DRAFT – Cost Growth Target Program rules
May/June 2024 Version

Redlines signify changes made since the previously posted versions of the draft rules, which were those posted for RAC meeting #5. Previous redlines were accepted; the redlines below are the new changes.

Division 65
SUSTAINABLE HEALTH CARE COST GROWTH TARGET PROGRAM

409-065-0000 Purpose

Senate Bill 889 (2019 Legislature) established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority and House Bill 2081 (2021 Legislature) authorized accountability mechanisms to achieve a sustainable rate of health care cost growth. These rules (OAR 409-065-0000 to 409-065-0055) define reporting and accountability requirements to the Oregon Health Authority. Submitted data will inform the work of the Sustainable Health Care Cost Growth Target Program as it reports on health care cost drivers and trends.

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385
History:
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OHP 2-2021, temporary adopt filed 06/02/2021, effective 06/02/2021 through 11/27/2021

409-065-0005 Definitions

The following definitions apply to OAR 409-065-0000 to 409-065-0055:
(1) “Accident policy” means an insurance policy that provides benefits only for a loss due to accidental bodily injury.

(2) “Authority” means the Oregon Health Authority.

(3) “Cost Growth Target-1” or “CGT-1” means the Data Submission Template as set forth on the website of the Authority.

(4) "Cost Growth Target-2” or “CGT-2” means the Cost Growth Target Data Specification Manual as set forth on the website of the Authority.

(5) "Cost Growth Target-3” or “CGT-3” means the Cost Growth Target Waiver/Extension Request as set forth on the website of the Authority.

(6) "Cost Growth Target-4” or “CGT-4” means the Cost Growth Target Frontline Worker Data Submission Template as set forth on the website of the Authority.

(7) "Cost Growth Target-5” or “CGT-5” means the Cost Growth Target Performance Improvement Plan Template as set forth on the website of the Authority.

(8) "Cost Growth Target-6" or "CGT-6" means the Cost Growth Target Performance Improvement Plan Guidance

as set forth on the website of the Authority.

(9) "Cost Growth Target-7" or "CGT-7" means the Cost Growth Target Sub-Regulatory Guidance on Accountability document as set forth on the website of the Authority.

(10) "DCBS" means the Oregon Department of Consumer and Business Services.

(11) "Dental-only insurance" means an insurance policy that provides benefits only for dental services.

(12) "Disability policy" means an insurance policy that provides benefits for losses due to a covered illness or disability.

(13) "Frontline worker" means any worker whose total annual compensation is less than $200,000, adjusted by the annual percentage increase (if any) 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.

(14) "Health benefit plan" has the meaning provided in ORS 743B.005.

(15) "Health care" has the meaning provided in ORS 442.385.

(16) "Health insurance" has the meaning provided in ORS 731.162.

(17) "Hospital indemnity policy" means an insurance policy that provides benefits only for covered hospital stays.

(18) "Long-term care insurance" has the meaning provided in ORS 743.652.

(19) "Mandatory reporter" means any reporting entity determined to be a mandatory reporter in OAR 409-065-0010.

(20) "Medicare supplemental insurance" or "Medicare supplemental policy" has the meaning provided in OAR 836-052-0119.

(21) "Payer" has the meaning provided in ORS 442.385.

(22) "Performance improvement plan" (PIP) has the meaning provided in OAR 409-065-0040.

(23) "Program website" means the Authority's website for the Sustainable Health Care Cost Growth Target Program, currently at https://www.oregon.gov/oha/hpa/hp/pages/sustainable-health-care-cost-growth-target.aspx.

(23) "Provider organization" means an entity including but not limited to a clinic, health system, hospitals with primary care, medical group, accountable care organization, or independent practice association ~~that employs physicians or other health care personnel who render health care services to patients~~.

(24) "Specific disease policy" means an insurance policy that provides benefits only for a loss due to a covered disease.

(25) “Stand-alone prescription drug plan” means an insurance policy that provides benefits only for prescription drugs.~~–~~

(26) “Stop-loss plan” means insurance against the risk of economic loss assumed under a less than fully-insured employee health benefit plan as provided in ORS 742.065.

(27) “Third-party administrator (TPA)” means any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of Oregon or residents of another state from offices in Oregon, in connection with life insurance or health insurance coverage; or any person or entity who must otherwise be licensed under ORS 744.702.

(28) “Vision policy” means a health benefits plan covering only vision health care.

(29) “Voluntary reporter” means a payer or third-party administrator that does not meet the requirements to be considered a Mandatory reporter and elects to submit cost growth target data on a voluntary basis.

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409-065-0010 General Reporting Requirements for Mandatory Reporters

(1) Determination of a mandatory reporter.

(a) For payers or licensed third-party administrators, the Authority ~~shall~~must identify mandatory reporters using health insurance enrollment data from DCBS and Medicaid enrollment reports from the Authority.

(A) The Authority ~~shall~~must aggregate the most recent four (4) quarters of data.

(B) The Authority ~~shall~~must calculate the mean total lives for each payer and licensed third-party administrator for each reporting year.

(b) All payers or licensed third-party administrators with calculated mean total lives of 1,000 or more across all lines of business ~~shall~~must be mandatory reporters.

(c) The Authority ~~shall~~must make annual mandatory reporter determinations and provide written notification no later than April 30 of each year to all mandatory reporters subject to the reporting requirements of OAR 409-065-0010 to 409-065-0030 for the current year.

(2) All Mandatory reporters must submit data files in a manner and form as prescribed by 409-065-0015.

(3) The Authority ~~will~~must identify voluntary reporters that have calculated mean total lives of 1,000 or higher across all lines of business and invite them to participate in the annual data submission.

(4) New mandatory reporters submitting for the first time, or mandatory reporters that did not submit data in the previous year, must attend a data submission training session prior to their first submission of data, as provided by the Authority.

(5) A mandatory reporter may submit a waiver of reporting in compliance with OAR 409-065-0020.

(6) An entity may appeal the Authority's determination of mandatory reporter status pursuant to the procedure outlined in OAR 409-065-0050.

Statutory/Other Authority: ORS 442.386
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409-065-0015 Data Submission Requirements

(1) Annual data submission dates are provided in the CGT-2; the data submission dates must not be before September 1st of each year.

(2) Annual data submissions must be submitted on the CGT-1 in accordance with instructions published by the Authority in the CGT-2.

(3) Mandatory reporters, and voluntary reporters who agree to participate, must submit data files for all required lines of business as defined in the CGT-2 and OAR 409-065-0015 3(a) ~~below~~. Mandatory and voluntary reporters may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business as defined in the CGT-2 and OAR 409-065-0015 3(b) ~~below~~. Mandatory and voluntary reporters must submit data files without subtracting or adjusting any costs including those listed as reasonable causes of cost growth in OAR 409-065-0035.

(a) Required lines of business include:

(A) Commercial;
(B) Medicare; and
(C) Medicaid.

(b) Excluded lines of business include:

(A) Accident policy;
(B) Disability policy;
(C) Hospital indemnity policy;
(D) Long-term care insurance;
(E) Medicare supplemental insurance;
(F) Stand-alone prescription drug plans;
(G) Specific disease policy;
(H) Stop-loss plans;

(I) Supplemental insurance that pays deductibles, copays or coinsurance;
(J) Vision-only insurance;
(K) Workers compensation; and
(L) Dental-only insurance.

(c) A mandatory reporter that contracts with another entity remains responsible for reporting all required lines of business. If the mandatory reporter elects to have the data reported by a contracted entity, the mandatory reporter must notify the Authority and provide contact information for the contracted entity.

(4) The Authority ~~will~~must validate the submitted data on the CGT-1 in accordance with CGT-2.

(5) The Authority ~~will~~must review a submitted CGT-1 within 90 calendar days after confirming receipt. If the Authority finds errors during its review through edit checks or validation, the Authority ~~will~~must issue a notice of the error(s) to the mandatory or voluntary reporter, as applicable.

(a) Mandatory reporters must correct and resubmit data to the Authority within 30 calendar days after the date the Authority issues notice of the error(s). The Authority will consider the annual data submission complete after the mandatory reporter submits all necessary corrections and resubmissions, as determined by the Authority.

(b) Voluntary reporters may correct and resubmit data to the Authority, as applicable.

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385
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409-065-0020 Data Submission Waivers

(1) The Authority may grant a waiver or deadline extension to the data submission requirements in OAR 409-065-0015.

(2) If a mandatory reporter believes they are eligible for a waiver of all or part of the data submission requirements they may request a waiver of reporting requirements by submitting a CGT-3 to the Authority.

(a) Mandatory reporters must submit a CGT-3 form to request a waiver as follows:

(A) To request a partial waiver to the data submission requirements, mandatory reporters must submit a completed CGT-3 form to the Authority no later than 14 calendar days before the annual reporting deadline.

(B) To request a waiver of all data submission or validation requirements, mandatory reporters must submit a completed CGT-3 form to the Authority no later than 60 calendar days before the annual reporting deadline.

(b) The Authority ~~will~~must approve or deny the waiver request and provide written notification to the requestor within 14 calendar days following receipt of the request.

(3) If a mandatory reporter believes they need a deadline extension for the data submission requirements, they may request a deadline extension by submitting CGT-3 form to the Authority.

(a) Mandatory reporters may submit a CGT-3 form to request a deadline extension as follows:

(A) To request a deadline extension for data submission, mandatory reporters must submit a completed CGT-3 form to the Authority no later than 14 calendar days before the annual reporting deadline.

(B) To request a deadline extension for data correction, resubmission, or validation requirements, mandatory reporters must submit a completed CGT-3 form to the Authority no later than seven calendar days after the date of the notice issued by the Authority requesting data correction, resubmission, or validation.

(b) The Authority ~~will~~must issue its determination on a mandatory reporter's CGT-3 deadline extension request within 14 calendar days after the date of the request.

(4) If the Authority denies a CGT-3 request, the mandatory reporter may request a contested case hearing following the procedure outlined in OAR 409-065-0050.

(5) The Authority will only grant CGT-3 requests for one data submission cycle at a time.

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385
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409-065-0025 Data Submission Compliance and Enforcement

(1) Unless the Authority approves a waiver submitted pursuant to OAR 409-065-0020, a mandatory reporter fails to comply with general data submission requirements under OAR 409-065-0015 when a mandatory reporter:

(a) Fails to submit data files by the specified submission date, or
(b) Fails to submit data files for a required line of business.

(2) Unless the Authority approves a waiver submitted pursuant to OAR 409-065-0020, a mandatory reporter fails to comply with data file requirements when a mandatory reporter:

(a) Submits a data file in an unapproved layout;
(b) Submits a data element in an unapproved format;
(c) Submits a data element with unapproved coding;
(d) Fails to submit a required data element; or
(e) Fails to comply with validation and quality control efforts, including resubmitting or correcting data in a timely fashion as requested by the Authority.

(3) The Authority ~~will~~must issue a notice of noncompliance to mandatory reporters before imposing a civil penalty in accordance with (4). Mandatory reporters must come into compliance within 30 calendar days from the date the Authority issues its notice of noncompliance.

(4) The Authority may impose a civil penalty on a mandatory provider for a violation of this rule if the mandatory reporter does not come into compliance as required under (3). Pursuant to ORS 442.993, the Authority adopts the following schedule of civil penalties:

(a) Up to $500 per day starting from the data of the notice in (3) for each violation of OAR 409-065-0025(1)(a) through (b);

(b) Up to $400 per day starting from the data of the notice in (3) for each violation of OAR 409-065-0025(2)(a) through (e).

(5) Civil penalties ~~will~~must be imposed in the manner provided in ORS 183.745.

Statutory/Other Authority: ORS 442.386 & 442.993
Statutes/Other Implemented: ORS 442.386, ORS 442.385 & 442.993
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409-065-0028 General Reporting Requirements for Provider Organizations

(1) Determination of a provider organization that is required to report data.

(a) The Authority ~~shall~~must identify provider organizations with 10,000 or more attributed patients in at least one market using the annual report titled Health Care Cost Trends, which is set forth on the Program website.

(b) The Authority ~~shall~~must make annual determinations regarding which provider organizations are required to report data. The Authority ~~shall~~must provide written notification no later than April 30 of each year to all provider organizations required to report data for the current year.

(c) A provider organization may appeal the Authority's determination of the status as a provider organization required to report data pursuant to the procedure outlined in OAR 409-065-0050.

(2) Provider organizations with less than 10,000 attributed patients in a given market, pediatric provider organizations, or federally qualified health centers, as identified by the Authority in the annual report titled Health Care Cost Trends and set forth on the Program website, may voluntarily submit a complete CGT-4 to the Authority.

(3) Data submission requirements.

(a) Annual data submission dates are provided in the CGT-4; the data must not be submitted before September 1st of each year.

(b) The Authority ~~will~~must review a submitted CGT-4 within 90 calendar days after confirming receipt. If the Authority finds errors during its review through edit checks or validation, the Authority ~~will~~must issue a notice of the error(s) to the provider organization. Provider organizations must correct and resubmit data within 30 calendar days after the date the Authority issues notice of the error(s). The Authority will consider the annual data submission complete after the provider organization submits all necessary corrections and resubmissions, as determined by the Authority. Voluntary reporters may correct and resubmit data, as applicable.

(4) Data submission waivers

(a) The Authority may grant a waiver or deadline extension to the data submission requirements.

(b) If a provider organization believes they are eligible for a waiver of all or part of the data submission requirements they may request a waiver of reporting requirements by submitting a CGT-3 to the Authority.

(A) A provider organization must submit a CGT-3 form to request a waiver as follows:

(i) To request a partial waiver to the data submission requirements, provider organizations must submit a completed CGT-3 form to the Authority no later than 14 calendar days before the annual reporting deadline.

(ii) To request a waiver of all data submission or validation requirements, a provider organization must submit a completed CGT-3 form to the Authority no later than 60 calendar days before the annual reporting deadline.

(B) The Authority ~~will~~must approve or deny the waiver request and provide written notification to the requestor within 14 calendar days following receipt of the request.

(c) If a provider organization believes they need a deadline extension for the data submission requirements, they may request a deadline extension by submitting a CGT-3 form to the Authority.

(A) Provider organizations may submit a CGT-3 form to request a deadline extension as follows:

(i) To request a deadline extension for data submission, provider organizations must submit a completed CGT-3 form to the Authority no later than 14 calendar days before the annual reporting deadline.

(ii) To request a deadline extension for data correction, resubmission, or validation requirements, mandatory reporters must submit a completed CGT-3 form to the Authority no later than seven calendar days after the date of the notice issued by the Authority requesting data correction, resubmission, or validation.

(B) The Authority ~~will~~must issue its determination on a provider organization's CGT-3 deadline extension request within 14 calendar days after the date of the request.

(d) If the Authority denies a CGT-3 request, the mandatory reporter may request a contested case hearing following the procedure outlined in OAR 409-065-0050.

(e) The Authority will only grant CGT-3 requests for one data submission cycle at a time.

(5) Data submission Compliance and Enforcement

(a) Unless the Authority approves a waiver submitted pursuant to (4), a provider organization fails to comply with data submission requirements under (3) when a provider organization fails to submit data files by the specified submission date.

(b) Unless the Authority approves a waiver submitted pursuant to (4), a provider organization fails to comply with data file requirements when a provider organization:

(A) Submits a data file in an unapproved layout;
(B) Submits a data element in an unapproved format;
(C) Submits a data element with unapproved coding;
(D) Fails to submit a required data element; or
(E) Fails to comply with validation and quality control efforts, including resubmitting or correcting data in a timely fashion as requested by the Authority.

(c) The Authority ~~will~~must issue a notice of noncompliance to provider organizations before imposing a civil penalty under (6). Provider organizations must come into compliance within 30 calendar days from the date the Authority issues its notice of noncompliance.

(6) The Authority may impose a civil penalty on a provider organization for a violation of this rule if the provider organization does not come into compliance as required under (5). Civil penalties ~~will~~must be imposed in the manner provided in ORS 183.745. Pursuant to ORS 442.993, the Authority adopts the following schedule of civil penalties:

(a) Up to $500 per day starting from the date of the notice in (5)(c) for each violation of (5)(a);

(b) Up to $400 per day starting from the date of the notice in (5)(c) for each violation of (5)(b).

409-065-0029 Automatic Change in Monetary Limits for Frontline Workers

Monetary limits for frontline workers will automatically change, without the necessity for amending such rules, by annual percentage increase (if any) 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, as determined by the Authority. The Authority ~~shall~~must calculate the changes and post changes by June 1 of each year.

409-065-0030 Data Access and Disclosure

(1) The Authority may use and disclose data submitted to it under these rules in accordance with ORS 442.386 and any applicable Authority policies and state and federal rules, regulations, and statutes.

(2) The Authority may disclose data to payers or provider organizations in the administration of the program, excluding any information determined to be confidential pursuant to OAR 409-065-~~0040(12),~~0042, regarding the determination of a reasonable cause of cost growth.

(3) The Authority may provide a public use data set in compliance with applicable Authority policies and state and federal rules and regulations.

Statutory/Other Authority: ORS 442.386
Statutes/Other Implemented: ORS 442.386 & ORS 442.385
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409-065-0035 Reasonable Causes of Cost Growth

(1) The Authority ~~shall~~must not impose a performance improvement plan outlined in OAR 409-065-0040 or financial penalty outlined in OAR 409-065-0045 on an entity that exceeded the cost growth target due to unforeseen market conditions or other equitable factors, as enumerated in section (2) of this rule. The Authority ~~shall~~must conduct analyses to understand potential systematic causes, market conditions, or other factors that might result in entities exceeding the cost growth target. The Authority ~~shall~~must determine, on a case-by-case basis, when such a condition or factor or a combination of such conditions or factors suffices as a reasonable cause for an entity to exceed the cost growth target ("determination of reasonableness").

(2) Reasonable cause for exceeding the cost growth target includes but is not limited to:

(a) Changes in mandated benefits codified in Oregon Revised Statute, Oregon Administrative Rule, Federal law, or Federal Regulations, to the extent that the mandated benefits are not defrayed under applicable law;

(b) Changes in federal, state, or local law that increases costs, including, but not limited to workforce and labor requirements and compliance requirements~~.~~;

(c) New pharmaceuticals, and new uses of existing pharmaceuticals, or new medical treatments entering the market, including new medical procedures and devices;

(d) Changes in taxes related to health care or other administrative requirements including but not limited to changes in medical loss ratio rebate requirements pursuant to state or federal regulation;

(e) Acts of God such as natural disasters or pandemics;

(f) Entity investments to improve population health or address health equity including but not limited to investments in primary care or behavioral health;

(g) Macro-economic factors wholly outside of the ability of the entity to influence or mitigate, such as periods of significant inflation, supply chain shortages, or labor shortages;

(h) A provider organization's total compensation, defined as wages, benefits, salaries, bonuses, and incentive payments, paid to frontline workers;

(i) High-cost patient or member outliers defined as per member per year costs totaling $1 million or more; and

(j) Any other reasonable cause specified in writing by the Authority and published as guidance on the Program website.

(3) The Authority ~~shall~~must notify an entity in writing if the entity's cost growth for that measurement period exceeded the cost growth target with statistical confidence and if the entity must participate in the Authority's determination of reasonableness process, as specified in writing by the Authority and published on the Program website.

(4) Entities must participate in conversations regarding the determination of reasonableness process with the Authority. Participation may include, but is not limited to, the entity or its delegate or authorized representative:

(a) attending meetings with the Authority,

(b) responding to Authority questions, or

(c) providing supplemental documentation, analysis or data as requested to support claims of reasonable cost growth.

(5) Failure of an entity to participate in conversations regarding the determination of reasonableness process upon request by the Authority may result in the Authority determining that the cost growth was unreasonable.

(6) As part of the determination of reasonableness process, an entity that exceeds the cost growth target with statistical confidence may submit analyses and supporting documentation to the Authority for any and all potentially acceptable reasons for cost growth as the entity may identify. Such analyses and supporting documentation may include but are not limited to:

(a) the quantified impact of the reasonable cause on the entity's cost growth with detailed explanation of how the entity calculated the impact;

(b) what the entity's cost growth would have been had it not been for the reasonable cause, including a detailed explanation of how the entity calculated the cost growth;

(c) sufficient documentation to support the claim of a reasonable cause; and

(d) the aggregate amount of total compensation using a methodology posted by the Authority in sub-regulatory documentation on the Program website, if a provider organization claims total

compensation paid to frontline workers as a reasonable cause, as specified in (2)(h) of this rule and OAR 409-065-0028.

(7) The Authority may request additional information, documents and analyses as the Authority may require to evaluate an entity's assertation of reasonable cause for exceeding the cost growth target.

(8) No person shall file or cause to be filed with the Authority any statement, report, or other information required or permitted to be filed and known to such person to be false or misleading in any material aspect.

(9) After reviewing information submitted by the entity, the Authority ~~shall~~must determine whether the entity's claim of reasonable cost growth for the measurement period is acceptable.

(a) The Authority ~~shall~~must determine that a payer or provider organization's cost growth is reasonable if all of the cost growth above the cost growth target is due to one or more~~a~~ reasonable cause~~s~~, as described in this rule.

(b) If the Authority determines that any amount of cost growth above the cost growth target is unreasonable, accountability mechanisms shall apply, as specified in OAR 409-065-0040 and OAR 409-065-0045.

(10) The Authority ~~shall~~must issue a notice of intent to impose one of three possible determinations: cost growth is due to an acceptable reason(s), cost growth is not due to an acceptable reason(s), or the reason(s) for cost growth cannot be determined.

(11) The Authority may, subject to OAR 409-065-0030, publish the final outcome of the conversations regarding the determination of reasonableness process.

(12) The Authority ~~will~~must notify the payer or provider organization in writing if a Performance Improvement Plan is required, as per OAR 409-065-0040.

(13) A payer or provider organization that has received a determination that cost growth is not due to an acceptable reason may request a contested case hearing pursuant to the procedure outlined in OAR 409-065-0050.

409-065-0040 Performance Improvement Plans (PIP)

(1) A payer or provider organization that exceeds the cost growth target with statistical confidence, as such term is described by the Authority in the Statistical Analysis guidance posted on the Program website, and without reasonable cause, in accordance with 409-065-0035, during a measurement year for Medicaid, Medicare Advantage, or the commercial insurance market, ~~shall~~must complete the performance improvement plan (PIP) template enumerated in (2).

(2) The Authority ~~shall~~must develop and publish on the Program website a PIP template (titled CGT-5), PIP Instructions and Manual (titled CGT-6), and Guidance on Accountability (titled CGT-7).

(a) The PIP is a document written by a payer or provider organization and approved by the Authority that specifies how the certain factors will result in reduced cost growth such that future cost growth does not exceed the cost growth target. These factors must:

(A) ~~identifyies~~ Identify key cost growth drivers and the specific actions a payer or provider organization will take to address those key cost growth drivers;
(B) ~~identifyies~~ Identify an appropriate timeframe or timeframes by which the payer or provider organization will reduce the cost growth and cost growth drivers; and
(C) ~~includes~~Include clear metrics for success to be used for evaluating progress and completeness.

(b) A payer or provider organization ~~shall~~must use the document titled CGT-5, to describe:

(A) ~~the~~ The root cause(s)of cost growth including, but not limited to, any causes identified during discussions with the Authority regarding the determination of a reasonable cause for cost growth;

(B) ~~strategies~~ Strategies developed by the payer or provider organization to address the root cause or causes of cost growth in a specified timeframe, but no more than 24 consecutive months from the date the Authority approves the submitted PIP, unless extended by the Authority as per (10) of this rule;

(C) ~~specific~~ Specific and achievable outcome measures to track progress;

(D) ~~the~~ The strategy developed by the payer or provider organization to avoid negative effects on health care service availability, quality, and health equity;

(E) ~~the~~ The plan for adjusting the strategy during the duration of the PIP in response to unmet savings or measures, and any negative effects on quality, access, and health equity; and

(F) ~~the~~ The payer or provider organization's plan for how to apply any generated savings.

(3) The Authority ~~shall~~must collaborate with a payer or provider organization required to develop and undertake a PIP by providing technical assistance, which may include sub-regulatory guidance, office hours, a webinar published on the Program website, and consultation with the payer or provider organization at their request.

(4) The Authority may, at its sole discretion, agree to a payer or provider organization combining required PIPs for multiple markets or to a payer and provider organization submitting a PIP jointly developed in the event that the strategies to address the root cause or causes of cost growth would benefit from a collaborative PIP.

(5) The payer or provider organization must submit its PIP to the Authority no later than 90 calendar days from the date the Authority notifies the payer or provider organization in writing that a PIP is required. The payer or provider organization is responsible for completing and submitting a CGT-5 to the Authority.

(6) The notified payer or provider organization may request an extension to complete and submit a PIP by completing and submitting a CGT-3 to the Authority.

(a) The payer or provider organization must request an extension no less than 30 calendar days prior to the PIP submission deadline.

(b) The Authority may grant, at its sole discretion, an extension of no more than 45 calendar days for the payer or provider organization to submit a complete PIP.

(7) Within 30 calendar days of receipt, the Authority ~~shall~~must assess the submitted PIP to ensure it is complete and either approve the PIP or, if the PIP is incomplete, return it to the submitting payer or provider organization for revision with a specified deadline for the revised PIP, as determined by the Authority on a case-by-case basis.

(8) Following the Authority's approval of the PIP, the payer or provider organization ~~shall~~must submit progress reports every six months in a manner specified by the Authority and in collaboration with the entity, regarding all progress made in advancing the purpose of the PIP, including qualitative and quantitative data as specified in the PIP. The first report ~~shall~~must be due six months from the date the Authority approved the submitted PIP.

~~-~~(9) The Authority ~~shall~~must publish on the Program website all PIPs, progress reports, and relevant materials marked "PUBLIC" pursuant to the requirements of ~~(12) of this rule~~OAR 409-065-0042.

(10) At the request of the payer or provider organization, the Authority may grant one or multiple extensions to a payer or provider organization with an approved PIP to achieve the activities outlined in the PIP. The Authority ~~shall~~must publish on the Program website all granted extensions and any new applicable deadlines for activities and milestones in each PIP.

(11) At the full discretion of the Authority, the Authority may waive the requirement for a payer or provider organization to complete a PIP, or undertake an approved PIP that a payer or provider organization has implemented or is in the process of implementing. If waived by the Authority, the payer or provider organization will not be required to submit documents related to a PIP including but not limited to progress reports and other required documentation pertaining to the waived PIP.

~~(a)~~ In contemplating a waiver of an approved PIP, the Authority may take the following into consideration:

(a~~A~~) ~~the~~ The payer or provider organization's achievement of PIP goals ahead of the schedule specified in the PIP;

(~~B~~b) ~~unforeseen~~ Unforeseen market circumstances;

(~~C~~c) ~~the~~ The payer or provider organization's performance related to the cost growth target; or

(~~E~~d) ~~the~~ The payer or provider organization is required to develop a subsequent PIP.

~~(12) A payer or provider organization required to submit a PIP may claim portions of the PIP, and any reports or documents pertaining to a PIP, are a trade secret and exempt from disclosure under ORS 192.311 to 192.478.~~

~~(a) The payer or provider organization shall submit two versions of such materials to the Authority:~~

~~(A) One shall be marked as "CONFIDENTIAL" and shall contain the full unredacted version of the PIP and any reports or documents.~~

~~(B) The second shall be marked as "PUBLIC" and shall contain a redacted version of the PIP and any reports or documents pertaining to the PIP (from which the confidential portions have been removed or obscured) and shall be posted on the Program website.~~

~~(b) A payer or provider organization claiming confidentiality in respect of portions of a PIP and any reports or documents shall include a redaction log that provides a reasonably detailed statement of the grounds on which confidentiality is claimed and the reasoning for such redaction. This redaction log will be posted on the Program website.~~

(~~13~~12) If for a given year the Authority determines a payer or provider organization's cost growth to be acceptable, or indeterminate, which shall be a rare occurrence, in accordance with OAR 409-065-0035, no PIP will be required for that year.

(~~14~~13) No later than December 31, 2030, the Authority ~~shall~~must reassess and, if necessary, revise the PIP process outlined in these rules.

409-065-0042 Confidential Information

(1) An entity that submits information to the Authority may claim portions of the information a trade secret and exempt from disclosure under ORS 192.311 to 192.478.

(a) The entity ~~shall~~must submit two versions of such materials to the Authority:

(A) One ~~shall~~must be marked as "CONFIDENTIAL" and ~~shall~~must contain the full unredacted version of the document.

(B) The second ~~shall~~must be marked as "PUBLIC" and ~~shall~~must contain a redacted version of the document (from which the confidential portions have been removed or obscured) and ~~shall~~must be posted on the Program website.

(b) An entity claiming confidentiality ~~shall~~must include a redaction log that provides a reasonably detailed statement of the grounds on which confidentiality is claimed and the reasoning for such redaction. This redaction log ~~will~~must be posted on the Program website.

409-065-0045 Cost Growth Target Financial Penalties

(1) Pursuant to ORS 442.386, the Authority may impose a financial penalty on a payer or provider organization when:

(a) ~~the~~ The cost growth exceeded the target with statistical confidence, as defined by the Authority; and

(b) ~~the~~ The payer or provider organization's cost growth is without reasonable cause, or is not indeterminate, as defined in 409-065-0035, in the Medicaid, Medicare Advantage, or commercial insurance market for at least three out of five calendar years.

(2) The Authority ~~shall~~must not impose financial penalties before January 1, 2026, and the cost growth from 2021 to 2022 ~~shall~~must serve as the first year of a payer or provider organization's first five-year period described in section (1)(b) of this rule.

(3) The financial penalty ~~shall~~must be paid to consumers or designed to directly benefit consumers.

(4) The size of a payer or provider organization's financial penalty ~~shall~~must be based on how much the payer or provider organization exceeded the cost growth target and ~~shall~~must be determined as follows:

(a) A payer or provider organization's first instance of a financial penalty within a given market ~~shall~~must equal 5 percent of the net total cost above and below the cost growth target collectively in the five-year period.

(b) A payer or provider organization's second instance of a financial penalty within a given market ~~shall~~must equal 10 percent of the net total cost above and below the cost growth target in the five-year period.

(c) A payer or provider organization's third instance of a financial penalty within a given market ~~shall~~must equal 15 percent of the net total cost above and below the cost growth target in the five-year period.

(d) Each instance of a financial penalty within a given market ~~shall~~must increase by 5 percentage points of the net total cost above the cost growth target in the five-year period.

(e) The total cost above the cost growth target for a given performance period is calculated by the following steps:

(A) First, subtract ~~the product of~~from the payer or provider organization's per member per month (PMPM) cost in the ~~first~~ second year of the two-year performance period the product of ~~multiplied by one plus the cost growth target from~~ the payer or provider organization's per member per month (PMPM) cost in the ~~second~~ first ~~year of the two-year performance period the product of the payer or provider organization's per member per month (PMPM) cost in the first~~ year of the two-year performance period multiplied by the sum of one plus the cost growth target percent. The Authority ~~shall~~must use per member per month costs, as defined by the Authority in CGT-1 data submission template as total medical expenses. The mathematical formula is (PMPM year 2 – (PMPM year 1 * (1 + cost growth target percent))) = x.~~–~~ In this OAR 409-070-0045, the value "x" equals the calculated value of the mathematical formula in this section (4)(e)(A).

(B) Second, multiply "x" times the number of member months (MM) in the second year of the two-year performance period. The mathematical formula is (x * MM) = z.

(C) Repeat the steps in (4)(e)(A) and (4)(e)(B) for all five years of the five-year period. For years in which the payer or provider organization's cost growth exceeded the cost growth target, the calculated value of "x" and "z" will be a positive number. For years in which the payer or provider organization's cost growth was less than the cost growth target, the calculated value of "x" and "z" will be a negative number.

(D) Sum all values of ”z” calculated in (4)(e)(A) through (C). The result is the net total cost above the cost growth target.

(E) Multiply the value in (4)(e)(D) by the appropriate factor, as determined in (4)(a) through (4)(d).

(F) If the value calculated in (4)(e)(E) is zero or negative, the payer or provider organization will not be penalized for that five-year period.

(5) 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 five-year period will shift forward every year following payers’ submission of data as outlined in OAR 409-065-0010.

(6) The Authority may reduce the calculated financial penalty amount if the payer or provider organization is subject to one or more other penalties imposed by the State of Oregon or the federal government for the same measurement period or if the penalties threaten the solvency of the payer or provider organization. The Authority ~~shall~~must consult with DCBS on every instance of a penalty applying to a payer.

(a) Other penalties imposed by the State of Oregon or the federal government include, but are not limited to, rebates relating to the medical loss ratio. The amount of the other penalty or rebate imposed by the State of Oregon or the federal government ~~shall~~must be subtracted from the penalty amount calculated in (4).

(b) The Authority ~~shall~~must collaborate with DCBS ~~, as necessary,~~ when determining if a penalty imposed by the Authority will threaten the solvency of a payer and may reference information including but not limited to the payer’s risk-based capital amounts. The Authority ~~shall~~must handle confidential information received by DCBS in accordance with ORS 705.137 and may share confidential information with DCBS~~, in accordance with ORS 705.137, and s~~. Such sharing shall not constitute a waiver of the confidential status of such materials.

(c) The Authority may request financial information from provider organizations when determining if a penalty amount imposed by the Authority will threaten the solvency of a provider organization and may reference information including, but not limited to, audited financial statements.

(7) If the Authority determines a payer or provider is subject to financial penalty under this section, the Authority ~~will~~must prepare and serve a Notice of Intent to Impose a Financial penalty on the payer or provider organization. A payer or provider that has been served a Notice of Intent has 60 calendar days to either provide the Authority with a proposed plan for the financial penalty pursuant to (8) or file a written request for a contested case hearing pursuant to the procedures outlined in OAR 409-065-0050.

(8) The Authority ~~shall~~must publish sub-regulatory guidance on the Program website outlining allowable financial plans including a template for the proposed plan and the availability of additional technical assistance. Financial penalties must:

(a) ~~benefit~~ Benefit community members who reside in or in close proximity to a geographic area in Oregon that the payer or provider organization serves, and

(b) ~~not~~ Not directly and financially benefit the payer or provider organization.

(9) The payer or provider organization ~~shall~~must pay the totality of the financial penalty within 60 months after receiving a Final Order Imposing a Financial penalty from the Authority, inclusive of all appeal periods.

(10) The following payer and provider organizations are exempt from OAR 409-065-0045 and will not be subject to a financial penalty:

(a) ~~a~~ A Federally Qualified Health Center, as defined in 42 U.S.C. 254b, that is not affiliated with a hospital through ownership, governance, control, or membership.

(b) ~~a~~ A pediatric clinic or group of pediatric clinics that predominantly treat individuals under the age of 21, that is not affiliated with a hospital through ownership, governance, control, or membership.

(c) The Oregon Health Plan Open Card, also known as Fee For Service, Program.

(11) No later than December 31, 2030, the Authority ~~shall~~must reassess and, if necessary, revise the financial penalty calculation methodology outlined in this rule.

409-065-0050 Cost Growth Target Accountability Request for Consideration and Contested Case Hearings

(1) A payer or provider organization may request that the Authority reconsider any Notice of Intent or determination made under OAR 409-065-0000 through OAR 409-065-0055.

(a) A request for reconsideration must be submitted in writing to OHA, via email to HealthCare.CostTarget@oha.oregon.gov, within 30 days of the date of OHA's written Notice of Intent or determination. This request must include a detailed explanation of why the payer or provider organization believes OHA's decision is in error along with any supporting documentation. This request for reconsideration initiates an informal review process.

(b) New information may be provided by the payer or provider organization, or may be requested by the Authority, as part of the reconsideration process.

(c) A reconsideration may result in a modified Notice or in the reaffirmation of the original Notice. A request for reconsideration, supporting documentation and additional information, and OHA's determination ~~will~~must be posted on the Program website, although any information determined to be a trade secret and confidential under OAR 409-065-~~0040(12)~~ 0042 ~~will~~must be maintained as confidential.

(2) A payer or provider organization is entitled to an informal conference and contested case hearing as provided in this rule regarding Notices of Intent and determinations made under OAR 409-065-0000 through 409-065-0055.

(3) This section solely applies to informal conferences and contested case hearings requested on notices of intent and determinations made under OAR 409-065-0010 through 409-065-0030.

(a) An entity that wishes to contest a determination of mandatory reporter status or provider organization must submit a request a hearing within 20 calendar days after the Authority issues the determination of mandatory reporter status as outlined in OAR 409-065-0010.

(b) A payer or provider organization that wishes to ~~request a~~ contest a denial of waiver or extension request must request a hearing within 20 calendar days after the Authority issues its determination pursuant to OAR 409-065-0020.

(c) A payer or provider organization that wishes to contest a notice of intent to impose a civil penalty issued by the Authority regarding data submission or data filing requirements must request a hearing within 20 calendar days after the Authority issues the notice of intent pursuant to OAR 409-065-0025.

(~~3~~4) This section applies to informal conferences and contested case hearings requested on notices of intent and determinations made under OAR 409-065-0035 through 409-065-0045.

(a) A payer or provider organization that wishes to contest a determination that cost growth is not due to an acceptable reason(s) must request a hearing within 20 calendar days after the Authority issues the determination.

(b) A payer or provider organization that wishes to contest a notice of intent to impose a financial penalty issued by the Authority must request a hearing within ~~30~~20 calendar days after the Authority issues the notice of intent pursuant to OAR 409-065-0045.

(~~4~~5) Informal Conference Request.

(a) Upon receipt of a notice of intent and/or determination outlined in (~~2~~3) or (~~3~~4) of this rule, a payer or provider organization may request an informal conference with the Authority via email to HealthCare.CostTarget@oha.oregon.gov.

(b) The Authority will schedule an informal conference with the payer or provider organization. The purposes of this informal conference are to:

(A) Provide an opportunity to settle the matter;

(B) Give the parties and the Authority an opportunity to review the information which is the basis for the action; and

(C) Give the parties and the Authority the chance to correct any misunderstandings of the facts.

(c) If the payer or provider organization request a contested case hearing, the payer or provider organization may, at any time prior to the hearing date, request an additional informal conference with the Authority, which may be granted if the Authority finds at its sole discretion that the additional informal conference will facilitate the resolution of disputed issues.

(d) An informal conference may result in a modified notice of intent or determination or in the reaffirmation of the original notice of intent or determination.

(~~5~~6) Contested Case Hearing.

(a) In a contested case conducted pursuant to this rule, an Administrative Law Judge (ALJ) assigned by the Office of Administrative Hearings ~~will~~must conduct the contested case hearing pursuant to ORS 183.411 through 183.497, the Attorney General's Model Rules at OAR 137-003-0501 to 137-003-0700, and the provisions of these rules.

(b) The Authority's contested case hearings governed by this rule ~~shall~~must be open to the public.

(c) The issues to be considered in a contested case conducted pursuant to this rule ~~shall~~must be limited in scope to the facts and conclusions contained in the order or determination.

(~~6~~7) Proposed and Final Orders. The ALJ is authorized to serve a proposed order on all parties and the Authority unless prior to the hearing, the Authority notifies the ALJ that a final order may be served by the ALJ.

(a) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file written exceptions to the proposed order to be considered by the Authority, or the ALJ when the ALJ is authorized to issue the final order. The exceptions must be in writing and received by the Authority, or the ALJ when the ALJ is authorized to issue the final order, not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may be submitted without prior approval of the Authority.

(b) The Authority ~~shall~~must issue a final order within 30 calendar days of receipt of the proposed order, which may adopt some or all of the proposed order, as the Authority ~~shall~~ must determine in its sole discretion. The final order is effective immediately upon being signed or as otherwise provided in the order.

(c) After receiving the exceptions or argument, if any, the Authority may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority may issue an amended proposed order.

(~~7~~8) The time limits established in this rule may be waived or shortened by agreement among the parties and the Authority.

(~~8~~9) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.

409-065-0055 Annual Public Hearings

(1) The cost growth target program ~~shall~~must hold an annual public hearing regarding the growth in total health care expenditures in relation to the health care cost growth in the previous calendar year. The director of the Authority may request any payer or provider organization that is found to be a significant contributor to health care cost growth in the state or exceeds the cost growth target with statistical confidence, as defined by the Authority, and without reasonable cause, as defined in OAR 409-065-0035, during the performance year, to participate in an annual public hearing. If the payer or provider organization does not commit to participating in the annual public hearing, the director of the Authority may require participation. The Authority ~~shall~~must notify the payer or provider organization of the requirement to participate. Each such payer or provider organization that is required to participate in such hearing ~~shall~~must provide testimony on issues identified by the director of the Authority and provide additional information on actions taken to reduce such payer's or provider organization's contribution to state-wide and market-level health care costs.

(2) The director of the Authority may request that any other entity, including but not limited to a drug manufacturer or pharmacy benefit manager, that is found to be a significant contributor to health care

cost growth in this state during the performance year participate in such hearing. If the entity does not commit to participating in the annual public hearing, the director of the Authority may require participation. Any other entity that is required to participate in such hearing ~~shall~~must provide testimony on issues identified by the director of the Authority and provide additional information on actions taken to reduce such other entity's contribution to state-wide health care costs.

***Note: Cite to ORS 413.037 as authority for this OAR.