_1^2 - t_{\text{df},\alpha}^2\frac{V_1}{n_1}}$$

For more detailed information about the confidence interval formula, see the Statistical Analysis (PDF) document.

Using this equation, the demographic adjusted cost growth with 95% and 80% confidence intervals would be:

Demographic Adjusted Cost Growth	95% CI	80% CI
3.68%	-1.79% - 9.39%	0.85% - 6.57%

Conclusion: Although the 2020 to 2021 cost growth of MU clinics is 3.68% and appears to exceed the target, the confidence intervals are very wide and both included the 3.4% cost target. There is not enough statistical confidence to say MU clinics' cost growth is over the target for this time period.

13. How will OHA communicate with provider organizations about their cost growth target performance?

Following the calculation of performance relative to the cost growth target and applying statistical testing, OHA will share data with each provider organization. OHA intends to have 1:1 conversations with any provider organization that was found to have exceeded the cost growth target with statistical confidence. 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).

- Provider organizations will share any supplemental data and contextual information 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 provider organization's perspective.

14. What are acceptable reasons for exceeding the cost growth target?

The determination of reasonable factors will inform whether the 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 pandemic).

The Cost Growth Target Implementation Committee identified a list of potential factors that may cause an organization to reasonably exceed the target in a given year. These 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 Cost Growth Target Advisory Committee has continued to discuss and develop these factors. Excerpt from Nov 2022 Advisory Committee handout[2]:

DRAFT FOR DISCUSSION ONLY

Potentially Acceptable Reason	Description	Examples
Changes in mandated benefits	Changes to benefits mandated by state or federal law and policy. This may include: - Required coverage of specific services - Requirements to cover specific groups of people	- Coverage mandates for preventive care, cancer, reproductive health, genetic screenings, or fertility treatments - Coverage requirements for people with pre-existing conditions
Changes in taxes or	Increases due to changes in federal, state, or local taxes or administrative and operational	- New behavioral health tax, where dollars are not passed

In fall 2022, a new factor was added, macroeconomic factors[2]. Macroeconomic factors are economy-wide issues that increase costs; these may include significant inflation, supply chain shortages or costs, and substantial system-wide labor constraints.

The isolated impact of the identified factor, or the combination of identified factors must be significant enough to have caused the provider organization's cost growth to exceed the target. Factors should be completely outside of the control of the 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 provider organization disagrees with OHA's determination, the provider organization will be able to appeal. The appeal process and additional documentation for these 1:1 conversations will be developed as needed.

OHA intends to conduct rulemaking in summer/fall 2023 to codify the accountability process, including the determination of reasonable factors, performance improvement plans, and financial penalties. This timeline may change.

[2] see Nov 2022 Advisory Committee handout, *Acceptable Reasons for Exceeding the Cost Growth Target DRAFT*

15. 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 certainty 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.

16. 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 given their medical expense trend(s). See question #14 above.

17. Will OHA compare cost growth across provider organizations?

No. The purpose of the Cost Growth Target Program is to measure each provider organization's own cost growth, relative to themselves, rather than comparing organizations. Organization-level cost trends will be grouped together for the purposes of public reporting (e.g., all FQHC provider organizations in the Medicaid market will be displayed together in one figure) however, one entity's performance has no effect on another entity's performance.

18. 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.

19. How will provider organization performance be publicly reported?

Provider organization performance will be publicly reported first by market type (commercial, Medicaid, Medicare), then secondly by organization type (health system / group practice, Federally Qualified Health Center (FQHC), or pediatric practice). Groupings may change. Example from Feb 2023 CGT Technical Advisory Group: