Prepared by
Legislative Policy and
Research Office

Universal Access to Primary Care Work Group

Report and Policy Proposals

November 2020

UNIVERSAL ACCESS TO PRIMARY CARE WORK GROUP

TO: House Interim Committee on Health Care
FROM: Rep. Rachel Prusak, Rep. Raquel Moore-Green
DATE: November 24, 2020

Chair Salinas, Members of the House Committee on Health Care, and interested parties:

As members of the Oregon House of Representatives serving on the Universal Access to Primary Care Work Group, we want to provide additional context for the conversations that took place in the work group beginning last spring and ending in late October.

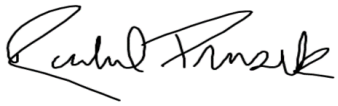
The Universal Access to Healthcare Work Group met over the course of 2018, and one of its recommendations for advancing toward the goal of a universal coverage system was a universal system of primary care for all residents. The work group encouraged the legislature to discuss this concept further in the 2019 session. Representative Prusak agreed to undertake this task and formed the work group on Universal Access to Primary Care.

We know access to primary care influences an individual's overall health and well-being, but many people encounter barriers that challenge this access. Our work group took the next step to break down those barriers. We also know policy interventions that improve access to comprehensive primary care include enhancing behavioral health and oral health, and in turn, these interventions reduce overall health care costs. We are proud of our work group because despite many of the members being health care clinicians working on the frontlines during a pandemic, they showed up. They know that the barriers that exist for the communities they serve, both rural and urban, are very real and must be addressed.

The following report will shed light on our research and findings. The data demonstrates that enhancing equitable access to primary care services will improve the health of Oregonians and reduce our state's health system costs. As a group, we believe access to comprehensive primary care must include better quality care and health outcomes than our current primary health care system delivers. We also recognized the importance of the entire primary care team having the ability to engage in care and that removing barriers to accessing behavioral health care on the same day as primary care will have great impacts on access to comprehensive care.

To make progress toward this goal, the Universal Access to Primary Care Work Group agreed we must advance policies that will increase access to and affordability of comprehensive primary care, increase support for and participation in Oregon's PCPCH model, expand and invest in telehealth, and finally advance alternative payment models across all payers.

We appreciate the opportunity to have co-chaired this outstanding group of professionals, and we hope that this work will advance policy that helps all Oregonians access primary care. Thank you.



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EXECUTIVE SUMMARY

In January 2020, Representative Salinas, Chair, House Committee on Health Care, created the Universal Access to Primary Care (UAPC) Work Group (announcement). Representatives Prusak and Moore-Green led the work group, which comprised twenty members who represented a wide-ranging set of primary care stakeholders, including primary care practitioners, behavioral health specialists, specialty providers, health system representatives, coordinated care organizations (CCOs), payers, and a patient advocate. The work group was tasked with developing proposals to move Oregon towards universal access to comprehensive primary care, based on available data and building on the body of existing research and current state reform initiatives. The work group was specifically tasked with considering and prioritizing:

1. policy options to ensure affordable primary care services are accessible to all residents;
2. identifying primary care models that provide access to comprehensive primary care for the communities they serve (e.g., behavioral and oral health); and
3. determining factors that influence the potential implementation of a system of universal primary care.

The work group met monthly from May through October to develop a set of primary care policy proposals. The logistics and focus of the work group were impacted by the novel coronavirus (COVID-19) pandemic. The initial meetings in March and April were cancelled, which compressed the timeline available for the work group to complete its work. There was an explicit recognition that the pandemic highlighted many pre-existing issues in primary care that the public health crisis exacerbated, including the vulnerability of primary care provider reimbursement and revenue models, inconsistent access to, and use of, telehealth, and racial and ethnic disparities in Oregon's health care system. The pandemic gave the work group new urgency to address such issues.

The work group's report describes barriers members identified as preventing equitable access to comprehensive primary care and offers policy proposals intended to address these barriers, while also aligning with and advancing reform efforts already underway. The set of policies, based on survey results from the work group on their expressed priorities, are designed to increase access to and affordability of comprehensive primary care, expand and invest in telehealth, and advance alternative payment models across all payers.

I. Increase Access to and Affordability of Comprehensive Primary Care

- Increase access to appropriate primary care services including preventive services by reducing (or eliminating) co-payments, multiple co-payments by an enrollee for physical health and behavioral health services delivered on the same day in a certified Patient-Centered Primary Care Home (PCPCH).
- Remove prior authorization for individuals who require primary care services including behavioral health services delivered in a primary care setting.

II. Increase Support for and Participation in Oregon's PCPCH Model

- Reimburse services provided by clinical and outpatient pharmacists, licensed and certified behavioral health practitioners, and oral health providers as members of Oregon's PCPCH medical home model.
- Expand the statutory definition of and primary care spending reporting requirements for the types of primary care providers and services--to include pharmacists, certain behavioral health practitioners, and naturopathic physicians--which supports team-based care in a medical home.

III. Barriers to Telehealth

- Direct the Department of Consumer and Business Services (DCBS) to work with commercial insurers to ensure telehealth is inclusive of primary care services and that place of care does not equate to lower reimbursement rates. Establish reimbursement parity for primary care telehealth services covered by state-regulated health benefit plans.
- Invest in statewide broadband infrastructure to increase access to telehealth among rural patients and other population groups with limited ability to access remote services.

IV. Advance Alternative Payment Models Across Payers

- Accelerate the alignment of multi-year value-based payment (VBP) models across payers to promote consistency and reduce administrative burden for primary care providers.
- Include dental, behavioral health, and pharmacy services in per-member per-month (PMPM) payments to primary care providers to increase access to comprehensive primary care.
- Sponsor a regional pilot program to test an Oregon-specific multi- or all-payer primary care value-based payment system and demonstrate implementation feasibility.
- Standardize capitation payment methodologies to reduce administrative burden on providers.

BACKGROUND: PERSPECTIVES ON PRIMARY CARE IN OREGON

Access to primary care in the United States influences an individual's overall health and well-being.[1,2,3] Many people encounter barriers that challenge appropriate access to primary care, including income, insurance status, affordability, race and ethnicity, geography, health status, and a maldistribution of the health care workforce.[4] At the same time, research indicates policy interventions that address disparities in insurance coverage and access to primary care can reduce gaps in health outcomes.[5,6] Moreover, improving access and removing barriers to comprehensive primary care that includes behavioral and oral health has been demonstrated to reduce overall health care costs.[7] Initiatives that reduce or remove barriers to care and care continuity include same-day access, no patient co-pays, convenient access to services via telehealth, and the use of integrated care teams. These initiatives can serve to increase the appropriate use of preventive and primary care services.

In March 2010, upon passage of the federal Affordable Care Act (ACA), Oregon prepared for the significant expansion of insurance coverage through Medicaid and the creation of an insurance exchange or Marketplace. Five years after the initial implementation of the ACA in 2014, the 2019 Oregon Health Insurance Survey reported that approximately 3.9 million Oregonians, or 94 percent, were insured. As Oregon implemented the ACA and increased coverage to hundreds of thousands of residents, the state was also transforming its delivery system through efforts such as the creation of patient-centered medical homes (PCMHs), fostering financial investments in the state's primary care infrastructure, working to integrate care delivery for physical, oral, and behavioral health services, and through the creation of coordinated care organizations or CCOs.

Recent Oregon Legislation

After implementation of the ACA in Oregon, the Legislative Assembly passed Senate Bill 231 (2015) requiring the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to report the percentage of medical spending allocated to primary care by the specified health care payers. Oregon Senate Bill (SB 934, 2017) requires regulated health insurance carriers and Medicaid CCOs to allocate at least 12 percent of their health care expenditures to primary care by 2023.

The annual spending report comprises claims and non-claims data. Claims data is based on fee-for-service claims submitted to the state's All Payer All Claims Reporting

[1] Shi, L. (2012). The Impact of Primary Care: A Focused Review. *Scientifica,* 1-22. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/pdf/SCIENTIFICA2012-432892.pdf

[2] Friedberg, M., Hussey, P., & Schneider, E. (2010). Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care. *Health Affairs,* 29(5). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0025

[3] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly, 83(3),* 457-502. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

[4] Agency for Healthcare Research and Quality (March 2012). National Healthcare Disparities Report 2011. AHRQ Publication No. 12-0006. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360918/

[5] Hargraves, L., Hadley, J. (2003). The Contribution of Insurance Coverage and Community Resources to Reducing Racial/Ethnic Disparities in Access to Care. *Health Services Research, 38(3),* 809-829. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360918/

[6] Smedley BD, Stith AY, Nelson AR, editors (2003). National Research Council. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (full printed version) Washington, DC: The National Academies Press.

[7] See Starfield et al. (2005).

Program (APAC), which receives medical claims, dental claims, pharmacy claims, payment amounts, member demographics, billed premiums and provider information. Data are received from insurance companies, third party administrators and pharmacy benefits managers. According to OHA and DCBS, non-claims-based payments are to "reward achievement of quality or cost-savings goals" or assist primary clinics in building "infrastructure and capacity" (pg. 6). Examples of non-claims-based payments include capitation or salary payments, Patient-Centered Primary Care Home (PCPCH) recognition payments, retrospective and prospective incentive payments, health IT and workforce payments (pg. 26). Non-claims-based payments ranged from 37 to 59 percent of total primary care spend depending on payer source (i.e., Medicare Advantage vs. CCOs).

In February 2020, OHA and DCBS released the most recent primary care spending report [8] using insurer data from 2018. In 2018, as a percent of total medical spending (see pg. 4) insurers reported the following:

- Commercial carriers allocated from 9.1 to 15.6 percent.
- Medicare Advantage plans allocated from 4.3 to 16.6 percent.
- Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) plans allocated from 11.1 to 15.5 percent.
- CCOs allocated from 10.6 to 22.6 percent to primary care.

For the purposes of reporting, Senate Bill 231 (2015) specifies the types of providers and services included or captured in the annual report. The lists below highlights both provider and service types included in the report.

Oregon Primary Care Spending Annual Report

Types of Primary Care Providers

- Physicians specializing in primary care including: (1) family medicine, (2) general medicine, (3) obstetrics and gynecology, (4) pediatrics, (5) general psychiatry, and (6) geriatric medicine.
- Naturopathic providers
- Physician assistants
- Nurse practitioners
- Primary care clinics
- Federally qualified health centers (FQHCs),
- Rural health centers

Types of Primary Care Services

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, excluding delivery
- Other primary care procedures

[8] Oregon Health Authority and Department of Consumer and Business Services. Primary Care Spending in Oregon: A Report to the Oregon Legislature. February 2020, pgs. 1-43. https://www.oregon.gov/oha/HPA/ANALYTICS/PCSpendingDocs/2020-Oregon-Primary-Care-Spending-Report-Legislature.pdf

PRIMARY CARE TRANSFORMATION AND PAYMENT REFORM

The organization, delivery, and payment structure for primary care in the United States has rapidly evolved over the past decade as evidenced by the advancement of primary care medical homes and value-based payment models. In Oregon, House Bill 2009 (2009) created the statewide Patient-Centered Primary Care Home (PCPCH) program. A decade later, over 600 clinics are recognized as PCPCH clinics. An evaluation study released in 2016 reported that PCPCH-designated clinics reduced health care expenditures, achieved notable savings on a per-person, per-quarter basis, and indicated the program achieved approximately $240 million in savings during the first three years.[9] Specific cost reductions reported included increased utilization of preventive and screening services, along with decreased specialty office visits and pharmacy claims.

A foundational component of Oregon's transformation of its primary care system is the alignment of financial models to support and invest in primary care. As reported by the Milbank Memorial Fund, states including Oregon have multi-payer programs working to reform payment models targeted at primary care service delivery.[10] The goal is to transition from the current fee-for-service reimbursement structure to alternative payment models that reward providers for quality, offer shared savings tied to performance outcomes, and over time, reimburse primary care providers through capitation or global budgets such as per-member per-month (PMPM) payments.[11] Alternative payment models are intended to support specific populations to ensure patients with complex chronic conditions receive appropriate care and wraparound services, and also support investments in team-based care and clinical infrastructure; resources required to operate as an advanced medical home.

The Health Care Payment Learning & Action Network (HCP LAN) developed a nationally recognized alternative payment model framework – see Figure 1. (pg. 5)[12] The framework depicts the continuum of payment models. Category one is the traditional, predominate payment or reimbursement model in primary care: fee-for-service (FFS). Category two is still predicated on a fee-for-service model but introduces reporting and pay-for-performance concepts. Categories three and four illustrate the transition from FFS to alternative payment models that include shared savings between insurers and providers, graduating to population-based payments.

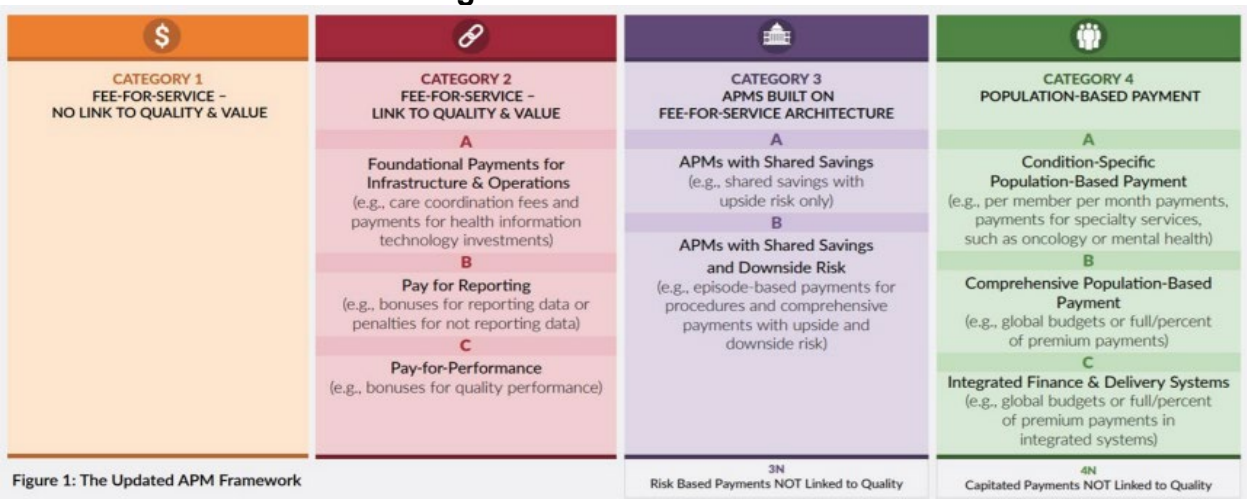
[9] Gelmon, S., Wallace, N., Sandberg, B., Petchel, S., Bournanis, N. (September 2016). Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings. OHSU & PSU School of Public Health. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf

[10] Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., Pivaral, K., Phillips, R., Bazemore, A., & Neumann Kane, A. (July 2019). Investing in Primary Care: A State-level Analysis. https://www.milbank.org/wp-content/uploads/2019/07/2019-PCPCC-Evidence-Report-Final.pdf

[11] Taylor, E., Bailit, M., Sayles, J. (September 2020). Prospective Payment for Primary Care: Lessons for Future Models. Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2020/09/LessonforFutureModels_Bailit_v4.pdf

[12] Health Care Payment Learning & Action Network (2019). APM Measurement Progress of Alternative Payment Models, 2019 Methodology and Results Report. https://hcp-lan.org/workproducts/apm-methodology-2019.pdf

Figure 1. APM Framework



Source: Health Care Payment Learning & Action Network (link)

Oregon's primary care practices have participated in a number of payment reform efforts including two recent national multi-payer payment reform initiatives: Comprehensive Primary Care (CPC) Classic (2014-2017) and CPC+ (2017-2018). Oregon Health and Science University (OHSU), which was contracted to provide technical assistance, offered several lessons learned from the CPC Classic and CPC+ payment reform initiatives. Researchers with OHSU highlighted areas for payment reform in primary care that need further attention and prioritization.[13]

Comprehensive care

- funding to support collaboration with pharmacists in primary care;
- continued improvements in access to behavioral health; and
- incentivizing coordination between primary care and specialties

Telehealth sustainability

- investing in new payment models needed to support telehealth services at parity with in-person visits;
- supporting infrastructure (e.g., broadband access, telehealth platforms) and capacity of practices to provide telehealth services; and
- accommodating reimbursement that does not exclude patients/practices in areas with limited broadband internet.

Health equity

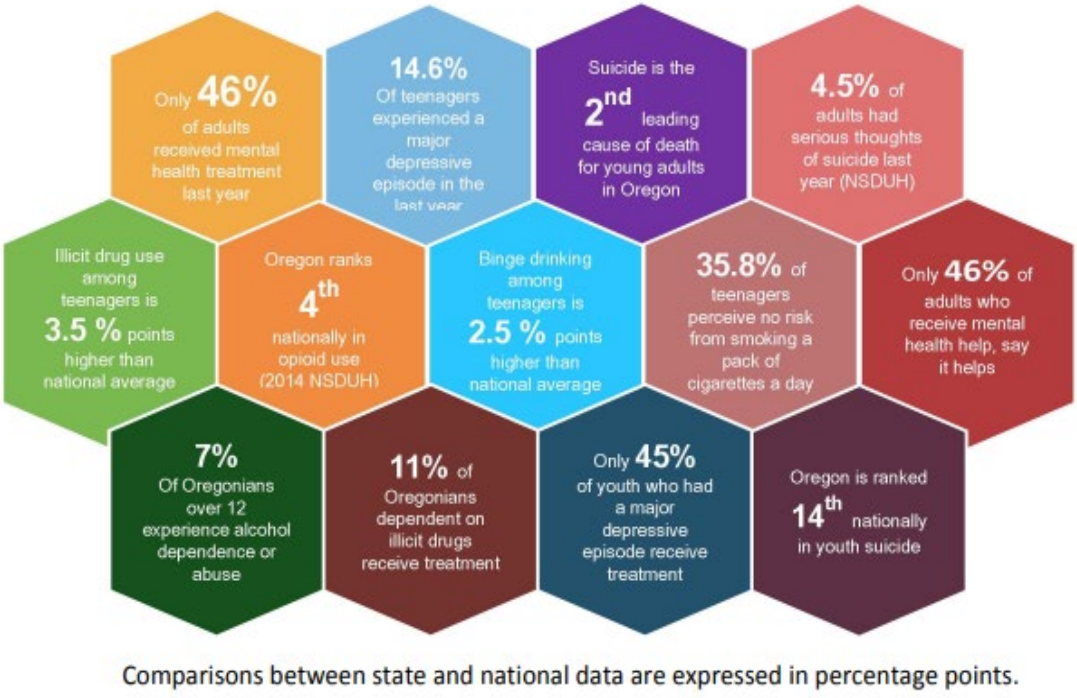
- flexible dollars allocated to social determinants of health (SDOH);
- funding for primary care, public health, and community-based organizations to collaborate and address patients' social needs;
- funding new modalities of care (e.g., home visits, clinical pharmacy services);
- incentivizing equitable access to care (e.g., certified interpreters); and
- innovating and working upstream of SDOH – targeting anti-oppression and systemic racism for providers and payers.

[13] Tseng, A., Snow, M. (September 8, 2020). Improving Access to Primary Care in Oregon. Oregon Health and Science University. https://www.oregonlegislature.gov/committees/2019I1-HHC/WorkgroupDocuments/Payment%20Reform%20Presentation%20-%20Ann%20Tseng%20and%20Martha%20Snow,%20Oregon%20Health%20and%20Science%20University.pdf

BEHAVIORAL HEALTH INITIATIVES

Oregon's behavioral health system is comprised of public and private entities that provide substance use and mental health services, including inpatient hospitalization, crisis services, intensive case management, outpatient and peer-support services, and prevention, among others. The components of the behavioral health system are many and multi-faceted, involving the Oregon State Hospital, acute hospitals, community treatment centers, the criminal justice system, state and local housing programs, and K-12 educational settings. According to Mental Health America, among 15 measures compiled from data collected across all 50 states used to assess prevalence of mental illness and substance use, Oregon ranks at the bottom - 50th. Adults and youth in Oregon have higher rates of any mental illness (AMI) and substance use disorder (SUD) compared to other states and ranks 24th in access to treatment, quality, and cost.

In 2016, the Oregon Health Authority created the Behavioral Health Collaborative (BHC) to develop recommendations to build a "21st century" behavioral health system in Oregon.[14] The BHC's report highlighted challenges individuals with behavioral health and/or chronic conditions experience in accessing behavioral health services. See Figure 2.



Data: SAMHSA Behavioral Health Barometer United States 2015 and OHA.[15]
Source: Oregon Health Authority.

[14] Oregon Health Authority (2016). Behavioral Health Collaborative Report. Accessed on Nov. 3, 2020 at: https://www.oregon.gov/oha/HSD/BHP/Documents/Behavioral-Health-Collaborative-Report.pdf

[15] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: United States, 2015. HHS Publication No. SMA–16–Baro–2015. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Accessed on Nov. 3, 2020 at: file:///C:/Users/droppeo/Downloads/sma16-baro-2015.pdf

According to the Oregon Health Authority, as of 2019, there were 28 work groups and advisory boards in Oregon related to behavioral health. One of these boards, the Behavioral Health Advisory Council, created by Governor Brown in October 2019 through Executive Order 19-06, was tasked with developing recommendations "aimed at improving access to effective behavioral health services and supports for all Oregon adults and transitional-aged youth with serious mental illness or co-occurring mental illness and substance use disorders." In October 2020, in advance of the 2021 legislative session, the Council recommended financial investments in behavioral health programs and services, behavioral health workforce, housing, and housing supports.[16]

Certified Community Behavioral Health Clinics (CCBHCs) are clinics designed to provide a comprehensive range of mental health and substance use disorder services, physical health screenings and primary care services. They were created through Section 223 of the Protecting Access to Medicare Act (PAMA), which established a demonstration program based on the Excellence in Mental Health Act. CCBHCs serve adults and children by providing a comprehensive array of services that are necessary to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and addictions. In 2015, Oregon was awarded a planning grant to develop CCHBCs to expand behavioral health services and workforce, pilot alternative payment methods, and align with ongoing health transformation efforts. In 2017, Oregon was awarded a two-year federal demonstration grant which was extended through May 2020. Oregon's CCBHCs provide crisis mental health services, targeted care management, peer support and family supports, outpatient mental health and substance use services, among other services. As of January 2020, there were 21 CCBHCs operated across Oregon by 12 different organizations that have met state and federal standards to become a CCBHC.

Integration of behavioral health into primary care and primary care into behavioral health settings is an important element in Oregon's Primary Care Transformation Initiative. Increasing access to behavioral health services and integration of behavioral and physical health services requires changing current payment models.

ALIGNMENT WITH OREGON'S CURRENT REFORM INITIATIVES

Through the work group's discussions, members offered differing perspectives and raised questions on whether and how the emerging policy proposals align with current reform initiatives in Oregon. Summarized below are reform initiatives identified as potentially intersecting with the work group and its policy proposals. The list of initiatives is not exhaustive and is offered to identify where there is clear overlap and alignment.

Senate Bill 231 (2015) also created the Primary Care Payment Reform Collaborative (PCPRC or Collaborative), directing OHA to support innovation and improvement in primary care. Senate Bill 934 (2017) further directed the Collaborative to advise OHA on:

[16] Governor Brown's Behavioral Health Advisory Council (October 2020). Recommendations. Accessed on Nov. 3, 2020 at: https://www.oregon.gov/oha/HSD/BHP/Documents/GBHAC-Final-Recommendations-Report.pdf

- use of value-based payment (VBP) methods to increase investment in primary care, align primary care reimbursement, and improve reimbursement methods, including by investing in the social determinants of health;
- increasing investment in primary care without increasing costs to consumers or increasing the total cost of health care; and
- facilitating the integration of primary care behavioral and physical health care.

The Collaborative (2016-ongoing) is comprised of 41 members who represent primary care providers, payers, and other key stakeholders involved in the delivery and financing of primary care services in Oregon. According to the Collaborative's 2019 progress report[17], there are considerable implementation challenges to payment reform in primary care, specifically:[18]

- lack of statewide infrastructure to support technical assistance to practices and payers, evaluation, or to monitor payer and provider participation;
- voluntary implementation of the Collaborative's recommendations by payers and providers;
- lack of engagement by employers with self-funded health plans;
- streamlining and coordination of VBP requirements, statewide; and
- variation in attribution methodology across payers.

Oregon's Collaborative is a critical partner and catalyst in partnering with stakeholders to further transform the state's primary care system. The proposals put forward by the UAPC Work Group strongly align with and support the Collaborative's ongoing work and lessons learned shared by the researchers with OHSU from the CPC Classic (2014-2017) and CPC+ payment reform initiatives.

The Governor's Telehealth Work Group (2020)
Starting in November 2020, DCBS and OHA will convene a series of stakeholder listening sessions, at the direction of the Governor's office, to gather feedback on the future of telehealth. These sessions will be open to the general public, but each will focus on feedback from a specific stakeholder group, including health care providers, health insurance carriers and consumers.

Additionally, OCHIN, Oregon Medical Association, and other organizations have also met periodically as a work group to discuss telehealth and its applications in primary care space.

Rural Broadband Capacity Program (2020)
The Oregon Business Development Department, commonly known as Business Oregon, helps facilitate the deployment and utilization of telecommunications

[17] Oregon Health Authority (April 2020). Oregon's Primary Care Transformation Initiative 2019 Progress Report. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/PCPRC%202019%20Progress%20Report.pdf
[18] DeMars, C. (September 8, 2020). Primary Care Payment Reform Collaborative. *Oregon Health Authority.* Slide 16. https://www.oregonlegislature.gov/committees/2019I1-HHC/WorkgroupDocuments/Payment%20Reform%20Presentation%20-%20Chris%20DeMars,%20Oregon%20Health%20Authority.pdf\

infrastructure to support innovation, create economic opportunities, and build quality communities throughout Oregon. In 2018, Business Oregon funded seven broadband planning and infrastructure projects in areas lacking adequate broadband service (defined as providing less than 25 million bits per second downstream and three million bits per second upstream) through the Rural Broadband Capacity Pilot Program. The Department received 25 applications totaling more than $4.8 million in requested funding for the $500,000 available through the pilot program.

On June 5, 2020, the Oregon legislative Emergency Board approved $20 million of the federal Coronavirus Relief Fund to continue the Rural Broadband pilot program and support the expansion of broadband capacity for schools, businesses, and healthcare providers to assist them in addressing the impacts of the COVID-19 pandemic.[19]

On June 26, during the first special session of 2020, the Oregon Legislative Assembly passed Senate Bill 1603 creating a state Broadband Fund and requiring Business Oregon to develop broadband program rules, apply certain preferences to grants and loans, establish procedures for distributing grant or loan funds, and report annually to the legislature. The measure also directs the Public Utility Commission to transfer up to $5 million per year from the universal service fund to the Broadband Fund.

Joint Task Force on Universal Health Care (2020-2021)
Created by Senate Bill 770, the task force is charged with recommending the design of the Health Care for All Oregon Plan intended to provide equitable, affordable, comprehensive and high-quality health care to every Oregon resident. This discussion has included conversations about single-payer systems and coordinating behavioral and mental health care[20]. Furthermore, the Task Force will explore policies to provide universal access to primary care services, alternative payment models including the use of global budgets, and administrative simplification across insurers and providers.

Sustainable Health Care Cost Growth Target Program (2019-2022)
Created by Senate Bill 889, the program is working to establish a health care cost growth target that will serve as a target for the annual per capita rate of growth of total health care spending in the state. Cost increases of health insurance companies and health care providers will be compared to the growth target each year. The program also evaluates and annually reports on cost increases and drivers of health care costs[21]. The Implementation Committee is exploring value-based payment models.

Table 1 lists the policy categories identified by the UAPC Work Group and their alignment with a number of current reform initiatives in Oregon (see next page).

[19] Oregon Legislative Fiscal Office (June 5, 2020). Fiscal Statement, Item 14 "Oregon Business Development Department. Accessed on Nov. 4, 2020 at:
[20] SB 770 (2019) https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770
[21] Sustainable Health Care Cost Growth Target https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx#:~:text=The%20Oregon%20Legislature%20through%20Senate,Oregon%20Health%20Authority%20(OHA).&text=A%20health%20care%20cost%20growth,care%20spending%20in%20the%20state

Table 1. Alignment of Work Group's Policy Proposals & Current Reform Initiatives

UAPC Work Group Policy Proposal Categories	Primary Care Payment Collab	Governor's Telehealth Workgroup	Universal Health Care Task Force	Cost Growth Target Program
Increase Access to and Affordability of Comprehensive Primary Care	●		●	
Increase Support for and Participation in Oregon's PCPCH Model	●			
Remove Barriers to Telehealth		?		
Support Investments in Broadband Infrastructure		?		
Advance Alternative Payment Models Across Payers	●		●	●
Promote Administrative Simplification and Standardization of Alternative Payment Models Across Payers			●	●
Support Statewide Expansion of Alternative Payment Reform Initiatives & Technical Assistance	●			

Source: Legislative Policy and Research Office

COVID-19 Pandemic and Telehealth

The novel coronavirus disease (COVID-19) has dramatically affected Oregon's primary care system. Providers have faced a broad range of new challenges in delivering care, including ensuring the safety of patients and staff with new reliance on personal protective equipment (PPE), unprecedented revenue loss from declines in utilization, rapid transition to increased telehealth demand and utilization, and navigating a quickly evolving federal and state policy landscape.[22] Table 2 highlights the early changes in telehealth utilization attributed to the pandemic.

Table 2. Health Insurance Claims and Reimbursements for Telehealth in Oregon

2019 March/April total number of claims	2020 March/April total number of claims	2019 March/April total amount in Telehealth	2020 March/April total amount in Telehealth
7,213	210,828	$717,904	$29,727,947

Source: Legislative Policy and Research Office
Data: Department of Consumer and Business Services, August 2020 (PPT).

[22] Vandehey, J. (August 24, 2020). Environmental Assessment of Telehealth During COVID-19. *Oregon Health Authority*. https://www.oregonlegislature.gov/committees/2019I1-HHC/WorkgroupDocuments/Telehealth%20Presentation%20-%20Jeremy%20Vandehey,%20Oregon%20Health%20Authority.pdf

In response to COVID-19, federal and state agencies issued guidance to quickly ease regulatory constraints to coverage, reimbursement, and types of technologies appropriate to expand access to physical and behavioral health services during the pandemic. The OHA, in partnership with DCBS, implemented temporary changes to telehealth in Medicaid and state-regulated health benefit plans to meet the increased demand for these services in Oregon. On March 24, the two agencies released joint guidance on telehealth for insurers and CCOs.[23] To promote and facilitate the use of telehealth, the guidance specifically provided that:

- Health plans must cover in-network telehealth services whenever possible and clinically appropriate.
- Providers may use all modes of telehealth delivery.
- Cost-sharing may be no more than for in-person services.
- Telehealth provider networks must be adequate.
- Pay parity for telehealth is strongly encouraged.
- Plans must waive requirements that could pose barriers.

In June 2020, Governor Brown released a statement highlighting a voluntary agreement with health insurers to continue to expand coverage and reimbursement through the end of 2020.[24] DCBS also released data on the initial impact of COVID-19 on telehealth. DCBS has also identified potential issues long-term around temporary federal changes to the Health Insurance Portability and Accountability Act (HIPAA) requirements and changes to Medicare by the Centers for Medicare and Medicaid Services (CMS).

On August 5, 2020, Governor Brown issued a joint statement with the governors of Washington, Colorado, and Nevada highlighting that the states had agreed on key issues that need to be incorporated into state and federal telehealth policies.[25] The seven key issues now reflected in a shared framework are:

1. Access
2. Confidentiality
3. Equity
4. Standard of Care
5. Stewardship
6. Patient Choice
7. Payment/Reimbursement

As demonstrated during the COVID-19 pandemic, telehealth has served as an important mechanism to expand access to physical and behavioral health services to thousands of Oregonians. Many of the regulatory restrictions temporarily relaxed during the pandemic, coupled with reimbursement parity for telehealth, led the work group to discuss whether to make these temporary changes—permanent, potentially through legislation in the 2021 session.

[23] Department of Consumer and Business Services, Oregon Health Authority. Telehealth Guidance. https://dfr.oregon.gov/insure/health/understand/Documents/DFR-OHA%20Telehealth%20Guidance.pdf

[24] Oregon Office of Governor Brown. Press Release: State of Oregon Announces Telehealth Agreement for Health Insurance Plans. https://dfr.oregon.gov/news/2020/Pages/telehealth-agreement-health-plans.aspx

[25] Oregon Office of Governor Brown Press Release (August 5, 2020). Oregon, Washington, Colorado, and Nevada Announce Coordination on Telehealth. https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=37091

WORK GROUP PROCESS (JAN-OCT. 2020)

In January 2020, Representative Prusak released the work group's charter, which outlined four goals:

1. Define and describe the types of primary care services currently available including areas of unmet need; identify existing gaps including but not limited to coverage, access, and health care workforce by geographic area and provider type.
2. Analyze policy options to ensure primary care services are affordable and accessible to all residents with minimal financial barriers such as point-of-service cost-sharing and insurance deductibles for services.
3. Identify primary care models that make efficient and effective use of integrated team-based approaches to help provide access to comprehensive primary care for the communities they serve.
4. Determine factors influencing the potential implementation of a system of universal primary care, such as potential effects on the existing health care system including administrative costs providers currently incur, and stability of the state's insurance marketplace.

The charter also prioritized a diversity of primary care providers, payers, patient advocates, and subject matter experts in the work group's membership.

Discussion Guide

To facilitate Representatives Prusak and Moore-Greene's request that the work group generate specific policy proposals based on the four stated goals, staff developed a discussion guide (see example) used at the monthly meetings to prompt member discussion, gather information provided by member stakeholders, and document identified issues and policy proposals. For each policy concept or category, members were asked to respond to the following two questions:

1. What are the 1-2 issues the work group should focus on "fixing" that will help sustain and grow Oregon's transformation in primary care?
2. Given what the COVID-19 crisis has demonstrated about primary care, the health care system, and our broader societal structures, what are immediate risks, opportunities, or actions that should be a focus of this work group?

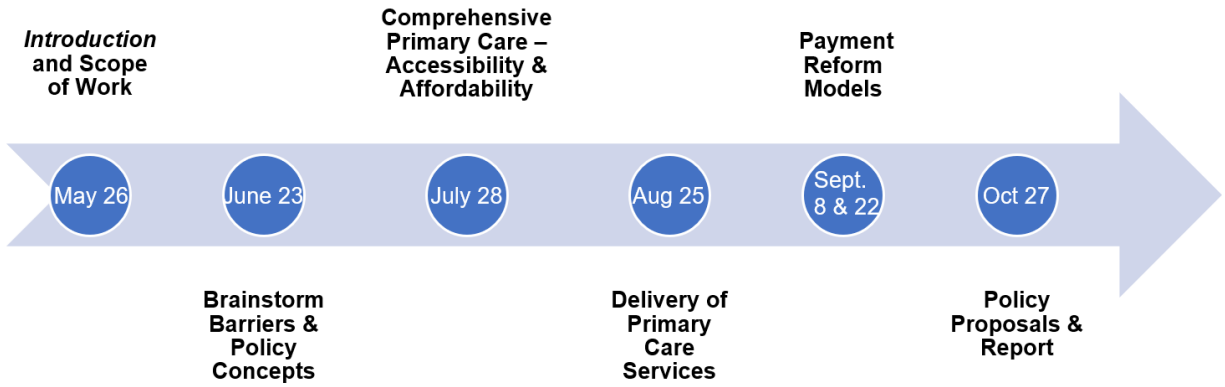
After each meeting, using the discussion guide template, staff summarized work group member responses, grouping by policy themes or areas highlighted during the monthly discussion. The discussion guides were also used to inform future meetings including identifying key issues, evidence-based practices, and potential presenters. Lastly, the discussion guides helped identify current or emerging Oregon policy reform efforts that intersect with the individual policy proposals.

Monthly Meetings

The group was delayed by several months due to the COVID-19 pandemic and began meeting virtually on May 26, 2020. The work group met monthly, in a virtual format, for

three hours for a total of seven meetings between May and October 2020. Prior to each meeting, staff worked with legislators to develop the agenda and identify presenters. Figure 3 outlines the timeline for the work group.

Figure 3. Work Group Timeline (May-October 2020)



Source: Legislative Policy and Research Office

May – The group focused on identifying and prioritizing topics members were interested in covering in the coming months as well as the effects of COVID-19 on primary care providers, patients, and practices. Dr. Evan Saulino joined the group to provide context on the history of primary care reform efforts in Oregon. Member responses to the discussion guide highlighted several key themes, including:

- Comprehensive primary care as defined by the integration of physical health, behavioral health, and oral health with a more expansive definition inclusive of social determinants of health.
- Statewide primary care payment reform for all payers, including widespread adoption of value-based payments, use of capitation, and transition to population-based payment methods.
- Service delivery expansion using information technology to offer services outside of physical clinic sites.
- Maintaining telehealth coverage and reimbursement across payer types post-COVID-19.
- Support of rural communities through focus on rural providers, hospitals, and communities, including creation of stable financial models for rural providers and hospitals to serve as physical hubs for individuals.
- Workforce needs and challenges among Oregon's public health system and how to integrate public health into primary care.
- Make primary care attractive for health care professionals.
- Uniform primary care benefit standards across all payers.

Members also identified challenges related to COVID-19:

- Potential transition of large numbers of commercially insured to Medicaid, which negatively affects current reimbursement models for both payers and providers.

- Gaps in coverage and care continuity for individuals who transition coverage due to COVID-19 related issues.

June – The group further refined the policy issues identified in May. Members identified policy concepts that needed further clarity and recommended experts and resources that could help the group with its work in the coming months. The group also discussed the importance of health equity, social determinants of health and the importance of including rural perspectives in the work group's discussion.

July – The group discussed policy issues and barriers related to access to comprehensive primary care. Dr. Evan Saulino, Dawn Creach, and Dr. Lynnea Lindsey participated in the meeting to provide feedback on the responses shared by individual members.

August – DCBS and OHA presented on recent federal and state regulatory changes to telehealth. Members identified policy issues and barriers on supporting a broader and more expansive role of telehealth post-COVID-19.

September – The group met twice. The first meeting was an informational meeting with presentations from state and national experts on payment reform. This meeting provided background information for the month's second meeting, which focused on potential payment reform policy proposals.

October – The group met to review the list of policy proposals, provide feedback to the draft report, and prioritize recommended policy proposals in advance of the 2021 legislative session.

WORK GROUP OBSERVATIONS: KEY BARRIERS IN PRIMARY CARE

During the July, August, and September meetings, members identified key barriers to accessing and supporting comprehensive primary care in Oregon. The barriers have been organized by policy categories based on members' discussion.

Barriers to Accessible and Affordable Comprehensive Primary Care
The policy barriers below affect primary care services affordability and accessibility to all residents:

- prior authorization creates barriers for patients receiving behavioral health care;
- inequities and inefficiencies caused by treating mental and dental health as separate from primary care;
- fragmented primary care model that does not include pharmacists, behavioral health, or dental providers;
- emergency room utilization for non-urgent medical conditions as a result of lack of access to primary care;
- difficulties placing student practitioners in hospitals during COVID-19, which may cause workforce issues in the future; and
- high costs of staffing and equipment incurred by primary care clinics.

Barriers to Primary Care Service Delivery
Providers face numerous challenges that hinder the effective and efficient delivery of primary care:

- inadequate reimbursement for and investment in primary care services that are inclusive of behavioral health, oral health, and pharmacy services;
- difficulties balancing provider and clinic schedules between same-day, scheduled, and telehealth appointments;
- lack of patient access to technology for effective telehealth appointments, particularly in rural areas;
- lack of reimbursement parity among providers when utilizing telehealth services; and
- limited use of health care language interpreters and three-way calling.

Barriers to Statewide Payment Reform
The final set of barriers discussed were around current limitations and challenges to advanced alternative payment models in primary care. Specific barriers identified were:

- inefficiency and administrative burden on providers participating in multiple alternative payment models;
- effects of COVID-19, which destabilized the fee-for-service payment model for primary care;
- challenges to capturing, attributing, and distributing cost savings to providers created by investments in primary care;
- perverse incentives in capitation models that may prioritize the healthiest and less expensive to treat patients over higher risk patients; and

- difficulty of aligning quality metrics with value-based payment models while not hindering a provider's ability to care for underserved populations or populations with a high prevalence of chronic disease burden.

WORK GROUP POLICY PROPOSALS

Early on, the work group expressed interest in expanding the definition of primary care; one inclusive of behavioral health, oral health, and clinical pharmacy. The current statutory definition of "primary care" is limited to family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.[26]

I. Access to Affordable Comprehensive Primary Care

The policy proposals detailed below are intended to ensure primary care services are affordable and accessible to all residents with minimal financial barriers, such as point-of-service cost-sharing and insurance deductibles. The proposals below are intended to enhance access to and support for Oregon's Patient-Centered Primary Care Home (PCPCH) clinics.

Access and Affordability

1. Increase access to appropriate primary care services including preventive services by reducing (or eliminating) co-payments and deductibles for primary care services (e.g., $5 co-pay), particularly among high-deductible health plans.
2. Eliminate insurance barriers to well visits including allowing well visits and annual visits to occur any time in a calendar year (vs. after 365 days).
3. Increase access to behavioral health services by limiting insurers' ability to define behavioral health services as a specialty service when such a designation creates additional or a high co-payment for an enrollee, regardless of payer source.
4. Remove prior authorization for individuals who require primary care services including behavioral health services delivered in a primary care setting.
5. Eliminate multiple co-payments and allow for only one minimal co-payment by an enrollee for physical health and behavioral health services delivered on the same day in a certified PCPCH to reduce cost barriers to accessing comprehensive primary care services such as behavioral health and clinical pharmacy.

Increase Support for and Participation in Oregon's PCPCH Model

1. For reimbursement, integrate clinical and outpatient pharmacists, licensed and certified behavioral health practitioners, and oral health providers into Oregon's PCPCH model as members of the medical home model. For example, insurers offer a separate PMPM for behavioral health in addition to a PMPM paid for PCPCH recognition.

[26] Chapter 575 Oregon Laws; Senate Bill [SB] 231 [2015]

2. Increase access to primary care by expanding the statutory definition of primary care providers to include pharmacists, certain behavioral health practitioners, and naturopathic physicians, which supports team-based care in a medical home including appropriate services. Ensure application and implementation of an expanded definition of primary care are consistent across Medicaid and commercial carriers.
3. Encourage commercial insurers to offer incentives to enrollees to select a recognized PCPCH provider to encourage use of Oregon's medical home model. Such an approach could assist providers in onboarding and managing the patient population at a given practice site to improve quality.
4. Incentivize insurers' utilization of clinics certified by Oregon's PCPCH program, including per-member per-month (PMPM) reimbursement by tier (1-5), to broaden use of the medical home model across payer types.
5. Provide financial incentives to rural, small, and independent providers to participate in Oregon's PCPCH program without requiring acceptance of significant financial risk.

II. Primary Care Service Delivery: Expansion and Use of Telehealth

The next set of policy proposals are designed to incentivize primary care services over urgent care, or other services in more costly settings, by improving access to telehealth services, enhancing coverage of telehealth services, and promoting reimbursement parity post-COVID-19.

Remove Barriers to Telehealth

1. Codify COVID-19 emergency telehealth requirements, including covered services and reimbursement parity.
2. Direct the Department of Consumer and Business Services (DCBS) to work with commercial insurers to ensure telehealth is inclusive of primary care services and that place of care does not equate to lower reimbursement rates. Establish reimbursement parity for primary care telehealth services covered by state-regulated health benefit plans.
3. Establish telehealth parity inclusive of behavioral health services among coordinated care organizations and commercial carriers.
4. Promote utilization of primary care services over urgent care or other services in more costly settings by reducing or eliminating co-pays and other out-of-pocket costs to access same-day services via telehealth.

Support Investments in Broadband Infrastructure

1. Incentivize alternative payment models that facilitate or promote telehealth services (e.g., supporting associated IT and staffing costs).
2. Create financial incentives to foster partnerships with local entities (e.g. local school districts) and internet service providers to increase access to remote Wi-Fi

services and locations that support telehealth service access in rural and underserved communities.
3. Invest in statewide broadband infrastructure to increase access to telehealth among rural patients and other population groups with limited ability to access remote services.

III. Statewide Alternative Payment Reform Models

The third and final set of policy proposals are to support and advance statewide payment models for primary care providers that are predictable, equitable, and demonstrate a shared commitment among public and private payers in Oregon consistent with current payment reform efforts.

Advance Alternative Payment Models Across Payers

1. Accelerate alignment of multi-year value-based payment (VBP) models across payers to promote consistency and reduce the administrative burden for primary care providers.
2. Encourage insurer utilization of capitation payments incorporating accountability and risk-adjustment mechanisms to reimburse PCPCH clinics.
3. Include dental, behavioral health, and pharmacy services in PMPM payments to primary care providers to increase access to comprehensive primary care.
4. Adopt and evaluate global payment systems for behavioral health services with the goal of removing transactional barriers to care (e.g., organizational barriers) across public and private payer sources.
5. Promote adoption of quality incentives aligned with Oregon's PCPCH model, specifically financial incentives among commercial plans to support providers ability to sufficiently budget for infrastructure to support the medical home within a given fiscal or calendar year.
6. Require Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) to adopt VBP principles for advanced primary care payment, including inpatient hospital services and specialty care.

Statewide Expansion of Alternative Payment Reform Initiatives and Technical Assistance

1. Expand and increase statewide technical assistance (TA) available for primary care providers including creating a sustainable funding mechanism for TA to assist primary care providers in transitioning to value-based payment models, which require staffing resources and infrastructure investment by primary care providers (e.g., risk adjustment, claims and quality measurement reporting and incentives).
2. Sponsor a regional pilot program to test an Oregon-specific multi- or all-payer primary care value-based payment system and demonstrate implementation feasibility.

3. Develop a "pay or play" assessment for all Oregon health insurers to support the development of a statewide primary care value-based payment system to ensure fairness across all payer types in Oregon.

Promote Simplification and Standardization Across Payers

1. Standardize capitation payment methodologies to reduce administrative burden on providers.
2. Increase detail and transparency in the state's annual Primary Care Spending in Oregon Report and associated reporting available via the All Payer, All Claims Reporting Program (APAC). Each PCPCH site would be assigned a unique identifier that could be utilized for all fee-for-service (FFS) claims and non-claims (VBP) reporting among insurers and APAC. This identifier would allow policymakers and researchers to identify and evaluate the portion of health care spending allocated by insurers and CCOs to primary care providers delivering comprehensive primary care services by PCPCH tier status.

WORK GROUP SURVEY RESULTS AND POLICY PROPOSALS

In October, staff distributed a survey to members to discern their policy priorities. In order to be maximally efficient with members' time, and to help narrow the scope of the policies for consideration in the 2021 Legislative Session, staff developed a set of questions to invite members to prioritize 20+ policy proposals. Sixteen out of twenty members responded to the survey. Preliminary results were shared with the work group, and on October 27, members discussed the highest and lowest priorities in each category and the process for categorizing the policy proposals.

Survey Limitations

It is important to note that while the survey was designed to measure the priorities of the primary care stakeholders represented on the work group, it was not intended as a tool to ascertain consensus on any policy proposal. Moreover, the survey was not designed to allow members to indicate whether they specifically did not support a policy proposal, only that they did not rank it as highly as other proposals. Based on the survey results, policies which members ranked higher among a defined group of proposals indicates broader agreement on that policy proposal. A bimodal distribution (roughly equal number of responses ranking a proposal low and high) indicates less agreement on a proposal as a *priority*. Members were invited to provide additional feedback on the proposals. See Appendix C for written responses from members.

Survey results are listed in the tables below by subcategory. The highest ranked proposals are highlighted in green. The numbers to the left of each proposal indicate the percentage and number of respondents who ranked each proposal at the corresponding level of priority.

I. Access to Affordable Comprehensive Primary Care

The 11 policy priorities that came out of the July meeting on comprehensive primary care were grouped into two subcategories of policy proposals: (1) access & affordability, and (2) increasing support for Oregon's PCPCH model.

In the first subcategory, access and affordability (Table 3), the two highest ranked proposals among the five proposals were:

Table 3. Ranked Priorities on Access to & Affordability of Primary Care (N=16)

Priorities (1 highest, 5 lowest)	1	2	3	4	5
1. Increase access to appropriate primary care services, including preventive services, by reducing (or eliminating) co-payments and deductibles for primary care services (e.g., $5 co-pay), particularly among high-deductible health plans.	38% 6	31% 5	19% 3	6% 1	6% 1
2. Eliminate multiple co-payments and allow for only one minimal co-payment by an enrollee for physical health and behavioral health services delivered on the same day in a certified Patient-Centered Primary Care Home (PCPCH), to reduce cost barriers to accessing comprehensive primary care services such as behavioral health and clinical pharmacy.	25% 4	19% 3	6% 1	38% 6	13% 2
3. Remove prior authorization for individuals who require primary care services, including behavioral health services delivered in a primary care setting.	19% 3	25% 4	25% 4	13% 2	19% 3
4. Increase access to behavioral health services by limiting insurers' ability to define behavioral health services as a specialty service when such a designation crates additional or a high co-payment for an enrollee, regardless of payer source.	13% 2	19% 3	38% 6	13% 2	19% 3
5. Eliminate insurance barriers to well visits including allowing well visits and annual visits to occur any time in a calendar year (vs. after 365 days).	6% 1	6% 1	13% 2	31% 5	44% 7

In the second subcategory, increasing support for and participation In Oregon's PCPCH (Table 4), the two highest ranked proposals among the five proposals were:

Table 4. Ranked Priorities on Increasing Support For and Participation In Oregon's PCPCH model (N=16).

Priorities (1 highest, 5 lowest)	1	2	3	4	5
1. Increase access to primary care by expanding the statutory definition of primary care providers to include pharmacists, certain behavioral health practitioners, and naturopathic physicians, which supports team-based care in a medical home including appropriate services. Ensure application and implementation of an expanded definition of primary care are consistent across Medicaid and commercial carriers.	63% 10	0% 0	6% 1	6% 1	25% 4
2. For reimbursement, integrate clinical and outpatient pharmacists, licensed and certified behavioral health practitioners, and oral health providers into Oregon's PCPCH model as members of the medical home model. For example, insurers offering a separate PMPM for behavioral health in addition to a PMPM paid for PCPCH recognition.	19% 3	38% 6	19% 3	19% 3	6% 1
3. Encourage commercial insurers to offer incentives to enrollees to select a recognized PCPCH provider to encourage use of Oregon's medical home model. Such an approach could assist providers in onboarding and managing patient population at a given practice site to improve quality.	19% 3	13% 2	13% 2	44% 7	13% 2
4. Provide financial incentives to rural small and independent providers to participate in Oregon's PCPCH program without requiring acceptance of significant financial risk.	0% 0	19% 3	31% 5	6% 1	44% 7
5. Incentivize insurers' utilization of clinics certified by Oregon's PCPCH program, including PMPM reimbursement by tier (1-5), to broaden use of medical home model across payer types.	0% 0	31% 5	31% 5	25% 4	13% 2

II. Primary Care Service Delivery: Expansion and Use of Telehealth

The seven policy proposals from August's meeting on primary care delivery models were grouped into two subcategories: (1) removing barriers to telehealth, and (2) support investments in broadband infrastructure.

In the removing barriers to telehealth subcategory (Table 5), among the four proposals, the highest ranked policy was:

Table 5. Ranked Priorities on Removal of Barriers to Telehealth (N=16)

Priorities (1 highest, 4 lowest)	1	2	3	4
1. Direct the Department of Consumer and Business Services (DCBS) to work with commercial insurers to ensure telehealth is inclusive of primary care services and that place of care does not equate to lower reimbursement rates. Establish reimbursement parity for primary care telehealth services covered by state-regulated health benefit plans.	25% 4	44% 7	19% 3	13% 2
2. Codify COVID-19 emergency telehealth requirements, including covered services and reimbursement parity.	31% 5	6% 1	31% 5	31% 5
3. Establish telehealth parity inclusive of behavioral health services among coordinated care organizations and commercial carriers.	25% 4	25% 4	25% 4	25% 4
4. Promote utilization of primary care services over urgent care or other services in more costly settings by reducing or eliminating copays and other out-of-pocket costs to access same-day services via telehealth.	19% 3	25% 4	25% 4	31% 5

In the second category, supporting Investments in broadband Investments (Table 6), the highest ranked proposal among the three proposals was:

Table 6. Ranked Priorities for Policies on Support Investments in Broadband Infrastructure (N=16)

Priorities (1 highest, 3 lowest)	1	2	3
1. Invest in statewide broadband infrastructure to increase access to telehealth among rural patients and other population groups with limited ability to access remote services.	63% 10	25% 4	13% 2
2. Create financial incentives to foster partnerships with local entities (e.g., local school districts) and internet service providers to increase access to remote Wi-Fi services and locations that support telehealth service access in rural and underserved communities.	19% 3	44% 7	38% 6
3. Incentivize alternative payment models that facilitate or promote telehealth services (e.g., supporting associated IT and staffing costs for clinics).	19% 3	31% 5	50% 8

III. Statewide Alternative Payment Reform Models

The 14 policy proposals related to payment reform, as discussed in the September meetings of the group (and subsequent meetings), were grouped into three sub-categories: (1) advancing alternative payment models across payers, (2) statewide expansion of alternative payment reform initiatives and technical assistance, and (3) promoting administrative simplification and standardization of alternative payment models.

In the first subcategory, advancing alternative payment models across payers (Table 7), the two highest ranked proposals among the seven proposals were:

Table 7. Ranked Priorities for Policies on Advancing Alternative Payment Models Across Payers (N=16)

Priorities (1 highest, 6 lowest)	1	2	3	4	5	6
1. Accelerate alignment of multi-year value-based payment (VBP) models across payers to promote consistency and reduce administrative burden for primary care providers.	38% 6	25% 4	13% 2	25% 4	0% 0	0% 0
2. Include dental, behavioral health, and pharmacy services in PMPM payments to primary care providers to increase access to comprehensive primary care.	38% 6	6% 1	19% 3	13% 2	6% 1	19% 3
3. Encourage insurer utilization of capitation payments incorporating accountability and risk-adjustment mechanisms to reimburse PCPCH clinics.	6% 1	19% 3	25% 4	19% 3	19% 3	13% 2
4. Adopt and evaluate global payment systems for behavioral health services with the goal of removing transactional barriers to care (e.g., organizational barriers) across public and private payer sources.	6% 1	19% 3	13% 2	13% 2	44% 7	6% 1
5. Promote adoption of quality incentives aligned with Oregon's PCPCH model, specifically financial incentives among commercial plans to support providers ability to sufficiently budget for infrastructure to support the medical home within a given fiscal or calendar year.	6% 1	19% 3	31% 5	25% 4	13% 2	6% 1
6. Adopt and evaluate global payment systems for behavioral health services with the goal of removing transactional barriers to care (e.g., organizational barriers) across public and private payer sources.	6% 1	19% 3	13% 2	13% 2	44% 7	6% 1
7. Require Public Employees' Benefit Board and Oregon Educators Benefit Board to adopt VBP principles for advanced primary care payment, including in-patient hospital services and specialty care.	6% 1	13% 2	0% 0	6% 1	19% 3	56% 9

In the second category, statewide expansion of alternative payment reform initiatives & technical assistance (Table 8), the highest ranked policy priorities were:

Table 8. Ranked Priorities on Statewide Expansion of APMs Initiatives & Technical Assistance (N=16).

Priorities (1 highest, 3 lowest)	1	2	3
1. Sponsor a regional pilot program to test an Oregon-specific multi or all-payer primary care value-based payment system and demonstrate implementation feasibility.	56% 9	19% 3	25% 4
2. Expand and increase statewide technical assistance (TA) available for primary care providers, including creating a sustainable funding mechanism for TA to assist primary care providers in transitioning to value-based payment models, which require staffing resources and infrastructure investment by primary care provides. (e.g., risk adjustment, claims and quality measurement reporting and incentives).	31% 5	13% 2	56% 9
3. Develop a "pay or play" assessment for all Oregon health insurers to support the development of a statewide primary care value-based payment system to ensure fairness across all payer types in Oregon.	13% 2	69% 11	19% 3

In the third category of policy proposals, promoting administrative simplification and standardization of alternative payment models (Table 9), the highest ranked policy proposal was:

Members noted that the scale of each of these proposals varied, with policy A being a much broader concept and policy B being a more specific strategy.

Table 9. Ranked Priorities for Promoting Administrative Simplification and Standardization of APMs (N=16)

Priorities (1 highest, 2 lowest)	1	2
1. Standardize capitation payment methodologies to reduce administrative burden on providers.	75% 12	25% 4
2. Increase detail and transparency in the state's annual Primary Care Spending in Oregon Report and associated reporting available via the All Payer, All Claims Reporting Program (APAC). Each PCPCH site would be assigned a unique identifier that could be utilized for all fee-for-service (FFS) claims and non-claims (VBP) reporting among insurers and APAC. This identifier would allow policymakers and researchers to identify and evaluate the portion of health care spending allocated by insurers and CCOs to primary care providers delivering comprehensive primary care services by PCPCH tier status.	25% 4	75% 12

APPENDIX A: WORK GROUP MATERIALS

Meeting date	Presenter, associated documents
May 26, 2020	Dr. Evan Saulino: Primary Care Presentation Staff: Discussion Guide, Meeting Summary, Meeting Video
June 23, 2020	Rep. Prusak: Racism- Public Health Crisis video Staff: Discussion Guide, Meeting Summary, Meeting Video
July 28, 2020	Dr. Evan Saulino, Dawn Creach and, Dr. Lynnea Lindsey Staff: Discussion Guide, Meeting Summary, Meeting Video
August 25, 2020	Andrew Stolfi & Jesse O'Brien, DCBS: Presentation Jeremy Vandehey, OHA: Presentation Staff: Discussion Guide, Meeting Summary, Meeting Video
September 8, 2020	Dr. Lisa Watkins, Milbank Foundation: Presentation Dr. Ann Tseng & Martha Snow, OHSU: Presentation Chris DeMars, OHA: Presentation Staff: Discussion Guide, Meeting Summary, Meeting Video
September 22, 2020	Work Group Member discussion Staff: Discussion Guide, Meeting Summary, Meeting Video
October 27, 2020	Staff: Survey Results, Meeting Video

APPENDIX B: SURVEY QUESTIONNAIRE

Universal Access to Primary Care Work Group - Policy Proposals

Introduction
This survey is administered by the Legislative Policy and Research Office (LPRO) on behalf of the Universal Access to Primary Care (UAPC) Work Group. Under the direction of Representatives Prusak and Moore-Green and the House Committee on Health Care, the UAPC Work Group has been charged with developing proposals to advance primary care in Oregon. The responses to this survey will be used by the workgroup to prioritize the set of policy proposals for the upcoming 2021 legislative session. Policy proposals described in the survey were identified by members during the monthly virtual meetings of the UAPC Work Group (May through September 2020).

Results will be reported on an aggregate level without any identification possible and shared with the work group on October 27th.

It should take only 10-15 minutes to complete the survey. The deadline to submit responses is October 22nd by 5pm.

Thank you for participating. We greatly appreciate your expertise and shared commitment to the UAPC Work Group.

If you have questions about the survey, please contact LPRO staff: Zoe Larmer, (503) 986-1508, Zoe.Larmer@oregonlegislature.gov

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Q1 ACCESS TO AFFORDABLE COMPREHENSIVE PRIMARY CARE
The first set of policy proposals are designed to ensure primary care services are affordable and accessible to all residents with minimal financial barriers such as point-of-service cost-sharing and insurance deductibles. The second set of policy proposals are designed to enhance access to and support for Oregon's PCPCH clinics. The policy proposals have been grouped into two categories (1) access and affordability, and (2) increase support for the Oregon PCPCH program.

Q1 a Please rank (drag and drop) the following policies regarding Access to and Affordability of Comprehensive Primary Care from your highest priority (1) to your lowest priority (5):

1. Increase access to appropriate primary care services including preventive services by reducing (or eliminating) co-payments and deductibles for primary care services (e.g., $5 co-pay), particularly among high-deductible health plans.
2. Eliminate insurance barriers to well visits including allowing well visits and annual visits to occur any time in a calendar year (vs. after 365 days).
3. Increase access to behavioral health services by limiting insurers' ability to define behavioral health services as a specialty service when such a designation

creates additional or a high co-payment for an enrollee, regardless of payer source.
4. Remove prior authorization for individuals who require primary care services including behavioral health services delivered in a primary care setting.
5. Eliminate multiple co-payments and allow for only one minimal co-payment by an enrollee for physical health and behavioral health services delivered on the same day in a certified Patient-Centered Primary Care Home (PCPCH), to reduce cost barriers to accessing comprehensive primary care services such as behavioral health and clinical pharmacy.

Q1 b Please rank (drag and drop) the following policies regarding Increasing Support for and Participation in Oregon's PCPCH Model from your highest priority (1) to your lowest priority (5):

1. Increase access to primary care by expanding the statutory definition of primary care providers to include pharmacists, certain behavioral health practitioners, and naturopathic physicians, which supports team-based care in a medical home including appropriate services. Ensure application and implementation of an expanded definition of primary care are consistent across Medicaid and commercial carriers.
2. Encourage commercial insurers to offer incentives to enrollees to select a recognized PCPCH provider to encourage use of Oregon's medical home model. Such an approach could assist providers in onboarding and managing patient population at a given practice site to improve quality.
3. incentivize insurers' utilization of clinics certified by Oregon's PCPCH program, including PMPM reimbursement by tier (1-5), to broaden use of medical home model across payer types.
4. For reimbursement, integrate clinical and outpatient pharmacists, licensed and certified behavioral health practitioners, and oral health providers into Oregon's PCPCH model as members of the medical home model. For example, insurers offering a separate PMPM for behavioral health in addition to a PMPM paid for PCPCH recognition.
5. Provide financial incentives to rural small and independent providers to participate in Oregon's PCPCH program without requiring acceptance of significant financial risk.

Q2 PRIMARY CARE SERVICE DELIVERY - EXPANSION AND USE OF TELEHEALTH

This set of policy proposals are to incentivize primary care services over urgent care or other services in more costly settings by improving access to telehealth services, enhancing coverage of telehealth services, and promoting reimbursement parity post-COVID-19.

The policy proposals have been grouped into two categories: (1) removal of barriers to telehealth, and (2) investing in broadband infrastructure.

Q2 a Please rank (drag and drop) the following policies regarding Removal of Barriers to Telehealth from your highest priority (1) to your lowest priority (4):

1. Codify COVID-19 emergency telehealth requirements, including covered services and reimbursement parity.
2. Direct the Department of Consumer and Business Services (DCBS) to work with commercial insurers to ensure telehealth is inclusive of primary care services and that place of care does not equate to lower reimbursement rates. Establish reimbursement parity for primary care telehealth services covered by state-regulated health benefit plans.
3. Establish telehealth parity inclusive of behavioral health services among coordinated care organizations and commercial carriers.
4. Promote utilization of primary care services over urgent care or other services in more costly settings by reducing or eliminating co-pays and other out-of-pocket costs to access same-day services via telehealth.

Q2 b Please rank (drag and drop) the following policies regarding Support Investments in Broadband Infrastructure from your highest priority (1) to your lowest priority (3):

1. Incentivize alternative payment models that facilitate or promote telehealth services (e.g., supporting associated IT and staffing costs for clinics).
2. Create financial incentives to foster partnerships with local entities (e.g., local school districts) and internet service providers to increase access to remote Wi-Fi services and locations that support telehealth service access in rural and underserved communities.
3. Invest in statewide broadband infrastructure to increase access to telehealth among rural patients and other population groups with limited ability to access remote services.

Q3 Statewide Alternative Payment Reform Models

The final set of policy proposals are to support and advance statewide payment models for primary care providers that are predictable, equitable, and demonstrate a shared commitment among public and private payers in Oregon consistent with current payment reform efforts. The policy proposals have been grouped into three categories: (1) advancing alternative payment models across all-payers, (2) statewide expansion of alternative payment models and technical assistance, and (3) simplification and standardization of alternative payment models across payers.

Q3 a Please rank (drag and drop) the following policies regarding Advancing Alternative Payment Models Across All-Payers from your highest priority (1) to your lowest priority (6):

1. Accelerate alignment of multi-year value-based payment (VBP) models across payers to promote consistency and reduce administrative burden for primary care providers.

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2. Encourage insurer utilization of capitation payments incorporating accountability and risk-adjustment mechanisms to reimburse PCPCH clinics.
3. Include dental, behavioral health, and pharmacy services in PMPM payments to primary care providers to increase access to comprehensive primary care.
4. Adopt and evaluate global payment systems for behavioral health services with the goal of removing transactional barriers to care (e.g., organizational barriers) across public and private payer sources.
5. Promote adoption of quality incentives aligned with Oregon's PCPCH model, specifically financial incentives among commercial plans to support providers ability to sufficiently budget for infrastructure to support the medical home within a given fiscal or calendar year.
6. Require Public Employees' Benefit Board and Oregon Educators Benefit Board to adopt VBP principles for advanced primary care payment, including in-patient hospital services and specialty care.

Q3 b Please rank (drag and drop) the following policies regarding Statewide Expansion of Alternative Payment Reform Initiatives & Technical Assistance from your highest priority (1) to your lowest priority (3):

1. Expand and increase statewide technical assistance (TA) available for primary care providers including creating a sustainable funding mechanism for TA to assist primary care providers in transitioning to value-based payment models, which require staffing resources and infrastructure investment by primary care provides. (e.g., risk adjustment, claims and quality measurement reporting, and incentives).
2. Sponsor a regional pilot program to test an Oregon-specific multi- or all-payer primary care value-based payment system and demonstrate implementation feasibility.
3. Develop a "pay or play" assessment for all Oregon health insurers to support the development of a statewide primary care value-based payment system to ensure fairness across all payer types in Oregon.

Q3 c Please rank (drag and drop) the following policies regarding Promoting Administrative Simplification and Standardization of Alternative Payment Models Across Payers from your highest priority (1) to your lowest priority (2):

1. Standardize capitation payment methodologies to reduce administrative burden on providers.
2. Increase detail and transparency in the state's annual Primary Care Spending in Oregon Report and associated reporting available via the All Payer, All Claims Reporting Program (APAC). Each PCPCH site would be assigned a unique identifier that could be utilized for all fee-for-service (FFS) claims and non-claims (VBP) reporting among insurers and APAC. This identifier would allow policymakers and researchers to identify and evaluate the portion of health care spending allocated by insurers and CCOs to primary care providers delivering comprehensive primary care services by PCPCH tier status.

Q4 Please select the top three policy categories that are important to you and your organization:

- ▢ Support Investments in Broadband Infrastructure
- ▢ Remove Barriers to Telehealth
- ▢ Advance Alternative Payment Models Across Payers
- ▢ Promote Administrative Simplification and Standardization of Alternative Payment Models Across Payers
- ▢ Support Statewide Expansion of Alternative Payment Reform Initiatives & Technical Assistance
- ▢ Increase Support for and Participation in Oregon's PCPCH Model
- ▢ Increase Access to and Affordability of Comprehensive Primary Care

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Q5 Based on your previous responses, please indicate your three highest priority policy proposals for the upcoming 2021 legislative session:

APPENDIX C: WORK GROUP MEMBER COMMENTS

1. CareOregon
2. PacificSource
3. Providence Health & Services

November 17, 2020

Representative Rachel Prusak
Representative Raquel Moore-Green
Oregon Legislative Assembly
900 Court Street
Salem, OR 97309

CareOregon Comments on Universal Access to Primary Care Workgroup Report

Dear Representatives Prusak & Moore-Green,

Thank you for your leadership in bringing together this wide-ranging group of primary care stakeholders to move Oregon towards universal access to primary care. We strongly believe ensuring access to comprehensive, high quality primary care is integral to achieving the goals of CCO 2.0 and moving Oregon's overall health system forward towards better health, better quality, and lower costs for all Oregonians.

CareOregon, a nonprofit that has served Oregon Health Plan members for over 25 years, is a founding member of Health Share of Oregon, the Coordinated Care Organization that contracts to manage Medicaid benefits in the Portland Metro area. CareOregon manages the behavioral health benefits for Health Share's 300,000 members, the physical health benefits for 200,000 of those members, and dental health benefits for 70,000 Health Share Members. Additionally, CareOregon manages OHP benefits for 45,00 members in Jackson County through ownership of Jackson Care Connect, and 30,000 members in Clatsop, Columbia and Tillamook counties through ownership of Columbia Pacific CCO.

CareOregon's mission is to build individual well-being and community health through partnerships, shared learning, and innovation. Partnering with primary care providers to serve over 400,000 Oregon Health Plan members across the state, we see an interconnectedness among the proposals developed by the workgroup. Central among them are the proposals intended to lay the groundwork for transitioning Oregon's primary care delivery system away from fee-for-service and towards value-based payment (VBP) in a thoughtful manner, and across all payers. While recognizing VBP is not a panacea for all the barriers discussed during the workgroup, prioritizing a transition to VBP can better align incentives and reimbursement for: behavioral health integration, enhanced access via optimized utilization of telehealth and in-person visits, a robust PCPCH staffed by an interdisciplinary team of health care professionals, and ultimately, to support further integration with specialist and hospital partners as well.

In addition to further highlighting the inequities in our health care system, the coronavirus pandemic laid bare the inherent weaknesses of operating a critical societal system on fee-for-service

reimbursement. With our mission to guide us, we advanced over $30 million to health care providers in our network to help protect the delivery system from the disruption caused by an abrupt shutoff of fee-for-service revenues. In combination with telehealth, a care delivery system operating under a VBP payment model could help to ensure financial stability for providers and a continuity of access to services for our members.

We are encouraged by the groundswell of support for VBP options in response to the challenges posed by the pandemic, both within this workgroup and other policy development arenas such as the Sustainable Health Care Cost Growth Target Implementation Committee. CareOregon looks forward to your continued partnership in policy development to improve the delivery of care and the overall health of our state.

Sincerely,

Stefan F. Shearer, MPA:HA
Public Policy & Regulatory Affairs Specialist
CareOregon

PacificSource

November 16, 2020

Representative Rachel Prusak
Representative Raquel Moore-Green
Oregon Legislative Assembly
900 Court St
Salem, OR 97309

Delivered via email: zoe.larmer@oregonlegislature.gov

Dear Reps. Prusak and Moore-Green,

Thank you for the opportunity to participate in the Universal Access to Primary Care Workgroup. Although the group necessarily had to meet and discuss topics virtually this year, we appreciate your efforts in working to develop a conversation about how to improve access to primary care. We would also like to acknowledge the work of the Legislative Policy and Research Office in staffing the workgroup. With that being said, we write to offer some comments on the draft report.

In general, multiple members of the workgroup noted that this report needs to be woven into the complex quilt of health reform efforts occurring within the state. There is a lot to be gained by close coordination with the other discussions occurring in Oregon, around cost containment,[1] in ways of continuing telemedicine,[2] and in new models of primary care.[3] We would also like to recommend framing the report in such a coordinating manner.

Also, please consider how widespread the impact of these recommendations will actually be on the overall insurance market. Earlier on in the workgroup, there was discussion on how much commercial insurance activity is covered by the state's Insurance Code. According to Department of Consumer and Business Services health insurance enrollment data from the second quarter of 2020, self-insured and stop-loss coverage (1,242,699) exceeds all regulated commercial insurance coverage (1,089,960).[4] These numbers align with earlier charts submitted by the department, which show that the commercial insurance market is not a dominant share of the overall payer mix in the state.[5] Without strategies to reach the Oregon Health Plan and the self-insured market, the overall effect of reforms could be limited.

[1] Sustainable Health Care Cost Growth Target Implementation Committee: https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx
[2] https://dfr.oregon.gov/news/2020/Pages/telehealth-agreement-health-plans.aspx
[3] Primary Care Payment Reform Collaborative: https://dfr.oregon.gov/news/2020/Pages/telehealth-agreement-health-plans.aspx
[4] Data available at: https://dfr.oregon.gov/business/reg/reports-data/annual-health-insurance-report/Pages/health-ins-enrollment.aspx
[5] https://olis.oregonlegislature.gov/liz/2017R1/Downloads/CommitteeMeetingDocument/110976

Turning to the specific recommendations, PacificSource would like to include the following comments for the written record:

- Value-based payments are an important component of ensuring that the health care sector in Oregon providers better care more efficiently. COVID-19 and its impact on functioning primary care offices certainly speaks to the need, at least conceptually, to figure out a different relationship between provider and payer. Nonetheless, moving parties away from the traditional fee-for-service model of reimbursements to value-based payments entails significant and complex work. Given that parties need to work out agreements over time, a voluntary framework would give parties the freedom to develop suitable solutions. A voluntary framework, however, may make ideas discussed in the workgroup like standardizing capitation rates difficult to implement in a voluntary framework.

- Delivering health care via remote methods increased exponentially as providers and patients alike embraced technology to continue with needed care. PacificSource alone experienced a significant increase in claims related to telemedicine. In fact, the most common claim for much of the summer consisted of 60-minute psychotherapy visits. Telemedicine certainly promises to bridge gaps in care, whether due to geographic distances or otherwise. In proposing changes, though, PacificSource would urge you to consider balancing modalities and attention to patient care. A physical exam is at times essential for adequate assessment. Audio or text only modalities of delivering patient care may not allow a provider to pick up on subtle yet important cues that indicate how a patient is responding to a new medication, for example.

- One idea discussed in in the draft report consists of limiting cost sharing for primary care visits. This was discussed at one of the workgroup meetings, but we wish to reiterate that legislating choices about cost sharing will have impacts in benefit design. For the so-called "metal level" plan tiers under the Affordable Care Act, the plans must meet a certain "actuarial value" for the coverage level of the plan.[6] These values are established every plan year by the Center for Medicare and Medicaid Services.[7] This value (or AV) is the percentage of total average costs for covered benefits. In practical terms, meeting the AV in a metal level tier is a balancing act: managing cost share in one area may increase cost share in another area. While emphasizing primary care in cost sharing may result in long-term savings, in the short term commercial carriers and policymakers will need to make decisions about whether decreases in cost share for primary care visits may need to be offset by cost sharing increases in other types of care or services.

- Another idea in the draft report is to limit cost sharing for high deductible health plans. As discussed in previous workgroup meetings, states may have limited flexibility to require changes in high-deductible health plans. High-deductible health plans exist as a necessity under federal tax law. In order for a person to save funds through a health savings account, the saver must also have a high deductible health plan.[8] Failure to maintain a high-deductible health plan can subject the plan member to additional

[6] 45 CFR § 156.140. The levels of coverage are: bronze, 60%; silver, 70%; gold, 80% and platinum, 90%.
[7] 45 CFR § 156.135.
[8] 26 USC § 223.

taxation. There are safe harbors for preventive services – including for annual wellness visits – that do not negate a high-deductible health plan.[9]

Thank you again for including these comments in the draft report.

Sincerely,

/s/

Richard Y. Blackwell
Director, Oregon Government Relations

[9] *See* 42 U.S.C. 1395x(hhh).

Providence Health & Services
4400 N.E. Halsey St., Building 2
Suite 599 Portland, OR 97213 www.providence.org/oregon

November 17, 2020

Representatives Rachel Prusak and Raquel Moore-Green
Co-Chairs, Universal Access to Primary Care Work Group

Re: Comments from Providence Health & Services

Dear Co-Chairs Prusak and Moore-Green,

Thank you for the opportunity to participate on the Universal Access to Primary Care Work Group (UAPC) during the 2020 interim. Providence Health & Services is deeply committed to providing access to high-quality, comprehensive primary care in our communities. In Oregon, we serve thousands of our fellow citizens every day in nearly 100 patient-centered primary care medical homes (PCPCH). Providence believes that health is a human right and ready access to primary care is an important component of realizing this right for Oregonians.

Providence appreciated that the UAPC report acknowledges the existence of other task forces and committees working to expand access to health care and reduce costs. One of the challenges at this moment in history is managing the conversations occurring across several settings. Coordinating solutions is essential to meeting the many statutory mandates and community priorities that these groups are formed to resolve. We would urge particular attention be paid to the work of the Senate Bill 889 implementation committee and on efforts to reduce the total cost of care. Cost is a component of maintaining access and we must be concerned about the toll that increasing costs have on the entire system of care.

Providence supports the following recommendations from the UAPC report:

- **Easing the way of consumers to access behavioral health and physical health services within a single PCPCH on the same day.** Providence was among the first to embed behavioral health services within our PCPCH's to promote access to services. This proposal would improve uptake of services by those who need them most.
- **Improving access to broadband services, especially in rural areas**. Providence provides services along the north coast, in the Gorge and in other rural communities across this state who do not have the same access to broadband as urban and suburban consumers.
- **Extending some of the emergency provisions for telehealth including:**

    - Allowing for a broader range of services, including physical therapy and occupational therapy, to be delivered via telemedicine.
    - Allowing patients to establish services with a provider via telemedicine.
    - Allowing for a time-limited (1-2 years) of payment parity for telemedicine services via two-way synchronous video services in order to enable efficiencies to emerge in practice patterns.
- **Expansion of advanced payment models (APM) in primary care, including patient assignment**. Providence supports expanding the use of value-based payment other APMs. We also believe flexibility in the use of these models is necessary to meet the needs of different provider types, practice size, and experience with APMs.

In addition, Providence has some concerns about the recommendations:

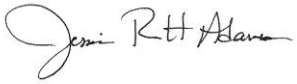
- **Proposals to eliminate cost-share or change plan design for high-deductible health plans and metal tier plans.** Providence shares the concerns of PacificSource; plan designs for Affordable Care Act compliant plans sold on the exchange and high-deductible health plans are not solely within the control of the state. Careful consideration to how changes to these plans will impact consumers in the long run must be evaluated. Providence encourages the legislature to identify other options, including the use of additional need-based patient assistance programs to address cost barriers to primary care. Providence also reminds members of the passage of House Bill 3076 (2019) that codified in statute practices of many non-profit clinics associated with hospitals and health systems – that is, the extension of financial assistance policies to primary care clinics. Patients with family incomes up to 400% of the federal poverty level have access to care at reduced costs at Providence clinics in Oregon.
- **Requirements for insurers to pay certain provider types as "primary care" or increase pay for certain provider types.** Legislators and the public should demand that each additional dollar invested into any health service improve access and increase quality. Increasing payment rates and expanding provider types assists certain provider groups in becoming more profitable, but it may not result in increased quality or access for consumers. Providence urges the UAPC and the legislature to carefully balance these kinds of requests against the requirements of Senate Bill 889 and other health care investments.
- **Extending some of the emergency provisions for telehealth including:**
    - Permanent expansion of payment parity which would not allow for the service to be part of a structure that enables compliance with the Senate Bill 889 work in the long run.
    - Payment parity for asynchronous and telephone visits which should not be paid for as a fee-for-service payment.

Providence appreciates the work of the committee to improve access to primary care. Our hope is the proposals the committee has raised will be vetted in conjunction with proposals being brought forward by other workgroups formed to implement the requirements for total cost of care as well

as existing collaboratives. Successful implementation of additional requirements depends on the ability to integrate with other existing initiatives. Providence looks forward to continuing to work with the legislature and other members of the UAPC to continue this discussion.

Sincerely,

Robin Henderson
Chief Executive of Behavioral Health
Providence Health & Services



Jessica Adamson
Director, Government Relations - Oregon
Providence Health & Services