January 24, 2012

To: Members of the OHPB Board

Re: The Art of Non-Discrimination

If I may paraphrase the concerns of Representative Thompson in committee last week, what's at the heart of this discussion is the impending reality that Oregon will be moving from 600,000 covered lives to 950,000 lives. We need to be darn sure that we do everything possible to bring online every available provider and use them to the top of their license.

There are two ways of doing that: passive and proactive.

I was dismayed to see the summary of federal and state non-discrimination language already codified into law. Not a single shred of it is working to ensure access to providers, or patient choice of providers. This barrier to access is a source of frustration that our members hear about every day.

The passive approach to making sure those 950,000 lives have access to the preventitive care they need is non-discrimination language – it's reusing the language that currently is not working, then enduring years of some as-of-yet-undefined dispute resolution process, and then more years of lawsuits when that fails to resolve access issues.

Arguably, it's a step in some direction that is not quite forward. But we could do so much more.

Approaching this proactively does not mean that we need to be prescriptive. The expectation that we have of the OHA going forward includes:

1. ***Set the expectation that CCOs must allow access to all available provider types.*** This needs to be in the business plan. It needs to be in the RFP. It needs to be on the websites. It needs to be in the application process. It does ***not*** mean they have to contract with every willing provider. It does mean that they need to be accountable to a patient's ***choice*** of licensed provider type. I have also raised the concern that thousands of FFS patients who currently see a Naturopathic Physician for their primary care may be forced to find a new doctor if access is not guaranteed. This is not just about non-discrimination and patient choice, it's also about continuity of care.

PO Box 5876 ♦ Portland OR 97228 ♦ 503-262-8586

2. ***Non-discrimination language.*** This component should reflect a patient's right to choose

3. ***Illuminate a rock solid dispute resolution process.*** Like with so many areas that might need dispute resolution, what happens when a CCO does discriminate against providers? We'd have to echo Felicia's previous comments on this. There needs to be clear steps, clear timelines, and clear remediation strategies.

4. ***Define provider and define "Primary Care Provider"*** – This can be done through administrative rule moving forward. But the state needs to have one consistent definition of who are eligible providers that a CCO *should* cover.

Using language from LC 97, and after discussions with staff, we have included adding language in **bold** and deleting language in *[bracketed italics]* as our technical recommendations to the bill. An explanation of why we suggest these changes is provided in italics after each change

"SECTION 8. (1) A fully capitated health plan, physician care organization or coordinated care organization may not discriminate in the participation or reimbursement of any health care provider based on the provider's license or certification if the provider is acting within the scope of the provider's license or certification, ***and may not discriminate against a patient's choice of provider type who are licensed or certified under ORS chapters 675, 677, 678, 679, 680, 681, 682, 683, 684, 685 and 689.*** A plan or organization must give written notice containing the reasons for its action if the plan or organization declines the participation of any provider or group of providers.

(Explanation: This specifically refers to the ORS defining the various different healthcare providers in Oregon. Rather than mandate an 'adequate number' of providers, we thought another way to look at this is to ***ensure that patients have a choice of provider type that is clearly defined****. This fits with the philosophy of transformation, and leads to the requirements of HB 3650 regarding "patient rights, responsibilities, engagement, and choice.")*

(2) Subsection (1) of this section does not:

(a) Require a plan or organization to contract with more providers than are necessary to meet the needs of its members;

[(b) Preclude the plan or organization from using different reimbursement amounts for different specialties or different practitioners in the same specialty; or]

(Explanation: We understand that you want CCOs to have the flexibility to "reward good outcomes." But we also know that in practice, this kind of language is used to pay some providers less for the same service. Either delete this section, or consider clarifying language to prevent reimbursement discrimination, while promoting incentivisation.)

(c) Preclude the plan or organization from establishing measures that are designed to maintain the quality of services and control costs and are consistent with the plan's or organization's responsibilities to its members." ***Any measures established by a plan or organization shall not function to direct treatment in a manner unfairly discriminative against any provider's scope of practice, and collectively shall be no more restrictive than those applicable under the same policy to care or services provided by other providers, but may allow for the management of the benefit consistent with variations in practice patterns and treatment modalities among different types of health care providers. A plan or organization may require that the provider's services be provided by a provider under contract with the insurer or shall be covered in a manner consistent with out-of-network provider reimbursement practices. [lifted from Vermont language, slightly modified]*** *http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT059.HTM*

(Explanation: This allows CCOs flexibility to establish parameters to ensure outcomes, without allowing discrimination on different modalities or treatment methods offered by different providers. It is lifted from Vermont language, which is significantly further down the medicaid transformation path than Oregon. It is language that is working well for them, but will need to be tweaked by LC to fit Oregon's unique CCO approach)

Thank you for considering these changes. We are happy to continue working with you and legislative council to thread the needle between being offensive and defensive with non-discrimination, all while allowing adequate flexibility to the CCOs.