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Lisa Emerson
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Division of Financial Regulation
Department of Consumer and Business Services
350 Winter St NE
Salem, OR 97301

RE: Feedback on Rules Advisory Committee Proposed Language 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 draft rules shared at our last Rules Advisory Committee Meeting. Providence supports the 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 to encourage value-based care arrangements throughout Oregon. It must be done thoughtfully and in a manner that encourages provider accountability. The industry must account for patients in the healthcare system to achieve overall quality and cost objectives. As Oregon continues this work, we must ensure that our process for attribution is patient-centered and encourages growth in value-based care adoption. The proposed language from the previous rulemaking advisory committee meeting meets many of Oregon's and Providence's shared objectives. We have two suggestions to further improve the Division's rules.

The rules should permit provider group/clinic-level attribution

Providence recommends that the Division make slight changes to ensure it is clear that a member may be assigned to either an individual provider or a provider group. That clarification would be consistent with existing attribution models and practices in both commercial and Medicare Advantage lines of business.

Provider business models and the terms to which they enter value-based care contracts vary. Providence is not a closed system, and our experience working with provider practices of different sizes and affiliations indicates that value-based care adoption will benefit from the flexibility that allows patient attribution at either the practitioner or clinic level. Clinics benefit from this attribution method, because it allows for team-based allocation, helps navigate access challenges where capacity is limited, and simplifies cases in which patients change PCPs within the same clinic. Some clinics may be reluctant to enter value based care arrangements without this flexibility.

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This clarification could be made any number of ways. One apprach could be to amend the definition of "primary care provider" within the proposed language to say: "Primary care provider" means an individual **or group of individuals** licensed or certified in this state to provide outpatient, non-specialty medical services or the coordination of health care [...]." If it is preferable not to deviate from the statutory definition of "primary care provider" in rule, another approach could be to state outside of the definitions that a carrier may assign to an individual or group of individuals who are "primary care providers."

Carriers should exercise discretion when prompting changes to a member-chosen PCP assignment

Providence appreciates that the Division has proposed to allow insurance carriers to prompt beneficiaries with utilization contrary to their PCP assignment with the option to change their selection. However, this should be a "tool in the toolbox" to ensure appropriate assignment, rather than a requirement. The proposed language can be read as a carrier requirement:

> "If the enrollee chooses a primary care provider, but has predominant claim utilization with a different primary care provider, the insurer **will** communicate with the enrollee the opportunity to select the primary care provider with predominant claim utilization."

Having the option to contact beneficiaries that predominantly visit a provider other than their assigned PCP is a useful tool to facilitate the allocation of care. However, requiring carriers to suggest reassignment to enrollees when they have made an affirmative choice of PCP contradicts the consensus principle discussed in the value based care workgroup as well as the rules advisory committee to prioritize patient choice. Furthermore, the requirement that insurers pursue every single member that fits the above criteria creates an excessive administrative and compliance burden for carriers. Complying with the above language would require carriers to allocate resources that they could better use for the benefit of their enrollees. Providence, therefore, recommends that the Division edit the excerpted language to say ". . . The insurer **may** communicate with the enrollee . . ."

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, Providence Health Plan