Exhibit: SB 1529 RAC - Primary Care Provider Assignment discussion material

Primary Care Payment Reform Collaborative
Primary Care Value-Based Payment Model

1) Base payment model

- Start the value-based payment (VBP) model design process with the following 2018 PCPRC recommendations:
    1. An all-payer primary care payment model aligned with CMS' (then) Comprehensive Primary Care Plus (CPC+) model, which includes the following payment model components:
        - Risk-adjusted advanced infrastructure payments
        - Performance-based incentive payments
        - Fee-for-service payments
        - Prospective payments (capitated or lump sum) for a defined set of primary care services
- Instead of pursuing a second primary care and behavioral health integration payment model, the Workgroup opted to draw behavioral health integration into the above model. (For further details, see VBP model sections on "infrastructure payments" and "aligned quality metrics.")
- A total cost of care (TCOC) shared risk arrangement between larger provider organizations and payers is not part of the primary care payment model but may be employed as a complement to the primary care payment model if mutually agreeable to the parties. A measure of TCOC should be incorporated as part of a practice's incentive payment where feasible and appropriate. (For further details, see VBP model section on "value incentives and rewards.")

2) Defining primary care practices and prerequisites for the VBP model

- Payers may choose to require Oregon Patient-Centered Primary Care Home (PCPCH) recognition for practice participation in the VBP model. If PCPCH recognition is not required for initial practice participation it must be obtained within three years.
    1. Practices should receive a strong recommendation to become PCPCH-recognized before engaging in VBP models.
    2. Payers should incentivize and reward PCPCH certification for practices with which they contract through supplemental payments (see recommendation #10 "infrastructure payments" further below).
- No other practice participation prerequisites should be required for participation in the model.
    1. Minimum practice size thresholds should not be applied.
    2. Performance pre-qualifications, e.g., quality measures, should not be applied.
- Phase-in period for practices: The phase-in for the VBP model should happen organically, with a goal of all practices phasing in within three years in a manner to be decided among payers and practices.

3) Defining primary care services to include in capitated payments for the VBP model

Guiding principles for services included

- The VBP model design should focus on services provided, not on specific provider types, allowing for inclusion of services provided by a diverse array of care team members.
- Guiding principles for whether services should be included in or excluded from the capitated service payments are as follows:
    1. Include services that are:
        - Widely performed by primary care practices
        - Represent a preponderance of primary care spending
        - Prone to overuse when paid fee-for-service
    2. Exclude services that are:
        - Performed at widely varying rates among providers and/or offered inconsistently
        - Subject to potential underutilization and where there is interest in incentivizing increased volume

Common code list of all services that will be included in the primary care capitation payments

- In addition to the principles outlined above, the Workgroup's recommendations were informed by an analysis of which codes health plans currently include in primary care capitation contracts, and which codes/services comprise the largest amount of total primary care spending in the commercial and Medicaid markets.
- The majority of Workgroup members agreed on including the following codes in primary care capitated payments for the VBP model:
    1. Office or outpatient visit for an established patient (99211-99215)
    2. Office or outpatient visit for a new patient (99202-99205)
    3. Telephone calls for patient management (99441-99443)
    4. Prolonged physician services (99354, 99355, 99358- 99360)
    5. Preventive medicine counseling or risk reduction intervention (99401-99404)
    6. Preventive medicine initial evaluation (99381-99387)
    7. Preventive medicine periodic re-evaluation (99391-99429)
    8. Administration of immunizations (90460, 90461, 90471-90474)
    9. Transitional care management services (99495, 99496)
    10. Medical team conference (99366-99368)
    11. Therapeutic, prophylactic or diagnostic injection (96372)
    12. Group preventive medicine counseling or risk reduction intervention (99411, 99412)
    13. Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes, 11-20 minutes, 21 or more minutes (99421, 99422, 99423)
    14. Non-face-to-face online medical evaluation (99444)
    15. Non-physician telephone services (98966, 98967)
    16. Online assessment, management services by non-physician (98969)

17. Annual wellness visit, personalized prevention plan of service (G0438, G0439)
18. Comprehensive geriatric assessment and treatment planning performed by assessment team (S0250)
19. Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month (S0320)

- All other codes are excluded from the primary care capitated payments.
- Behavioral health services should not be included in the capitation rate, and should instead be paid for using FFS payment, given that behavioral health services are provided with high variability across practices. A behavioral health infrastructure payment should be considered to support integrated behavioral health services not typically paid for under fee-for-service mechanisms.

4) Attribution and PCP selection

- An effective methodology for patient attribution is essential to the success of a prospective payment model covering a defined set of primary care services models. Providers accept accountability for managing a majority of care for their patients and to do so must know which patients are matched with which providers. Attribution forms the basis for measuring performance of physicians and provider groups, reporting data, and paying for patient care.
- The Workgroup revisited the attribution principles from the 2018 PCPRC report (Appendix B), which were developed to foster alignment and transparency on methodology, and to ensure outcome metrics associated with VBPs accurately reflect a clinic's patient population.
    a) Prioritize patient choice – always ask the patient for PCP in enrollment information (even if not "required" by the health plan).
    b) If the patient does not choose a PCP, attribute the patient to a provider based upon utilization/attribution process (as defined in Attachment B).
    c) If the patient chooses a PCP, but then has predominant utilization with another primary care provider, assign the patient to that provider and communicate to the patient opportunity to re-select their preferred PCP.
    d) If no patient choice and no prior utilization, assign all patients to primary care providers to enable the best opportunity to serve the entire insured population.
- The Workgroup will consider adding one additional principle to the 2018 Attribution Principles for the purposes of specifying the primary care VBP model.
    - Payers should have a patient correction process and work in partnership with providers to correct inaccurately attributed patients.

5) Prospective payment rate development methodology

- Analysis of historic per-member per-month (PMPM) spending should occur according to the following guidelines:
    1. For larger providers, payers and providers may agree to develop practice-specific rates on a case-by-case basis, or utilize a standard PMPM capitation rate based on a market-wide calculation.
    2. For smaller providers, payers may offer a standard PMPM capitation rate based on a market-wide or small practice-only calculation.
    3. Payers may also offer PMPM capitation rates specific to practices with special patient profiles, e.g., children with high medical complexity.
    4. Additional considerations:
        - The Workgroup acknowledged the challenge that certain services performed inconsistently across practices may fall under a general office visit billing code, and including the office visit billing code in the capitated payment may not guarantee adequate revenue for all services that fall under that code[1]. Therefore, looking at historic PMPM spending on a *practice-specific* basis may be the preferred approach to ensure adequate revenue for all services that fall under a general office visit code.
        - The Workgroup also acknowledged the limitations with developing payment rates based on historical spending, as such rates will reflect only the specific services that payers have traditionally covered and previous patterns of utilization. Therefore, prospective payment rates should include an additional increase to compensate for all capitated procedure codes not historically reimbursed by a given payer.
            - Pending adoption of this recommendation, OHA will ask the payers who do cover these services to confidentially share with OHA the associated PMPM costs in order to inform an adequate payment level for service codes included in the capitation payments.
- To ensure that capitation payments are accurate and fair to both payers and practices, payers should:
    1. apply monthly re-attribution to shift the prospective payment to a new primary care practice as quickly as possible, and
    2. monitor the percentage of primary care services delivered to attributed members outside the primary care practice and inquire of outlier practices.
- Rates should be updated annually and consider additional requirements and services provided by primary care.
- Payers should provide a general description of the rate methodology to providers using a common template to be developed by OHA.

[1] Workgroup members cited the following example: Most medication-assisted treatment (MAT) visits are billed under 99214 or 99215 (office or outpatient visit for an established patient, 30-39 or 50-54 minutes) but not all practices do MAT visits.

6) Accounting for patient cost-sharing in rate development

- Capitated payments should be adjusted to remove patient cost-sharing obligation, rather than paid using full "allowed" amount, with a subsequent retrospective deduction of the patient cost-sharing obligation. This approach anticipates the practice will receive additional revenue directly from the patient regarding services provided.

7) Risk adjustment

- Demographic risk adjustment: At a minimum, payers should risk adjust prospective primary care capitation payments and infrastructure payments based on age and sex.
- Clinical risk adjustment:
    1. For any application of clinical risk adjustment, separate methodologies should be used for adults and pediatric populations using a validated methodology specific to that population, as available.
    2. Clinical risk adjustment should be used when measuring a practice on total cost of care.
        - As noted under the "base payment model" section, a total cost of care shared risk arrangement between larger provider organizations and payers is not part of the primary care payment model but may be employed as a complement to the primary care payment model if mutually agreeable to the parties.
    3. Clinical risk adjustment should be optional for prospective primary care capitation.
        - *Considerations in favor of applying clinical risk adjustment*: Adjusting payments based on a clinical risk score can help ensure a more accurate estimate of how much it will cost to care for a patient population based on the patients' conditions. In addition, risk-adjusted capitation payments that reflect the relative clinical risk of the patient panel could result in higher capitated payments to providers who treat patients with greater health care needs.
        - *Limitations of clinical risk adjustment*: A commonly accepted methodology to estimate how much primary care someone needs based on their medical condition(s) does not yet exist.
            - Prospective payment rates can instead be calculated based on historical utilization with an additional payment increase to compensate for capitated procedure codes not historically reimbursed by a given payer, as described in the section on "rate development methodology".
    4. Clinical risk adjustment should be used for at least certain infrastructure payments.

- The risk adjustment methodology should include some parameters, including ensuring a limited amount of variance on payout amounts based on risk scores.
- Payers may limit the use of clinical risk adjustment to only apply to infrastructure payments that entail care management and other services involving support for patients with higher medical complexity.

- Social risk adjustment

1. OHA will convene a subcommittee of parties interested in developing a social risk adjustment pilot model. The subcommittee, in partnership with content experts, will identify and review social risk adjustment research, including methodologies in use nationally and in Oregon.
2. The proposal for subcommittee consideration includes the following:
    - Establish principles to guide the work.
    - Recommend a pilot to the VBP Model Development Workgroup, including social risk adjustment methodology, payer and provider participants and evaluation plan.
    - Explore funding opportunities for the pilot.
    - Implement and monitor the pilot.

8) Value incentives and rewards

- Practices should be rewarded for both high performance relative to external benchmarks and for improvement over time.
    1. External benchmarks can be national HEDIS benchmarks, statewide CCO benchmarks (for Medicaid), or statewide insurer-specific network benchmarks and aligned to the local environment. Performance criteria used in HEDIS measures, such as continuous enrollment, needs to be recognized in benchmark setting, and adjusted, depending upon the source of data.
    2. Improvement rewards should be equivalent to high performance rewards in order to provide a strong incentive for practices with lower performance scores to improve.
    3. Improvement targets should represent meaningful improvement and be reasonably attainable.
    4. Practices identified by payers as serving patient populations with unusually high medical and/or social risk may be held accountable only for improvement if the payer and practice agree that external benchmarks are not applicable.
    5. Measures for which there have been substantial specification changes are temporarily removed from the incentive methodology until new practice-specific and external benchmark data are available.

- Total eligible incentive payments should equal at least 10% of the value of annual projected practice service payments (capitated + fee-for-service) for the practice's attributed patients.

1. This doesn't mean the practice will earn the full 10%, but that it would do so if it met all incentive metrics.
2. Payers for which eligible incentive payments currently equal less than 10% may transition to 10% over three years.

- Incentive payments should be made as proximate to the practice's actions to achieve rewards as soon as possible.
    1. Payers should make certain reward payments during the course of the performance period if feasible, rather than at the end of the performance period, in order to ensure sufficient and sustainable resources for performance improvement investments.
    2. One suggested technique is to tie reward payments to delivery of specific services, e.g., bonus payment for each claim related to a prescribed screening.
    3. *Note:* Different methods can be used for different metrics. Some metrics might still be assessed for the calendar year after the year is complete if that is the most appropriate method.
- Incentives should be tied to a common set of performance measures used by commercial and Medicaid payers, with flexibility for limited use of common Medicaid-specific measures by CCOs.
- The methodology used to determine performance incentive payments should incorporate a measure of primary care practice performance managing total cost of care for its attributed adult-only population. The measure should be applied only for those practices with sufficiently large attributed populations, and with mechanisms to protect against the impact of random variation.

9) Aligned quality metrics

- A subgroup of the PCPRC should establish an aligned primary care measure set for the VBP model with a balance of child, adolescent and adult-focused measures. This aligned measure set should primarily be derived from the HPQMC's (or successor body's) primary care-focused measures, recognizing that the denominator definitions of the HPQMC measures will need to be modified to be applicable to primary care practices. Flexibility should be afforded for the consideration of non-HPQMC primary care-focused measures.
- Workgroup members recommended that the following parameters guide the work of the quality metrics subgroup:
    1. The total size of the primary care aligned measure set should not exceed eight measures.
    2. The subgroup may establish a menu of primary care measures for contractual performance incentive use by practices and payers at their discretion, and a smaller core set for use in all payer-practice contracts.
    3. The subgroup may establish different core measure sets for child and adolescent measures and for adult-focused measures.
    4. The subgroup should consider including at least one equity-focused measure in the aligned measure set menu.

5. The subgroup should consider including at least one measure assessing behavioral health integration in the aligned measure set menu, recognizing that there is currently a dearth of standardized measures that sufficiently capture behavioral health integration outcomes. Payers should consider focusing on structural and process measures that are likely to result in improved care, and the subgroup may consider any newly developed standardized measures for inclusion over time.

- The VBP model should specify that payer contracts should not include any quality incentive measures beyond those in the aligned primary care measure set.
- Payers and providers should endeavor to stratify quality metrics by REALD and SOGI as data allows.
- The quality metrics subgroup should meet annually to make updates due to changes in measure steward specifications, national measure endorsement, and/or changes to the composition of state-level measures.
- Every third year, the quality metrics subgroup should consider changes that reflect changing priorities and opportunities for improvement.

10) Infrastructure payments

- Infrastructure payments to all practices participating in the VBP model should include the following components:
    1. A base payment tied to Patient-Centered Primary Care Home Program (PCPCH) tier, which includes payments to non-PCPCH practices that are actively seeking to obtain PCPCH recognition; and
    2. Additional payments, as agreed upon by the payer and practice, for specific high-value services. These additional infrastructure payments should be for: a) services that are not already paid for via the PCPCH program, or b) services that are included in the PCPCH program where the practice has identified a need for additional financial support for implementation or sustainability. Examples of such services include, but are not limited to, the following:
        - Additional care management and care coordination supports for patients with higher levels of medical and social risk;
        - Traditional health worker services, including services from peer support specialists, peer wellness specialists, personal health navigators, community health workers, and doulas;
        - Integrated pharmacist services, such as medication consultations;
        - Addressing health-related social needs (HRSN), such as through HRSN screenings and supporting collaboration and data-sharing between primary care practices and social services organizations;
        - Infrastructure (technology and staff) to collect and use REALD and SOGI data;
        - Integrated behavioral health services not typically paid for under fee-for-service mechanisms; and

        - Innovative equity-focused services in response to an identified practice or community-specific need (e.g., funding for bus fares for patients with transportation needs).

- For services that fall under the second category of infrastructure payments which are also included in the PCPCH Recognition Standards, validation of the level of service for PCPCH-recognized practices should be tied to the corresponding PCPCH standard and measure, rather than via a separate or additional validation process.
- A primary care practice is eligible to receive an add-on to any infrastructure payment if the practice meets at least one of the following set of standards, which should include a minimum threshold for behavioral health clinician staffing ratio or population reach percentage:
    1. Patient-Centered Primary Care Home Measure 3.C.3: PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers[2]
    2. Integrated Behavioral Health Alliance (IBHA) Recommended Minimum Standards for PCPCHs Providing Integrated Health Care (https://cobhc.org/wp-content/uploads/2023/02/IBHA-Minimum-Standards-2.0-02062023.pdf)

11) Strategies to Protect against Unintended Adverse Consequences

- Payers and providers can consider a menu of strategies to help protect against potential unintended adverse consequences resulting from prospective payment (see Attachment C).

[2] Specifications for Patient-Centered Primary Care Home Measure 3.C.3 can be found in the PCPCH Recognition Criteria Technical Specifications and Reporting Guide: https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2020-PCPCH-TA-Guide.pdf.

Attachment A. Primary Care Value-Based Payment Model Principles

1. Support the unique needs of adult and pediatric populations to ensure equitable access to, and delivery of, care.
2. Support practices to provide the full scope of care patients need to address medical and social complexity, while not disincentivizing them from serving complex patients.
3. Align models and metrics across payers to ease administrative burden on practices and maximize healthcare teams' impact on health outcomes, while allowing for flexibility in implementation by diverse types of practices.
4. Support interdisciplinary teams to provide team-based care.
5. Support ability of practices to build and invest in partnerships with community-based organizations to increase patient access to services that address health-related social needs and social determinants of health.
6. Include metrics that are evidenced-informed and parsimonious; address all populations served by PCPCHs; have reasonable benchmarks and improvement targets; and incorporate total cost of care and financial sustainability.

Attachment B. Attribution principles from PCPRC 2018 Progress Report

Payers, purchasers, providers and patients will adopt the following principles for patient attribution to ensure more effective VBP-based investment in primary care. The intent of these principles is to foster alignment and transparency on methodology, and to ensure outcome metrics associated with VBPs accurately reflect a clinic's patient population.

1. Payers will adopt policies such as lower patient cost sharing, transformation in benefit design, and educational efforts to encourage patient choice of a primary care provider.
2. Payers, providers and patients will work together to develop and implement strategies to ensure that patients who want to identify their primary care providers can, and this patient choice will be prioritized for attribution, regardless of business line of coverage for those patients.
3. Payers, providers and patients should work collaboratively to ensure accuracy and agreement about patient attribution. Payers will ensure providers have clear and actionable information about patients assigned to them and providers will ensure the accuracy of the claims data they submit that support the attribution process. This information should be shared by payers at least quarterly.
4. Payers will use the same approach for attribution for performance measurement and financial accountability.
5. Payers will prioritize primary care providers and preventive care visits when analyzing claims or encounter data for attribution, and may consider other factors such as geographic location, family selection of primary care provider, and past claims.
6. Payers will use other claims-based evaluation and management visits if patient input cannot be obtained and preventive care visits cannot be used, and link those visits with primary care provider types. At least 24 months of claims-based data should be used, if available.
7. Payers will define which providers would be eligible to take on accountability for patients at the beginning of the performance period, and share this information with providers in advance. Identify clearly who can serve as primary care providers (for example, could recommend all providers in recognized PCPCHs).
8. To support payer alignment and ensure accurate attribution — which allows for proper VBPs being made to a provider or clinic — providers agree to work in good faith with payers to ensure billing practices allow for submission of complete claims data to payers.
9. The Collaborative will consider alignment across payers at level of attribution (clinic vs. individual provider).

Attachment C. Strategies to Protect against Unintended Adverse Consequences

Every payment model creates financial incentives. While a primary care capitation model is designed to alleviate some of the perverse incentives of fee-for-service payments (e.g., lack of flexibility in care delivery, the need for office visits for generate income), the model also introduces potential risks and challenges of its own. Specifically, a prospective payment model creates financial incentives that may lead to the following risks:

- Withholding or limiting care: Providers may withhold or limit care (i.e., inappropriately under-treat), either by reducing care delivered directly, or by reducing access to care for their panel (e.g., making it difficult to obtain appointments, being slow to return telephone calls). In addition, practices could take on more patients than they can realistically care for, resulting in limited appointment availability.
- Discouraging a panel of high morbidity patients: Providers may encourage a panel of healthier patients and/or to discourage practice selection by high morbidity patients. By doing so, providers will produce low demand for services under the capitated rate.
- Making too many specialty, urgent care and ED referrals: Providers may refer patients to specialist, urgent or emergency care when they can be more appropriately treated in the primary care setting. By so doing, the practice shifts the cost of delivering care to other providers, while retaining payment for the primary care practice.

The following is a menu of strategies that payers and providers can consider to help protect against potential unintended adverse consequences resulting from prospective payment:

- ***Strategies to mitigate against withholding care***

    1) Exclude from prospective payment, and then pay more for, care delivered outside of normal care delivery hours (using existing codes) to incentivize expanded access.
        - Note: The current Workgroup recommendations specify that codes for billing after-hours services (99050-99051) and the visit code be excluded from prospective capitated payments so as to incentivize the provision of after-hours care.
    2) Establish suggested thresholds for an acceptable panel size, recognizing that even those practices that maximize use of team-based care with practitioners operating at the top of their license can capably serve only so many patients. If thresholds are exceeded, this could trigger a conversation between the provider and payer to help identify when a practice may be over capacity.
    3) Use available payer data to identify early indicators of decreased access, or signs of potential withholding care.
        - Identification efforts could include:
            - using patient experience survey questions regarding access to care,
            - tracking trends in visit volume or patient engagement 'touches' over time, including via the different modes for care delivery (e.g., telehealth, group visits, etc.)
            - monitoring the availability of care outside of regular office hours, and/or

        - evaluating attributed patient voluntary turnover rates and investigating the reasons for patients exiting a practice.
    - Payers should ensure transparency if engaging in any of these approaches, including communicating the use of any approaches and sharing data with practices.
    - Payers and providers should collaborate regarding corrective action when measures and follow-up conversations indicate the need to do so.

- ***Strategies to mitigate against withholding care and discouraging a panel of high morbidity patients:***

    1) Adjust payments so that practices that treat patients with higher medical and social complexity are paid more relative to those that do not.
        - Risk-adjusted capitation payments that account for medical and/or social risk factors (in addition to age and sex) are meant to reflect the relative risk of the patient panel and could provide additional resources to providers who treat patients with greater care needs.
        - Additional supplemental payments could be provided to those primary care practices serving populations objectively identified as possessing higher needs. This could take the form of supplemental payments for care management.
        - Performance-based incentive payments could be tied to measures of quality for higher medical complexity patients.

- ***Strategies to mitigate against making too many specialty, urgent care and ED referrals***

    1) Track patterns of specialty care, urgent care and ED use and discuss observed aberrant patterns with practices.
    2) Incorporate TCOC as part of a practice's incentive payment where feasible and appropriate.