# Health Care Market Oversight HCMO-4: Determination of Covered Transaction Status

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Pursuant to OAR 409-070-0042, any party to a proposed material change transaction may use this form to request that OHA determine whether such transaction is a covered transaction under ORS 415.500 et seq. and OARs 409-070-0000 to 409-070-0085. Submission of this form is optional. Submit this form electronically as a portable document form (pdf) to OHA by email at [hcmo.info@oha.oregon.gov](mailto:hcmo.info@oha.oregon.gov).

Submission of this form does not toll any statutorily mandated timelines. OHA recommends you submit this form at least 210 days prior to the anticipated date of a planned transaction.

OHA may request additional information or documentation as needed to determine covered transaction status. This document and supporting materials are intended for state agency use and will not be publicly posted. OHA may publicly post its determination letter.

If any information you provide is confidential under public records law (ORS 192.311-192.478), please clearly mark it as such and provide a redaction log. For more information about HCMO’s approach to confidentiality, please see [HCMO Use of Confidential Information](https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/Confidential-Information.pdf).

## General Information about the Transaction and Entities

1. List all parties to the transaction. Add extra rows as needed.

|  |  |
| --- | --- |
| Party A (Applicant) | Click or tap here to enter text. |
| Party B: | Click or tap here to enter text. |

Click or tap here to enter text.

1. Provide the requested information for Party A.

|  |  |
| --- | --- |
| Legal entity name | Click or tap here to enter text. |
| Tax ID | Click or tap here to enter text. |
| Mailing address | Click or tap here to enter text. |
| Website | Click or tap here to enter text. |
| Contact Name | Click or tap here to enter text. |
| Title | Click or tap here to enter text. |
| Phone | Click or tap here to enter text. |
| Cell Phone | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |

1. Briefly describe the parties to the transaction. Include the following for each party:

Click or tap here to enter text.

* 1. Business lines or segments

Click or tap here to enter text.

* 1. Presence in Oregon, which may include market share, number of people served, and/or number of services provided

Click or tap here to enter text.

1. Provide the type of proposed material change transaction. (See OAR 409-070-0010.)

Merger

Acquisition

Affiliation

Contract

Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe the proposed material change transaction, including:
   1. Goals and objectives

Click or tap here to enter text.

* 1. Summary of transaction terms

Click or tap here to enter text.

* 1. Any exchange of funds between the parties, including the nature, source and amount of funds or other consideration (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).

Click or tap here to enter text.

1. Describe whether any changes in health care services are anticipated in connection with the proposed transaction.

Click or tap here to enter text.

## Covered Transaction Status Information

1. 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. Provide supporting documentation, if applicable.

Click or tap here to enter text.

1. Has one entity had an average annual revenue of $25 million or more for three most recent fiscal years?

Yes No Don’t know

1. 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

1. 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

1. Is the proposed transaction anticipated to eliminate or significantly reduce access to services? (See [Essential Services and Significant Reduction](https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-Essential-Services-and-Significant-Reduction-Guidance-FINAL.pdf) guidance document.)

Yes No Don’t know

1. Will the proposed transaction consolidate or combine providers contracting payment rates *or* insurers establishing health premiums?

Yes No Don’t know

1. Will the proposed transaction change presumed control of an entity? (For more information, see OAR 409-070-0025.)

Yes No Don’t know

## Supplemental materials

Submit the following materials with your submission:

Pre- and post-transaction organizational structure diagram

Copies of all current transaction agreements and term sheets

Documentation to support your responses, if applicable

Redaction log, if applicable