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Division of Financial Regulation
Department of Consumer and Business Services
350 Winter St NE
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RE: Feedback for Rules Advisory Committee on Primary Care Provider Attribution

On behalf of Providence, I want to thank you for the opportunity to share the organization's feedback on the Primary Care Provider (PCP) attribution rulemaking process, mandated by Senate Bill 1529 (2022). Providence supports policy objectives of SB 1529, and this rulemaking process will aid the organization's mission to ensure access to high-quality and affordable health care for Oregonians.

Providence agrees that assigning members/patients to providers is necessary for the encouragement of value-based care arrangements throughout Oregon. We also believe it must be done thoughtfully and in a manner that effectively encourages provider accountability. It is imperative that patients are accounted for in the health care system to achieve overall quality and cost objectives. As Oregon moves this work forward, we must ensure that our process for attribution is patient-centered and encourages growth in value-based care adoption. Below are a couple of strategies we can adopt to ensure this occurs.

"Primary Care Physician" Definition and Scope

Based on existing attribution models, and the way this work is done in other markets like Medicare Advantage, Providence would recommend that the Division address which provider types are eligible for patient assignment in the broadest terms possible.

For example, the rules should permit attribution of patients at either the provider or clinic level. Provider business models and the terms upon which they are willing to enter value-based care contracts differ. Providence is not a closed system. Our experience working with provider practices of different sizes indicates that value-based care adoption will benefit from flexibility in the ability to assign patients at either the practitioner or clinic level. Clinics benefit from this method of attribution because it allows for team-based allocation, helps navigate access challenges where capacity is limited, and simplifies cases in which patients change PCPs within

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the same clinic. The ability for carriers to attribute patients to PCPs at a clinic and individual level will facilitate the ability for providers to efficiently allocate care, mitigating potential barriers to access.

Providence also recommends deferring to general statutory language with respect to which providers can be selected by members as PCPs or assigned by a carrier, as opposed to limiting carrier attribution or provider eligibility by rule. The statute says:

> **"primary care provider" means an individual licensed or certified in this state to provide outpatient, nonspecialty medical services or the coordination of health care for the purpose of:**
> **(a) Promoting or maintaining mental and physical health and wellness; and**
> **(b) Diagnosis, treatment or management of acute or chronic conditions caused by disease, injury or illness.**

The first portion of that language is specific to "nonspecialty" providers. The second portion seems to refer to other providers that are focused on coordination of care. Only certain specialties are generally focused on care coordination, and there are generally accepted services that fall within traditional conceptions of "primary care." A good reference source with which many advisory committee members will be familiar is the OHA Primary Care Spending Committee report (https://www.oregon.gov/oha/HPA/ANALYTICS/PCSpendingDocs/2020-Oregon-Primary-Care-Spending-Report-Legislature.pdf) which lists primary care codes on pg. 40 and provider types that they considered to be "included in primary care" on pg. 9.

Attribution Methodology

Wherever possible, attribution should be based on the patient's choice or, in the absence of a patient selection, utilization history. There is one aspect of the Value-Based Payment Workgroup's recommendation that is inconsistent with that principle. Principle (c) indicates that carriers should override a patient's affirmative PCP selection if their utilization patterns are with another provider and offer an opportunity to "re-select" the original assigned PCP. We disagree and believe that doing so would be inconsistent with principle (a) requiring prioritization of patient choice. We believe that if a patient is consistently seeing a PCP other than their assigned PCP, and the carrier believes a change should occur, the carrier should not make a change without communicating with the member and provider in advance. Such a system upholds a patient's choice of preferred PCP while simultaneously informing them of any discrepancies, thus prompting informed PCP attribution. Principle (c) could be removed entirely and this would likely occur, but at a minimum we would suggest requiring communication and assent in advance of making a change to a member's selected PCP.

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Regarding principle (d) and the requirement to assign member in the absence of utilization data, we do appreciate the concerns raised by other carrier participants regarding provider capacity, systems limitations, protected health information, and the inherent inaccuracy of patient preference in attempting to assign members by geography. However, the text of SB 1529 likely does not leave room for leaving members unassigned. It says an insurer "must assign a beneficiary under the policy or certificate to a primary care provider if the beneficiary or a parent of a minor beneficiary has not selected a primary care provider by the 90th day of the plan year." This policy was intended to push carrier practices and product offerings (and employer purchasing) toward PCP-aligned products that comprehensively enable value-based care for the commercial market. While the policy may be disruptive, our understanding of the legislative intent is the disruption was an intentional nudge toward expanded provider risk arrangements.

Even so, effective assignment of members in the absence of utilization history is challenging. Our experience aligns with the statements of other carriers that 30% of members either do not select a PCP or have no utilization upon which to base an assignment. In the case that patients lack utilization history, Providence is in favor of allowing carriers to develop their own attribution methodologies and does not believe that the means of doing so should be prescribed in rule. Carrier attribution methodologies will inherently focus on geographic proximity and provider capacity, to the extent that information is available. Other factors, such as whether a proximate provider with capacity is or is not in a value-based care arrangement, may also be considered. It is important that the Division and all stakeholders understand that the industry lacks effective methods to keep and exchange real-time information on provider capacity. Instances where a member is assigned to a PCP and upon attempting to establish care learns that the PCP is not taking patients will occur. Each carrier should be prepared to engage their member when that occurs and help them find a PCP with capacity.

Providence has been a leader in supporting primary care medical homes for nearly a decade, collaborating with the state and the broader industry to support PCP-centric care models. These models, including member assignment, lead to improved quality and meaningful access changes. We appreciate the opportunity to participate in this conversation.

Sincerely,

/s/

Aaron Bals
Chief Compliance & Risk Officer