OREGON AMBULATORY SURGERY CENTER ASSOCIATION

Our Patients Come First

Suggestions for SB951

March 1, 2025

Members of the Committee,

We have reviewed the draft and have several suggestions that could address the compliance issue some have pointed out, as well as make it more likely to preserve patient access, including in rural areas. Surgical Centers and patients benefit from multiple ownership models and structures. This diversity means that clinics can thrive and survive in small and large communities, rural and urban. The bill should focus on the basic tenant that physicians need to make clinical decisions for patients.

We recommend that these (and the changes suggested by Ryan Grimm) be include so that we don't restrict normal business decisions, and discourage partnerships that allow our clinics to maintain and purchase state of the art equipment for our patients, and to even remain in operation in these challenging times.

- **Section 1 Control** –
  - Sub 2(a)-(b) – activities the MSO is prohibited from doing; includes "de facto control" in (F)
    - This is a confusing section when read with sub 2(d). Instead, perhaps we should try to limit the prohibited activity to that which is more clearly clinical.
    - We should try to include the clinic advisory committee as the governance body where decisions are reviewed/voted on before implementation.
  - Sub 2(b)(A)
    - This eliminates succession agreements, which is problematic.
  - (d) includes list of activities the MSO is permitted to do- assist in carrying out activities in (b), including business operations, accounting, VBC, payor contracts, quality metrics, and reimbursement
    - (d) is good but still creates confusion as to what an MSO can really do with respect to the activities in (b)
    - For example, (d)(i) expands the prohibition on the MSO making ultimate decision over business operations for the activities in (b). However, (d)(ii) permits an MSO to buy the assets of a PC (which is good). As a result, the MSO can buy the assets but cannot make decisions with respect to the use of those assets.

        - There needs to be a provision which allows the professional medial entity to grant power of attorney to the MSO for business and administrative operations that do not constitute the practice of medicine (**as currently defined by ORS 677.085**).
    - Various exemptions- telehealth is exempt only from 2(a)(A) if they do not have a physical presence in state.
        - This bill limits competition. It exempts hospitals who will consolidate physician employment. We have seen this already in places like Salem.
    - P 10 line 8 – Adds a new requirement that individual **who** is employed by MSO and PC must actively participate in clinical care
        - This is ok in part - We want the physician leaders to be actively engaged in the practice. That is the whole point. However, the provisions in (3)(a)(A)-(B), (b), and (d) undermine the integrated clinical leadership. (3)(a)(C) is fine (that is the market rate comp provision).

We hope that these, and the other suggestions offered by our President and Vice President, will be incorporated into a further amendment which can improve the bill and preserve patient access to critical surgical procedures in Oregon.

Thank you.