SB951 / Suggested -5 Changes

Chair Patterson and members of the Committee

For the record, my name is Ryan Grimm, the with the Portland Clinic.

I am speaking here as the President of the Oregon Ambulatory Surgery Center Association, representing 70+ surgical centers around the state, in each and every one of your districts.

Our members come in all sizes, small, medium and large.

They include all 5 ownership models:

- Physician owned
- Physician partnerships with management or national health expert groups.
- Physician partnerships with hospitals.
- Management / National Health Expert Owned
- Hospital Owned.

That broad mix benefits consumers. It leaves alternatives for all communities. It ensures that rural communities have the opportunity to retain surgical centers in their backyards.

We have been at the table on this bill for a year now.

We and others at this table have had meetings, offered amendments and suggestions, and joined together to urge for changes to protect our communities. We have recognized that the Legislature wants to do something, and we agree that physicians need to be at the center of decision making for patient care. That's what our clinic does, and what the 70 other members of OASCA do as well.

At this point, the -5 amendment still leaves us with serious concerns. There appear to be very few substantive changes from the introduced bill, SB951.

There are 3 overall concerns that our members have expressed:

1) We are concerned that it will prohibit Oregon clinics from attracting and retaining the most senior of our physicians, those who are incentivized by an "ownership" stake.

2) We are concerned that it will drive management companies and health expert groups away from Oregon. This will mean that in our small state, clinics will not be able to acquire the very, very expensive multi-million dollar surgical equipment that is leading to revolutionary advances in patient care and patient outcomes.

And 3) we are worried that as written, this bill will leave physician-owned clinics with only one alternative for sale and investment: hospital acquisition.

Don't get me wrong, we love our hospitals. Many of our clinics partner with them and are even owned by them. They do a great job. But we universally agree that the way to protect clinics from closure and maintain the broadest patient access to outpatient care is to keep the existing, and multi-ownership models alive and well. And in some communities, there is no hospital to swoop in to the rescue, or no hospital in a financial position to save a clinic. In those cases, our communities need a way to ensure that their important local clinic survives. This bill will discourage that, and discourage potential experts and investors in surgery from even looking at Oregon clinics.

There are 5 specific areas we'd like to draw your attention to in the bill, that others will go into in more detail:

#1) In multiple places, the bill still does not link its definitions to Oregon's clear, and already litigated "Practice of Medicine" statutes. That will lead to anybody's best guess or interpretation of what the bill covers.

#2) The bill, in Section 2 (a) C prohibits the delegation of contracting provisions. So, to flip that, what it does is that it appears to mandate that physicians in a clinic must handle all of the contracting. This is not what my physicians want to spend their time doing, and it is exactly the type of role that makes the most sense for MSOs. A similar change should be made in Section 2 (a) F (v through viii). There, the bill prohibits contracting out of basic administrative functions which, again, my physicians should not have to worry about: It prohibits: *(v) Setting policies for patient, client or customer billing and collection; (vi) Setting the prices, rates or amounts the professional medical entity charges for a medical licensee's services; or (vii) Negotiating, executing, performing, enforcing or terminating contracts with third party payors or persons that are not employees of the professional medical entity.*

This is basic stuff that clinic managers must be able to do.

#3) The dual employment provisions on page 7, lines 9-11, mean that a physician in an executive role could not continue to practice medicine. This is counterproductive, and again, will disadvantage us as we try to attract top level executives with medical experience to our systems.

#4) The Non-compete language in Section 7 and 8 need attention. We should make the non-compete based on and cover "decision makers", rather than making it cover a particular "ownership percentage." This would make more sense. I need to share that

many of our members would still like to be able to have a non-compete for owners, but perhaps require a 3 or 5 year vesting period to protect the investment a clinic makes in a new owner. Either approach would work better than what is in the current amendment.

#5) It is difficult for us to see how this bill is not going to cost the state millions of dollars. This seems to be the same fiscal approach used four years ago during passage of the "Mergers and Acquisitions" bill. That bill also had no "fiscal," but it clearly has cost the state millions of dollars. Indeed, there is a whole new staff team at OHA for this complex process, huge amounts have been charged for the Assistant Attorney General Reviews, and numerous public meetings and mediation sessions have been held.

#6) I know we're all concerned about malpractice insurance costs. Section 8, Page 19, lines 18 - 20 could amplify these concerns. This is the section listing exemptions from the "non-disparagement/non-disclosure" section, and it needs to include "malpractice" settlement agreements.

Finally, this draft still has what appear to be drafting errors, or at least inconsistencies.

For instance, Section 1 (a) A states that an MSO may not own any shares. But Section 2 (a) F refers to MSOs not being able to aquire a "majority of shares."

These are the types of errors that are causing concerns. Compliance with the bill as written will be difficult, and expensive. Basic definitional items must be consistent.

Again, we all agree that physicians should make the major health care decisions for their patients. We all agree that communities should be protected. However, the current draft of this bill could lead to clinic closures, challenges recruiting new physicians to Oregon, and higher health care costs for consumers. I hope that we can work to get some of the above mentioned ideas into the next amendment.

Thank you.