Oregon's Health Care Market Oversight Program

HB 2362 Hearing Report

Summary of Written Comments received during the public comment period January 1 through January 24, 2022

In chronological order of receipt

Sabrina Riggs, Courtni Dresser, Jen Lewis-Goff, Kristine Phillips Evertz, Dan Cushing, Doug Riggs representing a coalition of health providers (Exhibit 1)

Comment 1: Concerns with high filing fees and uncapped legal/outside advisor costs.

Response: OHA lowered the filing fees from the initially proposed fee schedule. Because the authorizing statute directs OHA to fund the program based on filing fees, OHA crafted a fee schedule that will sustain the program. Secondly, OHA did not specify in rule any cap of legal or outside advisor costs. OHA will notify the filing entity if OHA or DOJ intend to use outside advisors and will provide to the filing entity invoices with reasonably detailed summaries. This is consistent with DCBS practices with respect to Form A submissions.

Comment 2: There remains a general concern about how the Authority intends to enforce the program if standards being developed through rulemaking are not clear at the outset of the program. Using language such as making referrals to the Department of Justice (see OAR 409-070-0030(2)) or building in language about filing false or misleading information (see OAR 409-070-0080(3)) sets a tone at the outset that this is potentially a civil and criminal sanctioning program rather than a health care community standard building program

Response: The authorizing statute specifies that the Director of OHA may impose a civil penalty, as determined by the director, for certain violations. The director may also apply to the Circuit Court for Marion County for an order enjoining a person who has committed a violation. The final rules provide additional information about this statutory authority. The rules on referrals to the Department of Justice and filing false or misleading information do not change prior law. Nor do these rules signal a view that OHA sees this program as aimed at civil and criminal sanctioning rather than health care community standard building.

Comment 3: Providers need clarity on the added conditions OHA may impose under 0065(1) apart from those referenced in Section 2(18) of the statute.

Response: The conditions that OHA may impose will be specific to a given transaction. As such, OHA is not able to compile a comprehensive list of the possible conditions it may impose.

Comment 4: (*OAR 409-070-0010 Covered Transactions)*
In general, we appreciate that this section has been narrowed from original drafts. Providers also appreciate forthcoming guidance documents related to measuring the potential reduction of essential services, but do want to note that the items listed in (3) are difficult or impossible for independent providers to measure. Additionally, there should be a clear threshold or clear flexibilities allowed for the different considerations. As one RAC member pointed out, if a clinic moves down the block, it may result in a slightly longer commute to some patients—even if the new location has the capacity for additional providers.

Response: The Essential Services & Significant Reduction Guidance document published January 31, 2022 outlines specific measurements that an entity can apply to a situation to determine if the reduction of essential services as a result of a transaction is subject to the notification requirement. Secondly, one frequent comment OHA heard during the Rules Advisory Committee meetings was the importance that the notification requirements be very clear and objective. Rules that were flexible or allowed for different considerations would not be clear and objective. As such, OHA opted to make the rules clear and objective.

Comment 5: (OAR 409-070-0020 Excluded Transactions) As stated in previous comments, we greatly appreciate the changes to this section, particularly the removal of the requirement to apply for all exclusions and the addition of (3).

Response: No response needed.

Comment 6: *(OAR 409-070-0022 Emergency Transactions)* As outlined in previous letters, we believe that these emergency exemptions should only be used in a true emergency, and as such, we feel that the information requested by the authority is too onerous, and that the potential for hearings and/or a public comment period is inappropriate and will dissolve public confidence unnecessarily (Section 4).

Response: OHA used the statutory language as the basis for developing the form to be used for emergency exemption requests.

Comment 7: *(OAR 409-070-0030 Requirement to File a Notice of Material Change Transaction)* We appreciate that the proposed structure is a sliding scale, but maintain that the sliding scale should apply not just to the size of the entity, but also to the size of the transaction. We request this structure will be considered for the 2023-25 biennium.

Providers appreciate that fees can be returned to applicants who choose not to move forward, and that the Authority added language regarding estimations and detailed invoices in other portions of the rule.

Response: OHA will consider this suggestion when developing fees for the 2023-25 biennium.

Comment 8: *(OAR 409-070-0042 Optional Application for Determination of Covered Transaction)* Providers greatly appreciate the addition and edits to this section of the rule.

Response: No response needed.

Comment 9: *(OAR 409-070-0045 Form and Contents of Notice Material Change Transactions)* Providers appreciate the opportunity for a pre-filing conference.

Response: No response needed.

Comment 10: *(OAR 409-070-0050 Retention of Outside Advisors)* We appreciate the addition of a detailed invoice, the conflict of interest language (1a), and the notice prior to costs being incurred (4). However, the addition the Department of Justice to the requirements remains concerning. As well, approval of the transaction should not be hinged on reimbursement. And, entities should be made aware of the estimated potential costs when noticed that the Authority intends to use outside advisors, as this information may inform their decision to withdraw or move forward.

Response: The requirements of the Department of Justice in 409-070-0050(1) specify that OHA, or the Department of Justice as applicable, shall require retained advisors to certify in writing that they are not subject to any conflict of interests and will protect any confidential information. Additionally, rule -0050 allows the Department of Justice to retain outside advisors in accordance with the statute, which states that the Department of Justice may retain outside advisors.

OHA specified in the rule that any approval of a material change transaction shall be conditioned on the parties reimbursing OHA. Such a condition is reasonable, given the statutory authority for OHA to retain outside advisors and designate the transacting parties to bear the reasonable and actual cost of retaining the advisors.

Comment 11: (*OAR 409-070-0055 Preliminary 30-Day Review of a Notice of Material Change Transaction)* As outlined in our first letter, we maintain that the findings of the preliminary 30-day review should be disputable. Additionally, as stated in previous letters and RAC meetings, providers maintain that if the Authority is unable to meet the

30-day deadline outlined in statute and this rule, the transaction should be automatically approved (4). This is especially concerning to smaller clinics and practices who have less of an ability to pay for extensive consultant fees that may come with a comprehensive review. This requested change is consistent with existing Oregon statute in other areas, including ORS 723.022 (3).

Response: Statute and rule both specify the process for a contested case hearing, which can be requested after OHA issues its final order. The final order may be issued after the preliminary or comprehensive review. It is unclear how the reference to ORS 723.022, relating to amendment of a credit union's articles and bylaws, applies to the HCMO program.

For any proposed transactions for which a notice is submitted between March 1, 2022 and December 31, 2022, OAR 409-070-0055 (5) indicates that a transaction shall be deemed approved unless OHA notifies the applicants of a comprehensive review within 30 days of receiving the notice of transaction.

This transaction review process applies only to transactions that meet the materiality requirements specified in OAR 409-070-0015 (1): one entity must have an average annual revenue of $25 million or more in the last 3 fiscal years and the second entity must have an annual average revenue of $10 million in the last 3 fiscal years. For 2022, the proposed fee for a comprehensive review would be $5000 and for January through June of 2023, the maximum proposed fee for comprehensive review is $100,000. Transaction review fees do not need to come from a specific entity, so the financial responsibility could be shared by both parties, whose combined average annual revenue would be at least $35 million. In 2022, the proposed maximum fee of $5000 would represent at most 0.01% of the entities' combined average annual revenue. For the first half of 2023, the proposed maximum fee of $100,000 would represent at most 0.29% of the entities' combined average annual revenue.

Comment 12: *(OAR 409-070-0060 Comprehensive Review of a Notice of Material Change Transaction)* If a transaction is going to be subject to the comprehensive review, there needs to be clear, fair and transparent standards included in the rule as to when the review boards will be engaged, and the membership makeup of the boards. Our members look forward to further discussing these parameters at upcoming TAG meetings.

Response: OHA published draft guidance about this topic, solicited input, and committed to publishing the final guidance no later than February 15, 2022.

Comment 13: *(OAR 409-070-0065 Conditional Approval; Suspension of Proposed Material Change Transaction)* Further clarity is needed on the added conditions the Authority may impose under 0065(1) apart from those referenced in Section 2(18) of the statute.

Response: See response to Comment #3.

Comment 14: *(OAR 409-070-0080 Compliance with Conditions; Information Requests)* There remains a general concern about how the Authority intends to enforce the program if standards being developed through rulemaking are not clear at the outset of the program. Using language such as making referrals to the Department of Justice (see OAR 409-070- 0030(2)) or building in language about filing false or misleading information (see OAR 409-070- 0080(3)) sets a tone at the outset that this is potentially a civil and criminal sanctioning program rather than a health care community standard-building program.

Response: See response to Comment #2.

James Parr, Salem Health Hospitals & Clinics (Exhibit 2)

Comment 15: Administrative rules should be fair and able to be objectively enforced. This is foundational for public trust in the program and for organizations to effectively and efficiently plan. Transactions subject to review should be predictable with a fair amount of certainty. As crafted, the rules do not yet meet this reasonable standard.

Response: The rules outline clear criteria for what types of transactions are subject to review. Transactions that involve an entity with annual revenue of $25 million or more and a second entity with annual revenue of $10 million are subject to review. Moreover, the rules specify the types of transactions that are subject to review.

Comment 16: The Authority has deferred the work of crafting definitions for key terminology within the rules and has announced plans to issue sub-regulatory guidance. Sub regulatory guidance has no associated public engagement process, requires no filing with the Secretary of State and no notice to legislators. Changes to such guidance could be made with no warning or involvement of regulated entities. This adds to the uncertainty and opacity associated with these rules.

Response: OHA has implemented its defined process for engaging the public on sub-regulatory guidance documents: OHA hosted two Technical Advisory Group (TAG) sessions (Jan 14 and Jan 28) specifically on the sub-regulatory guidance defining ‘services essential to achieve health equity’ and ‘significant reduction’ of said services. These TAG sessions were open to the public, information was posted on the program website, and subscribers to the program’s listserv were notified. OHA has declared that any changes made in the future would have an effective date lag of 180 days to give entities time to adjust to any altered requirements.

Comment 17: We are also concerned about the level of fees proposed by the Authority. We understand that the Legislature chose to make this an Other Funds program. However, the fees as proposed, together with a blank checkbook for retention of outside experts, may drive up the cost of innovative partnerships that have the potential to accomplish the equity and cost containment goals set forth by the Legislature and the OHPB.

Response: See response to Comment #11.

Comment 18: Over time, these fees and the oversight process as outlined in these rules will add to the cost of health care in Oregon, discourage innovation, and impede progress toward achieving greater equity in the provision of health care that is supported by statute and the Oregon Health Policy Board.

Response: See response to Comment #11.

Comment 19: -0005 (14) (b) "services that are essential to achieve health equity" are not defined within these rules. These terms should be clearly defined to enable fair application of the law and a clear understanding of what is required by the program.

Response: See response to comment #16. OHA has published a sub-regulatory guidance document defining 'services essential to achieving health equity' and the thresholds for 'significant reduction' in a range of examples. The final document reflects input from the two public TAG sessions in January 2022.

Comment 20: -0010 (1), (3) The term "significantly reduce" is used twice in this section of rule, but is not defined. Section I(10)(c) of the Act requires the Authority to define "significantly reduce" in the text of rule, not as sub-regulatory guidance. We suggest that the Authority work with the RAC to craft a definition of this term for inclusion in the rules.

Response: See response to comment #19. The definition of "significantly reduce" was discussed in two public Technical Advisory Group meetings and input from interested parties was incorporated into the final version published on the program website on January 31, 2022. In the future, OHA will consider adding the content of the guidance document into the rule language.

Comment 21: -0010 (3)(c) In determining whether there are significant impacts, the Authority promises to consider a reduction in the number of providers serving individuals who are uninsured, or providers serving individuals who are underinsured." This language is not part of the statute and we request that it be removed.

Response: This section of rule provides detail on the ways in which ‘a transaction has the potential to have a negative impact on access to affordable health care in this state’ (language directly from statute), including by reducing the number of providers serving individuals with no or inadequate health insurance. ‘Uninsured individuals’ are referenced in statute, identified in ORS 415.510 as one of several priority populations on which OHA must focus its required quadrennial impact studies. Consequently, OHA finds it appropriate to identify ‘uninsured individuals’ as a specific priority population that may potentially be impacted by reductions in essential services as result of material change transactions.

Comment 22: -0010 (4) It appears that the Authority is assigning sub-regulatory guidance documents the same power as administrative rule. This language is not part of the statute. We request that it be removed.

Response: The language in 409-070-0010 (4) was requested during the RAC meetings by representatives of health care entities in order to ensure any subsequent change to this particular sub-regulatory guidance would not affect a health care entity’s determination of whether or not a planned transaction is subject to review.

Comment 23: -0015 The revenue triggers listed in this section are part of statute. However, we advise the Authority that they are so low as to include a wide range of transactions that do not rise to the level of a merger or acquisition of the size and scope discussed during deliberations on this bill. These low revenue triggers without appropriate exemptions combined with the Agency's extremely high fees are likely to increase the cost of health care for consumers rather than reduce it.

Response: Revenue thresholds as part of the materiality criteria reflect final decisions of legislators. OAR 409-070-0020 provides an extensive list of transactions that are excluded from this review process. For response on fees, please see response to Comment #11.

Comment 24: -0025 (1)(b) & (c) The definitions of control listed in these sections of rule are artificially low and not reflective of the actual health care marketplace. The definition of control should be set at 51 percent.

Response: The definition of control within a carrier or Coordinated Care Organization (CCO) (10% or more of voting securities) is based on thresholds utilized by the Department of Consumer and Business Services (DCBS). The thresholds of 10% or more of voting securities for carriers or CCOs and 25% or more for all other health care entities are rebuttable presumptions of control. Acquiring 50% or more of voting securities in any health care entity is an irrebuttable presumption of control.

Comment 25: -0045 (5)(a)(B) It is unreasonable for the Authority to require complete and final executed copies of transaction documents to be submitted within 15 days after the commencement of the comprehensive review period. This is not a requirement of the statute and the Authority can proceed with comprehensive review based on information contained within a term sheet. We suggest the following language, "Fifteen days before the projected end of the comprehensive review period, if the transaction was not approved following preliminary review. If the parties are unable to furnish complete and final executed copies of all the definitive agreements within that fifteen day period, then the running of the period for review of the notice shall be tolled upon such notification and shall not resume until the parties have furnished such executed copies."

Response: Content of the final definitive agreement may provide critical information about the nature of the transaction and its probable impacts on cost, access, quality and equity. The final definitive agreement needs to be considered as part of the comprehensive review and must be made available to OHA as early in the review period as possible. This is the same as DCBS requires for the Form A review of a carrier's acquisition.

Comment 26: -0045 (8) The Authority allows itself more than one standard for statements of revenue and revenue projections in this section of rule. This represents a lack of predictable, clear, and objective standards that should be the goal of these rules.

Response: This rule allows OHA to require statements of revenue and revenue projections be presented in accordance with generally accepted accounting principles (GAAP) or statutory accounting principles (SAP), as applicable. Some health care entities rely on GAAP while others rely on SAP. A previous version of this rule allowed only GAAP. The current version of the rule allows for entities to submit the statements on the basis the entity normally uses.

Comment 27: -0045 The Authority promises that its Analytic Framework will have standards that are clear, fair, predictable, and consistent - but the Analytic Framework is not contained within rule and does not exist as this date. Statements made by the Authority in rule should be objective and quantifiable.

Response: The final Analytic Framework document was made available on the HCMO website on January 31, 2022.

Comment 28: -0050 (2) The Authority requires reimbursement for "all reasonable and actual costs incurred by the authority in connection with its review of the material change transaction." The Authority should limit their expenditures of this type to a fixed amount.

Response: OHA has not limited the expenditures for review because there may be a proposed material change transaction that involves the largest of health care entities and could impact many different aspects of equity, cost, quality, and access across multiple geographic regions.

Comment 29: -0050 (4) I appreciate that the Authority has agreed to notify applicants before any costs are incurred when a transaction requires their use of outside advisors. If the Authority will commit to limiting their expenditures as I suggest above, then such notification would not be necessary.

Response: No response needed.

Comment 30: -0055 (2)(d) What is the objective standard for "substantially altering the delivery of health care in Oregon?" In order for regulated entities to comply, the Authority must limit itself to objective and quantifiable rules that can be equitably enforced. A definition of this phrase is needed in rule.

Response: The Analytic Framework document provides detailed information pertaining to the analyses OHA will conduct when reviewing a proposed material change transaction.

Comment 31: -0055 (4) In the event that the Authority fails to complete preliminary review within 30 calendar days, then the transaction should be considered approved without conditions.

Response: See response to Comment #11.

Comment 32: -0060 (2)(b) What is the quantifiable standard for "impacting a large number of residents in this state?"

Response: See response to Comment #30.

Comment 33: -0060 (2)(c) The rules lack clarity regarding a "significant change in the market share of an entity involved in the transaction." We suggest that the Authority consider a standard based on a 50% increase in the number of lives served.

Response: OHA will use the Herfindahl-Hirschman Index to measure market concentration, with a post-transaction HHI of greater than 2500 and an overall change between 100 and 200 units as a threshold for significant change. See the Analytic Framework document on the HCMO website for more details.

Comment 34: -0060 (9)(a)(A) What is the standard for "material anticompetitive effects in the region?" While there are examples given, it is not clear what the Authority would consider to be "material."

Response: See response to Comment #33. The Analytic Framework utilizes the HHI and the small but significant non-transitory increase in price (SSNIP) calculations as measures of market impact. The U.S. Department of Justice's Guidelines on SSNIP suggest a 5% benchmark as a significant increase but note that true impact varies on a case-by-case basis.

Comment 35: -0060 (10) Because tribes are only mentioned in this section of rule, it is not clear what circumstances would trigger a tribal consultation. The Authority threatens disapproval of a transaction if the parties do not agree to an extension of time necessary to accomplish a tribal consultation. Thus, the Authority has the obligation to clearly state when and why a tribal consultation would be needed within the context of rule. To do otherwise disregards tribal sovereignty and the tribes' important role as partners in the delivery of equitable health care in Oregon.

Response: OHA will follow its Tribal Consultation and Urban Indian Health Program Confer Policy to determine when Tribal Nations need to be notified of a proposed material change transaction. The policy requires a 60-day notice prior to implementation of a change that may impact Tribes.

Comment 36: -0075 (5) Rule text in this section is not clear.

Response: This section of the rule specifies that OHA's determination not to approve a transaction after preliminary review is interlocutory, i.e. not immediately appealable. This section also specifies that OHA's determination that a transaction is covered is interlocutory.

Comment 37: -0075 (9) It appears that the Authority is reserving the right to selectively enforce an order resulting from a contested case hearing. This is not part of the statute and we request that this section of rule be removed.

Response: OHA reserves the right to amend the order from the hearing to ensure it has the ability and capacity to enforce the conditions of the order, and ensure the conditions are in line with the statutory authority given to the HCMO program.

Russell Collins, Cambia Health Solutions (Exhibit 3)

Comment 38: we remain concerned that the draft rules are not consistent with the specific direction in HB 2362 that the Oregon Department of Consumer and Business Services ("DCBS") shall "make the final determination in material change transactions involving the sale, merger or acquisition of a domestic health insurer . . . ." BR 2362 Section 2 (3)(b). Existing statutes and regulations setting forth the authority of DCBS for transactions involving the acquisition of control for domestic health insurers in Oregon are sufficient, robust, and well-established to support the evaluation of transactions involving insurers. See ORS 732.523 and related regulations. Processes and procedures that add requirements that reduce the authority and expertise of DCBS when transactions only involve domestic insurers are inefficient and inconsistent with HB 2362.
Proposed OAR 409-070-0035 - In section (1), there should be specific reference to the authority of DCBS that is maintained in HB 2362 by adding reference that DCBS "shall make the final determination in material change transactions involving the sale, merger or acquisition of a domestic health insurer and shall coordinate with the Authority to incorporate the authority's review into the department's final determination." Including this specific reference will avoid confusion of the process undertaken by DCBS and this process undertaken by the Authority when a material transaction only involves a domestic health insurer.

Response: The material change transaction reviews prescribed by ORS 415.500 et seq do not limit the authority of DCBS in reviewing and approving transactions involving domestic carriers. DCBS retains ultimate decision-making authority in approving, approving with conditions or disapproving such a transaction. DCBS will initially receive the Notice of Material Transaction application, in addition to Form A, if applicable, and will consider the analysis of the HCMO review in making its final determination. HCMO and DCBS reviews of a proposed transaction will happen in parallel and the HCMO analysis of probable impacts to cost, access, quality and equity will supplement DCBS findings.

Comment 39: Similarly, there should be specific inclusion of terms that prohibit the absence of a timely response from the Authority from impacting the review or approval by DCBS of a sale, merger, or acquisition of material change transactions involving only domestic health insurers to be consistent with HB 2362.

Response: See response to Comment #11, which applies to transactions filed in 2022. DCBS' timeline for transaction review follows roughly the same timeline (between 4 to 6 months), so the processes will occur in parallel. DCBS will not issue its final approval without the recommendations from the HCMO analysis, but this program's timeline should not delay DCBS' decision-making process.

Comment 40: Proposed OAR 409-070-0045 - This section should include a specific exemption from any additional information to be filed for material change transactions involving only domestic insurers that goes beyond that required by ORS 732.517 to 732.546 and related rules. HB 2362 grants ultimate authority to DCBS for transactions involving domestic insurers only and any additional requirements of domestic insurers is inconsistent with this specific limitation of the Authority's filing requirements in this section.

Response: ORS 415.500 et seq., grants OHA the authority to assess all covered material change transactions, including those involving domestic insurers, and specifies additional priority factors in OHA's review of a proposed material change transaction, including a focus on cost, access, quality and equity. These elements are not specifically addressed in ORS 732.517 to 732.546 but will be applied to proposed transactions involving domestic carriers so that reviews under this program will be fair and consistent regardless of which type of entity is involved. DCBS retains the authority to make the final determination of approval for proposed transactions involving domestic insurers but the Department will take OHA's analysis and recommendations into consideration in its final decision.

Comment 41: Proposed OAR 409-070-0050 - For material transactions involving only domestic health insurers, this section should prohibit retention of any outside advisors beyond those required by DCBS to avoid duplication of efforts and inefficiency.

Response: See response to Comment #40. OHA may retain outside advisors to address the additional priority elements included in ORS 415.500 et seq., that are not specified in ORS 732.517 to 732.546, and therefore cannot limit itself to the types of advisors required by DCBS. However, to the extent possible OHA and DCBS will share outside advisors. For example, DOJ is retaining outside counsel that can advise both OHA and DCBS.

Comment 42: Proposed OAR 409-070-0060 - ORS 732.526 provides for public hearings for certain transactions within the authority of DCBS. This section should include a specific limitation that in no circumstance should a public hearing be conducted under this section where DCBS has scheduled or conducted a public hearing for a transaction involving domestic health insurers. Without this limitation, there could be multiple public hearings on a single transaction involving domestic health insurers.

Response: OHA's process for material change transaction review does not prescribe public hearings. Notice of Material Transaction applications are posted on the HCMO website for public comment and should a transaction require comprehensive review, OHA may convene a Community Review Board to gather representative feedback from those impacted by the proposed transaction. The Community Review Board process is notably different from a public hearing process, and while OHA will coordinate with DCBS on such efforts, the Community Review Board process may not meet DCBS'

public hearing requirements and the Department may need to schedule a public hearing separately. Both entities have an obligation to fulfill the public involvement requirements set forth in their respective governing laws.

Tom Karnes, PeaceHealth (Exhibit 4)

Comment 43: Covered Transactions (-0010) - The phrase "comprehensive management services" in Section (2)(d) remains ambiguous. As drafted, "comprehensive management services," means providing "all or substantially all the personnel, or manages all or substantially all the operations, of a health care entity." It is not clear how a health care entity is expected to measure "personnel" or "operations" for purposes of applying this test. For example, the Draft Rules do not provide direction on whether operations should be weighted in assessing whether certain services are "substantial" or what percentage or type of services would trigger that "substantial" threshold. This ambiguity risks deterring organizations from exploring collaborations intended to improve the patient experience and reducing the overall cost of care. We ask that the "comprehensive management services" category be removed or limited to only those that will eliminate or significantly reduce essential services.

Response: Given that an entity's relationship with a management service organization may be unique and the range of services provided may vary, OHA is unable to provide quantitative thresholds for when provision of these management services is indicative of control. A management service organization (MSO) can provide a range of services, from administrative and financial functions, or payer negotiations and group purchasing power, to taking over employment of non-clinical staff and ownership of hard assets that are then leased back to the medical practice. Some of these elements of MSO activity meet other criteria for change in control described in the rule. Entities need to consider the full nature of the agreement between the practice(s) and the MSO in order to determine if this kind of arrangement constitutes control according to the definition in section (-0005)(8) of the rule. OHA encourages entities to complete an application of Determination of Covered Transaction or request a pre-filing conference so OHA can preview relevant elements of a proposed transaction and provide guidance on whether it meets criteria for filing notice.

Comment 44: Acquisition of Control; Presumptions and Disclaimers (-0025) - The definition of "control" is too broad. In particular, the rebuttable presumption that control exists when one entity has voting control over 25% or more of any class of voting securities is out of step with governance structures for the types of closely held organizations that will make up most of the parties subject to House Bill 2362. For context, small ownership percentages such as 25% are sometimes an appropriate regulatory threshold for publicly traded companies with a large and diffuse number of owners. By contrast, nearly all of the transactions subject to House Bill 2362 will be closely held organizations. Any ownership percentage less than even 40% of a closely

held organization's voting securities is often merely a minority and passive position. We ask that the Draft Rules define control as at least 51% of decision-making authority.

Response: See response to Comment #24. Section (-0010) of the rules outlines other mechanisms of acquisition that are relevant to health care entities, including: acquiring assets and operations; provision of comprehensive management services; or merging tax identification numbers. If the securities ownership will be merely a minority and passive position, a party may submit a disclaimer of control.

Comment 45: In addition, the irrebuttable presumption of control based more than 50% of voting control currently set forth in the Draft Rules does not reflect the complex facts and circumstances that are often associated with evaluating control. We ask that the presumption be rebuttable.

Response: The acquisition of 50% or more of voting security is not rebuttable because such an acquisition constitutes a majority of the voting securities.

Comment 46: Retention of Outside Advisors (-0050) - We also ask that OHA set clear criteria for when outside experts will be needed under Section 0050, as well as a cap on total fees, so that parties are able to reasonably assess whether the regulatory costs outweigh the merits of proceeding with the transaction. Ambiguity over fees and other regulatory uncertainty is another unnecessary barrier to parties evaluating whether to invest time and resources in collaborations involving Oregon healthcare entities.

Response: OHA has posted to the HCMO website sub-regulatory guidance on Criteria for Using Outside Advisors, which were open for public comment until February 7, 2022.

Comment 47: Preliminary Review (-0055) - We thank OHA for revising Section (5) to provide that for filings before December 31, 2022 a notice will be deemed approved unless within the 30-day preliminary review period OHA makes a determination that a comprehensive review is appropriate. That 30-day automatic approval approach is in line with other successful regulatory review programs, including Federal Trade Commission reviews pursuant to the Hart-Scott-Rodino Act. We request that the automatic approval approach be extended beyond December 31, 2022.

Response: The provision allowing for presumed approval unless OHA notifies an applicant of comprehensive review within 30 days of receiving the Notice of Material Transaction was established to assist in phasing in this change to health care market regulation. OHA has opted to file permanent rules for this program that end this provision after December 31, 2022.

Comment 48: Sub-regulatory Process - OHA is relying heavily a sub-regulatory process to develop important components of the HCMO program. That approach disregards important due process and other protections that are afforded by administrative rulemaking.

Response: See response to Comment #20.

Andi Easton, Oregon Association of Hospitals and Health Systems (Exhibit 5)

Comment 49: After four meetings of the RAC and five iterations of the rules, we still cannot determine what is covered by the law and rules nor determine how OHA will judge whether a transaction is, in its mind, permissible. Basic, fundamental questions remain, and we are concerned that hospitals still do not know:
• Whether they are required to file notice of a proposed material change transaction for any particular transaction;
• What level of review the transaction is likely to undergo;
• How much the review will cost; and
• Whether the transaction is likely to be approved.

Response: OHA has published an array of guidance documentation on the HCMO website addressing these issues, including guidance on covered transactions, criteria for comprehensive review, fee schedule development and the Analytic Framework to be used in all stages of review.

Comment 50: Address the following concepts through rulemaking, as explicitly directed by HB 2362, and not through "sub-regulatory guidance."
• What it means to "eliminate or significantly reduce" essential services (HB 2362, Section 1 (10)(c));
• Criteria for when to conduct a comprehensive review and appoint a review board (HB 2362, Section 2 (8)(c)); and
• Criteria for approval or denial of a material change transaction (HB 2362, Section 2(2)).

Response: See response to Comment #49 and see documentation posted to the HCMO website, including: Essential Service and Significant Reduction Guidance; Comprehensive Review Criteria; Community Review Board Criteria; and HCMO Analytical Framework

Comment 51: We support the development of some sub-regulatory resources, such as a safe harbor list of excluded transactions, example scenarios describing how regulatory definitions or criteria apply, and flow charts to illustrate the filing and review process. However, such guidance is not the appropriate mechanism to define or

establish core concepts and criteria for which rulemaking is required by statute. The Authority's current approach denies interested parties the due process of administrative rulemaking, creates an unacceptable risk of arbitrary, inconsistent, and unfair decision making, and ultimately wastes resources.

Response: See response to Comment #16.

Comment 52: Creating more guidance documents does not necessarily create clarity. For example, the analytic framework is astonishing in its breadth and depth – and yet, because it is merely a "menu of potential analyses from which HCMO will choose…" (p. 1), entities still do not know how to prepare for a review. Further, this framework can change at any time with no notice or comment.

Response: The authorizing statute requires OHA to review proposed material change transactions. The Oregon Health Policy Board adopted criteria in the form of a framework document to operationalize the HCMO program. The rules and OHA's sub-regulatory guidance documents provide additional details about the analyses OHA will conduct when reviewing a proposed material change transaction. Because each proposed material change transaction will differ and will have different impacts, OHA is unable to direct entities how to prepare for a review that will guarantee approval.

Comment 53: We again propose that "eliminate or significantly reduce essential services" should mean that access to a service within the service areas of the entities, taken as a whole and among all service providers in the service areas, 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 essential service within the service areas.

Response: The threshold for significant reduction is one-third, as opposed to 50%, because one-third is a reasonable compromise among the individuals who participated in the Rules Advisory Committee and Technical Advisory Group meetings.

Comment 54: The first Technical Advisory Group meeting on January 14, 2022 illustrated how sub-regulatory guidance could be used to expand key concepts beyond what was included in the legislation. For example, HB 2362 allows review of new contracts, new clinical affiliations and new contracting affiliations that "will" eliminate or significantly reduce essential services (Section 1 (10)(c), emphasis added). The proposed guidance document issued on January 12, 2022 creates a test wherein a 50% reduction in any one service in any one of the listed categories would be considered "significant" and trigger review if that reduction occurs within 12 months of the transaction in question, regardless of whether the reduction in services is the direct result of the transaction and without a holistic look at any offsetting benefits of the transaction or the context of the service area. The word "will" in HB 2362 indicates a

much higher level of foreseeability and causality than the presumptions set forth in the draft guidance. In other words, there must be direct causality. HB 2362 also uses the term “essential services” (Section 1 (10)(c), emphasis added), which is consistent with our proposed holistic look at the service area in question. If the legislature intended for a reduction in any single service to trigger this review process, it would have so stated.

Response: The legislature specifically delegated the task of defining what “eliminate or significantly reduce” means to OHA. If the legislature intended to impose a specific threshold or definition it would have specifically included as much. By using “will cause,” legislature clearly intended to simply remove from consideration instances where there would obviously be no elimination or significant reduction in essential services. The threshold itself was for OHA to determine and OHA has exercised rule-making authority specifically granted by ORS 415.500(10)(c). If, as a result of a transaction, there is an elimination or significant reduction of a single given service identified as essential, then the transaction has resulted in a reduction of essential services, notably when accounting for the number of patients who would have received that service had it not been for the transaction. The reduction of essential services is merely a trigger for a review of a transaction, and OHA’s analysis will include a holistic look at a range of potential negative impacts and benefits of a proposed transaction when determining its approval of said transaction.

Comment 55: Criteria for when to conduct a comprehensive review and appoint a review board
The rules should make clear when entities should plan for a comprehensive review and when a review board will be appointed. The engagement of review boards should be limited to major transactions with potential for significant adverse impacts on access, equity, and cost to consumers.

Response: See response to Comment #50.

Comment 56: Criteria for approval or denial of a material change transaction
The rules should specify how entities must demonstrate that they meet the criteria for approval of a material change transaction. Further, the rules should state that the evaluation of whether a material change transaction meets the criteria for approval must be based on the foreseeable impacts of the transaction, supported by relevant data and other evidence, and balanced by consideration of the foreseeable impacts of not completing the transaction.
Instead, the rules as drafted add new criteria not included in the statute and fail to provide the clarity that would enable entities to anticipate whether a proposed transaction would meet the criteria. Clarity is an important component to ensuring a fair process.

Response: OAR 409-070-0055 delineates the criteria for approval of a transaction upon preliminary review. OAR 409-070-0060 (9) lists the criteria for approval of a transaction

upon comprehensive review. Subsection (a)(A) specifically cites the need to weigh probable negative impacts of a transaction (e.g., anticompetitive effects) against probable benefits of a transaction (e.g., increasing or maintaining services to underserved populations). OHA is unable to predict the exact circumstances and conditions of every transaction and therefore cannot be more prescriptive in its guidance on approval criteria.

Comment 57: Tailor the concept of "control" to focus on the material change transactions with the most significant potential community impact.
Proponents of HB 2362 expressed concern about large mergers and acquisitions, and OHA also stated this as its focus early in the RAC process. However, despite having pivoted in a significantly new direction with each iteration of the rules, the Authority has been unsuccessful in narrowing its focus to these most significant transactions. OHA should ensure that its rules do not broaden the scope of the HCMO Program beyond what the statute requires.

Response: The materiality requirement of at least $25 million in average annual revenue for one entity and at least $10 million in average annual revenue for the second entity involved in the proposed transaction is derived directly from statute and applies to all transactions, regardless of why the transaction also qualifies as covered under the statute. The rules provide clarifying detail to the definition of 'transaction' listed in statute, but do not deviate from the five statutory types of 'transaction.'

Comment 58: Given that the legislation includes certain "corporate affiliations" in addition to mergers and acquisitions (see HB 2362, Section 1 (1) and (10)(d)), one way the Authority could better tailor the rules to the statutory requirements is by adopting, as we have previously proposed, a definition of control that turns on the ability of a person to control the decision making of the governing body of an entity. The current definitions of control in proposed OAR 409-070-0025 set low thresholds that do not speak directly to control over decision making and will encompass far more transactions than the legislature intended. These definitions also refer to concepts that do not apply to many health care entities in Oregon, such as "voting securities."

Response: The definition of control in 409-070-0005 is consistent with this concept. The rule defines control as the "direct or indirect power to manage a legal entity or set the legal entities' policies" and further notes that control can be obtained by owning voting securities, by contract (other than a commercial contract for goods or nonmanagement services), or other means. Given the breadth of the definition of "voting securities," OHA believes it will apply to most health care entities in Oregon, including nonprofits.

Comment 59: Further, because control can look very different depending on the organization, any presumption of control should be rebuttable. Guidance in the form of examples or a running list of the Agency's determinations regarding control would be

welcome, but the essential components of the definition itself should be appropriately articulated in the rule.

Response: The rules specifically state that control is rebuttable if 10% to 49% of voting securities of a domestic insurer are acquired, or if 25% to 49% of voting securities of any other health care entity is acquired. This provision recognized the unique conditions in which control may change within an organization and establishes a process by which entities are able to explain their situation using the Rebuttal of Presumption of Control Form.

Comment 60: We request that the Program be delayed through action by the Governor or the legislature. We also urge OHA, the legislature, and the proponents of HB 2362 to work with us on our legislative proposals to fix inherent flaws in HB 2362 and craft a predictable, focused program worthy of Oregon's ability to be a leader in healthcare transformation and innovation.

Response: Absent further direction from the legislature, this program will begin on March 1, 2022, as stated in ORS 415.500 et seq.

Richard Blackwell, PacificSource (Exhibit 6)

Comment 61: We acknowledge that the underlying legislation (2021 House Bill 2362; the Act) left little time for the Oregon Health Authority (Authority) to spend the kind of time necessary to develop such complex rules, though as we noted in the rulemaking advisory committee process temporary rules would have conferred additional time on all parties. It is clear from the progression of the rules that this program is too multifaceted for such a rapid implementation period. We believe that as a result a number of unanswered questions remain, and should be addressed through rulemaking under the Administrative Procedures Act.

Response: OHA has opted to file permanent rules for this program.

Comment 62: Guidance so far seems to focus on providers, and does not begin to consider the permutations of insurance carrier and coordinated care organization transactions that may fall under the statutory scheme. We would hope that the Authority will re-commit to rulemaking in the future to provide clarity and involve interested members of the general public.

Response: Future edits and changes to the rules are possible and would be conducted using a Rules Advisory Committee.

Comment 63: -0005, Definitions
The definition of “health care entity” in the Act separated Medicare Advantage plans from carriers that offer health benefit plans. We do not believe the Act supports section (5) of the rule, which defines “carrier” as “any person that offers Medicare Advantage plans in this state.”

Response: We believe ORS 415.500(4)(a)(D) calls out Medicare Advantage plans because they are excluded from the term “carrier,” as defined in ORS 743B.005. OHA interprets the statute to mean any person, which could also be an entity, that offers Medicare Advantage plans in this state. The program authorized by statute does not regulate specific health insurance products, but rather regulates transactions involving entities.

Comment 64: Similarly, the definition of “essential services” in section (14) of the rule infers that both conditions must be present; namely, that essential services are both those on the Prioritized List of Services for the Oregon Health Plan and also those that are essential to achieve health equity. We believe that the text of the Act also requires both elements be present for a service to be considered “essential.” In other contexts, the Act uses the term “includes” to denote that any of the elements in a particular definition are covered.

Response: The proposed reading is inconsistent with the syntax of ORS 415.500(2): “Essential services” means: (a) Services that are [A]; and (b) Services that are [B]. By separately identifying “services essential to achieve health equity,” this definition acknowledges several key points:

1. Not all services on the Prioritized List are essential to achieve health equity, but because they are required to be covered by Medicaid are considered “essential.”
2. Health status is impacted by social determinants that cannot be addressed by clinical services alone, therefore the definition of “services essential to achieve health equity” must expand beyond the billable clinical services on the Prioritized List.
3. Clinical services are included on the Prioritized List after the Health Evidence Review Commission (HERC) evaluates available research to support the efficacy and cost-effectiveness of particular treatment modalities. Clinical research often lags behind the practical experience of providers and communities who have tested new approaches to care delivery, especially culturally-specific treatment models, and there continues to be bias in where clinical research efforts are focused and how clinical studies are conducted. These systemic limitations render the Prioritized List unable to be comprehensive of all treatment modalities that have the ability to achieve positive health outcomes and address health inequities for all populations.

Comment 65: -0010, Covered Transactions

In paragraph (1)(e)(C) of the rule, we remain unclear what the Authority meant when it included transactions that would “consolidate or combine insurers when establishing health benefit premiums.” We would ask for more clarity within the rule text.

Response: The statute directs OHA to focus in part on health care costs. The testimony submitted by the sponsors of the bill included research articles that link consolidation with higher health care costs. OHA narrowed the types of transactions that are subject to review by focusing in part on the transactions that relate to consolidation when establishing health benefit premiums.

Comment 66: We believe that section (3) should be removed entirely, and the rules themselves should clarify what transactions are covered by the Act. The guidance document risks creating conflicts between the Act and the rules, does not provide the wider public with the notice and opportunity for comment on the changes, and does not provide the certainty to the Authority or to entities contemplating transactions needed to ensure the law is being properly applied.

Response: Section (3) provides additional details about the elimination or significant reduction of essential services.

Comment 67: -0022, Emergency Transactions
As we noted in our first comment letter, a supervisory event under the Insurance Code or under rules modeled off of the Insurance Code and found in OAR chapter 410, division 141 should be on its face an approved emergency.
As we noted before, the Department of Consumer and Business Services (DCBS) could assume control of the operations of a carrier well before there is any time to file a request with the Authority. In those situations, since DCBS must make certain findings about the condition of the insurer prior to acting, meeting the statute provides a per se case of an emergency. Likewise, OAR 410-141-5365 already allows the Authority to take action against a coordinated care organization in the event of "hazardous operation," which in prudential supervision covers the situations in this rule.
We ask the agency re-consider language we submitted in our first comment letter:
(8) The Authority will deem a transaction an emergency under this rule if the transaction results from:
(a) The Department placing an insurer in supervision under ORS 734.043, obtaining an order of rehabilitation under ORS 734.150, or obtaining an order of liquidation under ORS 734.180; or
(b) The Authority ordering a coordinated care organization to take one or more of the actions described in OAR 410-141-5365.

Response: OHA and DCBS would agree that a transaction proposed under the circumstances described above (being placed under DCBS supervision or a CCO meeting hazardous operations criteria) would generally constitute an emergency according to the definition in rule. However, this does not automatically exempt such a

transaction from review, as section (-0022) reads that both the Authority and the Department 'may' exempt a transaction from review. OHA and DCBS still reserve the right to perform their due diligence and assess whether a transaction under these circumstances is in the best interest of the community and the long-term financial health of all parties involved.

Comment 68: As with our comments on rule -0010, if the Authority wishes to "publish from time to time a list of other categories or types of transactions that shall be exempt from review" as stated in section (6) of the rule, it should do so through the rulemaking process.

Response: Other members of the Rules Advisory Committee, including representatives of health care entities, supported the use of sub-regulatory guidance documents as a way to exempt categories or types of transactions from review. OHA has opted to do so in order to be able to add categories or types of transactions to the safe harbor list as needed.

Comment 69: Finally, in subsection (3)(e) of the rule, we ask that the Authority clarify that supervisory information shared with other regulators under ORS 705.137 or protected under applicable provisions contained in ORS chapter 731 should not be disclosed.

Response: OAR 409-070-0070 describes OHA's obligations of confidentiality, specifically citing any materials exempt from disclosure under ORS 705.137.

Comment 70: -0025, Acquisition of Control
In subsection (1)(a) of the rule, control of a domestic health insurer entails holding 10% of any class of voting securities. During the rulemaking advisory committee, the Authority noted that this standard was found in the Insurance Code. On further review, the 10% standard in the Insurance Code refers to acquiring the assets of an insurer, not a change in control. See ORS 732.518; 732.521.

Response: OHA has opted to align with the reporting thresholds, when applicable, that DCBS uses. The 10% threshold in ORS 732.567 applies to the control of an insurer.

Comment 71: However, we understand the difficulty in defining "control." One potential path may be to set one standard of control for publicly-traded companies, where beneficial ownership may be freely accessed in databases like the EDGAR system of the U.S. Securities and Exchange Commission, and another for closely-held companies, where 51% may more accurately signify control unless found otherwise.

Response: OHA has opted to define the control thresholds in terms of entities that are insurers or Coordinated Care Organizations, versus other kinds of organizations.

Comment 72: -0035, Material Change Transactions Involving a Domestic Health Insurer
Under section 2(3) of the Act, DCBS makes the final determinations in material change transactions involving a domestic health insurer. DCBS must also coordinate with the Authority to incorporate the review into the department's final determination. We believe that the authority of DCBS to make the final determination should also extend to when a comprehensive review is appropriate. The Authority and DCBS should agree as equal partners when a comprehensive review process is warranted.

Response: The statute grants OHA the authority to determine the need for and conduct a comprehensive review.

Comment 73: -0042, Optional Application for Determination of Covered Transaction Status
We would request the agency consider allowing parties to request an opinion without disclosing identities. No amount of adopted rule or guidance can take into account every situation; in other regulatory contexts, attorneys may request a "no-action" letter from an agency. These letters typically introduce a hypothetical fact pattern and request whether such activity could commence without drawing action (i.e., enforcement) from the agency. By asking for the names of the parties under subsection (2)(a) of the rule, the Authority might chill efforts by a party to understand if a transaction not yet even contemplated with another party would be a covered transaction.

Response: No-action letters are typically deployed to determine the legality of a proposed action and OHA does not claim to have legal expertise. OHA is not aware that DCBS provides anonymous no-action letters regarding proposed insurance transactions. OHA will consult the Department of Justice for questions regarding the legality of a proposed transaction. OHA does offer pre-filing consultation to help entities determine if a proposed transaction is material and covered and therefore subject to filing a notice. Because the type of entity involved, the specific population being served, and the ability of competing entities to absorb the probable impact of the proposed transaction are important factors in determining the need to file, it is imperative for entities to be identified in the Determination of Covered Transaction Status application. The fact that a proposed transaction is covered and subject to review does not mean the transaction will be denied, so this process should not deter entities from contemplating future transactions.

Comment 74: -0045, Form and Contents of Notice
In section (3) of the rule, we ask that the Authority clarify that "electronic" submission of application items should be done through encrypted or secure means.

Response: OHA does not require the submission of personal health information (PHI) or personally identifying information (PII) that would need to be protected through encrypted transmission. Some material about an entity's financial status or operations may be sensitive or confidential, and entities can opt to submit this information to OHA via a secure electronic method. However, most materials will be subject to public disclosure and OHA does not want to create any barriers to submission by requiring all information transfer to occur through secure means.

Comment 75: As with our comments on rule -0010, we believe that the Analytic Framework described generally in section (9) of the rule would benefit from the public process that is rulemaking, and should be adopted as such.

Response: OHA published the 25-page Analytic Framework on January 31, 2022. Such a document is too lengthy and detailed to be in rule.

Comment 76: -0050, Retention of Outside Advisors
In section (1) of the rule, the text states that the Authority may bypass “any otherwise applicable procurement process” as long as the outside advisor possess the requisite qualifications and expertise to review a proposed transaction. Certainly, the Public Contracting Code allows the Authority to conduct its own procurement, rather than the Department of Administrative Services. See ORS 279C.050. But the Code clearly requires the authority to conduct its own procurement “in accordance with” the Public Contracting Code. We request that clause be removed.

Response: OHA will follow its procurement and contracting rules in OAR chapter 943, division 60. When possible, OHA will retain a pool of outside advisors who have been selected through a formal request for proposal (RFP) process. If necessary, OHA may retain outside advisors for a transaction by procedures other than competitive procurement. For example, OHA may retain outside advisors without a competitive procurement if a review requires technical expertise beyond the capabilities of OHA’s regular outside advisors or if conflicts of interest disqualify OHA’s regular outside advisors, among other reasons.

The competitive procurement process can be lengthy and may hinder OHA’s ability to complete the comprehensive review within the prescribed 180-day period. When retaining outside advisors without a competitive procurement process, OHA and DOJ will verify the qualifications and expertise of advisors, resolve any conflicts of interest, and ensure that contracted advisors take appropriate steps to protect privileged or confidential information.

Comment 77: Subsection (1)(b) of the rule requires that “privileged” information in the possession of the Authority may be shared with outside advisors engaged by the authority, and the disclosure would not constitute a waiver of privilege. But the Act does

not require parties to turn over “privileged” information; section (13) of the Act states that entities subject to a review may not refuse to provide documents on the grounds that the information is “confidential.” We ask that the Authority amend this rule and other similar rules to state it will not require the submission of “privileged” information, and ensure that outside advisory do not share “confidential” information.

Response: This section of rule does not require entities involved in a proposed transaction to disclose any ‘privileged’ information. It allows privileged or confidential material to be shared with outside advisors, on the grounds that those advisors agree to protect this information from public disclosure. Privileged material may arise from other sources in the course of the comprehensive review, for example conversations between OHA and legal counsel that are protected by attorney-client privilege. Nowhere in the rules does OHA require applying entities to furnish privileged information for the purpose of transaction review.

Comment 78: -0060, Comprehensive Review
In section (4) of the rule, community review board members are treated as public officials for conflict of interest purposes. We also believe that community review board members should also be public officials for purposes of the Public Meetings Law. In particular, a quorum of review board members should not meet outside of designated public meeting times to deliberate on a course of action.

Response: A review board does not have voting or quorum requirements and therefore is not subject to the public meetings law, ORS 192.610(5). OHA will require Community Review Board members to comply with applicable code of conduct and ethics policies, but otherwise the actions of board members beyond the scope defined in ORS 415.500 et seq., and OAR 409-700-0060 are outside the purview of this program.

Comment 79: In section (5) of the rule, we would ask that the Authority include provisions to use modern communication tools, like videoconferencing software, in carrying out the public hearings. For example, if a transaction involves a carrier that participates in the individual health insurance market statewide, the statute appears to contemplate that a review board could hold up to 72 hearings (i.e., up to two hearings in each of Oregon’s 36 counties). We do not believe that the legislature intended for lengthy road shows in order to assess a transaction, but it could be required without clarification in rule.

Response: The rule as written does not preclude the use of teleconferencing technology to facilitate access to public hearing events, nor does it indicate county as the unit of service area.

Comment 80: In section (9) of the rule, the Authority will approve a transaction or recommend to DCBS to approve a transaction if “the transaction satisfies (a) below and

also satisfies either (b) or (c) below." We request more clarification on how parties will know which criteria the Authority will apply. Will the parties to the transaction be able to choose which subsection to meet? Or will the Authority choose which subsection is met?

Response: OHA will look for evidence that any criteria are met, but the rule as written requires that all aspects of (a) be met (no anticompetitive effects, not contrary to law, not jeopardizing financial stability of any participating entity, not hazardous or prejudicial to the public) AND either (b) the transaction benefits the public good or (c) the transaction will improve health outcomes for residents. If the applying entities feel their transaction best meets either (b) or (c), they can tailor their Notice of Material Change Transaction accordingly.

Comment 81: -0070, Confidentiality
In general, this rule essentially requires parties go through the upfront work of meeting the elements of the trade secret test in the Public Records Law, ORS 192.345(2). If a party goes through the work to provide a "confidential" copy of the application to the agency, the copy should on its face be protected under the trade secret exemption under ORS 192.345.

Response: This section of rule does require any entity claiming confidentiality of certain elements of their notice of transaction or subsequent documentation to furnish two versions of the documents, one that includes all information and another that redacts elements the entity considers 'confidential.' An entity claiming confidentiality must also include a redaction log that describes the grounds on which confidentiality is claimed, which can include the trade secret test described above. Subsection (2) details OHA's obligations for treating confidential material within this program.

Comment 82: -0080, Compliance with Conditions
Under section 2(19) of the Act, the Authority analyzes a transaction for compliance with conditions, cost trends and impacts on the cost growth target. This analysis occurs 1, 2, and 5 years out from the time of approval. However, under section (1) of the rule verification of compliance may occur at least 1, 2, and 5 years out, and possibly more frequently. We believe that the rules should align with the statutory responsibility of the Authority to review a transaction on a set interval.

Response: OHA accepts responsibility for analysis of the impacts of all transactions one, two and five years after a transaction has closed. However, some transactions may be approved with conditions, including conditions requested by the public, recommended by a Community Review Board or set forth by a contested case hearing. OHA reserves the right to engage in impact analysis of any given transaction in accordance with the recommended or judicially required conditions of approval.

Jessica Adamson, Providence Health & Services (Exhibit 7)

Comment 83: OAR 409-070-0005. Definitions
Health care entities and the public should have a consistent understanding of the criteria by which a transaction will be evaluated. One important area of clarification missing from the rule concerns what services are considered essential to achieve health equity. This definition is fundamental to ensuring that the Health Care Market Oversight Program is objective, clear and transparent.

Response: See response to Comment #4.

Comment 84: OAR 409-070-0010. Covered Transactions
Section (3)(b) – Providence objects to the language added to this subsection. Clinical experiences and training opportunities are outside of the scope of the authorizing statute and were never discussed as being within scope, we respectfully request that the following be removed: “or a reduction in the number of clinical experiences of training opportunities for individuals enrolled in a professional clinical education program.”

Response: OHA believes this new language, which was suggested by public comment, is a reasonable addition.

Comment 85: Section (3)(d) - As a Catholic health care system, Providence objects to this provision as being outside the scope of the authorizing statute and asks that it be removed. The restrictions described in the provision should be allowed, particularly if there is no net change in access to essential services (and we note, that 0010(2)(e) covers situations involving an actual reduction in essential service). Conscience objections are protected by the First Amendment, affirmed in law, and nothing in the regulations should require us to file notice based on these objections nor should we be prevented from practicing in a way that is consistent with our sincerely held religious beliefs, which are constitutionally protected.

Response: The motivation for decreasing availability of services is not part of the scope of this law. If the number of providers who deliver essential services is reduced by one-third, that is considered a significant reduction that will have negative impacts on the community being served and the transaction is therefore subject to review.

Comment 86: OAR 409-070-0025. Acquisition of Control; Presumptions and Disclaimers
Section (2) – Language in this section should be clarified and allow the OHA to determine that control doesn’t exist. Specifically, we recommend that the last sentence be revised as indicated by the bold language in the following, “The Authority **may or may not** determine, after giving persons that have an interest in the Authority's

determination notice and opportunity to be heard and after making specific findings of fact to support the determination, that control exists…"

Response: OAR 409-070-0025 does allow for rebuttal of control between 10% and 49% of voting securities for carriers and between 25% and 49% for all other health entities. Entities meeting these control criteria but wishing to rebut the actual experience of control can complete a Rebuttal of Presumption of Control form along with the Notice of Material Change Transaction application. Should OHA accept the rebuttal of control, the application fee will be refunded and the transaction will not be subject to review (assuming acquisition of control and materiality were the only criteria met for notification).

Comment 87: OAR 409-070-0055. Preliminary 30-Day Review of a Notice of Material Change
Section (4) – It is the accountability of OHA to complete the 30-day review in that time period. If review is not complete by the OHA within the statutory timeframe, the transaction should be deemed approved. If this is not possible, we suggest the OHA either allow parties to extend from 30-day to 60-day without the need for a full review or allow the entities to withdraw.

Response: See response to Comment #11.

Comment 88: OAR 409-070-0060. Comprehensive Review of a Notice of a Material Change Transaction
Understanding these are complex transactions, it's important that the OHA engage with health care entities to ensure there is clarity about the goals and structure of the transactions under review. The rules need to outline two separate processes for engagement – one for parties engaged in the transaction and one for the public. Specifically, we request:
If the OHA engages an expert, any findings will be made available to the parties at least 30-days prior to a public meeting or decision-making meetings by a review board. Parties to a transaction shall have the opportunity to submit their own report in response to one from the OHA expert in advance of a public meeting or meeting of a review board.

Response: In order to ensure fairness in the process, OHA will inform all audiences of the program's analysis, including input from outside advisors, at the same time. Entities pursuing a transaction will receive notice of the final order on the same day OHA posts the final order to the HCMO website. The one exception will be for transactions involving only domestic insurers, for which DCBS has authority of approval. OHA will convene with DCBS and the domestic insurers involved to review the program's analysis and recommendations to DCBS.

Comment 89: Any complaints regarding a potential transaction received by the OHA and used to render a decision should be made available to the parties in advance of a public meeting or meeting of the review board.

Response: Public comment about proposed transactions may be gathered from many sources and reviewed along varying timelines. All public comments relevant to this program will be posted to the HCMO website as soon as possible so all audiences have equal access.

Comment 90: Any potential conditions imposed in connection with approval of a transaction must be made available to the parties at least 45-days in advance of the OHA issuing a decision, and the parties must be given a meaningful opportunity to respond to the proposed conditions, including proposing alternative conditions. The OHA will provide a reasoned decision if rejecting proposed alternative conditions from parties to a transaction.

Response: There are no provisions in the statute for a formal response or counterproposal from applying entities. Should entities disagree with OHA's final order or wish to contest the conditions of approval included in OHA's final order, they have the right to request a contested case hearing within 30 days of OHA issuing said order.

ACLU, AFSCME, Basic Rights Oregon, Compassion & Choices, Family Forward Oregon, Oregon Health Equity Alliance, Oregon Nurses Association, OSPIRG, Planned Parenthood Advocates of Oregon, Pro-Choice Oregon, SEIU Local 49 (Exhibit 8)

Comment 91: we acknowledge the creation of detailed documents that explicitly address industry questions and concerns about which transactions would be subject to review; the addition of a nine-month period in which applications will not automatically be subject to full review at the conclusion of the 30-day review period; the addition of private conferences with agency staff in which applicants can request guidance; and the creation of a detailed analytic framework outlining what criteria will be used to review transactions. All of these changes, and many more, accommodate industry feedback and concerns raised throughout this process.

Response: No response needed.

Comment 92: Thresholds of Control
We support the proposed thresholds for control in OAR 409-070-0010(1)(b) and believe these changes are necessary to align with Section 1(a) of statute which specifically references partial or complete control. We understand why OHA has chosen to define "complete corporate control" as more than 50 percent. However, it is very possible that

“complete corporate control” of an entity could occur anywhere between 26 percent and 49 percent. For example, if there are more than two owners of an entity, one party could exercise control by holding a majority stake without owning more than 50 percent. Under the newest draft of the rules, these transactions would not trigger a review.
To address this issue, we ask that OHA utilize discretion to impose conditions during the initial review process that would trigger additional review if and when a “complete corporate control” threshold was reached for that specific transaction (be it 30 percent or 40 percent, for example). We believe this approach provides a middle ground that allows for predictability and clarity for the industry, but also flexibility to be responsive to the terms of each unique deal.

Response: Control of 50% or more of voting securities is considered irrebuttable control and subjects a proposed transaction to notice and review (assuming materiality criteria are also met). However, if any entity acquires 10% or more voting securities of a domestic insurer or 25% or more of voting securities for all other health care entities, this still triggers the requirement for notice (assuming materiality criteria are also met) but this level of control is rebuttable and the applying entity may submit a Rebuttal of Presumption of Control form along with the Notice of Material Change Transaction. Should OHA accept the rebuttal of control below 50% of voting securities, the Notice of Material Change Transaction will still be published but the entity will be refunded the filing fee and the transaction will not be subject to further review (assuming no other criteria for review are met). Should OHA not accept the rebuttal of control, the transaction will be subject to review and the associated fees.

Comment 93: Rebuttal of Presumption of Control
We are concerned about OAR 409-070-0025(2) as drafted and urge OHA to consider eliminating the option to bypass the review process by submitting a Rebutting Presumption of Control form. As currently structured, these “disclaimer of control” determinations could have the effect of exempting transactions from review even when they involve one entity acquiring substantial portions of another.
Guided by the statute, OHA already has a straightforward 30-day review process during which the agency will make a full determination about whether any change in control may have a negative impact on consumers. We urge the agency not to allow entities to bypass the established, transparent process developed for this purpose given that relatively small changes in ownership structure can have anti-competitive effects or even result in changes in access to essential services.
The statute explicitly calls out partial control situations, reflecting the reality that there can be implications for decision-making even when partial control changes take place. Rebutting that control with a three-question form is neither satisfactory nor in alignment with the sponsoring legislation. To truly determine the absence of control, OHA would need to require additional information from entities seeking to rebut the presumption of control and likely enter a situation that is duplicative of the 30-day process.
We believe OHA should either abandon the rebuttal process entirely or include language tying control not only to percentage ownership but also to influence over considerations outlined in the statute, such as negative impacts on access to affordable

healthcare and meeting the criteria outlined in the statute for approval of a comprehensive review (Section 2(9)).

Response: See response to comment #92. OHA has added clarifying language in 409-070-0025 that an entity filing a Rebuttal of Presumption of Control form must also submit a Notice of Material Change Transaction. The notice will provide additional information of potential relevance for OHA's control determination and will be posted on the program website for transparency.

Comment 94: Analytic Framework
While we appreciate that OHA did make a small change to OAR 409-070-0045 (9)(b), we remain concerned that limiting measurements to metrics that can be "meaningfully compared to current and past performance across Oregon and, if available, in other states" could be very challenging when assessing situations in individual communities. While the current draft analytic framework does not bear out this concern, we believe that guardrails should live in the rules rather than subregulatory documents. Therefore we suggest the following edit to OAR 409-070-0045 (9)(b): (b) Use measures of quality and access that can be meaningfully compared to current and past performance across Oregon and, if available, in other states. If data is unavailable to parse at an applicable/necessary level or across time, it will not be assumed that there is no impact. Qualitative information will be consulted as well.

Response: Nowhere is it stated that the absence of available data in a particular analytical domain will be equated with the presumption of no impact in that domain. OHA reserves the right to utilize all applicable data sources, including but not limited to those outlined in the Analytical Framework. We appreciate that this is not objectively stated, but should standardized and validated measures of quality and access not be applicable or available for a given entity, OHA will endeavor to gather additional sources of information to support a review of the transaction within the designated analytic domains. An entity's inability to generate data related to the standard measures of access and quality described in the Analytic Framework may itself present a concern for the quality of care and population management capacity of the entity that could trigger the need for a comprehensive review.

Comment 95: Adding Focus on Essential Services in Definition of Public Good
We believe OAR 409-080-0060 (9)(b) aligns with statute; however, we suggest one minor addition to add greater specificity to (b)(B). We suggest inserting "essential" before "services" to read:
"Increasing access to essential services in medically underserved areas." We believe this change better aligns with statute by emphasizing increasing access to "essential" services when defining public good.

Response: While statute language does flag reduction of 'essential' services as an element qualifying a proposed transaction for review, it does not limit how 'benefit to the

public good' is determined. Underserved areas by definition lack or experience a deficit in a range of services and it does not feel appropriate to limit the perceived benefits of a proposed transaction only to its potential impact on services identified as 'essential.'

Bryce Helgerson, Legacy Health (Exhibit 9)

Comment 96: Definitions (-0005)
Consistent with our comments during the RAC, we believe the definition of "control" remains too broad and, to date, remains unchanged. Our view is that control arises when an entity commands the governing body's decision making, not simply when they are one participant among others to the decision. We recommend clarifying the final rules so that they stipulate control exclusively applies to transactions that truly change the managing control of a health care entity.

Response: The current definition of control in subsection (8) reads "the direct or indirect power to manage a legal entity or set the legal entity's policies, whether by owning voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office." Section (-0025) presents examples of how that 'power to manage or set policies' can be observed or demonstrated within health care entity ownership or governance.

Comment 97: Covered Transactions (-0010)
Section (1)(a) includes a "consolidation" of a health care entity with another entity. HB 2362, Section 1 (10), refers only to a "merger." The statue does not apply to consolidations and therefore should be redacted from the rule.

Response: The rule includes "consolidation" to make clear that transactions that combine health care entities by a means other than a statutory merger are subject to review.

Comment 98: The draft rule's definition of an "acquisition" should not apply to the provision of comprehensive management services ((2)(d)) because such services are not an exercise of control.

Response: Provision of management services is identified in statute as a covered transaction, and OHA interprets this inclusion to mean that providing management services that support fundamental operational functions (including financial services, payer negotiations, practice management and administrative support, human resources, and ownership of tangible assets) is a means of exercising control over an entity's management and decision-making, in line with the definition of control presented in

section (-0005) of the rule. OHA notes that DCBS considers the provision of comprehensive management services to be an exercise of control.

Comment 99: Section (2)(e) should be eliminated. It describes a merger rather than an acquisition and is redundant to (1)(a).

Response: The statute defines the merger of tax identification numbers as a corporate affiliation, ORS 415.500(1)(b).

Comment 100: Emergency Transactions (-0022)
We note that Section (1) was changed to require that "…the transaction is urgently needed to protect the interest of consumers and to preserve the solvency of an entity other than a domestic health insurer." We request that the Agency revert back to "or." The statute does not require that the transaction involve a lack of solvency (see HB 2362, Section 2 (8)(a)), and a public health emergency transaction, for example, may not involve solvency.

Response: This section of rule describes the conditions under which OHA and DCBS 'may' exempt a proposed transaction from review and this exemption is contingent upon all three of the stated conditions being met:

1. The transaction is being proposed in response to an emergency situation
2. The transaction is urgently needed to protect the interest of consumers
3. The transaction is urgently needed to preserve the solvency of an entity

Exemption from review will be granted only if all 3 conditions are met, otherwise OHA and DCBS still reserve the right to perform their due diligence and assess whether a transaction under these circumstances is in the best interest of the community and the long-term financial health of all parties involved.

Comment 101: Disclaimers of Control (-0025)
As discussed above, what constitutes control of a health care entity is a complex, situation-dependent determination. As such, we recommend that all presumptions of control be rebuttable.

Response: See response to Comment #45.

Comment 102: Notice of OHA's findings, as expressed in Section (2), should not be provided to parties outside the transaction. The findings are confidential, legal decisions and parties outside the transaction are not positioned to comment on what the law considers to be "control" with respect to a particular entity.

Response: One of the goals of the statute is to make changes within the health care delivery landscape more transparent to the general public. OHA will follow regulations

and policies for the protection of confidential and privileged information from public disclosure but is held accountable to the public for transparency in this review process.

Comment 103: Retention of Outside Advisors (-0050)
We request removal of the reference to privileged information in Section (1). Privileged information should not be requested by or disclosed to OHA or outside advisors during the review.

Response: See response to Comment #77.

Comment 104: There should be a mechanism for parties to halt the review process if expenses escalate to the point that the transaction is no longer feasible.

Response: OAR 409-070-0045 (10) states that any party to a notice of material change transaction may rescind the notice at any time for any reason. If OHA has already begun the transaction review, the parties are still responsible for the filing fee and any expenses incurred (e.g., for outside advisors) prior to the withdrawal.

Comment 105: Comprehensive Review (-0060)
We appreciate that review board members will be required to file conflict of interest statements as required by HB 2362, Section 2 (11)(b). We recommend, however, that this take place before members are appointed to the review board in case exclusion due to an actual conflict is necessary.

Response: Per 409-070-0060, individuals with an actual conflict of interest will not be appointed to a Community Review Board.

Comment 106: We request that Section (7) be modified to allow the parties to the transaction to review and comment on the proposed findings of fact and conclusions of law, along with the Authority's proposed order, before it is released for public review. This will prevent confusion should the findings or order require any corrections or clarification to findings of fact.

Response: See response to Comment #88. OHA will be making conclusions based on its analysis of data that is either publicly available and based on data entities submit or report to national or state organizations (e.g., data reported to Centers for Medicaid and Medicare Services), data routinely submitted to OHA for payment or reporting, or information requested to be furnished by the entities themselves. Entities may disagree with OHA's interpretations or conclusions from these data, but OHA will assume that the information furnished to it is not false or misleading in any material respect, OAR 409-070-0080(3).

Comment 107: The comprehensive review process should not exceed 180 days. If the Agency fails to issue a decision within that time, the transaction should be deemed approved without conditions.

Response: As noted in section (-0060)(10) of the rules, OHA is required to complete the comprehensive review and issue its final order within 180 of receiving the notice of material transaction, unless an extension is mutually agreed upon by all parties. If a tribal consultation is required and cannot be arranged within the 180-day comprehensive review period, the transaction may be disapproved if the applying entities do not agree to an extension.

Comment 108: Confidentiality (-0070)
We encourage OHA to publish a summary, created by the filing party, of the information in the Notice of Material Change Transaction form rather than publicly posting the form itself. Given the likelihood that the notice will be heavily redacted due to the inclusion of confidential information, a summary will better serve the public.

Response: OHA's final order will be posted on the program's public website and will include a summary of the conditions and circumstances of a proposed transaction. However, OHA is committed to transparency in this process and has agreed to post the Notice of Material Change Transaction form so the public can view the terms of the transaction from the entities' own words and perspective.

Comment 109: Compliance with Conditions; Information Requests (-0080)
Any additional orders, whether related or unrelated to original orders, should only be issued after a notice and an opportunity for a hearing. We request that the final rule make that clear.

Response: The authority to issue additional orders described in this section relates only to monitoring compliance with conditions of approval outlined in the final order. If an entity disagrees with the conditions placed on initial approval, the entity has the right to request a contested case hearing within 30 days of