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Client Alert Commentary

Latham & Watkins Healthcare & Life Sciences Practice

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US State Regulatory Spotlight on Healthcare Transactions

Growing state-level oversight of M&A and other strategic transactions for healthcare provider businesses will impact growth strategies across major markets.

The volume of healthcare services transactions in the United States has risen significantly in the last 15 years, as providers and investors reconfigure around new delivery models trying to address systemic problems with access, quality, outcomes, and cost. New provider collaborations with payors and other strategic partners and an influx of private equity investment have driven the reconfiguration.

Many US legislators and regulators are questioning whether these developments are addressing or exacerbating existing systemic problems. The antitrust regulatory environment has shifted markedly with increased governmental focus on merger activity, particularly in healthcare. These questions and developments have also prompted a new expansion in state-level regulatory oversight of healthcare mergers and acquisitions, joint ventures, and other strategic transactions. Private equity and deals involving physician groups are clear targets. Whether or not a granular analysis of individual transactions will afford the desired macroeconomic insights remains to be seen. However, this political sojourn will dramatically impact the business plans and acquisition strategies for healthcare services businesses.

This Client Alert provides key takeaways, analysis, and action items for investors and providers, as well as an Appendix detailing the enacted and pending legislative and regulatory developments.

Key Takeaways

- Several states have increased oversight on more types and sizes of healthcare services transactions.
- Regulatory reviews will focus on anti-competitive behavior and effects as well as potential negative impacts to access to care, quality of care, and cost of care.
- Required disclosures will extend beyond basic transaction details, sometimes including projections and forecasts regarding future impacts resulting from the transaction, which could easily open the door for tangential operational audits.
- Details of the review processes are still to be determined but are likely to mimic and expand on pre-existing review regimes (e.g., Hart-Scott-Rodino Act (HSR), nonprofit health system AG reviews, certificate of need/exemption reviews, licensure change-of-control reviews) as well as raise serious concerns regarding the mobilization of state resources with sufficient capacity and expertise to provide meaningful, timely and efficient review.

- Competitors and customers may attempt to weaponize the review process through freedom of information requests for submitted materials and evaluation notes, lobbying efforts targeting state regulators, and public relations campaigns to foment opposition during public hearings.

- Given the broad capture of the new review regimes, review will largely not depend on deal structure.

- Some review processes require or encourage the reviewing agency to notify other relevant agencies about the pending transaction; increased coordination among relevant regulators could create additional deal execution challenges.

- Pre-closing review periods, increased disclosure requirements and opportunities for regulators to require public hearings, and proposed deal modifications promise that deals will take longer and the parties will have to address the increased executional cost and risk.

What Policy Objectives Are Driving These Reviews?

Whether in supporting pretext or hardwired into the legislation itself, a core set of common policy objectives resonate through these various transaction review proposals. Foremost are concerns about transactional impacts on systemic problems of healthcare accessibility, quality, cost, and equity. At a time when regulators are increasing antitrust oversight, regulatory suspicion that recent consolidation is fueling anti-competitive behavior is another motivating factor. Another such factor is some regulators' general unease with the role of private equity and management services organizations in healthcare delivery.

None of these policy considerations are particularly new or surprising, but the tone of recent reforms evidence greater skepticism. Claims about transactional benefits will be tested more, as transaction parties are pushed to provide more detail regarding post-closing operating plans, clearer measures for achieving those stated objectives, and mitigation strategies for potential negative effects. Some inquiries will go beyond the transaction and evaluate the capability of the parties to deliver on their promised benefits and advance the states' broader policy objectives. Such inquiries could include character and competency assessments for members of key leadership and holistic assessments of the parties' financial conditions and funding sources. These review processes also propose higher levels of accountability, empowering regulators to impose additional conditions to transaction approval, post-closing monitoring and reporting obligations, and — at the extreme — financial penalties for failure to deliver on measurable systemic benefits.

What Transactions Are Covered?

- **Broader application:** The new regimes expand review beyond traditional bounds (e.g., nonprofit public trust, certificate of need, and facility licensure reviews) to require review for transactions involving virtually any form of healthcare services provider organization.

- **Not just traditional change-of-control transactions:** The new regimes are not limited to traditional mergers and acquisitions, but often require review of any "material transactions," which may include minority ownership changes, joint ventures, collaboration agreements, and even some commercial arrangements. Indeed, purely internal restructurings and compliance-driven amendments could feasibly trigger notice and review in some states.

- **Specific targeting of physician practice management deals:** Many of the new regimes clearly contemplate physician practice transactions and "management services organizations," often coupled with political skepticism regarding the influence of private equity in such enterprises. New York and

proposals in California specifically reference “management services organizations” among the types of businesses subject to the transaction review process.

- **Smaller transactions:** The new regimes significantly lower the size of transaction and size of person thresholds (compared to existing HSR review thresholds), with lower limits defined by the number of providers (e.g., any group of seven or more providers, including mid-levels, in Washington State; a group of 20 or more providers in Illinois) or the volume of in-state revenues or projected increases in revenue (e.g., an increase of more than $25 million of in-state revenue in New York; more than $10 million of in-state revenue in Oregon).

What Will These Review Processes Look Like?

Most new reform proposals are high-level, focusing on policy objectives and sketching a basic outline of review standards, timing elements, and required submissions. However, much is left for the applicable regulatory agencies (state attorneys general and regulatory boards) to determine through the promulgation of additional administrative rules and regulations to effect the legislative intent. Looking at what these proposals contain — and assuming regulators will otherwise draw inspiration from familiar preexisting review regimes (e.g., certificate of need reviews, nonprofit public trust reviews and licensure reviews) — one can anticipate that the new review processes will share a number of common features, including:

- **Longer post-signing, pre-closing review periods:** Most of the new transaction review regimes require pre-closing submissions and clearance. Parties will also need to factor in additional time and resources for preparing initial submissions and navigating the subsequent review and approval process. Some states have ambitiously set their programs to coincide with applicable HSR review periods (generally 30 days, although the HSR review period can be extended substantially if the Federal Trade Commission conducts a full investigation). Others have adopted or proposed processes that allow several months for regulatory review. Parties will need to watch closely what additional administrative guidance regulators promulgate to answer important timing questions. These questions include: When/how will the parties know their submissions are complete? How do additional information requests and/or proposed transaction modifications impact the review timelines? How will the new reviews impact other regulatory review processes? How will transaction financing have to be structured to accommodate longer review periods? Will the terms of financing attract more scrutiny?

- **Low thresholds for transaction review:** Most of the new transaction review regimes extend their purview to enterprises and transactions that fall well below existing federal antitrust review standards. In varying ways, most states also provide minimum thresholds — typically defined by a number of providers or amount of revenue. However, each of these criteria raise additional questions. What providers count? On what basis? How is revenue defined and attributed to being in-state or out-of-state? Will states challenge the parties’ assessments? If so, what would that mean for a transaction that closes based on a good-faith belief in exemption from review? In many cases, these straightforward questions have complicated answers.

- **Enhanced disclosure obligations:** Disclosure requirements are extending beyond basic transaction terms to include required disclosures regarding the parties’ financing sources, general financial conditions, key operational matters (e.g., admission policies, billing and collections practices, and clinical quality oversight), and anticipated operational changes (e.g., changes in service offerings, staffing impacts, and participation in specific payor networks).

- **Impact analysis:** Some states are going further than mere disclosure requirements, mandating that the transaction parties submit statements and supporting materials regarding the impact of the

transaction (and the parties' post-transaction strategic planning) on competition in the local market(s), access to and quality of care, commitments to charity care, and planned countermeasures to mitigate potential negative impacts on the affected communities. In the extreme, one proposal pending in Washington State would require the commission of an independent third-party health equity assessment as part of each transaction review, with a focus on access and affordability, an assessment of systemic financial cost, and a discussion of transaction alternatives. These requirements in particular implicate antitrust issues, both at the state and federal levels, increasing the potential for follow-up federal and state antitrust investigations (even if the transaction is cleared).

- **Public notice and hearings:** Some states are drawing from prior experience with certificate of need and attorney general reviews to mandate public notice and hearings for transactions subject to the new review regimes. In states with public hearing processes, obtaining approval may be more complicated or prolonged. Competitors and other stakeholders may also try to weaponize public hearings for their own benefit.

- **Approval conditions and post-closing oversight:** In some states, the review process will not necessarily conclude with a binary approved/not approved result. Certain legislative proposals would authorize regulators to impose post-closing monitoring and reporting requirements, as well as potential liability for adverse impacts and failed objectives.

Action Items

Implementation of the new state-level review regimes will take time as state regulators develop the necessary additional administrative guidance and ramp up their internal personnel and infrastructure resources to deal with the new transaction review volume. Transactions during these dynamic early periods will face particular challenges and uncertainty as parties attempt to navigate these review processes while regulators are still refining their rules and regulations and developing precedent and customs. In the interim, provider organizations can take a number of steps to prepare, including:

- **Adjust existing investment models and acquisition playbooks** to anticipate longer transaction timelines, increased deal expense, and the potential of operational changes that might be required to obtain state transaction approval.

- **Apply best-in-class antitrust protocols and similar policies early and often** for all strategic transaction evaluations and communications, and engage antitrust counsel early to ensure coordination across reviews.

- **Augment your awareness training** for the corporate strategy, business development, and integration teams.

- **Reevaluate existing affiliation models and compliance infrastructure** to ensure the company is using best-in-class approaches with appropriate sensitivity to state idiosyncrasies.

- **Consider how transaction documents will allocate the costs and risks of review** (i.e., closing conditions, interim operating covenants, regulatory review covenants, and termination rights).

- **Consider transaction financing implications** (i.e., longer regulatory review and approval processes may necessitate longer (and potentially more expensive) third-party financing commitments than were previously required). The terms of financing packages may also need to be tailored depending on the focus and nature of regulatory review.

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CALIFORNIA

California Health Care Quality and Affordability Act

(CAL. HEALTH & SAFETY CODE § 127500)

Status: Enacted **Draft Regulations Published July 27, 2023**	**Applicable to Transactions Closing on or After April 1, 2024**
Regulating Authority	California Office of Health Care Affordability (OHCA)
Purpose	To increase transparency of mergers, acquisitions, and corporate affiliations that may impact market competition and affordability. The law grants OHCA broad authority to investigate anti-competitive consolidation among healthcare entities, which the California legislature has identified as a primary driver of escalating healthcare costs in the state.
Impacted Transactions	• Merger or acquisition involving a material amount of assets • Sale, transfer, lease, exchange, option, encumbrance, conveyance, or disposition of a material amount of assets • Change of control or governance involving a material amount of assets or operations
Impacted Healthcare Entities	Includes transactions involving any: • Ambulatory surgical center • Clinical laboratory • Community clinic • Specialty clinic • Healthcare service plan • Health insurer • Health system • Hospital • Imaging center • Pharmacy benefit manager • Physician practice with at least 25 physicians or otherwise considered "high-cost outliers" • Third-party administrator
Excluded Transactions / Materiality Threshold	Transactions already subject to review*, including those involving: • Healthcare service plans or health insurers reviewed by the Department of Managed Health Care, the Department of Insurance, or under the Knox-Keene Health Care Service Plan Act of 1975 • Non-profit corporations reviewed by the Attorney General Draft regulations propose to exclude certain de minimis transactions (e.g., healthcare entities with less than $25 million in annual revenue).
Timing of Initial Filing	At least 90 days prior to closing
Review Process	• Preliminary review • Potential cost and market impact review, including public notice and comment • If cost and market impact review is required once OHCA publishes its final report, a 60-day waiting period must expire before parties can close
Review Criteria	Preliminary review includes: • Access to healthcare services • Quality of care • Efficiency • Market competition • Costs for the state • Costs for consumers
Post-Closing Obligations & Monitoring	None specified — subject to further administrative guidance
Miscellaneous	Potential referral to Attorney General for review of unfair competition, anti-competitive behavior, or anti-competitive effects Final regulations expected in 2023 *Excluded transactions may be referred by the applicable reviewing authority to OHCA for a cost and market impact review.

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CONNECTICUT

An Act Concerning Notice of Acquisitions, Joint Ventures, Affiliations of Group Medical Practices and Hospital Admissions, Medical Foundations and Certificates of Need

PUBLIC ACT NO. 14-168 (CONN. GEN. STAT. § 19A-486l)

Status: Enacted	Effective October 1, 2014
Regulating Authority	Connecticut Attorney General (the CT AG)
Purpose	To monitor and regulate competition with respect to healthcare services
Impacted Transactions	• Merger and acquisition • Employment arrangement of substantially all physicians in a group practice • Affiliation between two or more entities to negotiate rates
Impacted Healthcare Entities	Transactions involving **a group practice and a**: • Hospital • Hospital system • Captive professional entity • Another group practice • Medical foundation • Entity organized or controlled by hospital or hospital system
Excluded Transactions / Materiality Threshold	Transactions involving two group practices that result in a group practice with seven or fewer physicians
Timing of Initial Filing	At least 30 days prior to closing
Review Process	None specified
Review Criteria	None specified
Post-Closing Obligations & Monitoring	None specified, other than annual reports noted below
Miscellaneous	Must notify the CT AG of any transaction that is subject to HSR review Hospitals and hospital systems affiliated with a group practice, and group practices comprising 30 or more physicians, must file an annual report with the Attorney General and Commissioner of Public Health. The report includes: • The names and specialties of each physician practicing medicine within the group practice • The names of the business entities providing the services • A description of services provided at each location • The primary service area served by each location

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ILLINOIS

Public Act 103-0526

(20 ILL. COMP. STAT. § 3960)

Status: Enacted	Proposed Effective Date: January 1, 2024
Regulating Authority	Office of the Illinois Attorney General (the IL AG)
Purpose	To amend the Illinois Antitrust Act — with corresponding amendments to the Illinois Health Facilities Planning Act and State Finance Act — to increase the IL AG's oversight of transactions involving healthcare facilities and large provider organizations to control cost and quality of care and protect the public from reduced competition due to transactions that are not subject to federal oversight
Impacted Transactions	• Merger and acquisition, excluding a corporate reorganization • Contracting affiliation between two or more entities to negotiate rates, excluding arrangements among entities under common ownership • Impacted transactions include those involving an out-of-state entity, if the out-of-state entity generates $10 million or more in annual revenue from patients residing in Illinois
Impacted Healthcare Entities	Transactions involving **two or more**: • Ambulatory surgery centers • Hospitals • Kidney disease treatment centers • Entities in "healthcare delivery or management" representing at least 20 healthcare providers in contracting with health plans or third-party administrators, including: - Physician organizations - Independent practice associations - Provider networks - Physician-hospital organizations - Accountable care organizations
Excluded Transactions / Materiality Threshold	None specified — subject to further administrative guidance
Timing of Initial Filing	At least 30 days prior to closing
Review Process	• IL AG may request additional information within 30 days of receipt of notice • 30-day waiting period after the parties have substantially complied with the IL AG's first request for additional information
Review Criteria	None specified — subject to further administrative guidance
Post-Closing Obligations & Monitoring	None specified — subject to further administrative guidance
Miscellaneous	If applicable, parties may satisfy the initial filing requirement by providing to the IL AG a copy of either: • The HSR filing submitted to the Federal Trade Commission or the Department of Justice • The application for a change of ownership with the Illinois Health Facilities and Services Review Board • Implementing regulations pending

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MASSACHUSETTS

MASS. GEN. LAW. C. 6D § 13; 958 CMR 7.00

Status: Enacted	Effective January 1, 2013
Regulating Authority	Massachusetts Health Policy Commission (HPC)
Purpose	To monitor healthcare spending growth and publicly report on the evolving structure and composition of the provider market
Impacted Transactions	Transactions involving any provider / provider organization, including: • Merger and acquisition with or by an insurance plan, a hospital, or health system, excluding a corporate reorganization • Merger and acquisition or other affiliation with provider / provider organizations that results in a $10 million or more increase in net patient service revenue or a near-majority of market share, excluding a corporate reorganization • Clinical affiliations in which each party has $25 million or more net patient service revenue, other than those solely relating to clinical trials or graduate medical education programs • Formation of a partnership, management services organization, or other structure to contract with health plans or third-party administrators
Impacted Healthcare Entities	Transactions involving any: • Entity in "health care delivery or management" that represents one or more providers in contracting with carriers or third-party administrators, including: - Physician organization - Physician-hospital organization - Independent practice organization - Provider network - Accountable care organization - Entity contracting with carriers for payment for healthcare service • Hospital • Person or entity qualified to provide healthcare services
Excluded Transactions / Materiality Threshold	Provider / provider organization with less than $25 million net patient service revenue
Timing of Initial Filing	At least 60 days prior to closing
Review Process	• Preliminary review within 30 days of receipt of notice • If required, a cost and market impact review which can take 185 days. This review will be required if HPC determines that the proposed transaction is likely to impact significantly the state's ability to meet the healthcare cost growth benchmark or the competitive market, or if the change in healthcare expenditure exceeded the healthcare cost growth benchmark of the previous calendar year. • Parties may not close until HPC has determined not to initiate a cost and market impact review or until at least 30 days after HPC has issued its final report on a cost and market impact review.
Review Criteria	Cost and market impact review includes: • Size and market share • Price and relative price compared to other providers • Impact on competition • Quality and patient experience • Cost and cost trends • Adjusted total medical expense • Consumer concerns • Availability and accessibility of similar services • Methods to attract patients and recruit healthcare professionals • Any at-risk, underserved, and government payor patients • Any low/negative margin services
Post-Closing Obligations & Monitoring	None specified
Miscellaneous	HPC may refer its final report to the Attorney General for review.

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MINNESOTA

H.F. NO. 402; MINN. STAT. § 145D (2023)

Status: Enacted	Effective May 26, 2023
Regulating Authority	Minnesota Attorney General (the MN AG) and Commissioner of Health (the Commissioner)
Purpose	To analyze the impact of healthcare transactions on healthcare costs, market consolidation, and quality, and prohibit transactions that substantially lessen competition or create a monopoly
Impacted Transactions	• Merger and acquisition • Sale, lease, security interest, or transfer of 40% or more of assets or ownership • Revenue-sharing agreements involving 40% or more of revenue • Governance changes that transfer control or responsibility to another entity, other transfers of control, and creation of new healthcare entities
Impacted Healthcare Entities	Transactions involving any: • Hospital • Hospital system • Captive professional entity • Medical foundation • Group practices of two or more physicians • Entities organized or controlled by, or which own or control, any of the above entities
Excluded Transactions / Materiality Threshold	Excluded transactions include: • Clinical affiliations to collaborate on clinical trials or provide graduate medical education • Contracts with healthcare providers for clinical services • Corporate reorganizations A streamlined notice process (rather than a full review) exists for transactions involving any healthcare entity with less than $80 million in historical or anticipated annual revenue.
Timing of Initial Filing	At least 60 days prior to closing
Review Process	The MN AG may extend the notice and waiting period for an additional 90 days and may include a public listening sessions or forums.
Review Criteria	Includes: • Harm to public health • Access to affordable and quality care • Effect on competition • Delivery of healthcare to underserved communities • Medical education and teaching programs • Market for skilled workers • Healthcare costs and cost trends • Wages and collective bargaining
Post-Closing Obligations & Monitoring	Commissioner may use the collected data to conduct analyses of the aggregate impact of transactions on access to or the cost of healthcare services, healthcare market consolidation, and healthcare quality, and will publish periodic public reports.
Miscellaneous	Additional disclosure requirements and review criteria for non-profit healthcare entities The MN AG may bring an action to unwind a transaction that violates the law or is contrary to the public interest. Implementing regulations pending

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NEVADA (PART 1)

NRS § 439A.126

Status: Enacted	Effective October 1, 2021
Regulating Authority	Nevada Department of Health and Human Services (DHHS)
Purpose	To monitor healthcare transactions and healthcare consolidation
Impacted Transactions	• Merger and acquisition of a hospital or group practice • Affiliation between group practices • Employment arrangement of substantially all physicians in a group practice • Contract for management of the hospital and contract for management of certain group practices
Impacted Healthcare Entities	• Hospitals • Physician group practices
Excluded Transactions / Materiality Threshold	Transactions involving a physician group practice that represents less than 20% of the physicians who practice a specialty in a primary service area or does not represent the largest number of physicians of any physician group practice that is a party to the transaction
Timing of Initial Filing	Within 60 days after consummation of the transaction or contract
Review Process	Notice only
Review Criteria	None specified
Post-Closing Obligations & Monitoring	DHHS will publish an annual report regarding market transactions and concentrations.

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NEVADA (PART 2)

NRS § 598A.390

Status: Enacted	Effective October 1, 2021
Regulating Authority	Nevada Attorney General (NV AG)
Purpose	To monitor healthcare transactions and healthcare consolidation
Impacted Transactions	• Merger and acquisition • Affiliation with another group practice or health insurance carrier • Employment arrangement of substantially all physicians in a group practice
Impacted Healthcare Entities	• Group practices • Health insurance carriers
Excluded Transactions / Materiality Threshold	• Transactions that would result in a group practice or health carrier providing less than 50% of any healthcare service within a geographic market • Transactions involving business entities under common ownership
Timing of Initial Filing	At least 30 days prior to consummation of the transaction
Review Process	Notice only
Review Criteria	None specified
Post-Closing Obligations & Monitoring	None specified
Miscellaneous	Providing a copy of any HSR filing to the NV AG satisfies the notice requirement

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NEW YORK

Disclosure of Material Transactions

(NY PUB. HEALTH LAW., ART. 45-A)

Status: Enacted	Effective August 1, 2023
Regulating Authority	New York State Department of Health (the Department)
Purpose	To increase regulatory oversight of physician practices, particularly given the trend of large physician practices being managed by investor-backed entities
Impacted Transactions	• Merger and acquisition, including a change of 10% or more of the direct or indirect ownership interests of a healthcare entity • Affiliation agreements • Formation of a partnership, management services organization, or other structure to contract with health plans, third-party administrators, pharmacy benefit managers, or other healthcare providers
Impacted Healthcare Entities	Transactions involving any: • Physician practices • Management services organizations
Excluded Transactions / Materiality Threshold	Excluded transactions include those that: • Are already subject to review (i.e., transactions involving hospitals, emergency medical services, home care services, hospices, continuing care retirement communities, fee-for-service continuing care retirement communities, or assisted living facilities) • Increase a healthcare entity's total gross in-state revenues by less than $25 million • Involve clinical affiliations for the purpose of collaborating on clinical trials or graduate medical education programs
Length of Review Period	At least 30 days prior to closing
Review Process	Notice only: summary will be posted on Department's website and will be subject to public review and comment
Post-Closing Obligations & Monitoring	None specified — subject to further administrative guidance
Miscellaneous	Notification by the Department to the antitrust, healthcare, and charities bureaus of the Office of the New York Attorney General Implementing regulations pending

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NORTH CAROLINA

Preserving Competition in Health Care Act

S.B. 16 / H.B. 737 (N.C. 2023)

Status: S.B. 16 Referred to Senate Committee on Rules and Operations on January 26, 2023; H.B. 737 Referred to House Committee on Health, if Favorable, Finance, if Favorable, Insurance, if Favorable, Rules, Calendar, and Operations on April 19, 2023	**Proposed Effective Date: December 1, 2023**
Regulating Authority	North Carolina Attorney General (the NC AG)
Purpose	To preserve competition in healthcare by regulating the consolidation and conveyance of hospitals
Impacted Transactions	• Merger and acquisition • Sale, transfer, lease, exchange, optioning, conveyance, or other disposition of a material amount of assets or operations • Transfer of control or governance, excluding corporate reorganization • Sales, transfers, conveyances, or other dispositions of a substantial portion of the hospital's assets made in a bankruptcy proceeding • Transactions determined by the NC AG to merit review due to meaningful effect on competition among hospital entities in North Carolina
Impacted Healthcare Entities	Hospitals and any entities affiliated by ownership or governance (e.g., holding company or subsidiary)
Excluded Transactions / Materiality Threshold	Transactions in the usual and regular course of activities of the hospital entity and for which the NC AG has provided a written waiver
Length of Review Period	A waiting period of at least 90 days with potential for additional 90-day extension
Review Process	• Public review and comment • Public hearing
Review Criteria	Includes: • Fair market value of transferred assets • Measures to avoid conflicts of interest for healthcare providers • Reasonableness of management or services contracts • Revocation of hospital privileges for any healthcare provider • Safeguards to maintain capacity for research and provider education • Effect on competition • Safeguards to ensure continued access to affordable services • Adverse effects on cost, availability, accessibility, or quality of services • Commitments to provide services to disadvantaged individuals and other benefits to community • Promotion of availability and accessibility of safe, essential, and quality services
Post-Closing Obligations & Monitoring	• Post-closing monitoring and quarterly reports by independent healthcare access monitor for at least three years (and possibly up to 10 years), at buyer's expense • Annual reporting on charitable activities and sale of charitable assets • 120 days' prior written notice of changes to financial assistance policy
Miscellaneous	The NC AG may contract with, at acquiring entity's expense, any state or US agency or experts or consultants to receive advice or assistance in its review.

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OREGON

Disclosure of Material Transactions

(OR. REV. STAT. §§ 415.500; 415.501; OR. ADMIN. R. 409-070-0000 TO 409-07-0085)

Status: Enacted	Effective January 1, 2023
Regulating Authority	Oregon Health Authority (OHA)
Purpose	To achieve universal access to adequate level of high-quality healthcare at an affordable cost, to reduce medical cost inflation, and to support accountability for the health of residents. The law is intended to rein in rising prices and preserve access to essential healthcare services and is motivated in part by research that consolidation in healthcare leads to higher prices without improving the quality of patient care.
Impacted Transactions	• Merger and acquisition, including a change of 50% or more (and a change of 25% or more is presumed to be a change of control for a healthcare entity) of the direct or indirect ownership interests of a healthcare entity • Formation of a contract, clinical affiliation, and contracting affiliation that will eliminate or significantly reduce essential services • Corporate affiliation • Formation of a partnership, joint venture, accountable care organization, parent organization, or management services organization that will eliminate or significantly reduce essential services, combine or consolidate providers of essential services when contracting with payors, or combine or consolidate payors when establishing health benefit premiums
Impacted Healthcare Entities	Transactions involving any: • Coordinated care organization • Health benefit plan • Hospital • Hospital system • Licensed or certified healthcare professional • Medicare Advantage Plan • Prepaid managed care health services organization • Entity that delivers healthcare items or services • Parent or an entity closely related to an entity that delivers healthcare items or services
Excluded Transactions / Materiality Threshold	Excluded transactions include: • Transactions that do not meet a materiality threshold of one party having at least $25 million and the other party having at least $10 million in average annual revenue • Transactions involving long-term care or residential treatment facilities • Clinical affiliations for the purpose of collaborating on clinical trials or graduate medical education programs • Corporate reorganizations
Timing of Initial Filing	At least 180 days prior to closing
Review Process	• Optional pre-filing conference • Two potential review periods — preliminary and comprehensive • Preliminary review period that includes public notice. If certain review criteria are met, approval within 30 days of receipt of complete filing. • If not approved at the conclusion of the preliminary review, a comprehensive review will be initiated. This includes the appointment of a review board and public hearing, and a decision within 180 days of receipt of complete filing.
Review Criteria	Includes: • Access to healthcare services • Quality of care • Cost to patients • Patient outcomes • Health equity • Competition in the market • Financial stability of the parties
Post-Closing Obligations & Monitoring	OHA may impose conditions on the transaction. OHA will conduct follow-up reviews of the transaction at the one-, two-, and five-year anniversaries of the closing of the transaction.

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PENNSYLVANIA

Amendment To Health Care Facilities Act

Status: SB 548 Referred to Health & Human Services Committee on May 15, 2023	Proposed Effective Date: 60 Days After Enactment
Regulating Authority	The Pennsylvania Attorney General (the PA AG)
Purpose	The legislation, originally introduced in 2022, was reintroduced in response to closures of Pennsylvania hospitals.
Impacted Transactions	• Merger and acquisition with another health system or provider organization • Affiliation agreements with another health system or provider organization to negotiate rates, excluding arrangements among entities under common ownership • Sale, transfer, lease, or other encumbrance of a material amount (which is $10 million or more) of a health system's assets • Capital distribution or similar reduction of a health system's equity capital by a material amount (which is $10 million or more)
Impacted Healthcare Entities	Health systems: • For-profit entities owning and operating one or more hospitals, nursing homes, or hospices Provider organizations: • Entities in "healthcare delivery or management" representing at least seven healthcare providers in contracting with health plans or third-party administrators including: - Physician organization - Physician-hospital organization - Independent practice association - Provider network - Accountable care organization
Excluded Transactions / Materiality Threshold	Transactions in which the PA AG determines no feasible alternative to prevent health system's closure or greater loss of healthcare services
Timing of Initial Filing	90 days prior to closing
Review Process	• Waiting period lasting at least 90 days with potential for extension • Public hearing with 14 days prior notice
Review Criteria	• Reduced competition or increased costs • Unfair methods of competition or unfair or deceptive practices • Reduced quality of care, including ability to offer culturally competent and appropriate care • Reduced access and availability of healthcare • Reduced access to care in rural, low-income, or disadvantaged communities
Post-Closing Obligations & Monitoring	None specified — subject to further administrative guidance if enacted
Miscellaneous	None

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RHODE ISLAND

Hospital Conversions Act

(R.I. GEN. LAWS § 23-17.14)

Status: Enacted	Effective 1997
Regulating Authority	The Rhode Island Department of Health (the RI DOH) and the Rhode Island Attorney General's Office (the RI AG)
Purpose	In response to national and regional private investments that result in the conversion of non-profit and public hospitals into for-profit hospitals, Rhode Island established standards and procedures for hospital conversions to protect the quality of medical services in the community.
Impacted Transactions	• Merger and acquisition that results in a change of 20% or more of ownership or assets • Lease, gift, joint venture, sale, or other disposition that results in a change of 20% or more of ownership or assets • Addition of new person with a controlling interest or controlling vote
Impacted Healthcare Entities	Any transaction involving a hospital and a for-profit corporation or a non-profit corporation
Excluded Transactions / Materiality Threshold	None specified
Timing of Initial Filing	180-day review period
Review Process	• Initial application • Public notice and comment • Public hearing
Review Criteria	Includes: • Suitability and track record • Access, quality, safety, and affordable care, including to underserved populations • Safeguards against referrals • Collective bargaining rights and workplace retention • Future employment needs and retraining of employees • Public interest (e.g., access to essential medical services, balanced healthcare delivery system) • Market share, services, and financial viability • Conditions of Approval for any previous conversions (for-profit conversions only)
Post-Closing Obligations & Monitoring	Approval may impose conditions on the transaction
Miscellaneous	Review process and review criteria differ if the transacting parties are non-profit corporations Certain transfer of ownership, assets, membership interest, authority, or control of a hospital require prior Change in Effective Control by the RI DOH with a recommendation from the Health Services Council.

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WASHINGTON (PART 1)

Disclosure of Material Transactions

(SB 5241 / HB 1263, 68TH LEG., REG. SESS. (WASH. 2023))

Status: SB 5241 Removed from Consideration on March 10, 2023; HB 1263 Referred to Civil Rights & Judiciary Committee on January 12, 2023	**Proposed Effective Date: January 1, 2024**
Regulating Authority	Washington Attorney General (the WA AG)
Purpose	To preserve or increase access to quality and affordable care in connection with transactions, including emergency care, primary care, reproductive care, end-of-life care services, and gender affirming care. The bill is intended to protect patients and providers by ensuring no one loses access to healthcare because of a merger, in part by requiring a public assessment to understand the impact of industry consolidation on access to local care.
Impacted Transactions	• Merger and acquisition, excluding corporate reorganization • Contracting affiliation between healthcare entities to negotiate rates, excluding arrangements among entities under common ownership
Impacted Healthcare Entities	Transactions involving **two or more**: • Hospitals • Hospital systems, including any entity affiliated with the parent through ownership or control • Entities in "healthcare delivery or management" representing at least seven healthcare providers in contracting with carriers, including: - Physician organizations - Physician-hospital organizations - Independent practice associations - Provider networks - Accountable care organizations
Excluded Transactions / Materiality Threshold	A streamlined notice process (rather than a full review) exists for transactions involving parties (other than hospitals or health systems) that either (a) generate less than $10 million in patient revenue in the state of Washington or (b) predominantly serve low-income, medically underserved individuals.
Timing of Initial Filing	At least 120 days prior to closing
Review Process	• Public notice and comment • Public hearing • Health equity assessment • Decision to disapprove transaction or impose conditions on transaction must be issued within 120 days of receipt of completed filing
Review Criteria	Includes: • Access to healthcare services • Quality of care • Cost to patients and health plans • Underserved populations • Health equity • Competition in the market • Financial stability of the parties
Post-Closing Obligations & Monitoring	Submission of annual reports for ten years following the closing of the transaction

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WASHINGTON (PART 2)

Healthcare Transactions Notification Requirement

(WASH. REV. CODE §§ 19.390.010–090)

Status: Enacted	**Effective January 1, 2020**
Regulating Authority	Washington Attorney General (the WA AG)
Purpose	To ensure that competition beneficial to consumers in healthcare markets across Washington remains vigorous and robust
Impacted Transactions	• Merger and acquisition, excluding corporate reorganizations • Contracting affiliation to negotiate rates, excluding arrangements among entities under common ownership • Impacted transactions include those involving an out-of-state entity, if the out-of-state entity generates $10 million or more in healthcare services revenue from patients in Washington
Impacted Healthcare Entities	Transactions involving **two or more**: • Hospitals • Hospital systems • Entities in "healthcare delivery or management" representing at least seven healthcare providers in contracting with carriers, including: - Physician organizations - Physician-hospital organizations - Independent practice associations - Provider networks - Accountable care organizations
Excluded Transactions / Materiality Threshold	None specified
Timing of Initial Filing	60 days prior to closing
Review Process	The WA AG may request additional information from the parties and may serve civil investigative demands to investigate potential antitrust violations.
Review Criteria	None specified — subject to further administrative guidance
Post-Closing Obligations & Monitoring	None specified — subject to further administrative guidance
Miscellaneous	Providing a copy of any HSR filing to the WA AG satisfies the notice requirement