APPENDIX A

Definition of "Health Care Entity"

ORS 415.500(4)(a) defines "**health care entity**" as:

- (4)(a)(A): An individual health professional licensed or certified in this state;
- (4)(a)(B): A hospital, as defined in ORS 442.015;
    - ORS 442.015(15) defines "**hospital**" as:

        (a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

            (A) Medical;
            (B) Nursing;
            (C) Laboratory;
            (D) Pharmacy; and
            (E) Dietary; or

        (b) A special inpatient care facility as that term is defined by the authority by rule.

            - Oregon Administrative Rule 333-071-0205(35) defines "**special inpatient care facility**" as "a facility with inpatient beds that are designed and utilized for special health care purposes, including but not limited to a rehabilitation hospital, substance use disorder treatment facility, freestanding hospice facility, or a religious institution."
- (4)(a)(B): A hospital system, as defined by [OHA];
    - OAR 409-070-0005(19) defines "**hospital system**" as:

        (a) A parent corporation of one of more hospitals and any entity affiliated with the parent through ownership, governance, control, or membership; or

        (b) A hospital and any entity affiliated with the hospital through ownership, governance, control, or membership.
- (4)(a)(C): A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;
    - OAR 409-070-0005 defines "**carrier**" as:

(a) A carrier as defined in ORS 743B.005 (but excluding subsection (d) thereof); or

(b) Any person that offers Medicare Advantage plans in this state.

- ORS 743B.005 defines "**carrier**" as "any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;
(b) A health care service contractor;
(c) A health maintenance organization;
(d) ***
(e) Any other person or corporation responsible for the payment of benefits or provision of services.

- (4)(a)(D): A Medicare Advantage Plan;

- (4)(a)(E): A coordinated care organization or a prepaid managed care health services organization, as both terms are defined in ORS 414.025;

  - ORS 414.025 defines "**coordinated care organization**" as "an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572 (Coordinated care organizations).

  - ORS 414.025 defines "**prepaid managed care health services organization**" as "a managed dental care, mental health or chemical dependency organization that contracts with OHA under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

- (4)(a)(F): Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services.

  - OAR 409-070-0005(16)(g) restates[1] this provision as follows: "Any other person or business entity that is a parent organization of, has control over, is controlled by, or is under common control with, an entity that has as a primary function the provision of health care items or services."

    - OAR 409-070-0005(24) refers to ORS 731.116 for the definition of "**person**," which defines the term as "an individual or business entity."

[1] Where the Oregon Administrative Rules draw directly from a provision of the Oregon Revised Statutes, additions to the relevant statute are indicated in red and moves are indicated in green.

- OAR 409-070-0005(4) refers to ORS 731.116 for the definition of "**business entity**," which defines the term as "a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity."

- OAR 409-070-0005(8) defines "**control**" as "the direct or indirect power to manage a legal entity or set the legal entity's policies, whether by owning voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office.

ORS 415.500(4)(b) excludes from the definition of "**health care entity**" the following:

- (4)(b)(A): Long term care facilities, as defined in ORS 442.015.
    - ORS 442.015(18)(a) defines "**long term care facility**" as "a permanent facility with inpatient beds, providing:

      (A) Medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services; and

      (B) Treatment for two or more unrelated patients.

    - ORS 442.015(18)(b) provides that "**long term care facility**" "includes skilled nursing facilities and intermediate care facilities but does not include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

- (4)(b)(B): Facilities licensed and operated under ORS 443.400 to 443.455.
    - ORS 443.410: Residential care facilities, residential training facilities, residential training homes, residential treatment facilities, and residential treatment homes

APPENDIX B

Definition of "Material Change Transaction"

ORS 415.500(10) defines a "**transaction**" as:

(a) A merger of a health care entity with another entity;

(b) An acquisition of one or more health care entities by another entity;

(c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services.

(d) A corporate affiliation involving at least one health care entity; or

(e) Transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization, as prescribed by the authority by rule.

OAR 409-070-0010(1) provides details for what counts as a "**covered transaction**," stating "Pursuant to ORS 415.500(6) and (10) and subject to the materiality standards under OAR 409-070-015, transactions that are subject to review under these rules are the following:

(a) A merger or consolidation of a health care entity with another entity;

(b) An acquisition of a health care entity by another entity;

(c) A transaction to form a new contract, new clinical affiliation or new contracting affiliation between or among health care entities that will eliminate or significantly reduce [] essential services;

(d) Formation of a corporate affiliation involving at least one health care entity; or

(e) A transaction to form a new partnership, joint venture, accountable care organization, parent organization or management services organization, [] between or among health care entities that will:

(A) Eliminate or significantly reduce essential services;

(B) Consolidate or combine providers of essential services when contracting payment rates with payers, insurers, or coordinated care organizations; or

(C) Consolidate or combine insurers when establishing health benefit premiums."

OAR 409-070-0010(2) provides that **acquisition of a health care entity** occurs when:

(a) Another person acquires control of the health care entity including acquiring a controlling interest as described in OAR 409-070-0025.

- OAR 409-070-0025(1) provides presumptions for determining whether a transaction with a health care entity results in the acquisition of direct or indirect control of that health care entity:

  (a) A transaction shall be rebuttably presumed to involve an acquisition of control of a health care entity that is a domestic health insurer or a coordinated care organization if a person, directly or indirectly, acquires voting control of ten percent (10%) or more of any class of voting securities of the domestic health insurer or the coordinated care organization.

  (b) For a health care entity other than a domestic health insurer or coordinated care organization, a transaction shall be rebuttably presumed to involve an acquisition of control of the health care entity if a person, directly or indirectly, acquires voting control of twenty-five percent (25%) or more of any class of voting securities of the health care entity.

  (c) For any health care entity, a transaction shall be irrebuttably presumed to involve an acquisition of control of the health care entity if a person, directly or indirectly, acquires voting control of more than fifty percent (50%) of any class of voting securities of the health care entity.

- OAR 409-070-0025(2)-(5) provides procedures for an entity to rebut the presumptions in subsection (1)(a) and (b) above.

(b) Another person acquires, directly or indirectly, voting control of more than fifty percent (50%) of any class of voting securities of the health care entity other than a domestic insurer as described in OAR 409-070-0025(1)(c);

(c) Another person acquires all or substantially all of the health care entity's assets and operations;

(d) Another person undertakes to provide the health care entity with comprehensive management services; or

(e) The health care entity merges tax identification numbers or corporate governance with another entity.

OAR 409-070-0010(3) defines a "**significant reduction of services**" as occurring "when the transaction will result in a change of one-third or more of any of the following:

(a) The health care entity merges tax identification numbers or corporate governance with another entity.

(b) A reduction in the number of providers, including the number of culturally competent providers, health care interpreters, or traditional healthcare workers, or a reduction in

the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program;

(c) A reduction in the number of providers serving new patients, providers serving individuals who are uninsured, or providers serving individuals who are underinsured;

(d) Any restrictions on providers regarding rendering, discussing, or referring for any essential services;

(e) A decrease in the availability of essential services or the range of available essential services;

(f) An increase in appointment wait times for essential services;

(g) An increase in any barriers for community members seeking care, such as new prior authorization processes or required consultations before receiving essential services; or

(h) A reduction in the availability of any specific type of care such as primary care, behavioral health care, oral health care, specialty care, pregnancy care, inpatient care, outpatient care, or emergent care as relates to the provision of essential services.

OAR 409-070-0010(4) provides, "Any change in the sub-regulatory guidance document pertaining to paragraph (3) of this rule shall be effective no less than 180 calendar days after publication."

ORS 415.500(6)(a) defines "**material change transaction**" as:

(A) A transaction in which at least one party had average revenue of $25 million or more in the preceding three fiscal years and another party:

(i) Had an average revenue of at least $10 million in the preceding three fiscal years; or

(ii) In the case of a new entity, is projected to have at least $10 million in revenue in the first full year of operation at normal levels of utilization or operation as prescribed by the authority by rule.

(B) If a transaction involves a health care entity in this state and an out-of-state entity, a transaction that otherwise qualifies as a material change transaction under this paragraph that may result in increases in the price of health care or limit access to health care services in this state.

ORS 415.500(6)(b) expressly excludes from the definition of "**material change transaction**":

(A) A clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs.

(B) A medical services contract or an extension of a medical services contract.

- ORS 415.500(7)(a) defines "**medical services contract**" as "a contract to provide medical or mental health services entered into by:"

  (A) A carrier and an independent practice association;

  (B) A carrier, coordinated care organization, independent practice association or network of providers and one or more providers, as defined in ORS 743B.001;

  (C) An independent practice association and an individual health professional or an organization of health care providers;

  (D) Medical, dental, vision or mental health clinics; or

  (E) A medical, dental, vision or mental health clinic and an individual health professional to provide medical, dental, vision or mental health services.

- ORS 41.500(7)(b) provides, "**Medical services contract**' does not include a contract of employment or a contract creating a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or 70 or under any other law authorizing the creation of a professional organization similar to those authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule."

(C) An affiliation that:

(i) Does not impact the corporate leadership, governance or control of an entity; and

(ii) Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386.

(D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity:

(i) Maintains responsibility, oversight and control over the patient care and services; and

(ii) Bills and receives reimbursement for the patient care and services.

(E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b.

OAR 409-070-0015(1) provides that "a covered transaction under OAR 409-070-0010 is a material change transaction and shall be subject to review under these rules if:

(a) At least one party to the transaction [] had average annual revenue of $25 million or more in the party's three most recent fiscal years; and

(b) Another party to the transaction:

(A) Had [] average annual revenue of [] $10 million or more in [] that party's three most recent three fiscal years; or

(B) If such party is a newly organized legal entity, is projected to have at least $10 million in revenue over its first full year of operation at normal levels of utilization or operation. A party is a newly organized legal entity if:

i. The entity is newly formed or capitalized in connection with the transaction or in connection to a health care entity or the purposes of a transaction including but not limited to a special purpose entity; or

ii. The entity is an existing entity whose form of ownership is changed in connection with the transaction. Changes in the form of ownership include but are not limited to a change from physician-owned to private equity-owned and publicly-held to a privately-held form of ownership.

OAR 409-070-0015(2) provides, "A covered transaction under OAR 409-070-0010 that qualifies as material under paragraph (1) of this rule shall be subject to review under these rules notwithstanding that the transaction involves a health care entity located in this state and an out-of-state entity if the transaction may increase the price of health care services or limit access to health care services in this state.

Under both ORS 415.500(9) and OAR 409-070-0005(27), "**revenue**" is defined as:

(a) Net patient revenue; or

(b) The gross amount of premiums received by a health care entity that are derived from health benefit plans.

ORS 415.500(2) defines "**essential services**" as:

(a) Services that are funded on the prioritized list described in ORS 414.690 [Prioritized List of Health Services];[2] and

(b) Services that are essential to achieve health equity.

[2] The Prioritized List of Health Services can be found at https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx (last accessed Aug. 18, 2023).

ORS 415.500(5) defines "**health equity**" as "the meaning prescribed by the Oregon Health Policy Board and adopted by [OHA] by rule."

OAR 409-070-0005(18) defines "**health equity**" as "a health system having and offering infrastructure, facilities, services, geographic coverage, affordability and all other relevant features, conditions and capabilities that will provide all people with the opportunity and reasonable expectation that they 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 their socially determined circumstances."

OAR 409-070-0005(28) defines "**services that are essential to achieve health equity**" as:

(a) Any service directly related to the treatment of a chronic condition;

(b) Pregnancy-related services;

(c) Prevention services including non-clinical services; or

(d) Health care system navigation and care coordination services.

OAR 409-070-0010(3) defines a "**significant reduction of services**" as occurring "when the transaction will result in a change of one-third or more of any of the following:

(a) An increase in time or distance for community members to access essential services, particularly for historically or currently underserved populations or community members using public transportation;

(b) A reduction in the number of providers, including the number of culturally competent providers, health care interpreters, or traditional healthcare workers, or a reduction in the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program;

(c) A reduction in the number of providers serving new patients, providers serving individuals who are uninsured, or providers serving individuals who are underinsured;

(d) Any restrictions on providers regarding rendering, discussing, or referring for any essential services;

(e) A decrease in the availability of essential services or the range of available essential services;

(f) An increase in appointment wait times for essential services;

(g) An increase in any barriers for community members seeking care, such as new prior authorization processes or required consultations before receiving essential services; or

(h) A reduction in the availability of any specific type of care such as primary care, behavioral health care, oral health care, specialty care, pregnancy care, inpatient care, outpatient care, or emergent care as relates to the provision of essential services.

OAR 409-070-0020 provides a list of transactions that are not "material change transactions" subject to OHA review.

APPENDIX C

OHA Procedures and Review of Material Change Transactions

Optional Application for Determination of Covered Transaction Status

OAR 409-070-0042(1) provides: "Any party to a proposed transaction may, but shall not be required to, submit a written application to the Authority requesting a determination whether such transaction is a covered transaction pursuant to these rules. The Authority shall notify the applicant in writing of its determination within 30 calendar days following receipt of the application and any additional information requested by the Authority. If the Authority determines that the proposed transaction is a covered transaction, and the parties desire to pursue the transaction, the parties shall file a notice in accordance with these rules."

OAR 409-070-045(2) provides: "A party or the parties to a material change transaction for which a filing will be made under this rule are encouraged to contact the Authority and arrange for a pre-filing conference. If the Authority decides to conduct a comprehensive review under OAR 409-070-0060, the Authority shall offer the parties or parties a comprehensive review conference. The pre-filing conference or comprehensive review conference shall preview the transaction and filing and the Authority's expectations for the review of the transaction including timing, the use of outside experts, the potential involvement of a community review board in accordance with OAR 409-070-0062, and other relevant issues."

Notice Requirement and Fees

ORS 415.501(3)(a) provides, "A notice of a material change transaction involving the sale, merger, or acquisition of a domestic health insurer shall be submitted to the Department of Consumer and Business Services . . . ."

ORS 415.501(4) provides, "An entity shall submit to the authority a notice of a material change transaction, other than a transaction described in subsection (3) of this section, in the form and manner prescribed by the authority, no less than 180 days before the date of the transaction and shall pay a fee prescribed in ORS 415.512." *See also* OAR 409-070-0030(1)–(2) (same).

- ORS 415.512(1) provides, "The Oregon Health Authority shall prescribe by rule a fee to be paid under ORS 415.501(3), proportionate to the size of the parties to the transaction, sufficient to reimburse the costs of administering ORS 415.501."

- OAR 409-070-0030(3) sets the fees as follows:

  (a) The fee amount shall be $2,000 for an emergency transaction in accordance with OAR 409-070-0022 or a preliminary review in accordance with OAR 409-070-0055.

  (b) The fee amount for a comprehensive review shall be based on the average annual revenue or projected revenue, as applicable, in accordance with OAR 409-070-0015(1), of the following entity (the "smaller entity"):

(A) For transactions between two entities, the entity with smaller revenue; or

(B) For transactions involving more than two entities, the entity with the second largest average annual revenue.

(c) Comprehensive review fees shall be determined as follows:

(A) For transactions involving more than two entities, the entity with the second largest average annual revenue.

(B) For transactions in which the revenue of the smaller entity is greater than or equal to $50 million and less than $200 million, the fee shall be $80,000.

(C) For transactions in which the revenue of the smaller entity is greater than or equal to $200 million and less than $500 million, the fee shall be $90,000.

(D) For transactions in which the revenue of the smaller entity is greater than or equal to $500 million, the fee shall be $100,000.

(d) The fee amount for a comprehensive review includes the fee associated with the preliminary review.

OAR 409-070-0045(9) provides, "The Authority's review of the information provided in a notice of material change will be analyzed using the Analytic Framework, published on the Program website, with standards that:

(a) Are clear, fair, predictable, and consistent;

(b) Use measures of quality and access that can be meaningfully compared to current and past performance across Oregon and, if available, in other states; and

(c) Include equity analyses that stratify cost, quality, and access data by the characteristics specified in the definition of health equity to the greatest extent allowable by data availability.

Comprehensive Review

ORS 415.501(9) identifies the statutory criteria for OHA to approve material change transactions as follows: "A health care entity may engage in a material change transaction if , following a comprehensive review conducted by the authority and recommendations by a review board appointed under subsection (7) of this section, [OHA] determines that the transaction meets the criteria adopted by the department by rule under subsection (2) of this section and:

(a) (A) The parties to the transaction demonstrate that the transaction will benefit the public good and communities by:

(i) Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of

cost growth that exceeds the target that the entity demonstrates is the best interest of the public;

(ii) Increasing access to services in medically underserved areas; or

(iii) Rectifying historical and contemporary factors contributing to a lack of health equities or access to services; or

(C) The transaction will improve health outcomes for residents of this state; and

(b) There is no substantial likelihood of anticompetitive effects from the transaction that outweigh the benefits of the transaction in increasing or maintaining services to underserved populations.

OAR 409-070-0060(6) further provides that OHA "shall approve [or recommend approval of] a material change transaction" if it "determines that the transaction satisfies (a) below and also satisfies either (b) or (c) below:"

(a) There is no substantial likelihood that the transaction would:

(A) Have material anticompetitive effects in the region (such as significantly increased market concentration among providers when contracting with payers, carriers, or coordinated care organizations, or among carriers when establishing health benefit premiums that is likely to increase costs for consumers) not outweighed by benefits in increasing or maintaining services to underserved populations;

(B) Be contrary to law;

(C) Jeopardize the financial stability of a health care entity involved in the transaction; or

(D) Otherwise be hazardous or prejudicial to consumers or the public.

(b) The transaction will benefit the public good and communities by:

(A) Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is in the best interest of the public;

(B) Increasing access to services in medically underserved areas; or

(C) Rectifying historical and contemporary factors contributing to a lack of health equity or access to services.

(c) The transaction will improve health outcomes for residents of this state.

Preliminary Review

ORS 415.501(5) provides the following requirements for OHA's preliminary review of a material change transaction:

> "[T]he authority shall conduct a preliminary review to determine if the transaction has the potential to have a negative impact on access to affordable health care in this state and meets the criteria in subsection (9) of this section."
>
> **[** See Comprehensive Review section above for provisions in subsection (9) **]**

OAR 409-070-0055(1) provides: "Pursuant to ORS 415.501(5) and after receipt of a complete notice of material change transaction …, [OHA] shall complete a preliminary review to determine whether the proposed material change transaction meets one or more of the criteria set forth in [OAR 409-070-0055(2)].

OAR 409-070-0055(2) provides the following criteria:

(a) The material change transaction is in the interest of consumers and is urgently necessary to maintain the solvency of an entity involved in the transaction;

(b) The material change transaction is unlikely to substantially reduce access to affordable health care in Oregon;

(c) The material change transaction is likely to meet the criteria set forth in OAR 409-070-0060 [Comprehensive Review of a Notice of a Material Change Transaction];

(d) The material change transaction is not likely to substantially alter the delivery of health care in Oregon; or

(e) Comprehensive review of the material change transaction is not warranted given the size and effects of the transaction.

ORS 415.501(6) provides: "Following a preliminary review, the authority or the department shall approve a transaction or approve a transaction with conditions designed to further the goals described in subsection (1) of this section based on criteria prescribed by the authority by rule, including but not limited to:

(a) If the transaction is in the interest of consumers and is urgently necessary to maintain the solvency of an entity involved in the transaction; or

(b) If the authority determines that the transaction does not have the potential to have a negative impact on access to affordable health care in this state or the transaction is likely to meet the criteria in [ORS 415.501(9) (above)].

OAR 409-070-0065(1) references OHA's authority to approve a material change transaction with conditions, and refers to OAR 409-070-0000

<u>Fee Schedule</u>

OAR 409-070-0030(3) provides a fee schedule for material change transaction reviews, including a sliding scale for fees for comprehensive reviews.

Contested Case Hearings

OAR 409-070-0075 provides procedures for a party to contest OHA's final order on a material change transaction.

"All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals." OAR 409-070-0075(11).