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August 26, 2024

VIA E-MAIL

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Re: Request for Information - 014 UHG-Amedisys Comprehensive Review

Dear Jenny,

I write in response to the Oregon Health Authority's July 11, 2024, Request for Information in the above-referenced matter. Below you will find the OHA requests and UnitedHealth Group's ("UHG's") corresponding responses.[1]

I. Operation of Amedisys following Close

[redacted]

b. Describe any plans to change the organizational structure of the acquired Amedisys home health centers in Oregon from what is depicted in the chart.

There are no plans to change the organizational structure of the acquired Amedisys home health centers in Oregon.

[1] The responses and materials attached hereto include non-privileged responsive information. UHG and Amedisys are not waiving attorney-client, attorney work product, or any other legally applicable privilege, and to the extent this response includes any information or documents subject to any such privilege, the production is inadvertent, and the parties reserve all rights to request sequestration and or return of the materials.

c. Describe any plans to change the organizational structure of LHC home health centers in Oregon from what is depicted in the chart.

There are no plans to change the organizational structure of LHC home health centers in Oregon.

[redacted]

a. What are the components of UHG's "benefits platform"? Describe each component.

The components of the Optum benefits platform are listed below, with further information about each component provided in Exhibit 24.

b. What are the components of LHC's "human capital integration." Describe each component, including activities and progress to date.

The components of UHG's human capital integration (or "People Integration") are identified and explained in Exhibit 24. UHG completed high-level comparisons during due diligence for the LHC transaction but, this work has not progressed to-date due to ongoing review.

c. How will this transition affect benefits and other employment terms for employees of (i) Amedisys, and (ii) LHC home health and hospice agencies in Oregon?

Employees of Amedisys and LHC home health and hospice agencies in Oregon will become employees of Optum/UnitedHealth Group and will be able to participate in the benefit plans described above. Their other terms of employment will not be changed.

25. The Amedisys Disclosure Letter to Agreement and Plan of Merger by and among UnitedHealth Group Incorporated, Aurora Holdings Merger Sub Inc. and Amedisys, Inc. dated June 26, 2023 ("Disclosure Letter") identifies a Professional Agreement between Oregon Nurses Association ("ONA") and Amedisys Oregon, LLC ("Collective Bargaining Agreement"). OHA understands that Amedisys and ONA are currently in talks to renegotiate this contract. Please describe the status of the negotiations.

Amedisys Oregon, L.L.C. and the Oregon Nurses Association are currently re-negotiating the Collective Bargaining Agreement dated April 1, 2021, to March 31, 2024. [redacted]

27. The response to item #16 of OHA's Request for Information dated March 15, 2024 ("March 15th RFI") stated that "UnitedHealth Group has no current concrete plans for changes in Optum's or Amedisys's operations, structure, strategies, policies, officers, employees, or any other area of corporate activity […]." Please describe *any and all* plans (they do not need to be "concrete") pertaining to the areas identified in subparts a. through h. of item #16 of the March 15th RFI. If UHG does not anticipate making any changes in a specified area, please state as much.

UHG has not made any plans pertaining to the areas identified in subparts a. through h. of item #16 and no changes are currently anticipated. Integration planning relating to these areas will occur after the closing of the transaction.

28. The response to item #19 of the March 15th RFI stated that "UHG has not made any concrete plans at this time pertaining to Amedisys operations in Oregon […]." Please describe *any and all* plans (they do not need to be "concrete") pertaining to the areas identified in subparts a. through m. of item #19 of the March 15th RFI. If UHG does not anticipate making any changes in a specified area, please state as much.

UHG has not made any plans pertaining to the areas identified in subparts a. through m. of item #19 and no changes are currently anticipated. Integration planning relating to these areas will occur after the closing of the transaction.

[redacted]

a. Describe and provide examples of the naviHealth services that would be provided in Oregon.

naviHealth provides post-acute and home health utilization management services to UnitedHealthcare in connection with Medicare Advantage plan members in the state of Oregon. These management services are provided to UnitedHealthcare rather than directly to Medicare Advantage plan members. Examples of such services include concurrent reviews for skilled nursing facility and home health episodes. naviHealth performs concurrent review for home health episodes as part of its Home Health Utilization Management program, which uses CMS criteria to assist health plans in managing member utilization of home health providers.

b. How many UHC MA members in Oregon are currently receiving (i) home health, and (ii) hospice services from providers other than Amedisys or LHC?

Approximately [redacted] percent of UnitedHealthcare Medicare Advantage members who have received home health services in Oregon in 2024 used a provider other than LHC or Amedisys. UnitedHealthcare does not have information on which hospice providers provided hospice services to its Medicare Advantage members in Oregon because hospice services are paid for by Medicare.

c. Describe the patient population(s) (e.g., demographics, health status) that would potentially receive such services in Oregon.

As noted above, naviHealth provides home health management services to health plans and does not provide services directly to patients in Oregon.

d. Describe how these services might impact home health or hospice patient experience or quality of care.

naviHealth's services relate to home health utilization management and do not impact home health or hospice patient experience or quality of care.

b. Does Amedisys have any existing partnerships or other agreements with home infusion therapy providers serving patients in Oregon? If so, please identify these providers.

Amedisys does not have any existing partnerships or other agreements with home infusion therapy providers serving patients in Oregon.

c. Describe any plans to incentivize Amedisys patients receiving infusion services from unaffiliated infusion providers who switch to Optum Rx Infusion (Optum Infusion Pharmacy). In doing so, include any planned marketing efforts, patient education, financial incentives, free services, or other offers.

UHG does not have any plans to incentivize Amedisys patients receiving infusion services from unaffiliated infusion providers who switch to Optum Rx Infusion (Optum Infusion Pharmacy).

d. Describe any plans to incentivize Optum Rx Infusion (Optum Infusion Pharmacy) patients receiving home health services from unaffiliated home health providers who switch to Amedisys. In doing so, include any planned marketing efforts, patient education, financial incentives, free services, or other offers.

UHG does not have any plans to incentivize Optum Rx Infusion (Optum Infusion Pharmacy) patients receiving home health services from unaffiliated home health providers who switch to Amedisys.

e. Given that Optum Rx Infusion (Optum Infusion Pharmacy) has a single location in Oregon, describe any plans to accommodate the increase in Optum Rx Infusion (Optum Infusion Pharmacy) patients that would be expected from the "cross-enterprise partnership."

To accommodate any increase in Optum Rx Infusion patients in Oregon, UHG would hire additional staff as needed.

[redacted]

c. Describe any plans to incentivize UHC MA members receiving home health services from an unaffiliated provider to switch to Amedisys. In doing so, include any planned marketing efforts, patient education, financial incentives, free services, or other offers.

There are no plans to incentivize UHC MA members receiving home health services from an unaffiliated provider to switch to Amedisys.

33. Describe any plans by UHG to encourage enrollment by Amedisys home health patients in UHC MA plans.

Specifically:

a. Describe any plans for providing information on Medicare enrollment options (including information sessions, pamphlets, or other outreach) to Amedisys patients.

b. Describe any plans to provide bonuses or other compensation-based incentives to UHG employees or contractors for enrolling Amedisys patients in UHC MA plans.

c. Describe any plans for offering free services, discounts, or other membership perks to Amedisys patients who switch from Original Medicare or another Medicare Advantage plan to UHC MA.

There are no plans to encourage enrollment in UHC MA plans that are specific to Amedisys home health patients. UHC provides no bonuses or other compensation-based incentives for enrolling Optum patients in UHC MA plans and has no plans to do so. CMS Medicare Advantage regulations prohibit UHC from providing certain members with special services, discounts, or other membership perks that are not offered to all members.

34. Once LHC and Amedisys have been fully integrated into UHG/Optum, describe the anticipated roles and responsibilities of (i) UHG/Optum, and (ii) the LHC and Amedisys subsidiaries, respectively, for each of the below functions. Identify the Optum/ UHG policies, systems, or infrastructure applicable to each function.

a. Clinical staffing and hiring
b. Administrative staffing and hiring
c. Compensation and benefits
d. Payer contracting
e. Billing and payment
f. Patient care practices
g. Patient enrollment practices
h. Financial assistance/charity care

UHG has not made any plans to integrate LHC or Amedisys into UHG/Optum with regard to these functions. LHC continues to manage these functions in accordance with its policies and practices that applied prior to its acquisition by Optum. Amedisys similarly will continue to manage these functions in accordance with its current policies and practices, subject to integration planning that is expected to begin following the close of the transaction.

i. Sourcing of supplies, technology, and related services

LHC and Amedisys will continue to manage these functions in accordance with their current policies and practices, [redacted]

II. Contracting for Home Health and Hospice Services following Close

35. Does UHG anticipate making any changes to UHC MA or other insurance contracts with home health providers in Oregon following the close of the transaction?

a. Describe any plans to change reimbursement rates, cost-sharing, network status, network tier, prior authorization requirements or other terms of UHC's contract(s) with Amedisys for home health or hospice services in Oregon.

UHG has no plans to change the terms of UHC's contract with Amedisys for home health or hospice services in Oregon.

b. Describe any plans to change reimbursement rates, cost-sharing, network status, network tier, prior authorization requirements, or other terms of UHC's contracts with unaffiliated home health or hospice providers in Oregon.

UHG has no plans to change reimbursement rates, cost-sharing, network status, network tier, prior authorization requirements, or other terms of UHC's contracts with unaffiliated home health or hospice providers in Oregon.

c. Describe any plans to change reimbursement rates, cost-sharing, network status, network tier, or prior authorization requirements associated with Amedisys home health providers in Oregon, *relative to* unaffiliated home health providers.

UHG has no plans to change reimbursement rates, cost-sharing, network status, network tier, or prior authorization requirements associated with Amedisys home health providers in Oregon, relative to unaffiliated home health providers.

d. Describe any plans to terminate contracts between UHC and unaffiliated home health providers in Oregon.

UHG has no plans to terminate contracts between UHC and unaffiliated home health providers in Oregon.

e. Describe any plans to offer UHC MA plans in Oregon that include only LHC and Amedisys home health providers.

UHG has no plans to offer UHC MA plans in Oregon that include only LHC and Amedisys home health providers.

36. Does UHG anticipate making any changes to Amedisys's contracts with Oregon commercial health insurance (including MA) carriers or plans following the close of the transaction?

a. Describe any plans to terminate contracts between Amedisys and third-party health insurance (including MA) carriers or plans in Oregon.
b. Describe any plans to change reimbursement rates, cost-sharing, network status, prior authorization requirements, or other terms of Amedisys's contracts with third-party health insurance (including MA) carriers or plans in Oregon.

UHG has no plans to make any changes to Amedisys's contracts with Oregon commercial health insurance (including MA) carriers or plans following the close of the transaction.

37. Does Optum/UHG have any plans for Amedisys or LHC home health agencies to stop accepting patients with traditional (fee-for-service) Medicare?

Neither Optum nor UHG have any plans for Amedisys or LHC home health agencies to stop accepting patients with traditional (fee-for-service) Medicare.

38. Identify each instance in which, following closing of the 003 United-LHC transaction, the entities proposed renegotiating a contract with a health plan. For each instance, please identify:

a. Proposal(s) made by the entities.
b. Counterproposal(s) made by the health plan.
c. Final outcome of the negotiations.

Contract renegotiations between LHC and health plans generally are not specific to Oregon but instead occur on either a national or regional basis. In most cases when LHC proposes renegotiating a contract with a health plan, the health plan either does not respond or declines to negotiate. LHC does not track all such cases where a proposed renegotiation never progressed. The cases in which contract renegotiations did progress are listed in Exhibit 38. The proposals and counterproposals made by the parties are not always tracked and therefore are not available in all cases. This information is provided in Exhibit 38 where it is available.

III. Asserted Benefits of the Transaction

39. The response to item #22 of the March 15th RFI describes home health care clinical programs deployed by LHC nationwide (Choose Control, Clearway, VentriCare, and Active Minds) that will be implemented at Amedisys locations in Oregon. Please describe plans for implementing these programs in Oregon. In your response, please address:

a. The timeline for implementation at Amedisys home health locations in Oregon.
b. Plans for training Amedisys staff on these programs.
c. Any changes to Amedisys electronic health record or other systems required for implementation.

d. The response notes that Amedisys currently offers home health clinical programs for heart failure, chronic obstructive pulmonary disease, and diabetes. Describe why replacing those programs with LHC's VentriCare, Clearway, and Choose Control programs, respectively, would be expected to improve patient outcomes.

Response

Timeline for Implementation of Clinical Programs at New Home Health Locations & Plans for Training New Clinical Staff

Before deploying a new clinical program at any home health location, LHC evaluates three key considerations:

(1) **Whether the clinical program is applicable to the patient population served by that individual agency:** LHC reviews patient data at each agency to assess the specific needs—e.g., conditions, patient population, etc.—served by that agency to determine whether the clinical program would materially impact patient care delivered at that agency. For instance, if an agency does not serve any chronic obstructive pulmonary disease (COPD) patients and the company believes referral sources for COPD patients in an area may not refer many such patients to a new provider, it may not be worthwhile to deploy LHC's COPD clinical program at that location.

(2) **Whether the leadership and clinical staff are stable:** For agencies with a high rate of turnover, the investment to train staff that are highly likely to leave soon after may not make sense. Instead, LHC works to resolve the underlying issues leading to high staff turnover and then, once those are resolved, may proceed to deploy a new clinical program.

(3) **The agency's quality level:** If an agency is struggling to maintain high quality of care, LHC will first work with that agency to improve its overall quality level, before implementing a new clinical program. This process helps to ensure that the quality of the agency does not suffer further and local agency staff do not become further overwhelmed as a result of implementation of the new clinical program.

LHC will continue to follow the above process to deploy its home health clinical programs at Amedisys locations post-closing. This will involve a detailed review of each Amedisys agency's patient data to identify the locations that are most likely to benefit from each of LHC's clinical programs. LHC will also need to review each of Amedisys's agencies for potential staff turnover and/or quality issues, though LHC has no reason to believe that any such issues exist at Amedisys's

Oregon agencies. In fact, CMS rates all three of Amedisys's Oregon-based agencies between 4.0 and 4.5.[2]

Additionally, for newly acquired agencies, LHC conducts a compliance review process, which includes verification of clinicians' licenses, background checks, and getting new clinicians up to speed on LHC's quality compliance and basic training programs. The previously enumerated process typically takes approximately six months.

After the above process is complete, when deploying a new clinical program at a home health agency, LHC also conducts remote training on the program and sends a team of clinicians on-site to provide in-person training. Additionally, LHC deploys the relevant queues and templates to the agency's electronic health record system (Homecare Homebase) to allow the clinician to follow the clinical program's protocols when treating patients. Absent any unexpected surprises, LHC expects it will be able to deploy new clinical programs at agencies within a year of closing.

Limited Changes Expected to Amedisys's Electronic Health Record System for Implementation of New Clinical Programs

Since Amedisys also uses Homecare Homebase as its system of record, LHC expects that the only change that will be needed to implement any new clinical programs will be deploying the appropriate queues and templates that correspond to each new clinical program that will be adopted by each Amedisys agency.

LHC Will Evaluate Amedisys's COPD, Diabetes, and Heart Failure Clinical Programs, Including Outcomes Data, and Will Then Adopt the Program that is Most Successful

LHC is committed to continually improving its clinical programs based on its collective experience and as industry practices evolve. As such, LHC does not intend to automatically replace Amedisys's clinical programs covering COPD, diabetes, and heart failure with LHC's clinical programs covering these conditions. Rather, LHC's medical staff intend to evaluate both parties' clinical programs to assess which clinical program has the greatest impact on patient health, as well as identify opportunities for further refinement of the program being retained based on the combined firm's best practices and experience. LHC will ultimately adopt whichever clinical program has been most effective, subject to such modifications as may be applicable to further enhance patient care and outcomes.

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[2] *Home Health Care Agencies*, U.S. Centers for Medicare & Medicaid Services (July 17, 2024), https://data.cms.gov/provider-data/dataset/6jpm-sxkc.

40. The response to item #22 of the March 15th RFI describes Amedisys's home health care programs for fall reduction and wound care that will be implemented at LHC locations in Oregon. Please describe plans for implementing these programs. In your response, please address:

a. The timeline for implementation at LHC/Optum home health locations in Oregon.
b. Plans for training LHC/Optum staff on these programs.
c. Any changes to LHC/Optum electronic health record or other systems required for implementation.

Response

LHC expects to adopt the same implementation and training processes as outlined in its response to Request #39.

Similarly, because LHC and Amedisys both use Homecare Homebase, LHC expects that the only change to its electronic health record system needed to adopt Amedisys's clinical programs for fall reduction and wound care will be deploying new queues and templates relevant to those programs.

41. The response to item #22 of the March 15th RFI notes that a result of the transaction, LHC will be able to expand its pediatric hospice program into Amedisys hospice locations in Oregon. As a result, UHG/Optum will be able to offer pediatric hospice services to Douglas County residents in and around Roseburg. Please describe plans for offering these services following closing of the transaction. In your response, please address:

a. The types of hospice services that will be offered to pediatric patients.
b. The number of pediatric patients UHG/Optum expects to serve annually.
c. Any research or information collected on the demand for pediatric hospice services for residents of Douglas County.
d. Plans for staffing and training, including new employee onboarding and existing staff training.
e. Timeline for the expansion and implementation.
f. Strategy for reimbursement for these services. Does UHG/Optum expect these services to be covered by Medicaid and commercial health insurance plans?

Response

Types of Hospice Services That Will be Offered to Pediatric Patients

LHC's mission is and has always been to serve all hospice-eligible patients, including children. LHC views pediatric hospice care as including the perinatal period, infancy, childhood, adolescence and young adulthood. The company differentiates between pediatric and adult hospice care due to inherent differences with treating children, different Medicaid coverage rules, and greater family involvement in care plan development. However, it does not otherwise categorize or segment pediatric care into different types, though each patient would, of course, have unique needs.

Number of Pediatric Patients that LHC Expects to Serve Annually

While demand for pediatric hospice may change year to year, in 2023, LHC served 128 hospice patients nationwide under the age of 21.

Demand for Pediatric Hospice Services in Douglas County

LHC does not routinely collect research or information on demand for pediatric care in any county in the U.S. However, OHA's own data shows that in Douglas County in 2022, 20 individuals under the age of 24 died; in 2021, 14 individuals under the age of 24 died; and in 2020,

15 individuals under the age of 24 died.[3] While OHA's data does not identify the cause of death, many of these children may have benefited from hospice care had it been available.

LHC's implementation and growth strategy for pediatric hospice services is not dependent on local demand in select cities, counties or states. LHC does not pick and choose only a limited set of locations to offer pediatric care. Rather, like all of its clinical programming, the decision to launch pediatric hospice services is national. Though implementation will necessarily take place over time and may occur in stages, LHC's strategy is simply to have pediatric hospice capabilities available at all of its locations in case needed. Significant local demand for pediatric hospice care is not critical here because nurses trained in pediatrics can easily be re-deployed for adult hospice care when demand for pediatric hospice services is low.

Plans for Staffing and Training & Timeline for Expansion and Implementation

To assist with LHC's pediatric hospice care, the company has formalized a consulting relationship with a leading palliative pediatrician, Dr. Conrad Williams, who directs LHC's pediatric clinical programing nationally and advises on procedures, patient eligibility, treatment protocols on difficult cases, etc. With his assistance, LHC has developed internal guidance for pediatric hospice eligibility criteria and proprietary training materials for pediatric hospice care. The company has also launched the American Association of College of Nursing's ("AACN") End-of-Life Nursing Education Consortium Pediatric Hospice Certification through its learning management system.

Following the closing of the proposed transaction, these pediatric hospice care resources will be shared with Amedisys's nursing staff as well, including at Amedisys's hospice location in Douglas County. LHC's National Hospice Clinical Operations Coordinator will also oversee and deliver additional and continuous training related to pediatric hospice care for the combined firm's nursing staff, as needed. LHC also plans to enter into a consulting arrangement with an Oregon-based pediatrician to provide local support to the combined company's hospice locations in the state and to act as liaison with patients' existing pediatricians. LHC does not otherwise anticipate any additional staffing needs to begin offering pediatric hospice care in Douglas County. Barring any unforeseen issues, LHC expects to be able to begin servicing pediatric hospice patients in Douglas County—a first for the county—within 6-12 months of closing.

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[3] *Decedent demographics by county,* Oregon Health Authority Center for Health Statistics, https://visual-data.dhsoha.state.or.us/t/OHA/views/CountyDash/CountyDash_demo?%3AisGuestRedirectFromVizportal=y&%3Aembed=y.
LHC considers pediatric hospice care to be care for individuals under the age of 21. However, OHA's data does not identify the number of deaths for individuals under the age of 21, only 24 and under.

No Specialized Reimbursement or Payer Contracting Strategy Required for Pediatric Hospice Services

Pursuant to Section 2302 of the Affordable Care Act titled "Concurrent Care for Children," pediatric patients that elect for hospice care through Medicaid can continue receiving aggressive, potentially curative treatment for their condition(s), such as chemotherapy, radiation, hospital stays, ventilators, etc.[4] These patients do not waive their Medicaid entitlements for other treatments of their terminal condition by electing for hospice coverage, meaning that Medicaid plans are required to pay providers for both categories of care for the same pediatric patient, provided that they meet eligibility criteria.[5] The concurrent care model has been codified in most states, including in Oregon, to maximize access to care for terminally ill children.[6]

Section 2302 of the Affordable Care Act, titled Concurrent Care for Children†
Seriously ill children who are <21 years of age and have a 6-month prognosis are entitled to receive hospice benefit in addition to all necessary disease-directed therapies with the goal of providing access to comprehensive care to live as long and as well as possible. Medicaidshall continue to be responsible to pay for disease-directed therapies in addition to the hospice benefit providing comfort-directed therapies.

Medicaid shall reimburse appropriate Medicaid-enrolled providers directly through the usual and customary Medicaid billing procedures. A hospice provider shall not be responsible for life-prolonging treatment, medications prescribed by non-hospice providers/subspecialists, or any aspect of the patient's medical care plan that is focused on treating, modifying, or curing a medical condition (even if that medical condition is also the hospice-qualifying diagnosis). Life-prolonging services and hospice services shall be billed and reimbursed separately, meaning the child can receive services concurrently.

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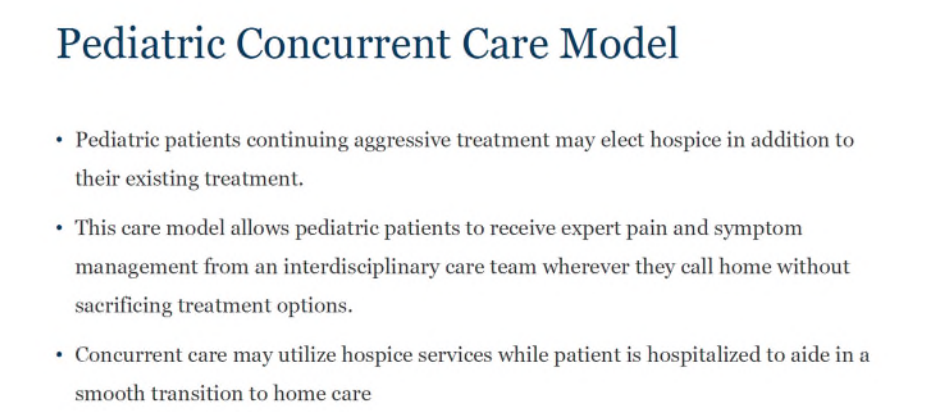
4 *Pediatric Concurrent Care*, National Hospice and Palliative Care Organization (2024), https://www.nhpco.org/palliativecare/pediatrics/pediatric-concurrent-care/.

5 *Determination of Hospice Medication Coverage in CHILDREN*, National Hospice and Palliative Care Organization (October 2020) (Exhibit 41).

6 *See* OAR 410-142-0110 – Concurrent Care for Children
(1) Under Section 2302 of the Affordable Care Act, Medicaid or Children's Health Insurance Program (CHIP) eligible children are eligible to receive curative treatment upon the election of the hospice benefit.
(2) The criteria for receiving hospice services does not change for children eligible for Medicaid and CHIP programs. However these children may now receive hospice services without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition.
(3) All other eligibility, coverage, and hospice rules for the Division of Medical Assistance Programs apply.



For hospice treatments and/or other related medications and costs that are not covered under Medicaid, pediatric patients may have supplemental coverage under private insurance plans. Some children may also receive coverage under Medicare if their illness has resulted in long-term disability under Medicare's rules. LHC does not deploy any specialized or unique reimbursement or payer contracting strategy for pediatric hospice care. Coverage and reimbursement terms for these services are typically included as part of the company's broader negotiations with each payer for adult hospice care. As such, LHC does not need to contract with new, additional, or separate payers to service hospice-eligible pediatric patients in Oregon, including in Douglas County following closing of the proposed transaction.

42. The response to item #22 of the March 15th RFI describes benefits associated with value-based care arrangements.

a. The response cites a study of outcomes associated with CMS' Home Health Value-Based Purchasing (HHVBP) program and states that this program was "intended to test the types of value-based care programs that UHG and LHC are aiming to implement." Please clarify why the results of this study are applicable to UHG/Optum home health value-based care arrangements. In doing so, please describe how the HHVBP program is similar to UHG/Optum value-based care programs.

b. The response also cites internal Optum studies finding reductions in health care utilization associated with Optum's value-based care programs. Has Optum studied how these programs impacted patient experience, patient health outcomes, or other quality of care measures? If so, please describe the results.

c. The response describes that LHC contracted with a managed Medicaid plan in Louisiana to provide home health services under a value-based compensation methodology. Describe any plans for development or implementation of a similar value-based compensation methodology in Oregon.

Response

CMS's Home Health Value-Based Purchasing Program (HHVBP) Program Study is Directly Relevant to LHC's Value-Based Care Strategy

The most common type of LHC value-based arrangement adjusts fee-for-service payments to LHC based on its agencies' performance on specific outcome and process measures of quality, including hospital readmission rates, emergency department utilization, primary care physician follow-up, and timely initiation of care.[7] In the same way, CMS's HHVBP adjusts traditional Medicare fee-for-service payments to participating home health agencies based on those agencies' performance on specific outcome, process, and patient experience measures of care, including emergency department utilization without hospitalization and unplanned hospitalizations.[8] That is, both LHC's most common value-based arrangements and CMS's HHVBP program adjust fee-for-service payments to home health agencies based on agencies' performance on specific measures of quality, including measures of patients' hospital and emergency department utilization.

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7 *See* Exhibit 42.

8 Alyssa Pozniak, Eric Lammers, Purna Mukhopadhyay et al., *Association of the Home Health Value-Based Purchasing Model with Quality, Utilization, and Medicare Payments After the First 5 Years*, JAMA Network (Sept. 23, 2022), https://jamanetwork.com/journals/jama-health-forum/article-abstract/2796639.

Analysis of the HHVBP program shows that the program resulted in statistically significant declines in unplanned hospitalizations and outpatient emergency department use (two utilization outcome measures affecting payment rates under the HHVBP), which contributed to an estimated average annual reduction in Medicare spending of $190 between 2016 and 2020.[9]

Studies Analyzing Value-Based Care Arrangements Consistently Demonstrate Positive Impacts on Quality

Measuring the results of specific clinical programs and/or other efforts to shift to value-based care is challenging, and research and industry analysis remain ongoing. Notwithstanding, reductions in health care utilization, including the examples highlighted in our April 30 response, inherently reflect improvements to patient experience and patient health outcomes. Fewer hospital admissions/readmissions, reduced emergency room visits, and shorter hospital stays themselves result in less distressing healthcare journeys for patients. They also signal fewer severe complications requiring hospitalization, which themselves reflect improved patient health outcomes and also lead patients to suffer less mental anguish from and during the course of their treatment.

To date, UHG has conducted or commissioned several studies aimed at identifying trends in improved outcomes and quality of care for patients resulting from value-based care initiatives.

> **A 3-D Model for Value-Based Care: The Next Frontier in Financial Incentives and Relationship Support**.[10] The study was performed by researchers at Harvard Medical School and the Harvard T.H. Chan School of Public Health in collaboration with United Healthcare to explore the next frontier of value-based care. This research demonstrated that successful value-based care models have three dimensions: financial incentives related to (1) improvement in quality, (2) reduction in spending, and (3) non-financial infrastructure supports that care provider organizations may receive in their work with payers. The authors also found that value-based care programs were consistently associated with spending and utilization reductions and, at a minimum, no negative impact on clinical

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[9] *Dr. Alyna T. Chien & Meredith B. Rosenthal, A 3D model for value-based care: The next frontier in financial incentives and relationship support, UnitedHealthcare,* https://www.uhc.com/content/dam/uhcdotcom/foundation/blog/pdf/Harvard%20Report_FINAL.pdf

[10] Dr. Kenneth Cohen, Omid Arneli, Christine E. Chiasson, et al., *Comparison of Care Quality Metrics in 2-Sided Risk Medicare Advantage vs Fee-for-Service Medicare Programs*, JAMA Network (Dec. 12, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799376?resultClick=3. *See also, Medicare Advantage patients in Optum accountable care models associated with better care quality than those in traditional Medicare*, UnitedHealth Group (Feb. 7, 2023), https://www.unitedhealthgroup.com/newsroom/posts/2023/2023-02-08-optum-jama-study-shows-optum-ma-patients-are-healthier.html.
The study focused on 'Spending and Quality' value-based care programs, which the authors defined as initiatives that incorporate eligibility criteria for, and magnitude of, shared savings awards based on an organization's quality performance. These programs are distinguishable from 'Quality only' or 'pay-for-performance only' programs where organizations are eligible for financial bonuses or penalties based on a predefined set of quality measures.

quality, patient experience or mortality. In some cases, including the full range of multi-payer, private commercial payer and public payer-backed value-based care programs, quality actually increased.

In one case study, the report analyzed Mount Sinai Health System's partnership with a labor union in Atlantic City. There, the parties developed a financial structure whereby Mount Sinai was incentivized to work with patients towards prevention and ensuring that members received as much of their care as possible within the health center. The result was an approximate 33% reduction in emergency department visits, which flowed into cost savings, and achieving a Net Promoter Score of 86.

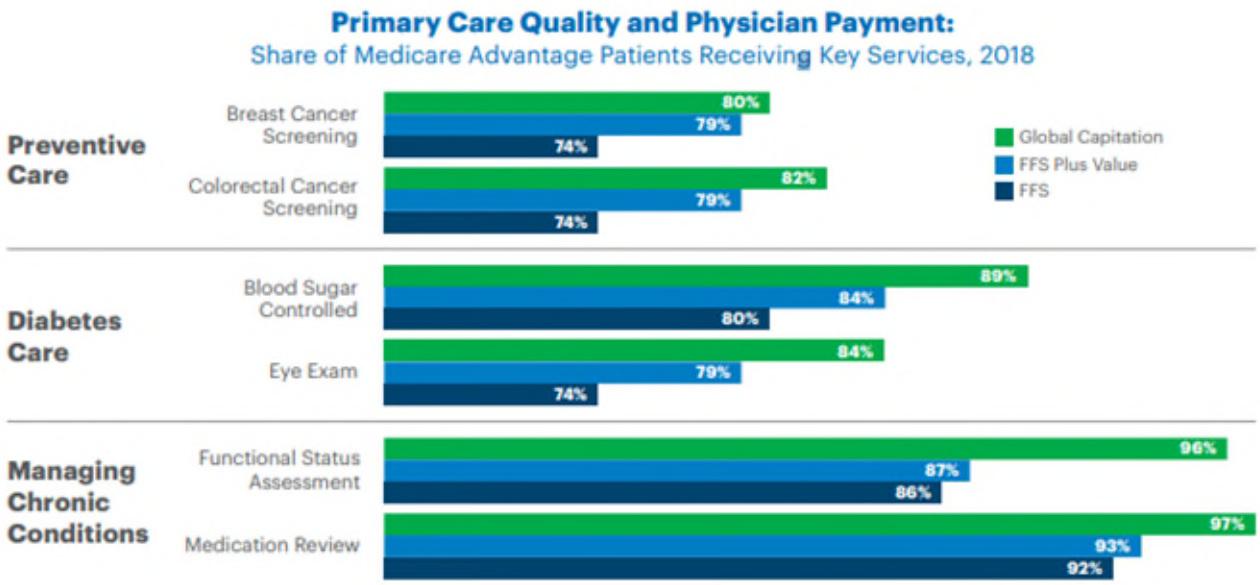
In another case study involving Mount Sinai's bundled payment program for knee replacements, the health system and the participating payer developed a program that incentivized Mount Sinai to invest in the entire continuum of treatment. Mount Sinai set up a Joint School to help prepare patients for surgery and explain what the journey would entail, began interviewing patients in their home to assess practical risks such as the potential for falls, offered free ride service for follow-up appointments, and appointed a navigator to help guide patients through recovery and act as liaison with medical staff. In the first two years, the program achieved 91% patient satisfaction "because [patients] recognized that they were getting more than a surgery; the outcome was improved mobility and reduced pain."

Comparison of Care Quality Metrics in 2-Sided Risk Medicare Advantage vs Fee-for-Service Medicare Programs.[11] In a first-of-its-kind study, researchers associated with Optum and the Harvard T.H. Chan School of Public Health found that Optum patients enrolled in fully accountable Medicare Advantage plans—where Optum providers take full financial and clinical responsibility for patients—consistently experienced higher quality of care and efficiency. The study compared Optum patients in fully accountable Medicare Advantage plans with a national random sample of administrative claims data for patients served by traditional Medicare on a fee-for-service basis. Across all 8 metrics examined, Optum's accountable Medicare Advantage model resulted in healthier outcomes, namely 18% lower odds of hospital admissions, 11% lower odds of emergency room visits, 9% reduction in hospital readmissions within 30 days, 6% reduction in return rates to the emergency room within 30 days, 14% lower odds of avoidable emergency room visits, 10% lower odds of hospital admissions for stroke or myocardial admissions, and 44%

[11] Dr. Kenneth Cohen, Omid Arneli, Christine E. Chiasson, et al., *Comparison of Care Quality Metrics in 2-Sided Risk Medicare Advantage vs Fee-for-Service Medicare Programs*, JAMA Network (Dec. 12, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799376?resultClick=3. *See also, Medicare Advantage patients in Optum accountable care models associated with better care quality than those in traditional Medicare*, UnitedHealth Group (Feb. 7, 2023).

lower odds of hospitalization for chronic obstructive pulmonary disease or asthma exacerbation.

Global Capitation Payments Result in the Highest-Quality Primary Care for Seniors.[12] In a study analyzing more than 5 million enrollees in UHC's Medicare Advantage products, UHG found that members of Medicare Advantage plans involving global capitation—where physicians accept full financial risk for patients' overall health care costs—consistently receive key services related to preventative care, diabetes care and chronic condition management at higher rates than members of Medicare Advantage plans where primary care physicians are paid either on a fee-for-service or fee-for-service plus basis. This analysis was based on metrics from the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS). And as set out in greater detail below, patients treated under global capitation were screened at higher rates for breast cancer, colorectal cancer and controlled blood sugar levels, and received more eye exams, functional status assessments and medication reviews.



The researchers concluded that global capitation provides the right incentives for value-based care, as it positions physicians to (1) prioritize preventive services and care management programs; (2) spend more time engaging with patients; (3) use evidence-

[12] *Global Capitation Payments Result in the Highest-Quality Primary Care for Seniors*, UnitedHealth Group (2020), http://www.uhg.com/global-capitation-research.

based clinical guidance; (4) avoid unnecessary patient interventions; and (5) focus on keeping patients out of the hospital.

OptumCare Primary Care Physician Practices Deliver More Value to Patients, Outperforming Hospital-Owned Practices on Quality and Cost.[13] In an Optum analysis of quality and cost using 2018 UHC commercial claims data, OptumCare primary care physician practices outperformed hospital-owned practices by 2.4 percentage points on quality and 3.5 percentage points on total cost of care. This comparison is notable because hospital-owned primary care physician practices are not necessarily incentivized to support value-based care, including preventative care measures and hospital admission reductions.

Medicare Advantage is Addressing Social Determinants of Health at Scale to Improve Health Outcomes and Advance Health Equity.[14] A UHG study analyzed the effectiveness of UHC initiatives to address various social needs of patients that may affect health outcomes and quality of life, including financial health, nutrition, housing, and transportation. UHC screened 4.7 million of its Medicare Advantage enrollees in 50 states and the District of Columbia for social needs using a combination of health risk assessments, in-person visits, phone calls, and analysis of surveys, claims, and administrative data. Social needs were identified among 1.3 million enrollees who wanted help, and UHC provided 2.3 million social needs referrals to 1 million enrollees (2.3 per enrollee). 853,000 MA enrollees ultimately were connected to social needs services and supports that met at least one social need. UHC estimated the value of those services to represent average per enrollee savings of $1,489 per enrollee for those receiving social services referrals, $2,179 per enrollee for those receiving Medicare Savings Program referrals, and $5,100 per enrollee for those receiving Low Income Subsidy program referrals.[15]

UHG's Acquisition of Amedisys Will Increase the Likelihood of Oregon Payers Engaging in Value-based Care Planning Because Payers are More Likely to Engage on Value-based Care Arrangements with Providers with Increased Scale and Operational Flexibility

UHG is committed to implementing value-based care initiatives nationwide, including in Oregon, and across all business lines to ensure that patients are able to receive the right care, at the right time, and in the right setting. Efforts to identify and assess opportunities to accelerate the

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[13] *OptumCare Primary Care Physician Practices Deliver More Value to Patients, Outperforming Hospital-Owned Practices on Quality and Cost,* Optum, Inc. (Jan. 12, 2022), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2023/2022.01.12%20Optum%20PCP%20Practice%20Ownership%20-%20WEB.pdf.

[14] *Medicare Advantage is Addressing Social Determinants of Health at Scale to Improve Health Outcomes and Advance Health Equity*, UnitedHealth Group (Sept. 28, 2023), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2023/2023-MA-Social-Determinants-Brief.pdf.

[15] The value figures are based on UHC's conservative estimates of the fair market value of goods and services that would have otherwise been expended by enrollees had they paid out-of-pocket.

transition from fee-for-service models to value-based care models, including for home health services, are ongoing, but depend heavily on cooperation and buy-in from payers. Implementation of value-based care programs is complex because it requires payers to change how they record and account for medical services provided to patients and compensation schemes for providers. As such, payers may be hesitant to explore changes to the status quo absent significant economic opportunity to reduce their costs. The challenge of payer buy-in is especially acute in the home health space since these services typically represent a *de minimis* proportion of total spend for any given payer. Also, LHC does not usually have sufficient data to identify individual payers' specific pain points and cost drivers, particularly as those can vary widely depending on the geography and patient population, to be able to make its case for implementation of a value-based care arrangement. While UHG and LHC stand ready and willing to enter into value-based care arrangements for home health services in Oregon and nationwide, payer engagement remains a critical gating item to their development, implementation and expansion.

Notwithstanding the inherent challenges of attracting payer interest in value-based compensation methodologies, UHG's proposed acquisition of Amedisys increases the likelihood of payer engagement because the increased scale in Oregon and elsewhere expands the combined firm's geographic coverage and number of patients served, thus increasing the potential scope of savings for any given payer. Payers typically do not want to enter into value-based arrangements with smaller providers because there would be low economic upside to justify the investment. Additionally, smaller providers struggle to provide sufficient assurances to payers that they have the operational flexibility, financial backing, and track record to succeed in value-based care arrangements. By contrast, the combination of LHC and Amedisys affords even greater opportunities for administrative and operational efficiencies that can generate more shared savings to ensure the sustainability of value-based arrangements. When combined with LHC and UHG's commitment, experience and success with value-based care, the proposed transaction will only help to further accelerate this transition.

43. The response to item #22 of the March 15th RFI includes an analysis of the distance between Amedisys/LHC nurses and patients in Oregon.

a. Please clarify how this analysis accounted for the geographic service area restrictions outlined in Oregon Administrative Rule (OAR) 333-035-0160.

b. The response states that LHC home health nurses in Medford traveled up to 80 miles to visit patients in Roseburg. Were travel distances exceeding 60 miles subject to a waiver under OAR 333-035-0160(4)?

c. Please list all Amedisys or LHC hospice agency locations that have obtained a waiver of geographical restrictions per OAR 333-035-0160(4). Include the effective date of any such waiver.

d. Provide any plans, analyses, reports, presentations, or other materials developed by UHG, Optum, and/or LHC related to the "more efficient utilization of home health nursing staff" expected following closure of the transaction as discussed on pages 25-27 of the response.

e. Approximately how many additional patients would LHC and Amedisys home health agencies be able to serve in Oregon if these plans were implemented?

f. Describe (i) Amedisys, and (ii) LHC rules and requirements for reimbursing travel expenses/mileage of clinical staff for travel to patient locations in Oregon. Include information on reimbursement amounts/rates.

Response

Scope of Oregon Administrative Rule (OAR) 333-035-0160

OAR 333-035-0160 is only applicable to hospice agencies. The analysis provided in our April 30 response to Request #22 was limited to home health agencies, and no waiver of the geographic restrictions of OAR 333-035-0160(4) is required for home health locations.

More Efficient Scheduling Will Increase Nursing Capacity and Access to Care at LHC and Amedisys Locations

The proposed transaction will enable LHC to take a more holistic view of scheduling across its own and current Amedisys locations in Oregon to ensure that nurses can be deployed to serve patients located closest to them. For instance, and as explained in our April 30 response, for 3,186 out of 6,285 visits (51%) made by nurses from LHC's home health location in Salem in 2023, an Amedisys nurse lived closer to the patient than the closest LHC nurse. Similarly, for 6,385 out of 20,016 visits (32%) made by nurses from Amedisys's home health location in Portland that year, an LHC nurse lived closer to the patient than the closest Amedisys nurse. Cumulatively, this analysis suggests that there was theoretically a more efficient staffing alternative for 11,610 out of

59,925 home health visits (19%) made by LHC and Amedisys in Oregon in 2023, if the relevant nurse schedulers had had access to LHC and Amedisys's combined nursing staff in the state. Improved utilization of nursing staff in this way could have saved full-time nurses approximately 29% or more than 40 miles per week in travel distance and almost two hours per week in travel time. According to Amedisys data, each patient visit is comprised of approximately ~~15~~ minutes of drive time and ~~76~~ minutes of patient care time,[16] meaning that if nurses' travel distances and times were reduced by 29%, LHC and Amedisys could provide an additional 3,052 patient visits annually across their combined six agencies in Oregon post-closing.

Amedisys's Reimbursement Policy for Travel Expenses

Amedisys's policy on mileage reimbursement is contained in Section 4.14 of its Policy Manual.[17] The policy provides that all employees who use their own motor vehicle for business-related travel are eligible for reimbursement. Mileage to and from a clinician's home to their first and last appointment, respectively, is considered part of the employee's daily commute and therefore not reimbursable, unless the commute involves an exceptional distance.

The current national mileage reimbursement rate for Amedisys's clinical staff is [redacted] per mile. However, members of collective bargaining units may be reimbursed at different rates pursuant to applicable collective bargaining agreements. Amedisys currently has an agreement with a bargaining unit of the Oregon Nurses Association (ONA) covering certain employees in Portland, Oregon.[18] The current mileage reimbursement rate for those covered employees is [redacted] per mile. Amedisys's mileage reimbursements are generally processed as non-taxable payments to employees.

LHC's Reimbursement Policy for Travel Expenses

Pursuant to LHC's Mileage Reimbursement Policy (No. 2.2.007),[19] all LHC staff, other than employees of LHC's Home and Community Based Services (HCBS) division, are entitled to reimbursement for ordinary-course business-related travel in accordance with the policy.[20] Reimbursable expenses include travel between patients' homes and between a patient's home and the employee's assigned office location. Mileage associated with commuting to and from the employee's home to their assigned office location is not reimbursable. To the extent a clinician travels directly from their home to their first appointment or to their home from their last

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16 Based on Amedisys data regarding patient visits at its Portland and Salem home health locations. Amedisys's Roseburg home health location was excluded from this analysis, as there is no overlap between Amedisys's home health agency in Roseburg and any LHC home health agency.

17 *See Policy Manual*, Amedisys, Inc. (December 2023) (Exhibit 43-1).

18 *See* Collective Bargaining Agreement between Oregon Nurses Association & Amedisys Oregon, L.L.C., April 1, 2021 until March 31, 2024 (Exhibit 43-2).

19 *See Mileage Reimbursement*, LHC Group, Inc. (February 12, 2023) (Exhibit 43-3).

20 Employees of LHC's HCBS division are subject to a division-specific expense reimbursement policy.

appointment, the distance between the clinician's home and assigned office location is deducted from the reimbursable mileage.

Mileage reimbursement rates are set by region and reviewed twice per year. The current reimbursement rate for mileage expenses in Oregon is [redacted] per mile, which will remain in place until at least December 2024.

IV. Oregon Health Care Providers Acquired by UHG/Optum

The below questions apply to Optum's prior acquisitions of Oregon Medical Group, GreenField Health, Family Medical Group NE, The Davies Clinic, SCA surgery centers, and LHC group. These entities are collectively referred to as "acquired Oregon health care providers." To the extent your response differs across these providers, please respond separately for each entity.

44. Please provide information and data on the acquired Oregon health care providers by completing the following Excel workbooks (attached):

a. ***Family Medical Group NE data workbook.xlsx***
b. ***GreenField data workbook.xlsx***
c. ***Mt Scott and Cornell Surgery Centers data workbook.xlsx***
d. ***NW Spine and Pain data workbook.xlsx***
e. ***Oregon Medical Group data workbook.xlsx***
f. ***SCA practices acquired in 2017 data workbook.xlsx.***

The requested information and data for the SCA surgery centers are provided in the Excel workbooks in Exhibit 44. Please note that SCA does not own the ambulatory surgery centers listed above and does not employ the physicians who provide medical services at the centers. The owner of each center is responsible for admitting physicians to the medical staff of each center to provide surgical and other medical services to their patients and is responsible for credentialing the medical staff at the centers. SCA provides certain management services to the owners of the centers, including financial services support, IT support, compliance training and auditing, administrative clinical support, human resources guidance, materials management support, and other operational support.

45. Describe UHG's approach to physician practice acquisitions as it relates to Oregon. Specifically:

a. What are UHG/Optum's goals in pursuing these acquisitions?

UHG has no Oregon-specific acquisition strategy as it relates to physician practice acquisitions. In general, these acquisitions expand Optum's outpatient offerings in the region, expand access to alternate high-quality sites of care while reducing the cost of care for payors and patients.

b. What criteria does UHG/Optum use to identify and evaluate acquisition targets? Identify the metrics, data, and other information sources used.

UHG considers the following information to evaluate potential acquisition targets:

46. Describe UHG's approach to ambulatory surgery center (ASC) acquisitions as it relates to Oregon. Specifically:

a. What are UHG/Optum's goals in pursuing these acquisitions?

UHG has no Oregon-specific acquisition strategy as it relates to ASC acquisitions. In general, these acquisitions expand Optum's outpatient offerings in the region, expand access to alternate high-quality sites of care while reducing the cost of care for payors and patients.

b. What criteria does UHG/Optum use to identify and evaluate acquisition targets? Identify the metrics, data, and other information sources used.

UHG considers the following information to evaluate potential acquisition targets:

47. Describe UHG's approach to home health or hospice provider acquisitions as it relates to Oregon. Specifically:

a. What are UHG/Optum's goals in pursuing these acquisitions?

UHG has no Oregon-specific acquisition strategy as it relates to home health or hospice provider acquisitions. In general, these acquisitions create an end-to-end post-acute network that enhances Optum's ability to meet patient care needs. Furthermore, integrating these capabilities provides Optum with the ability to manage appropriate care utilization and reduce hospital

readmissions as well as the ability to develop innovative value-based reimbursement models in the home.

b. What criteria does UHG/Optum use to identify and evaluate acquisition targets? Identify the metrics, data, and other information sources used.

UHG considers the following information to evaluate potential acquisition targets:

48. Regarding solely Oregon Medical Group, GreenField Health, Family Medical Group NE, and The Davies Clinic, describe the roles and responsibilities of (i) UHG/Optum, and (ii) the practice, for each of the below functions. Identify the Optum/ UHG policies, systems, or infrastructure applicable to each function.

a. Clinical staffing and hiring
b. Administrative staffing and hiring
c. Compensation and benefits for clinical staff
d. Payer contracting
e. Billing and payment
f. Patient care practices
g. Patient enrollment practices
h. Financial assistance/charity care
i. Sourcing of supplies, technology, and related services

Each of the functions above are managed through Optum Care Delivery, a division of Optum Care. These are standard business functions and there are no applicable UHG/Optum policies.

49. Regarding SCA surgery centers in Oregon, describe the roles and responsibilities of (i) UHG/Optum, and (ii) the ASC for each of the below functions. Identify the Optum/ UHG policies, systems, or infrastructure applicable to each function.

a. Clinical staffing and hiring
b. Administrative staffing and hiring
c. Compensation and benefits for clinical staff
d. Payer contracting

e. Billing and payment
f. Patient care practices
g. Patient enrollment practices
h. Financial assistance/charity care
i. Sourcing of supplies, technology, and related services

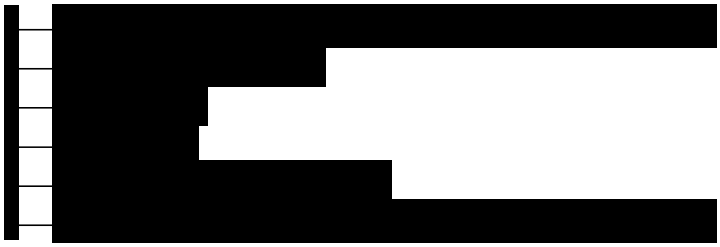
As noted in the response to Item 44 above, SCA operates ambulatory surgery center (ASCs) by providing certain management services but not does employ the physicians or other clinical staff at the ASCs and is not responsible for payer contracting, billing and payment, or the other functions listed above for such clinicians. The management services provided by SCA are coordinated by an on-site administrator at each center.

50. What criteria and metrics are used to assess the success of acquired provider groups or health care companies post-acquisition? Please respond specifically for:

a. Physician practices

b. ASCs

c. Home health and hospice agencies



51. Describe any changes at Oregon Medical Group since the acquisition by UHG/Optum related to:

a. Range of services offered.

b. Insurance plans with which the provider contracts; please list any contracts that were terminated and any new contracts entered into since close.
c. Policies or practices for patient referral to other providers.
d. Administrative responsibilities of clinical staff.
e. Patient enrollment and discharge/dismissal policies.
f. Practices and procedures for documenting/coding patient diagnoses.
g. Financial assistance/charity care policies.
h. Billing and payment practices or policies, including practices for billing for prescription refill requests received from a pharmacy and responding to patient email inquiries.
i. Branding or practice names (including d/b/a names).

There have been no changes in any of the areas listed above since the acquisition by UHG/Optum other than changes in services and patient enrollment policies driven by clinician departures. With regard to patient enrollment, adult primary care enrollment has been closed to new patients due to clinician capacity limitations.

j. Electronic Health Records systems.

OMG has transitioned to using Epic since the acquisition by UHG/Optum.

52. Since its acquisition by Optum, how many employees have left Oregon Medical Group ("OMG")?

a. How many OMG employees have left voluntarily or resigned since the acquisition? Identify the employment position, title, and (as applicable) qualification/specialty of each such employee.
b. How many employment positions were eliminated as a result of the acquisition? Identify each such position, including the aggregate compensation amount paid (including fringe benefits) for the position and the basis for your conclusion that the elimination of that position was attributable to the acquisition.
c. For employees that left voluntarily or resigned from Oregon Medical Group, what reason(s) have departing employees given for their decision to leave OMG? Please list reasons in order of frequency.
d. What has OMG/Optum done to date to prevent further departures? Describe how these actions are expected to reduce departures and retain employees.

The requested information regarding the employees who have left Oregon Medical Group since its acquisition by Optum on December 6, 2020, is provided in Exhibit 52. In response to Item 52.b, certain positions were eliminated after the acquisition because they were duplicative with existing Optum functionalities.

53. Describe any changes at GreenField Health since the acquisition by UHG/Optum related to:

a. Range of services offered.

There have been no changes other than those driven by clinician departures.

b. Insurance plans with which the provider contracts; please list any contracts that were terminated and any new contracts entered into since close.

The following contracts were terminated: Devoted MA, Humana MA, Regence Alliance. Optum participated in these programs via Legacy Health Partners. Optum terminated the contracts with Legacy Health Partners and the associated health plans because Legacy Partners was unwilling to contract in specific locations only.

c. Policies or practices for patient referral to other providers.

There have been no changes to the practices or policies for patient referrals to other providers**.**

d. Administrative responsibilities of clinical staff.

There have been no changes to responsibilities of clinical staff.

e. Patient enrollment and discharge/dismissal policies.

There have been no changes to patient enrollment and discharge/dismissal other than those driven by clinician departures. Namely, adult primary care enrollment has been closed to new patients due to clinician capacity limitations.

f. Practices and procedures for documenting/coding patient diagnoses.

There have been no changes to practices and procedures for documenting/coding patient diagnoses.

g. Financial assistance/charity care policies.

Oregon Medical Group policies were adopted in February 2023.

h. Billing and payment practices or policies, including practices for billing for prescription refill requests received from a pharmacy and responding to patient email inquiries.

Oregon Medical Group policies were adopted in February 2023. These policies do not allow billing for prescription refill requests.

i. Branding or practice names (including d/b/a names).

There have been no changes to branding or practice names.

j. Electronic Health Records systems.

Following the acquisition, GreenField Health has transitioned to the Family Medical Group instance of Epic.

54. The response to item #12 of OHA's March 15th RFI regarding GreenField Health stated, "The offices were consolidated to provide better support and coverage for patients, staff and clinicians." Please explain how the closure of the GreenField Health System Barnes Road location improved coverage for patients.

Staff shortages rendered it difficult to keep two locations fully operational. By consolidating offices, GreenField Health was able to preserve patient access by ensuring clinicians have sufficient medical assistant and physician service representative coverage.

55. Describe any changes at Family Medical Group NE since the acquisition by UHG/Optum related to:

a. Range of services offered.

There have been no changes other than those driven by clinician departures.

b. Insurance plans with which the provider contracts; please list any contracts that were terminated and any new contracts entered into since close.

The following contracts were terminated: Devoted MA, Humana MA, Regence Alliance. Optum participated in these programs via Legacy Health Partners. Optum terminated the contracts with Legacy Health Partners and the associated health plans because Legacy Partners was unwilling to contract in specific locations only.

c. Policies or practices for patient referral to other providers.

There have been no changes to policies or practices for patient referral to other providers.

d. Administrative responsibilities of clinical staff.

There have been no changes to administrative responsibilities of clinical staff.

e. Patient enrollment and discharge/dismissal policies.

There have been no changes to patient enrollment and discharge/dismissal other than those driven by clinician departures. Namely, adult primary care enrollment has been closed to new patients due to clinician capacity limitations.

f. Practices and procedures for documenting/coding patient diagnoses.

There have been no changes to practices and procedures for documenting and coding patient diagnoses.

g. Financial assistance/charity care policies.

Oregon Medical Group policies were adopted in February 2023.

h. Billing and payment practices or policies, including practices for billing for prescription refill requests received from a pharmacy and responding to patient email inquiries.

Oregon Medical Group policies were adopted in February 2023. These policies do not allow billing for prescription refill requests.

i. Branding or practice names (including d/b/a names).

There have been no changes to branding or practice names.

j. Electronic Health Records systems.

There have been no changes to the Electronic Health Records systems.

56. Describe any changes at The Davies Clinic since the acquisition by UHG/Optum related to:

a. Range of services offered.

No material changes other than those driven by clinician departures.

b. Insurance plans with which the provider contracts; please list any contracts that were terminated and any new contracts entered into since close.

The following contracts were terminated: Devoted MA, Humana MA, Regence Alliance. Optum participated in these programs via Legacy Health Partners. Optum terminated the contracts with Legacy Health Partners and the associated health plans because Legacy Partners was unwilling to contract in specific locations only.

c. Policies or practices for patient referral to other providers.

There have been no changes to policies or practices for patient referral to other providers.

d. Administrative responsibilities of clinical staff.

There have been no changes to administrative responsibilities of clinical staff.

e. Patient enrollment and discharge/dismissal policies.

There have been no changes to patient enrollment and discharge/dismissal other than those driven by clinician departures. Namely, adult primary care enrollment has been closed to new patients due to clinician capacity limitations.

f. Practices and procedures for documenting/coding patient diagnoses.

There have been no changes to practices and procedures for documenting/coding patient diagnoses.

g. Financial assistance/charity care policies.

Oregon Medical Group policies were adopted in February 2023.

h. Billing and payment practices or policies, including practices for billing for prescription refill requests received from a pharmacy and responding to patient email inquiries.

Oregon Medical Group policies were adopted in February 2023. These policies do not allow billing for prescription refill requests.

i. Branding or practice names (including d/b/a names).

There have been no changes to branding or practice names.

j. Electronic Health Records systems.

Following the acquisition, the Davies Clinic transitioned to Epic.

57. Describe any changes at SCA surgery centers in Oregon since their acquisition by UHG/Optum related to:

a. Range of services offered.

The only change in services offered at SCA surgery centers in Oregon since their acquisition by UHG/Optum is that a provider began offering urology services at Mt. Scott Surgery

Center urology in 2022 until that provider moved out of state. The ASC services offered at the centers have remained the same.

b. Insurance plans with which the provider contracts; please list any contracts that were terminated and any new contracts entered into since close.

See Exhibit 57.

c. Policies or practices for patient referral to other providers.

SCA does not refer patients to other providers. Primary care and other physicians refer patients to the surgeons who operate in the SCA surgery centers.

d. Administrative responsibilities of clinical staff.

There have been no changes since the acquisition.

e. Patient enrollment and discharge/dismissal policies.

SCA does not have copies of policies from prior to the acquisition and is unaware of any changes.

f. Practices and procedures for documenting/coding patient diagnoses.

SCA does not document or code patient diagnoses. That is done by physicians prior to their use of a surgery center.

g. Financial assistance/charity care policies.

SCA does not have copies of policies from prior to the acquisition and is unaware of any changes.

h. Billing and payment practices or policies.

SCA does not have copies of policies from prior to the acquisition and is unaware of any changes.

i. Branding or practice names (including d/b/a names).

Mt. Scott Surgery Center, LLC changed to Surgery Center of Mt. Scott. LLC. Cornell Surgery Center, LLC changed to Cornell Surgicenter, LLC.

j. Electronic Health Records systems.

There have been no changes since the acquisition.

58. Describe the current compensation structure (including base salary, bonus/incentive pay components, and benefits) for the following clinicians at acquired Oregon health care providers. In doing so, identify all metrics used to determine any incentive/bonus-based compensation.

a. Physicians
b. Nurse practitioners
c. Physician assistants

The requested information regarding the current compensation structure at the acquired Oregon health care providers is provided in Exhibit 58.

59. Describe the contractual employment terms for physicians and advanced practice providers at the acquired Oregon health care providers relating to:

a. Non-compete requirements

The following practices apply to all Oregon healthcare providers affiliated with Optum, except for the Corvallis Clinic, P.C.:

[redacted]

The Corvallis Clinic, P.C. became affiliated with Optum March 21, 2024. [redacted]

b. Non-disclosure requirements

Optum Oregon employees are not required to sign non-disclosure agreements as a condition of their employment. Employment agreements since the acquisition by Optum have

included a standard confidentiality provision. This provision prohibits the disclosure of information that is confidential and proprietary to the practice during or after the provider's employment by Optum:

V. Other Topics

60. Please provide a copy of the purchase agreement and related agreements between Amedisys and VCG Luna, LLC, an affiliate of VitalCaring Group (the "Divestiture Agreement").

a. Please include any and all disclosure schedules and exhibits that are referenced by or incorporated into the Divestiture Agreement.

A copy of the Divestiture Agreement and its disclosure schedules and exhibits are provided in Exhibit 60.

b. Please provide a list of all third parties that are required to approve the Divestiture (either by contract or regulatory approval), along with an update on the status of those approvals.

The consents and approvals required for the Divestiture are identified in Section 3.8 of the Disclosure Letter that is included with the Divestiture Agreement provided in Exhibit 60. The parties plan to submit the required notices in accordance with the timing described in Attachment 3.8 to the Disclosure Letter. The parties also plan to submit notification and report forms in connection with the Divestiture to the Federal Trade Commission and U.S. Department of Justice pursuant to the Hart Scott Rodino Antitrust Improvements Act of 1976 (HSR Act).

c. To the extent any approval is contractually based and related to the provision of healthcare products or services (or the supply of products or services in connection therewith) please describe any conditions to consent any such third parties have made (e.g., raising the rates of products or services, more favorable terms, contract extensions, etc.).

No third parties have required any conditions to consent in connection with the Divestiture.

61. Describe any current or past policies, practices, or initiatives by UHG to encourage enrollment of Optum patients in UHC MA plans. Specifically:

a. Describe any information on Medicare enrollment options (including information sessions, pamphlets, or other outreach) provided by UHG representatives to patients at Optum-owned provider groups.
b. Describe any bonuses or other compensation-based incentives offered to UHG employees or contractors for enrolling Optum patients in UHC MA plans.
c. Describe any free services, discounts, or other membership perks offered to Optum patients who switch to UHC MA or to OptumRx Medicare Part D plans.

There are no current or past policies, practices, or initiatives by UHG to encourage enrollment in UHC MA plans that are specific to Optum patients. Optum invites non-affiliated brokers to its clinics to assist patients with Medicare enrollment and any questions about Medicare in general (*i.e.*, not limited to UHC Medicare Advantage Plans). UHC provides no bonuses or other compensation-based incentives for enrolling Optum patients in UHC MA plans and has no plans to do so. CMS Medicare Advantage regulations prohibit UHC from providing certain members with special services, discounts, or other membership perks that are not offered to all members.

62. Has UHG/Optum issued loans or provided other financial assistance to independent provider organizations in
Oregon? If so, please provide the following information:

a. Name of provider.
b. Description of financial service(s) (e.g., short-term loan, credit facility, etc.).

c. Date of issue or agreement to provide service.
d. Terms (loan/credit amount, duration, interest rate, etc.).

The requested information is provided in Exhibit 62.

63. The response to item #15 (Appendix I) of OHA's March 15, 2024, Request for Information for the 1-Year Follow-Up Review of 003 United-LHC indicates UHC's commercial health insurance plans were contracted with [redacted] home health or hospice providers as of January 1, 2024. Please confirm whether this is accurate, and if needed, provide a revised list.

The Excel file submitted as Appendix I contains two tabs. The first (14 – Effective as of Jan. 2023) lists the providers that were contracted as of January 1, 2023. The second (15 – Effective after Jan. 2023) lists the additional providers that were added after January 1, 2023. The two tabs together list all providers that were contracted as of January 1, 2024.

64. Do LHC or Amedisys staff currently conduct Health Risk Assessments ("HRAs") for patients in Oregon or other states?

a. If yes, describe the circumstances in which HRAs are offered to Amedisys or LHC patients.
b. If no, describe any plans to offer HRAs to Amedisys or LHC patients in the future.

LHC and Amedisys staff do not currently conduct Health Risk Assessments for patients in Oregon or other states and have no plans to do so.

65. Describe Optum's internal processes for patient referrals by Optum-employed clinicians to home health care.

a. Provide all documents, including policies, written guidelines/rules, or other materials prepared for Optum-employed clinicians related to home health care referrals.
b. Provide examples of information/materials provided to Optum patients regarding their options for home health services.
c. Are Optum-employed clinicians subject to any policies, rules, compensation schemes, or other incentives that would make it relatively less attractive or convenient for them refer patients to unaffiliated home health providers as compared to LHC/Amedisys? If so, please describe same.

Optum-employed physicians may refer their patients to any home health provider. Optum has no policies or other materials prepared for Optum-employed clinicians in Oregon relating to home health care referrals and Optum provides no Optum-issued materials to patients in Oregon regarding their options for home health services (individual physicians may provide information

on home health providers directly to their patients). Optum-employed clinicians in Oregon are not subject to any policies, rules, compensation schemes, or other incentives that would make it relatively less attractive or convenient for them refer patients to unaffiliated home health providers as compared to LHC/Amedisys.

66. Describe Optum's internal processes and guidelines for patient referrals by Optum-employed clinicians to hospice care.

a. Provide all documents, including policies, written guidelines/rules, or other materials prepared for Optum-employed clinicians related to hospice care referrals.
b. Provide examples of information/materials provided to Optum patients regarding their options for hospice services.
c. Are Optum-employed clinicians subject to any policies, rules, compensation schemes, or other incentives that would make it relatively less attractive or convenient for them refer patients to unaffiliated hospice providers as compared to LHC/Amedisys? If so, please describe same.

Optum-employed physicians may refer their patients to any hospice care provider. Optum has no policies or other materials prepared for Optum-employed clinicians in Oregon relating to hospice care referrals and Optum provides no Optum-issued materials to patients in Oregon regarding their options for hospice services (individual physicians may provide information on hospice providers directly to their patients). Optum-employed clinicians in Oregon are not subject to any policies, rules, compensation schemes, or other incentives that would make it relatively less attractive or convenient for them refer patients to unaffiliated hospice providers as compared to LHC/Amedisys.

67. Please provide a copy of the Optum Care Network (OCN) Provider Manual applicable to Oregon.

Please see Exhibit 67.

68. Please provide a sample management services agreement or similar agreement between OCN and an Oregon-based physician group member of OCN.

Please see Exhibit 68.

69. Does Optum negotiate value-based care or other reimbursement agreements with UHC or other payers on behalf of OCN member clinicians? If so, please describe Optum's role.

No, Optum does not negotiate value-based care or other reimbursement agreements with UHC or other payers on behalf of OCN member clinicians.

70. Describe Optum's processes and guidelines for patient referrals by OCN member clinicians to home health and hospice care.

a. Provide all documents, including policies, written guidelines/rules, or other materials prepared for OCN member clinicians related to home health and hospice care referrals.

Optum does not have policies, written guidelines/rules, or other materials prepared for OCN member clinicians specifically related to home health and hospice care referrals.

b. Are OCN member practices or clinicians subject to any policies, rules, compensation schemes, or other incentives that would make it relatively less attractive or convenient for them refer patients to unaffiliated providers as compared to Optum-owned or affiliated providers? If so, please describe same.

OCN member are not subject to any policies, rules, compensation schemes, or other incentives that would make it relatively less attractive or convenient for them refer patients to unaffiliated providers as compared to Optum-owned or affiliated providers.

* * *

This letter and its attachments and appendices contain confidential business and financial information that qualifies as trade secrets as identified in the enclosed confidentiality log that is provided pursuant to ORS 415.501 and ORS 192.345(2).

Best regards,

Anthony Swisher

/s/ Anthony Swisher

Counsel to UnitedHealth Group Incorporated