Recommendations in Summary

This document lists the full Implementation Committee recommendations that were approved on January 12, 2021, organized by each of the Committee's workstreams.

The final recommendations report provides additional detail about Committee considerations for each recommendation and initial thoughts about operationalizing and implementing the recommendations.

Cost Growth Target Recommendations:

1. The State should measure Total Health Care Expenditures when measuring state performance against the cost growth target. Total Health Care Expenditures should be defined as the "allowed amount"[1] of claims-based spending from a payer to a provider, all non-claims-based spending from a payer to a provider, pharmacy rebates and the net cost of private health insurance.

2. Total Health Care Expenditures should be inclusive of spending on behalf of Oregon residents who are insured by Medicare, Medicaid, or commercial insurance, or are self-insured for commercial coverage, and receive care from any provider in or outside of Oregon. Spending by the Indian Health Services for Oregon residents and for Oregonians incarcerated in a state correctional facility should be included in Total Health Care Expenditures to the extent OHA determines their data are accessible, comparable and collection of data can be replicated over time.

    a. Out-of-state residents who receive care from Oregon providers may be included should the data be reportable, consistent across insurers, and replicable over time. Whether out-of-state residents are included will be decided upon by OHA when it develops the technical measurement specifications following the completion of the Implementation Committee's work.

3. The annual per capita health care cost growth target should be 3.4% for 2021-2025 and then 3.0% for 2026-2030.

    a. In 2024, the successor committee should review 20-year historic values of Oregon's per capita gross state product trend and median wage trend to determine whether the annual 2026-2030 target is set appropriately. Trend is calculated by determining the flat average annual percent change of the nominal per capita gross state product

[1] "Allowed amounts" refers to the price 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.

and median wage over the last 20 years. After reviewing the data, the successor committee should make a recommendation to the Oregon Health Policy Board to keep the target at 3.0%, or to increase or decrease the target from 3.0%.

4. In order to assess performance against the cost growth target, providers with accountability for Total Medical Expense (defined as claims-based and non-claims based payments to providers, net of drug rebates) should be organized by payers using existing total cost of care contracts in initial data submissions, until the Oregon Provider Directory is available to support this work.[2] OHA will conduct an analysis to identify a geographical or regional approach for providers who can have total medical expense accountability, but cannot be organized by existing total cost of care contracts.

5. Payers should use their own attribution methods for assigning Oregon residents to a provider. Payers will need to share the attribution methodology with OHA. OHA will assess the commonalities between attribution methodologies and consider adjusting how attribution is performed in future years.

6. In order to account for changes in population health over time, each payer should use its own risk adjustment methodology. Payers will need to share the risk adjustment methodology with OHA.

7. The Committee recommended that OHA should perform a statistical analysis to determine what the minimum primary care-attributed population size will be for providers and for payers, by each line of business, for reporting performance relative to the target in March 2020. Subsequently, OHA developed a rigorous approach to determining whether performance against the cost growth target was statistically reliable and recommended that the minimum population for public reporting be 10,000 lives across all payers or 5,000 lives under any one line of business.

    a. OHA should take a balanced approach to gather the maximum amount of data possible while maintaining statistical rigor. OHA should work with a to-be-established technical advisory group consisting of data submitters to finalize the data submission criteria.

    b. In October 2020, the Committee recommended a tiered approach to accountability, including reporting of performance, based on statistical confidence. This approach

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[2] OHA is developing a statewide provider directory. The provider directory will leverage data from existing, trusted data sources. The ability for health care entities to use one trusted, single and complete source of provider data is essential to improving system efficiencies and patient care coordination, while helping reduce costs for Oregonians. More information online at: https://www.oregon.gov/oha/HPA/OHIT/Pages/PD-Overview.aspx

should determine when a payer or provider organization would be held accountable for performance against the cost growth target over one or more years. Testing for statistical confidence is a foundational step before any of the accountability mechanisms (described below) would apply.

8. OHA should collect data from insurers starting with calendar years 2018 and 2019 and the first performance year of the cost growth target should measure trend between calendar years 2020 and 2021.

9. OHA should ensure that performance against the cost growth target for calendar years 2020 and 2021 (at a minimum) is reported with enough context for the public to understand the effect the pandemic had on spending.

Data Use Strategy Recommendations:

10. Publicly reported data analysis should be performed for providers, payers, purchasers, policy makers, public health and the general public, with a particular interest in actionable information for providers.

11. OHA should employ data use strategy principles and goals recommended by the Committee (see Appendix).

Taking Action Recommendations:

12. OHA, in partnership with payers and providers, should advance adoption of value-based payment (VBP) using a) principles for the use of advanced value-based payment models (see Appendix), and b) a voluntary compact, intended to commit Oregon's payers and providers to taking action to implement the principles.

13. OHA should support timely and actionable data flowing between payers and providers to inform strategies to meet the cost growth target.

Quality and Equity Recommendations:

14. The Health Plan Quality Metrics Committee (HPQMC) should identify a subset of its existing menu of quality measures for reporting as part of the Sustainable Health Care Cost Growth Program, while aligning with the CCO, PEBB, and OEBB contractual measure sets as much as possible.

    a. Some committee members requested that HPQMC prioritize the following domains: equity and disparities, prevention and early detection, and acute, episodic and procedural care.

15. OHA should work with the Oregon Health Policy Board (OHPB), the Health Equity Committee (HEC), and the HPQMC in 2021 to develop a plan and identify measures for monitoring unintended consequences of the cost growth target. OHA should also collect qualitative information after the cost growth target is implemented to determine whether there are any possible unintended consequences not previously anticipated, as well as any positive impacts of the cost growth target.

16. OHA should advance equity by focusing cost analyses on variation in utilization and cost across populations and publish the information as part of the Data Use Strategy. This work will inform future policy conversations about mechanisms to reduce inequities related to costs.

Accountability Recommendations:

17. Performance Improvement Plans (PIPs) should be the first accountability mechanism for payers or provider organizations who exceed the cost growth target with statistical certainty and without a reasonable basis for doing so.

    a. PIPs should be applied at the market level.[3]

18. The "escalating accountability mechanism" for payers or provider organizations who exceed the cost growth target at the market level with statistical certainty and without a reasonable basis across multiple years should be a meaningful financial penalty.

    - Escalating accountability should be triggered when a payer or provider organization exceeds the cost growth target without a reasonable basis in any three out of five years.

    - Escalating accountability should apply at the market level, but in deciding whether to invoke a financial penalty and how much, the payer or provider organization's overall performance across markets would be considered.

    - The amount of the financial penalty should vary based on how much a payer or provider organization has exceeded the cost growth target, with OHA adjusting the penalty based on considerations, including, but not limited to:

        - Size of the payer or provider organization
        - Extent to which the payer or provider organization exceeds the target
        - Good faith efforts to contain health care cost growth

[3] Market level refers to Medicaid, Medicare, and Commercial. Health care cost growth will be combined across contracts for each of these market levels (e.g. the commercial market refers to cost growth across all of a provider's commercial contracts, rather than all of a provider's commercial contracts with a specific payer).

- Collaboration and cooperation with the program
- Avoiding "double fining" an integrated payer and provider organization unless there is reason for both the payer and provider sides to be held accountable for cost growth[4]
- Interaction with other rebates and penalties (e.g. medical loss ratio rebates)
- Credibility of performance / small numbers (if not already addressed by size threshold and statistical testing)
- Overall performance against the cost growth target, including in other markets and in aggregate across all markets
- Other relevant circumstances or factors

19. OHA will work with DCBS to ensure that a financial penalty does not create a separate regulatory issue related to solvency.

20. The escalating accountability measure can be applied earlier than they would be under the rolling three-out-of-five-year approach described above, for payers or provider organizations that are not participating in the program (e.g. failing to submit data or performance improvement plans, refusing to engage in conversations about cost growth and cost drivers, making no efforts to contain costs, etc.).

21. OHA may assess fines for late or incomplete submission of data and/or performance improvement plans, similar to existing compliance measures for data submission to the All Payer All Claims Database.

Governance Recommendations:

22. The Implementation Committee should continue to meet throughout 2021 to oversee the health care cost growth target program launch and initial implementation, including to inform the development and implementation of the Data Use Strategy, understand initial cost growth trends and cost drivers, finalize plans for quality and equity measurement, identify additional technical assistance and supports necessary for payers and providers to meet the cost growth target, and to identify additional opportunities for lowering costs.

    a. Implementation Committee membership may change in 2021 as needed. Under SB 889, committee membership changes in 2021 will be made by the Governor.
    b. The Implementation Committee may meet less frequently in 2021 than in 2020.

23. OHA should convene an ad hoc technical advisory group (TAG) in 2021 open to payers who will be submitting data, provider organizations, and other interested parties to work with

[4] Integrated payers and provider organizations should be treated as a single organization for escalating accountability and would also not be subject to "double fining."

OHA to finalize the data submission template and specifications, and data validation process.

24. Governance for the health care cost growth target program in 2022 and beyond should be informed by a new Committee, consisting of health care payers and provider organizations, business/employer representatives, as well as consumer representatives. There should be some overlap between current members of the Implementation Committee and the new Committee to ensure continuity. The new Committee should be responsible for:

    a. Overseeing ongoing program implementation
    b. Revisiting the cost growth target value for 2026-2030 (and beyond)
    c. Reviewing and understanding cost growth trends and cost drivers and advising OHA, DCBS, and OHPB on the impacts of cost growth.
    d. Monitoring for unintended consequences
    e. Exploring opportunities to improve equity
    f. Reviewing and understanding progress toward VBP goals
    g. Identifying and addressing opportunities to reduce cost growth as reveled by the Data Use Strategy, or otherwise identified
    h. Informing public hearings.

25. The Oregon Health Policy Board (OHPB) should be responsible for hosting and convening annual public hearings. OHPB may also hold regional or other meetings related to health care cost issues throughout the year prior to the annual public hearing.

For More Information
https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx