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TESTIMONY BEFORE THE OREGON SENATE COMMITTEE ON HEALTH CARE
Hearing on SB 951
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Hearing Room B, Oregon State Capitol

Submitted by:
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Chair Patterson, Vice-Chair Hayden, and Members of the Senate Committee on Health Care,
Thank you for the opportunity to testify today on Senate Bill 951. My name is Peter Ricoy, and I am an attorney with Beeghly Ricoy Law Group. I've been practicing in healthcare law for about 20 years, and I regularly advise a range of healthcare clients—including physician groups, nurse practitioners, hospitals, and health plans—on compliance with Oregon healthcare laws, including the corporate practice of medicine doctrine.

I am not testifying on behalf of any client today, and my clients hold a range of perspectives on this legislation. While I am not here to expressly support or oppose SB 951, I do have views on its implications. My testimony will focus on two key points: (1) my overall perspective on the bill and its approach to regulating MSO involvement in healthcare, and (2) areas of ambiguity or uncertainty in the bill's language that should be clarified to prevent inconsistent interpretations and unintended consequences.

Given the complexity of healthcare regulation, clarity in legislative drafting is critical to ensuring compliance and avoiding unnecessary legal disputes. To that end, I have identified specific provisions where additional precision could improve the bill's effectiveness while reducing the risk of confusion or enforcement challenges. I encourage legislative counsel to carefully review these areas to ensure the bill achieves its intended objectives with minimal unintended disruption.

I. WE SHOULD EMPOWER OREGON INGENUITY, CREATIVITY AND INNOVATION

We all share the goal of ensuring that clinical decisions remain unimpeded by financial or business influences that could compromise patient care. At the same time, cost reduction and efficiency have been core components of the Triple Aim, and Oregon has been a leader in healthcare innovation. Greater flexibility in how physicians structure their clinical and business interests fosters innovation and supports outstanding patient care in our state.

Physicians are highly trained in providing exceptional care, but there is no reason they should not also be able to collaborate with the best business minds to improve healthcare delivery and efficiency. If

left in its current form, many of my clients will not understand why you are essentially handcuffing physicians and other healthcare licensees from designing and participating in innovative solutions, and restricting their ability to be paid for their contributions. For example, I do not see why physicians should be prohibited from holding an ownership stake in the MSOs that provide services to their own practices—this seems like a natural alignment of interests. While I am not opposed to SB 951, I urge the committee to consider whether certain restrictions could unnecessarily limit physicians' ability to develop innovative, effective delivery models that serve Oregonians while advancing the Triple Aim. Instead of imposing rigid constraints, we should trust our physicians to make thoughtful, strategic decisions that enhance care and improve system-wide efficiency.

II. KEY AREAS FOR CLARIFICATION IN SB 951

1. Clarify Whether Physicians May Own an Interest in an MSO That Provides Services to Their PME.

- **Potential Prohibition on Physician Ownership of an MSO That Contracts With Their Own PME**. Section 1(2)(a)(A) prohibits an MSO or any MSO agent (defined to include a shareholder, director, officer, member, manager, employee, or independent contractor of the MSO) from owning or controlling shares in a PME with which the MSO has a management contract. Under a strict reading, this means that if a physician owns both an interest in a PME and an ownership stake in the MSO that services the PME, the physician—by virtue of being a shareholder of the MSO—would be prohibited from retaining ownership in both. This could eliminate physician-led MSO models, even where there is no real risk of improper MSO control over clinical decision-making.

- **Clarification Needed to Preserve or Prohibit Physician MSO Ownership**. If the legislature intends to prohibit physicians from owning MSOs that contract with their own PME, the current language already achieves that—though perhaps more broadly than necessary. If, instead, the intent is to allow physicians to own both a PME and an MSO so long as safeguards prevent undue MSO control, the bill should be revised to explicitly permit such ownership under defined conditions. From my perspective, Oregon physicians should, of course, be able to own interests in the MSOs that support their practices—why wouldn't we want that? But at the end of the day, this is a policy decision for the legislature. My advocacy here is on behalf of clarity, so that all stakeholders understand what is and is not permitted under the law.

2. Clarify the Scope and Impact of the Fair Market Value (FMV) Compensation Exception.

- **The FMV Exception Allows Physicians to Work for Both a PME and an MSO, but With Limits**. Section 1(3)(a) creates a narrow exception allowing a medical professional to work for both a PME and an MSO, despite the prohibitions in Section 1(2). However, this is only permitted if the professional is compensated at fair market value (FMV), does not control or manage the PME through the MSO, and provides services within their licensed scope of practice. Without this exception, the bill would prohibit a physician from being both a PME owner or employee and a consultant or independent contractor for an MSO that services their PME. This restriction significantly limits how physicians can

participate in MSO structures.

- **Clarification Needed on Whether This Also Prohibits Physicians From Sharing in MSO Profits**. The legislation explicitly allows physicians to receive FMV compensation for their work with an MSO, but it is unclear whether physicians are prohibited from receiving additional financial benefits—such as profit distributions or equity-based compensation. If the intent is to ensure physicians are only compensated as hourly or salaried service providers, this should be made explicit. Conversely, if the intent is to allow physicians to participate in MSO financial success beyond fixed FMV compensation, then the bill should be revised to clarify that they may receive profit-based compensation under certain conditions.

- **Physicians and Other Licensees Should Be Allowed to Share in the Benefits They Help Create**. In my view, this restriction should be changed. The bill effectively limits physicians to mere hourly or salaried compensation, preventing them from reaping the benefits of their contributions to innovative healthcare solutions. If a group of physicians successfully organizes both a PME to provide clinical services and an MSO to manage operations efficiently, and in doing so helps Oregon's CCO program save millions of dollars—why should those physicians be forced into a mere service-provider role instead of sharing in the value they create? Oregon Healthcare leaders have championed innovative, physician-led solutions to advance the Triple Aim, but without careful clarifications, this bill could potentially stifle physician entrepreneurship, ingenuity, and participation in the financial success of their own innovations. Physicians are not just providers; they are critical partners in advancing healthcare, and excluding them from business opportunities will ultimately limit creative solutions that could improve patient care and system efficiency.

3. Clarify Whether an MSO Can Ever Own Any Interest in a PME.

- **Conflicting Provisions Regarding MSO Ownership**. Section 1(2)(a)(A) appears to completely prohibit an MSO from owning any shares in a Professional Medical Entity (PME), stating that an MSO and its agents "may not own or control shares" in a PME. However, Section 1(2)(a)(F) prohibits an MSO from "acquiring or financing the acquisition of a majority of shares" in a PME, which implies that minority ownership may be permitted. These provisions create uncertainty as to whether MSOs are barred from any ownership stake in a PME or whether they may hold a limited, non-controlling interest.

- **Clarifying the Intended Scope of the Prohibition**. If the intent is to prohibit all MSO ownership of PME shares, Section 1(2)(a)(F) should be revised to remove the reference to "majority ownership" to eliminate any implication that minority ownership is permissible. If, instead, the intent is to allow MSOs to hold a minority interest while barring majority control, Section 1(2)(a)(A) should be modified to specify that only controlling ownership is prohibited. From a policy perspective, I would recommend allowing some minority ownership to provide flexibility in structuring business arrangements and aligning financial incentives without jeopardizing the clinical independence of providers, which I have seen done effectively in practice. Regardless of the policy choice, the statute should

be revised to make the rule clear and unambiguous.

4. Clarify Whether Section 1(2)(a)(C) Conditions Are Prohibitions or Allowable Restrictions.

- **Conflict Between Sections 1(2)(a)(C) and 1(2)(c).** Section 1(2)(a)(C) explicitly prohibits an MSO from "control[ling] or enter[ing] into an agreement to control or restrict the sale or transfer" of PME ownership interests based on the conditions listed in **Section 1(2)(b).** This language suggests that MSOs **cannot** impose ownership restrictions based on those events. However, **Section 1(2)(c)**—when read alone—states that certain events do justify a restriction on ownership transfers, which could be interpreted as **permitting** MSOs to impose such restrictions. This creates a direct inconsistency: one section states that MSOs may not restrict ownership based on these events, while another suggests that these events may justify restrictions.

- **Clarifying Whether Ownership Restrictions Are Prohibited or Allowed**. The legislature should clarify whether MSOs are prohibited from restricting ownership transfers based on the listed conditions or whether those conditions are intended to be valid and enforceable reasons for restricting transfers. If the intent is to prohibit MSOs from imposing such restrictions, Section 1(2)(c) should be revised to state: "Conditions under which an MSO may not restrict a sale of the professional medical entity's stock, interest, or assets include:" If, instead, the intent is to allow restrictions based on the listed events, then Section 1(2)(a)(C) should be revised to permit such restrictions, ensuring consistency. From a policy perspective, I would favor allowing reasonable ownership restrictions based on these events, as they reflect legitimate business and regulatory concerns. However, the most critical issue is ensuring that the bill does not create contradictory provisions that could lead to uncertainty or legal challenges.

5. Clarify Whether Section 1(2)(a)(C) and 1(2)(c) Apply to Forced Transfers, Not Just Restrictions.

- **The Bill Addresses Restrictions on Transfers but Does Not Address Forced Sales**. Sections 1(2)(a)(C) and 1(2)(c) focus on restrictions that limit or prevent ownership transfers but do not explicitly address situations where an agreement requires a transfer under certain conditions. In practice, many PME agreements include mandatory transfer provisions, such as requiring a shareholder to sell their interest if they lose their medical license. As currently written, it is unclear whether these provisions are permitted or whether they would also be considered a prohibited form of control by an MSO.

- **Proposed Clarification to Address Mandatory Transfers**. If the intent is to regulate both restrictions on transfers and mandatory transfers, Section 1(2)(c) should be revised to state: "Conditions under which a professional medical entity may restrict or require a sale of the professional medical entity's stock, interest, or assets include:" Similarly, if the legislature intends for MSOs to be prohibited from both restricting and mandating transfers, Section 1(2)(a)(C) should be revised to clarify that MSOs may not "control, restrict, or require" the sale or transfer of ownership interests based on the listed conditions. This revision would ensure that the bill clearly applies to both limitations on

transfers and forced sales, preventing ambiguity in its enforcement.

6. Clarify Whether Exempted Organizations Remain Restricted by Governance and Ownership Rules.

- **Potential Conflict Between the Section 1(1)(3)(e)** Exemption and Sections 2–5. Section 1(1)(3)(e) exempts certain organizations—PACE organizations, hospitals, long-term care facilities, residential care facilities, and IPAs—from the prohibitions in Section 1(2) if they qualify as PMEs. However, this exemption applies only to Section 1(2) and does not explicitly extend to Sections 2, 3, 4, and 5, which impose restrictions on PME governance and ownership transfers. As a result, even though these organizations are exempt from Section 1(2), they may still be unable to structure their ownership and governance arrangements as intended if their governing documents remain subject to the requirements in later sections of the bill.

- **Clarification Needed to Ensure the Exemption Is Meaningful.** If the legislature intends for these organizations to be fully exempt from both the prohibitions in Section 1(2) and the governance and ownership restrictions in Sections 2–5, the bill should be revised to explicitly extend the exemption. If the legislature only intended to exempt them from Section 1(2) while keeping them subject to governance restrictions, that should also be clarified so stakeholders understand the actual limitations. Without clarification, these entities may face uncertainty as to whether they can rely on the exemption in practice.

- **Consider Also Exempting These Organizations from the Restrictive Covenant Prohibitions in Sections 6–8.** If the intent is to give these organizations flexibility in structuring their operations, the bill should also explicitly exempt them from Sections 6, 7, and 8, which impose prohibitions on restrictive covenants, including non-compete and non-solicitation agreements. These organizations have a direct interest in how care is delivered to their patients and residents, and the ability to impose reasonable restrictive covenants—such as limiting a departing provider from immediately soliciting patients or residents—could be important to maintaining continuity of care. If these organizations are intended to have more flexibility in structuring their arrangements, an explicit exemption from Sections 6–8 should also be considered.

III. CONCLUSION

I appreciate the committee's work in addressing this important issue and urge careful consideration of the areas of ambiguity I have outlined. I welcome any questions and look forward to engaging in further discussion to ensure that SB 951 is implemented in a manner that provides clarity and legal certainty for all stakeholders.

Thank you for your time and consideration.

Respectfully submitted,

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