

Sustainable Health Care Cost Growth Target

Implementation Committee Recommendations
Final Report to the Oregon Legislature

Senate Bill 889 (2019)
January 2021





January 20, 2021

To the Committees of the Legislative Assembly related to health:

At our January 5, 2021 Oregon Health Policy Board (OHPB) meeting, we unanimously voted to support the recommendations of the Sustainable Health Care Cost Growth Target Implementation Committee to implement a health care cost growth target to help contain costs across all payers and providers, and to commit to our role in program implementation. This work is a foundational pillar toward building a sustainable health care system and will help us take Oregon's transformation efforts to the next level.

Senate Bill 889 (2019) established the Health Care Cost Growth Target Program under the oversight of the Oregon Health Policy Board and we have closely followed the work of the Implementation Committee over the last year as it has developed recommendations for the program. We know that health care costs in Oregon have been growing faster than the national average and the high cost of care is a challenge for Oregon families.

We look forward to continuing to work with the Implementation Committee, the Oregon Health Authority, and the Division of Consumer and Business Services to launch the Health Care Cost Growth Target Program. As we move into implementation, OHPB will work to ensure that the Program:

- Helps contain costs for consumers without jeopardizing access or quality
- Helps improve equity by making health care more affordable and accessible to all Oregonians
- Informs future policy conversations about how to eliminate health inequities caused by costs

We will also ensure the program includes consumer voices and will work to balance consumer and industry perspectives in understanding health care cost growth, key drivers of health care cost growth, and the impacts of that cost growth.

The Oregon Health Policy Board looks forward to prioritizing this work in 2021, as directed by the Governor. We see the Health Care Cost Growth Target Program as an opportunity to support both the executive and legislative branches in tackling health care costs, and we look forward to engaging with the legislature moving forward, including through our convening of the annual public hearings. This will be a learning process, and the Board welcomes ongoing engagement and evaluation as we commit to successfully launching the Program.

Sincerely,

David Bangsberg, MD, MPH
Chair, Oregon Health Policy Board

Oscar Arana, MBA
Vice-Chair, Oregon Health Policy Board



January 15, 2021

Senate Bill 889 (2019) established Oregon’s Sustainable Health Care Cost Growth Target Program and the Implementation Committee to select the cost growth target and design an implementation plan. The Committee was charged with 14 specific tasks, including establishing the methodology for measuring the cost growth target statewide, for payers, and for provider organizations (hospitals and large clinics); identifying opportunities for lowering costs, improving the quality of care and improving the efficiency of the health care system by using innovative payment models for all payers; recommending the governance structure for the program; and recommending accountability measures.

The Committee held 12 meetings from November 2019 – January 2021 to develop these recommendations through a collaborative process, balancing senior health care industry leadership with business, workforce, and consumer representation to come to consensus on challenging and complex issues. Committee members repeatedly put their own interests aside to meet the common imperative of containing health care costs.

Committee conversations emphasized the importance of quality and equity, and the need to monitor for unintended consequences as the program rolls out. The Committee also brought a strong focus on advancing value-based payment models across the state to help payers and provider organizations meet the cost growth target.

The Sustainable Health Care Cost Growth Target Implementation Committee approved the final set of recommendations on January 12th and is pleased to submit them to the legislature. The attached report provides the summary of recommendations, as well as details about the Committee conversations and additional context for program implementation. The Health Care Cost Growth Target Program and these recommendations are a foundational step towards building a sustainable health care system and continuing Oregon’s transformation efforts.

The Committee encourages legislators to move forward with passing accountability legislation in the 2021 session (HB2081) to fully launch the program.

Thank you for the opportunity to provide these recommendations. We appreciate the chance to serve Oregonians in this important effort to control health care costs.

Sincerely,

Jack Friedman, Chair

Kevin Ewanchyna, MD, Vice Chair

Executive Summary

The Sustainable Health Care Cost Growth Target Program

About the Program

In 2019, the Oregon Legislature passed Senate Bill 889, establishing the Sustainable Health Care Cost Growth Target Program, and convening an Implementation Committee under the direction of the Oregon Health Policy Board. Oregon is the fourth state to adopt a health care cost growth target, and the second to do so legislatively, with more states following (see map).

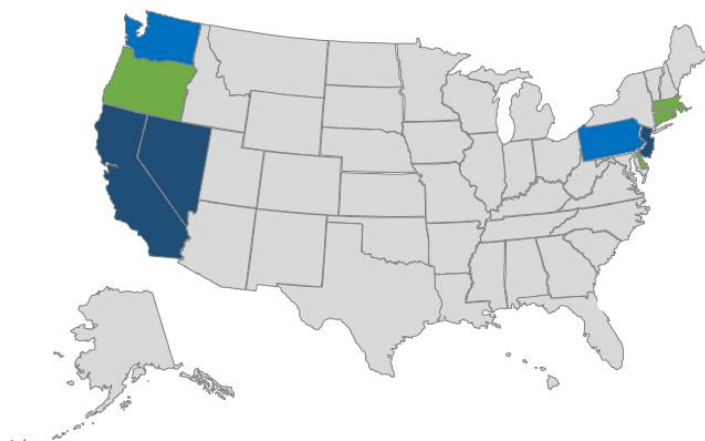
The Committee was appointed in October 2019 and was charged with designing the implementation plan for the Program. The Committee was directed to report its recommendations to the Oregon Health Policy Board and the Legislature no later than September 15, 2020. However, the Committee paused its work for several months during the COVID-19 public health emergency and finalized its recommendations in January 2021.

How Cost Growth Targets Work

The cost of health care in Oregon is projected to continue growing faster than both the state's economy and Oregonians' wages. When the cost of health care grows faster than the economy and wages, it means that Oregonians are left paying a larger percentage of their income on health care. Rising health care costs also mean less money for investments in wages, retirement, and critical public services.

The health care cost growth target is intended to serve as a budget target for the annual per capita rate of growth of total health care spending in the state. Health insurance companies' and health care providers' health care spending will be compared to the cost growth target each year, and the program will report on cost increases and drivers of health care costs annually. The cost growth target will bring everyone to the table to work towards a common goal of holding health care costs down.

States implementing cost growth targets, December 2020



Please note that this report uses "costs" and "spending" interchangeably

- Established
- Committed to Development
- Active Discussions Underway

Implementation Committee Recommendations Summary

The Committee addressed the charges in SB 889 by organizing the conversations into six workstreams. A brief description and a summary of recommendations in each workstream is provided below.

Additional detail about Committee considerations for each recommendation and initial thoughts about operationalizing and implementing the recommendations are included in the full report and appendices.

Implementation Committee Workstreams



Cost Growth Target

This workstream contains activities related to the development of a cost growth target and establishing an implementation timeline.

- The annual per capita health care cost growth target should be 3.4% for 2021-2025 and then 3.0% for 2026-2030.
- In 2024, the future governance committee should review economic indicators and health system performance against the cost growth target to determine whether the annual 2026-2030 target was set appropriately and if adjustments are needed.
- The cost growth target should be measured at four different levels: (1) statewide, (2) by market (Medicaid, Medicare, Commercial), (3) by payers, and (4) by provider organization.
- The first performance year of the cost growth target should measure cost growth between calendar years 2020 and 2021. OHA will collect data for 2018 and 2019 to

understand what health care cost growth in Oregon looked like prior to COVID-19, as well as understanding the impact of COVID-19 on health care spending.

- OHA should convene a technical advisory group to finalize the data submission process.

Data Use Strategy

This workstream includes activities related to using Oregon’s All Payer All Claims (APAC) data and other data sources to understand cost and cost drivers relative to the cost growth target.

- The Implementation Committee adopted Data Use Strategy Goals and Principles to guide planned analyses, data requirements, and transparent reporting for the program.
- Additional analyses to understand health system performance cost drivers, unintended consequences, equity, and unreasonable variation in cost growth should be conducted using Oregon’s APAC data and other data sources.
- Additional work with the Implementation Committee and a Technical Advisory Group will be needed to understand data collection methods, cost drivers, variation in cost growth, and unintended consequences of the cost growth target.

Quality & Equity

This workstream includes activities related to the measurement of quality of care, in alignment with the Health Plan Quality Metrics Committee approaches, with a strong focus on inequities in health care.

- The Health Plan Quality Metrics Committee should identify a subset of its existing menu of quality measures for reporting as part of the Health Care Cost Growth Target Program.
- OHA, the Oregon Health Policy Board, the Health Plan Quality Metrics Committee, and the Health Equity Committee should work together in 2021 to develop a plan and identify measures for monitoring unintended consequences of the cost growth target, as well as positive impacts.

Taking Action

This workstream includes activities related to strategies required to lower the growth in health care costs by payers, providers, and the state. This includes identifying opportunities for

lowering costs, improving the quality of care, and improving the efficiency of the health care system by using innovative payment models, and determining the technical assistance and support necessary to help payers and providers achieve the cost growth target.

- The Implementation Committee adopted principles for accelerating the adoption of advanced value-based payment models across the state.
- OHA should support the development of a voluntary compact to commit Oregon's payers and providers to taking action to implement the principles.

Accountability

This workstream includes activities related to recommending accountability processes, as well as future governance for the program.

- There should be a collaborative process between the state and payer and provider organizations to implementing the cost growth target program, to help everyone achieve the cost growth target and improve health care affordability.
- Performance Improvement Plans should be the first accountability measure for payers and provider organizations who exceed the cost growth target with statistical certainty and without a reasonable basis for doing so. PIPs will be the continuation of the transparent and collaborative process between OHA and stakeholders to understand cost drivers and to support efforts to contain cost growth.
- Payers and provider organizations who exceed the cost growth target with statistical certainty and without a reasonable basis across multiple years should be subject to a meaningful financial penalty.
- The Implementation Committee should continue to meet throughout 2021 to continue to develop the Health Care Cost Growth Target Program and oversee initial implementation.
- A future governance committee should be established to oversee the Health Care Cost Growth Target Program in 2022 and beyond. Membership should include health care payers and provider organizations, business/employer representatives, and consumer representatives.

Transparency

This workstream includes activities related to public reporting and sharing of information.

- Program information should be shared through three primary mechanisms: (1) development and publication of public-facing reports; (2) publication of data files; and (3) public hearings.
- Public hearings should be held annually, after the publication of the annual health care cost trend report, to discuss performance and strategies to improve performance. Smaller stakeholder convenings could occur during the year to address specific strategies.

For More Information

Please contact HealthCare.CostTarget@dhsosha.state.or.us

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Acknowledgements

Staff at the Oregon Health Authority prepared this publication on behalf of the Implementation Committee.

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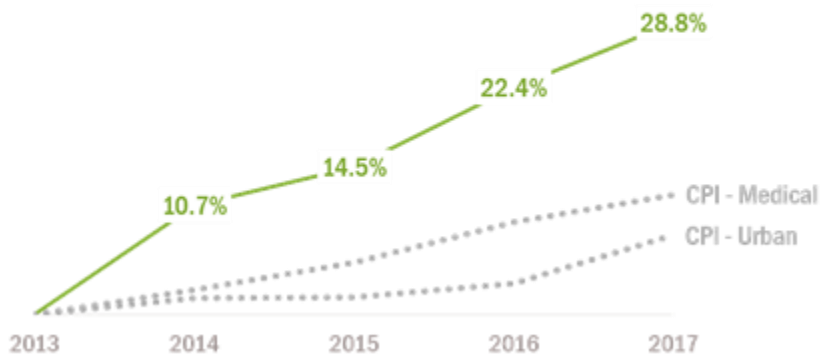
Oregon Health Authority. SB 889 (2019). Sustainable Health Care Cost Growth Target Implementation Committee Recommendations Report to the Oregon Legislature. Salem, OR. January 2021.

Introduction

Health Care Costs in Oregon

The cost of health care in Oregon is projected to continue growing faster than both the state's economy and Oregonians' wages. When the cost of health care grows faster than the economy and wages, it means that Oregonians are left paying a larger percentage of their income on health care. Rising health care costs also mean less money for investments in wages, retirement, and critical public services.

Total paid amounts per person in Oregon increased 6.5 percent per year on average from 2013-2017.



Data sources: Oregon's All Payer All Claims database. Includes only claims-based payments for all lines of business. Non-claims payments such as value-based payments or alternative payment methodologies are not included. Carriers' profit margin and administrative overhead not included. Compared to Consumer Price Index (CPI) for All Urban Consumers and Medical Care, U.S. Bureau of Labor Statistics.

There are many factors that affect health care costs, but the Centers for Medicaid and Medicare Services attribute 50% of projected spending growth to a rise in prices; 33% of projected spending growth is due to use and intensity of services, and only 17% is due to demographics.¹

A 2018 study comparing Oregon to four other states (Maryland, Minnesota, Colorado and Utah) found that Oregon has higher prices and lower utilization.² More recent research from the Health Care Cost Institute found that Oregon's average Commercial service prices are almost 170% of Medicare prices (third highest in the country).³

¹ Sisko et al, "National Health Expenditure Projections, 2018-2027: Economic and Demographic Trends Drive Spending and Enrollment Growth." *Health Affairs*, 2019.

² Healthcare Affordability; Untangling Cost Drivers, Network for Regional Healthcare Improvement, 2018.

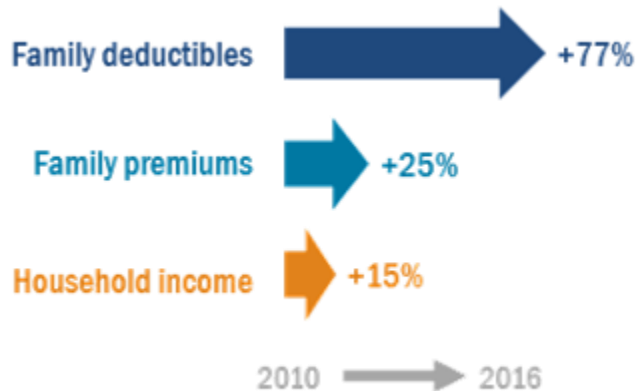
³ Comparing Commercial and Medicare Professional Service Prices, Health Care Cost Institute, 2020.

Impact of Costs on Oregon Consumers

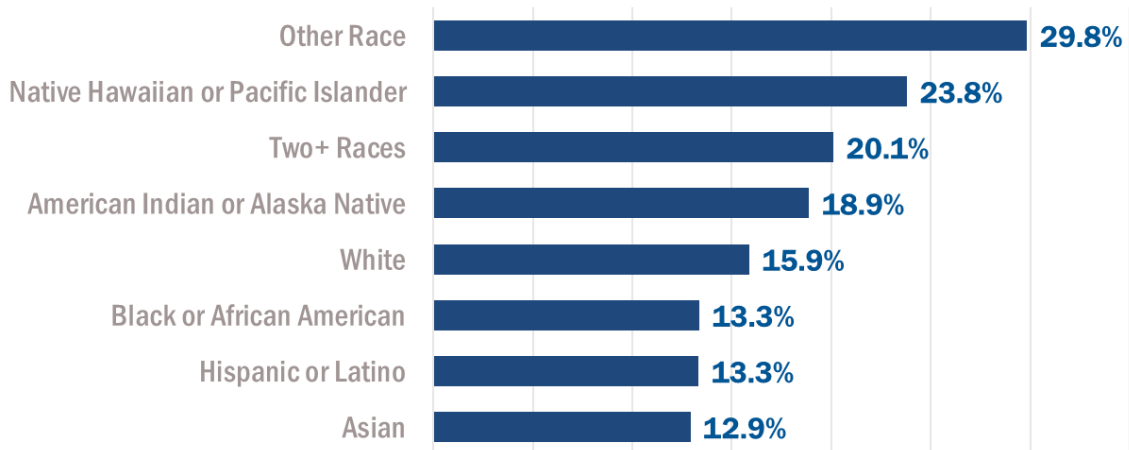
The burden of health care costs is high on Oregon families. In 2016, Oregon premiums equated to almost a third of a family’s total income, and deductibles and premiums grew faster than household income between 2010 and 2016 (77% and 25% growth respectively, compared to 15% growth in income).⁴

Communities of color are more likely to be impacted by high health care costs.⁵

Oregonians who report other race, two or more races, or Native Hawaiian/ Pacific Islander race are more likely to have delayed any type of care in the past year because of costs.



Percent of Oregonians who reported they delayed any type of care in the past year because of cost, by race/ethnicity

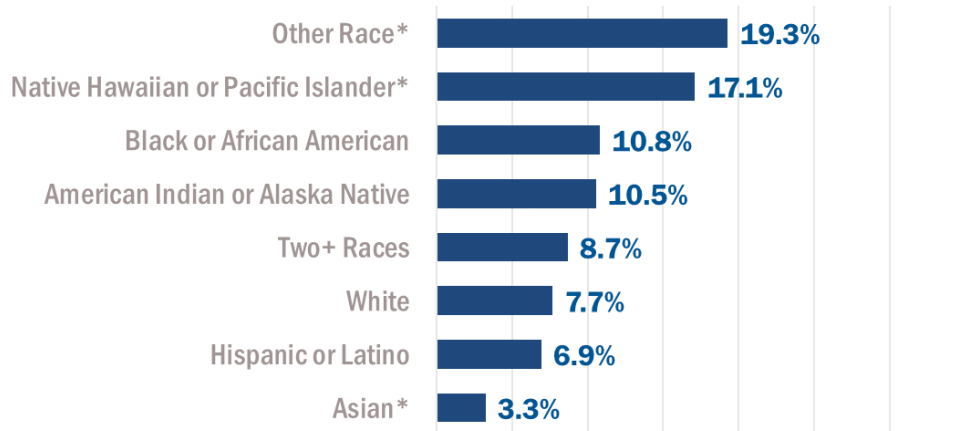


⁴ The Burden of Health Care Costs for Working Families. April 2019. <https://ldi.upenn.edu/brief/burden-health-care-costs-working-families>

⁵ Oregon Health Insurance Survey data, 2019.

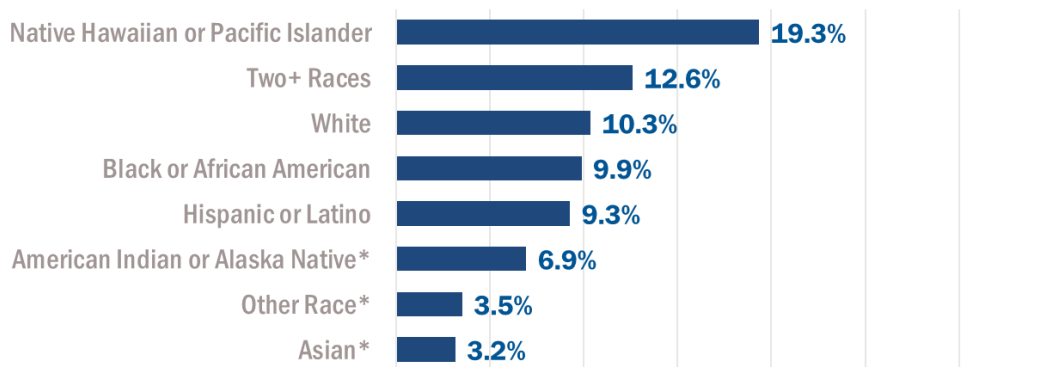
Black/African American and American Indian/Alaska Native Oregonians are more likely to report they were unable to pay medical bills in the past year, and Native Hawaiian/Pacific Islander Oregonians or Oregonians reporting two or more races are more likely to report difficulty paying medical bills over time.⁶

Percent of Oregonians who reported they were unable to pay medical bills *in the past year*, by race/ethnicity



* Interpret data with caution. Sample sizes are small for this group.

Percent of Oregonians who reported problems paying off medical bills *over time*, by race/ethnicity



* Interpret data with caution. Sample sizes are small for this group.

⁶ Oregon Health Insurance Survey data, 2019.

Why did Oregon pursue a cost growth target approach?

The idea for a health care cost growth target in Oregon came from Senate Bill 419 (2017) – the Joint Interim Task Force on Health Care Cost Review. The 419 Task Force was convened to study the feasibility of creating a hospital rate-setting process in Oregon modeled on the process used in Maryland. After studying Maryland as well as payment reform models in Massachusetts, Pennsylvania, and Vermont, the Task Force recommended moving forward with a health care cost growth target program similar to Massachusetts’ cost containment approach.⁷

“ To respond to Oregon’s health care cost challenges, we are recommending a new approach to achieving a sustainable health care system. This is an Oregon solution, a plan to control total health care expenditures across – *all payers and providers* – by establishing a health care spending benchmark: a statewide target for the annual rate of growth of total health care expenditures.

This solution supports accountability for total costs of care applied to all payers, public and private, and builds on Oregon’s existing health care reform efforts around cost containment and payment reform. A foundational underpinning for these efforts is ensuring the long-term affordability and financial sustainability of Oregon’s health care system, for patients and providers.”

Health care cost growth targets are intended to serve as a budget target for the annual per capita rate of growth of total health care spending in the state. A health care cost growth target brings payers and providers to the table to work towards a common goal of holding health care costs down. Taking a total cost of care approach allows Oregon to look at all contributors to health care spending, rather than focusing on just one aspect such as high prices.

Health care cost growth targets are intended to ensure that health care costs do not outpace other economic growth, such as general inflation or wages, and health care cost growth target programs create transparency by studying and publishing the reasons for cost growth. Health insurance companies’ and health care providers’ health care spending will be compared to the cost growth target each year, and the Health Care Cost Growth Target Program will report on cost increases and drivers of health care costs annually.

A note about integrated systems

While we reference payers and providers throughout this report in keeping with SB 889’s language, there will be instances during implementation of the Health Care Cost Growth Target Program when the program will need to clarify whether organizations such as Kaiser

⁷ Senate Bill 419 Joint Interim Task Force on Health Care Cost Review Report to the Oregon Legislature, September 2018. <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/150143>

Permanente that are both payers and providers (i.e. an integrated system) should be treated as payers or provider organizations, or if a hybrid approach is needed. OHA will continue to address this question during the implementation process in collaboration with integrated systems.

Establishing Legislation

Senate Bill 889 passed in the 2019 legislative session with broad bipartisan support, building on the 419 Task Force recommendations to establish the Health Care Cost Growth Target Program and a Committee appointed by the Governor to design an implementation plan for Program.⁸

The Health Care Cost Growth Target Program will expand upon the existing per capita cost growth target programs already in place for the Oregon Health Plan and public employee health insurance programs statewide, to include other payers and provider organizations.

Governor's Directive

In her October 2019 letter to the Oregon Health Policy Board appointing members of the Implementation Committee⁹, Governor Brown further directed the Committee to ensure:

- A target rate of growth is selected that provides an aggressive restraint to cost growth so that health care costs grow at a sustainable rate for families and businesses in Oregon.
- Transparency of cost drivers is prioritized, and the program provides meaningful information – utilizing Oregon's All Payer All Claims database and other data sources – to identify and report publicly on areas of high cost, cost growth drivers, and variation in price and utilization.
- The program provides information on cost drivers and savings opportunities to other programs within the Oregon Health Authority and the Department of Consumer and Business Services to support respective roles in setting, negotiating, or approving affordable health plan rates.
- Health care quality is a key component of the program, with a focus on inequities and reducing disparities in health care.
- Robust enforcement and accountability tools are recommended to hold health insurance carriers and providers accountable for meeting the target, including presenting a legislative concept for the 2021 Legislative Session for authority needed to implement the recommendations.

⁸ Senate Bill 889, Enrolled. <https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled>

⁹ <https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Governor-Appontment-Letter-10-18-2019.pdf>

Implementation Committee

The Implementation Committee was first convened in November 2019 to review their charge and begin the work. The Committee adopted a charter in December, including the following guiding principles.¹⁰

The Committee's recommendations will:

- Support the establishment of a cost growth target by January 1, 2021
- To the extent practical, be inclusive of all populations and all categories of spending
- Recommend a stable target upon which payers, providers, and policymakers can rely for several years at a time
- Develop a target and reporting methods that are statistically robust
- Be sensitive to the impact that high health care spending growth has on Oregonians
- Align recommendations with other state health reform initiatives to lower the rate of growth of health care costs
- Promote collaboration across payers and providers, and encourage collective action to meet the cost growth target
- Be mindful of state financial and staff resources required to implement recommendations, and
- Focus on the charges delegated to the Committee by SB 889 and the Governor and avoid topics and recommendations that are beyond the Committee's assignment.

The Implementation Committee agreed to address all aspects of their charge from SB 889 and the Governor's directive by organizing their specific tasks into several areas of activity (see description of each Workstream on the next page) and by learning from other states' cost growth target programs where applicable. The Committee also committed to a robust stakeholder engagement process.

The Committee is supported by agency staff, with subject matter expertise provided by Bailit Health.¹¹

¹⁰ Implementation Committee Charter adopted December 2019.

<https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Approved%20Implementation%20Committee%20Charter.pdf>

¹¹ <http://www.bailit-health.com/>

IMPLEMENTATION COMMITTEE WORKSTREAMS



Cost Growth Target

Activities related to the development of a cost growth target, including the methodology to establish the cost growth target, selecting the target values, identifying the data that payers and providers shall report to the program and which payers and providers are required to report, and establishing an implementation timeline.



Data Use Strategy

Activities related to using Oregon's All Payer All Claims (APAC) data and other data sources to understand cost and cost drivers relative to the cost growth target, including a system to identify unjustified variations in prices or in health care cost growth, and the factors that contribute to unjustified variation.



Quality & Equity

Activities focused on the measurement of quality of care, in alignment with the Health Plan Quality Metrics Committee approaches, with a strong focus on inequities in health care.



Taking Action

Activities related to strategies required to lower the growth in health care costs by payers, providers, and the state. This includes identifying opportunities for lowering costs, improving the quality of care, and improving the efficiency of the health care system by using innovative payment models, and determining the technical assistance and support necessary to help payers and providers achieve the cost growth target.



Accountability

Activities including recommending accountability processes for failure to meet the cost growth target and for not following program requirements, as well as future governance for the program.



Transparency

Activities related to public reporting and sharing of information for each of the above areas.

IMPLEMENTATION COMMITTEE MEMBERS

| Committee Member | Title and Organization |
|---|---|
| Jack Friedman, Chair | Former Chief Executive Officer, Providence Health Plan |
| Kevin Ewanchyna, Vice-Chair | Vice President and Chief Medical Officer and President, Samaritan Health Services and Oregon Medical Association |
| Patrick Allen | Director, Oregon Health Authority |
| Kraig Anderson | Senior Vice President and Chief Actuary, Moda Health |
| Kathryn Correia | President and Chief Executive Officer, Legacy Health |
| Angela Dowling | President and Chief Revenue Officer, Regence BlueCross Blue Shield of Oregon |
| Jessica Gomez | Chief Executive Officer, Rogue Valley Microdevices |
| Felisa Hagins | Political Director, SEIU Local 49 |
| Ruby Haughton-Pitts | State Director, AARP Oregon |
| K. John McConnell | Director, Center for Health Systems Effectiveness, OHSU |
| Mark McMullen | State Economist, Oregon Office of Economic Analysis |
| William Olson | Chief Operating Officer, Providence Health & Services - Oregon |
| Jordan Papé | Chief Executive Officer, The Papé Group |
| Ken Provencher | President and Chief Executive Officer, PacificSource |
| Shanon Saldivar | Co-Owner and Agent, Chamness Saldivar Agency, Vice-Chair of the Marketplace Advisory Committee |
| Andrew Stolfi | Director, Department of Consumer and Business Services; Insurance Commissioner |
| Jenny Smith William (Bill) Ely ¹² | Chief Financial Officer, Kaiser Foundation Health Plan Vice President, Actuarial Services, Kaiser Foundation Health Plan |
| Jennifer Welander | Chief Financial Officer, St. Charles Health System |

¹² Jenny Smith left Kaiser in spring 2020 and was replaced on the Implementation Committee by William (Bill) Ely.

Recommendations in Summary

This section lists the full recommendations made by the Implementation Committee through its December 16, 2020 meeting and approved on January 12, 2021, organized by each of the Committee’s workstreams. The next section provides additional detail about Committee considerations for each recommendation and initial thoughts about operationalizing and implementing the recommendations.

Cost Growth Target Recommendations:

1. The State should measure Total Health Care Expenditures when measuring state performance against the cost growth target. Total Health Care Expenditures should be defined as the “allowed amount”¹³ of claims-based spending from a payer to a provider, all non-claims-based spending from a payer to a provider, pharmacy rebates and the net cost of private health insurance.
2. Total Health Care Expenditures should be inclusive of spending on behalf of Oregon residents who are insured by Medicare, Medicaid, or commercial insurance, or are self-insured for commercial coverage, and receive care from any provider in or outside of Oregon. Spending by the Indian Health Services for Oregon residents and for Oregonians incarcerated in a state correctional facility should be included in Total Health Care Expenditures to the extent OHA determines their data are accessible, comparable and collection of data can be replicated over time.
 - a. Out-of-state residents who receive care from Oregon providers may be included should the data be reportable, consistent across insurers, and replicable over time.
 - b. Whether out-of-state residents are included will be decided upon by OHA when it develops the technical measurement specifications following the completion of the Implementation Committee’s work.
3. The annual per capita health care cost growth target should be 3.4% for 2021-2025 and then 3.0% for 2026-2030.
 - a. In 2024, the successor committee should review 20-year historic values of Oregon’s per capita gross state product trend and median wage trend to determine whether the annual 2026-2030 target is set appropriately. Trend is calculated by determining

¹³ “Allowed amounts” refers to the price paid by the insurer to the provider and the patient liability owed directly to the provider, regardless of whether the patient actually paid the owed amount. The allowed amount is not necessarily what the organization collects.

the flat average annual percent change of the nominal per capita gross state product and median wage over the last 20 years. After reviewing the data, successor committee should make a recommendation to the Oregon Health Policy Board to keep the target at 3.0%, or to increase or decrease the target from 3.0%.

4. In order to assess performance against the cost growth target, providers with accountability for Total Medical Expense (defined as claims-based and non-claims based payments to providers, net of drug rebates) should be organized by payers using existing total cost of care contracts in initial data submissions, until the Oregon Provider Directory is available to support this work.¹⁴ OHA will conduct an analysis to identify a geographical or regional approach for providers who can have total medical expense accountability, but cannot be organized by existing total cost of care contracts.
5. Payers should use their own attribution methods for assigning Oregon residents to a provider. Payers will need to share the attribution methodology with OHA. OHA will assess the commonalities between attribution methodologies and consider adjusting how attribution is performed in future years.
6. In order to account for changes in population health over time, each payer should use its own risk adjustment methodology. Payers will need to share the risk adjustment methodology with OHA.
7. The Committee recommended that OHA should perform a statistical analysis to determine what the minimum primary care-attributed population size will be for providers and for payers, by each line of business, for reporting performance relative to the target in March 2020. Subsequently, OHA developed a rigorous approach to determining whether performance against the cost growth target was statistically reliable and recommended that the minimum population for public reporting be 10,000 lives across all payers or 5,000 lives under any one market.
 - a. OHA should take a balanced approach to gather the maximum amount of data possible while maintaining statistical rigor. OHA should work with a to-be-established technical advisory group consisting of data submitters to finalize the data submission criteria.

¹⁴ OHA is developing a statewide provider directory. The provider directory will leverage data from existing, trusted data sources. The ability for health care entities to use one trusted, single, and complete source of provider data is essential to improving system efficiencies and patient care coordination, while helping reduce costs for Oregonians. More information online at: <https://www.oregon.gov/oha/HPA/OHIT/Pages/PD-Overview.aspx>

- b. In October 2020, the Committee recommended a tiered approach to accountability, including reporting of performance, based on statistical confidence. This approach should determine when a payer or provider organization would be held accountable for performance against the cost growth target over one or more years. Testing for statistical confidence is a foundational step before any of the accountability mechanisms (described below) would apply.
- 8. OHA should collect data from insurers starting with calendar years 2018 and 2019 and the first performance year of the cost growth target should measure trend between calendar years 2020 and 2021.
- 9. OHA should ensure that performance against the cost growth target for calendar years 2020 and 2021 (at a minimum) is reported with enough context for the public to understand the effect the pandemic had on spending.

Data Use Strategy Recommendations:

- 10. Publicly reported data analysis should be performed for providers, payers, purchasers, policy makers, public health, and the general public, with a particular interest in actionable information for providers.
- 11. OHA should employ data use strategy principles and goals recommended by the Committee (see Appendix).

Taking Action Recommendations:

- 12. OHA, in partnership with payers and providers, should advance adoption of value-based payment (VBP) using a) principles for the use of advanced value-based payment models (see Appendix), and b) a voluntary compact, intended to commit Oregon’s payers and providers to taking action to implement the principles.
- 13. OHA should support timely and actionable data flowing between payers and providers to inform strategies to meet the cost growth target.

Quality and Equity Recommendations:

- 14. The Health Plan Quality Metrics Committee (HPQMC) should identify a subset of its existing menu of quality measures for reporting as part of the Sustainable Health Care Cost Growth Program, while aligning with the CCO, PEBB, and OEBC contractual measure sets as much as possible.
 - a. Some committee members requested that HPQMC prioritize the following domains: equity and disparities, prevention and early detection, and acute, episodic, and procedural care.

15. OHA should work with the Oregon Health Policy Board (OHPB), the Health Equity Committee (HEC), and the HPQMC in 2021 to develop a plan and identify measures for monitoring unintended consequences and positive impacts of the cost growth target. OHA should also collect qualitative information after the cost growth target is implemented to determine whether there are any possible unintended consequences not previously anticipated, as well as any positive impacts of the cost growth target.
16. OHA should advance equity by focusing cost analyses on variation in utilization and cost across populations and publish the information as part of the Data Use Strategy. This work will inform future policy conversations about mechanisms to reduce inequities related to costs.

Accountability Recommendations:

17. Performance Improvement Plans (PIPs) should be the first accountability mechanism for payers or provider organizations who exceed the cost growth target with statistical certainty and without a reasonable basis for doing so.
 - a. PIPs should be applied at the market level (e.g. Medicaid, Medicare, and Commercial).¹⁵
18. The “escalating accountability mechanism” for payers or provider organizations who exceed the cost growth target at the market level with statistical certainty and without a reasonable basis across multiple years should be a meaningful financial penalty.
 - Escalating accountability should be triggered when a payer or provider organization exceeds the cost growth target without a reasonable basis in any three out of five years.
 - Escalating accountability should apply at the market level, but in deciding whether to invoke a financial penalty and how much, the payer or provider organization’s overall performance across markets would be considered.
 - The amount of the financial penalty should vary based on how much a payer or provider organization has exceeded the cost growth target, with OHA adjusting the penalty based

¹⁵ Health care cost growth will be combined across contracts for each of these market levels (e.g. the commercial market refers to cost growth across all of a provider’s commercial contracts, rather than all of a provider’s commercial contracts with a specific payer).

on considerations, including, but not limited to:

- Size of the payer or provider organization
- Extent to which the payer or provider organization exceeds the target
- Good faith efforts to contain health care cost growth
- Collaboration and cooperation with the program
- Avoiding “double fining” an integrated payer and provider organization unless there is reason for both the payer and provider sides to be held accountable for cost growth¹⁶
- Interaction with other rebates and penalties (e.g. medical loss ratio rebates)
- Credibility of performance / small numbers (if not already addressed by size threshold and statistical testing)
- Overall performance against the cost growth target, including in other markets and in aggregate across all markets
- Other relevant circumstances or factors

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

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

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

Governance Recommendations:

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

¹⁶ Integrated payers and provider organizations should be treated as a single organization for escalating accountability and would also not be subject to “double fining.”

- a. Implementation Committee membership may change in 2021 as needed. Under SB 889, committee membership changes in 2021 will be made by the Governor.
 - b. The Implementation Committee may meet less frequently in 2021 than in 2020.
23. OHA should convene an ad hoc technical advisory group (TAG) in 2021 open to payers who will be submitting data, provider organizations, and other interested parties to work with OHA to finalize the data submission template and specifications, and data validation process.
24. Governance for the Health Care Cost Growth Target Program in 2022 and beyond should be informed by a new Committee, consisting of health care payers and provider organizations, business/employer representatives, as well as consumer representatives. There should be some overlap between current members of the Implementation Committee and the new Committee to ensure continuity. The new Committee should be responsible for:
- a. Overseeing ongoing program implementation
 - b. Revisiting the cost growth target value for 2026-2030 (and beyond)
 - c. Reviewing and understanding cost growth trends and cost drivers and advising OHA, DCBS, and OHPB on the impacts of cost growth
 - d. Monitoring for unintended consequences
 - e. Exploring opportunities to improve equity
 - f. Reviewing and understanding progress toward value-based payment goals
 - g. Identifying and addressing opportunities to reduce cost growth as revealed by the Data Use Strategy, or otherwise identified
 - h. Informing public hearings.
25. The Oregon Health Policy Board (OHPB) should be responsible for hosting and convening annual public hearings. OHPB may also hold regional or other meetings related to health care cost issues throughout the year prior to the annual public hearing.

Terminology

This report uses “costs” and “spending” interchangeably.

This report also uses “payer”, “insurer”, and “carrier” interchangeably.

Recommendations in Detail

Cost Growth Target

SELECTING THE COST GROWTH TARGET

In their January 2020 meeting, the Implementation Committee agreed on two criteria to help select the cost growth target:

1. The cost growth target should be a predictable target based on an economic indicator
2. The cost growth target should rely on objective data sources with transparent calculations (conducted by an entity that does not have a conflict of interest).

The Implementation Committee reviewed multiple economic indicators that the cost growth target might be based on, including forecasted and historic Gross State Product (GSP) and Potential Gross State Product (PGSP), as well as median wage and income data.¹⁷

Economic Indicators Reviewed

| | | Historic (1999-2019) | Forecast (2025-2029) |
|---------|----------|-------------------------|-------------------------|
| Economy | GSP/PGSP | 3.5% (GSP) | 3.8% (PGSP) |
| Wage | Median | 2.7% (2001-2018) | 3.9% |
| Income | Median | 3.1% | 3.5% |

The Committee also considered the current cost growth target for the Oregon Health Plan (Medicaid) and for public employee plans, the consumer price index (inflation), and stakeholder encouragement to set an aggressive target that would reduce the level of health care spending relative to the rest of the economy, and not merely maintain spending at its current level.¹⁸ The Committee also considered how many years it should set the cost growth target for and determined that establishing the target for a 10-year period would help payers and providers plan for future contracting and rate setting.



The Implementation Committee recommended that the annual per capita health care cost growth target should be 3.4% for 2021-2025, and then 3.0% for 2026-2030.

Oregon's initial annual per capita health care cost growth target of 3.4% is similar to the initial health care cost growth targets selected by other states, including Massachusetts (3.6% for the first five years, then 3.1%), Rhode Island (3.2% for the first four years), Connecticut (3.4% in 2021, with annual reductions to 2.9% in 2023-2025), and Delaware (3.8% in the first year, with

¹⁷ https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/2.12.20%20Presentation%20Slides_updated.pdf

¹⁸ <https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/2.12.20%20Public%20Testimony.pdf>

annual reductions down to 3.0% in the fourth year). For comparison, per capita national health care spending increased 4.2% between 2017 and 2018, and 4.1% between 2018 and 2019.¹⁹ In Oregon, average annual per capita health care spending across all payers has been approximately 5.6% (1991 through 2014).²⁰

ADJUSTING THE COST GROWTH TARGET

The Implementation Committee is charged with specifying the “frequency and manner” in which the target should be reevaluated and updated and so considered the various mechanisms other state health care cost growth target programs have adopted for revisiting their targets and making any necessary modifications.

State Mechanisms for Adjusting Targets

| State Mechanisms for Adjusting Targets | |
|--|--|
| Massachusetts | The Health Policy Commission can vote to modify the target in the second five years of the program; after the first 10 years, the Health Policy Commission can adjust the target to any value. |
| Delaware | The State Finance Committee reviews the target methodology annually and can make changes if the Potential Gross State Product (PGSP) forecast has changed in a “material way.” |
| Rhode Island | Only “highly significant” changes in the economy will trigger revisiting the target; this has not been defined. The Committee elected not to make any changes despite the economic impact of COVID-19. |



The Implementation Committee recommended that in 2024, the future governance committee should review 20-year historic values of Oregon’s per capita gross state product trend, median wage trend and health system performance against the target to determine whether the annual 2026-2030 target is set appropriately.²¹

¹⁹ Anne B. Martin, Micah Hartman, David Lassman, Aaron Catlin “National Health Care Spending in 2019: Steady Growth for the Fourth Consecutive Year” Health Affairs. Published online 16 December 2020.

²⁰ CMS Health Expenditures by State of Residence, 1991-2014. [https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.02022](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence)
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence>

²¹ Trend is calculated by determining the flat average annual percent change of the nominal per capita gross state product and median wage over the last 20 years.

After reviewing the data, the future governance committee should make a recommendation to the Oregon Health Policy Board to keep the target at 3.0%, or to increase or decrease the target from 3.0% for 2026-2030.

The Committee also suggested revisiting the health care cost growth target prior to 2024 to understand the impact of COVID-19 and any potential implications for the Health Care Cost Growth Target Program.

DEFINING THE COST GROWTH TARGET

Defining Total Health Care Expenditures

The intent of the health care cost growth target is to measure the annual per capita rate of growth for total health care expenditures in the state. The Implementation Committee considered what types of spending should be included in Oregon’s definition of total health care expenditures, i.e. what is subject to the cost growth target.



The Implementation Committee recommended that Total Health Care Expenditures should be defined as the “allowed amount” of claims-based spending from an insurer to a provider, all non-claims-based spending from an insurer to a provider, pharmacy rebates, and the net cost of private health insurance.

“Allowed amounts” refers to the price paid by the insurer to the provider and the patient liability owed directly to the provider, regardless of whether the patient actually paid the owed amount. The allowed amount is not necessarily what the organization collects. The state should conduct additional analysis to understand the impact of bad debt and financial assistance on the Total Health Care Expenditure calculation.

Whose Total Health Care Expenditures are being measured?

Given SB 889’s directive to include all payers and providers, and the Committee’s previously adopted definition for Total Health Care Expenditures (THCE) to include all payments made to providers and cost sharing by Oregon residents, the Committee focused on including health care spending for all Oregonians.



The Implementation Committee recommended Total Health Care Expenditures should be inclusive of spending on behalf of Oregon residents who are insured by Medicare, Medicaid, or commercial insurance, or are self-insured for commercial coverage, and receive care from any provider in or outside of Oregon.

Spending by the Indian Health Services for Oregon residents and for Oregonians incarcerated in a state correctional facility should be included in Total Health Care Expenditures to the extent OHA determines their data are accessible, comparable and collection of the data can be replicated over time.

OHA estimates that health care costs for over 90 percent of Oregonians are captured in the THCE calculation.

- The commercial population consists of all group and individual coverage, TRICARE²² and the Federal Employees Health Benefit Plan (FEHBP), as well as the Public Employee Benefit Plan and Oregon Educators Benefit Plan (PEBB/OEBB).
- Medicare includes all Medicare Advantage coverage, as well as Medicare Fee For Service data, which will be requested from CMS.
- Medicaid includes the Oregon Health Plan and Cover All Kids, through Coordinated Care Organizations (CCOs) or Fee For Service (FFS).

The largest population that will not be included in the THCE calculation is the uninsured, for whom there isn't an efficient or effective mechanism for collecting data on their out-of-pocket health care costs.

Populations included in the Total Health Care Expenditure calculation



State corrections and Indian Health Services each represent less than 1 percent of Oregonians.

The Committee also considered whether Oregon residents seeking care outside of Oregon and out-of-state residents seeking care inside of Oregon should be included in the calculation.

- ✓ The Implementation Committee recommended OHA may include out-of-state residents who receive care from Oregon providers should the data be reportable, consistent across insurers, and replicable over time.
This will be determined in the final technical measurement specifications.

²² TRICARE is the health care program of the United States Department of Defense Military Health System.

APPLYING THE COST GROWTH TARGET

Oregon’s health care cost growth target is calculated and applied at four different levels:

1. Statewide
2. By Market (Medicare, Medicaid, Commercial)
3. By Payer (Medicare Fee-For-Service; Medicare Advantage; Medicaid Fee-For-Service; Medicaid Coordinated Care Organizations; and Commercial insurers, including self-insured)
4. By Provider Organization (large provider organizations reported on individually, smaller provider organizations reported on in aggregate, and spending for members who could not be attributed to specific provider organizations).

To address SB 889’s directive that the cost growth target should apply to all payers and providers in the state, the Implementation Committee looked at considerations for measuring cost growth at the insurer and provider levels.

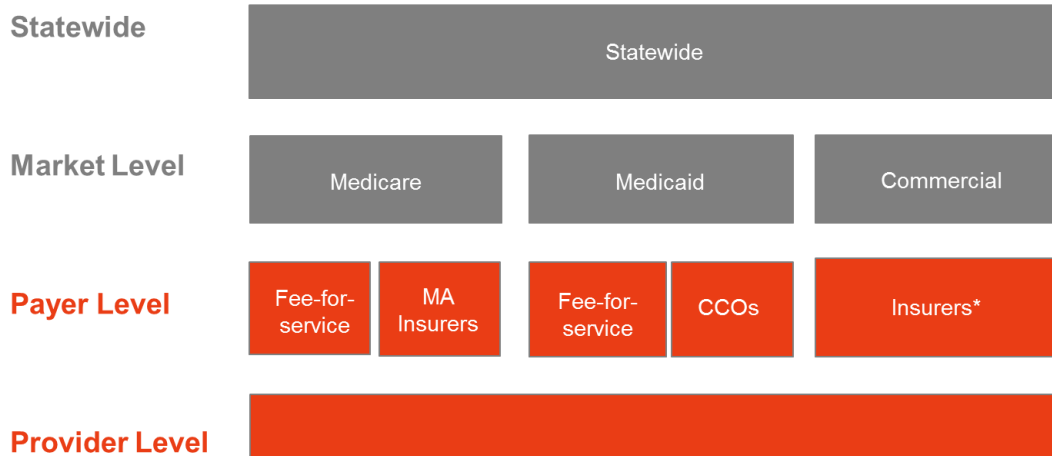


The Implementation Committee recommended that OHA should perform a statistical analysis to determine what the minimum attributed population size will be for payers and for provider organizations, by each market, for reporting performance relative to the target. Subsequently, OHA developed a rigorous approach to determining whether performance against the cost growth target was statistically reliable and recommended minimum population sizes for data submission and for public reporting.



The Committee recommended that OHA should take a balanced approach to gathering the maximum amount of data possible while maintaining statistical rigor.

The cost growth target applies at four different levels



*for insured and self-insured business

Cost growth at the payer level

Payers offering comprehensive medical benefit can appropriately be held to a cost growth target, but enrollment size needs to be taken into account to be able to detect accurate and reliable change in annual per capita total health care expenditures.

To ensure the Health Care Cost Growth Target Program is capturing as much of the state as possible, the criteria for data submission should be as broad as possible. However, the Implementation Committee only wants to publicly report on individual payers that have a reasonable number of members in Oregon.

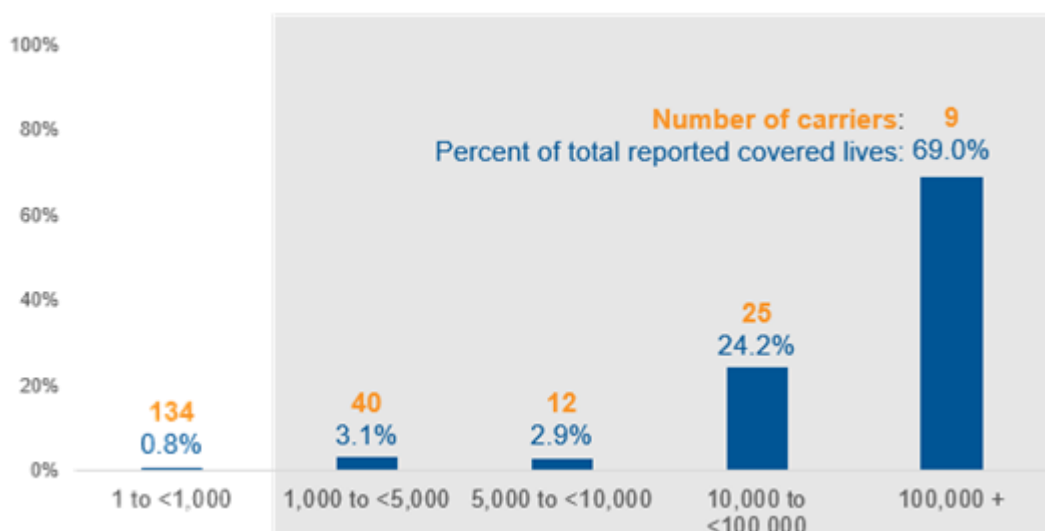
The Committee accepted OHA's proposed criteria for data submission and for public reporting.

- ✓ Payers and Third-Party Administrators (TPAs) with at least 1,000 covered Oregon lives across all lines of business should be required to submit data.
- ✓ Payers and TPAs with at least 5,000 lives in a given market (e.g. Medicaid, Medicare, Commercial) should be included in public reporting. All others should be reported in aggregate.

Payers and TPAs who meet the criteria for public reporting will then have their performance against the cost growth target tested for statistical significance. Only payers and TPAs with statistically significant growth year over year will be held to accountability measures (described in the Accountability section). See Appendix 3 for more details on the statistical testing.

An analysis of DCBS' enrollment data indicates that there are more than 80 potential data submitters, representing almost all covered Oregon lives. There are 134 additional payers and TPAs who collectively have less than 1% of covered Oregon lives that would not be required to submit data or be included in the Health Care Cost Growth Target Program (see chart below).

All payers and TPAs with at least 1,000 covered Oregon lives, Q1 2020



These payers and TPAs may be included in the Health Care Cost Growth Target Program in the future if their covered Oregon lives increase.

Self-insured payers

There is no known universe of all self-insured payers in Oregon. DCBS tracks self-insured payers that use TPAs and there are 85 known self-insured payers who use TPAs in Oregon. Of those, 20 have 5,000 or more covered Oregon lives (more than 95% of the market).

However, the State does not know how many Oregon self-insured payers do not use a TPA (i.e. a company that pays claims for its employees directly), nor how many covered lives they might represent. On March 1, 2016, the U.S. Supreme Court ruled in *Gobeille v. Liberty Mutual* that states may no longer require ERISA self-insured plans to report claims to all-payer claims database. While OHA estimates that 61% of self-insured Oregonians are included in the All Payer All Claims (APAC) database, the state does not have a comprehensive source of information on the self-insured market.²³

The Implementation Committee recommended asking self-insured payers to submit data and including them in public reporting if they meet the criteria (described above); however, there will be no way to tell how complete reporting compliance is. As several self-insured payers do voluntarily submit data to Oregon's APAC database, it is reasonable to expect some will voluntarily participate in the Health Care Cost Growth Target Program data submission.

Cost growth at the provider level

When measuring total cost of care at the provider level, not all the elements included in the agreed upon definition for Total Health Care Expenditures (above) are appropriate. To measure provider cost growth, the Implementation Committee recommended removal of the net cost of private health insurance and pharmacy rebates to look at Total Medical Expenditures (TME).

Next, the Implementation Committee focused on identifying which provider organizations should be held responsible for their performance relative to the cost growth target. Not all provider organizations can be held accountable for Total Medical Expenditures, as TME accountability typically applies to provider organizations that could in theory take on contracts where they are responsible for the total cost of care²⁴ because they:

²³ <https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/Gobeille-v-Liberty-Mutual-Decision.pdf> and <https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/One-payer-Self-Insured-Lives-and-APAC-Oct-2020-Final.pdf>

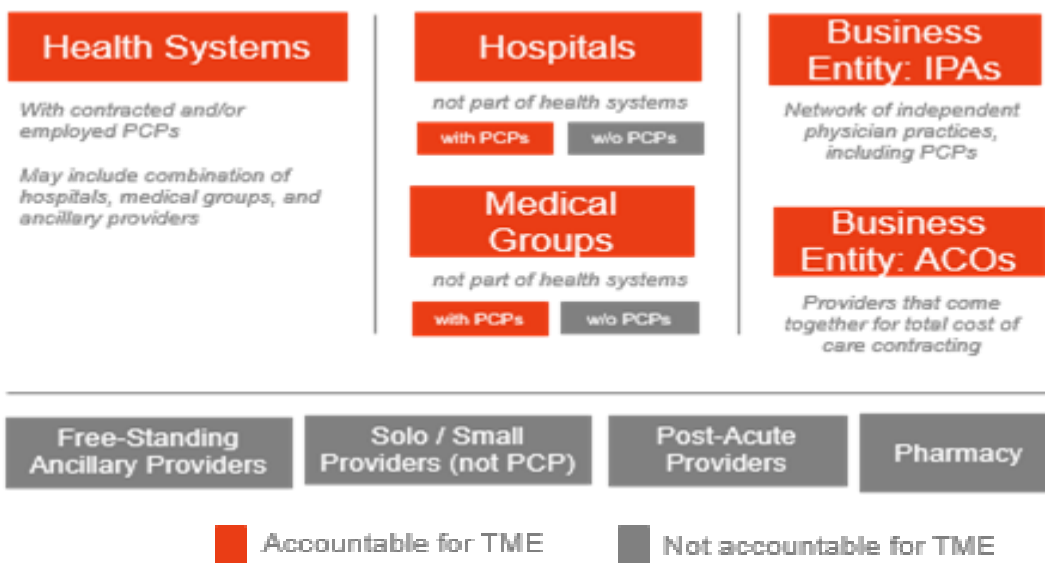
²⁴ Provider organizations do not have to be in total cost of care contracts to be TME accountable. Total cost of care contracts are agreements between payers and provider organizations wherein a provider organization accepts clinical and financial responsibility for an entire population of patients, regardless of where a patient receives care.

- Include primary care providers who direct a patient’s care and/or
- Can influence where a patient receives care to promote high value providers and care

The Implementation Committee considered which types of provider organizations could have TME accountability using the above criteria. The intent is to track health care cost growth for provider *organizations*, but not to measure or report health care cost growth at the individual clinician level.

The chart below provides a conceptual model for determining which provider organizations could be held accountable for Total Medical Expenditures. The types of provider organizations that might have accountability for Total Medical Expenditures have primary care providers who can direct a patient’s care or influence where a patient receives care. The purpose of using primary care provider affiliation is to identify organizations subject to cost growth target performance assessment; it is not to penalize primary care provider spending or single out any individual primary care providers. See Attribution section below for more detail.

Conceptual Map of Provider Organizations



To assess performance against the cost growth target, provider organizations with TME accountability will be organized by payers using existing total cost of care contracts in initial data submissions, until the Oregon Provider Directory is available to support this work. OHA will continue to develop an approach to aggregating provider organization data from different payers using the data submission templates.

OHA will also conduct an analysis to identify a geographical or regional approach for provider organizations who can have TME accountability but cannot be organized by existing total cost of care contracts.

Determinations of provider organization TME accountability should also consider the size of the provider organization (i.e. the number of attributed patients they have each year). Provider organizations must have sufficient patient volume to be able to detect accurate and reliable changes in annual per capita total medical expenditures, and to help prevent situations where smaller provider organizations may exceed the health care cost growth target due to a few unusually complex and expensive patients.

The Committee accepted OHA’s proposed criteria for public reporting for provider organizations.

✓ OHA should publicly report the performance of provider organizations with at least 10,000 unique all-payer attributed lives, or at least 5,000 attributed lives within any one market (e.g. Medicaid, Medicare, Commercial).

There is not currently a definitive list of which provider organizations meet these criteria; OHA is developing a preliminary list of provider organizations that are likely to meet these criteria and will share that in early 2021. The list of accountable provider organizations will be updated based on initial data submissions from payers later in 2021.

Note that while the first performance year compares cost growth from 2020 to 2021, accountability measures will not be applied for this first performance year. See the Accountability section for more details.

Provider organizations who meet criteria for public reporting will then have their performance against the cost growth target tested for statistical significance. Only provider organizations with statistically significant growth year over year will be held to accountability measures (described in the Accountability section). See Appendix 3 for more details on the statistical testing.

Comparison to other states

Oregon’s criteria for data submission and public reporting differs from other states with health care cost growth target programs, to reflect the legislative direction to include as many payer and provider organizations as possible, as well as the diversity of the domestic insurance market and payer and provider contracting arrangements. Oregon also intends to introduce greater statistical precision before applying any accountability mechanisms.

| | |
|----|--|
| MA | Insurers must report on providers who have 3,000 or more attributed lives at the individual payer level, but performance is only published for the largest providers. |
| DE | Insurers report on their top 10 providers. The Delaware Health Care Commission will only publicly report performance for providers who have 10,000 lives for commercial and Medicaid populations, and 5,000 lives for Medicare populations with an individual payer. |

RI

Each insurer reports data on 7 ACOs that meet the minimum threshold of 10,000 lives for the payer’s commercial and Medicaid populations, and 5,000 lives for the payer’s Medicare populations.

CALCULATING THE COST GROWTH TARGET

Data sources



The Implementation Committee recommended performance relative to the cost growth target should be calculated using data supplied by payers.

Each year, payers who meet the criteria for data submission will submit health care cost data to OHA using the specified templates. Payers will report on provider entities who meet criteria. This data will be used to calculate performance relative to the cost growth target.

The data submission template, specifications, and process for payers to submit data will be finalized with a technical advisory group in 2021.

OHA will request Medicare Fee For Service data from CMS, to capture Medicare spending more fully. OHA will also provide Medicaid Fee For Service data.

The Data Use Strategy section below describes the types of analysis possible with these data, and other data sources that will be used to understand what is driving health care cost growth.

Attribution

To measure Total Medical Expenditures for provider organizations, payers must attribute Oregon residents to a specific provider organization. Payers will be using primary care attribution as the basis for calculating Total Medical Expenditures for provider organizations. Primary care attribution includes attribution to organizations (hospitals, medical groups, FQHCs, IPAs) that employ or contract with primary care physicians.

The Committee considered various approaches for attribution, including whether a common attribution methodology could be adopted.



The Implementation Committee recommended payers should use their own primary care attribution methods for assigning Oregon residents to a provider organization. Payers will need to share the attribution methodology with OHA.

OHA will assess the commonalities between attribution methodologies and consider adjusting how attribution should be performed in future years.

Risk adjustment

A payer or provider organization’s population – including its clinical risk profile – may change over the course of a year. Some of these changes will have an impact on spending growth, e.g. a population that is sicker than last year would be expected to have higher spending.

Performance relative to the cost growth target needs to be risk adjusted for provider organizations and for the payers year over year, but not at the market or statewide levels, since these populations are large enough to be stable over time. Performance does not need to be risk adjusted *across* provider organizations or payers, however, since the sole focus of the cost growth target is to compare a payer or provider organization's performance to its own prior performance.

The Committee considered whether each payer should use their own risk adjustment methodology, or whether a common risk adjustment methodology could be adopted statewide.



The Implementation Committee recommended each payer should use its own risk adjustment methodology to account for changes in population health over time.

Payers will report to OHA on which risk adjustment methodology they used, and if they change risk adjustment methodologies, will submit the previous year's data with the new methodology to ensure accurate year-over-year comparisons.

STATISTICAL TESTING

The Implementation Committee agreed that once OHA has calculated the annual cost growth for payers and provider organizations as described above, it should apply a statistical test to determine whether or not that payer or provider organization has truly exceeded the cost growth target for that year. The statistical testing will be done for each payer and provider organization at the market level (e.g. Medicaid, Medicare, Commercial).

Only payers and provider organizations who exceed the cost growth target with statistical confidence should be held accountable.

- A payer or provider organization should be held accountable for performance against the cost growth target in any year if a difference can be detected at 95% confidence.
- A payer or provider organization should be held accountable for performance against the cost growth target in the second year if a difference can be detected at 80% confidence for two consecutive years.²⁵
- If a payer or provider organization demonstrates it has exceeded the cost growth target at 80% confidence in 3 out of 5 years, it should also be held accountable.
- No action should be taken in any years for payers or provider organizations who appear to exceed the target, but where OHA cannot detect a difference at 80% confidence.

²⁵ Two years with 80% confidence each year = 93% confidence.

See Appendix 3 for more details about the statistical methodology.

The examples below illustrate how a payer or provider organization might be subject to accountability mechanisms based on multiple years of performance relative to the cost growth target and the statistical testing.

| | Y1 | Y2 | Y3 | Y4 | Y5 |
|-------------------------|-----|-----|-----|----|----|
| Met Target? | | | | | |
| Statistical confidence? | 60% | 80% | 80% | | |
| Accountable? | NO | NO | YES | NO | NO |

Payer or provider organization exceeds the cost growth target at 80% confidence in two consecutive years, subject to accountability mechanisms in Y3.

| | Y1 | Y2 | Y3 | Y4 | Y5 |
|-------------------------|-----|-----|----|----|----|
| Met Target? | | | | | |
| Statistical confidence? | 95% | 80% | | | |
| Accountable? | YES | YES | NO | NO | NO |

Payer or provider organization exceeds the cost growth target in Y1 at 95% confidence and is subject to accountability mechanisms.

Payer or provider organization exceeds the target in Y2 at 80% confidence and is subject to accountability mechanisms again in Y2 because of two consecutive years.

| | Y1 | Y2 | Y3 | Y4 | Y5 |
|-------------------------|----|-----|----|-----|-----|
| Met Target? | | | | | |
| Statistical confidence? | | 80% | | 80% | 80% |
| Accountable? | NO | NO | NO | NO | YES |

Payer or provider organization exceeds the cost growth target in Y2 at 80% confidence, and again in Y4 at 80% confidence. This is not 2 consecutive years, so they are not subject to accountability mechanisms in Y4.

They exceed the cost growth target again in Y5 at 80% confidence and are subject to accountability mechanisms in Y5 because of 2 consecutive years AND 3 out of 5 years.

| | Y1 | Y2 | Y3 | Y4 | Y5 |
|-------------------------|-----|-----|-----|-----|-----|
| Met Target? | | | | | |
| Statistical confidence? | 40% | 60% | 60% | 50% | 60% |
| Accountable? | NO | NO | NO | NO | NO |

While the payer or provider organization appears to exceed the cost growth target in all five years, this cannot be detected at an 80% confidence level and they are not subject to any accountability mechanisms.

IMPLEMENTATION TIMELINE

The Implementation Committee agreed that it will be important to understand what health care cost growth in Oregon looked like prior to COVID-19, as well as to understand the impact of COVID-19 on health care spending.

- ✓ The Implementation Committee recommended OHA should collect data from insurers starting with calendar year 2018.

OHA will initially collect data from insurers for calendar years 2018 and 2019. This will help ensure data submission templates and validation processes are worked out, and provide context leading into the first performance year of the cost growth target.

OHA will also initially collect data for calendar year 2020; this will allow Oregon to be able to report pre, during, and post pandemic health care spending and cost growth.

- ✓ The Implementation Committee recommended the first performance year of the cost growth target should measure trend between calendar years 2020 and 2021.

Performance against the cost growth target for calendar years 2020 and 2021 (at minimum) should be reported with enough context for the public to understand the effect the pandemic had on spending.

OHA proposes reporting cost growth between 2018 and 2019, and 2019 and 2020 at the state and market levels only. Cost growth between 2020 and 2021 will be the first performance year, and performance will be reported by state, by market, by payer and by provider organization. A more detailed reporting timeline is included in the Accountability section.

OUTSTANDING QUESTIONS

There are still several technical details related to operationalizing the Cost Growth Target that will be worked through with the Technical Advisory Group (TAG) in 2021. These include:

- Unattributed care
- Combining data across payers
- Attributing non-claims to specific entities, and
- How to treat entities that are both payers and provider organizations

Data Use Strategy

The Data Use Strategy is a planned approach for understanding the impact of the health care cost growth target and the factors contributing to health care cost and cost growth in Oregon. The Data Use Strategy guides the planned analyses, data requirements, and commitment to transparency for the Health Care Cost Growth Target Program.

The Implementation Committee's conversations included the following:

- Identifying unreasonable variation in prices, cost, cost growth, and non-price contributing factors to cost and cost growth
- Identifying what types of data OHA should collect and annually report on relative to the Cost Growth Target Program, including types of analyses and key audiences.
- Informing recommendations for public reporting and public hearings (see Transparency section below)

Additional work with the Implementation Committee and a Technical Advisory Group will be needed to understand data collection methods, cost drivers, variation in cost growth, and unintended consequences of the cost growth target.

DATA USE STRATEGY GOALS & PRINCIPLES

To guide these conversations, the Committee first adopted Data Use Strategy Goals and Principles (see full text in Appendix 1).

Goals

- Ensure timely and accurate measurement of performance relative to the cost growth target at the state, insurance market, insurer/CCO, and large provider levels
- Produce routine analyses that pinpoint leading opportunities to reduce health care spending by the state, payers, purchasers, and Oregonians in a manner that will not harm patients
- Interpret health care spending analyses and link findings with recommended actions for the State, policymakers, insurers/CCOs, providers and employer purchasers.
- Produce routine public reporting and communication products to share progress, challenges, and opportunities with consumers.

DATA SOURCES

The Health Care Cost Growth Target Program will use multiple data sources.

| Data Source | Purpose |
|---|--|
| Data submitted by payers | Measuring performance relative to the cost growth target |
| Data from Oregon’s All Payer All Claims (APAC) database and other sources | Measuring health care system performance, including understanding cost drivers, looking at unreasonable variation, and monitoring for unintended consequences of the target. |

POTENTIAL ANALYSIS

The Implementation Committee considered many potential analyses that could inform the future Cost Growth Target Program (see below); however, the Committee did not prioritize or recommend a specific analytic plan.



The Implementation Committee recommended that analysis be conducted for providers, payers, purchasers, policy makers, public health, and the general public, with a particular interest in actionable information for providers.

OHA proposed several initial analyses and reports, described in the Transparency recommendations. Additional analyses and reports will be developed in future years with stakeholder input and in collaboration with other partners.

Examples of potential analyses

- Massachusetts’ Annual Report on the Performance of the Health Systems
<https://www.chiamass.gov/annual-report/>
- Colorado’s All Payer Claims Database Annual Report
<https://www.civhc.org/wp-content/uploads/2019/01/2018-CO-APCD-Annual-Report-incl.-Appendices.pdf>
- Washington Health Alliance’s Spending Trend Analysis
<https://www.wacommunitycheckup.org/highlights/inpatient-spending-trends-in-washington-state/>
- Network for Regional Healthcare Improvement (NRHI)’s Total Cost of Care Benchmark Report
<https://www.nrhi.org/nrhi-member-work/healthcare-affordability/>

Quality & Equity

While the Implementation Committee has organized its work into separate workstreams, including “Quality & Equity,” equity is fundamental to Oregon’s cost growth target program and closely linked to quality, affordability, and more.



The Implementation Committee considered several strategies for addressing quality and equity,

1. PUBLIC REPORTING ON A STANDARD SET OF QUALITY MEASURES

The Committee considered how to build on Oregon’s quality measure reporting experience, including existing efforts to align quality measures across payers and providers. The Health Plan Quality Metrics Committee (HPQMC) was established in 2015 under the Oregon Health Policy Board to be the single body to align health outcome and quality measures used in Oregon, and to ensure that measures are coordinated, evidence-based, and focused on a long-term statewide vision.²⁶



The Implementation Committee recommended that the HPQMC should identify a subset of its existing menu of quality measures for reporting as part of the Sustainable Health Care Cost Growth Program, while aligning with the CCO, PEBB, and OEBC contractual measure sets as much as possible.²⁷

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

The Committee agreed with the importance of measurement alignment, especially for providers, but noted ongoing challenges with developing and adopting equity measures, and the importance of differentiating between stratifying measures to identify disparities and measures that directly address equity. Committee members also noted that there may be some

²⁶ <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics-Committee.aspx>

²⁷ HPQMC’s aligned measure menu for 2021 includes 55 health care quality measures that span six domains of care. <https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/2021-Aligned-Measures-Menu.pdf>

variation in public reporting on quality measures, as not all measures may apply to a certain market (e.g. Medicaid, Medicare, Commercial).

Comparison to other states

Other states have made similar commitments to quality measurement as part of their health care cost growth target programs.

| | |
|----|---|
| MA | Includes health care quality measures selected from the Commonwealth’s Standard Quality Measure Set and other measures of interest to stakeholders as part of Annual Report. Domains include patient experience, hospital readmissions, maternity-related care, medication safety, healthcare associated infections, and more. Measures have evolved over time. |
| DE | Established health care quality benchmarks alongside a cost growth target; insurers report performance measures annually. Measures include emergency department utilization, statin therapy for patients with CVD, and state level population health measures like obesity and tobacco use. |
| CT | The Quality Council will develop healthcare quality benchmarks during 2021 as part of the health care cost growth target program. These may include clinical quality, over/under utilization, and patient safety measures. |

2. MONITORING FOR UNINTENDED CONSEQUENCES

Because payers and provider organizations could potentially take actions that impede access to needed care or have other adverse effects on members and patients to meet the cost growth target, the Committee recognized the importance of monitoring unintended consequences.

✓ The Implementation Committee recommended that OHA should work with the Oregon Health Policy Board, the Health Equity Committee (HEC), and the HPQMC in 2021 to develop a plan and identify measures for monitoring unintended consequences of the cost growth target.

Some potential things to monitor might include:

- Unintended consequences on the health care workforce
- Access to care, including access to telehealth services
- Patient experience, such as getting needed care
- Preventive care measures, such as cancer screenings
- Transparency and comparability of the cost of medical services

All selected measures should be calculated at state, payer, and provider levels where possible over time, starting with a pre-COVID time-period (e.g. 2018 or 2019). All measures should be stratified by population using the best available data (e.g. by race/ethnicity, language, gender, age, disability, etc.). Measures may also be reported by geographies of interest.

The Committee suggested that OHA should also collect qualitative information after the cost growth target is implemented to determine whether there are any possible unintended consequences not previously anticipated.

Comparison to other states

Connecticut is also exploring measuring for unintended consequences as part of their health care cost growth target program.

Connecticut’s Unintended Consequences Measures (in development)

| | |
|---|--|
| Underutilization | <ul style="list-style-type: none"> • Changes in preventive and chronic care measures • Changes in member experience getting needed care quickly • Changes in member grievance filings (complaints due to no / limited, or delayed access) • Anti-stinting measures (to be developed) |
| Out-Of-Pocket Spending | <ul style="list-style-type: none"> • Growth in out-of-pocket spending in CT compared to other states • Growth in premiums in CT by plan, and compared to other states |
| Impact on Marginalized Populations | <ul style="list-style-type: none"> • Change in utilization for communities of color in the lowest income zip codes by service category (to be developed) |

3. ANALYSES AND ACTIVITIES TO IMPROVE EQUITY

Preventing unintended consequences doesn’t advance equity – it only monitors for worsening of inequity. Oregon can also use analyses to identify variation in utilization, spending, cost growth, and cost growth drivers for given populations, then identify and address specific barriers that might be contributing to that variation. These analyses will help inform future policy conversations about how to improve equity and reduce inequities. Analyses may also measure the potential positive impact of the cost growth target on health equity concerns.



The Implementation Committee recommended that one way to advance equity is for OHA to focus cost analyses on variation in utilization and cost across populations and publish the information as part of the Data Use Strategy.

The Committee was very supportive of this strategy and recommended prioritizing staff resources to work on this strategy above the unintended consequences strategy.

4. ADDITIONAL STRATEGIES

The Committee also considered additional strategies, including convening provider collaboratives to act on data, continuing to address low-value care and avoidable complications, and making space for new opportunities that will be revealed through ongoing analysis and new policy priorities. It will be important to define what success looks like from a consumer perspective and consider consumer-centric measures in all of the above strategies.

Committee members also emphasized the importance of cross-market strategies.

DATA SOURCES

The quality and equity strategies and analyses described above would use Oregon's All Payer All Claims Database and other data sources; payers will not be required to provide member level demographic data as part of the initial Health Care Cost Growth Target Program data submissions to support these analyses.

Taking Action

Taking Action refers to steps that the state, payers and provider organizations can take to reduce cost growth and the work required to improve affordability and advance equity, as directed by SB 889 and Governor Brown. It also includes acting upon opportunities informed by the state’s experience with COVID-19.

The Committee began by considering a menu of possible pathways for Taking Action and discussing which are most important for lowering health care cost growth that can be pursued now or in the near future.

Possible Pathways for Taking Action



| | |
|---|--|
| 1 | State, payer, and provider options to increase use of value-based payments |
| 2 | State, payer, and provider options to rebuild a resilient delivery system based upon COVID-19 lessons, and contribute to lower cost growth |
| 3 | State-facilitated options to assist payers/providers in meeting the cost growth target |
| 4 | Collaborative work to reduce cost growth jointly pursued by multiple private sector organizations |
| 5 | Other Implementation Committee ideas to support reduced cost growth |

The Implementation Committee’s discussion focused primarily on increasing the use of value-based payments (VBP). While there was strong interest in this pathway, the Committee expressed concern that stakeholders have been talking about increasing VBP for years, without seeing much change. The Committee was clear that simply endorsing VBP would not be sufficient and explored voluntary and collaborative ways to expand VBP across all lines of business.

VBP PRINCIPLES

The Committee developed principles to align efforts across public and private initiatives and markets to the extent possible, including the self-insured market, bringing an aggressive focus on advanced value-based payment arrangements across the state.



The Implementation Committee adopted principles for the use of advanced value-based payment models (see Appendix 2), and recommended OHA, in partnership with payers and providers, advance adoption of value-based payment (VBP) through the development of a voluntary compact that will commit Oregon’s payers and providers to taking action to implement the principles.

While the Implementation Committee did adopt the principles, several risks and concerns for self-funded plans were noted. Depending on a payer’s commercial book of business, it may be more difficult to meet these VBP targets, as employers are less likely to be interested in prospective payment models, especially in initial years. As payers demonstrate that VBP models result in reduced costs and improved outcomes, employers may be more open to these arrangements, but are unlikely to be early adopters. Given these concerns, Regence BlueCross Blue Shield was unable to support the VBP targets and timeline in principle #8.

Potential risks for employers were also raised, including how the move to value-based payment arrangements may impact multi-state employers’ coverage options and costs for Oregon employees, and how VBP arrangements may obscure specific costs for procedures and services. Implementation of advanced payment models should be accompanied by public transparency of price information, implemented through the Sustainable Health Care Cost Growth Target Data Use Strategy.

The Committee agreed it will be important to have a technical group monitoring implementation and progress toward the VBP targets.

VOLUNTARY COMPACT

The VBP principles will form the basis of the Oregon VBP Compact, a voluntary commitment by payers and providers across the state to participate in and spread VBPs. The Compact, while not a legally binding document, will demonstrate a commitment to the VBP Principles, including the targets for VBP implementation.

The Compact will be supported by and implemented through the VBP Compact Workgroup. This workgroup will be jointly convened and sponsored by the Oregon Health Authority and the Oregon Health Leadership Council (OHLC). The first step in this collaborative partnership will be for plans, providers, and governmental entities to sign the Compact. Once a critical mass of organizations signs the Compact, the VBP Workgroup will convene.

Representatives from OHA, OHLC, Oregon Association of Hospitals and Health Systems, Oregon Medical Association, and the Public Employee Benefits Board developed a draft charter for the VBP Workgroup (see Appendix 4). These groups are committed to working in partnership to support the implementation of the Compact and the widespread adoption of VBPs statewide.

VBP Workgroup Charge

“ The Workgroup will identify paths to accelerate the adoption of VBP across the state; highlight challenges and barriers to implementation and recommend policy change and solutions; coordinate and align with other state VBP efforts; and monitor progress on achieving the Compact principles, including the VBP targets.”

OTHER STRATEGIES

- ✓ The Implementation Committee recognized the importance of timely and actionable data flowing between payers and providers to inform strategies to meet the cost growth target.

Accountability

To inform Implementation Committee discussion on potential accountability mechanisms, OHA began developing operational details and processes for how accountability would work in the cost growth target program.²⁸ This section provides those details, as well as specific Committee recommendations on accountability measures.

INTENT

The Oregon Health Authority intends to take a collaborative approach to implementing Oregon’s cost growth target program, including working in partnership with payers and provider organizations to help everyone achieve the cost growth target and improve health care affordability.

OHA intends to establish a collaborative data and information sharing process between the state and payer and provider organizations with the goal that the state and the payer or provider organization share a common understanding about whether a payer or provider organization was above or below the cost growth target in a given year and why.

OHA intends for any accountability mechanisms to apply as a last resort only after transparency and collaborative efforts to contain costs do not have an impact.

CHARGE

The Implementation Committee was charged with recommending accountability and enforcement²⁹ processes, which may be phased in over time, including:

- Measures to ensure compliance with reporting requirements;
- Procedures for imposing a performance improvement plan, or other escalating enforcement actions when a payer or provider fails to remain at or below the target; and
- Measures to enforce compliance with the health care cost growth target in programs administered by OHA and DCBS.

²⁸ Cost Growth Target Annual Process – draft for Committee discussion, December 2020
<https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/07.%20Cost%20Growth%20Target%20Program%20Annual%20Process%2012.09.20.pdf>

²⁹ Implementation Committee members noted in November that “accountability and enforcement” have different meanings, despite SB 889 treating them as synonyms. Moving forward, the program will use “accountability” to refer to the combination of strategies and processes that apply when a payer or provider organization does not meet the health care cost growth target.

Before any accountability measures are applied, OHA will determine whether payers and provider organizations exceeded the target by

- (1) Validating payer data submissions;
- (2) Applying statistical testing to ensure confidence in results (see below); and
- (3) Discussing with payer and provider organizations potential reasons for cost growth over the target and determining whether those have a reasonable basis.

Accountability mechanisms will only be applied to payers or provider organizations that exceed the cost growth target with statistical certainty and without a reasonable basis, and those that fail to report data and/or participate in the program.

STATISTICAL TESTING

In October 2020, the Implementation Committee adopted an approach to accountability based on statistical confidence. This approach will determine when a payer or provider organization could be held accountable for performance against the cost growth target over one or more years. Testing for statistical confidence is a foundational step before any of the accountability mechanisms described in this section will apply.

OHA will apply statistical testing for payers and provider organizations to determine which category each payer and provider organization falls into for the performance year:

| | |
|----------|--|
| 1 | Achieved the target; positive recognition |
| 2 | Unable to determine performance relative to the target with statistical confidence; not subject to accountability mechanisms |
| 3 | Exceeded the target, triggering a 1:1 conversation; may be subject to accountability mechanisms |

See the Cost Growth Target section above and Appendix 3 for more information about the statistical testing process.

UNDERSTANDING KEY FACTORS DRIVING COST GROWTH

Following the statistical testing, OHA will hold 1:1 conversations with any payers and provider organization that was found to have exceeded the cost growth target with statistical confidence. OHA will coordinate with DCBS for commercial payer conversations. At the 1:1 conversation:

- OHA will share its findings and any interpretations, including identification of key factors that may have caused cost growth to exceed the target that year based on its independent analysis.
- Payers and provider organizations will share any supplemental data that sheds light on factors that influenced cost growth performance, and potential interpretations, including key factors that may have caused cost growth to exceed the target that year.

The purpose of these meetings is to identify key factors that caused cost growth to exceed the target that year.

DETERMINATION OF REASONABLENESS

After identifying the key factors that caused cost growth to exceed the target in a given year, OHA will determine if exceeding the cost growth target was or was not reasonable based on consideration of potentially substantiating factors, with consideration of the payer or provider organization’s perspective. This determination will inform whether the payer or provider organization should be held accountable for that year’s performance.

A mix of factors may be the cause of cost growth, including factors that cannot be anticipated (e.g., COVID-19). Some of the potential factors that may cause an organization to reasonably exceed the target in a given year include, but are not limited to:

- Changes in mandated benefits
- New pharmaceuticals or treatments / procedures entering the market
- Changes in taxes or other administrative factors
- “Acts of God” – natural disasters, pandemics, other
- Changes in federal or state law
- Investments to improve population health and/or address health equity

The isolated impact of the identified factor, or the combination of identified factors must be significant enough to have caused the payer or provider organization’s cost growth to exceed the target. Factors should be completely outside of the control of the payer or provider organization and may be environmental, market-based, or governmental in nature.

However, not all factors can be predicted, so this will not be a fixed list of criteria, but rather an opportunity to understand what has happened during the year.

If a payer or provider organization disagrees with OHA’s determination, the payer or provider organization will be able to appeal. An appeals process will be developed in 2021.

OTHER STATES

Oregon is taking a rigorous and conservative approach to identifying payers and provider organization’s performance relative to the target through the statistical testing step, allowing OHA to take a more active approach to accountability than other states.

Accountability Mechanisms by State

| | |
|-----------|--|
| MA | The Commission can require health care entities that exceed the cost growth target to file and implement a performance improvement plan. MA uses a minimum population threshold to determine which payers and provider organizations might be subject to accountability. |
| CT | N/A |
| DE | N/A |
| RI | N/A |

PERFORMANCE IMPROVEMENT PLANS

Performance improvement plans (PIPs) are required by SB 889. “Annually, the program shall (c) for providers and payers for which health care cost growth in the previous calendar year exceeded the health care cost growth benchmark: (A) Analyze the cause for exceeding the health care cost growth benchmark; and (B) if appropriate, require the provider or payer to undertake a performance improvement action plan.”



The Implementation Committee recommended Performance Improvement Plans should be the first accountability mechanism for payers or provider organizations who exceed the cost growth target with statistical certainty and without a reasonable basis. PIPs should be applied at the market level.³⁰

When do PIPs apply?

PIPs will be automatically triggered for any payer or provider organization that OHA determines has unreasonably exceeded the cost growth target during any performance year for one or more markets. OHA will retain discretion to waive PIP requirements. Any waiving of PIP requirements for a given performance year would be equitably applied to all payers or provider organizations experiencing the market condition or other factor leading to the waiver.

³⁰ Market level refers to Medicaid, Medicare and Commercial. Health care cost growth will be combined across contracts for each of these market levels (e.g. the commercial market refers to cost growth across all of a payer or provider’s commercial contracts, rather than all of a provider’s commercial contracts with a specific payer, or vice versa).

How are PIPs developed?

OHA will notify any payers or provider organizations that they are required to submit a performance improvement plan for a given year, and will provide the performance improvement plan template, guidelines, and timeframe for submission. OHA will schedule a call with the payer or provider organization to explain expectations and how OHA will collaborate with the organization in PIP development.

OHA wants to ensure that performance improvement plans have integrity and will provide a basis for future evaluation of performance. Payer or provider organizations developing PIPs will benefit from understanding OHA's expectations. It will be important for OHA to collaborate with payers and provider organizations in developing PIPs.

- OHA will offer technical assistance to payers and provider organizations that are required to submit a PIP. This may include webinars or office hours, individual consultation with technical assistance providers or staff, or other guidance.
- Payers and provider organizations that are required to submit a PIP will have a contact(s) at OHA with whom they can work in developing their PIPs.

In 2021, the Implementation Committee may continue to consider the role of a third party working with OHA and payers and provider organizations to develop PIPs and oversee progress toward agreed-upon objectives.

General Parameters for PIPs

- PIPs must be centered on identified key cost growth drivers and develop concrete action steps to address these cost growth drivers in any identified lines of business.
- PIPs must identify an appropriate timeframe by which the payer or provider organization will reduce such cost growth drivers and be subject to evaluation by OHA consistent with the identified timeframe.
- PIPs should have clear metrics for success, to be used for evaluation of PIP progress and completeness.
- PIP implementation may extend for more than one year, however, payer and provider organization performance relative to the cost growth target will continue to be assessed annually.

PIPs and annual PIP progress reports will be publicly reported, as part of the program's commitment to transparency.

ESCALATING ACCOUNTABILITY

SB 889 required the Implementation Committee to consider in its recommendations possible escalating accountability mechanisms for exceeding the cost growth target in addition to Performance Improvement Plans.

What is the escalating accountability mechanism?

The Committee considered a range of options for the escalating accountability mechanism, including financial penalties, rate review, price caps, price growth caps, contract review, Attorney General enforcement of charitable trust and non-profit regulations, and contractual actions for Coordinated Care Organizations and PEBB/OEBB health plans.



The Implementation Committee recommended the “escalating accountability mechanism” for payers and provider organizations who exceed the cost growth target at the market level, with statistical certainty and without a reasonable basis across multiple years, should be a meaningful financial penalty.

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

- Size of the payer or provider organization
- Extent to which the payer or provider organization exceeds the target
- Good faith efforts to address health care costs
- Collaboration and cooperation with the program
- Avoidance “double fining” an integrated payer and provider organization unless there is reason for both the payer and provider sides to be held accountable for cost growth³¹
- Interaction with other rebates and penalties (e.g. medical loss ratio rebates)
- Credibility of performance / small numbers (if not already addressed by size threshold and statistical testing)
- Overall performance against the cost growth target, including in other markets and in aggregate across all markets
- Other relevant circumstances or factors

OHA will work with DCBS to consider any impacts of the financial penalty on an organization’s solvency. Some Committee members felt it would be important to ensure that financial penalties do not affect an organization’s solvency; others felt that there should be no guarantee

³¹ Integrated payers and provider organizations should be treated as a single organization for escalating accountability and would also not be subject to “double fining.”

that “flagrant offenders” who continue to exceed the cost growth target should remain in business. The Implementation Committee may need additional discussion about the size of the financial penalty, impact on solvency, and the calculation in 2021.

When does the escalating accountability mechanism apply?

The financial penalty would only apply in a targeted fashion to specific payers or provider organizations that continually exceed the target and where transparency and collaborative improvement efforts have not been successful at cost containment.

- ✓ The Implementation Committee recommended the financial penalty should apply to a payer or provider organization that exceeds the cost growth target for a given market, with statistical certainty, without a reasonable basis, in any three out of five years.
- ✓ The Committee recommended that the escalating accountability measure can also be applied earlier than it would under the rolling three-out-of-five-years approach, for payers or provider organizations that are not participating in the program (e.g. failing to submit data or performance improvement plans, refusing to engage in conversations about cost growth and cost drivers, no efforts to contain costs, etc.).

COMPLIANCE WITH REPORTING REQUIREMENTS

The Committee emphasized the importance of ensuring that the Health Care Cost Growth Target Program collects the data necessary to assess performance relative to the cost growth target.

- ✓ The Implementation Committee recommended OHA may assess fines for late or incomplete submission of data and/or performance improvement plans, similar to existing compliance measures for data submission to the All Payer All Claims database.

OHA will establish administrative rules for the required data submission for the cost growth target program in 2021 under its statutory authority to collect cost and quality data from insurers (ORS 442.373 and 442.386). Under these administrative rules, if a payer who meets the membership size thresholds for data submission does not meet the established reporting requirements (including timeliness of submission and completeness of submission), OHA may impose financial penalties.

OHA intends to align these civil penalties with those used in the All Payer All Claims (APAC) data program, as codified in OAR 409-025-0150.³²

³² <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=258324>

OHA will provide payers with written notification of each failure to comply with data submission requirements prior to imposing any civil penalties. Payers will have 30 calendar days to come into compliance with the data submission requirements. If payers do not come into compliance after 30 days, OHA will impose civil penalties of at least \$100 / day and potentially increasing to \$500 / day, depending on the degree of non-compliance with the requirements. The final amounts for civil penalties will be determined through the rulemaking process.

A payer who fails to submit data may also be subject to the financial penalty, described in the Escalating Accountability section above.

Note the APAC program has not yet had to impose a civil penalty on a mandatory data reporter. All data reporters have come into compliance after a written notification has been issued.

Failure to Develop a Performance Improvement Plan

The Implementation Committee recommended OHA may impose compliance penalties on payers and provider organizations for not meaningfully engaging with OHA in the development and implementation of a PIP. Meaningful engagement may include the following:

- Meeting with OHA staff to discuss and develop PIPs
- Responding to requests for information about PIPs
- Submitting PIPs using the required templates and meeting the established timelines
- Completing and submitting regular reports on PIP implementation and progress
- Demonstrating a good faith effort to implement and complete PIPs

If the payer or provider organization is not willing to meaningfully engage with OHA in the development and implementation of the PIP and required PIP reporting, OHA may impose penalties not to exceed \$500 per day. OHA will provide written notification of any failure to meet requirements prior to imposing any civil penalties. Payers and provider organizations will have 30 calendar days to come into compliance with any requirements.³³

A payer or provide organization who fails to develop a PIP may also be subject to the financial penalty, described in the Escalating Accountability section above.

WHAT HAPPENS TO FINANCIAL PENALTY AND COMPLIANCE PENALTY DOLLARS?

Any funds collected from these penalties will be used to support programs to expand health care coverage and to support populations adversely impacted by high costs. Additional detail will be developed in the future.

³³ For reference: Massachusetts' statutory requirements for Performance Improvement Plans, Chapter 224, Section 10 (2012). <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

ACCOUNTABILITY TIMELINE

This calendar represents public reporting on cost growth and the *earliest* that accountability measures would be applied to a payer or provider organization exceeding the cost growth target as described above. This calendar is for illustration only. There may be years where performance improvement plans (PIPs) and other escalating measures are not applied, which would shift timelines, and some reporting timelines may be subject to change depending on the data submission and validation process.

| Calendar Year | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|--|---|--|---|---|---|
| Data Analysis Year | Baseline measurement: 2018-2020 ³⁴ | Year 1 measurement: Cost growth from 2020 to 2021 | Year 2: Cost growth from 2021 to 2022 | Year 3: Cost growth from 2022 to 2023 | Year 4: Cost growth from 2023 to 2024 | Year 5: Cost growth from 2024 to 2025 | Year 6: Cost growth from 2025 to 2026 |
| Public Reports and Public Hearings | Baseline report and first public hearing ³⁵ - 2018-2020 data - COVID-19 impact | Year 1 report and second public hearing: 2020-2021 performance | Year 2 report and third public hearing: 2021-2022 performance | Year 3 report and fourth public hearing: 2022-2023 performance | Year 4 report and fifth public hearing: 2023-2024 performance | Year 5 report and sixth public hearing: 2024-2025 performance | Year 6 report and seventh public hearing: 2025-2026 performance |
| Payer/ Provider Performance Identified | No. Aggregate reporting only | Yes | Yes | Yes | Yes | Yes | Yes |

³⁴ Baseline data for 2018-2020 submitted and validated. List of accountable provider organizations identified. 2018-20 trend sent to payers and provider orgs.

³⁵ May be 2022, depending on how long the initial data submission and validation process takes.

| Calendar Year | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|-------------|-------------|--|---|---|--|--|
| Accountability: PIPs | N/A | N/A | PIPs, based on Year 2 performance. PIPs publicly reported | PIPs, based on Year 3 performance PIPs publicly reported PIP progress reports publicly reported | PIPs, based on Year 4 performance PIPs publicly reported PIP progress reports publicly reported | PIPs, based on Year 5 performance PIPs publicly reported PIP progress reports publicly reported | PIPs, based on Year 6 performance PIPs publicly reported PIP progress reports publicly reported |
| Accountability: Escalating Measure | N/A | N/A | N/A | N/A | N/A | Escalating measures apply, based on payers or providers exceeding the cost growth target in 3 out of 5 years (Years 1-5) | Escalating measures apply, based on payers or providers exceeding the cost growth target in 3 out of 5 years (Years 2-6) |

Governance

SB 889 directed the Implementation Committee to recommend the governance structure for the Health Care Cost Growth Target Program. SB 889 also established the Health Care Cost Growth Target Program to be administered by OHA in collaboration with DCBS, subject to the oversight of the Oregon Health Policy Board (OHPB). The Committee considered short-term and longer-term approaches for governance.

IN 2021

OHA initially assumed the Implementation Committee would sunset after completing this initial set of recommendations. However, SB 889 established the Implementation Committee through January 2, 2022. Given the ongoing conversations to inform the launch of the Health Care Cost Growth Target Program, OHA proposed that the Implementation Committee continue meeting through 2021.



The Implementation Committee recommended that it should continue to meet throughout 2021 to oversee the Health Care Cost Growth Target Program launch and initial implementation, including to:

- inform the development and implementation of the Data Use Strategy,
- understand initial cost growth trends and cost drivers,
- finalize plans for quality and equity measurement,
- identify additional technical assistance and supports necessary for payers and providers to meet the cost growth target, and
- identify additional opportunities for lowering costs.

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

IN 2022 AND BEYOND

After the original Implementation Committee sunsets in January 2022, the Health Care Cost Growth Target Program will need ongoing oversight.



The Implementation Committee recommended governance for the Health Care Cost Growth Target Program in 2022 and beyond should be informed by a new Committee, consisting of health care payers and provider organizations, as well as business/employer representatives and consumer representatives.

There should be some overlap between current members of the Implementation Committee and the new Committee to ensure continuity.

The new Committee should be responsible for:

- Overseeing ongoing program implementation

- Revisiting the cost growth target value for 2026-2030 (and beyond)
- Reviewing and understanding cost growth trends and cost drivers and advise OHA, DCBS and OHPB on the impact of cost
- Monitoring for unintended consequences
- Exploring opportunities to improve equity
- Reviewing and understanding progress toward VBP goals
- Identifying and addressing opportunities to reduce cost growth as revealed by the Data Use Strategy, or otherwise identified
- Informing public hearings.

TECHNICAL ADVISORY GROUP

Throughout 2020, the Implementation Committee has identified details that require additional technical development. OHA proposed an new technical advisory group (TAG) in 2021 to address these details.



The Implementation Committee recommended that OHA should convene an ad hoc technical advisory group (TAG) in 2021 open to payers who will be submitting data, provider organizations, and other interested parties to work with OHA to finalize the data submission template and specifications, and data validation process.

The TAG will not be a decision-making body and will have open membership, not appointed seats. OHA will invite all data submitters to participate (similar to the current APAC and Metrics TAG structures).

PUBLIC HEARINGS



The Implementation Committee recommended the Oregon Health Policy Board (OHPB) should be responsible for hosting and convening annual public hearings.

OHPB may also hold regional or other meetings related to health care cost issues throughout the year prior to the annual public hearing.

See the Transparency section below for additional information about public hearings.

WHO IS RESPONSIBLE FOR WHAT?

| | |
|--|---|
| Adjusting the cost growth target? | Future Implementation Committee (in 2024) |
| Deciding if a payer or provider organization should be put on a PIP? | OHA |

| | |
|---|--|
| Selecting which payers or providers should testify at the public hearing? | OHPB, with input from future Implementation Committee |
| Recommending quality measures for cost growth target program? | 2021 Implementation Committee + Health Plan Quality Metrics Committee (HPQMC) |
| Identifying opportunities to address health care cost growth | Shared responsibility across all payers, provider organizations, Committees, workgroups, and agencies. |

Transparency

Transparency is a key component of Oregon’s Health Care Cost Growth Target Program and it cuts across the Implementation Committee’s focus areas. Transparency will help us understand cost drivers and opportunities for lowering costs.



The Implementation Committee recommended three primary mechanisms for sharing information from the Cost Growth Target Program: development and publication of reports, publication of data files, and public hearings.

PUBLIC REPORTING

The primary mechanisms for transparency will be the development of public facing reports that will be used to inform all audiences, consistent with the goals of the Data Use Strategy.

- Reports will meet all state and federal data privacy laws
- Reports may be static or interactive, and may involve supplemental material
- Reports will likely evolve over time (new analyses, ad hoc topics, etc.)
- Reports will be published on OHA’s website

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

Annual health care cost trend report

The annual health care cost trend report should include both performance relative to the cost growth target and information about health care system performance. The tables below describe potential analyses that can be included in the annual report.

Performance relative to the cost growth target

| | |
|--------------------|---|
| Description | Annual per capita growth rate for Oregon’s total health care spending, expressed as the percentage growth from the prior year’s per capita spending |
| Analyses | <ul style="list-style-type: none">• Success in achieving the health care cost growth target*• Per capita growth over time*• Per capita growth over time as compared to growth in selected comparison states• Per capita growth over time compared to other economic indicators |

*required per SB 889

Health care system performance: underlying cost trends

| | |
|--------------------|--|
| Description | Analyses of cost drivers <i>and</i> cost growth drivers, highlighting where targeted stakeholder action is needed to restrain cost growth. |
| Analyses | <ul style="list-style-type: none"> • Geographic, demographic and/or condition-specific variation • Utilization • Service intensity • Price variation • Low-value care • Potentially preventable services |

Health care system performance: impact of the cost growth target

| | |
|--------------------|--|
| Description | Analyses targeting the impact of the cost growth target, including, but not limited to, understanding any unintended consequences. |
| Analyses | <ul style="list-style-type: none"> • Premium growth • Benefit levels • Consumer out-of-pocket spending • Quality of care (process, outcome, patient experience) • Access to care • Health care disparity and health care inequity • Employer spending • Clinician satisfaction • Workforce impacts • Consolidation impacts |

It will take time to develop all these analyses and incorporate them into the annual health care cost trend public report. The Committee agreed to phase in public reporting. See the table below and the Accountability timeline in the prior section for more detail.

| | First Public Report | Impact of COVID-19 Report | First Performance Report |
|----------------------------|----------------------------|----------------------------------|---------------------------------|
| Release Date (est.) | 2021 | 2021 | 2022 |
| Years | 2018-2019 | 2018-2020 | 2018-2021 |

| | First Public Report | Impact of COVID-19 Report | First Performance Report |
|---|---|---|--|
| Performance relative to the cost growth target | <i>Change 2018-2019</i> <ul style="list-style-type: none"> • State level • Market level | <i>Change 2019-2020</i> <ul style="list-style-type: none"> • State level • Market level | <i>Change 2020-2021</i> <ul style="list-style-type: none"> • State level • Market level • Insurer level • Provider level |
| Underlying cost trends | Initial look at cost drivers | Impact of COVID-19 on cost drivers | Deeper look at cost drivers and price variation |
| Impact of the cost growth target | Baseline analysis of premiums, quality, access, and consumer spending | Impact of COVID-19 on premiums, access, quality, and consumer spending | Deeper look at impacts and adverse consequences |

OHA may also publish ad hoc reports in 2021 that begin to speak to cost trends and cost drivers using APAC and other datasets, while developing the annual reports on performance against the cost growth target.

Audiences for Public Reporting



The Implementation Committee recommended publicly reported data analysis should be performed for providers, payers, purchasers, policy makers, public health, and the general public, with a particular interest on actionable information for providers.

Implementation Committee members also noted the importance of ensuring cultural and regional sensitivity when reporting out on this work to the public.

Publication of Data Files

Data files can be made available for researchers and other interested parties to perform their own analysis. This could be as simple as posting Excel files with the summary data used to develop publicly reported analyses on OHA’s website, consistent with how OHA currently publishes Hospital Payment Report data.

Any data files posted will meet all applicable privacy laws. This is in addition to the existing public release and data request processes for APAC data.

Publication of Performance Improvement Plans

OHA will also publish performance improvement plans (PIPs) for any payers or provider

organizations who are required to develop one based on their performance relative to the cost growth target in a given year (see Accountability recommendations above). OHA will also make annual progress reports, or summaries of progress, on PIPs publicly available.

Any files posted will meet all applicable privacy laws, and PIP templates will clearly identify which sections may be published.

PUBLIC HEARINGS

The purpose of public hearings is to foster a common understanding across stakeholders and state leaders of the biggest challenges and opportunities related to health care costs. The public hearings will be grounded in performance relative to the cost growth target and will support open dialogue around opportunities for improving care and reducing costs.



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

Frequency



The Implementation Committee recommended holding annual public meetings to discuss performance against the cost growth target and strategies to improve performance. Smaller stakeholder meetings could occur during the year to address specific strategies.

Format

The Implementation Committee reviewed the format and content used in Massachusetts' public hearings, including request for pre-filed testimony from payers and providers; a report on performance against the cost growth target; testimony from executive and/or legislative branches; testimony from a cross-section of the health care market on challenges and opportunities for improving care and reducing costs; and public comment.



The Implementation Committee recommended including the elements used by Massachusetts in their public hearings, in a formal but collaborative approach.

Public hearings should include invited presentations from:

- Payers and provider organizations performing at or below the target
- Payers and provider organizations performing above the target
- Employer purchasers
- Consumer advocates
- Executive and legislative branch representatives

Public hearings should ensure participation of an appropriate cross-section of stakeholders and geographies. Public hearings should also make space for public comment.

Supplemental Materials

The Implementation Committee charter, roster, and all agendas, minutes, and meeting materials, including meeting recordings, are available online at:

<https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>

The full text of SB 889 (2019) is available at:

<https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled>

The Governor's Letter appointing the Implementation Committee is available at:

<https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Governor-Appontment-Letter-10-18-2019.pdf>

The proposed accountability legislation for the 2021 session is HB 2081, available at:

<https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2081>

Appendices

1. **Data Use Strategy Goals and Principles**
2. **Principles for Increasing the Use of Advanced Value-Based Payment Models**
3. **Statistical Methodology**
4. **Draft VBP Workgroup Charter**
5. **Letter of Support from Milbank Memorial Fund**

Appendix 1

Data Use Strategy Principles and Goals

Data Use Strategy Principles

1. OHA (in collaboration with DCBS) should assume responsibility for the design, production and public distribution of routine, all-payer statistical analyses that:
 - a. assess cost growth target attainment;
 - b. examine health care cost and cost growth drivers;
 - c. provide access and quality measure analysis for the purposes of assessment of, including, but not limited to the possible adverse impacts of cost-focused actions, including on health disparities, and
 - d. provide information on cost drivers and savings opportunities to other programs within OHA and DCBS and to other health care purchasers to support their respective roles in setting, negotiating, or approving affordable health plan rates.
2. OHA should involve external stakeholders in the design of analyses.
3. The methodologies employed in OHA statistical analyses should be fully transparent.
4. OHA analyses of health care cost and cost growth drivers should identify:
 - a. payers and large providers, when it is statistically valid to do so, and
 - b. opportunities for improved cost management
5. OHA should continue to support using APAC data for:
 - a. research and evaluation activities, and
 - b. provider, consumer, and employer purchaser efforts to improve health care access, equity, quality, or cost management.

including for increased publication of APAC data and making APAC data available at a reasonable cost, within constraints of state and federal laws and regulations.
6. OHA should employ a data strategy framework that supports multisector collaboration to help achieve the cost growth target.

Data Use Strategy Goals

- Ensure timeline and accurate measurement of performance relative to the cost growth target at the state, insurance market, insurer/CCO, and large provider levels.
- Produce routine analyses that pinpoint leading opportunities to reduce health care spending by the State, payers, purchasers, and Oregonians in a manner that will not harm patients.
- Interpret health care spending analyses and link findings with recommended actions for the State, policymakers, insurers/CCOs, providers and employer purchasers.
- Produce routine public reporting and communication products to share progress, challenges, and opportunities with consumers.

Appendix #2

Principles for Increasing the Use of Advanced Value-Based Payment Models

Purpose

SB 889 prescribes that the Sustainable Health Care Cost Growth Target Implementation Committee (Implementation Committee) shall “Identify opportunities for lowering costs, improving the quality of care and improving the efficiency of the health care system by using innovative payment models for all payers, including payment models that do not use a per-claim basis for payments.”

For the purposes of this document, “innovative payment models” are referred to as “advanced value-based payment models” and are defined to include HCP-LAN Categories 3A and higher.³⁶ This encompasses payment models with upside risk only, combined upside and downside risk, as well as prospective payment models. Prospective payment models include capitation, global budgets, prospective episode-based payment, and budget-based models with prospective payment and retrospective reconciliation.

These principles build on value-based payment (VBP) efforts for Coordinated Care Organizations and the Primary Care Payment Reform Collaborative.³⁷ Their intent is to align efforts across public and private initiatives and markets to the extent possible, including the self-insured market, bringing an aggressive focus on advanced value-based payment arrangements across the state.

After the Implementation Committee finalizes and adopts these principles, OHA will convene payers, providers, and purchasers to develop a voluntary compact. After the voluntary compact is signed, OHA will convene a technical group of payers, providers, and purchasers to further develop and support implementation of advanced VBP models.

Principles

1. All members of the Sustainable Health Care Cost Growth Target Implementation Committee, plus representatives of other larger insurer, purchaser and provider organizations in the state, should develop a voluntary compact to increase the use of

³⁶ For an explanation of the Health Care Payment Learning and Action Network’s Alternative Payment Models (HCP-LAN) framework, including a description of its defined payment models, see <https://hcp-lan.org/apm-refresh-white-paper/>.

³⁷ While these principles are conceptually and directionally aligned with the CCO 2.0 VBP Roadmap and with recommendations from the Primary Care Payment Reform Collaborative, they do push Oregon payers and providers to adopt advanced VBP models more quickly. A CCO who signs the voluntary compact and works to meet the targets outlined in these principles will not be in conflict with their contractual requirements.

advanced value-based payment models to Oregon’s providers that commit the signatories to these principles and to concrete action steps to achieve these principles.

2. The fee-for-service payment system has fundamental flaws and has not led to sustainable costs or promotion of improved quality, outcomes, or health equity in the health system.
3. Providers, particularly those paid on a fee-for-service basis, face unique challenges due to the ongoing COVID-19 pandemic. Increasing the use of advanced value-based payment models will help stabilize Oregon’s health system.
4. Advanced value-based payment models are a critical strategy to contain costs to meet the established health care cost growth target. The appropriate advanced value-based payment models may look different across the state, but implementation should be guided by these principles.
5. Prospective budget-based and quality-linked payment, where a provider is paid up front for a population of patients and a predefined set of services, should be the primary payment model utilized wherever feasible for the following reasons:
 - a. It provides critical financial stability to providers, particularly for small, independent, and rural providers, through a consistent source of revenue, which is an important part of alleviating the most damaging economic consequences of the pandemic.
 - b. It gives providers the flexibility to address the most critical health needs of their patients, including non-medical social supports that might improve health and save costs, rather than having to rely on reimbursable treatments.
 - c. It allows for investment in a population of patients, and for flexibility in the type of provider delivering care and the type of care provided, which supports more holistic patient-centered care.
 - d. It is supportive of the Cost Growth Target because it defines a budget for the care of a population of patients.
6. Prospective budget-based and quality-linked payments are not feasible today for all Oregon providers due to lack of experience with advanced value-based payment and/or small provider size. Therefore, where they are not feasible to implement for a given line of business or provider, advanced payments models that include both shared savings and downside risk should be utilized, consistent with the intent of moving towards prospective payment models. Where value-based payment models categorized as 3B and higher are not feasible, payers and providers should implement value-based payment models categorized as 3A.

7. Payers should have the following percentage of all their payments under **advanced value-based payment models** (3A and higher) in the following time periods:
 - a. 35% by 2021³⁸
 - b. 50% by 2022
 - c. 60% by 2023
 - d. 70% by 2024

8. Payers should have the following percentage of their payments to primary care practices and general acute care hospitals³⁹ made under advanced value-based payment models, (3B and higher) in the following time periods:
 - a. 25% by 2022
 - b. 50% by 2023
 - c. 70% by 2024

9. Health plan enrollees should be encouraged or required to select a primary care provider, whether or not required by benefit design, to support advanced payment model effectiveness.

10. Small and safety net providers should be offered technical assistance by payers and/or by OHA's Transformation Center to set them up for success under advanced value-based payment models. Those with limited experience in value-based payment, such as behavioral health providers, should also be considered for technical assistance.

11. The structure of advanced value-based payment models should be aligned across payers to allow providers to have a sufficient volume of similar value-based arrangements to make meaningful change in their clinical practice and reduce administrative burden. Structural alignment should include but not be limited to the use of common performance measures.

12. Advanced value-based payment models should be designed with consideration of how to reduce excess capacity in the system, while recognizing reasonable health system overhead required to maintain flexible stand-by capacity. Implementation of value-based payment models should not be used to reduce wages of low-income healthcare workers.

³⁸ While contracts for 2021 may have been signed, nothing precludes a payer from offering to renegotiate contracts to offer advanced value-based payment models.

³⁹ Non-federal, non-specialty hospitals open to the general public providing broad acute care.

13. Advanced value-based payment models should be designed and implemented with consideration for unintended consequences, including potential adverse impacts on health care quality.
14. Advanced value-based payments models should be designed to promote health equity, as well as to mitigate adverse impacts on populations experiencing health inequities by:
 - a. employing payment model design features and measures to protect against stinting,
 - b. ensuring prospective payments are sufficient to cover the cost of infrastructure changes to support health equity (e.g. traditional health workers, changes to IT systems to track equity),
 - c. providing additional supports (e.g. technical assistance, infrastructure payments) for providers serving populations experiencing health inequities,
 - d. ensuring new upside or downside risks will not exacerbate existing inequities, and
 - e. ensuring providers serving populations experiencing health inequities who are at greater risk of closure due to COVID-19 remain open.

Future efforts may also include adjusting payments based on social risk factors.

15. Implementation of advanced payment models should be accompanied by public transparency of price information, implemented through the Sustainable Health Care Cost Growth Target Data Use Strategy.
16. These principles represent the shared vision of the Implementation Committee as of October 2020. The passage of time and additional experience with advanced value-based payment implementation could inform future modifications to the targets herein. OHA should convene signers of the voluntary compact no later than fall 2022 to revisit these principles and the compact to ensure effectiveness in advancing payment reform and supporting reduced cost growth in Oregon.

References

HCP LAN framework:

<https://hcp-lan.org/apm-refresh-white-paper/>

CCO 2.0 VBP roadmap:

<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx>

Primary Care Payment Reform Collaborative:

<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx>

Appendix 3

Statistical Methodology

How Oregon will implement statistical tests assessing whether health insurance carriers and provider organizations have met the 3.4% cost growth target

Background

Purpose of this document: Describe the statistical methods OHA will use to assess carriers and provider organizations against the health care cost growth target to determine whether these entities are subject to accountability mechanisms identified by the Implementation Committee. Provide examples of calculations.

Guidance from the Implementation Committee: Instead of choosing a minimum population a priori as other states have done, the Committee requested that OHA take a more statistically rigorous approach that will still include as many carriers and provider organizations as possible.

During the [October Implementation Committee meeting](#), the Committee agreed with the following thresholds:

- A carrier or provider organization would be held accountable for performance against the cost growth target in any year if a difference can be detected at 95% confidence.
- A carrier or provider organization would be held accountable for performance against the cost growth target in the second year if a difference can be detected at 80% confidence for two consecutive years.
- If a carrier or provider organization demonstrates they have exceeded the cost growth target at 80% confidence in 3 out of 5 years, they would also be held accountable.
- No action would be taken in any years for carrier or provider organizations who appear to exceed the target, but we cannot detect a difference at 80% confidence

While not discussed with the Implementation Committee in October, future governance bodies may wish to also look at longer-term trends, such as cost growth over a five-year period, not just the year-over-year growth in each of those five years. This analysis will be important in future program years.

Intent

OHA wants to identify three categories of carriers and provider organizations:

| | Analysis: | Designation: |
|---|---|---|
| 1 | Upper confidence interval is fully below the target | Achieved the target; positive recognition |
| 2 | Confidence interval intersects with the target | Unable to determine performance relative to the target with confidence, not subject to accountability |

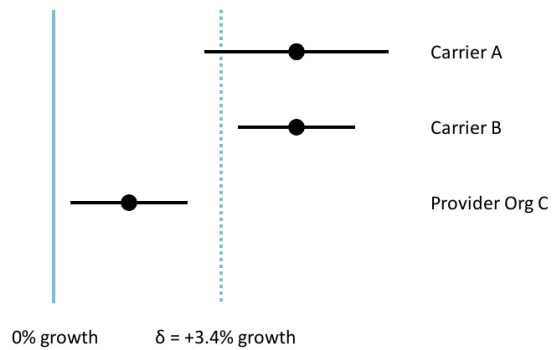
| | | |
|---|--|--|
| 3 | Lower confidence interval is over the target | Exceeded the target; may be subject to accountability mechanisms |
|---|--|--|

This document presents the statistical methodology to assess confidence intervals. Many online resources provide an introduction to statistics and confidence intervals.⁴⁰

Example: Mean Per Capita Costs between Year 1 and Year 2

The figure to the right shows three different cost growth amounts, signified by the black dot, and confidence intervals, represented by the horizontal lines to the immediate left and right of each black dot.

As the graphic shows, Carrier A’s mean per capita cost from year 1 to year 2 grew by more than 3.4%. However, given the number of individuals (N) and the variance of Carrier A’s member costs, the 95% confidence intervals ($\alpha = .05$) is such that we **cannot** say that Carrier A exceeded the growth with 95% confidence.



Carrier B on the other hand exceeds the target with 95% confidence. Provider Organization C’s mean per capita cost growth is less than 3.4% and we can say they have achieved the cost target with 95% confidence.

Carrier A would not be subject to accountability mechanisms. Carrier B would be subject to accountability mechanisms. Provider C would be given positive recognition for achieving the target.

Statistical Testing

Methods: A one-tailed t-test suffices for conducting the analysis explained above. OHA staff compared a t-test and a non-inferiority test. The steps to calculate the t-test and a one-sided test for inferiority are the same. The growth of mean per capita costs from one year to a second will be assessed with the ratio of year 2 divided by year 1.

Using a ratio to test the null hypothesis:

⁴⁰ <https://www.khanacademy.org/math/statistics-probability>
<https://www.khanacademy.org/math/statistics-probability/confidence-intervals-one-sample>
<https://courses.lumenlearning.com/introstats1/chapter/introduction-confidence-intervals/>

$$H_0: \frac{\bar{X}_2}{\bar{X}_1} \leq \rho$$

According to the 3.4% cost growth target, $\rho = 1.034$, which suggests the result of dividing the second year's mean per capita cost by the first year's mean per capita cost is less than or equal to 1.034. This hypothesis can be re-written as:

$$H_0: \bar{X}_2 - \rho\bar{X}_1 \leq 0$$

In which the second year's mean per capita cost minus the product of 1.034 and the first year's mean per capita cost is less than or equal to zero.

Two different calculations must be made: one is calculating the t-statistic and the other is calculating the confidence intervals at 95% and, when necessary, 80%.

To calculate the t-statistic and confidence intervals we must pool variances and there are two different formulae depending on whether the two variances are similar or not. Calculating the confidence intervals also requires the pooled variances. Again, there are two approaches depending on if the variances are similar or not.

In summary, the percent cost growth from year one to year two is a ratio of two means. In other words, the average per capita cost of year one divided by the average per capita cost of year two, minus one, yields the percentage growth. If that growth exceeds 3.4% and is statistically significant at 95% or 80% confidence, then we can say that entity exceeded the cost growth target. The 95% confidence threshold will be used for year-to-year assessment, while the 80% confidence threshold will be used for assessing cost growth target achievement in two consecutive years and in three out of five years.

Calculating the confidence interval for the ratio of two means requires a version of Fieller's theorem. We cannot, however, calculate covariance of paired measurements because we don't have individual-level data and not all measurements will be paired. The formulae below allow us to apply Fieller's approach calculating ratios without needing the covariances.

Formulae -

| Notation Table | |
|----------------|---|
| i | Year index, 1 = prior year, 2 = current year |
| df | Degrees of freedom |
| n_i | Sample size for year i |
| V_i | Variance (or standard deviation squared) for year i |
| \bar{X}_i | Mean per capita cost for year i |
| ρ | Growth target ratio |

The original formula to calculate pooled variance:

$$V_{\text{pool}} = \frac{1}{n_i - 1} \sum_{j=1}^{n_i} (y_j - \bar{y}_i)^2$$

The original formula requires individual-level data and cannot be used under our data collection framework. Instead, we will use this formula for pooling the variance of two samples:

$$V_{\text{pool}} = \frac{V_1(n_1 - 1) + V_2(n_2 - 1)}{n_1 + n_2 - 2}$$

When the variances are similar:

The formula for the degrees of freedom is

$$\text{df} = n_1 + n_2 - 2$$

T-statistic:

$$t = \frac{\bar{X}_2 - \rho \bar{X}_1}{\sqrt{V_{\text{pool}} \left(\frac{1}{n_2} + \frac{\rho^2}{n_1} \right)}}$$

Confidence interval:

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

When the variances are different, which will be the most likely scenario:

The formula for degrees of freedom for the t-statistic is:

$$\text{df} = \frac{\left(\frac{V_2}{n_2} + \rho^2 \frac{V_1}{n_1} \right)^2}{\frac{V_2^2}{n_2^2(n_2 - 1)} + \frac{\rho^4 V_1^2}{n_1^2(n_1 - 1)}}$$

T-statistic:

$$t = \frac{\bar{X}_2 - \rho \bar{X}_1}{\sqrt{\frac{V_2}{n_2} + \frac{\rho^2 V_1}{n_1}}}$$

Degrees of freedom for calculating the confidence interval:

$$\widehat{df} = \frac{\left(\frac{V_2}{n_2} + \left(\frac{\bar{X}_2}{\bar{X}_1}\right)^2 \frac{V_1}{n_1}\right)^2}{\frac{V_2^2}{n_2^2(n_2-1)} + \frac{\left(\frac{\bar{X}_2}{\bar{X}_1}\right)^4 V_1^2}{n_1^2(n_1-1)}}$$

Confidence interval:

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

Example with mock data:

Each carrier will submit payment data for provider organizations stratified by line of business. To calculate the carrier’s cost growth, OHA staff will use a weighted value to assess cost growth. For example, the carrier submits the following data:

For 2018

| Paid entity | Line of Business | Average per capita spending | Members |
|------------------------|------------------|-----------------------------|---------|
| Hospital System Z | Medicaid | \$5,000 | 20,000 |
| Hospital System Z | Commercial | \$8,000 | 55,000 |
| Main St Provider Group | Medicaid | \$800 | 7,750 |
| Main St Provider Group | Commercial | \$1,000 | 32,000 |
| Totals | Medicaid | \$5,800 | 27,750 |
| Totals | Commercial | \$9,000 | 87,000 |

For 2019

| Paid entity | Line of Business | Average per capita spending | Members |
|------------------------|------------------|-----------------------------|---------|
| Hospital System Z | Medicaid | \$5,500 | 17,000 |
| Hospital System Z | Commercial | \$7,800 | 60,000 |
| Main St Provider Group | Medicaid | \$850 | 6,000 |
| Main St Provider Group | Commercial | \$1,100 | 40,000 |

| | | | |
|--------|------------|---------|---------|
| Totals | Medicaid | \$6,350 | 23,000 |
| Totals | Commercial | \$8,900 | 100,000 |

The carrier's average per capita spending for their Medicaid business in total grew by 9.5%, which is calculated by $[\$6,350/\$5,800-1]$.

The carrier's average per capita spending for their Commercial business grew by -1.1%, which is calculated by $[\$8,900/\$9,000-1]$.

The weighted per capita spending in 2018 was \$8,226 and the weighted per capita spending in 2019 was \$8,423. These values are weighted by the number of members. Therefore, the weighted growth for all of this carrier's lines of business combined is 2.4%. This carrier has many more commercial lives than Medicaid lives, which is why the weighted average is closer to the commercial average of -1.1% than it is the Medicaid average of 9.5%.

Calculating confidence intervals: In addition to the data described above, carriers will also have to submit either the variance or the standard deviation of the per capita spending for each row.

For example, in the 2019 data the carrier above would have to calculate the total spent for each of the 17,000 Medicaid members attributed to Hospital System Z and calculate the variance or standard deviation on that distribution. Similarly, the carrier will need to analyze the 23,000 total Medicaid lives and calculate the variance or standard deviation of the per capita costs of that distribution.

For 2018

| Paid entity | Line of Business | Average per capita spending | Members | Standard deviation |
|------------------------|------------------|-----------------------------|---------|--------------------|
| Hospital System Z | Medicaid | \$5,000 | 20,000 | \$2,000 |
| Hospital System Z | Commercial | \$8,000 | 55,000 | \$3,000 |
| Main St Provider Group | Medicaid | \$800 | 7,750 | \$350 |
| Main St Provider Group | Commercial | \$1,000 | 32,000 | \$475 |
| Totals | Medicaid | \$5,800 | 27,750 | \$2,000 |
| Totals | Commercial | \$9,000 | 87,000 | \$3,000 |

For 2019

| Paid entity | Line of Business | Average per capita spending | Members | Standard deviation |
|-------------------|------------------|-----------------------------|---------|--------------------|
| Hospital System Z | Medicaid | \$5,500 | 17,000 | \$2,000 |

| | | | | |
|------------------------|------------|---------|---------|---------|
| Hospital System Z | Commercial | \$7,800 | 60,000 | \$4,500 |
| Main St Provider Group | Medicaid | \$850 | 6,000 | \$500 |
| Main St Provider Group | Commercial | \$1,100 | 40,000 | \$675 |
| Totals | Medicaid | \$6,350 | 23,000 | \$3,000 |
| Totals | Commercial | \$8,900 | 100,000 | \$5,250 |

OHA staff will use the average per capita spending, the number of members, and the standard deviation of the per capita costs to calculate the confidence intervals, which will tell us if the growth rate is less than or greater than the cost growth target with 95% or 80% confidence – whichever alpha value is required for that situation.

We must pool variances to calculate confidence intervals. This will apply when calculating:

- The weighted per capita growth for a given carrier. In the example above, we must pool the variances of the carrier’s Medicaid line of business and the commercial line of business.
- The aggregate per capita growth for a provider organization whose data is listed in multiple carriers’ data submission. We must pool the variances of all the rows that list Hospital System Z to determine whether that entity’s growth is less than or greater than the cost growth target with 95% or 80% confidence.
- The aggregate per capita growth for the whole line of business. We must pool the variances of all “Medicaid total” rows from all data submitters to determine if, as a whole, we achieved or exceeded the target in the Medicaid market statewide. OHA will replicate this for every line of business.

Note: after aggregating all data for a given line of business across the state, the confidence intervals will almost surely be very narrow due to the large number of members. Therefore, pooling variances and calculating the confidence intervals at the market and state level may not be necessary, but we will do so regardless.

Technical Assistance to data submitters: OHA will provide technical assistance and guidance to carriers submitting data. Topics will include how to prepare data before calculating standard deviation, calculating the standard deviation, and how to report values in the template.

Example Calculations for the T-statistic and Confidence Intervals

Example calculations use the initial health care cost growth target of 3.4%.

Calculations for each year

Using the example data above, we first must calculate the pooled variance for each year using the pooled variance equation:

$$V_{\text{pool}} = \frac{V_1(n_1 - 1) + V_2(n_2 - 1)}{n_1 + n_2 - 2}$$

For 2018: $V_{\text{pool}} = [2,000^2 * (27,750 - 1) + 3,000^2 * (87,000 - 1)] / (27,750 + 87,000 - 2)$
 $= 7,790,872.172064$

As noted before, the weighted per capita spending in 2018 was \$8,226. This formula yields a pooled variance of 7,790,872.

For 2019: $V_{\text{pool}} = [3,000^2 * (23,000 - 1) + 5,250^2 * (100,000 - 1)] / (23,000 + 100,000 - 2)$
 $= 24,091,557.891185$

As noted before, the weighted per capita spending in 2019 was \$8,423. This formula yields a pooled variance of 24,091,558.

Calculations for growth over both years:

Now that we have the carrier’s pooled variances for all lines of business in each year, we can calculate the t-statistic and confidence intervals of the growth of the mean per capita spending amounts.

We already calculated the following:

| | Weighted per capita average | Pooled variance | Sample size (total members) |
|------|-----------------------------|-----------------|-----------------------------|
| 2018 | \$8,226 | 7,790,872 | 114,750 |
| 2019 | \$8,423 | 24,091,558 | 123,000 |

Because the variances differ, we must use the following formula to calculate the t-statistic:

$$t = \frac{\bar{X}_2 - \rho\bar{X}_1}{\sqrt{\frac{V_2}{n_2} + \frac{\rho^2 V_1}{n_1}}}$$

$t = (\$8,423 - 1.034 * \$8,226) /$
 $\sqrt{[(24,091,557.891185 / 123,000) + 1.034^2 * (7,790,872.172064 / 114,750)]}$

$t = -82.684 /$
 $\sqrt{(195.86632431 + 1.069156 * 67.894310867)}$

$t = -82.684 /$
 16.3846269

$t = -5.04564$

Calculating confidence intervals:

The weighted growth from \$8,226 to \$8,423 is 2.4%. Now we apply the statistical test to assess the confidence intervals to see if the carrier achieved the target with 95% confidence. We can calculate the confidence intervals for unequal variances by using the formula:

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

Where $t_{\hat{df}, \alpha}$ equals the t-statistic given the degrees of freedom (\hat{df}) and the value of alpha (α). For 95% confidence, the alpha value is 0.05, which means:

$$t_{\hat{df}, 0.05} = 1.644861 \text{ (when using a one-sided test)}^{41}$$

For 80% confidence, the alpha value is 0.20, which means:

$$t_{\hat{df}, 0.20} = 0.841623 \text{ (when using a one-sided test)}$$

For 95% confidence, the upper and lower estimates are calculated as follows:

Numerator:

$$= (\$8,226 \times 8,423) \pm \sqrt{(\$8,226^2 \times 8,423^2 - (\$8,226^2 - 1.644861^2 \times 7,790,872.172064/114,750) \times (\$8,423^2 - 1.644861^2 \times 24,091,557.891185/123,000))}$$

$$= 69,287,598 \pm \sqrt{[67,667,076 \times 70,946,929 - (67,666,892.307) \times (70,946,399.070)]}$$

$$= 69,287,598 \pm \sqrt{[4,800,771,236,609,604 - 4,800,722,345,439,136]}$$

$$= 69,287,598 \pm \sqrt{[48,891,170,468]}$$

$$= 69,287,598 \pm 221,113.47871$$

Denominator:

$$= (\$8,226^2 - 1.644861^2 \times 7,790,872.172064/114,750) = 67,666,892.307$$

Upper estimate:

$$= (69,287,598 + 221,113.47871) / 67,666,892.307 = \mathbf{1.02721891177}$$

Lower estimate:

$$= (69,287,598 - 221,113.47871) / 67,666,892.307 = \mathbf{1.02068355981}$$

⁴¹ For the complete list of statistical tables: <https://onlinelibrary.wiley.com/doi/pdf/10.1002/0471733199.app1>

The weighted growth rate from year 1 to year 2 was 2.4%, as calculated before and the 95% confidence interval range is 2.07%, which is the rounded percent value of the calculated lower estimate of 1.02068, and 2.72%, which is the rounded percent value of the calculated upper estimate of 1.02721. Therefore, we can say with 95% certainty that this carrier across all lines of businesses achieved the cost growth target by growing less than 3.4%. This example of a carrier achieving the cost growth target with 95% confidence matches the abstract example presented as “provider organization C” at the beginning of this document.

The same methodology can be used to calculate each line of business for a given carrier.

Calculating provider organizations’ growth rates:

The same approach can be used to calculate a provider organization’s growth rate. Unlike the carrier calculation, which requires two levels of variance pooling – weighted across a single year’s many lines of business and across multiple years – a provider calculation will require three levels of variance pooling.

First, we must use data from multiple carriers (e.g. look for “Hospital System Z” in all carrier reports) and pool the variances for each line of business such that the commercial spending has a pooled variance, Medicaid spending has a pooled variance, etc.

Secondly, we must pool the variances across multiple years within each line of business to calculate the confidence intervals of the provider’s Medicaid growth. This would be repeated for the next line of business to calculate the confidence intervals of the provider’s commercial growth, and again for Medicare Advantage and all lines of business.

Thirdly, we must pool all lines of business and all years to assess a provider’s overall growth that is weighted appropriately for their mix of lines of business.

After pooling the multiple levels of variance, we then assess confidence levels at 95% and 80% using the formulae outline above.

References:

Beyene, Joseph and Moineddin, Rahim. “Methods for confidence interval estimation of a ratio parameter with application to location quotients” *BMC Med Res Methodol* 2005; 5:32.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1274325/>

Franz, V.H. “Ratios: A short guide to confidence limits and proper use” October 2007.

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Fieller, E. C. “Some Problems in Interval Estimation.” *Journal of the Royal Statistical Society. Series B (Methodological)*, vol. 16, no. 2, 1954, pp. 175-185. *JSTOR*, www.jstor.org/stable/2984043. Accessed 16 Nov. 2020.

Appendix 4

Draft VBP Compact Workgroup Charter

Draft November 2020

Charge⁴²

The Value-Based Payment (VBP) Compact Workgroup (Workgroup) is charged with ensuring the VBP Compact is successfully implemented. The Workgroup will identify paths to accelerate the adoption of VBP across the state; highlight challenges and barriers to implementation and recommend policy change and solutions; coordinate and align with other state VBP efforts; and monitor progress on achieving the Compact principles, including the VBP targets.

Goals

The primary goal of the Workgroup is to accelerate the adoption of VBPs statewide across clinical, insurance, and geographic markets. This work will support Oregon's sustainable cost growth target. The Workgroup also will provide leadership to coordinate and align with other groups focused on statewide VBP initiatives.

Deliverables

- A "Statewide VBP Roadmap" (Roadmap) that outlines a plan for implementing the Compact and is focused on lowering the rate of cost growth, improving quality and outcomes, and fostering health equity.
- An evaluation framework to monitor progress toward achieving Roadmap goals (e.g. measuring VBP's impact on achieving Oregon's cost growth target and achievement of quality measures).
- Recommendations to address challenges and barriers to VBP implementation.
- An annual public report detailing Roadmap implementation progress.

Critical Workstreams

The Workgroup will oversee a variety of workstreams necessary to achieve its goals. These include, but are not limited to:

- Workstreams directly related to deliverables:
 - Development of the Roadmap

⁴² The Compact and *Principles for Increasing the Use of Advanced Value-Based Payment Models* should guide the Workgroup's efforts.

- Monitoring and evaluating progress on Roadmap goals via the evaluation framework and annual report
- Identifying barriers to Compact implementation and making recommendations to address them.
- Other workstreams:
 - Planning for, and overseeing, delivery of technical assistance for providers and payers to support successful Roadmap implementation, including:
 - Identifying and communicating promising VBP models;
 - Identifying and sharing strategies to ensure VBP's support health equity and minimize risks of exacerbating disparities
 - Identifying opportunities for alignment across payers and providers (e.g. metrics, attribution)
 - Identifying and overseeing strategies to (a) communicate the contents to, and galvanize support for, the Roadmap and (b) develop communication resources for providers, patients, and other stakeholders
 - Identifying accountable parties for managing the bodies of work (i.e. creation of an accountability matrix).

Out-of-Scope

- Revision of Compact principles
- Negotiating payment rates
- Drafting VBP contract language
- Replicating work of other VBP-focused groups
- Political advocacy with legislature or other government entities

Responsibilities and Accountabilities

- The Workgroup is an advisory body to signers of the Compact.
- The Workgroup has a monitoring function to oversee implementation of the Compact, but it is not a regulatory body and does not have legal authority to enforce the Compact.
- The Workgroup's deliverables will be submitted to organizations that convene signers of the Compact: the Oregon Association of Hospitals and Health Systems (OAHHS), Oregon Health Authority (OHA), Oregon Health Leadership Council (OHLC), Oregon Medical Association (OMA), Public Employees' Benefit Board (PEBB) / Oregon Educators Benefit Board (OEBB). The Workgroup will provide updates to these groups at least twice per year.
- The Workgroup also will provide deliverables and updates to the Sustainable Health Care Cost Growth Target Implementation Committee at least twice per year.
- The Workgroup will send its annual report to the Oregon legislature. The Workgroup will provide additional information and updates to the legislature, as requested.
- The Workgroup will coordinate and seek alignment with other groups and efforts focused on VBP spread including, but not limited to:

- Sustainable Health Care Cost Growth Target Implementation Committee
- Primary Care Payment Reform Collaborative
- OHLC Best Practice Committee
- CPC+
- CCO 2.0 VBP requirements
- PEBB/OEBB VBP plans

Membership

Membership in the Compact Implementation Workgroup will include representation from the following organizations that have signed the Compact:

- Health plans
- Providers
 - Hospitals
 - Independent practices (large and small providers)
 - Primary care providers
 - Specialists
- PEBB/OEBB
 - Labor representation
 - Employer representation
- OHA

The Workgroup may establish temporary committees with broader membership to address specific workstreams.

The Workgroup will be no larger than 15 individuals. The following entities, which convene signers of the Compact, will select three representatives each at their discretion:

- OAHHS (hospitals)
- OHA (includes two representatives from PEBB/OEBB representing labor and management)
- OHLC (includes at least one health plan member)
- OMA (includes clinical practice)

Once the Workgroup is convened, it will select three at-large members, at least one of whom has expertise in health equity.

All members will serve for the duration of the Workgroup, or until 2024.

Staffing and Resources

The Workgroup will be staffed by the Oregon Health Authority, with resource support from participating organizations as needed. To support collaboration (e.g. in setting agendas), staffing assistance will be provided by OAHHS, OHLC, and OMA.

Meeting Logistics, Voting Rights, Decision Rules, Communication

- The Workgroup will determine rules of engagement, including decision making, meeting cadence, and communication protocols and responsibilities. The Workgroup should consider consensus-based decision making.
- The Workgroup is not a public body and is not subject to public meeting laws.
- The Workgroup will post meeting summaries on the OHLC website and consider other ways to engage and communicate with stakeholders to build trust and transparency.

Timeline

The Workgroup is chartered until 2024, in alignment with the Compact targets. After two years, the Workgroup will re-evaluate its work to ensure it has been effective and make any modifications necessary.

Appendix 5

Letter of Support from Milbank Memorial Fund



Rachel Block
Program Officer

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www.milbank.org

January 6, 2021

Jeremy Vandehey
Director, Health Policy and Analytics
Oregon Health Authority
500 Summer Street NE, E-64
Salem, OR 97301

Sent via email

Dear Mr. Vandehey:

Health care costs continue to grow faster than the economy – which means states, businesses and households have to spend more on health care and less on other essential activities. Oregon has already taken several steps to address health care costs. With this foundation in place, the Milbank Memorial Fund is now providing technical assistance to states like Oregon to systematically measure health care costs and advance coordinated strategies to slow health care cost growth. In addition to Milbank, this program is supported by the Peterson Center on Healthcare.

The key elements of Oregon’s model include:

- Providing state leadership to address health care costs and engage stakeholders to develop a statewide strategy;
- As a key component of that strategy, setting a target for health care cost growth and collecting data to monitor performance against the target;
- Analyzing health care system data to identify specific factors driving health care costs; and
- Advancing coordinated public and private actions aimed at reducing health care cost growth or making health-related investments that will help to bend the health care cost curve.

The OHA has recognized that this multi-faceted coordinated approach is important because simply tracking health care costs will not alter the trajectory of cost growth - all four elements of the strategy need to be aligned and coordinated.

The OHA’s long term commitment to health care transformation work shows this is not a short-term strategy - a sustained focus and multiple levers targeting health care cost growth will be required. Sustaining that focus means the state and stakeholders continue to commit to

achieve a shared goal – building a more sustainable health care system – and commit the necessary resources to implement the strategy.

As reflected in the Sustainable Health Cost Growth Implementation Committee’s recommendations, the Oregon Health Authority has already made significant progress on many of these fronts. I look forward to working with you on this next important phase of the state’s sustainable health care cost work.

Sincerely,

Rachel Block

Rachel Block, Program Officer



HEALTH POLICY AND ANALYTICS

Office of Health Policy

Email: HealthCare.CostTarget@dhsoha.state.or.us

You can get this document in other languages, large print, braille, or a format you prefer. Contact External Relations Division at 503-945-6691 or email OHA.ExternalRelations@state.or.us. We accept all relay calls, or you can dial 711