No. 24-3770

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS,

Plaintiff-Appellant,

v.

STATE OF OREGON; OREGON HEALTH AUTHORITY; Doctor SEJAL HATHI,

Defendants-Appellees.

APPELLEES' SUPPLEMENTAL EXCERPTS OF RECORD

Appeal from the United States District Court
for the District of Oregon

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APPELLEES' SUPPLEMENTAL EXCERPTS OF RECORD

Pursuant to Circuit Rule 30-1.7, appellee submits the following Appellees' Supplemental Excerpts of Record, as indexed below.

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PORTLAND DIVISION

OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS, Plaintiff, v. STATE OF OREGON; OREGON HEALTH AUTHORITY; and DAVID BADEN, in his official capacity as Director of Oregon Health Authority, Defendants.	Case No. 3:22-cv-01486-SI DECLARATION OF YOUNGWOO JOH

I, YoungWoo Joh, hereby declare:

1. I am an Assistant Attorney General at the Oregon Department of Justice, and I am assigned to represent Defendants in this case. I make this declaration based on personal knowledge and I am competent to testify to the matters set forth below. I make this declaration in support of the Defendants' combined opposition Plaintiff's cross-motion for summary judgment

and reply in support of Defendants' motion for summary judgment.

2. Attached as Exhibit 1 is a true and correct copy of a sub-regulatory guidance document, titled "Health Care Market Oversight Frequently Asked Questions," dated March 10, 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

3. Attached as Exhibit 2 is a true and correct copy of a sub-regulatory guidance document, titled "Safe Harbor and Transactions Not Subject to Review," dated March 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

4. Attached as Exhibit 3 is a true and correct copy of a sub-regulatory guidance document, titled "Are Changes in Ownership of Assets Changes in Control?" dated February 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

5. Attached as Exhibit 4 is a true and correct copy of a sub-regulatory guidance document, titled "Defining Essential Services & Significant Reduction," dated January 31, 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

6. Attached as Exhibit 5 is a true and correct copy of a sub-regulatory guidance document, titled "Health Care Market Oversight Analytic Framework," dated October 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

7. Attached as Exhibit 6 is a true and correct copy of a sub-regulatory guidance document, titled "Criteria for Comprehensive Review of Material Change Transactions," dated February 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

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8. Attached as Exhibit 7 is a true and correct copy of a sub-regulatory guidance document, titled "Criteria for Community Review Boards," dated February 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

9. Attached as Exhibit 8 is a true and correct copy of a sub-regulatory guidance document, titled "Use of Outside Advisors for Material Change Transaction Review," dated February 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

10. Attached as Exhibit 9 is a true and correct copy of a sub-regulatory guidance document, titled "Timeline for Furnishing Final Definitive Agreements," dated February 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

11. Attached as Exhibit 10 is a true and correct copy of a sub-regulatory guidance document, titled "Entities Subject to Review," dated October 2022, which I downloaded from the Oregon Health Authority, Office of Health Policy website on August 18, 2023, at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-Rules.aspx.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 18, 2023.

s/ YoungWoo Joh
YoungWoo Joh
Assistant Attorney General

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Health Care Market Oversight
Frequently Asked Questions

This document provides high-level information about the Health Care Market Oversight program. Please see ORS 415.500 et seq. and OAR 409-070-0000 through 409-070-0085 for legal requirements.

What is this new program? What does it do? Who does it apply to?

As set forth in the authorizing legislation, the new Health Care Market Oversight (HCMO) program exists to make sure that health care entity transactions support:

- Health equity,
- Lower costs for consumers and payers,
- Increased access, *and*
- Better patient care

HCMO was established by HB 2362, which the Oregon Legislature passed in 2021. This mandate requires the Oregon Health Authority (OHA) to review and approve proposed material change transactions between health care entities, including

- hospitals,
- health insurance companies,
- Medicare Advantage plans,
- coordinated care organizations,
- individual licensed health professionals, and
- other entities providing health care products or services.

A **transaction** occurs when two or more business entities combine.

Material change transactions are those that meet program requirements and must be reviewed OHA.

The statute does not require OHA to review transactions between long-term and residential care facilities. See the program administrative rules for specific definitions: https://www.oregon.gov/oha/HPA/HP/Pages/health-care-market-oversight.aspx.

Which transactions are subject to review?

Transitions are subject to review when:

1. One of the entities has a revenue of at least $25 million and another has a revenue of at least $10 million[1], and
2. Transactions fall within one of the following categories:
    - Mergers and acquisitions
    - Affiliations and contracts that will eliminate or significantly reduce essential services
    - New partnerships, joint ventures, accountable care organizations, parent organizations, or management services organizations that will:
        - eliminate or significantly reduce essential services;

[1] When more than two entities are consolidating, there is no revenue requirement for subsequent entities

- consolidate or combine providers of essential services when contracting payment rates with payers; or consolidate or combine insurers when establishing health benefit premiums

What is excluded from review?

The following transactions are not required to file notice:

- clinical affiliations to collaborate on clinical trials or graduate medical education,
- medical services contracts,
- affiliations that do not affect corporate leadership or control of an entity and are necessary to adopt advanced value-based payment methodologies
- corporate restructuring
- transactions involving a clinic designated as a Federally Qualified Health Center
- all affiliations and contracts that do not significantly reduce or eliminate essential services

What is the process for an entity that is planning a transaction?

Step 1 Entities consider an optional pre-filing conference with OHA during which staff from OHA can inform the entity if the transaction is subject to review

Step 2 The entity completes and submits the Notice of Material Change Transaction Form. The form and instructions are posted on the program website: https://www.oregon.gov/oha/HPA/HP/Pages/health-care-market-oversight.aspx

Step 3 OHA will conduct a preliminary review of the transaction and decide to approve, approve with conditions, or conduct a more comprehensive review. OHA may ask entities to provide more information to inform the review process.

Step 4 If approved, entities can proceed with the transaction, adhering to any conditions of the approval. If not approved after the comprehensive review, entities may contest the decision. See 409-070-0075 for more information.

What resources and technical assistance are available?

Technical assistance: You can request free technical assistance from program staff by emailing hcmo.info@dhsoha.state.or.us.

Pre-filling conference: You can consult with program staff to see if your transaction is subject to review and discuss the filing process, what information may be requested, and submission timing.

Pre-comprehensive review conference: If OHA determines that your transaction will require a comprehensive review, you can request a conference with OHA staff to discuss the plan and timeline for the comprehensive review.

Guidance documents: OHA has published multiple guidance documents on the program website: https://www.oregon.gov/oha/HPA/HP/Pages/health-care-market-oversight.aspx

When does this program start?

The program begins March 1, 2022. This means that any qualifying transaction that closes on March 1, 2022 or later is subject to review.

When is the deadline to file notice for entities that are planning a transaction?

An entity must file a notice of material change transaction at least 180 calendar days prior to the proposed effective or closing date of the transaction.

Will the program have a ramp-up period and what does that mean?

Yes. From March 1, 2022 until December 31, 2022, OHA will approve all transactions unless program staff notify an entity of serious concerns that require review. Program fees are also waived through the end of 2022.

What are the timeframes of this program?

Entities must file a notice of material change transaction at least 180 calendar days before the proposed effective date of the transaction.

OHA must complete a preliminary review within 30 calendar days of when an entity files a notice of material change transaction. If a transaction requires a comprehensive review, OHA will complete the comprehensive review within 180 calendar days of when an entity files a notice of material change transaction.

How can community members or interested parties provide input on a proposed transaction?

OHA will publicly post all notices of proposed transactions to the program website and solicit written public comment. Anyone may share input about a proposed transaction. Public comments may be used to assess the impact of a proposed transaction on communities and people or groups interested in the transaction.

Under HB 2362, OHA may convene a community review board to make recommendations related to transactions that receive a comprehensive review. Community review boards must include members of affected communities, consumer advocates, and health care experts. See the program website for administrative rules and guidance documents that provide more information about the role of community review boards: https://www.oregon.gov/oha/HPA/HP/Pages/health-care-market-oversight.aspx.

A **preliminary review** looks at the submitted information to understand the potential effects of a transaction. Preliminary reviews are completed within 30 days of when OHA receives a completed notice.

A **comprehensive review** involves a more detailed look at the potential effects of a transaction and may include additional data sources, methodologies, and community engagement approaches. Comprehensive reviews are completed within 180 days of when OHA receives a completed notice.

What is the review and approval process?

When an entity files a transaction notice, OHA will conduct a preliminary review to determine how the transaction may affect health care access, health equity, quality of care, and costs for consumers and payers. After the preliminary review, OHA will either approve the transaction, approve with conditions, or require a comprehensive review. Transactions may be approved after preliminary review if they:

- Are in the interest of consumers
- Are urgently needed to maintain the solvency of an entity
- Are unlikely to reduce access to affordable health care
- Are unlikely to substantially alter the delivery of health care in Oregon

OHA may conduct a comprehensive review if there are concerns about the effects of a transaction on equity, access to care, quality of care, or health care costs**.** After a comprehensive review, OHA may approve a transaction if it:

- Is lawful,

- Does not have anti-competitive market effects,
- Will not harm the financial sustainability of a health care entity involved in a transaction,
- Will not be hazardous to consumers or the public, and
- Will benefit public and community good *or* improve health outcomes for the state.

Some entities are already required to submit transaction information to other regulatory authorities. How will OHA work with these other regulatory authorities to streamline processes for entities?

Where inter-agency information sharing is needed, OHA will share the minimum necessary information in accordance with regulations or contractual agreements governing privacy and confidentiality. We will collaborate with the following agencies and programs:

- **Department of Consumer and Business Services (DCBS).** OHA will collaborate with DCBS on any transaction involving at least one domestic insurance company. OHA and DCBS will each carry out their own review, and OHA will provide a recommendation to DCBS, who will decide the outcome of the review.
- **Department of Justice (DOJ).** OHA may rely on legal advice and analysis by DOJ as needed. Depending on the scope of work and internal capacity, DOJ may contract with an external law firm for legal counsel.
- **Other OHA programs and divisions.** For any transaction involving a Coordinated Care Organization (CCO), the program may coordinate with other OHA programs that regulate CCO activities. The program may consult with other OHA programs regarding data and quantitative methods, particularly relating to measures of cost and hospital performance. Staff of other OHA programs may provide analytic support on reviews and share data collected by the programs on an as-needed basis.

How is the program funded?

The program is funded with General Funds for the 2021-2023 biennium, after which program costs will be covered by fees collected from entities involved in transactions. Fees will be determined based on the type of review required and the revenue of entities filing a transaction notice. Entities that are not required to submit a transaction notice will not be subject to any fees. OHA will begin collecting fees for transaction notices filed as of January 1, 2023.

What fees will entities pay when they file a transaction notice?

Fees are waived in 2022. OHA will collect fees for transaction notices filed on or after January 1, 2023. OHA will determine and post fee amounts prior to January 1, 2023.

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Oregon Health Authority
HEALTH POLICY AND ANALYTICS
Office of Health Policy

Safe Harbor and Transactions Not Subject to Review

The Health Care Market Oversight program was created to ensure that transactions involving health care entities support the goals of health equity, lower costs, increased access, and better care. This document presents transactions that are **not subject to review** due to safe-harbor protection or because the authorizing statute or final rules specifically exclude the transaction from review. This document also lists examples of transactions that are excluded from review.

For more information, visit the program website at https://www.oregon.gov/oha/HPA/HP/Pages/health-care-market-oversight.aspx.

Exempted Transactions Due to Safe-Harbor Status

In accordance with OAR 409-070-0022(6), the following table lists transaction types that are exempt from review by the Health Care Market Oversight program.

Effective Date	Transaction
3/1/2022	Material change transactions in which one of two entities involved in the transaction is a solo practice and the transaction is the direct result of either the death or retirement of the provider in the solo practice.
3/1/2022	Material change transactions approved in writing by the Oregon Health Authority between July 27, 2021, enactment date of the authorizing legislation, and February 28, 2022. The terms, conditions, and agreements that comprise the transaction must remain unchanged from what the Oregon Health Authority approved.

The Oregon Health Authority may add to the above list of exempted transactions and re-post on the program website (https://www.oregon.gov/oha/HPA/HP/Pages/health-care-market-oversight.aspx) at any time.

Transactions may also be exempted from review in an emergency situation pursuant to OAR 409-070-0022. Entities may apply for an emergency exemption by completing the Emergency Exemption Form and emailing to hcmo.info@dhsoha.state.or.us.

Excluded Transactions in Accordance with Statute & Rule

The authorizing statute (ORS 415.500) and rule (ORS 409-070-0020) specifies transactions that are **not** subject to review under the Health Care Market Oversight program. The following types of transactions are **not** subject to review:

- Clinical affiliations formed for the purpose of collaborating on clinical trials or graduate medical education programs.
- Medical services contracts or an extension of a medical service contract as defined by ORS 415.500(7)(a).
    - Note: a 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. This type of contract may be subject to review.
- An affiliation that does not impact the corporate leadership, governance or control of an entity and is necessary to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386.
- Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient services or provides administrative services relating to the provision of patient services if the second health care entity:
    - maintains responsibility and control over the patient services,
    - bills and receives reimbursement for the patient services, and
    - does not provide comprehensive management services.
- Transactions involving Federally Qualified Health Centers.
- Transactions that consist solely of corporate restructures that do not change the ultimate control of the health care entity and do not result in the acquisition of control of the entity by any person not previously affiliated with the entity.
- Agreements between an affiliate and a health care entity that are subject to ORS 732.574(2)(d)(D), which include management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements.

Examples of Excluded Transactions

All of the examples below are transactions that do not meet the Health Care Market Oversight program criteria and are excluded from review. For illustrative purposes, all examples below are assumed to meet the entity revenue thresholds of greater than or equal to $25 million and $10 million.

The table below shows both the details of the transaction example and an explanation as to why it is excluded from review by the Health Care Market Oversight program.

As a reminder, the Health Care Market Oversight program is charged with reviewing the following types of transactions:

1. Merger
2. Acquisition
3. New contract, new clinical affiliation, or new contracting affiliation that will eliminate or significantly reduce essential services
4. Corporate affiliation, defined as a health care entity that controls, is controlled by, or is under common control with another legal entity
5. New partnership, joint venture, accountable care organization, parent organization or management services organization that will:
    a. Eliminate or significantly reduce essential services,
    b. Consolidate providers of essential services when contracting payment rates with payers, or
    c. Consolidate insurers when establishing health benefit premiums

Examples of Transactions Excluded from Review	Explanation
The sale of 10% of the voting shares of a medical group.	There is no change of control in this example, because for entities that are not insurers or Coordinated Care Organizations, control is not rebuttably presumed until 25% of voting shares has been acquired.
Four medical groups affiliate to form a new management services organization to provide billing and collection services to the four medical groups. The new management services entity will not negotiate on behalf of the medical groups with payers. No changes in control and no reduction of essential services.	Although this transaction results in a new management services organization, there is no consolidation of providers of essential services when contracting payment rates with payers.
Two insurers want to share resources. No change of control. Establishing health benefit premiums is not a component of the affiliation.	No change of control. There is no consolidation of insurers when establishing health benefit premiums.
Hospital contracts with medical group to provide specialty call coverage to Emergency Department in hospital.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Hospital contracts with staffing agency to provide locum tenens physician services in hospital.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Hospital contracts with medical group to provide electronic health record access to medical group to access common patients for care purposes.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Rural hospital contracts with a “nighthawk” remote radiology service provider for nighttime imaging reads for the Emergency Department.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Hospital and medical group contract to provide NICU staffing services.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Hospital contracts with an affiliate to provide electronic medical record services to the hospital or vice versa.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Large medical group contracts with a third-party administrator to assist the group with the administrative components of contracting with payors.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Rural hospital and urban hospital enter into transfer agreement for transfer of patients to a higher level of care.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Clinic and medical group enter into agreement for space in a medical office building.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Two clinics agree to share space, exam rooms, and resources. The clinics are not combining providers when contracting rates with payers.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Multiple medical groups offer their support and logos in favor a specific housing initiative.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.

Examples of Transactions Excluded from Review	Explanation
Rural hospital recruits primary care physician to community.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Two hospitals offer joint continuing medical education to their medical staffs.	The statute specifically excludes from the program clinical affiliations that are formed for the purposes of collaborating on graduate medical education programs.
Community call agreement to cover hospital Emergency Departments.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
New joint venture formed between dialysis company and hospital to deliver dialysis services on a non-exclusive basis. No change in essential services and no combining providers when contracting payments rates with payers.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Parent entity of provider of contraception services affiliates with a national pro-choice organization and the national organization provides, among other things, a strategic advocacy affiliation.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Contract between a hospital or medical group and a billing company or a human resources company. The contract does not allow for combining payment rate negotiations with payers.	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
Two health systems enter into contract or purchase order with a supplier of supplies (gloves, equipment, etc.).	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers. If these two health systems are also insurers, in this example there is no consolidation of insurers when establishing health benefit premiums.

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Oregon Health Authority
HEALTH POLICY AND ANALYTICS
Office of Health Policy

Are Changes in Ownership of Assets Changes in Control?

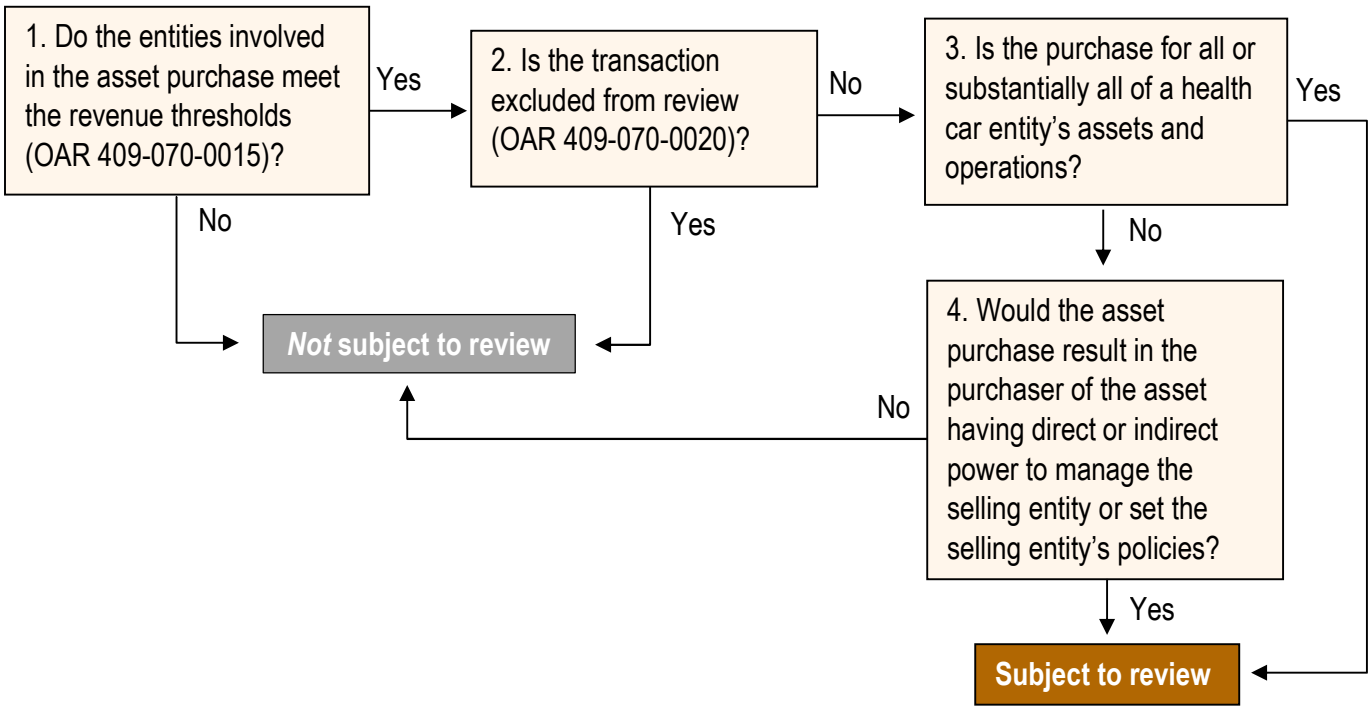
Changes in control are an important concept for the Health Care Market Oversight Program. To determine if a transaction is subject to review by the Program, entities may need to determine whether the transaction would result in a change of control. This document provides additional guidance for entities to determine if a proposed transaction involving a change in ownership of assets would be a change in control. The guidance is based on the provisions regarding control provided in ORS 415.500 and the Oregon Administrative Rules for the Program.

Changes in Ownership of Assets

As defined in OAR 409-070-0005, the concept of control relates to the direct or indirect power to manage a legal entity or set the legal entity's policies. (See below for complete definition).

A change in ownership of assets does not necessarily equate to a change in control. As codified in OAR 409-070-0010(2), a transaction in which a person or entity acquires all or substantially all of a health care entity's assets and operations is considered an acquisition and is therefore subject to review. However, the purchase of only some of an entity's assets does not, by itself, equate to an acquisition.

When determining if a purchase of assets is a material change transaction and therefore subject to review, entities should consider the following four questions:



1. The first question is whether the entities involved in the asset purchase meet the revenue thresholds outlined in OAR 409-070-0015.
2. If the revenue thresholds are met, entities should determine whether the transaction is otherwise excluded from review under OAR 409-070-0020.
3. If the answer to question 1 is "yes," and the answer to question 2 is "no," the third question is whether the purchase is for *all or substantially all* of the health care entity's assets and operations. In this case, the asset purchase is an acquisition under OAR 409-070-0010 and therefore subject to review.
4. Finally, if the answer to question 3 is "no," the fourth question is whether the asset purchase would result in the purchaser having direct or indirect power to manage the selling entity or set the selling entity's policies. If the answer is "no," then the sale of the asset would not, in isolation, result in a change of control.

A material change transaction that is reviewable may also include a proposed asset purchase.

Examples:

1. A hospital enters into a lease purchase arrangement whereby all of its furniture and equipment is sold to a financing company. The hospital corporation retains ownership of the hospital's building and land and the right to operate the hospital and determine the scope of hospital operations. The financing company has not acquired all or substantially all of the hospital's assets and operations. Therefore, there has been no change of control.
2. A hospital sells all of its furniture, equipment, buildings, and land to a management company but retains its corporate structure and license. The management company acquires the right to operate the hospital and determine the scope of hospital operations. The management company has acquired all or substantially all of the hospital's assets and operations. Therefore, there has been a change of control.

Calculating Control Percentage

As defined in OAR 409-070-0025, control is rebuttably presumed when an entity acquires 10% or more of any class of voting securities for domestic health insurers and Coordinated Care Organizations or 25% or more of any class of voting securities for entities other than domestic health insurers and Coordinated Care Organizations. A person may seek to rebut this presumption through an application for disclaimer of control (for insurers and CCOs, a disclaimer of affiliation), which is submitted to DCBS for domestic health insurers and to OHA for other health care entities. Control is irrebuttably presumed when an entity acquires 50% or more of any class of voting securities of any health care entity. (See below for the complete OAR 409-070-0025).

The purchase of an asset does not, by itself, entail the acquisition of any voting securities. Therefore, entities should not include an asset purchase when determining the acquired percentage of any class of voting securities, unless other provisions of the transaction give the asset purchaser the voting rights of a security holder.

Reminder – if an acquisition includes all or substantially all of a health care entity's assets as part of a covered material change transaction, that transaction is subject to review by the Health Care Market Oversight Program.

Statutory and Rule Guidance

ORS 415.500

(1) “Corporate affiliation” has the meaning prescribed by the Oregon Health Authority by rule, including:

(a) Any relationship between two organizations that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete corporate control; and

(b) Transactions that merge tax identification numbers or corporate governance.

(6)(b) “Material change transaction” does not include:

(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.

OAR 409-070-0005 Definitions

(8) "Control" means 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.

(29) “Voting security” means a security that entitles the owner or holder of the security to vote at a meeting of shareholders, a membership interest having voting rights in a limited liability company or nonprofit corporation, a partnership interest having voting rights in a limited or general partnership or any other type of instrument that confers on the holder of the instrument voting rights in the governance of a legal entity. A “voting security” also includes a security that is convertible into a voting security or that is evidence of a right to acquire a voting security.

OAR 409-070-0010 Covered Transactions

(2) An 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;

(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 409-070-0020 Excluded Transactions

(1) Pursuant to Section 1(6)(b) and (7) of the 2021 Act, the following transactions are not material change transactions subject to review under these rules:

…

(c) An affiliation that, pursuant to Section 1(6)(b)(C) of the 2021 Act:

(A) Does not impact the corporate leadership, governance or control of a health care entity; and

(B) Is necessary to adopt AVP methodologies to meet the health care cost growth targets under ORS 442.386.

…

(f) A transaction that consists solely of a change in the immediate or intermediate ownership of a health care entity but which (i) does not change the ultimate ownership or control of the health care entity, and (ii) does not result in the acquisition of control of the health care entity by any person not previously affiliated with the health care entity.

OAR 409-070-0025 Acquisition of Control; Presumptions and Disclaimers

(1) The following presumptions will apply in determining whether a transaction involving 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.

(2) A person seeking to rebut the presumption described in paragraph (1)(b) of this rule shall apply to the Authority for a disclaimer of control determination. Such application must show that the proposed transaction does not (or would not) in fact result in control of the health care entity, or that control would not be changed by the proposed transaction, and must fully disclose all material relationships and bases for control between the disclaimer applicant and the person(s) to which the disclaimer applies, as well as the basis for disclaiming control or change of control. The Authority may determine, after giving persons that have an interest in the Authority's determination notice and opportunity to be heard and after making specific findings of fact to support the determination, that control exists (or would exist) in fact or would be changed by a proposed transaction.

(3) A disclaimer application filed under paragraph (2) of this rule is effective unless, within thirty calendar days after the Authority receives the disclaimer application, the Authority notifies the disclaimer applicant that the disclaimer has been disallowed.

(4) Paragraphs (2) and (3) of this rule do not apply to transactions involving a domestic health insurer or a coordinated care organization. For a domestic health insurer, the disclaimer of affiliation procedure is in ORS 732.568. For a coordinated care organization, the disclaimer of affiliation procedure is in OAR 410-141-5315.

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Defining Essential Services & Significant Reduction

Introduction

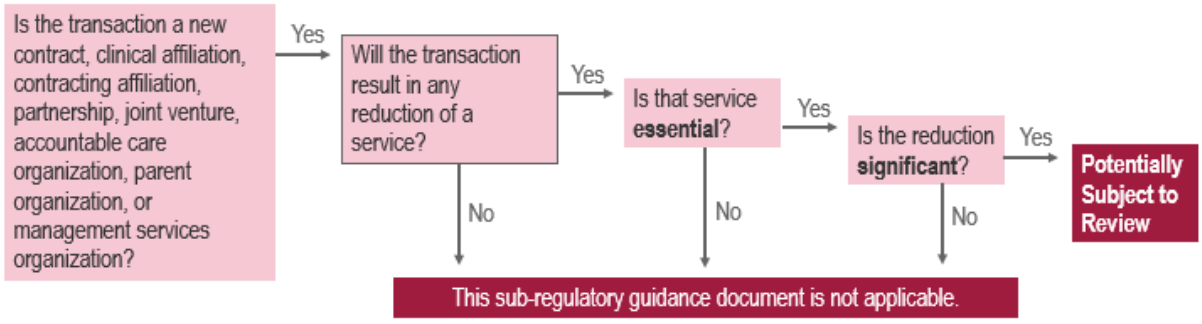
Per OAR 409-070-0010, proposed new contracts, new clinical affiliations, or new contracting affiliations that will eliminate or significantly reduce essential services are subject to review under the Health Care Market Oversight (HCMO) program.[1] Additionally, proposed transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization between or among health care entities that will eliminate or significantly reduce essential services are subject to review. This document refers to each of these transaction types as "relevant transactions."

OHA sought input from a Technical Advisory Group (TAG) to develop a rubric that health care entities can use to determine if a proposed relevant transaction is subject to review. Health care entities must be able to operationalize the definition of "services that are essential to achieve health equity" and determine if the proposed relevant transaction will result in a "significant reduction" of essential services.

This document outlines a two-part test in which health entities can:

1. Determine if a proposed transaction will result in a reduction of an essential service, and
2. Determine if that reduction is "significant"

Figure 1: Flowchart showing when this sub-regulatory document is applicable[2]:



As indicated in Figure 1, this document is not applicable if a proposed relevant transaction will not reduce essential services. The elimination of an essential service will be considered a significant reduction of that service.

[1] Draft rules were filed with the Office of the Secretary of State on December 21, 2021. See https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/2021-12-21_409-070-NoticeFilingTrackedChanges.pdf. OHA held a Rules Hearing on January 19, 2022, and accepted comments from the public through January 24, 2022. OHA expects to release final rules in early February 2022.

[2] A proposed transaction is only reviewable if the entities party to the proposed transactions meet the financial thresholds specified in HB2362 and the transaction is not otherwise exempt. For more information, see OAR 409-070-0010.

Purpose of the Technical Advisory Group

The purpose of the TAG was two-fold:

1. Further specify the concept of "essential services" which, in accordance with the statute, includes "services that are essential to achieve health equity"; and
2. Specify how a health care entity will determine if a transaction will *significantly* reduce essential services.

415.500 et seq. (House Bill 2362) defines essential services as "services that are funded on the prioritized list described in ORS 414.690" **and** "services that are essential to achieve health equity". All services funded on the prioritized list are therefore "essential." The Legislature did not specify which services are "essential to achieve health equity," thus it was OHA's task to specify additional services that are not funded on the prioritized list but are essential to achieve health equity. These additional services should be defined in such a way that allows for entities to determine if the services they provide fit that definition. In other words, the definition must be clear and practical. The determination of whether a service meets the definition of "essential" will in some cases serve as a deciding factor for whether an entity must submit a notice of material change transaction.

The Oregon Health Authority's prioritized list consists of 662 conditions and the corresponding codes for diagnoses and treatment procedures.[3] As of January 1, 2022, the first 472 conditions on the prioritized list are funded.[4] At present, these conditions are therefore essential for the purposes of the Health Care Market Oversight Program. The prioritized list and what is funded on the list may change according to the Health Evidence Review Committee. Examples of funded conditions include but are not limited to pregnancy, prevention services, substance use disorder, reproductive services, diabetes, and many more.

Definition of Services that are Essential to Achieve Health Equity

About the Definition

The Oregon Health Authority uses the following definition of health equity[5]:
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. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- *The equitable distribution or redistribution of resources and power; and*
- *Recognizing, reconciling, and rectifying historical and contemporary injustices.*

Many of the services funded on the prioritized list are essential to achieve health equity. The following definition of *additional* services that are essential to achieve health equity should not be misconstrued as the only services that are essential to achieve health equity in a general sense. The following proposed definition of services that are essential to achieve health equity apply only to operationalizing the HCMO program (i.e., for entities determining whether or not a material change

[3] For more about the prioritized list, see https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx
[4] https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2022%20Prioritized%20List%20of%20Health%20Services.pdf
[5] https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

transaction will be subject to review).

Services that are Essential to Achieve Health Equity

The services listed below are essential to achieve health equity.

i) Any service directly related to the treatment of a chronic condition is essential to achieve health equity for the purposes of administering the HCMO program. The term chronic condition is defined as:

- a condition that lasts one year or more and
- requires ongoing medical attention or limits activities of daily living or both.[6]

The beforementioned phrase "directly related to" means services that are intended to treat the condition or the symptoms of that condition.

ii) **Pregnancy-related services are essential** to achieve health equity for the purposes of administering the HCMO program. Most pregnancy-related services are funded on the prioritized list and are therefore already essential. Any other pregnancy-related service is also considered essential.

iii) **Prevention services, including non-clinical services, are essential** to achieve health equity for the purposes of administering the HCMO program. Many prevention services are funded on the prioritized list and are therefore already essential. Prevention services include appropriate screenings, chronic disease prevention programs, nutritional education programs, programs that encourage activity among children, and more. The term "non-clinical" in this context means services rendered outside of a clinical setting or rendered by individuals without medical training (e.g., a school-based program to encourage physical activity).

iv) **Health care system navigation and care coordination services are essential** to achieve health equity for the purposes of administering the HCMO program. Many of these services are funded on the prioritized list and are therefore already essential. Health care system navigation and care coordination services include assisting new patients and new health plan members with accessing needed care, helping individuals access referrals, translation services, and more.

[6] Center for Disease Control, National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/chronicdisease/about/index.htm. Access January 6, 2022.

How to Determine if a Transaction will *Significantly* Reduce Essential Services

A "significant reduction" of services occurs when a transaction will result in *any* of the concepts outlined in draft OAR 409-070-0010 (3) changing by the following amounts or more:

Table 1: Definition and Examples of a Significant Reduction of Essential Services

Draft OAR language from 409-070-0010(3)	Determining "significant reduction"	Example
(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	A transaction that would result in an increase of one-third or more of the median time or distance travelled for existing patients is considered a significant reduction. A transaction is also considered a significant reduction if the transaction will result in an increase of one-third or more of the distance between the health service location and the closest public transportation access point such as a bus, train, or light rail stop; this does not apply to entities that are less than 1 mile away from a public transportation access point and does not apply to entities that are more than 10 miles away from a public transportation access point.	A hospital is proposing to acquire a large clinic. The transaction would result in the clinic closing and the medical providers who render essential services would serve the clinic's existing patients out of a building on the hospital's campus. The median travel time of existing clinic patients is 30 minutes and median travel time to the new location would be more than 40 minutes, which is one-third greater than 30 minutes. This is considered significant.
(b) A reduction in the number of providers, including the number of culturally competent providers[7], health care interpreters, or traditional healthcare workers, or a reduction in the number of clinical experiences or training	A transaction that would result in a decrease of one-third or more of trained culturally competent providers, health care interpreters, or traditional healthcare workers is considered a significant reduction. A transaction that will result in a decrease of	A proposed merger of two large clinics would result in one clinic reducing the number of traditional health workers from 20 to 13. These traditional health workers provide health system navigation and care coordination services. This reduction is more than one-third and is considered significant.

[7] Cultural competency is defined as "a lifelong process of examining the values and beliefs and developing and applying an inclusive approach to health practice in a manner that recognizes the content and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families, and communities". See OAR 943-090-0000 through 943-090-0020

Draft OAR language from 409-070-0010(3)	Determining "significant reduction"	Example
opportunities for individuals enrolled in a professional clinical education program.	one-third or more of the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program is considered a significant reduction.	
(c) A reduction in the number of providers serving new patients, providers serving individuals who are uninsured, or providers serving individuals who are underinsured. [8]	A transaction that would result in a decrease of one-third or more of the number of providers serving new patients or individuals who are uninsured is considered a significant reduction. Additionally, a reduction is considered significant if the transaction will result in the number of providers decreasing such that the number of patients who are responsible for the entire cost of a visit increases by one-third or more.	A proposed material change transaction would result in a clinic reducing the number of essential service providers who see uninsured patients from 25 to 15 providers. Such a reduction is more than one-third and is therefore significant.
(d) Any restrictions on providers regarding rendering, discussing, or referring for any essential services	A transaction that would result in any decrease of one-third or more of any given essential service as a result of restrictions placed on providers rendering, discussing, or referring for an essential service is considered a significant reduction.	Two hospitals propose to merge and as a result, one hospital would reduce its maternity services and provide less than one-third of the births as it did before the transaction. Such a reduction is considered significant.
(e) A decrease in the availability of essential services or the range of available essential services	A transaction that would result in any decrease of one-third or more of essential services due to the lack of availability is considered a significant reduction.	A health system proposes to acquire a multi-specialty clinic. The transaction would not change the overall number of 15 providers employed by the clinic but would let go of all 5 Cardiologists, who provide services funded on the prioritized list, and

[8] For the purposes of the Health Care Market Oversight Program, the term "underinsured" means individuals who have medical insurance, but also face deductibles and other out-of-pocket spending that serves as a significant barrier when accessing health care services. Entities involved in a transaction that will reduce the number of providers serving individuals who are underinsured should analyze the number of patients whom the entity bills for the full cost of a visit.

Draft OAR language from 409-070-0010(3)	Determining "significant reduction"	Example
		subsequently hire other specialists. The number of essential services related to cardiology has been reduced by more than one-third. Such a reduction is considered significant. A second example is if the transaction above would not change the overall number of 15 providers employed by the clinic, but they would no longer accept patients with the Oregon Health Plan. Such a reduction of availability of essential services is considered significant.
(f) An increase in appointment wait times for essential services	A transaction that would result in an increase of one-third or more of appointment wait times is considered significant.	A private equity firm proposes to acquire a clinic that provides services funded on the prioritized list. Appointment wait times would increase from 5 business days to 9 business days due to the terms of the transaction. Such an increase is more than one-third and is considered significant.
(g) An increase in any barriers for community members seeking care, such as new prior authorization processes or required consultations before receiving essential services	A transaction that would result in a decrease of one-third or more of the availability of an essential service due to any barrier such as new prior authorization processes, required consultations or delays.	A health system proposes to acquire a clinic and would impose new prior authorizations for substance use disorder treatment (an essential service). It can be assumed that the new prior authorization process would likely reduce the number of rendered treatment visits from 1,000 to 500. Such a decrease is more than one-third and is considered significant.
(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	A transaction that would result in a decrease of one-third or more of the specified types of care, as measured by the number of providers or services rendered, is considered significant.	A private equity firm proposes to acquire a multi-specialty clinic and would reduce the number of behavioral health providers who render services funded on the prioritized list. The transaction would reduce the number of providers from 24 to 16. Such a reduction is one-third and is considered significant.

Determining Significant Reductions of Essential Services for Transactions Involving Insurers

The statutory language in HB 2362 and the Health Care Market Oversight Program does not entail an evaluation of an insurer's network or network adequacy. Rather, the statute focuses on *changes* in the provision of essential services that result from covered material change transactions.

For transactions involving insurers, a significant reduction of essential services occurs when an insurer reduces or eliminates coverage of essential services in any of their health plan products as a result of the transaction. A reduction in coverage or complete removal from coverage of essential services by the insurer as a result of the transaction increases out-of-pocket spending for consumers and therefore raises relevant concerns about access and equity. In this case, the transaction would be subject to review and a notice of material change transaction would be required.

For transactions involving an insurer and a health care delivery entity (e.g., hospital, health system, provider group, clinic), where the delivery system itself is altered as a result of the transaction, all other considerations for determining a significant reduction of essential services outlined in this document shall apply (e.g., increasing time or distance to services, decreasing number of providers of services, etc.).

Timing of Reductions of Essential Services

The statute and rules require entities to submit a notice of material change transaction in some instances when the transaction will result in a significant reduction or elimination of essential services. For the purposes of the Health Care Market Oversight program, entities must consider any significant reduction or elimination of essential services that will occur within twelve months after the effective date of the transaction and the reduction is intended, anticipated, or under the control of the entity. In other words, significant reductions of essential services that occur twelve months after the transaction effective date should be presumed to result from the transaction if those reductions are intended, anticipated, or under the control of the entity. Reductions that are both unforeseen and uncontrollable by the entity, such as but not limited to when a provider leaves or retires, or when a pandemic disrupts health care services, shall not be considered changes that were a result of a transaction.

The purpose for this twelve-month timeline is to provide specificity for entities as they determine if a transaction is subject to review under the Health Care Market Oversight Program. The program does not oversee decisions that an entity makes unilaterally regarding what services they will provide, expand, or reduce; the program's oversight is relegated to transactions and reductions in essential services that result from a transaction.

Examples of Applying the Rubric

Example A: Two large multi-specialty clinics are discussing a new clinical affiliation between the two entities, and as a result of that affiliation there would be a reduction of services. The entities' average annual revenue exceeds the statutory thresholds of $10 million and $25 million, and the proposed transaction is not otherwise exempt from review. Each clinic has 30 providers – 60 providers in total - that range in specialty. The transaction would result in decreasing the number of oncologists from ten to eight. No other changes would occur.

Step 1: Are the services that those oncologists provide "essential"?

- Are the services funded on the prioritized list?
- Are the services directly related to the treatment of a chronic condition, pregnancy-related service, prevention service, or navigation/care coordination service?

In this example, the answer to both questions is yes because cancer treatment services provided by oncologists at the clinic are funded on the prioritized list. Even if the treatments provided by the oncologists were not funded on the prioritized list, the services would still be essential because cancer is considered a chronic condition. The services to be reduced would therefore be considered "essential."

Step 2: Is the reduction of the essential service "significant"?

- Is the nature of the service reduction reflected in any of the eight categories specified in Table 1 above?

Applying the example to the concepts in OAR 409-070-0010(3)	Does this meet the definition of "significant"?
(a) There is no change in location and no closing of any locations	No
(b) There **is a reduction** of providers, but not by one-third or more	No
(c) There **is a reduction** of providers serving new patients and individuals who are uninsured or underinsured, but not by one-third or more	No
(d) There are no restrictions regarding rendering, discussing, or referring to any essential services	No
(e) There **is a decrease** in the availability of essential services, but not by one-third or more because there are other oncologists to provide the essential services	No
(f) There **is an increase** in appointment wait times, but in this example the eight oncologists will serve patients such that wait times do not increase by one-third or more	No
(g) There is no increase in any barriers for community members seeking care	No
(h) There **is a reduction** of a specific type of care, namely oncology care, which is a specialty, but the decrease is not by one-third or more	No

This transaction will result in a reduction of essential services, but the reduction is not significant. The material change

transaction is not subject to review under the HCMO program because it is a clinical affiliation that will not "significantly" reduce essential services.

Example B: A hospital and a clinic are discussing a contracting affiliation, and as a result of that contracting affiliation some primary care providers would be moved from practicing in the clinic to practicing on the hospital's campus in a neighboring city 25 miles away. The entities' average annual revenue exceeds the statutory thresholds of $10 million and $25 million, and the proposed transaction is not otherwise exempt from review.

Step 1: Are the primary care providers' services "essential"?

- Are the services funded on the prioritized list?
- Are the services directly related to the treatment of a chronic condition, pregnancy-related service, prevention service, or navigation/care coordination service?

Primary care services and related treatments are funded on the prioritized list and primary care providers routinely treat chronic conditions, provide prevention services, and provide navigation and care coordination services. The services are "essential."

Step 2: Is the reduction of the essential service "significant"?

- Is the nature of the service reduction reflected in any of the eight categories specified in Table 1 above?

Applying the example to the concepts in OAR 409-070-0010(3)	Does this meet the definition of "significant"?
(a) There **is an increase** in time and distance for community members. The median distance traveled by patients to the clinic is 10 miles, and at the new location on the hospital campus would be 15 miles. This is greater than an increase of one-third.	**Yes**
(b) There is no reduction of providers.	No
(c) There is no reduction of providers serving new patients and individuals who are uninsured or underinsured.	No
(d) There are no restrictions regarding rendering, discussing, or referring to any essential services.	No
(e) There is no decrease in the availability of essential services.	No
(f) There is no increase in appointment wait times	No
(g) There is no increase in any barriers for community member seeking care, such as prior authorizations or required consultations before receiving essential services.	No
(h) There is no reduction of a specific type of care.	No

This transaction will result in a reduction of essential services, and that reduction is significant. The material change transaction is subject to HCMO review because this is a contracting affiliation that will significantly reduce essential services.

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Oregon Health Authority
HEALTH POLICY AND ANALYTICS
Office of Health Policy

Health Care Market Oversight Analytic Framework

Overview

This framework describes the analytic approach of the Oregon Health Authority's Health Care Market Oversight program (HCMO) for conducting reviews of material change transactions pursuant to ORS 415.500 et seq. The framework is grounded in the goals, standards and criteria for transaction review and approval outlined in OAR 409-070-0000 through OAR 409-070-0085. This document outlines the analytic methods, performance measures, and sources of information HCMO expects to use for reviews of material change transactions.

This document provides the menu of potential analyses from which HCMO will choose in reviewing a particular material change transaction (hereafter, "transaction"). HCMO does not expect to complete every analysis described here for every transaction review. The specific facts of the proposed transaction, the availability of reliable data, and time constraints associated with preliminary and comprehensive review periods will affect the analyses included in HCMO's review of any given transaction. These considerations are further described in the section entitled "Application of the Framework." As the program matures, HCMO may update this framework as needed to reflect current practice, provide additional details on methodologies and measures, incorporate newly available data sources, and clarify implementation of the framework for specific transactions.

Contents

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Nature of the Transaction and Characteristics of the Entities

Before starting the analysis, HCMO will review the Notice of Material Change Transaction form (hereafter, "notice") and proposed agreement or term sheet to extract key facts about the transaction, including:

Type of transaction: Merger, acquisition, affiliation (clinical, corporate, contracting), contract, partnership, joint venture, formation of Accountable Care Organization (ACO), parent organization, or management services organization.
Entities involved in the transaction: Type(s) of health care entities (hospital, health system, physician group, Coordinated Care Organization [CCO], insurer, etc.), service lines, facilities owned or operated, size (volume, revenue, capacity, employees), geographic area(s) of operation, patient demographics (including payer mix), existence of clinical or contracting affiliations, major contracting relationships, ownership/control of other businesses.
Ownership/governance/operational structure: Ownership type (public/private; for-profit/non-profit, LLC/corporate, etc.), governance, and operational structure of the parties to the transaction and any changes in ownership, governance, or operational structure resulting from the transaction.
Objectives: Rationale for the transaction; main benefits expected from the transaction.
Post-transaction plans: New investments, management or operational changes, including changes to services anticipated or planned to be implemented after the transaction closes.
Anticipated impact: Applicant's expectations for the impact of the transaction on access to affordable health care, health care cost growth, access to services in medically underserved areas, health inequities, and competition in health care markets.

If necessary, HCMO will consult with the Oregon Department of Justice (DOJ) on whether the transaction meets the criteria for a material change transaction under OAR 409-070-0005 through OAR 409-070-0025. For purposes of establishing these basic facts, HCMO may request supplementary information from the entities if the above information is not contained in the notice, proposed agreement, or term sheet.

Analytic Domains

HCMO analysis will focus on four domains: **cost, access**, **equity**, and **quality**. For each domain, HCMO will assess:

- The **current performance** of the entities involved in the transaction, based on relevant outcome metrics prior to the transaction. Current performance will be measured relative to performance of other comparable health care entities (see" Identifying Comparator Entities" for details on how comparator entities will be identified). When possible, multiple years of data will be used to assess current performance.
- The likely **impact of the transaction** on performance, given current performance, known details of the transaction, characteristics of the health care market(s) in which the entities operate, and the entities' goals and plans post-transaction. Impact analyses will seek to anticipate the entities' post-transaction performance and compare this to expected performance in the absence of the transaction. Focus will be on short-term (12-month) impacts of the transaction, although longer term impacts will also be considered. Impact analyses will be informed by academic research on the effects of similar transactions.

The Outcomes and Analysis section describes, for each domain, the key outcomes HCMO will assess and the methods HCMO may use to determine the likely impact of the transaction. Outcome metrics and analytic methods for a given transaction will depend on several factors, as described in the following section.

Application of the Framework

This section describes the main factors influencing the types of outcome measures and analyses HCMO will perform in reviewing a given transaction. These include the level of review (preliminary versus comprehensive), the characteristics of the entities, and the nature of the transaction.

Level of Review

Following a preliminary review, HCMO may determine that a comprehensive review is required if there are indications that the transaction may lead to significant adverse effects in any of the domains of cost, access, equity, or quality. (Please refer to HCMO sub-regulatory guidance: Criteria for Comprehensive Review of Material Change Transactions.[1]) Preliminary and comprehensive reviews may differ on multiple dimensions, including:

- **Quantitative analyses.** The number of outcome measures assessed, the level of granularity at which measures are calculated, the degree of adjustment of measures to account for provider- or population-specific factors, and the level of sophistication of statistical/econometric analyses.
- **Data sources.** The number of data sources used, reliance on confidential data and documents provided by the entities (subject to request), use of third-party proprietary databases.
- **Use of qualitative methods.** Qualitative analysis for preliminary reviews will be limited to review of publicly available documents, reporting, and any public comments submitted in response to the notice. Comprehensive reviews may include collection of qualitative information and in-depth analysis of documents obtained from the entities.

Table 1 provides an overview of HCMO analyses and data sources for preliminary and comprehensive reviews. The two left-hand columns list the data sources HCMO will use for preliminary reviews and the associated analyses. The two right-hand columns provide a menu of possible data sources and analyses for comprehensive reviews.

For current performance analysis during preliminary review, HCMO will examine a limited set of measures of cost, access, equity and quality using readily available administrative data (e.g., claims, hospital discharge data), existing reporting, and other publicly available information and documents. Additional information needed for preliminary analysis may be requested to supplement or clarify the contents of the notice, including details about the transacting entities, recent quantitative data, current policies and procedures, or narrative about patient and community engagement efforts. Please see Table 2 below for a list of supplemental items that may be requested during the preliminary review period.

For domains and outcomes identified as concerning during the preliminary review, HCMO will expand its analysis of current performance during comprehensive review by adding measures, using additional data sources for calculating measures, and calculating measures at a more granular level. For impact analysis, HCMO will generally employ more sophisticated statistical or econometric techniques during comprehensive review. To obtain additional data sources needed for more in-depth quantitative analysis, HCMO may request internal data from the entities or leverage third-party databases.

In addition to quantitative analyses, comprehensive reviews may include qualitative data collection and analyses, for example, input from community members as part of a Community Review Board (CRB), interviews with representatives of the entities and community groups, and review of internal documents requested from the entities relating to integration planning or quality improvement. (For more information on CRBs, please refer to HCMO sub-regulatory guidance: Criteria for Community Review Boards.[2])

[1] Guidance is available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Criteria-for-Comprehensive-Review.pdf.
[2] Guidance is available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Community-Review-Board-Criteria.pdf.

HCMO may retain outside advisors such as economists, accountants, actuaries, qualitative researchers, attorneys, and health care quality experts to carry out the more sophisticated and detailed analyses that may be required for a comprehensive review. HCMO does not expect to retain outside advisors for preliminary reviews, except on rare occasions where state agencies lack the necessary expertise. (Please refer to HCMO sub-regulatory guidance: Criteria for OHA Use of Outside Advisors for Material Change Transaction Review.[3])

Type of Entity

HCMO will review material change transactions involving any health care entity. Per OAR 409-070-0005, the types of entities meeting the definition of a "health care entity" include:

- Individual health professionals licensed or certified in Oregon.
- Hospitals.
- Health systems.
- Carriers offering a health benefit plan or Medicare Advantage plan.
- Coordinated care organizations.
- Other entities as defined in OAR 409-070-0005 (16)(f)-(g) and (17).[4]

The type(s) of entities engaging in the material change transaction will determine the measures HCMO uses to assess current performance and implementation of impact analyses in each domain. For example, in the access domain, measures of payer mix would be relevant for hospitals, health systems and physician groups. For carriers, HCMO would examine the size and composition of the provider network. In the cost domain, price, market share, and spending measures would be defined differently depending on the types of services offered by the entity.

Nature of the Transaction

HCMO's analytic approach will also differ based on the type of transaction (e.g., merger, acquisition, affiliation, partnership, joint venture, etc.) and the specific facts of the transaction (e.g., the associated change in ownership, governance, management, or operational structure). In addition to being relevant for the choice of analyses, these factors may affect the domains of focus (e.g., cost, access, quality, or equity) for impact analyses. For example, a contracting affiliation in which there are no changes in management or operations of either entity would be less likely to have implications for access than an acquisition in which the entities plan to integrate management and operations.

[3] Guidance is available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Outside-Advisors.pdf.

[4] Guidance is available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Entities-Subject-to-Review.pdf.

Table 1: Summary of Analyses and Data Sources for Transaction Reviews

	PRELIMINARY REVIEW		COMPREHENSIVE REVIEW	
Domain	**Data Sources**	**Analyses**	**Potential Additional Data Sources**	**Potential Additional Analyses**
Cost	- All Payer All Claims (APAC) data - Hospital discharge data - Audited financial statements - CCO/Hospital financial reporting - Cost growth target data - DCBS health insurer data - Publicly available data on hospital/health system characteristics (e.g., CMS, AHRQ) - Other information provided in notice	- Nature of the transaction - Characteristics of the entities (including entity ownerships and structure) - Market share/Market concentration analysis - Financial analysis (solvency, profitability) - Relative prices - Historical price growth - Total spending on health care services (absolute/relative, growth rate)	- Pricing/contract data - Interviews with representatives of transacting or comparator entities - Information on participation in value-based payment models - Documents relating to integration planning - Community Review Board (CRB) convening - Provider cost data	- Additional/more granular outcome measures - Diversion analysis - Willingness-to-Pay (WTP) analysis - Merger simulation - Synthesis of CRB opinions and recommendations - Analysis of interview transcripts/notes - Retrospective analysis of price changes following previous similar transactions - Assessment of potential efficiencies from integration - Qualitative analysis of interview transcripts/notes - Document review
Access	- APAC data - Hospital discharge data - CCO/Hospital financial reporting - Census data - Press releases and other public statements by the transacting entities - Other information provided in notice - Public comments submitted in response to notice	- Service volume (absolute and relative to service area/ comparator entity volume) - Number of providers/clinicians - Payer mix - Patient demographics	- CRB convening - Documents relating to integration planning - Workforce/capacity data - Enrollment data - Contract data (carriers) - Interviews with representatives of transacting or comparator entities - Emergency Department Information Exchange (EDIE)	- Additional/more granular outcome measures - Retrospective analysis of access outcomes following previous similar transactions - Analysis of service line profitability - Synthesis of CRB opinions and recommendations - Document review - Qualitative analysis of interview transcripts/notes
Equity	- APAC data - Financial reporting	- Community Benefit spending	- CRB convening - Enrollment data	- Synthesis of CRB opinions and recommendations

	PRELIMINARY REVIEW		COMPREHENSIVE REVIEW	
Domain	**Data Sources**	**Analyses**	**Potential Additional Data Sources**	**Potential Additional Analyses**
	- Health equity reporting - Census data - Community benefit reporting - Community health/equity assessments - Press releases and other public statements by the entities - Documents relating to integration planning - Public comments submitted in response to notice	- Patient demographics - Quality/access outcomes stratified by patient demographics - Document review	- Social needs screening/referral data - Interviews with representatives of priority population groups or community-based organizations - Health Care Workforce Reporting Program - Workforce directory/survey data - Traditional Health Worker/Health Care Interpretation registries	- Additional/more granular outcome measures - Provision of care coordination/social services referral - Qualitative analysis of interview transcripts/notes - Provision of translation/interpretation services - Utilization of traditional/community health workers - Workforce diversity/representation of community
Quality	- APAC data - Existing quality reporting (e.g., CCO metrics, hospital quality, Medicare, NCQA) - DCBS health insurer data - CAHPS survey data - Other relevant information provided in notice - Public comments submitted in response to notice	- Clinical quality measures - Patient outcome measures - Patient experience measures - Participation in national or statewide care delivery transformation efforts	- Documents relating to quality management/integration planning - Interviews with representatives of entities - Electronic health record extracts - Information on participation in value-based payment models - CRB convening - Grievance and appeals reporting - Entity-administered CAHPS results	- Additional/more granular outcome measures - Document review; assessment of potential quality improvements from integration - Qualitative analysis of interview transcripts/notes - Synthesis of CRB opinions and recommendations - Retrospective analysis of quality outcomes following previous transactions

Table 2: Supplemental information that may be requested for preliminary review

Area/Domain	Supplemental Information
Nature of the transaction and characteristics of the entities	- Chart showing all entities involved in the transaction and their relationships to one another (e.g., ownership stake, control, management) pre- and post-transaction; may involve a more detailed chart necessary for transaction review and a separate more redacted chart for public posting - Description of all entities involved in the transaction, their role in the transaction, and their connection to patient care - Annual national and Oregon revenue for all entities involved in the transaction in the previous year(s) - Business registration and/or incorporation documents (if business is primarily registered in another state) - Current investigations, regulatory action, fines, or formal complaints filed against any entity involved in the transaction
Cost	- For hospitals: Hospital Price Transparency Law-compliant data (if not readily available online), summarized or filtered as relevant - For carriers: Transparency in Coverage-compliant data (if not readily available online), summarized or filtered as relevant
Access	- For providers: patient payer mix from recent year(s), at minimum identifying patients covered by Medicare, Medicaid (Oregon Health Plan), commercial, and uninsured; may request coverage by specific carrier if relevant to the transaction - Patient/member demographic information from recent year(s), including race, ethnicity, language, age, sex, disability, gender identity, sexual orientation, zip code*Provider/staff demographic information from recent year(s) - Number of providers and/or full-time equivalent (FTE) and patient/staff ratios, by provider type as relevant to the transaction
Equity	- Documentation/description of culturally and linguistically appropriate services** provided or offered - Policy/procedure and patient-facing materials around provision of interpretation services - Policy/procedure and patient-facing materials around unpaid/charity care and patient financial assistance - Policies or action plans to identify and reduce health disparities and inequities across patient/member population - Documentation/description of community involvement in entity governance or decision-making - Documentation/description of programs, initiatives, or events intended to engage the community served and build relationships; examples include health fairs, patient education programs, or sponsored health-related events - Documentation/description of participation in community groups, including community organization boards, Coordinated Care Organization (CCO), participation in Regional Health Equity Coalitions (RHECs), support of county health department efforts or other local government activities (e.g., school districts, Parks and Recreation, Early Learning Hubs) - Community investments or benefits aimed at addressing health inequities and/or social determinants of health - For CCOs: most recent version of Health Equity Plan - For relevant entities: narrative around health equity strategy and/or specific elements related to health equity from most recent submission for accreditation to National Committee for Quality Assurance (NQCA), the Patient-Centered Primary Care Home (PCPCH) program, the Joint Commission, or other quality-related bodies - Consumer Assessment of Healthcare Providers and Systems (CAHPS) or other patient experience survey results and/or quality reporting data disaggregated by patient/member demographics

Area/Domain	Supplemental Information
Quality	- For carriers and providers: most recent quarterly/annual CAHPS or other patient experience survey results prior to transaction - For CCOs: most recent version of the Transformation Quality Strategy (TQS) and quality incentive metric performance - For Medicare certified providers: most recent quality reporting data prior to transaction that reflects performance on full patient population for all applicable CMS quality reporting program measures - For relevant entities: narrative around quality improvement strategy or projects and summary of performance on included quality indicators from most recent submission for accreditation to NCQA, PCPCH or Joint Commission - Most recent data on patient/member complaints and grievances

* HCMO promotes the collection of REALD-compliant data but will accept all demographic information currently collected.
** Culturally and Linguistically Appropriate Services (CLAS) are defined as effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Information about national CLAS standards can be found on the Health and Human Services (HHS) website.

Decision Criteria

HCMO will adhere to the criteria for approval outlined in OAR 409-070-0055 and OAR 409-070-0060. Tables 3 and 4 below map these criteria to HCMO's analytic domains. Findings from analysis of each domain will be considered in unison, and no a-priori weights will be applied to domain-specific results when arriving at a decision.

Table 3: Domain Relevance to OAR Criteria for Approval following Preliminary Review

OAR Criteria for Approval following Preliminary Review	Domain Relevance			
At least ONE must apply:	Cost	Access	Equity	Quality
In the interest of consumers and is urgently necessary to maintain the solvency of an entity	●	●	●	●
Unlikely to substantially reduce access to affordable health care in Oregon	●	●	●	
Likely to meet the criteria set forth in OAR 409-070-0060*	●	●	●	●
Not likely to substantially alter the delivery of health care in Oregon	●	●	●	●
Comprehensive review is not warranted given the size and effects of the transaction	●	●	●	

Table 4: Domain Relevance to OAR Criteria for Approval following Comprehensive Review

OAR Criteria for Approval following Comprehensive Review	Domain Relevance			
	Cost	Access	Equity	Quality
ALL must apply:				
No substantial likelihood of anticompetitive effects not outweighed by benefits in increasing or maintaining services to underserved populations	●	●	●	●
No substantial likelihood of being contrary to law*				
No substantial likelihood of jeopardizing the financial stability of a health care entity involved in the transaction	●			
No substantial likelihood that the transaction would otherwise be hazardous or prejudicial to consumers or the public	●	●	●	●
At least ONE must apply:				
Reduces growth in patient costs in accordance with health care cost growth targets under OAR 442.386 or maintains a rate of cost growth that exceeds the target that the entity demonstrates is in the public interest	●	●	●	●
Increases access to services in medically underserved areas		●	●	
Rectifies historical and contemporary factors contributing to a lack of health equity or access to services		●	●	
Improves health outcomes for residents of this state		●	●	●

*HCMO may rely on an assessment by the Department of Justice during preliminary review of whether the transaction is likely to be contrary to law.

Outcomes and Analyses

This section describes, for each domain, the key outcomes HCMO will use to assess performance and provides an overview of the methods that may be used to determine the likely impact of the transaction. Where possible, the description distinguishes between analyses performed during preliminary review versus comprehensive review.

Market Definition

Definition of the primary service area (PSA) of each health care entity involved in the transaction is fundamental to subsequent analyses. HCMO will use the methodology described in Appendix C to determine the zip codes that comprise the PSA(s) of all relevant entities. This geographic definition is used to identify other competing service providers operating in the region and the Oregon population potentially impacted by the transaction. This information supports several subsequent analyses:

- **Market share.** What share of total patient volume or revenues across comparable health care entities in the geographic service area is attributable to each of the entities?
- **Market concentration.** Calculating the Herfindahl-Hirschman Index (HHI) from market shares, how concentrated or competitive is the market?
- **Impacted population.** What are the demographic and socioeconomic characteristics of the people living in the PSA? Does this population have unique health needs?
- **Market geography.** Does the geography of the region present barriers to accessing services?

Cost

HCMO will assess current performance and the likely impact of the transaction on four broad cost outcomes: market share, prices, spending, and financial condition. The below subsections describe the assessment questions and analytic methods HCMO expects to use for current performance and impact analyses, respectively.

Current Performance

- **Prices.** How do the entities' prices for health care services compare to similar entities or other reference datasets?
- **Spending.** How do the entities' total expenditures for health care services compare to similar entities?
- **Financial condition.** What is the financial condition of the entities, including revenues, profitability, and ability to meet financial obligations? Are any of the entities facing an immediate risk of insolvency?

A list of potential measures for each outcome is provided in Appendix A.

Market shares will be calculated in aggregate across all health care services offered by the entities and disaggregated by payer and type of service. For example, in the case of a hospital system, market shares may be calculated for inpatient versus outpatient services and by Major Diagnostic Category (MDC). For a physician group, market shares may be calculated by specialty (primary care, cardiology, oncology, etc.).

For preliminary reviews, prices will be calculated based on allowed and paid amounts from claims or other publicly available pricing data. For hospitals, HCMO may rely on existing Hospital Payment Reports (also known as SB 900 reports) for common inpatient and outpatient procedures. Where possible, relative prices will be calculated separately for each payer and standardized to account for differences in service volume, service mix, patient acuity, and insurance product type. HCMO will examine relative prices in aggregate across all services, by place of service, and by type of service. HCMO may request additional data on pricing (including bonus and performance payments) from the entities when carrying out a comprehensive review.

For price outcomes, HCMO's analysis will focus on the commercial market, where prices for health care services are determined by negotiations between payers and providers. While consolidation may affect pricing in other markets (e.g.,

Medicaid) as well, the commercial market is likely to be more directly impacted.

If any of the entities claim to be facing an immediate risk of insolvency, HCMO will perform an initial assessment of the financial condition of the entity in question as part of the emergency review (if requested) or preliminary review. In the absence of insolvency risk, comprehensive reviews are required by OAR 409-070-0060 to include an assessment of the likelihood that the transaction would jeopardize the financial stability of one of the health care entities.

Impact Analysis

Assessment of the cost impacts of the transaction will examine how each of the outcomes are likely to change due to the transaction.

- **Market share.** How concentrated is the health care market in which the entities operate? How (if at all) will concentration change as a result of the transaction?
- **Prices.** How (if at all) will the transaction affect the prices consumers (e.g., patients, members) or payers (e.g., insurers, employers, and governments) pay for health care services?
- **Spending.** How (if at all) will the transaction affect total health care expenditures for the entities and the state as a whole?
- **Financial condition.** How (if at all) will the transaction impact the financial condition of the entities? If there is an immediate risk of insolvency, is the transaction likely to significantly reduce this risk? In the case of an acquisition, will the transaction reduce the financial security of the acquired entity?

HCMO will consider results across all four outcomes in arriving at a finding on the overall cost impacts of the transaction. Appendix B details the approaches HCMO will use to assess likely impacts in the cost domain. These methods include concentration (Herfindahl-Hirschman Index) analysis, diversion analysis, Willingness-to-Pay (WTP), merger simulation, and analysis of potential efficiencies from integration.

Access

HCMO will assess current performance and the likely impact of the transaction on three broad access outcomes: availability of services, payer mix, and patient demographics. The below subsections describe the assessment questions and analytic methods HCMO expects to use for current performance and impact analyses, respectively.

Current Performance

- **Availability of services.** What is the volume of services (e.g., primary, specialty, behavioral health, oral health, emergency, urgent care, inpatient/outpatient, maternity, etc.) provided by the entities? How does this compare to overall utilization of these services in the geographic service area? What is the ratio of service utilization/provider counts to population?
- **Payer mix.** What is the payer mix of the entities? How does this compare to the overall population in the geographic service area and to other nearby provider organizations?
- **Patient demographics.** What is the composition of the patient/member population based on race/ethnicity, gender, language, disability status, income/social determinants of health, and medical/behavioral health complexity? How does this compare to the overall population in the geographic service area and to other health care entities?

A list of potential measures for each outcome is provided in Appendix A.

Impact Analysis

- **Availability of services.** What is likely impact of the transaction on the volume of services (e.g., primary, specialty, behavioral health, oral health, emergency, urgent care, inpatient/outpatient, maternity, etc.) provided by the entities?
- **Payer mix.** What is likely impact of the transaction on the payer mix of the entities?
- **Patient demographics.** What is the expected impact of the transaction on the demographics of the population served by the entities?

HCMO will consider impact analysis results across all four measures in arriving at a finding on the overall access impact of the transaction. To assess impacts on access measures, HCMO will consider factors such as the entities' current performance on access measures, any plans to consolidate service lines, or any plans to improve availability of services, shift payer mix, or enhance access for particular populations. HCMO will also consider any concerns about adverse impacts on access outcomes voiced by members of the public, specifically by community members within the geographic service area of the entities.

For comprehensive reviews, HCMO may request to review the entities' plans and proposals in the context of integration planning. Of particular interest would be the level of detail of these plans or proposals (for example, inclusion of specific locations for expansion, assessments of provider capacity, number of clinicians needed, resource commitments, and timelines). In addition, HCMO may rely on financial analysis of service line or facility-level profitability to assess the potential for access reductions, as profitability is likely to be a factor in any decision to discontinue services or shift the location of services. HMCO may convene a CRB to provide input on potential access impacts. Where possible, HCMO may also rely on retrospective quantitative analysis of previous transactions involving the relevant entities to assess impacts of those transactions on access.

Equity

HCMO will assess current performance and the likely impact of the transaction on four broad equity outcomes: equitable access, equitable quality, community engagement, and equity-enhancing services. The below subsections describe the assessment questions and analytic methods HCMO expects to use for current performance and impact analyses, respectively.

Current Performance

- **Equitable access.** How does patient or member utilization of the entity's services vary by race/ethnicity, gender, language, disability status, income, and other characteristics? How (if at all) does utilization among populations experiencing health inequities (e.g., low-income individuals, racial/ethnic groups, people with disabilities, LGBTQ+, people with limited English proficiency) differ from that of other patients or members? How does this compare to other similar health care entities?
- **Equitable quality**. How does the entity's performance on quality measures vary by race/ethnicity, gender, language, disability status, income, and other characteristics? How (if at all) does care quality for populations experiencing health inequities (e.g., low-income individuals, racial/ethnic groups, people with disabilities, LGBTQ+, people with limited English proficiency) differ from that of other patients or members? How does this compare to other similar health care entities?
- **Community engagement:** What is the extent of the entities' investment in the communities they serve? How much do they spend on community-level initiatives to address health inequities and social determinants of health? What is the ratio of this spending to operating profits? How do the entities involve the community in the decision-making process for such investments?
- **Equity-enhancing services.** Do the entities provide services that promote health equity, such as preventive services, coordination with social services, services provided by community/traditional health workers, culturally

appropriate services, chronic disease management services, and translation/interpretation services?

A list of potential measures for each outcome is provided in Appendix A. For assessing equitable quality and access measures, preference during preliminary review will be placed on claims-based measures whose results can be disaggregated by population demographics available within existing data sources, including race, ethnicity, age, language, gender, and disability status. Additional information may be obtained from existing health equity or community benefit reporting, community health assessments, etc. For comprehensive reviews, HCMO may use additional data sources such as workforce data and information on referrals to community-based organizations.

Impact Analysis

- **Equitable access.** How will the transaction affect the entities' provision of services for populations experiencing health inequities, overall and relative to other populations?
- **Equitable quality**. How will the transaction affect the entities' performance on quality measures for populations experiencing health inequities, overall and relative to other populations?
- **Community engagement:** What is the likely impact of the transaction on the level of investment in the entities' local communities, particularly as it pertains to initiatives to address health inequities and social determinants of health? How will the transaction affect the entities' ability to respond to community needs?
- **Equity-enhancing services.** What is the likely impact of the transaction on the entities' provision of services that promote health equity?

HCMO will consider impact analysis results across all four measures to arrive at a finding on the overall equity impact of the transaction. To assess these impacts, HCMO will consider factors such as the entities' track record in addressing health inequities (as measured by the analysis of current performance), integration plans post-transaction, and any health equity plans or assessments developed in connection with the transaction. Of particular interest would be the level of detail of such plans (for example, identification of priority populations and services, inclusion of specific locations for expansion, assessments of provider capacity and workforce representation, number of clinicians needed, resource commitments, and timelines). Any consolidation of service lines or facility closures resulting from the transaction would be concerning if the changes are likely to disproportionately affect populations experiencing health inequities. Additionally, HCMO will consider whether the transaction brings a shift in management from the local/facility level to a higher organizational level (e.g., system). This may affect the entities' ability to provide services that are responsive to community-level socioeconomic and demographic characteristics, as well as their ability to identify effective strategies for addressing health inequities.

HCMO will also consider any concerns about impacts on equity outcomes voiced by members of the public, specifically by community members within the geographic service area of the entities. For comprehensive reviews, HCMO may convene a CRB or conduct interviews with representatives of priority population groups or community-based organizations to obtain input on potential equity impacts. (Please refer to HCMO sub-regulatory guidance: Criteria for Community Review Boards.[5])

Quality

HCMO will assess current performance and the likely impact of the transaction on three broad quality outcomes: clinical processes, patient outcomes, and patient experience. The below subsections describe the assessment questions and analytic methods HCMO expects to use for current performance and impact analyses, respectively.

Current Performance

- **Clinical processes.** How do the entities perform on quality measures related to clinical processes? How does this compare to the statewide average or national benchmarks?
- **Patient outcomes.** How do the entities perform on quality measures related patient outcomes? How does this

[5] Guidance is available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/Draft-Community-Review-Board-Criteria-20220121.pdf.

compare to the statewide average or national benchmarks?

- **Patient experience.** How do the entities perform on quality measures related to patient experience? How does this compare to the statewide average or national benchmarks?

A list of potential measures for each outcome is provided in Appendix A. For preliminary reviews, HCMO will focus on measures that can be calculated from readily available administrative data (e.g., claims), publicly available reports, scorecards, or rankings, and measures already calculated at the entity-level for quality reporting purposes. For comprehensive reviews, if there are concerns about adverse quality impacts, HCMO may request additional data from the entities, such as Electronic Health Record (EHR) extracts or entity administered Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data.

HCMO will also consider the entities' participation and performance in national or statewide care delivery transformation efforts, as well as participation in quality-based risk contracts. For comprehensive reviews, HCMO may request and review additional documentation from the entities on quality improvement activities, such as:

- Quality improvement plans
- Implementation of quality tracking/improvement systems
- Governance for quality management
- Participation in population health management programs
- Electronic health record use and interoperability

Impact Analysis

- **Clinical processes.** What is the likely effect of the transaction on performance on quality measures related to clinical processes?
- **Patient outcomes.** How might the transaction impact performance on quality measures related patient outcomes?
- **Patient experience.** How might the transaction impact performance on quality measures related patient experience?

HCMO will consider impact analysis results across all four measures in arriving at a finding on the overall quality impact of the transaction. At the preliminary review stage, HCMO will assess how any potential anti-competitive effects of the transaction identified under the cost domain might affect the entities' incentives for quality improvement or quality-enhancing innovation. HCMO will also consider the entities' track record in delivering high quality health care services (as measured by the analysis of current performance) and any concerns about adverse impacts on quality outcomes voiced by members of the public, specifically by community members within the geographic service area of the entities.

For comprehensive reviews, HCMO may request to review the entities' plans and proposals for integration of clinical or administrative operations post-transaction. These would be relevant to assessing the degree of integration or coordination in the production of health care services that would result from the transaction. They would also be informative for understanding quality improvement initiatives planned as part of integration activities. Based on these plans and the entities' current performance on quality, HCMO would consider the impact of the transaction on quality improvement opportunities and the development of quality improvement initiatives through access to a shared pool of capital, patients and knowledge. Of particular interest would be the level of detail of these plans or proposals (for example, inclusion of specific service lines, assessments of quality improvement opportunities, required platforms and systems, resource commitments, and timelines). HCMO may interview representatives of the entities to obtain additional information on such plans and their proposed implementation. HMCO may also convene a CRB to provide input on potential impacts of the transaction on patient experience. In cases where an entity has engaged in a similar transaction previously, HCMO may perform statistical analyses to assess whether the previous transaction was associated with any adverse effects on quality.

Follow-up Reviews

HCMO is statutorily required to evaluate the impact of each transaction one, two, and five years after closing. Analyses performed during the preliminary or comprehensive review of the proposed transaction will be revisited to assess for any changes likely driven by the transaction. These follow-up reviews will focus on several key areas:

- **Conditions for approval.** HCMO will gather information and perform analyses to verify that all entities are meeting any conditions attached to transaction approval. Examples include confirming that facilities remain operational, rates of service access are being maintained, costs have not significantly increased, or that quality of care has not declined.
- **Commitments in the notice.** Transaction approval may be predicated on statements or commitments presented in the notice itself, particularly around access and cost. Follow-up reviews will confirm whether entities are upholding those commitments, for example maintaining a similar payer mix among patients served.
- **Areas of concern.** Preliminary or comprehensive review may identify issues that do not contradict conditions for transaction approval but do raise concerns for consumers, for example existing poor quality of care from a provider or limited access to services within a region. HCMO may determine that these issues are unlikely to be changed by the given transaction, or improvement in these areas might not be attached as a condition to approval. Follow-up analyses can provide transparency around the entities' independent efforts to make improvements to service delivery.
- **Post-transaction changes.** Follow-up reviews will assess what other changes have occurred within the entities post-transaction that may impact delivery of health care services in the future, for example organizational restructuring, changes to leadership or staffing, closing or downsizing of facilities or lines of service, or reduced resources to programs meeting special health care needs. Impacts of these changes may not be detectable in early follow-up reviews but may be identified as areas of concern to revisit in subsequent analyses.

HCMO may request additional information from entities to support follow-up review. This may include updates to supplemental items requested during preliminary or comprehensive review. Given the time lag in administrative data, HCMO may also request more current data collected by the entities to more accurately measure short-term impacts of the given transaction.

Identifying Comparator Entities

This section describes HCMO's approach to identifying comparator entities for purposes of assessing relative performance and market shares. This will be based on three main considerations: geographic service area, facility type (in the case of provider organizations), and type of service.

Geographic Service Area

To identify comparator entities, HCMO will first define the geographic area in which the majority of the entities' customers (patients, members) reside.

For provider organizations, HCMO will calculate the primary service area (PSA) as the set of contiguous of zip codes around the provider location from which the entity draws 75% of its patients.[6] Appendix C provides an example of this

[6] The 75% threshold is used by the U.S. Department of Justice and Federal Trade Commission to calculate PSAs for antitrust oversight of Medicare Accountable Care Organizations (ACOs). The federal agencies note that, while the PSA does not necessarily correspond to a "relevant market" for antitrust purposes, it is a useful screen for evaluating competitive effects of ACOs. (See Federal Trade Commission/Department of Justice, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, October 28, 2011, available at https://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf.)

calculation for a general acute care hospital. HCMO may rely on commonly used, pre-existing service area definitions, if these are roughly consistent with the service area identified by the 75% method.

For insurance carriers and CCOs, HCMO will use plan service areas and CCO service areas, respectively.

Facility Type

HCMO will identify the type(s) of facilities at which the provider organization's services are offered (e.g., inpatient acute care hospital, specialty hospital, ambulatory care center, clinic.) In selecting comparator hospitals, HCMO may also consider other commonly accepted classifications, such as the level of trauma care provided, designation as a teaching hospital, safety-net hospital, or critical access hospital.

Type of Service

HCMO will consider the type(s) of service(s) offered by the health care entity. For inpatient facilities (e.g., hospitals), a service type is defined as Major Diagnostic Category (MDC). For physicians, a service type is the physician's primary specialty (primary care, cardiology, oncology, etc.) For outpatient facilities, service types would be defined as categories of services based on procedure (CPT/HCPCS) codes.

For payers, HCMO will consider factors such as the type of plan offered (e.g., POS, PPO, or HMO) and the market segments served (e.g., commercially insured, Medicare, Medicare Advantage, Oregon Health Plan, or individual/marketplace).

Collaboration with Other State Agencies and Programs

HCMO will coordinate and collaborate on an as-needed basis with other state agencies and programs that oversee health care entities in Oregon in reviewing material change transactions. Coordination may be required when there is overlap of agencies' oversight responsibilities. Additionally, communication or collaboration for the purpose sharing expertise and data will facilitate expedient, high-quality reviews, avoid duplication of work, and reduce the need for data requests from the entities. Where inter-agency sharing of information is needed, HCMO will share a minimum necessary information in accordance with regulations or contractual agreements governing privacy and confidentiality.

- **Department of Consumer and Business Services (DCBS).** HCMO will collaborate with DCBS on any transaction involving at least one domestic insurance carrier. HCMO and DCBS will each carry out their own review, and HCMO will provide a recommendation to DCBS, who will decide the outcome of the review.
- **Department of Justice (DOJ).** HCMO may rely on legal advice and analysis by DOJ as needed. Depending on the scope of work and internal capacity, DOJ may contract with an external law firm for legal counsel. (Please refer to HCMO's sub-regulatory guidance: Criteria for OHA Use of Outside Advisors for Material Transaction Review.[7])
- **OHA Office of Actuarial and Financial Analytics (OAFA).** For any transaction involving a CCO, HCMO will coordinate its review activities with OAFA to avoid duplication of effort. HCMO and OAFA will come to a mutually acceptable decision on the outcome of the review.
- **Other OHA Programs, including Cost Growth Target, Hospital Reporting, and All Payer All Claims (APAC) Programs.** HCMO will consult with the Cost Growth Target, Hospital Reporting, and APAC programs within OHA regarding data and quantitative methods, particularly relating to measures of cost and hospital performance. Program staff may provide analytic support on HCMO reviews and share data collected by the programs on an as-needed basis. HCMO may also consult with the Certificate of Need (CN) program if the transaction involves facility or service expansion projects potentially subject to CN rules.

[7] Guidance is available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Outside-Advisors.pdf.

Appendices

A. Measures

Table A1 displays a menu of measures HCMO may use to analyze current performance and assess impacts of the transaction in each domain. Not all of these will be applicable to each transaction, and exact definitions will depend on the specifics of the health care services in question. This list is not exhaustive; HCMO may incorporate other measures not included here. This list will be updated periodically as additional measures or new data sources are considered during the course of HCMO reviews.

To measure outcomes at the entity level, HCMO will use National Provider Identifier (NPI) information from the NPI form submitted with the notice, supplanted with additional NPI information available to the Oregon Health Authority (e.g., from provider enrollment databases).

Table A1: HCMO Outcome Measures Menu

Domain	Outcome	Measure
Cost	Market share	Share of inpatient general acute care discharges (by payer, specialty) Share of outpatient visits (by payer, specialty) Share of adult primary care visits (by payer) Share of specialty provider visits (by payer) Share of enrollment in large group/small group/individual market(s) Share of Net Patient Service Revenues (by payer)
	Price	Prices for commercial inpatient services, relative to other similar entities (or state average), by payer (based on paid/allowed amounts) Prices for commercial outpatient services, relative to other similar entities (or state average), by payer Prices for commercial services relative to Medicare Bonus and performance payments Out of pocket payments Premiums
	Spending	Total cost of care (PMPM) Total resource use (PMPM) Annual spending growth (overall and by major spending category) Health status adjusted total medical expense (HSA TME) for patients attributed to each entity's PCPs, by payer Percentage of spending in value-based-payment contracts (by LAN category)
	Financial condition	Payer mix (Medicaid, Medicare, commercial, individual/marketplace, charity care) Operating revenues and expenses (per discharge or other unit) Other income and expenses Operating margin Total margin Total net assets on hand Readily available cash/investments Current ratio Debt-to-capital ratio Average age of plant Medical loss ratio

Domain	Outcome	Measure
		Equity & consolidated investments Profitability by service line or facility
Quality	Clinical processes	Participation and performance in national/statewide care delivery transformation efforts Revisits for frequent Emergency Department (ED) users Participation in quality-based risk contracts Medical home (e.g., PCPCH tier) Integration of behavioral health/oral health care with physical health care (e.g., avoidable ED visits, avoidable hospitalization, follow-up after hospitalization)
	Patient outcomes	Patient safety (falls, healthcare-associated infections, medication safety, etc.) All-cause readmissions Avoidable complications Low value care Prevention/screening (e.g., immunization, cancer screening, well-care visits, contraception use) Chronic disease management Maternity (e.g., low-risk caesarian delivery, postpartum care)
	Patient experience	Overall rating of health care/provider/health plan (CAHPS) Getting care quickly (routine/urgent care) (CAHPS) Staff explained medicines/gave patient discharge information Customer care service Patient/ consumer complaints Language access to culturally responsive services
Access	Availability of services	Number of visits for/ number of providers offering - Primary care - Specialty care - BH care (including SUD treatment) - Dental care/ oral health - Emergency care - Urgent Care - Inpatient (acute/non-acute) - Outpatient (including ambulatory surgical centers) - Prenatal/maternity Provider to population ratios - Primary care - Pediatric - Geriatric - Nurses - Specialists - Counselors and therapists Provider network size, composition Provider direct patient care FTE Number of PCPs accepting new patients
	Payer mix	Payer mix based on gross patient service revenue (GPSR)

Domain	Outcome	Measure
	Patient demographics	Case mix index (CMI) Composition of patients/members served by: - Race/ethnicity - Sex/gender - Language - Income level - Disability status - Medical/behavioral health complexity
Equity	Equitable access	Service utilization stratified by race, ethnicity, age, language, gender, disability status, etc. Access disparities between populations experiencing health inequities (low income, racial/ethnic groups, LGBTQ+, people with disabilities, people in rural areas, HNA populations) and other populations. Workforce diversity/representation of community (by occupation): - Language - Race/Ethnicity
	Equitable quality	Quality domain measures stratified by race, ethnicity, age, language, gender, disability status, etc. Quality disparities between populations experiencing health inequities (low income, racial/ethnic groups, LGBTQ+, people with disabilities, people in rural areas, non-English speaking, HNA populations) and other populations. For example, - Avoidable hospitalization - Avoidable ED visits - Readmissions within 30 days
	Community engagement	Community Benefit Spending Percentage of profits allocated to community-level investments Established relationships or collaborations with community-based organizations
	Equity-enhancing services	Volume of services relative to population served: - Services related to the treatment of a chronic condition - Prevention services, including non-clinical services - Pregnancy -related services - Culturally appropriate services - Translation and interpretation services - Care navigation/coordination services - Services provided by Traditional Health Workers or Community Health Workers - Screening for social needs - Referrals to community-based organizations for social services

Approach to Selection of Quality and Equity Measures

HCMO will seek to apply consistent and standardized metrics to health plan, health system and provider organization performance to assess current performance and potential impacts in each domain. Hundreds of validated and standardized measures exist to quantify processes and outcomes regarding safety, quality, access, and patient experience across all applicable health care entities. Needing to balance thoroughness with expediency, HCMO will select key measures that can serve as broader indicators of the overall ability of an entity to equitably provide high quality care. Within the state of Oregon, several committees under the purview of the Oregon Health Policy Board have been tasked to consolidate and

prioritize a menu set of measures to drive quality improvement, systems transformation and health equity across sectors, and several programs have successfully or are currently utilizing these measures to drive process efficiencies and better health outcomes for Oregonians. HCMO will borrow from these measure sets and associated technical specifications whenever possible. During preliminary review, preference will be placed on metrics that can be constructed using readily available data sources (e.g., APAC, hospital discharge data) and measures already calculated at the entity-level for other reporting purposes (e.g., CCO metrics, hospital quality metrics, Medicare metrics, NCQA accreditation data, etc.).

B. Methods for Analyzing Cost Impacts

This appendix describes the approaches HCMO may use to assess the likely impact of a material change transaction in the cost domain. The specific facts of the proposed transaction, the availability of reliable data, and time constraints associated with preliminary and comprehensive review periods will affect the analytic methods for a given transaction.

Concentration (HHI) Analysis

Concentration is a measure of the degree of competition in a market; highly concentrated markets are generally characterized by a smaller number of firms and higher market shares for individual firms. (See Glossary for additional definitions.) When a transaction involves health care entities offering similar products or services (a "horizontal" transaction), the level of concentration in the market and the change in concentration resulting from the transaction is useful as an initial screen for potential anticompetitive effects.

Market concentration will be measured using the Herfindahl-Hirschman Index (HHI), a measure commonly used by federal and state antitrust enforcement agencies. HHI is calculated as follows:

$$HHI = (S_1^2 + S_2^2 + S_3^2 + \cdots S_n^2)$$

Where S_1 is market share (in percentage points) of firm 1 and n is the total number of competitors in the market. By summing the squared values of market shares, the HHI gives greater weight to firms with larger market shares.

Transactions occurring in concentrated markets and those involving a significant change in concentration are more likely to have adverse effects on competition and lead to price increases. For horizontal transactions under preliminary review, HCMO will use the HHI thresholds specified in the U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines[8] to identify transactions that may have anticompetitive effects (see Table B1 below). Transactions meeting the HHI thresholds for "high" or "moderate" levels of concern would indicate the need for a comprehensive review.

Table B1: HHI Thresholds

Post-transaction HHI	HHI Change	Level of Concern
> 2,500	> 200	High (if both). Presumed likely to enhance market power:
> 2,500	>= 100 and <= 200	Moderate (if both). Potentially raises significant competitive concerns and often warrants scrutiny.
>= 1,500 and <= 2,500	>= 100	Moderate (if both). Potentially raises significant competitive concerns and often warrants scrutiny.
< 1,500	< 100	Low (if either). Unlikely to have adverse competitive effects and ordinarily requires no further analysis.

There may be instances where a transaction does not lead to an increase in HHI but nevertheless has the potential to reduce competition. One such case is "cross-market" consolidations, for example, a hospital system acquiring a hospital outside its service area. If both parties negotiate with a common buyer (e.g., an insurer), and customers of the buyer (e.g., large employers) value the inclusion of both parties in their bundle, the consolidated entity may be able to negotiate higher

[8] U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, August 19, 2020, available at https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf.

prices for hospital services.[9] In this example, HCMO may determine that a comprehensive review is needed so that further analyses (such as diversion analysis and Willingness-to-Pay, described below) can be conducted.

Diversion Analysis

HCMO may use diversion analysis to assess the likely price effects of a transaction under comprehensive review. The diversion ratio seeks to measure the impact on the probability that consumers will choose a given product or service if a competing product or service is excluded from their choice set (e.g., due to consolidation). It is commonly used by federal antitrust agencies to screen for anti-competitive effects of hospital mergers.[10] Using the example of a hospital merger, diversion analysis quantifies the extent to which patients consider the merging hospitals to be substitutes for one another. This, in turn, affects the bargaining power of the merged entity in reimbursement rate negotiations with insurers. When hospitals are close substitutes, the costs to an insurer of failing to reach agreement with the merged entity (via reduced value of its provider network) are higher than the costs of failing to reach agreement with either of the merging hospitals individually, resulting in higher reimbursement rates compared to pre-transaction rates.

The diversion ratio from hospital k to hospital l is:

$$d_{kl} = \frac{\left(\sum_i prob_{il\backslash k} - \sum_i prob_{il}\right)}{\sum_i prob_{ik}}$$

Where $prob_{il}$ is the fitted probability that patient i is treated at hospital l, $prob_{ik}$ is the fitted probability that patient i is treated at hospital k, and $prob_{il\backslash k}$ is the fitted probability that patient i is treated at hospital l under the hypothetical exclusion of hospital k. In this example, the diversion ratio is derived from estimating a regression model of patient hospital choice using hospital discharge data. This parameter can be used to calculate the value of diverted sales; if this value is small (e.g., 5% or less), the merger is unlikely to lead to significant price increases.[11]

Willingness-to-Pay (WTP) Analysis

Another possible approach for assessing price impacts from a merger or acquisition under comprehensive review is Willingness-to-Pay (WTP) analysis. WTP is a measure of provider market power based on a bargaining model of provider-insurer price negotiation. It assumes that when competing providers merge, they negotiate on an all-or-nothing basis (i.e., the insurer must contract with both providers in order to contract with either provider). When this happens, the insurer's cost of failing to reach agreement with the merged entity (in terms of welfare loss for the insurer's members) is higher than the sum of losses associated with failing to reach agreement with each provider individually. This increases the bargaining power of the merged entity and leads to higher reimbursement rates.

WTP is measured as the change in member welfare (consumer surplus) associated with the merged provider's inclusion in an insurer's network. The increase in market power associated with the merger is the net change in WTP associated with the combination of the two providers. WTP is obtained by estimating a regression model of patient provider choice.[12]

Merger Simulation

Merger simulation involves regression analysis to estimate the equilibrium price effect of a merger. Such approaches have been used in federal investigations of hospital mergers. For example, Farrell (2011) describes a simulation model used by the Federal Trade Commission that regresses case-mix adjusted prices on WTP per discharge and measures of cost. Like diversion and WTP analysis, merger simulation requires significant time and resources and could therefore only be conducted under a comprehensive review.

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[9] See for example, Dafny et al (2019).

[10] See for example, Farrell et al (2011) and U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, August 19, 2020, available at https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf.

[11] The Horizontal Merger Guidelines generally define "small" as 5% or less.

[12] See Vistnes & Town (2001) and Dranove & Sfekas (2009).

Analysis of Vertical Transactions

The diversion analysis and WTP methods were both developed for analysis of horizontal transactions and do not necessarily apply to vertical consolidation (for example, the acquisition of a physician group by a hospital). Federal antitrust agencies have not yet settled on guidelines for assessing market power and price effects of vertical transactions.[13]

For vertical transactions, HCMO will perform an HHI analysis for both upstream and downstream markets as part of preliminary review. Although HHI is not necessarily indicative of competitive concerns in the case of vertical consolidation, it remains relevant for assessing likely competitive effects. Anticompetitive effects from vertical mergers are less likely if neither of the entities has significant market power prior to consolidation. Furthermore, a vertical merger may result in a horizontal effect due to higher concentration in one of the affected markets. For example, a hospital's acquisition of multiple physician practices may reduce the number of competitors in the local physician services market.

For comprehensive reviews, HCMO will consider other options for assessing price effects from vertical transactions, such as measuring the likelihood of foreclosure and raising rivals' costs. Merger simulation may also be used. Foreclosure occurs when an upstream merged firm refuses to supply rivals of its downstream division with an input. In the example of acquisition of a physician group by a hospital, two types of foreclosure are possible: foreclosure of rival hospitals from access to physician services, and foreclosure of rival physician practices from hospital services. High diversion ratios and a high margin for downstream operations relative to upstream operations have been found to be associated with higher likelihood of foreclosure.[14] To assess the likelihood of foreclosure, HCMO may thus calculate the margin for hospital services relative to physician services, diversion ratios between the acquiring hospital and competing hospitals, and diversion ratios between the acquired physician group and other competing groups.

Raising rivals' costs is a less extreme form of foreclosure wherein the upstream division of the merged firm charges downstream rivals more for the input. HCMO may consider diversion ratios and relative margins as indicators of the likelihood of raising rivals' costs.

In the case of a hospital acquisition of a provider group, HCMO will also assess the ability of the hospital to obtain higher facility fees for physician services due to the transaction.

Potential Efficiencies from Integration

Any claim by the entities that the transaction would generate substantial cost savings (e.g., from economies of scale) would need to be substantiated by the entities and possibly reviewed by an outside advisor as part of a comprehensive review. HCMO may request to review the entities' plans and proposals for integration of clinical or administrative operations post-transaction. These would be relevant to assessing the degree of integration or coordination in the production of health care services that would result from the transaction and resulting opportunities for realizing any cost savings. Based on these plans and the entities' current performance on cost, HCMO would consider the impact of the transaction on opportunities for cost reduction and the likelihood that anticipated efficiencies would materialize. Of particular interest would be the level of detail of related plans or proposals (for example, inclusion of specific service lines, assessments of cost reduction opportunities, systems integration plans, resource commitments, and timelines). HCMO may interview representatives of the entities to obtain additional information on such plans.

In the case of vertical transactions, HCMO will also consider opportunities for vertical integration to reduce transaction costs (for example, associated with contracting), facilitate communication and coordination, and harmonize incentives of the

[13] In September 2021, the Federal Trade Commission and U.S. Department of Justice withdrew their guidelines for vertical mergers published in 2020. The agencies committed to continue working to review and update merger guidelines to reflect current economic theory and the dynamics of modern markets. (See https://www.ftc.gov/news-events/press-releases/2021/09/federal-trade-commission-withdraws-vertical-merger-guidelines.)

[14] See Lustig et al (2020).

transacting firms.[15] This may result in lower costs, improved quality, and increased investment and innovation.

More generally, HCMO will consider claims of cost savings from integration efficiencies in the context of the competitive environment facing the entities post-transaction. Anticipated cost savings, if they materialize, do not necessarily translate into lower negotiated rates with insurers or reduced costs for patients.

Financial Analysis

If the entities are requesting an emergency exemption, HCMO will perform an emergency review to determine the financial condition of the entity in question, the risk of insolvency, and the likelihood that the transaction would significantly reduce this risk. In the absence of insolvency risk, for transactions under comprehensive review, HCMO would assess the likelihood that the transaction would jeopardize the financial stability of one of the health care entities (in accordance with OAR 409-070-0060). This might occur, for example, if the acquiring entity holds a significant amount of debt or has a track record of relying heavily on debt financing to grow its operations.

Financial analyses would include a multi-year review of financial performance and credit rating based on standard metrics obtained from profit & loss and balance sheet statements. If an entity has been involved in previous mergers, acquisitions, or other combinations, HCMO may examine the impact of those transactions on the entity's financial condition. When analyzing a proposed transaction involving only carriers, HCMO will coordinate with DCBS to avoid duplication of analyses.

[15] See for example, Salop (2016). One often cited impact of vertical consolidation is the elimination of double marginalization (EDM) benefit. This occurs when a merger allows the downstream firm to acquire the upstream firm's input at a price=marginal cost, giving the downstream firm an incentive to reduce prices after the merger.

C. Example of Primary Service Area Calculation

Primary Service Areas (PSAs) will generally be calculated by service line, subject to data availability. For example, PSAs may be calculated for inpatient general acute care services, inpatient specialty acute care services, outpatient/ambulatory services, primary care services, and other service lines.

To calculate the PSA of a general acute care hospital:

1. For each zip code in Oregon, identify the number of general acute care discharges from the hospital of interest by patient zip code of residence for the most recent year(s) for which data is available.
2. Rank zip codes by number of discharges.
3. Starting with the facility's zip code, add contiguous zip codes to the map based on discharge volume rank. A zip code with a high volume of discharges that is not immediately contiguous with the facility zip code may be permanently excluded from the PSA, or only temporarily excluded until subsequent zip codes are added that fill in the geographical gap.
4. Continue to add zip codes until the total discharge count from zip codes contiguous with the facility constitutes 75% of the hospital's total discharges. The final zip code added to reach 75% of discharges may result in total PSA discharge volume exceeding the threshold.
5. If the resulting PSA completely encircles a zip code or set of zip codes not included in the PSA (due to low discharge volume), add encircled zip codes to the PSA to create a solid geographical area. This may also result in a PSA discharge volume over 75% but creates a more visually coherent geographic service area.

Glossary

Market – A collection of buyers and sellers that enter into agreements to purchase and sell a product or service. Markets are typically defined in terms of product/service and geographic reach (e.g., local, state, national, international, global).

Competition – A situation in a market in which firms or sellers independently strive to attract buyers for their products or services by varying prices, product characteristics, promotion strategies, and distribution channels.

Concentration – A measure of the degree of competition in the market; highly concentrated markets are generally characterized by a smaller number of firms and higher market shares for individual firms.

Market power – Also referred to as monopoly power, the power of a single firm or group of firms to set price profitably above the level that would prevail under competition. Increases in market concentration may confer market power.

Consolidation – The combination of two or business units or companies into a single, larger organization. Consolidation may occur through a merger, acquisition, joint venture, affiliation agreement, etc.

Horizontal consolidation – The combination of two or more business units or companies that formerly competed with one another. In health care, the combination of two hospitals or two insurers would be considered horizontal consolidation.

Vertical consolidation – The combination of two companies or business units in different lines of work or operating at different levels of the supply chain. In health care, the acquisition of an ambulatory care clinic by a hospital or the merger of a health plan with hospital system would be considered a vertical consolidation.

Health equity –As defined by OHA:

> *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. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
>
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling, and rectifying historical and contemporary injustices.*

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Criteria for Comprehensive Review of Material Change Transactions

The Health Care Market Oversight program was created to ensure that proposed health care transactions support the goals of health equity, lower costs, increased access, and better care. Under ORS 415.500 et seq., the Oregon Health Authority (OHA) will monitor changes to the health care market by reviewing proposed material change transactions. OHA will complete a preliminary review within 30 days of receipt of a Notice of Material Change Transaction. In accordance with OAR 409-070-0060, if at the conclusion of the preliminary review OHA determines not to approve the transaction, it will move to a 180-day comprehensive review. This document outlines the criteria OHA will use to determine whether a transaction can be approved following preliminary review and hence whether the transaction should undergo a comprehensive review.

Criteria for Comprehensive Review

OHA will conduct a comprehensive review of a material change transaction if, at the conclusion of preliminary review, OHA cannot establish that the transaction meets one or more of the criteria for approval of the transaction set forth in OAR 409-070-0055. Consistent with these criteria, a transaction will move to comprehensive review only if all the below conditions apply:

1. Preliminary review indicates that the transaction may have adverse impacts on the domains of cost, access, quality, or equity (see below for definitions) and more information or analysis is needed to establish the scope, magnitude, or likelihood of such impacts.
2. The transaction is not urgently needed to maintain the solvency of one of the entities, or the transaction is urgently needed to maintain solvency, but the benefit of avoiding solvency may be offset by adverse impacts on cost, access, quality, or equity (hence the transaction may not be in the interest of consumers).
3. The transaction may substantially alter the delivery of health care in Oregon through adverse impacts on cost, access, quality, or equity.
4. The potential adverse effects of the transaction would (if they occur) have a meaningful impact on consumers (e.g., patients or insurance plan members) or groups of consumers.

Assessing the Potential for Adverse Impacts

This section details the circumstances under which OHA would conclude that the transaction may have an adverse impact in each of the domains.

Cost Domain

A transaction may have an adverse impact in the cost domain if it has the potential to result in any of the following:

- An increase in market concentration, as measured by the Herfindahl-Hirschman Index (HHI), of 100 points or more such that the post-transaction HHI is 1,500 or higher.[1]
- An increase in prices (premiums, cost sharing, provider reimbursement rates) for health care services paid by consumers (e.g., patients, members) or payers (e.g., insurers, employers, or governments).
- An increase in total health care expenditures for the entities or the state.

[1] For details on calculation of HHI and relevant thresholds, see Health Care Market Oversight Program Draft Analytical Framework, available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/Health-Care-Market-Oversight_Analytic-Framework_Draft-1.14.22.pdf.

Example of a transaction with potential adverse impact on cost:
A group of pediatricians is entering into a new affiliation with another pediatrician group. Under the affiliation, the two groups would negotiate service rates jointly with a major commercial payer. There are no other pediatricians in the joint service area of the two physician groups. The Notice of Material Change Transaction does not mention any financial challenges as motivation for the affiliation agreement. The increase in market concentration for pediatric primary care services resulting from the transaction is likely to increase the entities' bargaining power with payers, which could result in higher negotiated rates for services. The transaction may therefore have an adverse impact on prices for pediatric services.

Access Domain

A transaction may an have adverse impact in the access domain if it has the potential to result in any of the following:

- A reduction in availability of services (e.g., through a reduction in the number of providers or locations offering services).
- A reduction in access for specific subpopulations (e.g., due to discontinuation of certain business lines or reduction in services targeting specific groups, such as Medicaid members or persons with behavioral health conditions).

Example of a transaction with potential adverse impact on access:
A health system is acquiring a rural hospital and plans to eliminate inpatient mental health/substance use disorder services at the rural hospital to generate system-wide efficiencies. The hospital's financial reports suggest it is in good financial condition, and the Notice of Material Change Transaction does not mention any financial challenges. As a result of the acquisition, some patients in the rural hospital's service area would need to travel substantially greater distances to receive services. The health system does not have a plan in place for maintaining access to these services.

Equity Domain

A transaction may have an adverse impact in the equity domain if it has the potential to result in any of the following:

- A disproportionate reduction in availability of services for populations experiencing health inequities (e.g., low-income individuals, certain racial/ethnic groups, LGBTQ+ individuals, people with disabilities, people with limited English proficiency).
- A disproportionate decrease in quality for populations experiencing health inequities.
- A reduction in engagement with the local community or reduced consideration of community needs in decisions regarding service provision or investment. (For example, if there are plans that would reduce the involvement of a community board in a hospital's decision-making or reduce community involvement in the hospital's community benefit planning.)
- A reduction in availability of culturally appropriate services, translation/interpretation services, traditional/community health workers, or social needs screening/referral services.

Example of a transaction with potential adverse impact on equity:
A large primary care clinic serving 50% Medicaid, 45% commercial, and 5% uninsured patients is being acquired by a medical group based in another region of the state. The clinic is financially stable, has strong ties to the surrounding community and a record of engagement with local community organizations on projects addressing housing and food insecurity. Under the acquisition, management of care delivery, including decisions on services, staffing, and clinical practices would move from the clinic staff to management and clinical personnel at the acquirer's main location. A community-based organization submits public comments to OHA expressing concern that the acquisition would exacerbate health inequities by reducing responsiveness to the needs of the local population.

Quality Domain

A transaction may have an adverse impact in the quality domain if it has the potential to result in any of the following:

- A worsening of performance on quality measures related to clinical processes (e.g., use of evidence-based practices or participation in care delivery transformation initiatives).
- A worsening of performance on quality measures related to patient outcomes (e.g., increases in avoidable Emergency Department visits, hospitalizations, readmissions, or complications).
- A worsening of performance on quality measures related to patient experience (e.g., patients' overall rating of care, wait times, customer service complaints).

Example of a transaction with potential adverse impact on quality:
A hospital is acquiring a profitable ambulatory surgery center (ASC) located in its service area. Five years earlier, the hospital acquired another ASC outside its service area. Shortly after the acquisition, there were multiple public reports of clinical malpractice and evidence (as measured by multiple HEDIS metrics) of an overall deterioration in quality at the acquired ASC. OHA receives public comments pointing to this history and arguing that the acquisition would lead to a similar deterioration of quality.

Statutory and Rule Guidance

ORS 415.500 et seq.

ORS 415.501(6)

Following a preliminary review, the authority or the department shall approve a transaction or approve 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 subsection (9) of this section.

ORS 415.501(7)(a)

Except as provided in paragraph (b) of this subsection, if a transaction does not meet the criteria in subsection (6) of this section, the authority shall conduct a comprehensive review and may appoint a review board of stakeholders to conduct a comprehensive review and make recommendations as provided in subsections (11) to (18) of this section. The authority shall complete the comprehensive review no later than 180 days after receipt of the Notice unless the parties to the transaction agree to an extension of time.

ORS 415.501(8)(c)

The authority shall prescribe by rule:

(c) Criteria for when to conduct a comprehensive review and appoint a review board under subsection (7) of this section that must include, but is not limited to:
    A. The potential loss or change in access to essential services;
    B. The potential to impact a large number of residents in this state; or
    C. A significant change in the market share of an entity involved in the transaction.

ORS 415.501(9)

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, the authority 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

(B) 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.

Administrative Rules

OAR 409-070-0055 (2) – Criteria for approval following a preliminary review

At the conclusion of the preliminary review described in paragraph (1) of this rule, the Authority shall approve, or approve with conditions as provided in OAR 409-070-0065, a material change transaction, or, in the case of a material change transaction involving a domestic health insurer, recommend to the Department that the transaction be approved, if the Authority determines that the transaction meets one or more of 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;

(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.

OAR 409-070-0060 (1) – Comprehensive review

Pursuant to ORS 415.501(7), the Authority shall conduct a comprehensive review of a proposed transaction if the Authority determines not to approve the transaction at the conclusion of its preliminary review.

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Criteria for Community Review Boards

The Health Care Market Oversight program was created to ensure that transactions involving health care entities support the goals of health equity, lower costs, increased access, and better care. Under ORS 415.500 et seq., the Oregon Health Authority (OHA) will monitor changes to the health care market by reviewing proposed material change transactions. As defined in ORS 415.500 et seq., Community Review Boards provide recommendations and input to OHA about proposed material change transactions and include members of affected communities, consumer advocates, and health care experts.

Community Review Boards represent a key strategy to support the goals of the Heath Care Market Oversight (HCMO) program, particularly goals 2 and 3 listed below, per OAR 409-070-0000:

1. Improve health, increasing the quality, reliability, availability, and continuity of care and reducing the cost of care for people living in Oregon.
2. Achieve health equity and equitable access to care.
3. Implement a process that is transparent, robust and informed by the public, including the local community, through meaningful engagement.
4. Use resources wisely and in collaboration with the Department of Justice when applicable.

This document provides further clarification and criteria for when OHA may convene a Community Review Board.

Role of Community Review Board

A key role of the Community Review Board is to provide recommendations about whether OHA should approve, approve with conditions, or reject proposed transactions and recommend conditions that may be necessary to ensure that approved transactions advance health equity. Community Review Boards also provide information about potential effects of a transaction, including how the transaction could impact health equity, access to care, outcomes for specific populations, cost, and quality of care.

Type of Transaction

OHA may convene a community review board for any transactions that receive a comprehensive review. OHA will not convene community review boards for emergency reviews or transactions that are subject only to a preliminary review. OHA will notify entities as soon as possible after determining that a Community Review Board is warranted.

Criteria for Convening a Community Review Board

ORS 415.500 et seq. states that, in determining whether to convene a community review board, the Oregon Health Authority shall consider the potential impacts of the proposed transaction, including, but not limited to, any of the following:

A. The potential loss or change in access to essential services.
B. The potential to impact a large number of residents in this state.
C. A significant change in the market share of an entity involved in the transaction.

A. Potential loss or change in access to essential services

ORS 415.500 et seq. defines "essential services" as services that are funded on the prioritized list described in ORS 414.690[1] and services that are essential to achieve health equity. OHA has identified the following services as essential to achieving health equity[2]:

- Any service directly related to the treatment of a chronic condition
- Pregnancy-related services
- Prevention services, including non-clinical services
- Health care system navigation and care coordination services

OHA may convene a Community Review Board for transactions that receive comprehensive review if analyses reveal that there may be any changes to essential services.

B. Potential to impact a large number of residents in this state

OHA will consider a proposed transaction to impact a "large number of residents" if the transaction will impact a market that includes 50,000 or more residents.

C. Significant change in the market share of an entity involved in the transaction

Market share refers to the proportion of total products and services provided by a particular health care entity. For example, an entity that provides more services to more consumers and generates more revenue in a region would have a greater market share.

Horizontal transactions occur when two entities that provide similar products or services join (e.g., one hospital acquires another or physician practices merge to form a larger group practice). For horizontal transactions, OHA defines a "significant change" in market share based on the standards for evaluating market concentration outlined in the US Department of Justice and Federal Trade Commission Horizontal Merger guidelines.[3] These guidelines use the post-merger level of market concentration and the change in concentration resulting from a merger, both measured using the Herfindahl-Hirschman Index (HHI), as an initial screen for potential anticompetitive effects. An increase in HHI of 100 points or more, resulting in a post-merger HHI of 1,500 or greater (i.e., a moderately or highly concentrated market) generally prompts further analysis by the agencies of the merger's competitive effects. For the purpose of determining whether to convene a Community Review Board, OHA will consider a change in market share to be "significant" if the HHI resulting from the transaction is 1,500 or greater *and* the increase in HHI is greater than 100 points. The following changes would qualify as a significant change:

Post-transaction HHI	Post-transaction Market Classification	Significant change threshold
1500 to 2500	Moderately Concentrated Markets	HHI increase of more than 100 points
Above 2500	Highly Concentrated Markets	HHI increase of more than 100 points

Please refer to the Health Care Market Oversight Analytic Framework for more information about how market share is defined and how market concentration is calculated.

[1] https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2022%20Prioritized%20List%20of%20Health%20Services.pdf
[2] Service essential to achieve health equity may be refined by a Technical Advisory Group that will convene in January 2022.
[3] U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines: https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf

Additional considerations

In addition to the items listed above, OHA may convene a Community Review Board if any of the following are present:

- The transaction involves a Medically Underserved Area, as designated by the federal Health Resources and Services Administration (HRSA).[4] A region may be designated as a Medically Underserved Area if it has a shortage of primary care providers.
- The transaction involves a Health Professional Shortage Area, as designated by HRSA. A region, facility, or population group may be designated as a Health Professional Shortage Area if it has a shortage of primary care, mental health, or dental health providers.[5]
- The transaction may adversely affect the health services of priority and underserved populations and communities.
- OHA lacks necessary data or information about affected populations and would benefit from engaging members of the community. This may include information about how the proposed transaction could impact health equity or access.
- Members of the affected community express a need to convene a Community Review Board and OHA agrees that a community review board is warranted.

Process for Engaging Community Review Boards

When a Community Review Board is deemed appropriate, OHA will publicly post and disseminate information about the board, including, but not limited to time and location of scheduled meetings, member application materials and process steps, and a summary of the proposed transaction. Individuals interested in participating in a Community Review Board will complete an application and declare any conflicts of interest. The application will include questions about an individual's experience and background, demographic characteristics, and interest in joining the Community Review Board.

Applicants will be selected for a Community Review Board based on these criteria:

- OHA will recruit members from geographic areas and communities that may be affected by the proposed transaction, including consumers who have been affected by previous transactions, consumers of services provided by entities, health care providers affected by previous transactions, health care providers who have contracts with entities, and/or health care providers who provide services similar to those provided by entities.
- No more than one-third of the members may be representatives of institutional health care providers, including hospitals, health systems, or medical groups.
- Individuals who are employed by an entity party to a transaction or a similar-sized competitor may not participate in the community review board.
- OHA will support the recruitment of diverse Community Review Board members, seeking to include individuals with different lived experiences and self-reported identities.[6] Community Review Board members should proportionally reflect the diversity of the overall affected population.

[4] HRSA Medically Underserved Area finder: https://data.hrsa.gov/tools/shortage-area/mua-find
[5] HRSA Health Professional Shortage Areas: https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation
[6] Lived experience refers one's life experience based on self-reported identity, such as race, ethnicity, language, disability, age, sex, gender identity, sexual orientation, social class, and intersections among these identities, or other socially determined circumstances that may impact health equity and an individual's ability to reach their full health potential and well-being.

Statutory and Rule Guidance

ORS 415.500 et seq.

Section 2 (8)

The authority shall prescribe by rule:

(a) Criteria to exempt an entity from the requirements of subsection (4) of this section if there is an emergency situation that threatens immediate care services and the transaction is urgently needed to protect the interest of consumers;

(b) Provision for the authority's failure to complete a review under subsection (5) of this section within 30 days; and

(c) Criteria for when to conduct a comprehensive review and appoint a review board under subsection (7) of this section that must include, but is not limited to:

(A) The potential loss or change in access to essential services;

(B) The potential to impact a large number of residents in this state; or

(C) A significant change in the market share of an entity involved in the transaction.

Section 2 (11)

A review board convened by the authority under subsection (7) of this section must consist of members of the affected community, consumer advocates and health care experts. No more than one-third of the members of the review board may be representatives of institutional health care providers. The authority may not appoint to a review board an individual who is employed by an entity that is a party to the transaction that is under review or is employed by a competitor that is of a similar size to an entity that is a party to the transaction.

A member of a review board shall file a notice of conflict of interest and the notice shall be made public.

Section 2 (15)

A review board may hold up to two public hearings to seek public input and otherwise engage the public before making a determination on the proposed transaction. A public hearing must be held in the service area or areas of the health care entities that are parties to the material change transaction. At least 10 days prior to the public hearing, the authority shall post to the authority's website information about the public hearing and materials related to the material change transaction, including: (a) A summary of the proposed transaction; (b) An explanation of the groups or individuals likely to be impacted by the transaction; (c) Information about services currently provided by the health care entity, commitments by the health care entity to continue such services and any services that will be reduced or eliminated; (d) Details about the hearings and how to submit comments, in a format that is easy to find and easy to read; and (e) Information about potential or perceived conflicts of interest among executives and members of the board of directors of health care entities that are parties to the transaction.

Section 2 (16)

(16) The authority shall post the information described in subsection (15)(a) to (d) of this section to the authority's website in the languages spoken in the area affected by the material change transaction and in a culturally sensitive manner.

Section 2 (17)

The authority shall provide the information described in subsection (15)(a) to (d) of this section to:

(a) At least one newspaper of general circulation in the area affected by the material change transaction;

(b) Health facilities in the area affected by the material change transaction for posting by the health facilities; and

(c) Local officials in the area affected by the material change transaction.

Section 2 (18)

A review board shall make recommendations to the authority to approve the material change transaction, disapprove the material change transaction or approve the material change transaction subject to conditions, based on subsection (9) of this section and the criteria adopted by rule under subsection (2) of this section. The authority shall issue a proposed order and allow the parties and the public a reasonable opportunity to make written Enrolled House Bill 2362 (HB 2362-B) Page 5 exceptions to the proposed order. The authority shall consider the parties' and the public's written exceptions and issue a final order setting forth the authority's findings and rationale for adopting or modifying the recommendations of the review board. If the authority modifies the recommendations of the review board, the authority shall explain the modifications in the final order and the reasons for the modifications. A party to the material change transaction may contest the final order as provided in ORS chapter 183.

Administrative Rules

OAR 409-070-0060. Comprehensive Review of a Notice of Material Change Transaction

(2) Pursuant to Section 2(11) of the 2021 Act, a comprehensive review may include the appointment by the Authority of a community review board to participate in the conduct of the comprehensive review and the making of recommendations to the Authority on the approval or disapproval of the transaction, or the approval of the transaction as modified or subject to conditions. The Authority, at its discretion, may convene a community review board to advise the Authority on the impact of the transaction to the community. In determining whether to convene a community review board, the Authority shall consider the potential impacts of the proposed transaction, including, but not limited to:

(a) The potential loss or change in access to essential services.

(b) The potential to impact a large number of residents in this state.

(c) A significant change in the market share of an entity involved in the transaction.

(3) A community review board convened by the Authority under paragraph (2) of this rule shall consist of members of the affected community with emphasis on persons who are representative of populations that experience health disparities, consumer advocates and health care experts. Not more than one-third of the members of the community review board may be representatives of corporate providers. The Authority may not appoint to a community review board an individual who is employed by an entity that is a party to the transaction that is under review or is employed by a competitor that is of a similar size to an entity that is a party to the transaction. As part of the community review board appointment process, the Authority will notify coordinated care organization community advisory councils, as defined in ORS 414.575, representing the affected community.

(4) Members of a community review board shall be considered public officials subject to the conflict-of-interest requirements in ORS chapter 244. If a member of the community review board possesses a potential conflict of interest, as defined in ORS 244.020, the member shall file a notice of conflict of interest, which shall be made public, and the Authority shall determine whether the member has an actual conflict of interest, as defined in ORS 244.020. If the Authority determines that a member of the community review board has an actual conflict of interest, as defined in ORS 244.020, it shall appoint a replacement member to the community review board.

(5) Hearings and proceedings before a community review board shall be conducted pursuant to subsections (15) through (17) of section 2 of the 2021 Act.

(6) A community review board shall make written recommendations to the Authority on a proposed transaction based on the criteria listed in paragraphs (2) and (8) of this rule.

OHA Health Equity Definition

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. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.

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Oregon Health Authority
HEALTH POLICY AND ANALYTICS
Office of Health Policy

Use of Outside Advisors for Material Change Transaction Review

The Health Care Market Oversight Program was created to ensure that transactions involving health care entities support the goals of health equity, lower costs, increased access, and better care. Under ORS 415.500 et seq., the Oregon Health Authority (OHA) will monitor changes to the health care market by reviewing proposed material change transactions. This document describes how and when OHA will use outside advisors to support transaction reviews and determine potential impacts on markets and communities.

Criteria for Using Outside Advisors

When OHA receives a notice of a proposed transaction, a preliminary review must be completed within 30 days.[1] If the proposed transaction does not meet the criteria for approval within the preliminary review time period, OHA will complete a comprehensive review within 180 days of filing.[2] OHA may engage outside advisors for material change transactions that receive a comprehensive review. OHA will not engage outside advisors to support preliminary or emergency reviews. The table below describes criteria for OHA to engage outside advisors to support material change transaction reviews.

Why OHA may engage outside advisors	Example scenarios
An independent third-party is needed to ensure transparency, equity, and/or credibility	A party to a transaction requests involvement of an outside advisor. A proposed transaction is unusually complex.
OHA staff lack the specialized capabilities, experience, or expertise to conduct the review	The review will require using specific analytic methodologies for which OHA staff do not have expertise (e.g., specific accounting methods).
OHA does not have the resources or capacity to perform aspects of a review process	OHA receives multiple concurrent notices that require comprehensive review and requires outside advisors to ensure that OHA can complete the reviews in 180 days.
There are relevant conflicts of interest that limit OHA's ability to ensure independent or unbiased findings	One or more entities is in a partnership or relationship with OHA that could impact or be impacted by the review. One or more entities is involved in legal action with OHA that could impact or be impacted by the review. Staff conflict of interest (e.g., a member of the Health Care Market Oversight team is related to an employee of a transaction entity). See DHS/ OHA Conflict of Interest policy for more information.

[1] See OAR 409-070-0055 for more information regarding preliminary reviews
[2] See OAR 409-070-0060 for more information regarding comprehensive reviews

Service Categories

OHA will engage outside advisors who are qualified and have expertise in evaluating material change transactions and analyzing health care costs, quality, access, equity, and markets. This may include:

- Legal counsel
- Actuarial services and analysis
- Economic analysis and modeling
- Financial and valuation analysis
- Social equity analysis
- Health impact analysis
- Accounting services

The Oregon Department of Justice (DOJ) is not considered an outside advisor. “Legal counsel” in the list of service categories above refers to Special Assistant Attorneys General, i.e. lawyers or law firms retained by DOJ to advise state agencies.

Contracting Process

OHA will retain a pool of outside advisors that have been selected through competitive procurement when possible. If necessary, OHA may retain outside advisors for a proposed transaction review by procedures other than competitive procurement. For example, OHA may retain outside advisors without a competitive procurement if a review requires technical expertise beyond the capabilities of OHA’s regular outside advisors or if conflicts of interest disqualify OHA’s regular outside advisors, among other reasons.

Each outside advisor will have an executed contract that details compensation, e.g., hourly rates, and service categories. OHA will publicly post a list of potential outside advisors. OHA may also engage with outside advisors contracted by DOJ, the Oregon Department of Administrative Services, or the Oregon Department of Consumer and Business Services.

OHA will ensure that outside advisors are not subject to any conflicts of interest and will execute any necessary agreements to protect the confidentiality and privacy of information disclosed by entities during material transaction reviews. To avoid conflicts of interest and delays to transaction review, parties to a transaction should not engage any of OHA’s publicly announced outside advisors in connection with a material change transaction if the party has not previously engaged the advisor. Parties should not consult or contract with OHA’s publicly announced outside advisors for technical or other assistance with a material change transaction.

Statutory and Rule Guidance

ORS 415.500 et seq. (14) The authority or the Department of Justice may retain actuaries, accountants or other professionals independent of the authority who are qualified and have expertise in the type of material change transaction under review as necessary to assist the authority in conducting the analysis of a proposed material change transaction.

Administrative Rules

OAR citations reflect proposed rule language. Upon filing of final rules for the Health Care Market Oversight program, this document will be updated to capture any changes to the proposed language.

OAR 409-070-0050. Retention of Outside Advisors

(1) Pursuant to Section 2(14) of the 2021 Act, the Authority or the Department of Justice may retain at the expense of the parties to a material change transaction any actuaries, accountants, consultants, legal counsel and other advisors not otherwise a part of the Authority's staff as the Authority may reasonably need to assist the Authority in reviewing the proposed material change transaction. The retention of such advisors shall not be subject to any otherwise applicable procurement process, provided that the Authority or the Department of Justice, as applicable, shall make a determination that such advisors have the requisite qualifications and expertise to review the proposed transaction. The Authority or the Department of Justice, as applicable, shall require that the retained advisors certify in writing that:

(a) They are not subject to any conflict of interest associated with reviewing a given transaction, and

(b) They will protect any confidential information disclosed to them in the course of their review of the transaction. Material that is privileged or confidential and therefore exempt or determined by the Authority to be exempt from public disclosure under Section 2(13)(b) of the 2021 Act may be shared with the retained advisors, and such disclosure shall not constitute a waiver of the privileged or confidential status of the material.

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Timeline for Furnishing Final Definitive Agreements

The Health Care Market Oversight program was created to ensure that proposed health care transactions support the goals of health equity, lower costs, increased access, and better care. Under ORS 415.500 et seq., the Oregon Health Authority (OHA) will monitor changes to the health care market by reviewing proposed material change transactions. Per OAR 409-070-0045, the Notice of Material Change Transaction must include either final executed copies of all the definitive agreements that will be used to close and document the transaction or a term sheet.

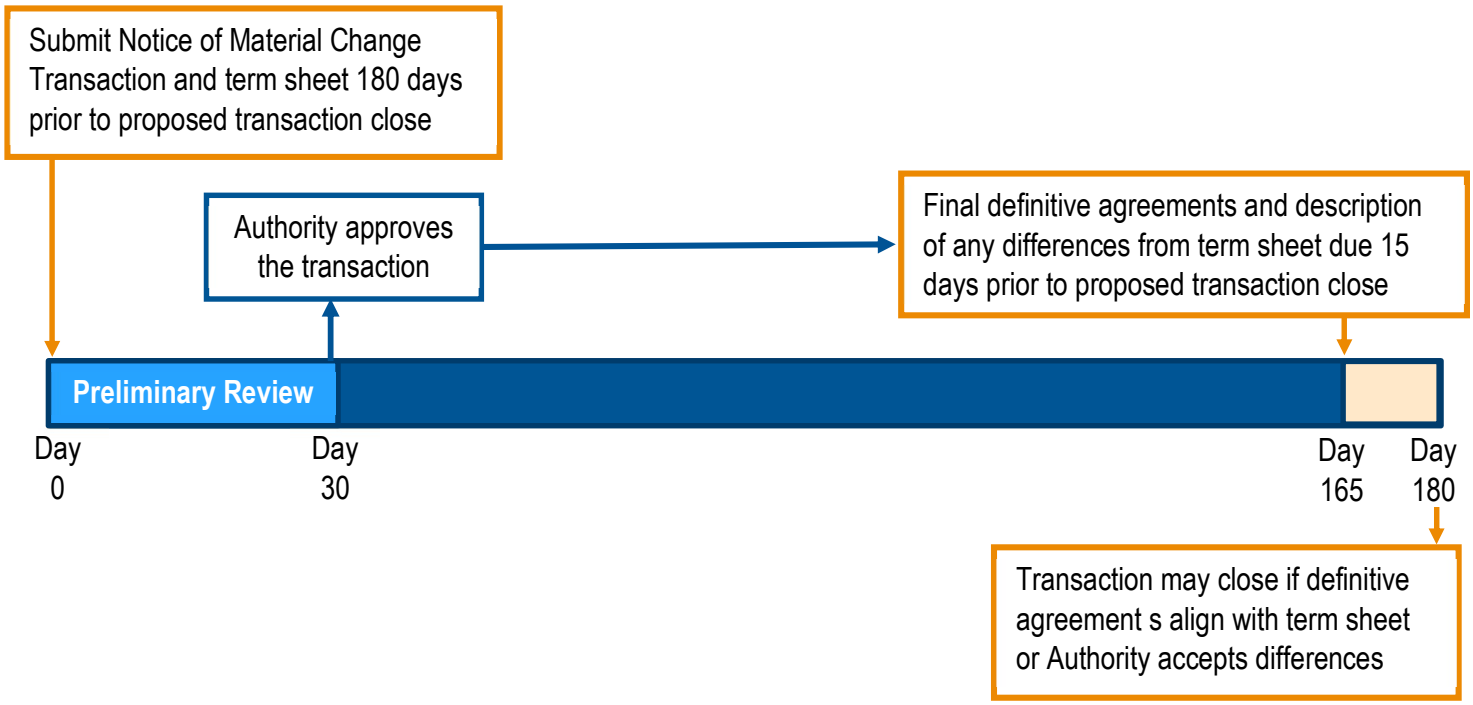
If the entities provide final executed copies of the definitive agreements with the Notice, and the terms of the transaction do not change during OHA's review period, no further documentation is required under OAR 409-070-0045. When entities submit a term sheet as part of their Notice, they are required by OAR 409-070-0045 to submit final executed copies of all definitive agreements within a specified timeline detailed below.

Timeline for Furnishing Final Definitive Agreements

If the filing entity provides a term sheet as part of the Notice of Material Change Transaction, the entity is still responsible for providing final executed copies of all definitive agreements, along with a detailed description of any changes between the submitted term sheet and the final definitive agreements. Due dates for provision of these documents depend on OHA's review process and the transaction approval status.

Definitive Agreement Submission upon Approval after Preliminary Review

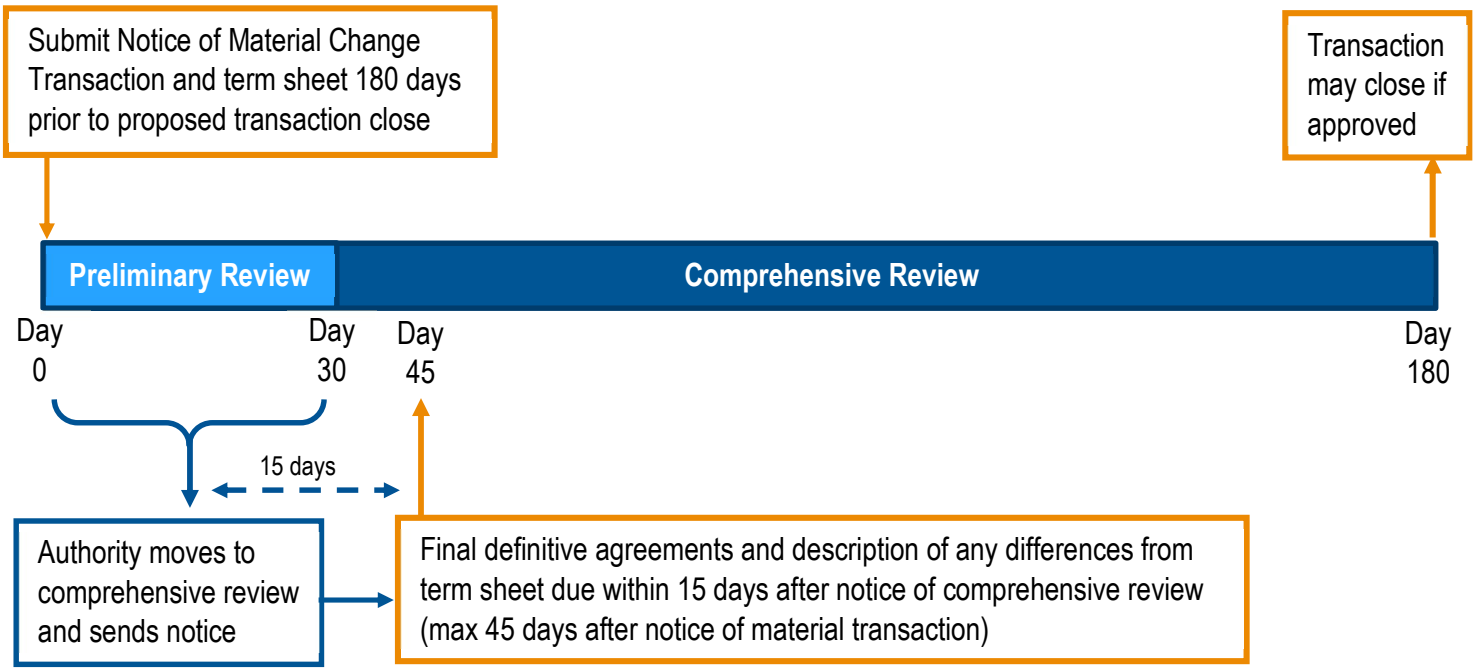
If OHA approves the transaction, or approves with conditions, upon **preliminary review** (up to 30 days after notification), final definitive agreements and description of any differences from the term sheet must be provided no later than 15 days prior to the proposed closing date of the transaction. If the Notice of Material Change Transaction was timely and submitted 180 days prior to the intended closing date, the final definitive agreements and description of any differences from the term sheet are due no later than 165 days after notification.



If the contents of the final definitive agreements are materially different from the submitted term sheet, OHA may withdraw or modify initial approval of the transaction. Material differences include, for example, a change in the type of transaction (e.g., a joint venture instead of corporate affiliation), a change in the entities involved in the transaction, or changes to the governance or operational structure resulting from the transaction.

Definitive Agreement Submission if Comprehensive Review is Required

If OHA determines the transaction requires **comprehensive review**, entities must provide final executed copies of all definitive agreements and a description of any differences from the term sheet no later than 15 days after OHA's notice of comprehensive review. OHA may provide notice of comprehensive review at any point in the 30-day preliminary review period. If an entity is unable to provide the final definitive documents within 15 days of receiving notice of comprehensive review, OHA will delay the comprehensive review until the documents are received. The comprehensive review period will be extended by the number of days the provision of these materials is delayed. If the contents of the final definitive agreements are materially different from the submitted term sheet, OHA may extend the comprehensive review period as needed.



Summary: Definitive Agreement Submission

The entity can provide final executed copies of all definitive agreements with the Notice of Material Change Transaction, OR

If the entity provides a term sheet with the Notice of Material Change Transaction (Day 0), the final definitive agreements are due:

- No later than Day 165 if the transaction is approved (or approved with conditions) by the end of the preliminary review.
- 15 days after notice of comprehensive review (at maximum by Day 45).

Administrative Rules

409-070-0005 (27)

"Term sheet" means a memorandum of understanding or letter of intent setting forth the negotiated terms and conditions of the proposed transaction in reasonable detail, signed by the parties to a proposed transaction, or any other equivalent document that sets forth an agreement in principle for a proposed transaction.

409-070-0045 (5)

A notice of material change transaction shall include either complete and final executed copies of all the definitive agreements pursuant to which the transaction will be documented and closed or a term sheet. If a notice is filed on the basis of a term sheet, then:

(a) The parties must furnish the Authority with complete and final executed copies of all the definitive agreements pursuant to which the transaction will be documented and closed, together with a detailed description of any respect in which the definitive agreements depart from the term sheet, no later than:
   A. Fifteen days before closing the transaction, if the Authority approved the transaction without comprehensive review; or
   B. Fifteen days after the commencement of the comprehensive review period if the transaction was not approved following preliminary review. If the parties are unable to furnish complete and final executed copies of all the definitive agreements within that fifteen day period, then the running of the period for review of the notice shall be tolled upon such notification and shall not resume until the parties have furnished such executed copies.

(b) To the extent that the definitive agreements materially deviate from the term sheet, the Authority may extend the review period and may withdraw or modify an order based on the term sheet.

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Oregon Health Authority
HEALTH POLICY AND ANALYTICS
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Entities Subject to Review

The Health Care Market Oversight (HCMO) program was created to ensure that transactions involving health care entities support the goals of health equity, lower costs, increased access, and better care. This document provides a list of the types of entities that may be subject to review when materiality and transaction criteria are met. This list is not comprehensive, and additional entity types may also be subject to review. For more information, visit the program website.

Entities Subject to Review

According to Oregon Revised Statute (ORS) 415.500(4)(a), a "health care entity" includes:

A. An individual health care professional licensed or certified in this state;
B. A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule;
C. A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;
D. A Medicare Advantage plan;
E. A coordinated care organization (CCO) or a prepaid managed care health services organization, as both terms are defined in ORS 414.025; and
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.

Oregon Administrative Rules (OAR) 409-070-0005(15)(g) further defines "health care entity" to include:

G. Any other entity that 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. (The term "control" is defined in OAR 409-070-0005(7).)

Per statute, the following types of entities are **not** subject to review:

- Long term care facilities, as defined in ORS 442.015; and
- Residential Facilities and Homes, as defined in ORS 443.400, and excluding facilities referenced in ORS 443.405, that are licensed and operated under ORS 443.400 to 443.455.

The table below provides examples of entities that may be subject to review under ORS 415.500(4)(a)(F) or OAR 409-070-0005(15)(g). Transactions involving an entity subject to review must also meet the HCMO criteria for materiality under OAR 409-070-0015 and qualify as a covered transaction under OAR 409-070-0010. For more information, see the program's Oregon Administrative Rules 409-070-0000 through 0085.

Examples of Entities Subject to Review

In addition to the entities explicitly named in statute, the table below provides examples of entity types that may be subject to review because they:

- Have a primary function of providing health care items or services;
- Are closely related to an entity that has a primary function of providing health care items or services; or
- Are a parent organization or other entity that has control over, is controlled by, or is under common control with an entity that has a primary function of providing health care items or services.

Entity Type	Description	Primary function is provision of health care	Closely related to an entity that provides health care	Control over an entity that provides health care
Pharmacy	Pharmacies dispense and sell prescription drugs.	✓		
Oral health provider	Oral health focuses on care for a patient's mouth, teeth, gums and oral-facial system. Oral health providers include dentists, orthodontists, endodontists, and other providers who specialize in dental care.	✓		
Eye care provider	Health care professionals that provide services related to the eye or vision. Eye care providers include optometrists, ophthalmologists, and other vision care providers.	✓		
Medical group	Two or more physician practices organized as a single legal entity (e.g., partnership, professional corporation, or other association), as defined in 42 CFR 417.	✓		
Independent physician association (IPA)	Association of independent physician practices that contract jointly with payers, share administrative and management resources, and pursue other joint ventures, as defined in ORS 734B.002(9) and 42 CFR 417.		✓	
Management services organization (MSO) or dental support organization (DSO)	MSOs and DSOs provide administrative and business management services to care providers. MSOs/DSOs may provide financial, contract management, and population health services.		✓	
Pharmacy benefit manager (PBM)	PBMs manage prescription drug benefits on behalf of health insurers. PBMs negotiate prices and rebates with manufacturers, and fees with pharmacists.		✓	
Third Party Administrator (TPA)	TPAs provide administrative services for health insurance plans, as referenced in ORS 744.702. Services may include billing, claims processing, regulatory compliance, and other operational services.		✓	

Entity Type	Description	Primary function is provision of health care	Closely related to an entity that provides health care	Control over an entity that provides health care
Accountable Care Organization (ACO)	ACOs are groups of hospitals, physicians, and other health care providers who agree to coordinate care and assume responsibility for the total cost of care for patients, as defined in 42 CFR 425.		✓	
Private equity firm owning 25% or more of a health care entity	Private equity (PE) firms are privately held companies that invest in or acquire other private companies.			✓

The Oregon Health Authority may update and re-post the list of entities subject to review at any time.

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