

# Health Care Market Oversight (HCMO) Program Determination of Covered Transaction Status

Please fill out and submit this form to [hcmo.info@dhsoha.state.or.us](mailto:hcmo.info@dhsoha.state.or.us).

Use this form to request that OHA determine whether a planned transaction must submit a notice of material change transaction. Submission of this form is optional. Please submit this form at least 210 days prior to the effective date of a planned transaction. OHA will review this form and provide written notice of covered transaction status. OHA may request additional information or discussion as needed to determine covered transaction status. This document is intended for state agency use and will not be publicly posted.

## I. General Information about the Transaction and Entities

1. Name, title, organization, and email address of the individual completing this form.

Name	
Title	
Organization	
Email Address	

2. What type of transaction is the applicant proposing<sup>1</sup>?

Merger                       Contract                       Other (specify) \_\_\_\_\_  
 Acquisition                       Affiliation

3. What is the proposed effective date of the transaction?

4. Please list the entities involved in the transaction. (Add page if there are additional entities.)

	Entity name	Type of entity <sup>2</sup>
Entity 1		
Entity 2		
Entity 3		

<sup>1</sup> Please see OAR 409-070-0010.

<sup>2</sup> Please see 409-070-0005(16).

5. Briefly describe the nature and objectives of the proposed material change transaction, including any exchange of funds between the parties (such as any arrangement in which one party agrees to furnish the other party with a discount, rebate, or any other type of refund or remuneration in exchange for, or in any way related to, the provision of health care services) and whether any changes in health care services are anticipated in connection with the proposed transaction.

6. Describe why you believe this transaction is not a covered transaction per ORS 415.500 et seq. and OARs 409-070-0000 through 409-070-0085.

7. Has one entity had an average annual revenue of \$25 million or more for three most recent fiscal years?  
 Yes       No       Don't know
8. Has another entity had an average annual revenue of \$10 million or more for three most recent fiscal years?  
 Yes       No       Don't know       Not applicable
9. Are any proposed new legal entities projected to have at least \$10 million in revenue for the first full year?  
 Yes       No       Don't know       Not applicable
10. Is the proposed transaction anticipated to eliminate or significantly reduce access to services?<sup>3</sup>  
 Yes       No       Don't know
11. Will the proposed transaction consolidate or combine providers contracting payment rates or insurers establishing health premiums?  
 Yes       No       Don't know
12. Will the proposed transaction change presumed control of an entity?<sup>4</sup>  
 Yes       No       Don't know

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<sup>3</sup> Please see Essential Services and Significant Reduction Guidance document:  
<https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Essential-Services-and-Significant-Reduction-Guidance-FINAL.pdf>

<sup>4</sup> Please see 409-070-0025.