

Public Comments: Amend rules for the Health Care Market Oversight Program, including fee schedule

This document was last updated on June 16, 2026.

The [Health Care Market Oversight](#) (HCMO) program reviews proposed health care business deals to make sure they support Oregon's goals of health equity, lower costs, increased access, and better care.

This document presents written and verbal public comments related to the 2025-2026 rulemaking process and guiding principles document for the HCMO program. The Oregon Health Authority (OHA) conducted rulemaking on OAR 409-070-0000 through OAR 409-070-0085 and received public comments from July 29, 2025 to May 21, 2026 as part of the rulemaking process by email to hcmo.info@oha.oregon.gov. This document presents the comments in the manner and order they were received and may include typos or misspellings.

Personal contact information for those who made the comments has been removed, as well as personal health information.

OHA expresses no views on the substance of these comments. They are published for transparency and not as an endorsement by OHA of the views expressed.

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1. Subject: It's time HCMO had an independent, comprehensive, public review.

Received 07/29/2025

John Santa, M.D., M.P.H. submitted a [public comment](#) that is posted on the Oregon Health Policy Board webpage.

2. Subject: Urgent Need to Reform OAR 409-070-0022 Emergency and Exempt Transaction Criteria

Received 09/03/2025

Michael Huntington, M.D. and Bruce Thomson, M.D. submitted a [public comment](#) that is posted on the Oregon Health Policy Board webpage.

3. Subject: Learn from history and previous mistakes---HCMO needs an independent, comprehensive, public review to rebuild trust

Received 9/4/2025

John Santa, M.D., M.P.H. submitted a [public comment](#) that is posted on the Oregon Health Policy Board webpage.

4. No subject

Received 09/04/2025

Eighteen months have passed since Optum/United Health Group purchased the Corvallis Clinic. As a community physician and patient advocate I firmly believe that the purchase has negatively impacted access to health care. The Corvallis Clinic had been operating in financial straits for several years prior to the Optum transaction, as a result of the Clinic's expansion into Linn and Lincoln counties. The only purported Emergency was a coincident hack of United Health Group digital infrastructure.

In 2024, there were over 300 public comments made to the Oregon Health Care Market Oversight Committee (HCMO) in support of denying the Optum/Corvallis Clinic transaction from occurring. Now in 2025, evidence is accruing that the purchase has been detrimental to many patients throughout Benton, Linn and Lincoln counties. In the past 18 months of Corvallis Clinic ownership by Optum, numerous physicians (30 to 35, according to unconfirmed reports) have departed, service levels have declined, and potentially thousands of patients have lost access to care; exactly the outcomes that the Emergency Exemption was supposed to prevent. In addition, Optum/Corvallis Clinic prohibits its physicians from taking call at the Samaritan Regional Medical Center Emergency Room. Such self-serving action adds to the burden of emergency

call schedules for non-Optum/Corvallis Clinic physicians in our communities. It allows Optum physicians to avoid taking on patients who come to the emergency room. These patients often have limited resources to pay for healthcare, and they often have illnesses or injuries that result in high costs. By restricting Optum/Corvallis Clinic physicians from treating Emergency room patients, health care equity is compromised.

Had there not been significant loopholes in Oregon Administrative Rule 409-070-0022 ("Emergency and Exempt Transactions") governing health care mergers and acquisitions, our communities could have influenced the Optum/Corvallis Clinic transaction. The current rule is so broad that any financially distressed clinic or hospital can easily claim that its insolvency is an "Emergency" and endangers patient health and that immediate acquisition by a large corporate entity is the only solution. This provision allows major buyouts to evade needed scrutiny, transparency, and public accountability. Had HCMO allowed a public process (Community Board) within the communities impacted by this acquisition, our local communities may have had an influence on HCMO's approval of this transaction. Rather, our communities are left with significant and increasing difficulties in accessing health care.

The adverse effects of Optum's purchase of the Corvallis Clinic match those seen in Eugene after Optum acquired Oregon Medical Group in 2021, prior to HCMOs existence. In both cases, the Optum transactions have delivered ongoing significant harm that, now almost 4 years out, people in the Eugene Springfield region are still struggling to find a health care provider. Patient's in Benton, Linn and Lincoln counties can expect the same over the next 3-5 years

Specific Concerns about the Emergency Exemption Rule;

- The criteria are so vague ("immediately threatens health care services" and "urgently needed to protect the interests of consumers and to preserve the solvency") that any struggling entity could justify an exemption,
- The exemption process can bypass public comment and meaningful review, undermining transparency and leaving local communities powerless to oppose deals that significantly impact access to care,
- There is no requirement for enforceable commitments regarding provider retention, service continuity, disallowing non-compete clauses, or follow-up review after an exempted transaction.

Bruce Thomson, M.D., M.S.

5. Subject: REQUESTED Public Comment

Received 09/05/2025

Michael Huntington, M.D. and Bruce Thomson, M.D. submitted a [public comment](#) that is posted on the Oregon Health Policy Board webpage.

6. No subject

Received 09/08/2025

Compassion & Choices continues to support Oregon's Health Care Market Oversight program, particularly as it relates to protecting and expanding access to high-quality, patient-directed care for individuals at the end of life. Compassion & Choices is the nation's oldest, largest and most active nonprofit organization working to improve and expand patient-directed healthcare options at life's end. We are deeply invested in ensuring that all Oregonians are able to make healthcare decisions reflecting their values and preferences, especially during this vulnerable phase of life.

At the end of life, access to a full range of care options — including hospice and palliative care, advance care planning, and, in Oregon, the option of medical aid in dying — is essential. Unfortunately, consolidation in the healthcare sector often brings with it increased risk of care being restricted based on institutional doctrine rather than medical best practices or an individual's informed choices. Without strong oversight, mergers, acquisitions, and affiliations may impose policies that limit access to legally available end-of-life options, jeopardizing patient autonomy.

Oregon has long led the nation in advancing and improving end-of-life care. The HCMO program continues that legacy by promoting transparency, protecting patient rights, and ensuring that healthcare decisions are not dictated by market consolidation, but guided by ethical care and a patient's needs and values. It is crucial that the HCMO review process continues to explicitly examine the impact of proposed consolidations on access to end-of-life care and requires enforceable commitments to preserve and expand that access.

The people of Oregon deserve a healthcare system that honors their values and preferences throughout their lives. Compassion & Choices supports policies that empower patients and ensure that care is guided by compassion, not ideology.

Oregon's Healthcare Market Oversight program is a vital tool in safeguarding these principles.

Thank you for your commitment to advancing health equity and protecting access to care for all Oregonians.

Kevin Diaz

President and Chief Executive Officer

Compassion & Choices

7. No subject

Received 09/08/2025

Public Comment on OAR 409-070-0022 — Emergency and Exempt Transactions

To: Health Care Market Oversight Program, Oregon Health Policy Board, Oregon Health Authority.

Subject: Urgent Need to Reform OAR 409-070-0022 Emergency and Exempt Transaction Criteria

Dear Health Care Market Oversight Program Leaders,

I write as a concerned citizen, physician, and patient advocate in Benton and Linn counties regarding the loopholes in Oregon Administrative Rule 409-070-0022 ("Emergency and Exempt Transactions") governing health care mergers and acquisitions. The current rule is so broad that any financially distressed clinic or hospital can easily claim that its insolvency endangers patient health and that immediate acquisition by a large corporate entity is the only solution. This provision allows major buyouts to evade needed scrutiny, transparency, and public accountability.

The purchase of Corvallis Clinic by Optum (a UnitedHealth Group subsidiary) in 2024 serves as a local case example. Following this transaction, numerous physicians departed, service levels fell, and potentially thousands (data is not accessible to the

public but should be) of patients lost access to care—exactly the outcomes that the exemption process claimed it would prevent.

The Corvallis experience mirrors the Eugene experience following Optum's acquisition of Oregon Medical Group (OMG) in 2021. In 2024 OMG abruptly notified thousands of its patients that their care providers were no longer available. In both Eugene and Corvallis, the buyouts caused the significant harm that they purported to prevent.

Specific Concerns About the Rule

- The emergency exemption criteria are so vague ("immediately threatens health care services" and "urgently needed to protect the interests of consumers and to preserve the solvency") that any struggling entity could justify an exemption, regardless of the long-term or community impact.
- The exemption process can bypass public comment and meaningful review, undermining transparency and leaving local communities powerless to oppose deals that affect access to care effectively.
- There is no requirement for enforceable commitments regarding provider retention, service continuity, or follow-up review after an exempted transaction.

Requested Policy Improvements

1. Tighten Emergency Criteria: Define "emergency" using specific, transparent financial metrics (e.g., imminent payroll failure, actual closure notices), and require documented attempts at local remedies before permitting an external buyout.
2. Mandate Full Disclosure: Even in emergencies, require the acquirer to disclose details of the proposed transaction publicly.
3. Public Input and Accountability: Ensure every exemption includes a mandatory three-month public comment period.
4. Follow-up Review: Require all exempted transactions to undergo retrospective evaluation of patient access, provider retention, and community impact within twelve months.

5. Community Consultation: Involve affected counties, advocacy groups, and workforce representatives in the evaluation before finalizing exemptions.

Given the demonstrated negative local impact of recent health care consolidations, it is urgent that you close these loopholes, strengthen requirements for transparency, and protect Oregon communities from the unintended consequences of poorly regulated buyouts. We urge you to update OAR 409-070-0022 with these safeguards.

Respectfully,

Michael C. Huntington, MD

8. Voicemail

Received 09/09/2025

Yes, I uh agree with Dr. Huntington, whom I very much respect, about the Optum situations both in 4 years ago and now with the Corvallis clinic. Hopefully you all will recognize that there's a lack of true, effective process when you don't include public comment and so forth. And I suggest you all get your act a lot more aligned with the well-being of folks here in Oregon. My name is James Rodell, R-O-D-E-L-L. My phone number is [Redacted per ORS 192.377]. I live in Philomath. And I appreciate your considering these remarks and improving the process that you are part of affecting. Really. Thank you.

9. Corvallis clinic health care

Received 09/09/2025

To Whom it May Concern,

The potential debacle of your agency allowing Optum to purchase the Corvallis Clinic has come true. I have been a patient of the CC for 40+ years and the quality of care has fallen off tremendously. I can't blame the providers but the red tape etc seems to have affected their abilities to make decisions along with a decline in the morale of the staff. My urologist and primary care provider have both left the CC. Let's say they didn't retire but it appears they had hardships with Optum. This has affected me as I don't have any physician to turn to for any assistance. I can't express to you enough that you need to analyse more carefully any other situations where you are making

such a serious decision and to realize the consequences of your actions. Your decision has failed me.

Jim Ervin

Retired From OSU

Medicare Advantage patient

10. Voicemail

Received 09/09/2025

Hello, I'm just calling to voice my opposition to these emergency rules that allow these gigantic healthcare companies to swoop in and buy things like the Corvallis clinic. It's really ruining healthcare here. It's not helping anything. My son's pediatrician left the company. My wife's doctor left the clinic. We are not getting better care. We're getting worse, and I don't know what your emergency was that allowed this but stop destroying our local healthcare, please. Thank you. My name is John Hinderer. I'm in Corvallis, bye.

11. Health Care Market Oversight Public Listening Session #1, 9/12/2025

Received 09/12/2025

Michael Huntington, M.D. and Lauri Hoagland provided [public comment](#) at a HCMO listening session.

12. Feedback, 9/12/2025

Received 09/12/2025

Larry Kirsch submitted a [public comment](#) that is posted on the HCMO webpage.

13. No subject

Received 09/13/2025

EMTALA has been used to deny care and deaths are the result of. So far 2 of my family members have died after Experiencing EMTALA. The hospital/ ER is not accessible or available or anything but EMTALA. The Hospitals dictate care based on plan billing/ insurance coverage. United healthcare denies and EMTALA is result. Deaths are prevalent among medically fragile misdiagnosed patients who present with

wrong coverage at ER. The OHP plan will just kill ya fast as a “ medical con scam ; the hospital hates ya at entrance as the billing gets established at check in but care never happens/ wrong insurance/ poverty policy of EMTALA. Misdiagnosed patients die. Unlawful treatment, zero “ do no harm” policy abandoned as is patients who have a punishment ahead called “ pacific source community solutions “ EmTALA is your care plan and death is forced. Unconscionable actions of deprivation ongoing based on income/ medical insurance coverage combined with CCO con scam kills poor not rich. The cost of care is put on back of poor by denying healthcare. The cost to community is ; highest rate of mental illness and death by suicidal patients never receiving care; EMTALA deaths of medical fragile seniors who already survived the last patient dump (EMTALA) and then got dumped till death as the care is based on “ errors of records that are not errors but EMTALA results from lies and scams on patients ongoing; fraud waste and neglect by hospitals based on zip codes of patients financial records not “ patient needs.” Unless you stay away from hospitals “ death by EMTALA will kill ya faster than ; everything like Heart attack/ diabetes or stroke in parking lot of ER after dumping by the hospital due to care needs and a cop ready to arrest all patients with “ medical emergency conditions that hospitals hate ; mental illness is a cop arrest and a cuff at door of ER. Mentally unstable after a patient dump? Arrest them ASAP! Security guards guard care. It's not a public place or accessible care at Peace health hospital. God is watching and the Devil runs all hospitals. Grim reaper is EMTALA ; hospitals are Black Death chambers..... Welcome to hell. It's not healthcare. Jane Doe ; unnecessary care kill folks it's other name is EMTALA/? The “ healthcare for poor”ran by the Devil/ Hell and at a non profit that lost 11 billion last year and paid 0 tax.

14. Voicemail

Received 09/15/2025

Hi. My name is Elizabeth McCumber, and I'm a resident of Corvallis, Oregon, where recently our local health provider Corvallis Clinic was taken over by Optum. I am calling to say that this has been a nightmare for me as a local resident here. The clinic provides my primary health services my PCP and I have, and for my children as well, I have been dealing with months, like coming on like, half a year of wait time for well-checks for needed care. I was not able to see my primary care provider when I had, uh a health issue come up. I had to use urgent care services, and it was big bills for that. Um, it's, it's a disaster and this is not this is not what we want for our healthcare system. Personally, I want a single payer system. All of the fear mongering about long

wait lines and rationing of care-that's the hellscape we're living in right now and we don't have any other option. Like when I need care, there isn't any other place to go, other than the clinics that we have here in town. So to whatever extent this buyout is responsible for it we need to change the rules that allowed this to take place and we need to get some actual care here because our community is-I mean, I'm not the only one-our communities are really suffering for lack of care. My phone number is [Redacted per ORS 192.377]. Thanks for listening, bye.

15. Feedback -Public Comment on Expansion of Adapt, NeighborWorks Umpqua, and UCAN in Douglas County

Received 09/15/2025

To the Health Care Market Oversight Program,

"Feedback"

As a community member in Roseburg, I want to raise concerns not only about Adapt's expansion, but also about NeighborWorks Umpqua and UCAN, which have grown substantially in housing and service roles in our region.

Together, these organizations have acquired or controlled major properties, low-income housing developments, and service programs-often with substantial public funding or government partnerships. Yet during this same period, our community has seen:

- Rising homelessness that has not been resolved despite years of investment.
- Increased drug use and overdoses, putting strain on public health and safety systems.
- Growing crime and community disruption in neighborhoods affected by these issues.

It appears that the larger these organizations grow, the worse our outcomes become. Many residents perceive that homelessness and addiction have become an industry - with organizations and local governments profiting from the continuation of the problem instead of solving it.

I respectfully ask the HCMO program to:

1. Evaluate whether organizational growth in housing, behavioral health, and addiction services is actually improving outcomes for Oregonians.
2. Require accountability and transparency in how public funds and grants are used, particularly when tied to real estate development and property acquisition.
3. Ensure that future approvals or oversight actions prioritize measurable community benefits-like reduced overdoses, lower crime, and fewer unsheltered people-not just organizational expansion.

Our community deserves to see real progress on homelessness, addiction, and health care, not just bigger buildings and budgets for the organizations tasked with addressing these crises.

Thank you for considering these concerns.

Sincerely,

Ashley Hicks

Roseburg, Oregon

16. USofCare's Feedback on HCMO's Guiding Principles and Framework

Received 09/18/2025

The United States of Care [submitted a public comment](#).

17. No subject

Received 09/18/2025

During the 9/18/25 OHA Public Listening Session, Tom Sincic resubmitted his [9/4/24 public comment](#) from the 2024 Rules Advisory Committee.

18. Hospital Association of Oregon 2025 Public Comment on HCMO Program

Received 09/19/2025

The Hospital Association of Oregon [submitted a public comment](#).

19. Public Comment/Feedback from SEIU Local 49

Received 09/26/2025

SEIU Local 49 [submitted a public comment](#).

20. HCMO RAC COMMENTS

Received 11/02/2025

Larry Kirsch submitted a [public comment](#) that is posted on the HCMO webpage.

21. HCMO RAC Comments and Recommendations

Received 11/06/2025

Tom Sincic submitted a [public comment](#) that is posted on the HCMO webpage.

22. HCMO RAC Salem Health Comment

Received 11/06/2025

Salem Health Hospitals and Clinics submitted a [public comment](#) that is posted on the HCMO webpage.

23. No Subject

Received 11/12/2025

Thank you to the staff for your work on the red line draft of the Rules Amendments. It is very important that the process of reviewing material change transactions is transparent and furthers the goals of the statute.

One omission to the administrative rules at this point is that there is no mention of the interplay between the review process and compliance with the requirements of SB 951. This omission should be addressed at this time as the requirements of the bill are effective.

The changes to the fees in 409-070-0030(3)(a) and (b) need to have clear documentation as to how the calculation of agency costs were determined. The enabling act for the program requires that the fees charged reflect the cost of the program. Perhaps it is worth considering a sliding scale for fees as perhaps larger transactions require more staff time than transactions that are just over the threshold for review. It is important to keep in mind that the fees should not be beyond the cost of the program.

I am very concerned about the conflict-of-interest provisions applicable to the Community Review Board found in section 409-070-0062. Persons who have a conflict of interest should be barred from participating as members of the Board. I would suggest that section (3) be revised to add the following language:

The Authority may not appoint to a community review board an individual who has a financial stake in an entity that is a party to the transaction under review or has governance or decision-making authority for an entity that is a party to the transaction that is under review.

Section (4) would then be modified by deleting (a) and (b).

Finally, spouses or domestic partners of persons who are barred from participation on the Board should also be ineligible for appointment.

Thank you for this opportunity to comment.

Karen Christianson, J.D.

24. Comments on HCMO RAC Proposed Rules

Received 11/12/2025

In advance of the November 13 deadline, I am submitting my comments as part of the RAC process.

As an independent, physician-governed, Oregon-based healthcare practice, The Oregon Clinic urges OHA to prioritize collaboration with other high-value independent practices across the state. Post-pandemic challenges continue to strain healthcare delivery, and these pressures will intensify with HR1 and the anticipated increase in the uninsured population. Independent practices are essential to Oregon's healthcare ecosystem, and we must work together to reduce barriers so they can thrive.

From my recent experience, this process adds significant cost to material transactions in healthcare—costs that ultimately drive up the total cost of care, which is already trending in the wrong direction. I encourage OHA to use this opportunity to act as a solution partner by avoiding unnecessary and inflated costs that hinder innovation and transformation.

Independent provider groups need the ability to collaborate and preserve their independence without facing prohibitive costs and delays.

Specific Comments on Proposed Redlines:

1. 409-070-0015 Materiality Standard

- Recommend increasing the annual revenue threshold for one party from \$25 million to \$50 million over the three most recent fiscal years.
- Recommend increasing the threshold for the other party from \$10 million to \$20 million.
- I understand these changes may require legislative action and may not be applicable to RAC.

2. 409-070-0020 Excluded Transactions

- Recommend exempting transactions involving independent provider groups domiciled in Oregon.
- I understand these changes may require legislative action and may not be applicable to RAC.

3. 409-070-0022 Emergency and Exempt Transactions

- Recommend retaining the current requirement of 10 business days' advance notice prior to posting the application for public comment. The rationale for reducing this to 3 business days is unclear.

4. 409-070-0030 Requirement to File a Notice of Material Change Transaction

- The fees and administrative burden associated with this process are already excessive and risk stifling innovation at a time when Oregon healthcare urgently needs transformation.

5. 409-070-0050 Retention of Outside Advisors

- Recommend establishing a transparent and fixed schedule for the overall process and the use of outside advisors.

6. 409-070-0067 Violations and Civil Penalties

- The process is already onerous. Adding further penalties for independent practices struggling to survive undermines the goal of healthcare transformation in Oregon.

7. 409-070-0070 Confidentiality; Permitted Disclosures

- The proposed minimum of two days prior to public disclosure is insufficient. Recommend at least 10 business days to allow for proper review.

Thank you for considering these recommendations. I appreciate OHA's commitment to improving healthcare in Oregon and hope these adjustments will help foster collaboration and sustainability among independent practices.

Sincerely,
Tom Sanchez

25. Providence Comments on HCMO RAC 1, 11/13/2025

Received 11/13/2025

Providence submitted a [public comment](#) that is posted on the HCMO webpage.

26. HCMO RAC 1 Comments – OIMC

Received 11/13/2025

The Oregon Independent Medical Coalition submitted a [public comment](#) that is posted on the HCMO webpage.

27. Written Comment submitted by Oregon Health and Sciences University

Received 11/13/2025

Oregon Health and Sciences University submitted a [public comment](#) that is posted on the HCMO webpage.

28. Supplemental Comments for RAC Meeting #1

Received 11/13/2025

Thank you for inviting feedback through a Rules Advisory Committee (RAC) for rulemaking related to the Health Care Market Oversight Program. The following are supplemental public comments based upon the RAC Meeting #1 held on November 6, 2025. The comments below are not intended to be a comprehensive review of all of the rules and simply to add to comments made in the RAC Meeting #1.

The Oregon Medical Association (OMA) represents the interests of physicians and physician associates statewide. OMA members work throughout the entire health care system and represent the frontline caregivers in our state in different settings and care teams. Our interest in the HCMO program is to ensure that the goals of the program are kept front and center of all rulemaking and program operations especially the "goal of using resources wisely." In other words, is the HCMO program clearly achieving its policy goals and, if so, is the program doing so efficiently?

Our comments here will follow the flow of RAC Meeting #1 and provide additional context to comments we made or heard at the meeting.

Materiality Standard OAR 409-070-0015

We believe it is important to keep the concepts of "average annual revenue" and "net patient revenue" in mind especially in the fee setting area of the program and distinguish those clearly from "net income" which is not used in HCMO's rules. A medical clinic might have net patient revenue in the materiality range of \$10 million or more but that does not mean the clinic is profitable. A clinic's net income might be nearer to breakeven or even operating at a loss. Medical clinics today have not recovered financially from the global pandemic of five years ago and that is part of the reason why we have seen consolidation in the market and use of HCMO's emergency transaction rules.

Requirement to File a Notice of Material Change Transaction OAR 409-070-0030

We understand that the fee provisions will be discussed more fully at RAC Meeting #2 because proposed fees have not been published. We have a few comments to add to the discussion from RAC Meeting #1. As we commented earlier, the fees associated with the program should be related to the context of the transaction, transparent, and based upon efficiency. For example, a medical clinic that is distressed may meet the \$10 million threshold and will be subjected to the same fee as a transaction where a party may be financially stable. There is no factoring in for hardship in the current fee structure. Also, the addition of new fees for one year, two year and five year follow up seems outside the statute. Do we know if the Legislature intended to have later analytical work of the agency become an assessable fee? We think that needs a better understanding in the pending legal review after the RAC meetings are completed. Finally, as the agency gains experience with each transaction that is reviewed, we would hope to see cost reductions in the service provided in reviewing transactions. We will reserve comment on this area of the rules until we have a better understanding of the proposed fees.

Optional Application for Determination of Covered Transaction Status ORS 409-070-0042

We expressed our support for the ability of an applicant to seek the expertise of the agency on whether a transaction is a covered transaction. This does not appear to be a statutory requirement but we believe opening up access to the agency enhances compliance with the program. While there is a balance needed between ensuring

compliance and documenting all inquires to the agency, we think making every contact that seeks a determination from the agency publicly available could have a chilling effect on community stakeholders seeking basic input about compliance. Is there an alternate way to access the expertise of the agency for general discussion or could the presentation of this information be aggregated without identifying the party seeking guidance?

Retention of Outside Advisors OAR 409-070-0050

We understand the statute provides for the ability of OHA or the Department of Justice to retain consultants to assist with reviewing transactions and pass along reasonable and actual costs to one or more parties to a transaction. As the agency gains experience with reviewing transactions, we would anticipate the use of outside consultants would be reduced over time. Given helpful comments at the RAC Meeting #1 about the cost of consultants, it would be helpful to have any consulting fees capped at reasonable amounts and disclosed up front to the parties. We believe that OHA or DOJ would have the authority and ability to require reasonable flat fee proposals from consultants. Most medical clinics today will engage external consultants such as legal advisors and determine up front what fees will be. This sort of transparency is important in a program where one of the goals is to use resources wisely. Finally, we were surprised by the addition of a pass through of costs for a database for document management. Database costs are an unknown cost and historically in Oregon for state agencies, a rather significant cost. As the rules make their way toward a final legal review, we ask again whether this type of cost was anticipated by the Legislature in allowing reasonable consultant costs to be passed through to the parties.

Community Review Board OAR 409-070-0062

There is a new requirement to set a base number of individuals of the affected community, consumer advocates and health care experts. The statute is silent on the base number and we believe that was intentional to allow for flexibility depending upon where a transaction may be located. We do not believe a base number is required to be set in rule. Also, the term "institutional or corporate providers" is included in the rule and that is different from the term used in statute "institutional health care providers." We would suggest using the statutory term to avoid confusion that the rule might be creating a new undefined term.

As we commented at the meeting, the addition of new monetary penalties changes the culture of the program from a standards-based program to a penalty-based program. We simply point that out and believe the RAC would benefit from clear examples of how penalties would address specific issues with non-compliance that the program has experienced to date.

In closing, we are open to continuing the discussion about the HCMO rules in upcoming RAC Meeting #2 and reserve our ability to comment on any of the rules. Thank you for the work that has gone into the rulemaking process to date and for taking the time to engage stakeholders through a publicly accessible RAC process.

Mark

29. HAO Comments on HCMO RAC Meeting 1

Received 11/13/2025

The Hospital Association of Oregon submitted a [public comment](#) that is posted on the HCMO webpage.

30. Comment—RAC 2nd Meeting

Received 11/15/2025

Larry Kirsch submitted a [public comment](#) that is posted on the HCMO webpage.

31. Comment letter on HCMO Proposed Rules/CGT Workgroup Determination

Received 01/05/2026

PacificSource submitted a [public comment](#) that is posted on the HCMO webpage.

32. OBI Comments to OHA's HCMO 2025-2026 Rules Advisory Committee

Received 01/13/2026

Oregon Business and Industry submitted a [public comment](#) that is posted on the HCMO webpage.

33. USofCare Comments on HCMO Updated Rules

Received 01/15/2026

USofCare submitted a [public comment](#) that is posted on the HCMO webpage.

34. HCMO RAC Comments

Received 01/16/2026

Tom Sanchez submitted a [public comment](#) that is posted on the HCMO webpage.

35. HCMO RAC #3 Supplemental Public Comments, 1/16/2026

Received 01/16/2026

Thank you for inviting feedback through a Rules Advisory Committee (RAC) for rulemaking related to the Health Care Market Oversight Program. The following are supplemental public comments based upon the RAC Meeting #3 held on January 13, 2026.

The Oregon Medical Association (OMA) represents the interests of physicians and physician associates statewide. OMA members work throughout the entire health care system and represent the frontline caregivers in our state in different settings and care teams. Our interest in the HCMO program is to ensure that the goals of the program are kept front and center of all rulemaking and program operations especially the "goal of using resources wisely." In other words, is the HCMO program clearly achieving its policy goals and, if so, is the program doing so efficiently?

Our comments here will follow the flow of RAC Meeting #3 and provide additional context to comments we made or heard at the meeting.

Materiality Standard OAR 409-070-0015

We believe it is important to keep the concepts of "average annual revenue" and "net patient revenue" in mind especially in the fee setting area of the program and distinguish those clearly from "net income" which is not used in HCMO's rules. There still appears to be an incorrect perception in some of the RAC discussions that when a health care entity such as a medical clinic might have average annual revenue in the materiality range of \$10 million, that does not mean the clinic is profitable. A clinic's net income might be nearer to breakeven or even operating at a loss. In other words, there may not be sufficient funds to support high-cost regulatory reviews. Medical clinics today have not recovered financially from the global pandemic of five years ago and

that is part of the reason why we have seen consolidation in the market in Oregon and use of HCMO's emergency transaction rules. Applicants should have the ability to seek waivers from OHA in its discretion when the potential to lose local ownership and control of a health care entity is in jeopardy.

Requirement to File a Notice of Material Change Transaction OAR 409-070-0030

As we commented earlier, the fees associated with the program should be related to the context of the transaction, transparent, and based upon efficiency. For example, a medical clinic that is distressed may meet the \$10 million threshold and will be subjected to the same fee as a transaction where a party may be financially stable. There is no factoring in for hardship in the current fee structure. Also, we commented earlier too that the addition of new fees for one year, two year and five year follow up seems outside the statute. Finally, as the agency gains experience with each transaction that is reviewed, we would hope to see cost reductions in the service provided in reviewing transactions.

With respect to the proposed fee increases of preliminary reviews from \$2,000 to \$30,000 and the changes for comprehensive reviews in the first tier, as an example, from \$25,000 to \$200,000, we have concerns about HCMO achieving the goals of the program. Again, a medical clinic that meets the first tier revenue threshold may be looking to reorganize or merge with another local medical clinic to preserve its role as an independent medical clinic that serves local patients rather than simply be bought out or have its clinicians become employed by a much larger organization such as a hospital or a large out of state health plan supported medical group.

Given both the outsized fee increase and new risk of civil penalties, a medical clinic may forgo the uncertainty and costs of the HCMO program and simply not engage in reorganizing. We believe that the current HCMO approach will burden the parties that the program was supposed to support, locally owned and operated health care entities such as medical clinics. There simply has to be a better way to achieve the goals of the program and fund or reorganize the program rather than risk further consolidation and out of state ownership.

Retention of Outside Advisors OAR 409-070-0050

We understand the statute provides for the ability of OHA or the Department of Justice to retain consultants to assist with reviewing transactions and pass along reasonable and actual costs to one or more parties to a transaction. As the agency gains experience with reviewing transactions, we would anticipate the use of outside consultants would be reduced over time. Given helpful comments at earlier RAC meetings about the cost of consultants, it would be helpful to have any consulting fees capped at reasonable amounts and disclosed up front to the parties. We believe that OHA or DOJ would have the authority and ability to require reasonable flat fee proposals from consultants. Most medical clinics today will engage external consultants such as legal advisors and determine up front what fees will be. This sort of transparency is important in a program where one of the goals is to use resources wisely. We did appreciate OHA removing the provision that would pass through costs for a database for document management.

Violations and Civil Penalties OAR 409-070-0067

As we commented earlier, the addition of new monetary penalties changes the culture of the program from a standards-based program to a penalty-based program. We simply point that out and believe the RAC would benefit from clear examples of how penalties would address specific issues with non-compliance that the program has experienced to date so that parties have clear guidance and are not uncertain about the risks of civil monetary penalties.

In closing, we appreciated the comment in RAC #3 that OHA may be open to re-thinking an approach to the HCMO process including the proposed fee structure. We understand that may be outside the scope of a RAC process, but we wanted to clearly emphasize we are open to continuing the discussion about the goals and processes of HCMO. Thank you for the work that has gone into the rulemaking process and for taking the time to engage stakeholders through a publicly accessible RAC process.

Mark

36. OHSU Written Comments on 2025-2026 HCMO Permanent Rulemaking

Received 01/16/2026

Oregon Health and Sciences University submitted a [public comment](#) that is posted on the HCMO webpage.

37. HAO Written Comments for 2025-2026 HCMO RAC

Received 01/16/2026

The Hospital Association of Oregon submitted a [public comment](#) that is posted on the HCMO webpage.

38. Public Comment on Health Care Market Oversight Program Proposed Rules

Received 01/16/2026

OSPIRG submitted a [public comment](#) that is posted on the HCMO webpage.

39. HCMO RAC 3 Comments

Received 01/16/2026

Providence submitted a [public comment](#) that is posted on the HCMO webpage.

40. OIMC HCMO RAC Comments

Received 01/16/2026

The Oregon Independent Medical Coalition submitted [public comment](#) that is posted on the HCMO webpage.

41. RAC-Proposed Redlines

Received 01/20/2026

Larry Kirsch submitted [public comment](#) that is posted on the HCMO webpage.

42. HCMO Rules Public Comment

Received 05/15/2026

The Oregon Clinic submitted [public comment](#) that is posted on the HCMO webpage.

43. OIMC HCMO Written Comments

Received 05/15/2026

The Oregon Independent Medical Coalition submitted [public comment](#) that is posted on the HCMO webpage.

44. Eye Health Northwest HCMO Written Testimony

Received 05/19/2026

Eye Health Northwest submitted [public comment](#) that is posted on the HCMO webpage.

45. HCMO Proposed Rulemaking Public Comments – Oregon Specialty Group

Received 05/19/2026

Oregon Specialty Group submitted [public comment](#) that is posted to the HCMO webpage.

46. HCMO Rules proposal – public testimony

Received 05/20/2026

The Portland Clinic submitted a [letter](#) that is posted to the HCMO webpage.

47. HCMO Public Comment

Received 05/20/2026

The Oregon Medical Association submitted a [letter](#) that is posted to the HCMO webpage.

48. HAO Submitting Public Comment on HCMO NPRM

Received 05/21/2026

The Hospital Association of Oregon submitted a [letter](#) that is posted to the HCMO webpage.

49. Coalition Comments – HCMO Rules

Received 05/21/2026

Dalton Advocacy submitted a [letter](#) that is posted to the HCMO webpage from:

- Oregon Medical Association
- Osteopathic Physicians and Surgeons of Oregon
- Oregon Academy of Family Physicians
- Oregon Association of Orthopedic Surgeons

- Oregon Academy of Ophthalmology
- Oregon Chapter-American College of Emergency Physicians
- Oregon Psychiatric Physicians Association

50. OHSU Comments on 2025-2026 HCMO Program Permanent Rulemaking

Received 05/21/2026

Oregon Health and Sciences University submitted a [letter](#) that is posted to the HCMO webpage.

51. United States of Care Comments in support of HCMO proposed administrative rules

Received 05/21/2026

United States of Care submitted a [letter](#) that is posted to the HCMO webpage.

52. Southern Oregon Neurosurgery HCMO Testimony

Received 05/21/2026

Southern Oregon Neurosurgery submitted a [letter](#) that is posted to the HCMO webpage.

53. Health Care Market Oversight Program rules – comment

Received 05/21/2026

Providence submitted a [letter](#) that is posted to the HCMO webpage.

54. OBI Letter to OHA re: HCMO Proposed Rules

Received 05/21/2026

Oregon Business Industry submitted a [letter](#) that is posted to the HCMO webpage.

55. Public Comment – HCMO Rulemaking.

Received 05/21/2026

Asante submitted a [letter](#) that is posted to the HCMO webpage.

About HCMO

The Healthcare Market Oversight Program reviews proposed health care business deals to make sure they support statewide goals related to cost, equity, access, and quality. For more info, you can connect with HCMO staff:

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