Task Force Feedback on Provider Participation Requirements and Conditions Outstanding Design Element Draft

DECEMBER 2021

The paraphrased comments below were collected from Task Force on Universal Health Care members in response to a revised version of the Provider Participation Requirements and Conditions ODE Draft recommendation. The version they reviewed was developed to reflect the November 23, 2021 Task Force meeting conversation, and integrates "Option 2," in which all providers are required to participate, and therefore participating providers are permitted to see private pay patients, even for services covered by the Single Payer.

TF Member	Comment
Chad Chadwick	I concur with your language proposal and intent. I might flip the language in the 1st sentence of the third bullet to indicate that Private pay cannot be handled differently than single payer. Might be a bit clearer.
Sam Metz	I like the intended content and made no substantial changes in meaning.
John Santa	[The Private Pay provision] I have to think about. Here is why. The single payer needs to dramatically decrease admin expenses to reduce costs and to enable focus in the delivery system on providing health care not admin. If a provider is going to provide non covered services they must do so in a way that applies all of the admin expenses for those services to those services and NOT to the single payer services. That might mean a totally separate administrative system. Lets consider a plastic surgeon or a dermatologist or ENT who provides cosmetic services in addition to single payer services like breast reconstruction after mastectomy. The single payer does not want to pay for any of the marketing, billing, malpractice, capital equipment cost of the cosmetic services. At this point it seems that the provider would need to have a separate business to provide those services. Your sentences at the end seem to apply to coordination of benefits ie patient has a second coverage that may contribute—workers comp, motor vehicle etc. The single payer should absolutely take the lead in protecting their interests and holding the patient harmless. I have to do more thinking about this. I am worried that existing health insurers may try to survive by organizing "supplementary coverage" for services that the single payer does not cover or does not provide in a timely fashion etc. They would inevitably primarily market this to the wealthy. But given the single payer wants to be very comprehensive this should be unusual and might end up primarily focused on controversial areas---ie new drugs, new technology, new procedures etc etc. So it is defining exactly what do we mean by non covered. For example we would cover bone marrow transplant for bone marrow driven malignancies but what if some providers wanted to try these again on solid tumors. Let me think on this. I think the single payer should be the primary payer. That would mean it should take on all reasonable tasks to keep the delivery system focused on the patient and not payment. In so doing it would minimize as much as possible any administrative functions the providers have. It should coordinate payments with all other potential payers like worker's comp, accident, travel insurance. It should hold its members harmless but also vigorously pursue any revenue source. They

	key is to get the patient and the providers out of the middle of all the financial transactions. If the service is not a covered benefit then the patient is on its own. I am still uncertain what role the single payer should play when the patient is not a covered person. My sense is it would be most efficient for the provider's to "turn over" that account to the single payer in return for an average collection amount and let the single payer essentially be the collection agent. The bottom line is we want patients held harmless, delivery system focusing on what they are good at---providing care, single payer protecting the financial interests of patient and delivery system and state. I hope that helps.
John Santa	1) So it seems we are allowing self funded employers to take risk for health care services. That is an important exception to SB770. It also means many public employers might choose this option. That option might be fine but we should think through the risks and benefits of that. For example PEBB/OEBB could choose to remain self funded or subsets within them (U of O has often talked about separating from PEBB). It also means that some of those public employers might be raising money for health care expenses via separate tax strategies. And of course it means that they could have different benefit plans. Though it is possible that the employer could pay for a base benefit and the single payer "brings up" the employees to the single payer benefit. 2) Should we require/encourage self funded employers to work with the single payer for administrative services ie they are at risk but the single payer is the administrator? That relationship could be contingent on the employer offering the same benefit plan etc as the single payer. This might be a very attractive option from an expense point of view. Possible the Admin Services only could be done by the regional entity. 3) My thinking is driven by the assumption that for the first time in US history a state based single payer will be responsible for an entire population of a state. That means the single payer should have a relationship with ALL providers since ANY health care provided in the state could have an impact on the single payer. Hopefully that relationship will be comprehensive for 95% of clinicians (virtually all of their health care will be focused on single payer patients. But in some cases it will not be comprehensive but still be "significant" ie the plastic surgeon who mainly does cosmetic work but also does reconstruction post disease. Likely there will be a third category of clinicians who rarely if ever provide covered services BUT when the services they provide go wrong it will have an impact on the single payer. 4) My thinking is also driven by the necessity to dramatically reduce admin costs. If Self insured employers have differing benefit designs, cost sharing etc etc we are back to the same mess. Our focus should be on the delivery system doing what it does best---delivering health care. The single payer hopefully does what it does best---financing and administration.
Cherryl Ramirez	This looks good to me at first glance. Let me ask a couple of my members to see if they can see any gaps or caveats. Right now, several of them are having trouble getting the level of reimbursement they need for the wide and complex array of services they provide because they are viewed by payers the same as private practice therapists. So, I want to make sure they are compensated adequately

	under a single payer system. Maybe this is more detail than we need at this time, but I do worry about it.
Chuck Sheketoff	Looks good to me.
Dwight Dill	I think that pretty well covers it. The only question I have is as it pertains to out of state service recipients. I am referring to in-state providers that provide primary care services or specialty care services to out of state residents. Have we addressed that issue somewhere else or do we need not be concerned with those individuals. I don't believe we would expect the state to be the clearing house for billing for routine, non-emergent services provided to out-of-state individuals.