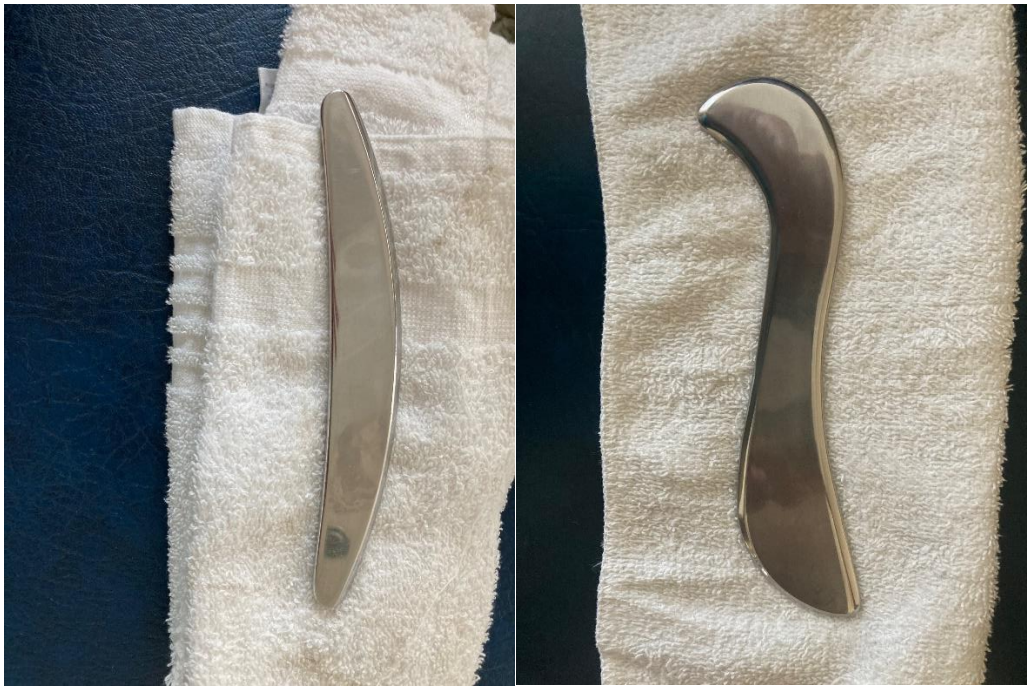
Public Comment Submission from:
Tom Sincic

Topic:
Health Care Expenditures

Will oral comments be provided as well:
Yes

To: UHPGB Members
From: Tom Sincic
Re: Health Care Expenditures
Date: July 15, 2024

According to a physical therapist, one of the massage tools below is $2000 used by the clinic and the other, which works just as well, is $10.99 available for purchase. Do you know which is which?



We are paying too much. There is waste and far too much profit in the system. It is time for health care transformation. The system is broken.

With Gratitude for Your Work!

Public Comment Submission from:
Tom Sincic

Topic:
Universal Health Plan Overarching Principles Recommendation

Will oral comments be provided as well:
Yes

Five Overarching Principles for the Universal Health Plan

Equity Principle:

1. Health care is a fundamental element of a just society, and must be secured for all individuals on an equitable basis by public means, similar to public education, public safety and public infrastructure.
    a. *"Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances."*
    b. Race, color, national origin, age, disability, wealth, income, citizenship status, primary language, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and pregnancy-related medical conditions may not create barriers to health care nor result in disparities in health outcomes due to the lack of access to care;
        i. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
        ii. The equitable distribution or redistribution of resources and power; and
        iii. Recognizing, reconciling, and rectifying historical and contemporary injustices.

Maximize Health:

1. Maximize health includes individual patient satisfaction and agency in their care, public health concerns and population measures as follows:
    a. Improving the health status of individuals, families and communities;
    b. Defending against threats to the health of the residents of this state;
        i. In the case of specifically identified community contagion, community, state and national interests to protect the population at large outweighs individual decision making for reaction to that contagion.
    c. Is responsive to the needs and expectations of the residents of this state as follows:
        i. A primary measure of success should be the attainment of every individual resident to be satisfied in their opportunity to make and act on timely, well-informed health decisions for themselves, unimpeded by external forces of bias, location, or financial impediments to access;
        ii. Making it possible for individuals to participate in decisions affecting their health and the health system;

iii. A participant in the Universal Health Plan may choose any individual provider who is licensed, certified or registered in this state or may choose any group practice; and
iv. A participant in the plan and the participant's health care provider shall determine, within the scope of services covered within each category of care and within the plan's parameters for standards of care and requirements for prior authorization, whether a service or good is medically necessary or medically appropriate for the participant.

Fair Distribution of Medical Resources:

1. Providing equitable access to person-centered care;
2. Removing any financial incentive for a health care practitioner to provide care to one patient rather than another;
3. Focusing on coverage of evidence-based health care and services;
4. The plan may not discriminate against any individual health care provider who is licensed, certified or registered in this state to provide services covered by the plan and who is acting within the provider's scope of practice; and
5. Give voice to the patient population in setting fairness such that:
    a. Matters of defining fairness and how it is applied to distribution of direct should be informed by the community itself, taking care to use a process that is inclusive and based on consensus.

Minimize Financial Hardship on Individuals, Families and Communities

b. Protecting individuals from the financial consequences of ill health; and
c. Removing cost as a barrier to accessing health care.
    i. There shall be no copays or deductibles

Community Ownership and Governance:

1. The Universal Health Plan shall have community ownership and governance to include:
    a. The plan shall cover health care services and goods from birth to death, based on evidence-informed decisions as determined by the board;
    b. Establishing measurable health care goals and guidelines that align with other state federal health standards;
    c. Promoting continuous quality improvement and fostering interorganizational collaboration;
    d. The components of the Universal Health Plan must be accountable and fully transparent to the public regarding information, decision-making and management through meaningful public participation; and
    e. Funding for the Universal Health Plan is a public trust and any savings or excess revenue must be returned to the public trust.

Public Comment Submission from:
David Ladwig

Topic:
Naming metrics, processes, changes for better health care system(s)

Will oral comments be provided as well:
Yes

July 11, 2024

To: Universal Health Plan Governance Board

Upon examination of the Five Workstreams in the document from the June meeting, I see little naming metrics, processes, changes for better health care system(s.)

In the call for committee members, under *Plan Design and Expenditures* - responsible for making recommendations to the board on the elements of the universal health plan, including eligibility, benefit design, quality improvement, provider reimbursements, cost containment strategies, and workforce needs, there are some spots that might create the remedies needed.

However, if the overarching goals for Oregon's Universal Health Plan go beyond a Single Payer covering Everyone, more specific attention needs to be explicitly named than in these documents to this point. Quality improvement done continuously coupled with cost containment strategies should be able to iteratively drive toward a better health care system than the same 'system' as now, except that system streamlined in payment.

In order to have the necessary data to assess, feedback, and improve population health regionally and state wide, there must be some ability defined for linkages between electronic health records (EHR), or at least work arounds for data coming out of all the separate systems presently used. This should include statutory authority to allow for this linkage (Under *Operations Workstream),* and progressive steps for how this would be implemented (*Under Transition and Implementation Workstream.)*

Thank you,

David Ladwig

Public Comment Submission from:
Dr. Vern Saboe Jr
Oregon Chiropractic Association

Topic:
Preventing Reimbursement Discrimination Within Oregon's Proposed, "Universal Health Plan."

Will oral comments be provided as well:
Yes

Congress of the United States
Washington, DC 20515

June 10, 2014

The Honorable Sylvia Mathews Burwell
Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell:

Thank you for your ongoing leadership as you continue working to implement the Affordable Care Act (ACA) and improve the nation's health.

With the knowledge that health insurers, state regulators and others are increasingly relying on the Department of Health and Human Services (HHS) for help in interpreting the ACA, we write to you today with concerns regarding guidance published jointly by HHS, the Department of Labor, and the Department of Treasury (the Departments) on the topic of the Affordable Care Act's "Non-Discrimination in Health Care" provision, codified at Section 2706(a) of the Public Health Service Act (42 U.S.C. §300gg-5(a)).

Overall, Section 2706(a) is an important patient-centered health insurance reform aimed at empowering consumers with a greater ability to seek care from the provider of their choice and safeguarding patient access to covered health services from the full range of providers licensed and certified to provide such services by their respective states. To that end, Section 2706(a) states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

Ahead of the provision's January 1, 2014 enforcement date, the Departments issued sub-regulatory guidance dealing specifically with Section 2706(a) which we believe to be misleading, inaccurate, and a threat to the very foundation of the provision. We respectfully ask that you work with your counterparts at the Department of Labor and Department of Treasury to correct this flawed FAQ in a way that more accurately reflects the language found in the law and the intent of Congress.

In the April 29, 2013 FAQ, the Departments assert that "reasonable medical management techniques" may supersede the broad protections under 2706(a). While a medical management technique that does not discriminate in coverage based on licensure or certification does remain allowable under the law, discrimination in coverage based on licensure or certification of the provider is forbidden even if such discrimination is wrapped in the flag of medical management. The ACA provides many new patient protections that prohibit improper practices by health plans or issuers even when those practices were labeled "medical management techniques" by those payers in the past. Even if the Departments did not intend to suggest that so-called medical management techniques that discriminate in coverage are somehow exempt from the law, the inclusion of such coverage criteria in the response confuses patients, providers, and payers.

Furthermore, the FAQ advises that section 2706 allows reimbursement rates to be determined based on "market standards and considerations." On this point, once again the language of the Affordable Care Act is quite clear—the law allows plans to vary reimbursement rates based on quality and performance, but there is no provision in the law that allows for continuing discrimination based on market standards and considerations. Existing market non-discrimination standards and considerations were precisely the reason Congress enacted Section 2706(a). Allowing discrimination to continue based on the market standards and considerations would be to ignore Section 2706(a), which outlaws such discrimination.

Section 2706(a) was intended to prohibit discrimination by insurers against certain types of providers. The FAQ published on April 29, 2013 provides advice that is contrary to Congressional intent. This provision is an important patient safeguard aimed at ensuring access to needed care and an ability to seek care from the provider of their choice. We respectfully ask that you work with your counterparts at the Department of Labor and Department of Treasury to correct this FAQ in a way that more accurately reflects the language found in the law and the intent of Congress. Thank you for your prompt attention to this matter.

Sincerely,

KURT SCHRADER
Member of Congress

BRUCE L. BRALEY
Member of Congress

EARL BLUMENAUER
Member of Congress

DORIS O. MATSUI
Member of Congress

JANICE D. SCHAKOWSKY
Member of Congress

DAVID LOEBSACK
Member of Congress

COLLIN C. PETERSON
Member of Congress

TERRI A. SEWELL
Member of Congress

CAROL SHEA-PORTER
Member of Congress

MICHAEL H. MICHAUD
Member of Congress

PETER A. DeFAZIO
Member of Congress

CHERI BUSTOS
Member of Congress

JARED HUFFMAN
Member of Congress

JULIA BROWNLEY
Member of Congress

ELEANOR HOLMES NORTON
Member of Congress

CHELLIE PINGREE
Member of Congress

PETER WELCH
Member of Congress

JARED POLIS
Member of Congress

ZOE LOFGREN
Member of Congress

THEODORE E. DEUTCH
Member of Congress

WILLIAM L. ENYART
Member of Congress

ALCEE L. HASTINGS
Member of Congress

ED PERLMUTTER
Member of Congress

LOUISE McINTOSH SLAUGHTER
Member of Congress

SUZANNE BONAMICI
Member of Congress

JAMES R. LANGEVIN
Member of Congress

COLLEEN W. HANABUSA
Member of Congress

CAROLYN McCARTHY
Member of Congress

STEVE ISRAEL
Member of Congress

MICHAEL M. HONDA
Member of Congress

KATHY CASTOR
Member of Congress

PETE P. GALLEGO
Member of Congress

TIMOTHY H. BISHOP
Member of Congress

JAMES A. HIMES
Member of Congress

MATT CARTWRIGHT
Member of Congress

DAVID N. CICILLINE
Member of Congress

LINDA T. SÁNCHEZ
Member of Congress

cc: The Honorable Jacob J. Lew, Secretary of the Treasury
The Honorable Thomas E. Perez, Secretary of Labor

PARCA

Ensuring Patients' Access to Care

December 16, 2020

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
H - 232 U.S. Capitol
Washington, D.C. 20515

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
317 Russell Senate Office Building
Washington, D.C. 20510

Dear Speaker Pelosi and Leader McConnell:

On behalf of the undersigned organizations representing the Patient Access to Responsible Care Alliance (PARCA), we are writing today in support of the provider nondiscrimination provision included in the recently released *No Surprises Act* and urging you to include this important provision in any year end package addressing surprise billing. We appreciate the bipartisan leadership that included this critical provision, including House leaders Chairman Pallone, Ranking Member Walden, Chairman Neal, Ranking Member Brady, Chairman Scott, Ranking Member Foxx, and Senate leaders Chairman Alexander and Ranking Member Murray.

As member organizations of PARCA, we represent non-MD/DO Medicare recognized healthcare providers who provide high-quality, evidence-based care to millions of Americans, especially to those living in rural and underserved areas. As the provider of choice for many patients, we understand the importance of ensuring providers are recognized to practice to the full scope of their training, education, certification, and experience as a way to increase access and competition, lower costs and maintain quality and safety.

We believe that this provision is a necessary part of striking an important balance between patients, providers, and insurers. The critical language around provider nondiscrimination (Sec. 108) is an important part of ensuring that patients have access to care, no matter where they live, by requiring insurers to treat providers fairly. PARCA believes that the federal government must help ensure the appropriate implementation of provider nondiscrimination protections under section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a)). By requiring the promulgation of this rule and prohibiting the exclusion of non-MD/DO providers from insurance networks based solely on the provider's licensure, this consumer-friendly provision promotes competition, consumer choice and access to high-quality healthcare. Our members can speak directly to how disparate treatment by insurers can adversely affect patient care.

PARCA has a firm commitment to putting patients first, to ensure that everyone can receive the care they need from the provider of their choice, and we strongly believe that provider nondiscrimination language is necessary to accomplish this goal and should be included in any

package. If we can be of any assistance to you or your staff, please do not hesitate to contact any of the organizations individually, or Matthew Thackston, Chair of PARCA at mthackston@aanadc.com. Thank you for your consideration.

Sincerely,

American Academy of Audiology
American Academy of PAs
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American Chiropractic Association
American College of Nurse-Midwives
American Nurses Association
American Occupational Therapy Association
American Optometric Association
American Podiatric Medical Association
American Psychological Association
American Speech-Language-Hearing Association
National Association of Pediatric Nurse Practitioners

June 1, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C., 20201

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Ave N.W.
Washington, D.C., 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C., 20220

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of the undersigned organizations representing the Patient Access to Responsible Care Alliance (PARCA), we are writing to you today to congratulate you all on your recent appointments, and to bring your attention to the urgent issue of provider nondiscrimination. H.R. 133, *The Consolidated Appropriations Act of 2021* included the *No Surprises Act,* which contained Section 108 on implementing protections against provider discrimination. This section requires your agencies to execute the provider nondiscrimination protections that were originally included under Section 2706(a) of the Public Health Service Act as implemented by Section 1201 of the *Patient Protection and Affordable Care Act* (ACA) which prohibits private health plans from discriminating against qualified licensed healthcare professionals based on their licensure. However, this provider nondiscrimination provision, which many of our organizations supported, was never implemented through a regulation. Our organizations are writing to ask you to promulgate rules on provider nondiscrimination in a way that protects patient access to care and promotes competition.

As member organizations of PARCA, we represent non-MD/DO Medicare recognized health and mental health providers who provide high-quality, evidence-based care to millions of Americans, especially to those living in rural and underserved areas. As the provider of choice for many patients, we understand the importance of ensuring providers are recognized to practice to the full extent of their training, education, certification, and experience as a way to increase access and competition, lower costs and maintain quality and safety. Collectively, PARCA member organizations represent over 4 million providers throughout the nation, with expertise in a wide variety of areas.

As organizations representing non-MD/DO Medicare recognized healthcare providers, our members in particular have been affected by the lack of enforcement of provider nondiscrimination rules. Health plans and insurers have on occasion refused to negotiate in good faith with our members, refused to allow our members in network, refused to contract with our members, have reimbursed our members unequally to our MD/DO colleagues and have added unnecessary requirements and difficulties for our members that other providers do not face. While these actions directly harm the provider, they also decrease patient access to care, limit competition and increase costs for consumers.

Non-MD/DO healthcare providers, acting within the scope of their license under applicable state law or regulation, should not face discrimination from payors that ultimately hurts patients. Because no enforceable regulation has been issued since the passage of the *ACA,* there is no mechanism in place to enforce this important provision. Congress sought to ensure that these protections are now enforced with the inclusion of Section 108 in H.R. 133. We believe that your agencies should promulgate a robust provider nondiscrimination rule that is in the best interests of consumers through promoting access to healthcare, consumer, and patient choice of safe and high-quality healthcare, reducing healthcare costs through competition, and allowing providers to practice to the full extent of their education, training, and licensure. The rules should take into account several critical considerations:

- Rulemaking should prevent health insurers, health plans, and payors from establishing varying reimbursement rates and varying reimbursement requirements for the same or similar covered services for all types of providers based solely on their respective state licensure. Equitable reimbursement for providers is a necessary step to expanding access to care. Rulemaking should ensure that health plans, health insurers and other payors are not engaging in prohibited contracting practices which discriminate with respect to participation under the plan or coverage based on licensure. While this section does not require health plans to accept any willing provider, this section prohibits them from discriminating based on licensure. Health plans, health insurers and other payors should also not be allowed to remove a provider from the network based solely on their licensure.
- Rulemaking should prohibit health plan issuers from including a stipulation or requirement for supervision or collaboration, or completion of an additional certification or training program, on a particular provider beyond state licensing requirements and any similar or correlating requirements placed on participating MD/DO physicians in order to credential that provider in their health plan network.
- Rulemaking should prohibit a health plan, health insurer, or payor from setting up arbitrary networking rules setting up geographic location limits for its network. Such restrictions can include only allowing on panels a certain class of provider within a given

specialty in a geographic region. Another restriction could be only allowing a specific provider type to participate in a shortage area yet restricting that provider type in its network in areas outside of the shortage area.

- Rulemaking should require that value-based payment arrangements not be allowed to discriminate against an entire class of provider based on their licensure.
- To ensure compliance, rulemaking should include a means to audit health plans, health insurers, and payors for compliance with the provider nondiscrimination provision.
- This rulemaking should only apply to licensed providers with the authorization to bill insurance plans.
- The rulemaking should provide for a monetary penalty for non-compliance with this provision as a way to ensure that payors are staying compliant.

The members of PARCA represent not only many of the non-MD/DO Medicare recognized healthcare and mental health providers who are often discriminated against by insurers, but the providers of choice for many patients, especially in rural and underserved areas, who are adversely affected by lack of access to care. We are urging your departments to promulgate a strong and enforceable provider nondiscrimination rule that protects the needs of patients and consumers.

The members of PARCA hope to be constructive partners in this effort and request a meeting with you and/or your staffs to further discuss this issue. You can reach out to Matthew Thackston, Chair of the PARCA Coalition at mthackston@aana.com or at (202) 741-9081. Thank you for your consideration, we look forward to hearing from you.

Sincerely,

American Academy of PAs
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American Chiropractic Association
American College of Nurse-Midwives
American Nurses Association
American Optometric Association
American Psychological Association
American Speech-Language-Hearing Association
National Association of Pediatric Nurse Practitioners
National Association of Social Workers
National League of Nursing

November 14, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C., 20201

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Ave N.W.
Washington, D.C., 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C., 20220

Dear Secretaries Becerra, Walsh and Yellen

On behalf of the undersigned organizations representing the Patient Access to Responsible Care Alliance (PARCA), we are writing to you today to express our strong concern about the lack of rulemaking on section 2706(a) of the Public Health Service Act. While we appreciate that your agencies conducted a listening session earlier this year, the rulemaking is now ten months past the statutory deadline set forth in the *No Surprises Act* and several self-imposed additional deadlines for rulemaking this year. We strongly request your agencies to conduct rulemaking in a swift manner to ensure that patients have access to the care they deserve from the provider of their choice.

As member organizations of PARCA, we represent non-MD/DO Medicare recognized health and mental health providers who provide high-quality, evidence-based care to millions of Americans, especially to those living in rural and underserved areas. As the provider of choice for many patients, we understand the importance of ensuring providers are recognized to practice to the full extent of their training, education, certification, and experience to increase patient access to care and competition, lower costs and maintain quality and safety. Collectively, PARCA member organizations represent over 4 million providers throughout the nation, with expertise in a wide variety of areas.

According to the Public Health Service Act Section 2706(a), "A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a

health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

Our organizations have highlighted multiple issues surrounding this provision stemming from the lack of official rulemaking and enforcement. Without proper rulemaking and enforcement, insurers will continue to be able to unfairly lower reimbursement, exclude, and add additional barriers to non-MD/DO healthcare providers, decreasing competition and limiting access to care, especially in rural and underserved areas. Additionally, Congress passed the *No Surprises Act* (P.L. 116-260), which included a January 2022 deadline for rulemaking. Members of both the House and the Senate have also sent multiple letters to your agencies laying out the need for rulemaking on this provision, as well as providing a framework for the Congressional intent on what the rulemaking should include. As you are aware, this provision was included in the *No Surprises Act* specifically because the agencies did not conduct rulemaking when section 2706(a) was included in the *Affordable Care Act* and signed into law in 2010.

We stand with lawmakers in supporting a strong rule that will ensure access to care for all Americans, including the millions of rural and underserved patients. We urge you to quickly develop a strong and enforceable provider nondiscrimination rule to ensure that patients have access to care from the provider of their choice. As always, we appreciate the work your agencies are doing on this important matter, to bolster the *Affordable Care Act* and patient access to care. If our coalition, or any of our member organizations can be help, please don't hesitate to contact the PARCA Chair, Matthew Thackston at mthackston@aana.com or (202) 484-8400. We look forward to continuing our dialogue on this important issue.

Sincerely,

American Academy of Audiology
American Academy of PAs
American Association of Nurse Anesthesiology
American Association of Nurse Practitioners
American College of Nurse-Midwives
American Chiropractic Association
American Nurses Association
American Podiatric Medical Association
American Speech-Language-Hearing Association
National Association of Pediatric Nurse Practitioners
National Association of Social Workers
National League for Nursing

Dexter A. Johnson
LEGISLATIVE COUNSEL

900 COURT ST NE S101
SALEM, OREGON 97301-4065
(503) 986-1243
FAX: (503) 373-1043
www.lc.state.or.us

STATE OF OREGON
LEGISLATIVE COUNSEL COMMITTEE

September 12, 2012

Representative Jim Thompson
900 Court Street NE H388
Salem OR 97301

Re: Participation of Chiropractic Physicians in Coordinated Care Organization Networks

Dear Representative Thompson:

You have asked for a legal opinion on the following question:

> If an Oregon "Coordinated Care Organization" (CCO) refuses to allow any (emphasis in original) chiropractic physicians within the CCO network to act in the capacity of a primary care provider providing primary care services (e.g. annual physical exams, wellness annual counseling, screening and wellness blood work, resting ECGs, lung function testing, nutritional counseling, smoking cessation and obesity prevention and treatment, non-pharmacological treatment of some of the 60 most common health conditions presenting to a primary care office, etc., etc.) [w]ould this violate ORS chapter 414 [section 4, chapter 80, Oregon Laws 2012] which states in part[:]
>
> > Section 4. (1) A fully capitated health plan, physician care organization or coordinated care organization may not discriminate with respect to participation in the plan or organization or coverage against any health care provider who is acting within the scope of the provider's license or certification under applicable state law.

The short answer to your question is yes.

Section 4, chapter 80, Oregon Laws 2012, states that a coordinated care organization (CCO) "may not discriminate with respect to participation in the . . . organization or coverage against any health care provider who is acting within the scope of the provider's license or certification under applicable state law." To answer your question, it is necessary to determine, first, whether the services you listed are within the scope of a chiropractic physician's license and, second, whether refusing to reimburse any chiropractic physician who provides those services constitutes the type of discrimination prohibited by the section.[1]

[1] Your question was whether a CCO may refuse to allow any chiropractic physician within the network to act in the capacity of a primary care provider. For purposes of this opinion, I am assuming that this means the refusal to reimburse a chiropractic physician for providing primary care services.

To determine whether primary care services are within the scope of a chiropractic physician's license, I read the Guide to Policy and Practice Questions published by the State Board of Chiropractic Examiners.[2] The guide addressed the following procedures as being within the scope of practice of a chiropractic physician:

- Annual physical exams
- Wellness annual counseling
- Screening and wellness blood work
- Resting electrocardiograms
- Lung function testing
- Nutritional counseling
- Obesity prevention and treatment

I also contacted Dave McTeague, Executive Director of the State Board of Chiropractic Examiners. He confirmed that all of the services in your list are within the scope of practice of a chiropractic physician. With respect to "non-pharmacological treatment of some of the 60 most common health conditions presenting to a primary care office," he responded that chiropractors may offer or prescribe over-the-counter drugs and other vitamins or mineral supplements.

The next question is whether the refusal to reimburse a chiropractic physician for providing those services constitutes discrimination with respect to participation in the CCO or with respect to coverage. As is relevant here, the dictionary defines "discriminate" as "to make a difference in treatment or favor on a class or categorical basis in disregard of individual merit." *Webster's Third New International Dictionary of the English Language* (unabridged ed., 2002). By reimbursing for primary care services provided by an allopathic physician, but not for the same services provided by a chiropractic physician, solely on the basis of the physician's license and even though both are licensed to provide the services, a CCO is treating the two classes of physicians differently on a basis other than individual merit in the extent to which the physicians may participate in the organization.

In addition, section 4, chapter 80, Oregon Laws 2012, also prohibits a CCO from varying reimbursement rates based on factors other than quality or performance measures. In the House Committee on Rules work session on the amendments to Senate Bill 1509 (2012), which became section 4, chapter 80, Oregon Laws 2012, I testified that a CCO could vary reimbursement rates based only on quality and performance measures. Representative Freeman further emphasized this point, and the committee adopted the amendment with that understanding. Therefore, a CCO also violates the section by varying reimbursement rates for covered services based only upon the provider's license and not based upon quality or performance measures.

Finally, ORS 414.625 (2)(k) provides that members of a CCO must have "a choice of providers within the coordinated care organization's network." Subsection (4), added by section 20, chapter 8, Oregon Laws 2012, requires the Oregon Health Authority, in selecting CCOs to serve a geographic area, to "optimize access to care and choice of providers." A CCO would be in conflict with these provisions if the CCO refused to permit any of its members to select a chiropractic physician as a primary care physician if that physician is licensed to provide primary care services.

[2] Available online at <http://cms.oregon.gov/OBCE/publications/Guide_to_Policy_Practice.pdf> (visited September 11, 2012).

I hope this answers your question. Please feel free to contact me if you have further questions or concerns.

The opinions written by the Legislative Counsel and the staff of the Legislative Counsel's office are prepared solely for the purpose of assisting members of the Legislative Assembly in the development and consideration of legislative matters. In performing their duties, the Legislative Counsel and the members of the staff of the Legislative Counsel's office have no authority to provide legal advice to any other person, group or entity. For this reason, this opinion should not be considered or used as legal advice by any person other than legislators in the conduct of legislative business. Public bodies and their officers and employees should seek and rely upon the advice and opinion of the Attorney General, district attorney, county counsel, city attorney or other retained counsel. Constituents and other private persons and entities should seek and rely upon the advice and opinion of private counsel.

Very truly yours,

Lorey H. Freeman
Senior Deputy Legislative Counsel

2017 ORS 743B.505[1]

Provider networks

- • **rules**

- Text
- News
- Annotations
- Related Statutes

(1) An insurer offering a health benefit plan in this state that provides coverage to individuals or to small employers, as defined in ORS **743B.005 (Definitions)**, through a specified network of health care providers shall:

(a) Contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure that all covered services under the health benefit plan, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay.

(b)(A) With respect to health benefit plans offered through the health insurance exchange under ORS **741.310 (Requirements for purchase of insurance through exchange and for participation of insurers in exchange)**, contract with a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of essential community providers for low-income, medically underserved individuals in the plan's service area in accordance with the network adequacy standards established by the Department of Consumer and Business Services;

(B) If the health benefit plan offered through the health insurance exchange offers a majority of the covered services through physicians employed by the insurer or through a single contracted medical group, have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and

timely access for low-income, medically underserved enrollees in the plan's service area, in accordance with network adequacy standards adopted by the Department of Consumer and Business Services; **or**

(C) With respect to health benefit plans offered outside of the health insurance exchange, contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure access to care by enrollees who reside in locations within the health benefit plan's service area that are designated by the Health Resources and Services Administration of the United States Department of Health and Human Services as health professional shortage areas or low-income zip codes.

(c) Annually report to the Department of Consumer and Business Services, in the format prescribed by the department, the insurer's plan for ensuring that the network of providers for each health benefit plan meets the requirements of this section.

(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider's license or certification in this state.

(b)This subsection does not require an insurer to contract with any health care provider who is willing to abide by the insurer's terms and conditions for participation established by the insurer.

(c)This subsection does not prevent an insurer from establishing varying reimbursement rates based on quality or performance measures.

(d) Rules adopted by the Department of Consumer and Business Services to implement this section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United States Department of Health and

Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect on January 1, 2017.