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Date: November 24, 2021

To: Health Care Market Oversight Program, *submitted electronically to:* hcmo.info@dhsoha.state.or.us

From: Dr. Micah Thorp, VP, Kaiser Permanente Northwest
Rebecca Williams, VP, CFO, Kaiser Foundation Health Plan of the Northwest

RE: House Bill 2362 Rules Advisory Committee

Kaiser Permanente (KP) appreciates the opportunity to provide additional feedback regarding the draft rules intended to implement HB 2362 following the rules advisory committee meetings that took place on October 25, 2021, November 4, 2021, and November 15, 2021. KP exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. As payers, providers, and the State work together to contain growth in the total cost of care we respectfully ask the Authority to ensure that everyday transactions necessary to provide health care and coverage are not subjected to additional administrative costs or burden and that innovative or charitable relationships designed to reduce costs and expand access are not impeded or discouraged. We appreciate your consideration and look forward to continued collaboration. Our detailed feedback is outlined below.

OAR 409-070-0005 Definitions

KP appreciates the amendments made to the definitions section in the most recent version of the draft rules[1]. We find that these changes provide additional clarity and accurately reflect legislative intent.

OAR 409-070-0010 Material Change Transactions: Covered Transactions

The most recent version of the draft rules[2] takes a different approach to describing covered transactions and provides that transactions involving a health care entity that forms a corporate affiliation, new partnership, joint venture, accountable care organization, parent organization, management services organization, or new contracts, new clinical affiliations, or new contracting affiliations are covered transactions if they meet one or more of the following elements: eliminate or significantly reduce essential services; change control of an entity; significantly increase market concentration among health care providers when contracting with payers, insurers, or coordinated care organizations; or significantly increase market concentration among insurers when establishing health benefit premiums.

We appreciate the Authority's efforts to provide a clear and workable framework, however, we are concerned that this new approach is broader than statutory language and intent, introduces additional ambiguity and may unnecessarily subject everyday transactions to a burdensome and expensive review process.

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[1] Health Care Market Oversight Program Draft Rules for the Rules Advisory Committee meetings (November 10, 2021) https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Draft-Rules-11.10.21-redline.pdf

[2] *Id*

New contracts, new clinical affiliations, and new contracting affiliations
We recommend that OAR 409-070-0010 (1) be amended to specify that new contracts, new clinical affiliations, and new contracting affiliations are only covered transactions if they directly result in the elimination or a significant reduction in essential services. This change is necessary to align with statutory authority and legislative intent. HB 2362, Section 1(10)(c) provides that new contracts, new clinical affiliations and new contracting affiliations are covered transactions only if they eliminate or significantly reduce essential services. This language reflects the careful balance the legislature sought to achieve when determining which transactions will be subject to review and ensures that everyday transactions necessary to provide health care and coverage will not be subject to unnecessary administrative cost or delay.

Change in control; Significant increase in market concentration
We are concerned that the new framework introduces ambiguity by using new criteria with undefined terms and elements. For example, it is not clear in the rules when a change in control of an entity would be assumed to occur or how to determine if a significant increase in market concentration among insurers or health care providers has occurred. In the list of examples provided by OHA[3], an affiliation or contract between a medical group and an IPA to contract with a commercial payer with no change of control would be subject to review due to an increase in market concentration among health care providers when contracting with payers, insurers or CCOs. However, this analysis does not consider the number of providers or insurers available to contract in the service area and how the transaction impacts contracting overall in the market. Instead, it seems to assume that any transaction would be significant. We are concerned that this approach is overbroad and pulls everyday transactions into an administratively complex and expensive review process contrary to legislative intent. Additionally, we note that provider groups or facilities may need to combine or streamline operations in response to population fluctuations and variations. We recommend that OAR 409-070-0010 (1) (c) be amended to include objective criteria to define "change control of an entity" and "significantly increase market concentration" to clearly identify which transactions are subject to review. We believe that control arises when an entity holds at least 51% of decision-making authority and suggest this threshold as the rebuttable presumption. We recommend that the definition of "significant increase in market concentration" consider the availability of providers and or insurers in the entire service area relative to the population being served. We believe that a reduction of 30% or more in providers or insurers available to contract relative to the population served is a reasonable rebuttable presumption for determining whether a significant increase in market concentration has occurred.

Eliminate or significantly reduce
We appreciate that the Authority included guidance in this section regarding the term "eliminate or significantly reduce". However, we recommend the rules contain objective parameters to help health entities determine the impact the transaction and whether it will be subject to review under this process. For example, a threshold for increased time or distance for community members to access essential services should take into account availability of services and providers in the service area overall as well as the availability of telehealth. This will help ensure that the process is objective, consistent, and predictable.

Additionally, we recommend deleting -0010(2) (g) and (h). We believe (g) is subjective and difficult to quantify. We agree that it is important for providers and issuers to reduce barriers to care whenever possible, however, prior authorization is an everyday, highly regulated process used to ensure that services are safe and effective. We don't believe that the existence of a prior authorization requirement applicable to

[3] https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-examples.pdf

one of the health care entities should determine whether a transaction is included in this review process. Further, we find that -0010(2) (h) is duplicative and that a reduction in access to services or providers is covered in (a)-(f) above.

Alternatively, we recommend the following definition: eliminate or significantly reduce essential services means that access to a service within the service area of the entities, taken as a whole and among all service providers in the service area, would be reduced, as a direct result of the material change transaction, by more than 50% and the remaining service providers will not have the capacity to increase service provision sufficient to meet the current need for the service within the service area". This definition takes into account both the specific change and the net impact to the community. Reduction of services, especially those that may be duplicative and/or unnecessary to maintain, may in fact benefit the community by redirecting resources and/or reducing the total cost of care. For example, shifts in community demographics may require additional services/providers to serve a growing geriatric population with a reduction in pediatric services or providers due to a shrinking pediatric population.

Existing Entities, Contracts & Affiliations
We recommend that OAR 409-070-0010 clarify that a covered transaction between and among two or more health care entities or affiliates only qualifies as a material change if the health care entities or affiliates did not previously have common ownership or a contracting affiliation. This will make it clear that reorganization, inter-company agreements and changes in ownership distribution under the same controlling entity would not be subject to review. This aligns with the approach Washington State has adopted to provide clarity and ensure efficiency.

Community-based organizations (CBOs)
We recommend that OAR 409-070-0010 specify that transactions involving a health care entity and a community-based organization that will not eliminate or significantly reduce access to essential services are not covered transactions. This will ensure that partnerships with or investments to benefit community-based organizations are not discouraged or unduly delayed. We recommend referencing the definition of community-based organizations found in OAR 813-047-0005.

OAR 409-010-0020 Excluded Transactions
KP appreciates the amendments made to this section that clarify excluded transactions do not require any filing or application with the Authority. This is critical due to high volume of these types of transactions and aligns with statutory intent to exclude everyday transactions that will not impact equity, cost, quality or access.

OAR 409-070-0042 Optional Application for Determination of Covered Transaction Status
We appreciate the inclusion of an optional process that allows entities to request a determination of whether a transaction is covered from the Authority. This will provide entities with certainty as to whether a transaction would be subject to review prior to commencement and will be helpful as entities weigh the costs/benefits of a proposed transaction against the associated fees and timeline of the review process.

OAR 409-010-0045 Form and Contents of Notice of Material Change Transaction
We appreciate the amendment to this section that allows entities to include a term sheet with the application filing instead of executed agreements. However, entities are still required to file complete and final executed copies of all definitive agreements no later than 15 days before closing the transaction if approved without comprehensive review or 15 days after commencement of the comprehensive review period. We believe that these deadlines will still create significant administrative burden, especially if the agreements must be amended based on findings from the comprehensive review. We recommend that OAR 409-010-0045(4) be amended to permit entities to file executed agreements no later than 60 days after disposition of the material change transaction by the Authority.

Fee Schedule (Table 1)
We appreciate that the Authority provided the Fee schedule as part of the RAC process, however, we are concerned that the significant filing fees applicable to years 2023 and beyond may discourage collaboration and stifle innovation. We recommend that OHA maintain the 2022 fee schedule through 2024 and meet with stakeholders in the interim to discuss the program requirements and funding to inform any future changes.

Transaction Examples

KP appreciates the Transaction Examples document[4] that OHA compiled and find it to be a helpful reference; we encourage OHA to maintain the document as an appendix to the rules. We identified the following transactions that we think would be helpful to include:

- Hospital, provider groups and other health care entities forming joint committees to oversee coordination of care or business operations among common patient groups
- Hospital group contracts for shared call arrangements
- Contracts to lease networks among health insurers and health care entities
- Providers contracting as a group to purchase malpractice insurance
- Contracts between concierge practices and other non-health entities
- Time-share arrangements between entities pursuant to 42 C.F.R. § 411.357(y)
- Shared service agreements between providers in the same sub-specialty to support community needs across facilities when the providers are employed by separate entities

[4] https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-examples.pdf