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Reply to:
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Lisa Emerson
Senior Health Insurance Programs Analyst
Department of Consumer and Business Services, Division of Financial Regulation
PO Box 14480
Salem, OR 97309

SENT VIA EMAIL

RE: Comments on Primary Care Payment Reform Collaborative Primary Care Value-Based Payment Model

Dear Mrs. Emerson:

Thank you for the opportunity to provide comments on the Primary Care Payment Reform Collaborative Primary Care Value-Based Payment (VBP) Model.

We appreciate the DFR's efforts soliciting feedback before drafting the rules. While there are some sections of the VBP Model that are not concerning, there are other sections that we would like the DFR to either not adopt the VBP recommendation or rewrite it such that it benefits both the consumer and payer/provider. We believe it's achievable. In addition, there are other sections which we are seeking further clarification to better understand the purpose and how both the payer and provider can operationalize it.

While the VBP Model doesn't address privacy concerns, we also have significant concerns about how complying with SB 1529 PCP assignment requirement will lead to HIPAA violations. Currently, our process of attribution involves the sharing of Protected Health Information (PHI)/Personally Identifiable Information (PII) with providers for their attributed population only when there is an established relationship between the provider and the patient based on either the patient's own direction (i.e., PCP selection) or through incurred claims. SB 1529 and the VBP Model recommendations force PCP assignment in certain cases, but do not address the HIPAA violations it creates across payers and providers because there will not be any proof of an existing relationship that would allow disclosure of PHI/PII. DFR must address the HIPAA compliance issues through this rulemaking. The cleanest way to address these concerns would be to only require PCP assignment if there is an existing provider/payer relationship.

We look forward to working with the DFR and Rule Advisory Committee (RAC) to adopt recommendations that make sense to operationalize and does not overwhelm a system currently unable to handle consumer requests for access to care because the PCP is either not taking any new patients or there is a long waiting period before they can be seen by a PCP.

Defining Primary Care Practices and Prerequisites for the VBP Model

Second Bullet: This mentions no additional prerequisites for Provider participation being available including no minimum practice thresholds. In the Base Payment Model, there is mention of "risk-adjusted advanced infrastructure payments." Without minimum practice thresholds in a number of patients, how are Payers expected to establish risk adjustment to Providers with patient populations too small to make risk adjustment statistically sound?

Attribution and PCP Selection

Second Bullet:

- Sub bullet (b) – This is a regression from our current methodology. We attribute less people following three claims versus our current 1 claim.
- Sub bullet (c) – If a patient chooses a PCP, but then has predominant utilization with another PCP, we prefer that the patient keep the PCP they chose rather than the plan assign the patient to the provider that the patient has predominant utilization with. In the alternative, we recommend a process where the plan reaches out to the patient to confirm they want to stay with the PCP rather than force the plan to assign them another PCP based on predominant utilization. Any process will also increase administrative costs for resourcing any type of outreach.
- Sub bullet (d) – This is very vague with respect to the method of assignment. Is the method up to the Payer? Will it be acceptable for the Payer to not assign a patient? We believe there should be some kind of provider/patient established relationship for PCP assignment. Is there a recommended approach to establish a patient and provider relationship in the absence of empirical data (i.e., claims or patient selection)?

Third Bullet:
How is "inaccurate" defined for the assigned population who are assigned without claims or patient communication? The latter two methodologies are well defined, but the assignment is up to interpretation which could mean there isn't the possibility of inaccuracy. How is it recommended to avoid positive selection by Providers to cherry-pick patients for the assigned population?

Prospective Payment Rate Development Methodology

Second Bullet: This will increase administrative costs due to constant reconciliation of monthly payments (and billings to commercial customers) due to common volatility from claims processing, eligibility, etc.

Accounting for Patient Cost-Sharing in Rate Development

We read this to mean the plan will make the Provider whole for their services without considering the patient's cost share. If our understanding is accurate, this would seem to increase the total cost of care. This could also incent Providers to prioritize access to patients who will have higher cost shares and/or who they deem more likely to pay, which would adversely affect underserved and underrepresented communities.

Thank you.

Sincerely,

A. Awuakye

Antoinette Awuakye
Senior Public and Regulatory Affairs Specialist

Cc: Mary Anne Cooper, Omar Amezquita