Health Care Market Oversight (HCMO)

Program Requirements and Guidance

September 2026

Published September 1, 2026

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Introduction

The Health Care Market Oversight (HCMO) program ensures 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 reviews proposed material change transactions and monitors health care markets. For more information, visit the program website.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact us by email at hcmo.info@oha.oregon.gov or by phone at 503-945-6161. We accept all relay calls.

This document, effective September 1, 2026, supersedes and replaces all prior sub-regulatory guidance issued by the HCMO program (apart from the “Defining Essential Services and Significant Reduction” guidance, which will be effective March 1, 2027). For more information about HCMO regulations and requirements, visit the following websites:

- Oregon Revised Statute 415.500 et seq.
- Oregon Administrative Rules 409-070-0000 through -0085
- Administrative Rules
- Guidance Documents

Abbreviations and Acronyms

ACO	Accountable Care Organization
ASC	Ambulatory Surgery Center
CCO	Coordinated Care Organization
DCBS	Department of Consumer and Business Services
DME	Durable Medical Equipment
DSO	Dental Support Organization
HCMO	Health Care Market Oversight
HEDIS	Healthcare Effectiveness Data and Information Set
HHI	Herfindahl-Hirschman Index
HRSA	Health Resources and Services Administration
IPA	Independent Physician Association
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, and Queer
MRI	Magnetic Resonance Imaging
MSO	Management Services Organization
NICU	Neonatal Intensive Care Unit
Notice	Notice of Material Change Transaction
OAR	Oregon Administrative Rules
ODHS	Oregon Department of Human Services
ODOJ	Oregon Department of Justice
OHA	Oregon Health Authority
ORS	Oregon Revised Statutes
PBM	Pharmacy Benefit Manager
PE	Private Equity
PET	Positron Emission Tomography
TAG	Technical Advisory Group
TPA	Third Party Administrator

Asset Ownership and Control

Are Changes in Ownership of Assets Changes in Control?

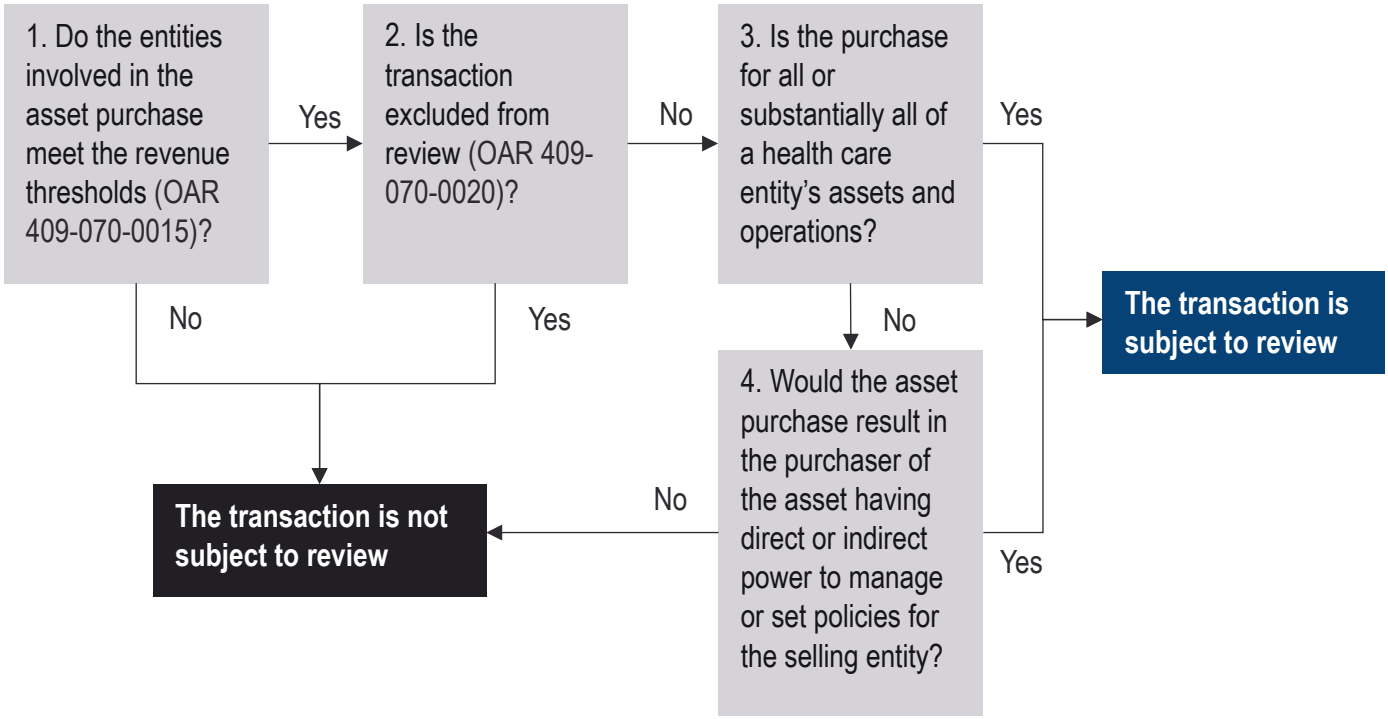
To determine if a transaction is subject to review by the Program, entities may need to determine whether the transaction would result in a change of control. This guidance provides information for entities to determine if a proposed transaction involving a change in ownership of assets would result in a change of 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 (CCOs) or 25% or more of any class of voting securities for entities other than domestic health insurers and CCOs. 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, in 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.

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 HCMO review.

Community Review Board

Role of Community Review Board

Community review boards comprise members of communities affected by a transaction, consumer advocates, and health care experts. A key role of the community review board is to provide recommendations about whether OHA should approve, approve with conditions, or disapprove proposed transactions. Community review boards may also recommend conditions to ensure that approved transactions advance health equity. Another role of a community review board is to 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

As outlined in statute, OHA may convene a community review board for transactions that receive a comprehensive review. OHA will not convene community review boards for emergency reviews, preliminary reviews, or follow-up reviews.

Criteria for Convening a Community Review Board

OHA may, at its discretion, convene a community review board for a transaction that receives a comprehensive review. Pursuant to ORS 415.501(8) and OAR 409-070-0062(2), in determining whether to convene a community review board, OHA considers 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

OHA may convene a community review board during a comprehensive review if the transaction may result in loss or changes to essential services. ORS 415.500 et seq. defines “essential services” as services that are funded on the Oregon Health Plan prioritized list (described in ORS 414.690) and services that are essential to achieve health equity.

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

OHA may convene a community review board if the transaction will impact a large number of residents in the state. Transactions impacting a “large number of residents” are those that impact a market with a population of 50,000 or more residents.

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

OHA may convene a community review board if the transaction will result in a significant change in market share for an entity involved in a transaction. Market share refers to the proportion of total products and services provided by a particular health care entity. In general, an entity that provides more services to more consumers and generates more revenue in a region would have a greater market share.

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 Merger Guidelines, issued December 18, 2023. These guidelines use the post-merger level of market concentration and market share and change in concentration and market share to determine whether there are anticompetitive effects.

The guidelines use Herfindahl-Hirschman Index (HHI) to assess market concentration. In determining whether to convene a community review board, OHA considers a change in market share to be significant if the post-merger HHI is greater than 1,800 and the change in HHI is greater than 100 suggests *or* the merged firms market share is greater than 30% and the change in HHI is greater than 100. (See the table below.)

Indicator	Threshold for significant change
Post-merger HHI	Market HHI greater than 1,800 *and* Change in HHI greater than 100
Merged firm's market share	Share greater than 30% *and* Change in HHI greater than 100

Please refer to the HCMO Analytic Framework for more information about how market share is defined and how market concentration is calculated.

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). 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.

- 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.
- OHA will seek to recruit consumers who have been affected by previous transactions, consumers of services provided by entities, health care providers operating in affected geographic areas, health care providers affected by previous transactions, 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.
- Community review board members may not be employed by an entity party to a transaction or a similar-sized competitor.
- OHA will support the recruitment of diverse community review board members and seek to include individuals with different lived experiences and self-reported identities.[1] OHA will aim for community review board members to reflect the diversity of the overall affected population.

[1] 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.

Criteria for Comprehensive Review

OHA will conduct a comprehensive review of a proposed material change transaction if, at the conclusion of preliminary review, OHA is unable to establish that the transaction meets one or more of the following criteria for approval of the transaction as set forth in ORS 415.501 and OAR 409-070-0055(2):

1. The transaction is in the interest of consumers (i.e. there are no adverse impacts on cost, access, quality, or equity) and is urgently needed to maintain the solvency of one of the entities involved in the transaction;
2. The transaction is unlikely to substantially reduce access to affordable health care in Oregon;
3. The transaction is likely to meet the criteria for comprehensive review, as outlined in OAR 409-070-0060 and ORS 415.501;
4. The transaction is not likely to substantially alter the delivery of health care in Oregon; or
5. Comprehensive review of the transaction is not warranted given the size and effects of the transaction.

Assessing the Potential for Adverse Impacts

This section details the circumstances under which OHA would conclude that the transaction may have an adverse impact on each of the domains of cost, access, equity, and quality. These domains are further described in HCMO's analytic framework.

Cost Domain

A transaction may have an adverse impact on 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 1,800 or higher.
- An increase in market concentration, as measured by the HHI, of 100 points or more such that the post-transaction market share of the merged firm exceeds 30%.
- 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.

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 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 have an adverse impact on 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 people 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 ("Notice") 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 on 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 on 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 in 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.

Confidential Information

Importance of Transparency

Transparency is an important objective of the HCMO program. By making information about proposed transactions public, HCMO informs communities about planned transactions before they happen and provides communities with the opportunity to offer input on how the transaction may impact them. Comments from members of the public are critical to informing OHA's review of proposed material change transactions.

Submitting Confidential Information to OHA

Pursuant to OAR 409-070-0070, an applicant may designate documents submitted in support of the Notice as confidential. In doing so, an applicant must follow the requirements of OAR 409-070-0070 and in the HCMO Technical Submission Specifications guidance. Specifically, an applicant must submit:

1. A full unredacted version of the document marked as "CONFIDENTIAL;"
2. A redacted version of the document (from which the confidential portions have been removed or obscured) marked as "PUBLIC" which will be made available to the public; and
3. A redaction log that provides a reasonably detailed statement of the grounds on which confidentiality is claimed, citing the applicable statutory basis for confidentiality of each portion.
4. OHA, in collaboration with the Oregon Department of Justice (ODOJ), will review claims of confidentiality. OHA may require additional information from an entity to justify their claims of confidentiality. Entities must timely respond to all inquiries and request for additional information. Failure to adequately justify grounds for confidentiality and timely respond to correspondence from OHA or ODOJ related to the claim of confidentiality may result in a denial of OHA accepting such confidentiality claims. In the event of such an occurrence, OHA will provide a minimum of five business days advance notification to the entities prior to the public release.

Confidential materials provided by an applicant in connection with a transaction that is subject to review by both OHA and the DCBS will be maintained as confidential materials in accordance with ORS 415.501(13)(c) and ORS 705.137.

Additional Information Requested by OHA

After receiving the Notice and during the review period, OHA may request additional information from an entity that is party to the material change transaction. Pursuant to ORS 415.501(13)(a), an applicant may not refuse to provide documents or other information on the grounds that the information is confidential. An applicant must follow the requirements of OAR 409-070-0070 when designating additional information and/or

documents submitted to OHA as confidential.

OHA's Use of Confidential Information

HCMO Reporting

If the HCMO program determines that certain confidential information is important to support OHA's decisions related to the transaction, OHA may seek consent from the person who provided the information or document to use specific statements or information from the confidential materials in HCMO reporting pursuant to ORS 415.501(13)(c). In such cases, HCMO will contact the individual via email prior to publication of any public reports, specifying the information or statements it is requesting to include in HCMO reporting.

Public Disclosure

An applicant's submission that complies with the requirements of OAR 409-070-0070 and is considered to be confidential will be maintained as confidential materials and will not be disclosed to any person without the consent of the person who provided such information pursuant to ORS 415.501(13)(c). Information protected under ORS 415.501(13)(c) is exempt from disclosure under ORS 192.311 to 192.478.

Interpretation of the Oregon Public Records Law, as determined by OHA upon advice of the ODOJ, shall determine if the confidential information claimed to be exempt under ORS 192.311 to 192.478 is in fact exempt from disclosure. OHA will not be liable to applicant or any other person for release of information applicant claims to be confidential under ORS 192.311 to 192.478 if determined not to be exempt.

Defining Essential Services & Significant Reduction

Effective July 2024

For guidance effective March 1, 2027, refer to "Essential Services and Significant Reduction."

The Health Care Market Oversight (HCMO) program ensures 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) reviews proposed material change transactions and monitors health care markets. For more information, visit the program website.

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This guidance outlines what services are considered "essential to achieve health equity" and what is considered a "significant reduction" of essential services.

Introduction

OAR 409-070-0010 outlines transactions that are subject to HCMO review. This guidance solely addresses the following types of proposed transactions ("relevant transactions"):

- A transaction to form a new contract, new clinical affiliation or new contracting affiliation between or among health care entities that will eliminate or significantly reduce essential services; and
- A transaction to form a new partnership, joint venture, accountable care organization, parent organization or management services organization between or among health care entities that will eliminate or significantly reduce essential services.

For information about other types of transactions subject to HCMO review, please consult OAR 409-010-0010.

Purpose of the Technical Advisory Group

To develop this guidance, OHA sought input from a Technical Advisory Group in January 2022. 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 can determine if a transaction will *significantly* reduce essential services.

ORS 415.500 defines essential services as services that are funded on OHA's prioritized list and "services that are essential to achieve health equity". All services funded on OHA's prioritized list are considered "essential services" for purposes of HCMO oversight.

OHA's prioritized list determines which services are covered by the Oregon Health Plan, based on clinical effectiveness and cost effectiveness. Examples of funded services include, but are not limited to, pregnancy, prevention services, substance use disorder, reproductive health services, diabetes, and many more. The prioritized list and what is funded on the list may change from time to time according to the Health Evidence Review Committee.

Whether a service meets the definition of "essential" will, in some cases, be a deciding factor for whether an entity must submit a notice of material change transaction.

Definition of Services that are Essential to Achieve Health Equity

OAR 409-070-0005 defines "health equity" as:

> a health system having and offering infrastructure, facilities, services, geographic coverage, affordability and all other relevant features, conditions and capabilities that will provide all people with the opportunity and reasonable expectation that they can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or their socially determined circumstances.

Many of the services currently funded on the prioritized list are also essential to achieve health equity.

The following section outlining *additional* services that are essential to achieve health equity applies only to operationalizing the HCMO program (i.e., for entities determining whether or not a material change transaction will be subject to review) and should not be misconstrued as the only services that are essential to achieve health equity.

Additional Services that are Essential to Achieve Health Equity

The additional services listed below are essential to achieve health equity for purposes of HCMO oversight.

1. **Any service directly related to the treatment of a chronic condition**. The term chronic condition is defined as:
    a. a condition that lasts one year or more and

b. requires ongoing medical attention or limits activities of daily living or both.[2] "Directly related to" means services that are intended to treat the condition or the symptoms of that condition.

2. **Pregnancy-related services**. Most pregnancy-related services are funded on the prioritized list and are therefore already essential. Any other pregnancy-related service is also considered essential.
3. **Prevention services, including non-clinical services**. 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).
4. **Health care system navigation and care coordination services**. 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.

Definition of Significant Reduction of Essential Services

Per OAR 409-070-0010, a significant reduction of essential services occurs when the transaction will result in a change of one-third or more of any of the following:

- 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 reduction in the number of providers, including the number of culturally competent providers, health care interpreters, or traditional healthcare workers, or a reduction in the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program;
- A reduction in the number of providers serving new patients, providers serving individuals who are uninsured, or providers serving individuals who are underinsured;
- Any restrictions on providers regarding rendering, discussing, or referring for any essential services;
- A decrease in the availability of essential services or the range of available essential services;
- An increase in appointment wait times for essential services;
- An increase in any barriers for community members seeking care, such as new

[2] 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.

prior authorization processes or required consultations before receiving essential services; or

- 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.

The following sections provide further analysis on this definition of significant reduction of essential services, and outlines how entities can:

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

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 OAR 409-070-0010(3) changing by one-third or more. Table 1 details changes that are considered a significant reduction.

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

OAR 409-070-0010(3) Language	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 following is considered a significant reduction: • the median time or distance travelled for existing patients. • 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 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

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
	a public transportation access point and does not apply to entities that are more than 10 miles away from a public transportation access point.	minutes. This is considered significant.
(b) A reduction in the number of providers, including the number of culturally competent providers[3], health care interpreters, or traditional healthcare workers, or a reduction in the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program.	A transaction that would result in a decrease of one-third or more of the following is considered a significant reduction: • trained culturally competent providers, health care interpreters, or traditional healthcare workers. • the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program.	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.
(c) A reduction in the number of providers serving new patients, providers serving individuals who are uninsured, or providers serving	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.	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

[3] 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

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
individuals who are underinsured. [4]	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.	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 subsequently hire other specialists. The number of essential services related to cardiology has

[4] 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.

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
		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

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
		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 ORS 415.500 does not require 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 or elimination of an insurer's coverage of essential services as a result of the transaction increases out-of-pocket spending for consumers and raises 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 apply (e.g., increasing time or distance to services, decreasing number of providers of services, etc.).

Timing of Reductions of Essential Services

ORS 415.501 requires entities to submit a notice of material change transaction when a covered transaction will result in a significant reduction or elimination of essential services. Entities should 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. Reductions that are both unforeseen and uncontrollable by the entity shall not be considered changes that were a result of a transaction. (Examples may include, but are not limited to, pandemic disruptions of health care services or provider turnover.)

The purpose of this twelve-month timeline is to provide specificity for entities as they determine if a transaction is subject to review under HCMO. 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. 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.

Statutory and Administrative Rule Guidance

Statutes

ORS 415.500(2)

(2) “Essential services” means:

(a) Services that are funded on the prioritized list described in ORS 414.690; and

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

Administrative Rules

OAR 409-070-0010. Covered Transactions *(Prior to July 2026 Rulemaking)*

(3) A significant reduction of services occurs when the transaction will result in a change of one-third or more of any of the following:

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

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

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

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

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

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

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

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

Emergency Exemptions

Transactions that Qualify for an Emergency Exemption

The HCMO program is required by statute to make rules about when an entity would qualify for an emergency exemption from HCMO review and what steps an entity must take to apply for one.

There are two conditions that must be met for a transaction to qualify for an emergency exemption:

- First, there must be an emergency situation that threatens health care services. Examples of this are a public health emergency (such as the COVID-19 pandemic) and when a health care entity like a clinic or hospital is on the verge of closing and going out of business.
- Second, the proposed transaction must be urgently needed to protect consumers' or patients' interests and to preserve the solvency of an entity. For example, a proposed transaction may prevent a health care entity like a clinic or hospital from going out of business, and the continuation of the clinic's or hospital's services is in consumers' interest.

An entity must be in significant financial distress and on the brink of closing in order to meet the HCMO criteria. Generally, in determining whether an emergency exemption should be granted the HCMO program will prioritize the availability of health care services for a community.

Applying for an emergency exemption

Complete the HCMO-2: Request for Emergency Exemption from Material Change Transaction Review (request) form and submit the request to HCMO. See below for next steps.

1. **If the request is submitted to HCMO prior to filing a Notice with HCMO**

   After this request is filed, the HCMO program will publish the request on the program website and provide a period for public comment unless the HCMO program determines that either the need for confidentiality of the entity outweighs the public interest or the nature and urgency of the emergency does not allow time for public comment. If the HCMO program determines that it will post the request, HCMO program staff must provide the entity with at least three (3) business days' advance notice before posting the request to the program website.

   If the HCMO program does decide to maintain the request as confidential, the HCMO program will publish the entity names and the type of the covered transaction on the program website at least 6 months after the transaction closes or immediately after an entity involved in the transaction discloses the nature of the emergency to the public, or the nature of the emergency is publicly known.

2. **If the request is submitted while HCMO Is already reviewing a submitted Notice**

   At any point during a preliminary or comprehensive review the entity can submit a request if there is an emergency situation that immediately threatens health care services, and the proposed transaction is urgently needed to protect the interest of the consumers and to preserve the solvency of the entity. Once a request is submitted, the remaining time period for preliminary or comprehensive will automatically pause while the HCMO program reviews the request.

   Since the HCMO program is already reviewing the transaction and the public is already aware of the transaction, HCMO will publish the request on the program website. The HCMO program will provide a period for public comment on the request unless the urgency of the need for the emergency exemption will not allow time for public comments.

   If the request is denied during the course of an ongoing HCMO program review, the paused preliminary or comprehensive review will resume with the same remaining time period in existence prior to the request filing.

A transaction that receives an emergency exemption is not reviewed or approved

If the HCMO program grants an emergency exemption, the HCMO program does not review the proposed transaction. This means that the proposed transaction is not subject to HCMO program requirements, and the entity is not required to file a Notice with the HCMO program. As a result of exempting a transaction from HCMO program review, the HCMO program does not have the authority to impose conditions on the proposed transaction or conduct follow-up reviews.

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(16)(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(8).)

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) and OAR 409-070-0005(16). 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 Health Care 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.

This table below is not comprehensive, and additional entity types may also be subject to review.

Entity Type	Description	Primary function is a provision of health care items or services	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.		✓	
Ambulatory surgical center (ASC)	ASCs provide outpatient services to patients such as same-day procedures that do not require overnight stays in a hospital.	✓		
Any other entity that received net patient revenue from the provision of health care items	Health care items include but are not limited to items that have been prescribed by a health care provider or that are covered by insurance. See materiality standard for additional information.	✓		
Behavioral health provider	Behavioral health pertains to mental health, substance use, and problem gambling disorders and treatment services.	✓		
Durable Medical Equipment (DME) provider or supplier	Businesses that supply, distribute, and may service DME. DME includes equipment that is durable (withstands repeated use) and used for a medical	✓		

Entity Type	Description	Primary function is a provision of health care items or services	Closely related to an entity that provides health care	Control over an entity that provides health care
	reason.			
Chiropractic, acupuncture, and massage provider	Chiropractic, acupuncture, and massage providers are licensed professionals.	✓		
Eye care or prescription corrective eyewear provider	Health care professionals that provide services related to the eye or vision. Eye care providers include optometrists, ophthalmologists, and other vision care providers. Includes entities that provide prescription corrective eyewear.	✓		
Hospice and home health agencies	Hospice agencies provide services to individuals with life-limiting illness. Home health agencies provide medical services to patients in their home.	✓		
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.001(10) and 42 CFR 417.		✓	
Imaging or radiology facility	An imaging or radiology entity provides x-rays, ultrasounds, PET (positron emission tomography), MRI	✓		

Entity Type	Description	Primary function is a provision of health care items or services	Closely related to an entity that provides health care	Control over an entity that provides health care
	(magnetic resonance imaging), or other types of imaging or radiological services to patients.			
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.		✓	
Medical group	Two or more physician practices are organized as a single legal entity (e.g., partnership, professional corporation, or other association), as defined in 42 CFR 417.	✓		
Medical Laboratory	Medical laboratories perform examinations on materials derived from the human body for the purpose of diagnosis, prevention of disease or treatment of patients by physicians, dentists and other persons who are authorized by license to diagnose or treat individuals.	✓		
Medical spa	An entity that provides medical treatments of a health-related condition. Medical treatments are often non-invasive, cosmetic, and under the supervision by	✓		

Entity Type	Description	Primary function is a provision of health care items or services	Closely related to an entity that provides health care	Control over an entity that provides health care
	licensed medical professionals.			
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.	✓		
Pharmacy	Pharmacies dispense and sell prescription drugs. Includes mail-order pharmacies.	✓		
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.		✓	
Physician group or practice	Two or more physicians are organized as a single legal entity.	✓		
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.			✓
Telehealth or virtual health care provider entity	Telehealth (also known as telemedicine) providers offer medical and/or behavioral health care services to patients through	✓		

Entity Type	Description	Primary function is a provision of health care items or services	Closely related to an entity that provides health care	Control over an entity that provides health care
	telecommunications such as phones or real-time video communication.			
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.		✓	
Urgent care center	Urgent care centers provide outpatient services to patients with an acute, but not life-threatening health care need.	✓		

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

Furnishing Final Definitive Agreements

Under ORS 415.501, entities are required to submit a Notice at least 180 days prior to the date of the transaction. Per OAR 409-070-0045, the Notice 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 as detailed below.

Timeline for Furnishing Final Definitive Agreements

Upon submitting a Notice, entities may either provide final executed copies of all definitive agreements with the Notice or provide a term sheet. If the filing entity provides a term sheet as part of the Notice, 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 providing these documents to OHA depend on the stage of OHA's review and the transaction approval status. If an entity provides a term sheet with the Notice, the final definitive agreements are due:

- No later than 15 days prior to closing if the transaction is approved or approved with conditions after a preliminary review
- 15 days after notice of comprehensive review

Follow-up Reviews

This guidance describes OHA's approach to conducting follow-up reviews.

What is a follow-up review?

ORS 415.501(19) directs OHA to conduct follow-up reviews for one, two, and five years following an approved transaction. Follow-up reviews must analyze:

- The health care entities' compliance with conditions placed on the transaction, if any;
- The cost trends and cost growth trends of the parties to the transaction; and
- The impact of the transaction on the health care cost growth target established under ORS 442.386.

This is not an exhaustive list. In conducting follow-up reviews, OHA may also analyze compliance with commitments made by the entities during the review and post-transaction changes in outcomes or areas of concern identified in the preliminary or comprehensive review.

Follow-up review process

Notification

HCMO staff will notify entities about initiating the review one year, two, and five years after the close of the transaction.

When starting a follow-up review, OHA will post information to its website. OHA accepts public comments throughout follow-up review period.

Requests for information

Pursuant to OAR 409-070-0080, 409-070-0082, and 409-070-0085, OHA may require the entities to provide additional information, reports, analyses and documentation as OHA requires to complete its follow up review. Entities are required to comply with requests for information pursuant to ORS 415.501(13) and OAR 409-070-0085. Failure to comply with OHA requests may result in OHA seeking all remedies available under law, including civil penalties .

Entities may designate information confidential in accordance with OAR 409-070-0070 and OHA will maintain information that is confidential in accordance with ORS 705.137 and ORS 415.013. For more information about OHA's handling of confidential information, please see HCMO Use of Confidential Information. OHA will post publicly shareable submissions for follow-up reviews to the HCMO website.

Analysis and reporting

OHA's follow-up analyses may include, but are not limited to, the following areas:

- Assessing compliance with any approval conditions

- Understanding changes that have occurred since the transaction and the impact of those changes on quality of care, access to care, and health equity
- Analyzing post-transaction changes in outcomes for any areas of concern identified in the initial or subsequent follow-up reviews

OHA's ability to analyze the factors listed above may vary depending on data availability, including reporting lag in data systems. As such, Year 1 and Year 2 reviews will largely focus on changes since the transaction and compliance with conditions, while Year 5 reviews are more likely to include analyses of impacts and outcomes.

After completing the follow-up review analysis, OHA will publish its findings in various reports. All reports will be posted to the HCMO website.

If entities are out of compliance with conditions, OHA may seek any and all available remedies under law.

Materiality Standard

For a transaction to be subject to review, it must meet certain revenue-based materiality requirements.

Revenue Thresholds

A material change transaction is subject to review if:

- At least one party to the transaction had average annual revenue of $25 million or more in the party's three most recent fiscal years; and
- Another party to the transaction:
    - Had average annual revenue of $10 million or more in that party's three most recent three fiscal years; or
    - If such party is a newly organized legal entity, is projected to have at least $10 million in revenue over its first full year of operation at normal levels of utilization or operation.

OHA looks at an entity's nationwide revenue—not solely Oregon revenue—when determining if the revenue threshold for materiality has been met. Please refer to the out-of-state entity guidance for situations where an entity serves a very small number of Oregon residents.

Revenue Definition

Under ORS 415.500(9), "Revenue" is defined as "(a) Net patient revenue; or (b) The gross amount of premiums received by a health care entity that are derived from health benefit plans."

Net patient revenue is revenue received in exchange for the provision of health care items or services to patients. Net patient revenue includes revenues from any source, including but not limited to, insurer reimbursements, patient paid amounts, including self-pay, and pass-through revenues derived on a per member, census, claims, or other utilization basis.

Party to the Transaction

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

Out-of-State Entities

The HCMO program reviews many different types of transactions involving many different types of entities. Other sections in the guidance document describe what types of transactions and entities are subject to HCMO review.

Pursuant to ORS 415.500(6)(a)(B), if a transaction involves a health care entity in Oregon and an out-of-state entity, a transaction that otherwise qualifies as a material change transaction is subject to review by the HCMO program if it may:

- result in increases in the price of health care, or
- limit access to health care services in this state.

Pursuant to OAR 409-070-0015(2), an entity is considered in-state for purposes of HCMO review if it:

- is based or domiciled in Oregon,
- owns or operates business locations in Oregon,
- is registered with the Oregon Secretary of State to conduct business in Oregon,
- is engaged in profit-seeking activity in Oregon, (e.g., a mail-order pharmacy that provides services in Oregon), or
- provides health care services to residents of Oregon.

There may be instances in which a foreign entity provides services to only a small number of Oregon residents. In this instance, the HCMO program considers the following in determining whether a foreign entity is considered "out-of-state":

a) The foreign entity must have served **no more than 100 Oregon residents** annually for each of the previous three fiscal years; or

b) The foreign entity is a health care insurer, the proposed transaction involves only health care insurers, and the combined market share held by the health care insurer immediately after the completion of the proposed transaction does not exceed five percent of the total market share in any market.

If seeking a Determination of Covered Transaction Status for a transaction involving an out-of-state health care insurer, entities may submit to OHA their Form E exemption filed with the Oregon Department of Consumer and Business Services if applicable.

If a foreign entity is deemed "out-of-state" under bullet a) or b) above, HCMO then determines whether the proposed material change transaction may either result in increases in the price of health care or limit access to health care services in this state. This analysis is covered in the "Potential Effects of the Transaction" section below.

Potential Effects of the Transaction

ORS 415.500(6)(a)(B) states that a transaction is subject to HCMO review if the transaction involves an out-of-state entity and "may result in increases in the price of health care or limit access to health care services" in Oregon."

Any type of consolidation, including horizontal, vertical, and cross-market consolidation as described below may increase the price of health care services.

- Horizontal consolidation occurs when two entities that provide the same type of services in the same geographic area merge, such as one hospital buying another hospital within the same metropolitan area.
- Vertical consolidation occurs when two entities that provide different (but related) types of services merges, such as a hospital buying a physician group.
- Cross-market consolidation occurs when two entities providing similar services in different geographic areas combine, including entities that operate in different states.

Further, any type of change in ownership has the potential to limit access to health care services **unless** the transaction is structured so as to preclude any changes in decision-making authority pertaining to access to health care services in Oregon, including the types of services available, staffing of services, contracting with payers, and any other matters that have the potential to change access to health care services for people in Oregon.

Outside Advisors

This guidance 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 deems a Notice, a preliminary review must be completed within 30 days, unless extended by agreement between OHA and the entities pursuant to OAR 409-070-0055(4) or tolled pursuant to 409-070-0085. If the proposed transaction does not meet the criteria for approval within the preliminary review time period, OHA will complete a comprehensive review pursuant to OAR 409-070-0060.

Per ORS 415.501(14), OHA may engage outside advisors to support material change transactions and parties to the transaction shall bear the cost of retaining outside advisors. The table below describes some examples of when OHA may engage outside advisors to support material change transaction reviews.

Reason to 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). The review requires specific subject matter expertise that OHA staff do not possess.
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 are 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 HCMO team is related to an employee of a transaction entity). See ODHS/ OHA Conflict of Interest policy for more information.

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
- Accounting services
- Claims analytics
- Health care management expertise
- Community engagement and facilitation expertise
- Academic expertise
- Regulatory experts

The ODOJ 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 ODOJ to advise state agencies).

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. For more information about HCMO’s handling of confidential information, please see HCMO Use of Confidential Information.

To avoid conflicts of interest and delays to transaction review, parties to a transaction should not engage any of OHA’s contracted 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 contracted outside advisors for technical or other assistance with a material change transaction.

Public Comments

Use of public comments

The HCMO program aims to ensure that material change transaction reviews are transparent, robust, and informed by the public, including the local community, through meaningful engagement. Public comments are an important way for HCMO program staff to engage with communities and learn from the public about transactions under HCMO review.

Public comment provides an opportunity for anyone to share thoughts and opinions about a specific topic with HCMO staff. Anyone can make a public comment. HCMO staff use public comments to inform transaction reviews, identify emerging issues, and understand potential impacts of a transaction on people and communities in Oregon. While HCMO staff consider the volume of public comments as an indicator of public interest, public comments are not considered to be “votes” in favor of or opposed to a transaction. OHA’s decision about whether to approve, approve with conditions, or disapprove a transaction is not determined by tallying the number of public comments in either direction.

OHA posts public comments to its program website and may include comments in HCMO reports and publications. Public comments that are related to a transaction will be posted on transaction-specific web pages. Generally, HCMO staff compile transaction-specific public comments into a single document to allow for easy access to all comments. HCMO staff may post some comments separately if they are lengthy or provided as separate documents.

OHA accepts public comments as they are. HCMO staff will not attempt to correct or address inaccurate statements in public comments. In general, HCMO staff do not respond to public comments beyond confirming receipt, though staff may answer clarifying or process questions.

When does HCMO accept public comments?

Anyone can submit a public comment to HCMO about any transaction, or anything HCMO-related at any time. At a minimum, for transaction reviews HCMO posts public comment periods to its website. HCMO program staff may also publicize public comment periods via its distribution list or other email lists, announcements in OHA newsletters, posts to OHA’s social media, or announcements to local media outlets.

Preliminary and follow-up reviews

For preliminary and follow-up reviews, the HCMO program accepts public comments throughout the duration of the review. The HCMO program may designate a public comment period, which is generally a minimum of two weeks for preliminary reviews. This purpose of the public comment period is to allow enough time for HCMO staff to consider public comments and include them, as relevant, into analyses, information requests for entities, and publications before issuing a decision. In accordance with OAR 409-070-

0055, HCMO will accept and publish comments received outside of the comment period but cannot guarantee that all comments received outside of the comment period will be considered during a transaction review.

Comprehensive reviews

For comprehensive reviews, the HCMO program accepts public comments throughout the duration of the review. Unless otherwise directed by OHA, once OHA issues its proposed findings of fact and conclusions of law after a comprehensive review, the HCMO program will provide the entities and the public up to 30 calendar days to submit written exceptions to the proposed order. Initiation of the written exception period will be posted to the HCMO website, and HCMO staff will promptly post any written exceptions received related to the proposed findings of fact and conclusions of law. Pursuant to ORS 415.501(18), OHA will consider written exceptions before issuing a final order setting forth its findings and conclusions.

Emergency exemptions

Emergency exemptions may be granted if there is an emergency situation that immediately threatens health care services or a transaction is urgently needed to protect the interest of consumers and the solvency of an entity. For more information, please see HCMO's Emergency Exemption guidance. OAR 409-070-0022 allows the HCMO program to solicit public comment for Emergency Exemptions filings after providing an applicant with three (3) days' notice before opening the public comment period. The HCMO program will hold a public comment period for emergency exemption filings unless OHA determines either of the following applies, per OAR 409-070-0022(4):

- The need to maintain confidentiality outweighs the public interest in providing comments.
- The nature and urgency of the emergency will not allow time for the filing and consideration of public comment.

Public comments received outside of review periods

The HCMO program may accept and post public comments about any transaction at any time, including comments received before a review starts. During reviews, HCMO staff may consider input from all public comments received to date, including those received outside of review periods.

Submitting public comments

To submit a public comment to the HCMO program, anyone may:

- Email hcmo.info@oha.oregon.gov
- Leave a voicemail at 503-945-6161
- Fill out the public comment form
- Provide verbal or written comments at a HCMO listening session, public hearing, or other public meeting during the public comment time

Commenters should not include sensitive or personal information that they do not want shared publicly. OHA cannot guarantee the anonymity of any public commenter. OHA may remove portions of public comments that contain threatening or inappropriate language prior to posting.

Commenters who wish to submit a comment to OHA to report any actions they believe may violate local, state, or federal laws, and are fearful of retaliation for reporting such information to OHA, should not provide a public comment and instead should leave a voicemail at 503-945-6161 or email hcmo.info@oha.oregon.gov. Such commenters should immediately notify OHA of such concerns at the onset of such communication.

Sharing verbal comments at a public meeting

When sharing verbal comments during a public meeting, please consider the following:

- Wait for the host to call your name to share a comment.
- Once you are called on, please speak clearly and state your name, where you live (city or county), any organization or group you represent, and any affiliation with the matter at hand, if applicable (for example, if you are a board member of a company involved that is party to a transaction under HCMO review).
- In public meetings, you will generally have a set amount of time to provide your comments, such as three minutes. The meeting host or facilitator will indicate time is up; please conclude your comments when your time ends.
- If you have materials that you would like to share with your comment, please send those in advance of your comments or after you are done. OHA does not permit commenters to share their screens to visually present such materials. If requested, OHA will publicly post such materials on its program website.
- Do not engage in disruptive, threatening, disparaging, or otherwise uncivil behavior. The meeting host will limit or end the comments of any person who engages in such misconduct.

Safe Harbor and Exempted Transactions

This guidance presents transactions that are not subject to review due to safe-harbor protection or because the authorizing statute or final rules specifically exempt the transaction from review. This guidance also lists examples of transactions that are not subject to review.

Excluded Transactions Due to Safe-Harbor Status

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.

The Oregon Health Authority may add to the list of excluded transactions due to safe-harbor status and re-post on the program website at any time.

Excluded Transactions in Accordance with Statute & Rule

The Oregon Revised Statute (ORS) 415.500 and Oregon Administrative Rule (OAR) 409-070-0020 specifies transactions that are not subject to review under the HCMO 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, as outlined on OAR 409-070-0025, does not result in the acquisition of control of the entity by any person not previously affiliated with the entity, and does not involve an agreement between the health care entity and another person that otherwise constitutes a covered transaction and is not excluded from review under OAR 409-070-0020(1)(a), (b), (d), or (g).

Examples of transactions that are not subject to review

Transactions subject to HCMO review are defined in OAR 409-070-0010. All of the examples below are transactions that do not meet the HCMO program criteria and are not subject to review. For illustrative purposes, all examples below are assumed to meet the entity revenue thresholds outlined in ORS 415.501(6). The table below shows both the details of the transaction example and an explanation as to why it is not subject to review by the HCMO program.

Examples of Transactions Not Subject to 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 CCOs, control is not rebuttably presumed until 25% of voting shares have 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.	The two insurers are not jointly 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	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.

Examples of Transactions Not Subject to Review	Explanation
access to medical group to access common patients for care purposes	
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 of a specific housing initiative	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.
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	No change of control. No reduction of essential services. No consolidation of providers when contracting payment rates with payers.

Examples of Transactions Not Subject to Review	Explanation
providers when contracting payments 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.

Violations and Civil Penalties

Pursuant to ORS 415.900, OHA may assess civil penalties for violations of HCMO requirements.

Civil Penalty Amounts

For each separate violation of OAR 409-070-0010, 409-070-0015, 409-070-0080 or 409-070-0082, OHA may issue a civil penalty up to $10,000.

OHA will determine if the entity has made documented efforts to comply with these rules and considers civil penalties to be a mitigating factor.

The procedure for civil penalties will be followed according to ORS 183.745.

Essential Services and Significant Reduction

(Effective March 1, 2027)

This guidance outlines what services are considered "essential to achieve health equity" and what is considered a "significant reduction" of essential services. This guidance will go into effect on March 1, 2027 per OAR 409-010-0010.

OAR 409-070-0010 outlines transactions that are subject to HCMO review. This guidance solely addresses the following types of proposed transactions ("relevant transactions"):

- A transaction to form a new contract, new clinical affiliation or new contracting affiliation between or among health care entities that will eliminate or significantly reduce essential services; and
- A transaction to form a new partnership, joint venture, accountable care organization, parent organization or management services organization between or among health care entities that will eliminate or significantly reduce essential services.

For information about other types of transactions subject to HCMO review, please consult OAR 409-010-0010.

Technical Advisory Group

To develop this guidance, OHA sought input from a Technical Advisory Group in January 2022. The purpose of the TAG was two-fold:

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

ORS 415.500 defines essential services as services that are funded on OHA's prioritized list and "services that are essential to achieve health equity". All services funded on OHA's prioritized list are considered "essential services" for purposes of HCMO oversight.

OHA's prioritized list determines which services are covered by the Oregon Health Plan, based on clinical effectiveness and cost effectiveness. Examples of funded services include, but are not limited to, pregnancy, prevention services, substance use disorder, reproductive health services, diabetes, and many more. The prioritized list and what is funded on the list may change from time to time according to the Health Evidence Review Committee.

Whether a service meets the definition of "essential" will, in some cases, be a deciding factor for whether an entity must submit a Notice.

Definition of Services that are Essential to Achieve Health Equity

OAR 409-070-0005 defines "health equity" as:

> a health system that provides all people with the ability to reach their full health potential and well-being and ensure that people are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or their socially determined circumstances.

Many of the services currently funded on the prioritized list are also essential to achieve health equity.

The following section outlining *additional* services that are essential to achieve health equity applies only to operationalizing the HCMO program (i.e., for entities determining whether or not a material change transaction will be subject to review) and should not be misconstrued as the only services that are essential to achieve health equity.

Additional Services that are Essential to Achieve Health Equity

The additional services listed below are essential to achieve health equity for purposes of HCMO oversight.

5. **Any service directly related to the treatment of a chronic condition**. The term chronic condition is defined as:
    a. a condition that lasts one year or more and
    b. requires ongoing medical attention or limits activities of daily living or both.[5]

    "Directly related to" means services that are intended to treat the condition or the symptoms of that condition.
6. **Pregnancy-related services**. Most pregnancy-related services are funded on the prioritized list and are therefore already essential. Any other pregnancy-related service is also considered essential.
7. **Prevention services, including non-clinical services**. 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).
8. **Health care system navigation and care coordination services**. Many of these services are funded on the prioritized list and are therefore already essential. Health

[5] 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.

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.

Definition of Significant Reduction of Essential Services

Per OAR 409-070-0010, a significant reduction of essential services occurs when the transaction will result in a change of one-third or more of any of the following:

- 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 reduction in the number of providers, including the number of culturally competent providers, health care interpreters, or traditional healthcare workers, or a reduction in the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program;
- A reduction in the number of providers serving new patients, providers serving individuals who are uninsured, or providers serving individuals who are underinsured;
- Any restrictions on providers regarding rendering, discussing, or referring for any essential services;
- A decrease in the availability of essential services or the range of available essential services;
- An increase in appointment wait times for essential services;
- An increase in any barriers for community members seeking care, such as new prior authorization processes or required consultations before receiving essential services; or
- 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.

The following sections provide further analysis on this definition of significant reduction of essential services, and outlines how entities can:

3. Determine if a proposed transaction will result in a reduction of an essential service, as defined above, and
4. Determine if that reduction is “significant.”

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 OAR 409-070-0010(3) changing by one-third or more. Table 1 details changes that are considered a significant reduction.

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

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
(i) 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 following is considered a significant reduction: • the median time or distance travelled for existing patients. • 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.
(j) A reduction in the number of providers, including the number of culturally competent providers[6], health care	A transaction that would result in a decrease of one-third or more of the following is considered a significant reduction:	A proposed merger of two large clinics would result in one clinic reducing the number of traditional health workers from 20 to

[6] 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

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
interpreters, or traditional healthcare workers, or a reduction in the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program.	• trained culturally competent providers, health care interpreters, or traditional healthcare workers. • the number of clinical experiences or training opportunities for individuals enrolled in a professional clinical education program.	13. These traditional health workers provide health system navigation and care coordination services. This reduction is more than one-third and is considered significant.
(k) A reduction in the number of providers serving new patients, providers serving individuals who are uninsured, or providers serving individuals who are underinsured. [7]	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.
(l) 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.
(m)A decrease in the availability of essential	A transaction that would result in any decrease of	A health system proposes to acquire a multi-specialty

[7] For the purposes of the HCMO 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.

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
services or the range of available essential services	one-third or more of essential services due to the lack of availability is considered a significant reduction.	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 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.
(n) 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 acquiring 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.
(o) An increase in any barriers for community members seeking care, such as new prior authorization processes or required consultations before receiving	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,	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

OAR 409-070-0010(3) Language	Determining "significant reduction"	Example
essential services	required consultations or delays.	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.
(p) 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 ORS 415.500 does not require 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 or elimination of an insurer's coverage of essential services as a result of the transaction increases out-of-pocket spending for consumers and raises concerns about access and equity. In this case, the transaction would be subject to review, and a Notice 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 apply (e.g., increasing time or distance to services, decreasing number of providers of services, etc.).

Timing of Reductions of Essential Services

ORS 415.501 requires entities to submit a Notice when a covered transaction will result in a significant reduction or elimination of essential services. Entities should 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. Reductions that are both unforeseen and uncontrollable by the entity shall not be considered changes that were a result of a transaction. (Examples may include, but are not limited to, pandemic disruptions of health care services or provider turnover.)

The purpose of this twelve-month timeline is to provide specificity for entities as they determine if a transaction is subject to review under HCMO. 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 Rubric

Example A

Two large multi-specialty clinics are discussing a new clinical affiliation between the two entities. 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.