Oregon Association of Hospitals and Health Systems

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Directors Allen and Vandehey,

On behalf of Oregon's 62 hospitals and the communities they serve, the Oregon Association of Hospitals and Health Systems (OAHHS) is providing these written comments as follow-up to the first Technical Advisory Group (TAG) meeting, held on January 14, 2022, regarding the development of sub-regulatory guidance for the Health Care Market Oversight (HCMO) Program.

The Authority's stated purposes for this meeting were to:

- Further specify the concept of "essential services" which, in accordance with the statute, includes "services that are essential to achieve health equity," and

- Specify how a health care entity will determine if a transaction will significantly reduce essential services.

As we have stated throughout the rules advisory process for the implementation of HB 2362, these concepts should be addressed through rulemaking, as explicitly directed by the law (HB 2362, Section 1 (10)(c)), and not through sub-regulatory guidance.

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. Creating more guidance documents does not necessarily create clarity.

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.[1] 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"will" in HB 2362 indicates a much higher level of foreseeability and causality than the presumptions set forth in the draft guidance.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.

Ultimately, the draft guidance document presented to the TAG creates more questions than it answers and further pushes the HCMO Program outside the boundaries of HB 2362. Under the proposed analysis, day-to-day decisions that any health care organization might make about how best to serve its patients and communities may become subject to a costly and unpredictable government review process when they are made in collaboration with another entity. This will have a chilling effect on innovation and collaboration. This is an illogical and irresponsible use of health care dollars, and we do not believe it reflects the intent of our legislators.

Sincerely,

Andi Easton
Vice president of government affairs
Oregon Association of Hospitals and Health Systems

[1] Examples we have provided in previous comment letters (on 11/19/2021 and 12/14/2021) demonstrating the need for a holistic look at the results of a transaction include:

i. A transaction may increase time or distance to access due to a change in location but offer more services, offer better care, and decrease wait times for appointments.

ii. A reduction of providers may not necessarily lead to a significant reduction in services.

iii. Managed care may place restrictions on providers to increase appropriate service utilization, control cost, and decrease waste. It may also place appropriate barriers to care, such as prior authorizations and consults to ensure that care is necessary. Consider, for example, a requirement that physical therapy be pursued before advanced imaging or surgery is offered for back pain. The rule incorrectly assumes that efforts made to decrease cost and improve efficacy are inappropriate activities.

iv. Changes in services may be necessary to address shifting community needs, such as adjusting the availability of pediatric vs. geriatric care, or may help optimize care delivery and access, such as closing a dialysis center because more in-home dialysis services are available.