Oregon's Health Care Cost Growth Target Program

CGT-7 Sub-regulatory Guidance: Determining Reasonableness & Accountability

June 2024

Oregon Health Authority

HEALTH CARE COST GROWTH TARGET

About

The Oregon Legislature through Senate Bill 889 (2019 Laws) and House Bill 2081 (2021 Laws) has established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority (OHA).

Every year, the cost growth target program collects data and reports on the annual per person rate of growth of health care spending in the state, by market, for health insurance companies (payers), and health care provider organizations compared to the target for annual health care spending growth. Payers and provider organizations with cost growth above the target, with statistical confidence, and without an acceptable reason, are subject to performance improvement plans (PIP) and financial penalties.

Oregon Administrative Rules (OARs) chapter 409, division 65 defines the operations of the cost growth target program, including reporting requirements and accountability measures.

This sub-regulatory guidance provides more information about the acceptable reasons for exceeding the cost growth target, how the determining reasonableness process works, potential questions that OHA may ask during the determination process, and potential analyses and information that payers and provider organizations may be asked to provide or that could be helpful to conduct to understand factors causing the excess cost growth.

OHA will not remove any reasons for cost growth from this list; only add to it over time. OHA may add to the list of acceptable reasons at any time. Any changes to the list will be updated in this document and reposted to the program website.

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

Version number	Date released	Description of change(s)
1.0	Aug 29, 2023	
2.0	Jan 24, 2024	Revised structure of document and expanded
2.1	March 1, 2024	Updated to address RAC meeting #1 comments
2.2	May 15, 2024	Updated to address RAC meeting #1-#4 comments
3.0	June 2024	Accept previous track changes

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1. What is "Determining Reasonableness"

Oregon's Health Care Cost Growth Target Program maintains a list of potential factors that may cause a payer or provider organization to reasonably exceed the cost growth target (see sidebar). Payers and provider organizations that exceed the cost growth target in a given year, with statistical confidence, for an acceptable reason, shall not be required to undergo a PIP and will not be penalized.

Determining reasonableness is the process that OHA and a payer or provider organization will go through to review and understand excess cost growth and factors causing the excess cost growth before OHA determines whether the payer or provider organization's cost growth is for an acceptable reason.

Determining reasonableness happens for each payer and provider organization at the market level (that is, Medicare Advantage, Medicaid, and Commercial[1]) as applicable.

Payers and provider organizations would only participate in determining reasonableness conversations for markets where they:

(1) have sufficient members or attributed patient lives to meet thresholds for inclusion in the cost growth target program, and

(2) exceeded the cost growth target with statistical confidence.

Acceptable Reasons for Exceeding the Cost Growth Target

This is not an exhaustive list of acceptable reasons and may be added to over time.

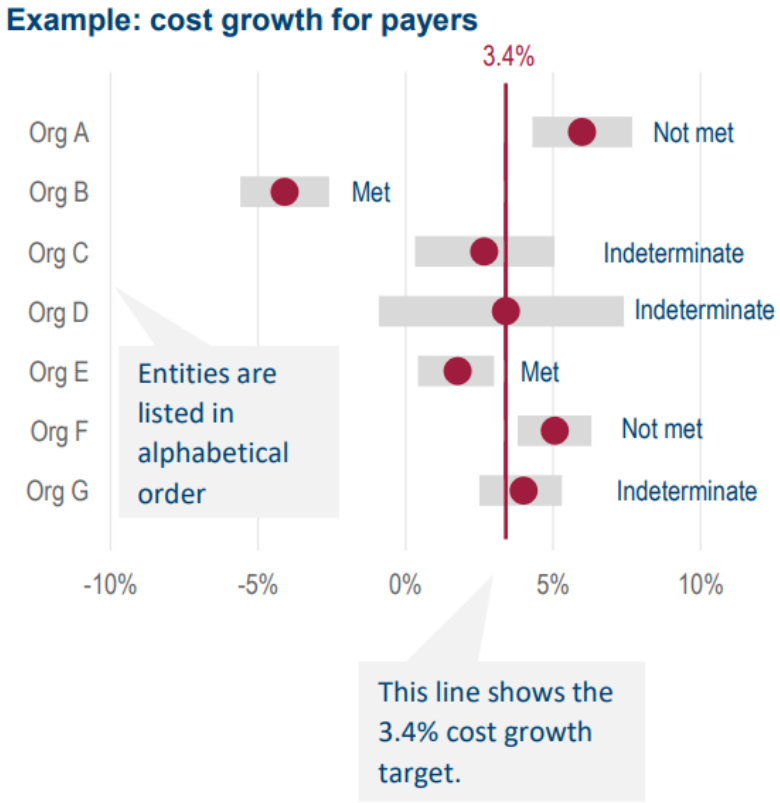
- "Acts of God" – natural disasters, pandemics, other
- Changes in federal or state law
- Changes in mandated benefits, to the extent that the mandated benefits are not defrayed under applicable law
- Changes in taxes or other administrative factors
- High-cost outliers
- High-cost outliers
- Investments to improve population health and/or address health equity
- Macroeconomic factors
- New pharmaceuticals and new uses of existing pharmaceuticals or new treatments / procedures / devices entering the market
- Total compensation for frontline workers

[1] The cost growth target program uses full claims-based spending to measure commercial cost growth at the payer and provider level. Partial claims spending is excluded from calculation. See Data Submission Manual for additional details. https://www.oregon.gov/oha/HPA/HP/Pages/cost-growth-target-data.aspx

Exceeding the cost growth target with statistical confidence

Confidence intervals help ensure that data are accurate and reliable by giving a range of plausible values. In calculating cost growth, OHA uses a 95% confidence interval, which means that we are 95% certain that an organization's cost growth value falls within that range.

The gray bars in the chart below show the confidence interval range, with longer bars indicating a greater range and smaller bars indicating a smaller range. Generally, organizations with a larger number of members or patients will have a shorter confidence interval bar, while a company with a smaller number of members or patients will have a longer bar.



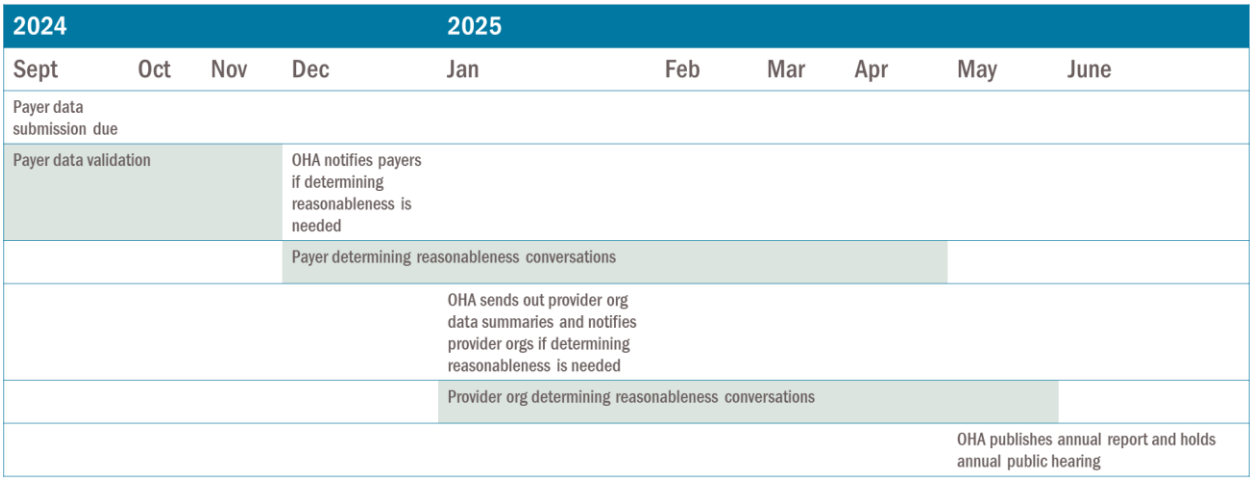
Payers and provider organizations must exceed the cost growth target with statistical confidence before they could potentially be required to develop a PIP. For any entities where cost growth is "indeterminate", no PIP and no penalty would apply for that year.

2. About the determining reasonableness process

When does the determining reasonableness process happen?

OHA will determine reasonableness as a separate process, following the completion of the data submission and validation process with payers and provider organizations, and generally prior to publication of the annual cost growth target report and public hearing.

Anticipated 2024-2025 timeline for payer and provider organization data validation and determining reasonableness.



Given that the outcome of all reasonableness conversations may not be concluded by the time OHA publishes the annual report and holds the annual public hearing, OHA will publish a supplemental report regarding the outcome of the reasonableness conversations.

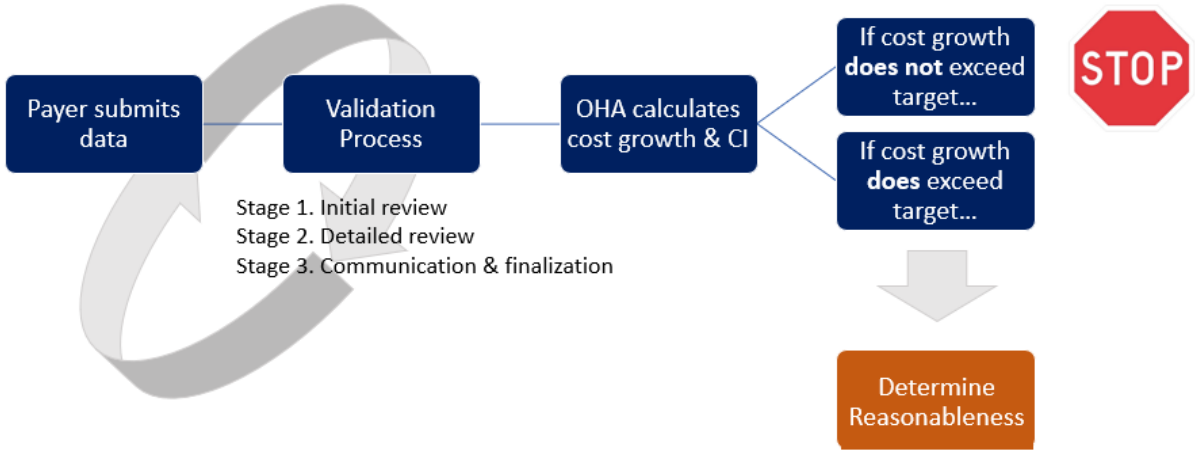
Note timelines are subject to change. Payers may complete the determining reasonableness process earlier if their data validation happens quickly; there may also be widespread delays for provider organizations if there are underlying data issues requiring lengthier resubmissions and validation with payers.

For Payers

Payers submit cost growth target data to OHA each year in the early fall – validation typically takes 1-2 months. After data validation is complete, OHA will calculate cost growth and statistical confidence to identify which payers need to move to determining reasonableness.

OHA anticipates being able to notify payers whether their cost growth exceeds the target and if a determining reasonableness conversation is warranted in December of each year (subject to change if data submission and validation is delayed).

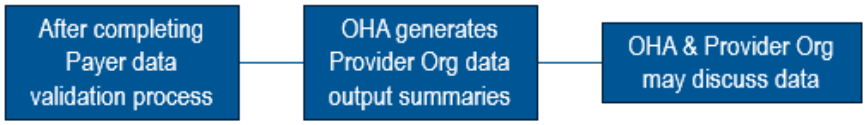
Data validation and determination of reasonableness for payers



For Provider Organizations

OHA must complete the data validation process with payers before compiling provider organization level cost growth and sending data output summaries to all provider organizations for their review. OHA calculates provider organization cost growth to identify which provider organizations have exceeded the cost growth target with statistical confidence and includes this information in the data output summary.

OHA anticipates being able to notify provider organizations whether their cost growth exceeds the target and if a determining reasonableness conversation is warranted in January of each year following the data submission in the previous year (subject to change if data submission and validation with payers is delayed).



Who participates in the determining reasonableness process?

Determining reasonableness conversations will be held individually with each payer and provider organization for each market as needed. OHA will notify payers and provider organizations if a determining reasonableness process is warranted.

Entities can request to hold their determining reasonableness conversations together if they wish. Some potential scenarios where this may be applicable could include:

- A payer who needs to have determining reasonableness conversations for both Medicare Advantage and Commercial markets.
- An entity that is subject to the cost growth target as both a payer and a provider organization (e.g., Providence, Kaiser).
- Pediatric provider organizations experiencing similar cost growth drivers.

OHA will coordinate with the Division of Consumer and Business Services (DCBS) for conversations involving commercial payers.

Payers

OHA meets with all payers to ensure complete and accurate data submission and validation; only payers who have exceeded the cost growth target with statistical confidence for a given market will participate in the determining reasonableness process.

Payers are responsible for participating in the determining reasonableness discussions with OHA. If a payer does not participate, OHA may not be able to determine that the cost growth was reasonable and the payer may be subject to a PIP or financial penalty.

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

Provider Organizations

All provider organizations are welcome to meet with OHA to discuss the data output summary and to address any potential concerns about the data each year. OHA may require meetings with certain provider organizations if there are specific questions or data validation issues.

Beginning with the 2024 data submission cycle, provider organizations who have exceeded the cost growth target with statistical confidence for a given market will participate in the determining reasonableness process.

Provider organizations are responsible for participating in the determining reasonableness discussions with OHA. If a provider organization does not participate, OHA may not be able to determine that the cost growth was reasonable and the provider organization may be subject to a PIP or financial penalty.

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 provider organizations would have needed to complete the determining reasonableness process?

Commercial	16 of 21 provider organizations
Medicare Advantage	10 of 12 provider organizations
Medicaid	6 of 47 provider organizations

Who should attend determining reasonableness conversations?

Each payer and provider organization can determine who will participate in determining reasonableness conversations with OHA.

For example, payers may wish to have the same participants in data validation conversations and determining reasonableness conversations or may wish to include other leadership or executives in the determining reasonableness conversation but not data validation. Payers and provider organizations may have different teams who should participate in determining reasonableness conversations for different markets.

Payers and provider organizations may also include external consultants or other partners in these conversations if they wish.

How determining reasonableness differs from data validation

For Payers

In the 2022 data cycle, measuring cost growth from CY20 to CY21, 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.

In the 2023 data cycle, measuring CY21 to CY22, and moving forward, OHA created more separation between 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, as the reasons for the data needing clarifications and there being unique cost drivers are often the same which makes for inevitable overlap.

The table below describes how OHA thinks about the validation process and illustrates how questions that arise during validation stage 3 may inform the determining reasonableness conversations (see Section 3 for additional questions).

Payer 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 no 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., abnormal values? • Are there any potential data issues that might require immediate resubmission?	Maybe – if needed to resolve any major questions or resubmission requests. If only minor issues, questions may be combined with stage 3

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.
 	
• How has retail pharmacy spending changed in the measurement period?
  ○ A more detailed look at generic vs brand vs specialty drug spending
  ○ 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?
  ○ What is the biggest 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.
	Yes – as many as it takes to ensure a valid data submission.

Payer Validation Stage	Meeting?
The goal is to leave the stage 3 meeting with validated data. A payer may need to resubmit data one or more times before stage 3 can be completed.	

For Provider Organizations

In the 2022 data cycle, measuring cost growth from CY20 to CY21, OHA discussed potential reasons for cost growth and cost growth drivers with some provider organizations as part of orientation to the cost growth target program and review of the data output summary. 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.

In the 2023 data cycle, measuring CY21 to CY22, and moving forward, OHA created more separation between questions asked in any data clarification conversations and the determining reasonableness process. However, it is unlikely that OHA can create a complete separation between the two processes, as the reasons for the data needing clarifications and there being unique cost drivers are often the same which makes for inevitable overlap.

The table below describes how OHA thinks about the data clarification process with provider organizations and illustrates how questions that arise during data clarification may inform the determining reasonableness conversations. See Section 3 below for additional questions.

Note all concerns related to attribution of patients to providers should be addressed during the data validation process, which may result in OHA facilitating conversations between payers and provider organizations to identify detailed lists of attributed members and revising the cost growth target data output prior to completing validation and moving on to determining reasonableness.

Provider Data Clarification	Meeting?
Stage 1: Review Data Output OHA sends each provider organization a compiled data output summary for the measurement period. OHA asks provider organizations to review the data and identify any potential issues, for example, a major discrepancy in payer mix and which payers are attributing lives compared to the provider organization's patient panel. OHA may also ask provider organizations to review TINs that have been rolled up or confirm any changes in TINs.	Maybe – if needed to resolve any questions or if it would be easier to talk through the data; may also be handled via email
Stage 2: Data Clarification OHA will request data clarification conversations with some provider organizations each year. Potential questions about the data that may be asked could include: • Questions about attribution, e.g. Are there any changes to attribution by payer that you were expecting to see? • Questions about overall trends, e.g. What were the main COVID changes your organization noticed from 2021 to 2022? • Questions about payer relationships, e.g. Did you renegotiate any major payer contracts during this measurement period? • Questions about services, e.g. Have you added or increased telehealth services during this time period?	Yes

After the data clarification conversations, there are two outcomes.

1. OHA and the provider organization finalize the data summary. If there are no outstanding questions, OHA will send the provider organization a confirmation email after the meeting. If the provider organization did not meet the cost growth target with statistical confidence, OHA will provide notification and the determining reasonableness conversation will be scheduled.

2. Data resubmission or modification is required. If the data clarification conversation revealed reporting errors that require follow-up and any possible corrections or resubmissions with payers, OHA will follow up with relevant parties via email. After any data resubmission or corrections, OHA will update the provider organization data output and send a new summary for review.

How to prepare for the determining reasonableness conversations

OHA will develop the agenda and potential questions for discussion for the determining reasonableness conversation and share with the payer or provider organization 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 for payers (see above) or in any data clarification conversations with provider organizations (see above).

To prepare, payers and provider organizations may wish to do some combination of the following:

- Review the data output provided by OHA for the measurement period and any information or questions surfaced during the validation/data review process.
- Identify cost growth drivers and factors influencing cost growth from the payer or provider organization's perspective (especially if different from any OHA perspective that was shared during the validation/data review process).

- Review the list of acceptable reasons for exceeding the cost growth target and additional details about each reason in Section 3 below.
- For any acceptable reason(s) the entity identifies as potentially applying: 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?
- For any acceptable reason(s) the entity identifies as potentially applying: 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?)

See Section 3 below for potential questions, suggested analyses and materials or documentation that may be helpful to support each "acceptable reason" for cost growth. Section 3 also clarifies OHA and the entity's role in preparing for these conversations and OHA's expectations for what an entity will do prior to the first conversation in the determining reasonableness process.

Note: entities are not required to conduct analysis or prepare materials for all potentially acceptable reasons for cost growth; only those reasons the entity wishes to explore for the measurement period.

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

What are the outcomes of the determining reasonableness process?

There are three potential outcomes for each payer or provider organization undergoing the determining reasonableness process for a given market in a given measurement period:

1. **Cost growth is for an acceptable reason**. This will be noted in public reporting and the payer or provider organization will not be subject to a PIP or financial penalty for this measurement period.

2. **Cost growth is not for an acceptable reason**. This will be noted in public reporting. The payer or provider organization will be subject to a PIP and financial penalty, as applicable.

3. **The reason(s) for cost growth cannot be determined.** If OHA and the payer or provider organization fail to identify an acceptable reason for cost growth or if the analysis and any supporting documentation is inconclusive, OHA will find that the reason for the payer or provider organization's cost growth is indeterminate. This should be a rare occurrence. To be clear, there is a difference between cost growth that is indeterminate relative to the target (see graphic in Section 1) and the *reason* for cost growth being indeterminate. This section pertains to the latter.

   If a payer or provider organization's reason for cost growth is not able to be determined in a single year, the payer or provider organization will not be subject to a PIP or financial penalty for that year.

How OHA documents the determination

Written Notice

When the determining reasonableness conversations are complete, OHA will provide written documentation to each payer and provider organization, summarizing who participated, key themes from the conversations, factors driving cost growth, key findings, and ultimately, OHA's determination. This will likely take the form of a formal letter or memo from OHA to the payer or provider organization.

This documentation will also include a summary of the payer or provider organization's cost growth over multiple measurement periods, so payers and provider organizations have a running record of performance.

Public Reporting

OHA will share the results of the determining reasonableness process for each payer and provider organization publicly. In its Annual Health Care Cost Trends report, OHA will include the following information for each payer and provider organization for each measurement period and applicable market:

- Cost growth rate (point estimate)
- Confidence intervals
- Performance in comparison to the target
- Whether determining reasonableness process is warranted or was initiated

The public will have the opportunity to provide comment on payer and provider organization cost growth relative to the target after the publication of the Annual Report and through the annual public hearing process. Public comment may provide additional contextual information to help inform OHA's determining reasonableness process.

OHA intends to publish a supplemental report later in the year documenting the outcomes of the determining reasonableness process for each payer and provider organization as applicable. The report will likely include:

- Whether determining reasonableness process occurred
- Results of determining reasonableness process

OHA intends to continue providing overall themes and reasons for cost growth in each year in its public reporting (see 2023 Annual Report). OHA has not yet determined if it will identify a specific reason for cost growth above the target for each individual payer and provider organization in public reporting.

OHA may also share the written summary (see above) publicly, although any confidential information may be redacted (see below).

OHA may also provide information about payer and provider organization cost growth and reasons for cost growth across multiple measurement periods to provide a public summary of payer and provider organization performance relative to the cost growth target over time.

Confidentiality

OHA intends to publicly share the result of the determining reasonableness process for each payer and provider organization – but specific details or materials shared with OHA during this process may be subject to confidentiality protections.

Appealing OHA's determination

If a payer or provider organization disagrees with OHA's determination, they will be able to appeal.

A payer or provider organization may request that OHA reconsider its reasonableness determination. A request for reconsideration must be submitted in writing to OHA (via email, HealthCare.CostTarget@oha.oregon.gov) within 30 days of the date of OHA's written notice of determination and must include a detailed explanation of why the payer or provider organization believes OHA's decision is in error along with any supporting documentation. OHA reserves the right to request additional information from the payer or provider organization.

OHA will inform the payer or provider organization in writing whether it has reconsidered its decision.

Request for reconsideration, supporting documentation and additional information, and OHA's decision will also be made public, although if the payer or provider organization may request that additional information in supporting documentation be kept confidential (see section above).

For more information about contested case hearings and other appeal processes, see OAR 409-065-0050.

3. Acceptable reasons for exceeding the cost growth target

This section describes the list of acceptable reasons for exceeding the cost growth target, provides clarification on what is included and excluded from the reasons, offers potential questions that OHA may ask about each reason, and provides suggested analyses and documentation that payers and provider organizations may be asked to provide or may wish to prepare if pursuing one of these reasons to explain cost growth above the target.

About the list of acceptable reasons

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.[2]

The Implementation Committee also specified that 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.

Acceptable reasons for exceeding the Cost Growth Target include but are not limited to…

- Changes in mandated benefits, to the extent that the mandated benefits are not defrayed under applicable law
- New pharmaceuticals and new uses of existing pharmaceuticals or new treatments / procedures / devices 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
- High-cost outliers

[2] Cost Growth Target Implementation Committee Recommendations Report, January 2021 https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf

Factors should be completely outside of the control of the payer or provider organization[3] and may be environmental, market-based, or governmental in nature.

Given concerns about inflation and the broader economy, the Cost Growth Target Advisory Committee agreed in January 2023 that "macroeconomic factors" should be added to the list.[4]

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.

The list of acceptable reasons is additive. The list of acceptable reasons for exceeding the cost growth target has always been intended to be a starting place for conversations, not an exhaustive list. The health care landscape is dynamic and not all changes affecting health care spending and cost trends can be predicted (e.g., "if we had developed this list in 2019, we wouldn't have known about COVID").

OHA will not remove any reasons from this list; only add to it over time. OHA may identify other acceptable reasons for cost growth through the data validation and determining reasonableness process each year as well as through public comment, Advisory Committee, and Oregon Health Policy Board discussions and may add to the list of acceptable reasons at any time. Any changes to the list will be updated in this document and reposted to the program website.

OHA will specify which measurement period(s) any other acceptable reasons for cost growth apply to when the list of acceptable reasons is updated. OHA may identify an acceptable reason or example of an acceptable reason during the determining reasonableness process for a year and apply it to all payers and provider organizations for that measurement period.

If not otherwise specified, changes to the list of acceptable reasons apply prospectively – if OHA identifies a new acceptable reason for a given measurement period, it will not apply to previously determined measurement periods.

Detailed description of acceptable reasons

The table below provides a description of each acceptable reason, examples of what would be considered appropriate or included for each reason, and examples that would be outside of each reason.

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

[4] Cost Growth Target Advisory Committee January 2023 Meeting Summary https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/02.-January-2023-Meeting-Summary.pdf

Acceptable Reason for Cost Growth	Description	May Include	Does Not Include
Changes in mandated benefits, to the extent that the mandated benefits are not defrayed under applicable law	Changes in health insurance plan benefits or coverage mandated by state or federal law and policy or regulation, to the extent that the mandated benefits are not defrayed under applicable law	• Required coverage of specific services, for example, coverage mandates for preventive care, cancer screening, reproductive health services, genetic screenings, or fertility treatments • Requirements to cover specific groups of people, for example coverage requirements for people with pre-existing conditions, or eligibility expansions, if the risk profile is significantly different than those currently covered	• Payer decisions about covered benefits not mandated by state or federal law and policy, for example, payer choice to offer coverage for certain cosmetic services or to add wellness programs in benefit package for employer purchasers • Benefit mandates where the state is covering or otherwise defraying the cost.

Acceptable Reason for Cost Growth	Description	May Include	Does Not Include
New pharmaceuticals and new uses of existing pharmaceuticals or new treatments / procedures / devices entering the market	New drugs or treatments that may be costly enough to drive market-level per person growth (i.e. the total cost of the drug or treatment based on price and utilization must be enough to affect per person cost growth trends for the commercial, Medicaid, or Medicare Advantage line of business for the payer or provider organization– that is, an expensive new drug with very low utilization is unlikely to affect an entity's cost growth trend). New uses of existing pharmaceuticals that may be costly enough to drive market-level per person growth.	• Hepatitis C treatments • Artificial organ transplants • COVID-19 tests and treatments • GLP1 weight loss drugs Note: an entity's utilization management strategies may affect the financial impacts of a new pharmaceutical/treatment or its new use.	• Payer decisions to preferentially cover brand or more expensive versions of drugs and treatments when there is a generic or biosimilar available • Provider organization decisions to direct patients to brand or more expensive versions of drugs and treatments when there is a generic or biosimilar available • Increasing pharmacy benefit management (PBM) fees or costs resulting from changing PBMs, changes in rebates, direct and independent compensation, or formulary placement

Acceptable Reason for Cost Growth	Description	May Include	Does Not Include
Changes in taxes or administrative factors	Increases in health care spending due to changes in federal, state, or local taxes, or operational costs resulting from new or changed administrative requirements.	• Staffing cost increases resulting from staffing ratio requirements • New taxes where dollars are not passed back through to providers	• Cost growth driven by fines, legal settlements, or other accountability mechanisms related to poor performance, non-compliance with regulations, data breaches, etc. • Cost growth due to executive compensation or bonuses • Investment losses
"Acts of God"	Natural disasters, pandemics, other unanticipated, catastrophic, wide-spread events and factors wholly outside of a payer or organizations control that could not have been prevented by reasonable foresight.	• Pandemics or public health emergencies, including the COVID-19 pandemic • Severe wildfires, floods, earthquakes, climate change, or weather events • War or civil unrest	
Changes in federal or state or local law	Federal, state, or local regulatory changes that increase costs, including new workforce and labor requirements, and new compliance requirements. May overlap with changes in taxes or administrative factors above.	• New salary floor for workforce • Minimum wage increase • New staffing level requirements • Mandated sick leave or paid time off • New facility upgrade requirements • New data security requirements • Changes or prohibitions on patient / member cost sharing	

Acceptable Reason for Cost Growth	Description	May Include	Does Not Include
Investments to improve population health and/or address health equity	One-time/short-term or long-term investments that the payer or provider organization makes to improve population health and/or address health equity, especially those that provide funding to communities, improve access to care, invest in underserved areas, and strengthen provider networks and technology infrastructure. Includes investments required by law and those made voluntarily.	• Investments in primary and preventive care, pediatric care, and/or safety net care, including county health departments • Investments in behavioral health • Funding to house low-income seniors • Funding for care coordination software • Payments to community-based organizations in an underserved area • Investments to improve language access • Investments to build a workforce that represents populations seeking care	Investments that are primarily internally focused, do not improve access, or do not channel funds to the community may not be acceptable. Costs associated with borrowing funds to make these investments are excluded from this reason.
Macroeconomic factors	Economy-wide issues that increase health care costs and are wholly outside of the ability of the entity to influence or mitigate.	• Significant inflation or other economic shifts • Supply chain shortages or supply costs • Significant, system-wide labor constraints • Pay increases for lower wage and front-line workers • Travel nurses or other costs related to workforce shortages	

Acceptable Reason for Cost Growth	Description	May Include	Does Not Include
Total compensation for frontline workers[5]	Total compensation, including wages, benefits, salaries, bonuses and incentive payments provided to a frontline worker by a provider (an individual, organization or business entity that provides health care). "Frontline worker" means any worker whose total annual compensation is less than $200,000, adjusted annually to reflect any percentage changes in the Consumer Price Index for All Urban Consumers, West Region (All Items), as published by the Bureau of Labor Statistics of the United States Department of Labor, excluding executive managers and salaried managers.		• Compensation for executive managers and salaried managers • Payer staff, management, and executive costs

[5] HB 2045 (2023) https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2045

Acceptable Reason for Cost Growth	Description	May Include	Does Not Include
High-cost outliers	High-cost outliers defined as per member per year costs totaling $1 million or more, whether or not subject to the Oregon Reinsurance Program		• Does not include the mere presence of high-cost outliers in an attributed population because every population has high-cost patients/members. The program focuses on year-over-year change

Other Contextual Information

In addition to the acceptable reasons for cost growth described above, OHA may also take into consideration during the determining reasonableness process contextual information about the payer or provider organization, including, but not limited to:

- Performance in other markets / lines of business
- Performance in other cost growth target states
- Performance relative to peers
- Baseline costs or relative prices, compared to rate of growth
- Implementation (or lack thereof) of guidelines or policies or initiatives to improve health outcomes and reduce costs
- Implementation of innovative strategies to reduce costs
- Consideration of net costs (e.g., costly new drugs may result in reductions in treatment costs)
- Provider organization operating costs
- Payer network adequacy requirements
- Actions to avoid adverse consequences for members or patients
- Public comment

Payers and provider organizations may also provide information to OHA on how they tried to address specific cost growth drivers and successes and challenges in addressing those cost growth drivers.

Responsibility

OHA is responsible for reviewing data and identifying potential trends and cost growth drivers prior to determining reasonableness conversations.

OHA monitors federal and state policy, statewide and sector specific trends, and other industry news and may be aware of factors affecting cost growth for payers and provider organizations coming into determining reasonableness conversations. OHA reviews data and other information to identify potential trends, key themes, and potential cost drivers prior to any determining reasonableness conversations with payers and providers.

OHA reviews each payer and provider organization's individual data prior to meeting and will identify potential cost growth drivers and questions to inform the determining reasonableness conversation. OHA may conduct additional analysis to inform potential acceptable reasons for cost growth and to understand specific or sector or market trends before each payer or provider organization meeting.

OHA will perform initial analysis on common cost drivers that affect multiple accountable entities. This will provide a more accurate and comprehensive assessment of system-wide issues that result in high-cost growth. If OHA identifies a market-wide acceptable reason for cost growth, OHA will notify all applicable entities. In such a scenario, all applicable entities would not be required to develop a PIP or would face a penalty for that year.

Payers and provider organizations are responsible for providing information as needed to support a determination of reasonableness.

Payers and provider organizations must provide justification and documentation as needed to support a determination of reasonableness due to one or more of the acceptable reasons for cost growth outlined in this document. Payers and provider organizations may choose which of the potential acceptable reason(s) they wish to pursue for a given measurement period; OHA will not require a payer or provider organization to provide information or analysis on all potential causes.

. See subsection below for additional detail on information that might be requested by OHA to back up payer and provider organization claims.

For example, Medicaid Coordinated Care Organizations (CCOs) were required by OHA to increase behavioral health benefits, which led to higher costs.

- OHA was aware of the behavioral health benefit requirement and is monitoring the increase in behavioral health spending across multiple CCOs. OHA is responsible for identifying the behavioral health requirement as a potential cost growth driver that might affect a specific CCO.

- The CCO is also responsible for identifying the behavioral health requirement / benefit change as a reason for their cost growth; the CCO is responsible for providing an analysis or otherwise quantifying the amount of cost growth due to the increased behavioral health benefit (versus other potential cost drivers).

Justifying a reason

For each of the acceptable reasons for exceeding the cost growth target listed above, this section suggests some questions that OHA may ask the payer or provider organization in the determining reasonableness process, and potential analyses and documentation that payers and provider organizations may be asked to provide to justify their cost growth.

OHA does not expect payers and provider organizations to complete comprehensive analyses or prepare justification prior to a first meeting to determine reasonableness. OHA and the payer or provider organization will discuss potential reasons for cost growth and their relative magnitude or impact on overall cost growth trends before identifying any potential analyses or documentation that payers or provider organizations may be asked to provide.

Payer and provider organization capacity to conduct analyses or gather documentation may also need to be discussed. If the payer or provider organization is unable to conduct an analysis or provide requested information needed to support a determination of reasonable cost growth, other potential avenues for conducting the analysis or gathering the information may be explored, including, but not limited to identifying potential analyses that OHA may conduct, or information that may be requested from another payer or provider organization.

If the payer or provider organization is unable to provide analysis or information to support a claim of reasonable cost growth, and analysis or information is not available from other sources, OHA may either:

- Find that the payer or provider organization's cost growth is not reasonable for that market for that measurement period

Enter an 'indeterminate' finding for that market for that measurement period [see Section 2 above]

See Section 2 above for additional details on confidentiality protections for any analyses and documentation payers or provider organizations may be asked to provide during this process.

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

OHA makes the final determination whether any payer or provider organization's cost growth was or was not reasonable based on consideration of potentially substantiating factors, the payer or provider organization's perspective and any additional information shared during the determining reasonableness process.

OHA may present information about payer and provider organization performance relative to the cost growth target and determinations of reasonableness as part of Cost Growth Target Advisory Committee meetings, Oregon Health Policy Board meetings, informational or educational webinars, and at the annual cost growth target public hearing. The Cost Growth Target Advisory Committee and the Oregon Health Policy Board may identify questions and concerns about cost growth and reasonableness, but they are not decision makers for cost growth target accountability.

See Section 2 above for more details on appealing OHA's determination of reasonableness.

Changes in mandated benefits to the extent that the mandated benefits are not defrayed

OHA monitors changes in mandated benefits each year, including federal and state legislated changes that apply to commercial, Marketplace, Medicare Advantage, and Medicaid plans. OHA will consult with DCBS on coverage mandates that affect commercial plans. OHA also monitors state-level policy changes that apply to Coordinated Care Organization benefits.

These changes will typically apply to all payers or provider organizations in the affected market and OHA may make blanket determinations that cost growth resulting from a given change in mandated benefits or eligibility expansion is an acceptable reason for cost growth exceeding the cost growth target in a given year.

Questions OHA may ask

- When did the benefit change happen? When was it rolled out? How did the payer or provider organization communicate about the benefit to members/patients/provider network/workforce?
- What is the payer or provider organization's perspective on how the benefit change impacted their health care cost growth?
- How much of the cost growth target overage is accounted for by the spend on the new benefit?
- What was the specific cost impact of the benefit change?
- Was there anything the payer or provider organization could have done to influence the cost impact of the new benefit?
- Were there specific contracts, market segments, etc. that were more or less affected by the new benefit?
- Were there any mitigating factors that affected the new benefit (e.g., if new prescription drug coverage, were there pharmacy rebates available?)

Suggested analysis or documentation

- Policy documents or other descriptions of coverage changes
- Any communications of the mandated benefit or eligibility change from regulatory bodies (e.g., DCBS bulletin, CMS rules).
- Number and percent of members or patients who utilized the new benefit
- Number, trend, other calculations demonstrating change in enrollment, case mix, demographic scores or risk pool resulting from eligibility changes.
- Costs associated with preparing to offer the new benefit
- Total spend and PMPM spend on new benefit
- Total spend on new benefit as a percentage of the applicable service category

- Total spend on new benefit as a percentage of the total market cost growth and PMPM trend
- Counterfactual: what the cost growth trend would have been without the new benefit

Example

Oregon mandates that commercial health plans must cover a new prescription drug for a certain condition. Payers should be able to identify the affected dates, produce analysis to illustrate how many members filled prescriptions for the drug, how much of the PMPM overall and for the retail prescription drug spend was due to the drug, what the cost growth trend would have been without the drug.

New pharmaceuticals or new uses of existing pharmaceuticals or new treatments / procedures / devices entering the market

OHA monitors industry wide trends and is generally aware of new pharmaceuticals and treatments that are entering the market or new uses of existing pharmaceuticals and are expected to be major cost drivers (e.g., GLP1 drugs). These changes will typically apply to all payers or provider organizations in the affected market and OHA may make blanket determinations that cost growth resulting from a given new pharmaceutical or treatment or new use of existing pharmaceutical is an acceptable reason for cost growth exceeding the cost growth target in a given year.

Questions OHA may ask

- When did the new drug or treatment enter the market? When did it become available to your members or patients?
- When was the existing drug approved for new use? When did your members or patients begin receiving the existing drug for new use?
- Were there any restrictions or limitations the payer or provider organization placed on the new drug or treatment? (e.g., prior authorization or other stepped treatment, lower tier on preferred drug lists, etc.).
- Did the payer or provider organization communicate about the new drug or treatment to members / patients / provider network / workforce?
- What is the payer or provider organization's perspective on how the new drug or treatment impacted their health care cost growth?
- How much of the cost growth target overage is accounted for by the end on the new drug or treatment?
- Was there anything the payer or provider organization could have done to influence the cost impact of the new drug or treatment?
- Was the new drug or treatment a factor in any payer/provider contract negotiations?
- Were there specific contracts, market segments, etc. that were more or less affected by the new drug or treatment?
- Were there any mitigating factors that affected the new drug or treatment (e.g., if new prescription drug, were there pharmacy rebates available?)

- Why do you believe your organization was more affected by the new treatment than other payer/providers?
- Did the new treatment costs replace any prior existing costs? (e.g., decrease in weight loss surgeries paired with increase in prescriptions for GLP1 drugs).
- If this is a new and expensive drug/treatment, is there overlap with any high-cost outlier analysis used to justify increased cost growth over this same time period?

Suggested analysis or documentation

- Policy documents or other descriptions of coverage changes, restrictions or other administrative considerations related to the new drug or treatment.
- Unit cost versus utilization impacts of new drug or treatment.
- Number and percent of members or patients who utilized the new drug or treatment.
- Total spend and PMPM spend on new drug or treatment.
- Total spend and PMPM spend on new drug or treatment as a percentage of the applicable service category.
- Total spend and PMPM spend on new drug or treatment as a percentage of total market cost growth and PMPM trend.
- Counterfactual: what the cost growth trend would have been without the new drug or treatment.

Example

A new experimental treatment for cancer enters the market. Payers should be able to provide information about whether or not they offered coverage for the treatment and if so, any restrictions or parameters placed around it. Payers should also be able to share information about the treatment that was communicated to members, information about preferred networks or referral patterns for the treatment, and utilization of the new treatment. Payers should be able to quantify the total spend and PMPM spend on the new treatment.

Provider organizations should be able to provide information about whether or not they offered the treatment, and if so, any restrictions or parameters placed around it. Provider organizations should also be able to share information about how the treatment was communicated to employees, partners, and patients, as well as referral patterns, preferred networks, and patient utilization of the new treatment.

Changes in taxes or administrative factors

Questions OHA may ask

- What was the cause of the change? Is it federal, state, local, internal? Does it apply to all entities of this type or is this a specific change for this payer / provider organization?
- When did the change in tax or administrative requirement come into play? Where/how does the change show up for the payer or provider organization? Is it applicable to all markets?
- What is the payer or provider organization's perspective on how change in tax or administrative requirement impacted their health care cost growth?
- How much of the cost growth target overage is accounted for by the change in taxes or administrative requirement?
- Why do you believe this change affected your organization more than other payers/providers?

Suggested analysis or documentation

- Documentation of policy, regulation or other notice of change
- Financial statements
- Quantification of the impact of the change in taxes or administrative requirement
- Counterfactual: what the cost growth trend would have been without the change in tax or administrative requirement.

"Acts of God"

These changes will typically apply to all payers or provider organizations in the state and OHA may make blanket determinations that cost growth resulting from an "act of god" is an acceptable reason for cost growth exceeding the cost growth target in a given year.

Questions OHA may ask

- How did the event affect your health care cost growth? When / how did it show up for your members or patients?
- What is the payer or provider organization's perspective on how the event impacted their health care cost growth?
- How much of the cost growth target overage is accounted for by the event?
- Was there anything the payer or provider organization could have done to influence the cost impact of the event?
- Was the event a factor in any payer / provider contract negotiations?
- Were there any mitigating factors that affected the cost impacts of the event (e.g., federal support payments for covid-19 relief).
- Why do you believe this change affected your organization more than other payers/providers?

Suggested analysis or documentation

- Quantification of the impact of the event, including but not limited to:
    - lost revenue from closures / drop in utilization
    - total spend on emergency response or new treatments / services that would not have been otherwise needed (e.g. covid-19 vaccine)
- Documentation of any mitigating factors or policies, relief funds, etc. (e.g., changes in telehealth reimbursement during covid-19)
- Counterfactual: what the cost growth trend would have been without the event

Changes in federal or state law

OHA monitors changes in federal and state law that may influence cost growth trend for payers and provider organizations. These changes will typically apply to all payers or provider organizations in the affected market and OHA may make blanket determinations that cost growth resulting from a given change in federal or state law is an acceptable reason for cost growth exceeding the cost growth target in a given year.

Questions OHA may ask

- When did the change happen? When was it rolled out?
- What is the payer or provider organization's perspective on how the change impacted their health care cost growth?
- How much of the cost growth target overage is accounted for by the change?
- Was there anything the payer or provider organization could have done to influence the cost impact of the change?
- Were there specific contracts, market segments, etc. that were more or less affected by the change?
- Were there any mitigating factors that affected the new change?

Suggested analysis or documentation

- Policy documents or other descriptions of the change
- Any communications of the change from regulatory bodies
- Any analysis from consultants, in-house experts, or professional organizations discussing the expected / projected impacts of the change
- Quantification of the impact of the change, including but not limited to:
    - Changes in salary floor or wage increases for payer / provider workforce
    - Changes in staffing costs from staffing requirements
    - Estimated or actual spend on upgrades or compliance activities
- Counterfactual: what the cost growth trend would have been without the change

Investments to improve population health and/or address health equity

Questions OHA may ask

- What were the investments made? What was the purpose of the investments? / Why were the investments made?
- To whom / where were the investments directed?
- Are these one-time or longer-term investments? Are these changes (increases, decrease) to previous / ongoing investments?
- How do the investments improve population health and/or address health equity?
- How are these investments different from other payments or funding requirements (e.g., community benefit floor)?
- How are these investments / funds improving access, investing in underserved areas, and/or strengthening provider networks?

Suggested analysis or documentation

- Documentation of the investment, which could include grant program documentation, award letters, funding requests from community, board or other meeting materials where investments were discussed, etc.
- Financial statements
- Documentation of payment / investment made. How much was it?
- Counterfactual: what the cost growth trend would have been without the investment?

Macroeconomic factors

Questions OHA may ask

- What specific macroeconomic factor resulted in exceeding the target?
- What is the payer or provider organization's perspective on how the macroeconomic factor impacted their health care cost growth?
- How much of the cost growth target overage is accounted for by the factor?
- Was there anything the payer or provider organization could have done to influence the cost impact?
- Were there specific contracts, market segments, etc. that were more or less affected?
- Were there any mitigating factors that affected the macroeconomic factor?

Why do you believe this change affected your organization more than other payers/providers?

Suggested analysis or documentation

- Documentation of the impact of the macroeconomic factor
- Changes in the costs of supplies, payroll costs, etc.

Frontline workforce compensation

This acceptable reason for cost growth was codified in statute for provider organizations only.

Required documentation

If a provider organization wants to pursue a determination of reasonable cost growth due to frontline workforce compensation, they will need to submit a CGT-4 data file, if they have not already done so, in accordance with OAR 409-065-0028.

The CGT-4 is a data template for provider organizations to report the details of their total compensation for frontline workers as well as other contextualizing data.

A provider organization must submit this data file to OHA as specified for any determination of reasonable cost growth related to frontline workforce compensation to be made.

Questions OHA may ask

- What proportion of total payroll and benefit expense were frontline workers?
- What proportion of overall operating expenses were frontline workers?
- How does frontline worker salary compare with physician and executive salary?
- Details of labor negotiations and future wage increases.
- What proportion of workers are covered under a labor agreement.

Suggested analysis or documentation

- Additional data on operating expenses
- Additional data on compensation for non-frontline workers (e.g., physician, management, executives)
- Relevant labor agreement documentation

High-cost outliers

For the purposes of the cost growth target program, OHA defines high-cost patient or member outliers as per member per year costs totaling $1 million or more.

OHA recognizes that payers and provider organizations will have high-cost members and attributed patients in each measurement year. Because the cost growth target methodology compares each payer and each provider organization to itself, looking at growth from the previous year, OHA expects that there will be high-cost members and attributed patients in each year.

To that end, this acceptable reason for cost growth focuses on *changes* in high-cost outliers, specifically if the payer or provider organization has more high-cost outlier members or attributed patients in the measurement period than they did in the prior year.

FAQ

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

Questions from the Provider Organization FAQ

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

OHA is taking the economic landscape, including 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.

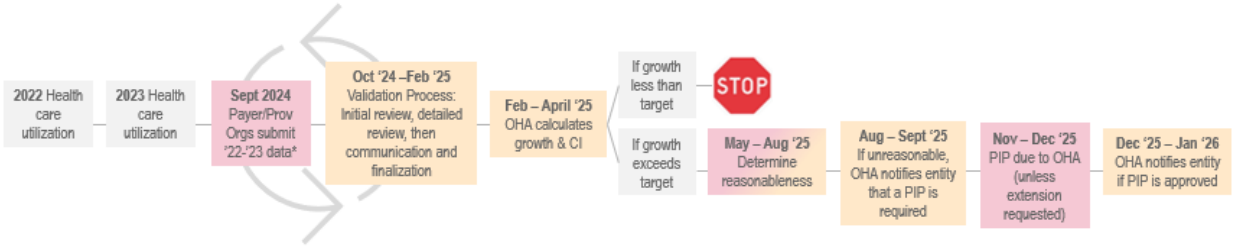
If benefits within a given line of business change significant year-over-year, the process for understanding drivers of cost growth, which includes holding 1:1 conversations with payers and provider organizations, will provide opportunity to surface these changes and understand their impacts on performance 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.

If a payer's cost growth above the target is found reasonable, does that reasonableness extend to any provider organizations that contract with that payer? What about vice versa; would a provider organization's reasonable growth extend to a payer with which the provider organization contracts?
Yes, if the member month attribution is sufficient to account for the entity's cost growth above the target, a given acceptable reason can be applied to another contracted entity.

4. Performance Improvement Plans

As outlined in OAR 409-065-0040, a payer or provider organization that exceeds the cost growth target with statistical confidence and without an acceptable/indeterminate reason will be required to develop a Performance Improvement Plan (PIP).

The following high-level timeline provides an example of 2021 and 2022 health care utilization, 2023 data submission, and the multiple steps that follow:



*Payers submit CGT-1 data template and provider organizations submit CGT-4 Frontline Worker data template.

The pink shapes represent actions taken by the accountable entity and the orange shapes represent actions taken by OHA. One shape – the determination of reasonableness discussion – is a shared action.

For more information, see additional guidance about PIPs including CGT-5 PIP Template and CGT-6 Instructions and Manual.

5. Financial Penalties

Pursuant to Oregon Revised Statute 442.386, the Authority may impose a financial penalty on a payer or provider organization when the cost growth exceeded the target with statistical confidence, and without reasonable cause, or is not indeterminate, in a market for at least three out of five calendar years.

The size of the financial penalty is based on how much the payer or provider organization exceeded the cost growth target within a given market (e.g., Oregon Health Plan, commercial, or Medicare Advantage).

The methodology for calculating the financial penalty is as follows:
Step 1 – identify the per member per month amount above the cost growth target.

(PMPM year 2 – (PMPM year 1 * (1 + cost growth target percent))) = x

Step 2 – Multiply the value “x” by the number of member months in the second year of the two-year performance period.

x * member months = z

Step 3 – Repeat the steps above for all five years in the five-year period. For years in which the cost growth was less than the cost growth target, the resulting value from the calculation will be negative. For years in which the cost growth was more than the cost growth target, the resulting value from the calculation will be positive.

Step 4 – Sum all values of “z” and the result is the net total cost above the cost growth target for the five-year period. If this value is zero or negative, the payer or provider organization will not be penalized for that five-year period.

A payer or provider organization’s performance in a given year will be counted only once towards the calculation of a net total cost above the cost growth target in a five-year period.

The financial penalty shall be paid to consumers or designed to directly benefit consumers. The financial penalty must benefit community members who reside in or in close proximity to a geographic area in Oregon that the payer or provider organization services, and not directly and financially benefit the payer or provider organization.

The following entities are exempt from financial penalties:

- Federally Qualified Health Centers;
- pediatric clinics or groups of pediatric clinics that predominantly treat individuals under age 21 that are also not affiliated with a hospital through ownership, governance, control, or membership; and
- the Oregon Health Plan (OHP) Open Card, also known as Fee For Service Program

For more information about financial penalties, see OAR 409-065-0045, penalty examples, and a penalty calculator published on the Cost Growth Target program website.