Health Care Market Oversight

Transaction 014
UnitedHealth Group – Amedisys
Comprehensive Review Report

June 12, 2026

OREGON HEALTH AUTHORITY

About this Report

This report summarizes analyses and findings from Oregon Health Authority's comprehensive review of the material change transaction between UnitedHealth Group Incorporated ("UHG") and Amedisys, Inc. ("Amedisys"). It accompanies the Findings of Fact, Conclusions of Law, and Final Order ("Comprehensive Review Order") issued by Oregon Health Authority on June 12, 2026. For legal requirements related to the transaction, please reference the Comprehensive Review Order.

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Executive Summary

The Oregon Health Authority's Health Care Market Oversight (HCMO) program reviews proposed health care business deals to make sure they support statewide goals related to cost, equity, access, and quality. On December 4, 2023, HCMO accepted a complete Notice of Material Change Transaction ("notice") from UnitedHealth Group Incorporated ("UHG") detailing plans to acquire Amedisys, Inc. ("Amedisys"). The Oregon Health Authority (OHA) completed a comprehensive review of the transaction on June 12, 2026, following an eight-month pause due to a federal lawsuit (see **Suspension** below).

About the Transaction

UHG is a for-profit, publicly traded company that provides health insurance plans and health care services nationwide. Its LHC subsidiary, acquired in 2023, operates home health and hospice agencies across the country, including five home health and four hospice agency locations in Oregon. Amedisys is a nationwide provider of home health, hospice, and palliative care services that operates three home health agencies and one hospice agency in Oregon. In June 2023, UHG and Amedisys announced that UHG would be acquiring Amedisys for approximately $3.3 billion, making Amedisys a wholly owned subsidiary of UHG and part of Optum Health. The transaction closed nationwide on August 14, 2025, with Oregon operations required to be held separately until OHA concluded its review of the transaction.

Federal Action

In late 2023, federal antitrust regulators at the U.S. Department of Justice ("USDOJ") launched an investigation into the proposed deal. In November 2024, USDOJ and four state Attorneys General sued UHG and Amedisys seeking to block the acquisition in the U.S. District Court for the District of Maryland ("Maryland D.C."), claiming that the acquisition was presumptively anticompetitive, including in Oregon, and violated federal antitrust laws. The parties reached a settlement in August 2025 resolving these claims and requiring that UHG and Amedisys divest 164 home health and hospice agencies in 19 states, not including Oregon. The Maryland D.C. issued its initial Final Order on December 9, 2025, following a lengthy public comment period, and subsequently issued a modified Final Order on February 2, 2026, extending certain deadlines for operations in New York.

OHA's Review

The Oregon Health Authority (OHA) assessed whether the transaction met the criteria for approval outlined in HCMO's statute and rules. On March 14, 2024, OHA concluded a preliminary review of the transaction and determined that a comprehensive review was warranted.

During comprehensive review, OHA conducted more in-depth analysis to understand how the transaction might impact access to affordable, equitable care for people in Oregon. OHA's analysis was guided by the approval criteria outlined in ORS 415.501(19) and OAR 409-070-0060(5). To inform the analysis, OHA reviewed documents and information submitted by the entities, analyzed data, and conducted background research. OHA accepted public comments throughout the review and received a total of 16 comments.

Suspension

OHA suspended its comprehensive review while the federal legal action was ongoing given concerns and allegations that the transaction was presumptively illegal in Oregon. Under the Final Order Suspending Transaction Review and Stipulated Preservation and Hold-Separate Agreement ("suspension order") OHA agreed that if the federal court permitted the transaction to be completed, UHG and Amedisys could close the transaction nationwide prior to the conclusion of OHA's review, provided that UHG refrain from fully integrating in Oregon and maintain Amedisys' home health and hospice agencies in Oregon as a separate operation until OHA's review was complete.

Key Findings

OHA's findings related to each of the comprehensive review criteria are summarized below.

Competitive Effects

OHA's analysis did not find evidence that the transaction would create a substantial risk of material anti-competitive effects in Oregon. Estimated increases in the Herfindahl-Hirschman Index (HHI) associated with the transaction are below thresholds used by federal antitrust regulators for presumed anti-competitive effects. Given market realities, vertical foreclosure (e.g., excluding third-party insurers or home health providers from UHG contracting) is unlikely to be profitable for UHG in Oregon. However, given the high levels of concentration among home health and hospice providers in Amedisys' Portland, Salem, and Roseburg service areas, complaints raised by providers in other states about UHG's anti-competitive behavior, and reported concerns among federal antitrust regulators, OHA has placed conditions on the entities intended to mitigate any risk of anti-competitive effects.

Lawfulness of the Transaction

Legal analysis of the transaction found no evidence that the transaction, as presented, is contrary to law.

Financial Stability

The transaction is unlikely to jeopardize the financial stability of Amedisys or UHG. Amedisys financial reports demonstrate that prior to the transaction's close, the company was both profitable and solvent. Amedisys' Board reviewed and approved the merger agreement, and its shareholders approved it almost unanimously. Despite headwinds in 2024-2025, UHG, as the largest health care company in the country, continues to grow its revenues, achieve profitability, and maintain a strong financial position. UHG is not assuming any additional debt to finance the transaction. As a subsidiary of UHG, Amedisys will likely be able to reduce its operating costs while further growing its revenues by serving more UHC members and Optum patients.

Impact on Consumers and the Public

In the year following UHG's acquisition of LHC in early 2023, two former LHC agency locations in Oregon have been relocated and one has closed entirely. Other UHG acquisitions involving physician groups in Oregon were followed by severe disruptions and reductions in access to health care services. Across the health care system, closures and service reductions usually impact people with low incomes, rural residents, and people of color more deeply than other groups, contributing to growing health inequities. OHA has imposed conditions on UHG aimed at preserving access to services and safeguarding care quality at UHG's home health and hospice

agencies in the state. Under OHA's conditions, the transaction is unlikely to be hazardous or prejudicial to consumers or the public in Oregon.

Potential to Benefit the Public Good and Communities

OHA expects that the transaction will improve care quality and health outcomes for home health patients in Oregon through the integration of LHC and Amedisys clinical programs. OHA also expects that the transaction will increase access to hospice services for pediatric patients in the medically underserved Roseburg area. To ensure this, OHA has imposed a condition on its approval of the transaction requiring that UHG's hospice agency in Roseburg have the capacity and expertise to offer hospice services to pediatric patients within one year of the Order date.

Conclusions and Decision

Based on comprehensive review findings, OHA **approved the transaction with conditions** on June, 12, 2026. (See the Comprehensive Review Order for details.) OHA determined that under the approval conditions (listed below), the transaction meets the criteria for approval following comprehensive review outlined in ORS 415.501(9) and OAR 409-070-0060(5).

For OHA to approve a transaction, the transaction must meet the criteria for A. *and* B. *or* C. listed below:

A. There is no substantial likelihood that the transaction would: • Have material anti-competitive effects in the region not outweighed by benefits in increasing or maintaining services to underserved populations; • Be contrary to law; • Jeopardize the financial stability of a health care entity involved in the transaction; or • Otherwise be hazardous or prejudicial to consumers or the public	***and***	**B.** The transaction will benefit the public good and communities by: • Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is in the best interest of the public; • Increasing access to services in medically underserved areas; or • Rectifying historical and contemporary factors contributing to a lack of health equity or access to services.
		or
		C. The transaction will improve health outcomes for residents of this state.

OHA determined that, under the approval conditions outlined below, the transaction meets criterion A, because there is no substantial likelihood that the transaction would have material anticompetitive effects in Oregon, be contrary to law, jeopardize the financial stability of UHG's home health and hospice business, or be otherwise harmful to consumers or the public. OHA further determined that subject to approval conditions outlined below, the transaction will benefit the public good and communities by increasing access to hospice services in a medically underserved area therefore satisfying criteria B. While not needed for OHA to approve the transaction, OHA further determined that the transaction also satisfies criteria C by improving health outcomes for home health patients in Oregon.

Approval Conditions

This transaction is approved subject to the conditions summarized below, which apply for a five-year period following the date of the Comprehensive Review Order ("order date"). Please see the Comprehensive Review Order for the legal wording of these conditions.

1. UHG must adhere to the representations made in the notice and subsequent filings with OHA.
2. For any future UHG transaction not subject to HCMO review that involves a home health or hospice agency licensed in Oregon, UHG must notify OHA at least 60 days prior to completing the deal.
3. If UHG anticipates making changes that would lead to non-compliance with any condition, UHG may petition OHA to waive or modify the relevant condition(s). UHG must submit the petition to OHA at least 60 days before making the change(s). OHA may approve or deny the petition.
4. Within six months of the date of the order date, UHG must administer an anonymous survey to clinical caregivers at UHG home health and hospice agencies in Oregon. UHG must administer a second survey within one year of the Order date, followed by annual surveys. Survey questions are listed in Exhibit A to the Comprehensive Review Order and cover topics such as care quality, workload, and job satisfaction. UHG must use an independent, third-party platform to administer the annual survey.
5. Within 180 days of the order date, UHG must establish a Home Health Committee composed of staff working at UHG's home health agencies in Oregon. The committee must meet quarterly and will be tasked with establishing benchmarks for the Oregon home health agencies, which must be tied to annual survey responses, and tracking performance on those benchmarks. UHG must provide the Home Health Committee with quarterly reports including data on survey responses, benchmark performance, and other metrics specified in Exhibit B-1 to the Comprehensive Review Order. If UHG home health agencies fail to meet a benchmark, UHG must develop a plan to improve performance, which will be subject to the Home Health Committee's approval. UHG must provide quarterly reports to the Home Health Committee on implementation of the plan.
6. Within 180 days of the order date, UHG must establish a Hospice Committee composed of staff working at UHG's hospice agencies in Oregon. The committee must meet quarterly and will be tasked with establishing benchmarks for the Oregon hospice agencies, which must be tied to annual survey responses, and tracking performance on those benchmarks. UHG must provide the Hospice Committee with quarterly reports including data on survey responses, benchmark performance, and other metrics specified in Exhibit B-1 to the Comprehensive Review Order. If UHG hospice agencies fail to meet a benchmark, UHG must develop a plan to improve performance, which will be subject to the Hospice Committee's approval. UHG must provide quarterly reports to the Hospice Committee on implementation of the plan.
7. UHG must use commercially reasonable efforts to continue to operate and maintain all Amedisys home health and hospice agencies in Oregon and maintain the capacity, services, and programs of these agencies. UHG may not close, consolidate, or relocate any agency if the relocation would substantially change the agency's geographic service area. If UHG believes that closures or service reductions are necessary based on changes in community need, quality/safety concerns, significant financial losses, or other reasons, UHG must apply to OHA for approval at least 60 days before taking any action.

8. Within one year of the order date, UHG must have built the capacity and expertise to provide pediatric hospice services at its Roseburg hospice agency.
9. UHG must not unreasonably favor its own home health agencies over third-party providers that are not affiliated with UHG. This extends to network participation, reimbursement and other contracting terms, prior authorization processes, and health plan member communications or incentives. UHG will be allowed to implement policies or programs designed to increase quality or improve patient outcomes.
10. UHG home health agencies must not unreasonably favor UnitedHealthcare ("UHC") health insurance plans or their members over third-party insurers that are not affiliated with UHG. This extends to network participation, reimbursement and other contracting terms, patient admissions/discharge, and marketing activities. UHG will be allowed to implement policies or programs designed to increase quality or improve patient outcomes.
11. UHG must continue to participate in all public health insurance programs in which Amedisys home health and hospice agencies participated as of the closing date, including Medicare and Medicaid (OHP).
12. UHG must submit an annual compliance report to OHA certifying and substantiating its compliance with all conditions.

OHA will conduct follow-up analyses one year, two years, and five years after the order date to monitor compliance with these conditions and assess the impact of the transaction on health care costs, quality of care, access to care, and health equity in Oregon.

Introduction

In 2021, the Oregon Legislature passed House Bill 2362, giving the Oregon Health Authority (OHA) the responsibility to review and decide whether some transactions involving health care entities should proceed. This report summarizes OHA's review and analysis of the transaction between UnitedHealth Group Incorporated ("UHG") and Amedisys, Inc. ("Amedisys") and presents OHA's findings and conclusions.

About HCMO

OHA's Health Care Market Oversight program (HCMO), launched in March 2022, reviews proposed health care transactions such as mergers, acquisitions, and affiliations to ensure they support statewide goals related to cost, equity, access, and quality. HCMO is governed by Oregon Revised Statute 415.500 et seq. and Oregon Administrative Rules 409-070-0000 through -0085.

In the authorizing statute, the Oregon Legislature specified what types of proposed transactions are subject to review and the criteria OHA must use when analyzing a given proposed transaction. The Oregon Legislature also authorized OHA to decide the outcome of a proposed transaction. After reviewing a given proposed transaction, OHA may approve, approve with conditions, or disapprove the transaction.

HCMO fits within OHA's broader mission of ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care. The program also supports OHA's goal of eliminating health inequities by 2030.

OHA's Review

On December 4, 2023, OHA accepted a completed HCMO Notice of Material Change Transaction ("notice") from UHG. The notice described UHG's plans to acquire Amedisys, a nationwide provider of home health, hospice, and palliative care services. This acquisition is referred to in this report as the "transaction," and UHG and Amedisys are referred to as "the entities." UHG proposed buying all of Amedisys' home health and hospice agencies, including three home health agencies and one hospice agency in Oregon.

Preliminary Review

On March 14, 2024, OHA completed a preliminary review of the transaction and determined that a comprehensive review was warranted. OHA issued a Comprehensive Review Determination and a Preliminary Review Summary Report detailing its preliminary analysis and concerns about the transaction.

Comprehensive Review

Comprehensive reviews include more in-depth analysis of data and information from the entities, public reports, and OHA sources. As part of a comprehensive review, OHA assesses whether a proposed transaction meets criteria for approval outlined in ORS 415.501(9) and OAR 409-070-0060(5). To do so, OHA may request additional information from the entities and obtain assistance from outside advisors.

OHA is required to complete a comprehensive review within 180 days from the date it accepts a complete notice. Per OAR 409-070-0085, OHA may toll (or "pause") the review period if it requires more information from the entities. When OHA issues such a request for information ("RFI"), the review period is paused until OHA has confirmed receipt of complete responses to the RFI. OHA issued two RFIs during this comprehensive review; the first on March 15, 2024, and the second on July 11, 2024.

The Oregon Department of Justice (ODOJ) provided legal consultation services, including legal analysis of the transaction under HCMO's comprehensive review criteria. Consistent with ORS 415.501(14) and OAR 409-070-0050, OHA contracted with an outside advisor to assist OHA in the review. OHA also consulted with the Health Facility Licensing & Certification Program at OHA, which is responsible for licensing and certifying home health and hospice agencies in Oregon. OHA accepted public comments throughout the duration of the review period. See **Appendices A** and **B** for more information on OHA's review and methodology.

Suspension

On December 13, 2024, OHA issued a Proposed Order of Suspension, suspending the comprehensive review until the resolution of a federal lawsuit seeking to block the transaction due to allegations that the acquisition in Oregon was presumptively illegal. (See **Federal Review and Legal Action** below for details.) OHA determined it was necessary to suspend the review under ORS 415.501(10) to ensure the transaction complies with all state and federal laws.

Timeline of OHA's Review

9/6/23: UHG submitted a notice of material change transaction.

12/4/23: OHA accepted a complete notice and began the preliminary review.

03/14/24: OHA completed the preliminary review and notified the entities that the transaction required a comprehensive review.

03/15/24: OHA sent a request for information (RFI) to the entities.

05/24/24: OHA received complete responses to the March RFI.

07/11/24: OHA sent a second RFI to the entities.

8/26/24 – 10/10/24: OHA received responses to the July RFI.

12/13/24: OHA suspended its comprehensive review due to federal legal action and presumptive illegal activity in Oregon.

8/7/25: OHA resumed the review following settlement of the federal legal action.

6/12/26: OHA concluded the review and approved the transaction with conditions.

On April 1, 2025, OHA issued a Final Order of Suspension ("Suspension Order") that included modifications and additional provisions addressing concerns from the entities about the proposed suspension. Exhibit A of the Suspension Order sets out a timeline for completion of OHA's review following the close of evidence in the federal lawsuit, or alternatively, following settlement of the lawsuit. The Suspension Order further included (as Exhibit B), a Preservation and Hold Separate Agreement, which stipulated that, if the federal court allowed the transaction to close, OHA would permit the entities close the transaction nationwide provided that the entities did not fully integrate in Oregon, and Amedisys' home health and hospice agencies in Oregon were maintained as a separate operation until the completion of OHA's comprehensive review.[i]

[i] Pursuant to the suspension order, UHG and Amedisys operations in Oregon were not permitted to fully integrate until OHA issued its Final Comprehensive Review Order.

OHA resumed the comprehensive review on August 7, 2025, following the announcement of a settlement in the federal lawsuit.[1]

Federal Review and Legal Action

According to Amedisys reports filed with the U.S. Securities and Exchange Commission (SEC), the entities notified federal antitrust regulators of the transaction (consistent with the Hart-Scott Rodino law[ii]) on July 5, 2023.[2] On August 4, 2023, the U.S. Department of Justice ("USDOJ") issued a request for more information about the deal.[3]

On November 12, 2024, USDOJ, together with the Attorneys General of Maryland, Illinois, New Jersey, and New York ("Plaintiffs") filed a lawsuit in the United States District Court for the District of Maryland ("Maryland D.C.") seeking to block the transaction on the grounds that it would violate federal antitrust laws.[4] Plaintiffs argued the transaction would be anticompetitive and illegal in hundreds of local markets across the country, including several home health markets in Oregon.

On August 7, 2025, USDOJ announced a settlement had been reached resolving these claims.[5] The settlement required that UHG and Amedisys divest 164 home health and hospice agencies in 19 states, not including Oregon. The Maryland D.C. issued its initial Final Order on December 9, 2025, following a lengthy public comment period, and subsequently issued a modified Final Order on February 2, 2026, extending certain deadlines for operations in New York.[6]

Although the federal lawsuit resulted in OHA suspending its comprehensive review to ensure the transaction was not illegal under federal law, OHA's review process and decision under the HCMO statute and rules are separate from the USDOJ's review and settlement.

[ii] For more information on the Hart-Scott Rodino premerger notification and review process, see the Federal Trade Commission's website.

About the Transaction

This section describes the entities involved in the transaction and the terms of the transaction.

UnitedHealth Group

UHG is a for-profit publicly traded company incorporated in Delaware and based in Minnesota. UHG offers health insurance plans and provides health care services nationwide. It is the largest health care company and the largest employer of physicians in the country.[7]

In 2024, the company served 145 million people across all its businesses.[8] UHG's operating profits in 2025 totaled $19.0 billion on $447.6 billion in annual revenues (an operating margin of 4.2%).[9] (See the callout box for additional metrics.[10])

UnitedHealth in 2025

145 million people served

$447.6 billion annual revenues

$19.0 billion operating profit

390,000 employees

165,000 clinical professionals

Business Units

UHG is organized into two main businesses: UnitedHealthcare ("UHC"), which provides health insurance plans, and Optum, which provides health care and related services.

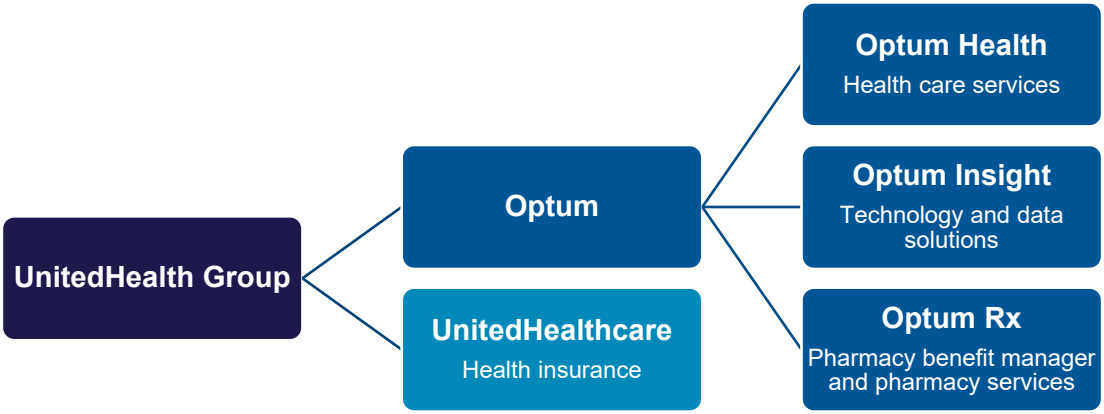
UHC was the largest provider of commercial and Medicare Advantage health insurance plans in the country as of 2023.[11] UHC also offers plans under state health insurance programs in 35 states, including Medicaid, Children's Health Insurance Plan (CHIP), Dual-Eligible Special Needs Plans (D-SNP), and Long-Term Services and Supports (LTSS).[12]

Optum consists of three business units:

- **Optum Health** services include primary care, specialty care, urgent care, post-acute care, in-home care, behavioral health services, ambulatory surgical care, hospice, and palliative care. Services are provided through a network of over 140,000 employed or affiliated clinicians.[13]

- **Optum Rx** is a pharmacy benefit manager (PBM) that administers prescription benefits for health plans and large employers. Optum Rx manages over $178 billion in pharmaceutical spending annually and contracts with more than 65,000 retail pharmacies nationwide that dispense medications to prescription plan members.[14] Optum Rx also operates a retail mail pharmacy (Optum Specialty Pharmacy) and infusion pharmacies.

- **Optum Insight** offers professional services and technologies aimed at improving clinical, administrative, and financial processes across the health care system. Customers include hospitals, health systems, physicians, health plans, and state governments.



Mergers & Acquisitions

UHG has a history of growth through mergers and acquisitions of health care providers and other health care companies. Over the past five years, UHG has been involved in a successive string of transactions worth billions of dollars. In 2023, UnitedHealth acquired LHC Group Inc. ("LHC"), a nationwide provider of home health and hospice services with multiple locations in Oregon, for $5.4 billion.[iii] Optum's physician practice transactions helped add a reported 20,000 clinicians to its roster of employed or affiliated physicians in 2023.[15] In 2022, UHG completed a $13 billion acquisition of Change Healthcare Inc., a health technology company. It also bought Refresh, a mental health provider with locations in 37 states.[16] Other large acquisitions include Landmark Health (an in-home medical care provider) in 2021 and AbleTo (a virtual behavioral health provider) in 2020.[17]

UnitedHealth Group in Oregon

UHG has a significant presence in Oregon, both as a health insurer and as a provider. UnitedHealthcare's commercial group, self-insured, and Medicare Advantage insurance plans served approximately 264,000 Oregon residents in the second quarter of 2024.[18] UnitedHealthcare was Oregon's largest Medicare Advantage insurer, with 23% of Medicare Advantage enrollees in the second quarter of 2024.[19] The company does not offer Medicaid plans or individual Marketplace plans in Oregon.

Optum's subsidiary companies (listed in the table below) provide a wide range of health care services to people in Oregon, including primary care, specialty care, behavioral health, surgeries, home health services, and hospice care.[20] (For a more detailed listing, please refer to Appendix B of UHG's notice.) UHG has acquired several Oregon-based physician groups, including Oregon Medical Group, GreenField Health, Family Medical Group Northeast, The Davies Clinic, and The Corvallis Clinic.[21] [iv] In 2022, approximately 140,600 people in Oregon received primary or specialty care from Optum Care providers.[22]

[iii] OHA reviewed and approved this transaction.

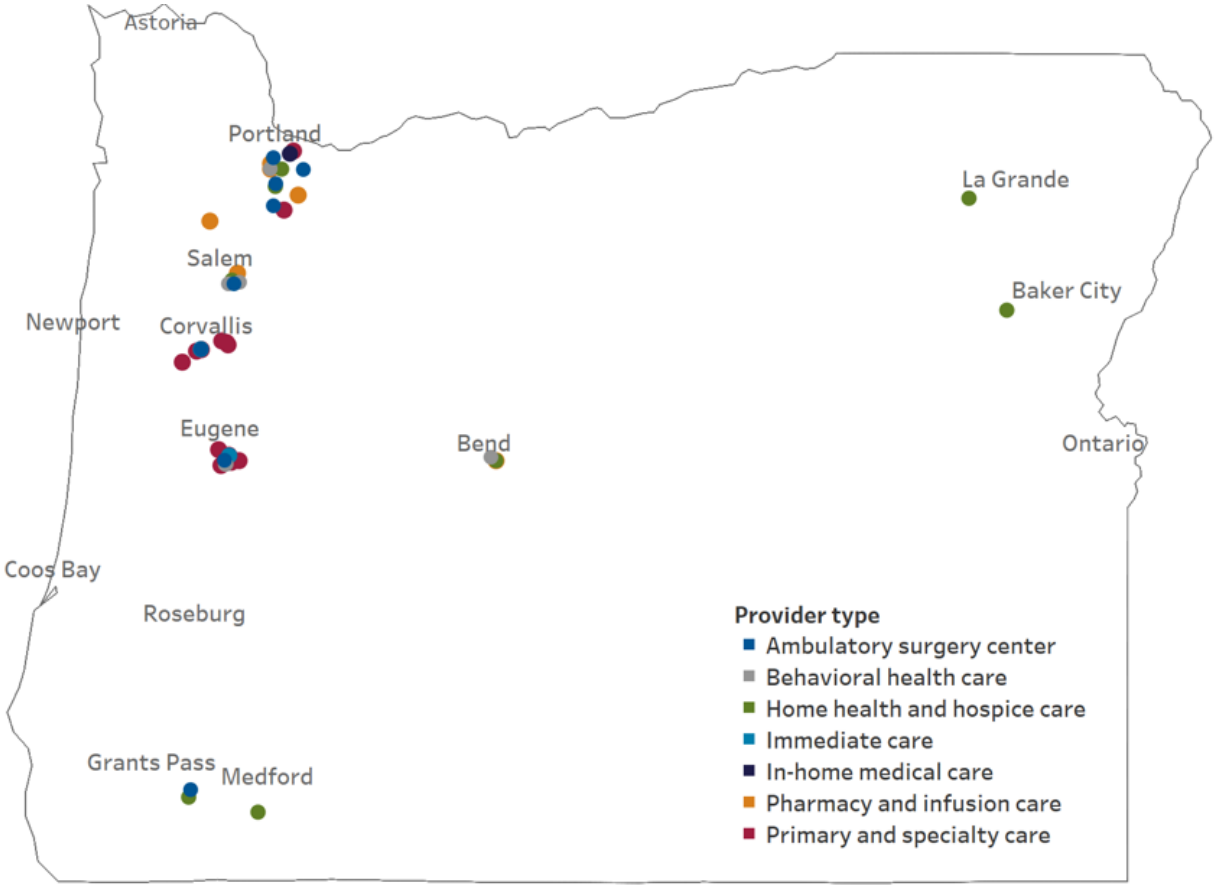
[iv] Optum and The Corvallis Clinic requested an emergency exemption from HCMO review. OHA determined that the entities met the criteria for emergency exemption under OAR 409-070-0022(1) and therefore granted the exemption. OHA did not receive a Notice of Material Change transaction for The Davies Clinic. The other acquisitions were completed prior to HCMO's launch (March 1, 2022) and therefore did not undergo HCMO review.

Optum companies operating in Oregon (as of December 2023)

Company	Service type(s)	Description
AbleTo Behavioral Health Services PC ("AbleTo")	Mental health care	Provides virtual mental health visits.
Genoa Healthcare LLC	Pharmacy	Partners with community-based providers across Oregon to dispense medications and other pharmacy services for people with complex health conditions.
Landmark Medical of Oregon, P.C. ("Landmark Health")	Home-based care	Provides home-based medical care to patients with complex needs throughout the tri-county area; office locations in Portland and Eugene.
LHC Group, Inc. ("LHC")	Home health Hospice	Provides home health and hospice services; operates 5 home health and 4 hospice locations in Oregon.
Optum Care Portland	Primary care Specialty care	Provides primary, specialty, and virtual care; operates 2 clinic locations in Oregon: GreenField Health System, LLC ("GreenField Health") and Family Medical Group NE.
Optum Infusion Services 404, LLC	Infusion therapy	Provides infusion therapy (medications delivered intravenously) in home or at a clinic; operates 1 location in Oregon.
Optum Medical Services, PC; Optum Health Care Services Company	Long-term/skilled nursing care	These two companies are part of the "Optum Health Services for I-SNP/IE-SNPs" subsidiary, which partners with health plans to provide health care services and care coordination to long-term skilled nursing facility (SNF) residents. Services are provided in long-term care facilities that Optum does not own.
Optum Pharmacies[v]	Pharmacy	Mail-order pharmacy that delivers medications to patients' homes.
Optum Rx, Inc.	Pharmacy benefit management	Administers prescription benefits for health plans and large employers.
Oregon Healthcare Resources	Primary care Specialty care	Provides primary, specialty, and virtual care; operates 10 clinic locations in Oregon, including the Davies Clinic, PC, under the name of Oregon Medical Group.
Refresh Mental Health, Inc.	Mental health care	Provides mental health therapy and treatment services; operates 8 locations in Oregon.
Surgical Care Affiliates, LLC ("SCA Health")	Surgical care	Provides ambulatory surgery services; operates 8 ambulatory surgical centers in Oregon under the names McKenzie Surgery Center, Grants Pass Surgery Center, Northbank Surgical Center, NW Spine & Pain, Oregon Outpatient Surgery Center, East Pavilion Surgery Center, and Mt. Scott Surgery Center.
XLHome, PC	Annual exams	Part of Optum's "HouseCalls" subsidiary. Provides in-home annual clinical exams on behalf of health plans and providers. HouseCalls does not have facility locations in Oregon.

[v] For the full list of Optum Pharmacy companies, see Appendix B to UHG HCMO Notice of Material Change Transaction.

As of August 2025, Optum companies operated from more than 45 locations in Oregon (see map below). These locations span 18 counties which together represent more than 80% of the state's population. Locations shown include 16 primary and specialty care locations, nine home health and hospice agency locations (not including Amedisys locations), eight ambulatory surgery centers, six pharmacy and infusion therapy locations, and six behavioral health provider locations. Locations are concentrated in the Portland metro area with clusters along the densely populated I-5 corridor.



Optum's subsidiaries include LHC, a nationwide home health and hospice provider that UHG acquired in February 2023. (OHA reviewed and approved the transaction.) LHC currently operates five home health agency locations and four hospice agency locations in Oregon, listed below. LHC agencies in Oregon served about 3,800 home health and 600 hospice patients in 2022.

LHC home health and hospice agencies in Oregon

Home Health Agencies	
Name	**Address**
Innovative Senior Care Home Health of Portland, LLC d/b/a Brookdale Home Health Portland	7750 SW Mohawk Street, Building G, Suite 7750, Tualatin, OR 97062
Salem Home Care, LLC d/b/a Assured Home Health	925 Commercial Street SE, Suite 310, Salem, OR 97302
Salem Home Care, LLC d/b/a Assured Home Health	9320 SW Barbur Blvd, Suite 350, Portland, OR 97219

Three Rivers Home Care, LLC	1867 Williams Hwy, Suite 109B, Grants Pass, OR 97527
Three Rivers Home Care, LLC d/b/a Southern Oregon Home Health	1340 Biddle Road, Suite 101, Medford, Oregon 97504
Hospice Agencies	
Name	**Address**
Health at Home Hospice – Portland, LLC d/b/a Assured Hospice	9320 SW Barbur Blvd, Suite 330, Portland, OR 97219
Heart 'n Home Hospice and Palliative Care, LLC	1550 NE Williamson Blvd, Suite 120, Bend, OR 97701
Heart 'n Home Hospice and Palliative Care, LLC	3330 Pocahontas Road, Baker City, OR 97814
Heart 'n Home Hospice and Palliative Care, LLC	1108 J Avenue, La Grande, OR 97850

Amedisys

Founded in 1982, Amedisys, Inc. ("Amedisys") is a for-profit publicly traded company incorporated in Delaware and based in Baton Rouge, Louisiana. Amedisys provides home health, in-home hospice, palliative care, and high-acuity care services across 38 states. The company works with more than 3,300 hospitals and 114,000 physicians nationwide. (See the callout box for additional metrics.[23])

Amedisys in 2024

499,000 people served

$2.3 billion annual revenues

$95 million operating profit

19,000 employees

38 states

Amedisys is among the largest providers of home health and hospice services in the country. In 2024, Amedisys served 499,000 patients, and its employees made over 10.7 million care visits.[24] The company describes its patients as being "typically 75 years old, often the sickest of the sick, and thus the most vulnerable. They're seeing multiple specialists and taking an average of 11 medications."[25]

Business Units

Amedisys is organized into three segments: home health, hospice, and high acuity care. (Amedisys previously also had a personal care segment, which it sold in 2023.[26]) The table below summarizes the services offered by each segment, the types of patients served, the clinicians and other staff involved in delivering care, and financial information.[27]

Amedisys business segments

	Home Health	Hospice	High Acuity Care
Services	– Administer medications. – Care for wounds. – Monitor vital signs. – Provide physical, speech and occupational therapy. – Help with personal tasks.	– Manage pain & symptoms – Personal care – Emotional support & counseling – End-of-life planning – Spiritual counseling – Bereavement support for loved ones	In-home medical services typically provided in a hospital or other facility.

	Home Health	Hospice	High Acuity Care
Patients	– People recovering from surgery or illness. – People with chronic health conditions or illnesses.	People with a terminal illness such as cancer, heart disease, lung disease, or Alzheimer's whose life expectancy is six months or less.	– People recovering from surgery or illness. – People with chronic illnesses.
Clinicians & other staff	– Skilled nurses – Physical therapists – Speech therapists – Occupational therapists – Social workers – Home health aides	– Nurse practitioners – Skilled nurses – Social workers – Hospice aides – Bereavement counselors – Chaplains	– Nurse practitioners – Skilled nurses
Net service revenues (2024)	$1.49 billion	$826 million	$32 million
Volume of services (2024)	441,945 admissions	48,426 hospice admissions	3,373 admissions
Number of locations (2024)	347 care centers	164 care centers	8 joint venture hospitals
Gross Profit (%) (2024)	$616 million (41%)	$396 million (48%)	$6 million (19%)

Because the majority of Amedisys patients are aged 65 or older, most of the company's revenue (approximately 70%) is from Medicare.[28] Home health is the largest segment by revenues, generating $1.49 billion in net service revenues in 2024, followed by hospice ($826 million). Home health and hospice were also by far the most profitable, with 2024 gross profits (margins) of 41% and 48%, respectively.[29]

Mergers & Acquisitions

Prior to the transaction, Amedisys had been steadily growing its nationwide footprint, following what the company's executives have called an "inorganic growth strategy."[30] The table below lists selected Amedisys acquisitions since 2015.

Amedisys' 2019 acquisition of Compassionate Care Hospice in 2019 made it the third largest hospice provider in the country.[31] Amedisys continued to grow its hospice segment in 2020 through the acquisition of Asana Hospice and AseraCare Hospice.

Amedisys established its high acuity care segment in August 2021 by acquiring Contessa Health ("Contessa"), a provider of "hospital-at-home" services.[32] The high-acuity care segment partners with large regional health systems through joint venture arrangements to provide hospital-level care in patients' homes.[33] In 2021, Amedisys acquired the home health and hospice assets of The Visiting Nurse Association of the Midlands, a non-profit based in Nebraska.[34]

Selected Amedisys acquisitions, 2015-2022

Year	Company Name	Company services	Approx. Purchase Price
2022	Evolution Health, LLC[35]	Home health care	$70 million
2021	The Visiting Nurse Association of the Midlands	Home health & hospice care	Undisclosed
2021	Contessa Health[36]	Hospital-at-home services	$250 million
2020	Homecare Preferred Choice, Inc. (AseraCare Hospice)[37]	Hospice care	$203 million
2020	Asana Hospice[38]	Hospice care	$66.3 million
2019	Compassionate Care Hospice[39]	Hospice care	$340 million
2018	Bring Care Home[40]	Personal care	Undisclosed
2017	Tenet Healthcare[41]	Home health and hospice care	$20.5 million
2016	Infinity Home Care[42]	Personal care	$63 million
2016	Associated Home Care[43]	Personal care	$28 million

In May 2023, Amedisys announced it had reached an agreement to be acquired by Option Care Health, Inc. ("Option Care"), a nationwide provider of infusion therapy services. On May 18, 2023, Option Care filed a HCMO notice with OHA. One month later, the deal fell through after UHG made an unsolicited bid for Amedisys, offering Amedisys shareholders a more attractive price for the company.[44] The agreement with Option Care required Amedisys to pay a "breakup fee" of $106 million, which UHG paid on its behalf.[45] (See **Transaction Timeline** below for more information.)

Amedisys in Oregon

In Oregon, Amedisys operates through its wholly owned subsidiary Amedisys Oregon, LLC. Amedisys has three home health agencies (Salem, Portland, and Roseburg), and one hospice agency in Roseburg. The company currently serves about 5,000 home health patients and 500 hospice patients in Oregon per year.[46]

Amedisys locations in Oregon

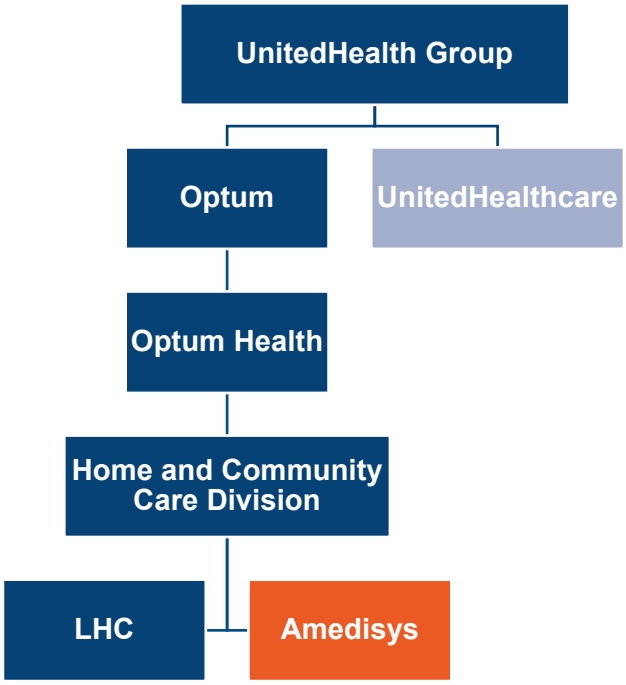
Agency Name	Address
Amedisys Home Health Care	12021 NE Glenn Widing Dr. Bldg. G, Portland, Oregon, 97220
Amedisys Home Health Care	1820 NW Mulholland Drive, Roseburg, Oregon 97470
Amedisys Home Health Care	3220 State Street, Suite 100, Salem, Oregon 97301
Amedisys Hospice Care	1820 NW Mulholland Drive, Roseburg, Oregon 97470

Transaction Terms

In June 2023, UHG announced plans to buy Amedisys for approximately $3.3 billion ($101 per share) in an all-cash transaction.[47] UHG and Amedisys signed a merger agreement on June 26,

2023, detailing the terms of the deal. The transaction closed nationwide on August 14, 2025, following settlement of the USDOJ's lawsuit (see **Federal Review and Legal Action**).[48] Timing of the closing and integration of the entities in Oregon was subject to the terms of the Preservation and Hold Separate Agreement between the entities and OHA set out in Exhibit B of the Suspension Order.

Following closing, Amedisys became a subsidiary of UHG and part of Optum Health's Home & Community Care division. This division currently houses the LHC subsidiary.



Divestitures

The USDOJ settlement required that UHG and Amedisys divest 164 home health and hospice locations across 19 states, not including Oregon.[49] These divestitures were intended to resolve the USDOJ's concerns that the deal would reduce competition among home health and hospice providers in these states. Purchasers of the divested locations include BrightSpring Health Services, Inc., the Pennant Group, Inc., and another entity to be approved by USDOJ.[50]

Rationale for the Transaction

The transaction is part of a broader trend of insurer investment in home-based health care services. Interest in home-based care and other services targeting older people has grown as the U.S. population ages and demand for these services increases.[51] It's generally cheaper to provide these services in the home than it is for patients to be admitted to a facility.

The entities have cited various reasons for pursuing the transaction in submissions to OHA, public reporting, and press releases. In the notice, UHG states:

"Adding Amedisys's high-quality home health and hospice care to Optum's existing suite of health care services, and Optum's extensive value-based care experience and resources, will accelerate the combined companies' ability to deliver integrated care, improving outcomes and patient experiences."

Advance Value-Based Care

In announcing the transaction, UHG and Amedisys argued it would help to advance the use of value-based care reimbursement models in home health care. UHG plans to use Optum's "value-based care expertise" to create more value-based care reimbursement models at Amedisys. UHG expects this will help improve patient outcomes and the patient experience, while decreasing costs.[52]

Value-based care refers to how a service is paid for by a health insurance company. Traditionally, health care is paid on a per-service basis (e.g., for a given procedure, the health insurance company pays the doctor a set dollar amount). Value-based care is different because it could include quality metrics or health outcomes as a factor in payment amount. Some value-based care allows for more flexibility and incentives for health care providers to deliver patient-centered, whole person care.

Grow Optum's Post-Acute Care Services

The acquisition would greatly increase Optum's capacity to provide post-acute care services, allowing it to provide home health and hospice care to more patients, including members of UHC insurance plans. UHG believes Optum can offer more seamless, integrated care to its patients by having this capacity in-house. This would ultimately help improve patient outcomes and reduce costs, for example, by lowering hospital readmissions. It would also give UHC better oversight of members' post-acute care, allowing for "appropriate utilization management." [53]

Strengthen Optum's Workforce

The transaction provides an opportunity for Optum to hire more home health and hospice workers, including nurses and other clinical staff. This would help address staffing shortages and shore up UHC's provider network. UHG stated:

> *Amedisys's skilled providers also will significantly augment Optum's home health and hospice workforce to support all payors with an owned, comprehensive network that would alleviate potential network adequacy and staffing concerns.*

Transaction Timeline

In 2020, Amedisys began a strategic evaluation of whether to remain a standalone entity or seek partnerships with or acquisition by other companies.[54] In October 2021, Amedisys received an all-cash offer from UHG to buy Amedisys for approximately 28% of the closing trading price per share. The Amedisys board determined that the offer was not representative of the value of Amedisys's assets and decided not to move forward with the proposal.

UHG subsequently asked Amedisys to provide a price range for a potential acquisition that would be representative of Amedisys's assets. The Amedisys board declined to do so and told UHG they may be interested in acquisition talks at a later date. In early 2022, Amedisys worked with outside advisors to accurately value Amedisys' business. The Amedisys board did not believe UHG would

provide a competitive offer for Amedisys, so the board directed leadership to not engage with UHG regarding a potential transaction.

In June 2022, the Centers for Medicare and Medicaid Services (CMS) released the proposed updated hospice payment rates and wage index for fiscal year (FY) 2023. Originally, CMS estimated that hospices serving Medicare beneficiaries would see a 2.7% increase in payments along with an increase in the aggregate cap amount. Later that year, CMS issued its proposed and final rule for FY 2023 featuring a final increase of only 0.7%. This final proposed rule greatly impacted Amedisys's future financial projections and negatively impacted the valuation of Amedisys common stock.

Amedisys' board subsequently directed leadership to look into potential partnerships or acquisitions. Between October 2022 and March 2023, Amedisys was contacted by multiple prospective buyers and partners. Amedisys entered into confidential agreements with five entities to further investigate these opportunities but ultimately decided not to move forward with any of them.

In March 2023, Option Care sent Amedisys a non-binding letter of interest proposing to combine Option Care with Amedisys in an all-stock transaction, where Option Care would purchase a majority of shares of Amedisys, with Amedisys retaining between 36-38% of the shares. In April 2023, Option Care sent a proposed merger agreement to Amedisys. Following a series of negotiations on the agreement terms, the final agreement allowed Amedisys to retain 35.5% of its shares while Option would purchase 64.5% of the shares. The agreement was executed on May 3, 2023.

On May 22, 2023, UHG contacted Amedisys expressing an interest in submitting a proposal and engaging in further discussions. Four days later, on May 26, 2023, UHG sent Amedisys an unsolicited non-binding all-cash offer to acquire all Amedisys common stock at $100 per share. This represented a higher valuation than the all-stock deal with Option Care. Shortly thereafter, on June 2, 2023, UHG sent an unsolicited written proposal reiterating the $100 per share figure along with additional terms relating to commitments and remedies. Following continued negotiations and due diligence, UHG notified Amedisys that it was willing to increase its proposed offer to acquire all outstanding shares of Amedisys Common Stock to $101 per share in cash.

Amedisys subsequently entered into an agreement with Option Care to terminate their merger agreement. This termination agreement was unanimously approved by Amedisys' board of directors on June 25, 2023. Amedisys and Option Care executed the termination agreement on June 26, 2023, and UHG paid the $106 million termination fee to Option Care.[55] On the same day, Amedisys entered into a merger agreement with UHG with UHG agreeing to pay $101 per share of Amedisys stock for a total purchase price of $3.3 billion.[56]

Post-Transaction Plans

Following the close of the transaction, Amedisys became part of Optum Health's Home & Community Care organization, which aims to provide a full continuum of post-acute care services (including preventive care, primary care, urgent care, home health, hospital services, palliative care, and hospice care) in the home through value-based reimbursement models.[57]

UHG stated that there were no plans for changing Amedisys's business operations, structure, strategies, policies, officers, or employees.[58] Amedisys employees would become employees of Optum/UHG and would participate in the Optum benefits plan.[59]

UHG expects that, because of the transaction, more UHC members and Optum patients will obtain home health care services from Amedisys. For example, the Notice states, "[The] transaction will reduce the growth in patient costs by ensuring Optum patients are referred to Amedisys services where appropriate […]."[60]

To accommodate a higher volume of Optum patients and UHC members receiving services from Amedisys following the transaction, UHG has stated it plans to expand its home heath capacity:

> *"If, as Optum expects, the demand for home health services increases as a result of the success of this integrated care model, then UHG plans to invest in the expansion of Optum's Home & Community assets, including Amedisys, by hiring more clinical staff and expanding geographically in order to meet the increased demand."*[61]

UHG has stated that the transaction would allow UHG to utilize Amedisys and LHC clinical staff more efficiently. UHG can deploy clinical staff to serve patients closer to their location, decreasing travel time. This allows LHC and Amedisys to serve more patients. UHG expects that this efficiency will allow Amedisys and LHC to provide an additional 3,052 patient visits each year across Oregon.[62]

Findings & Potential Impacts

OHA compiled available data and information to assess the potential impacts of the transaction on people in Oregon. OHA's sources of information included the following:

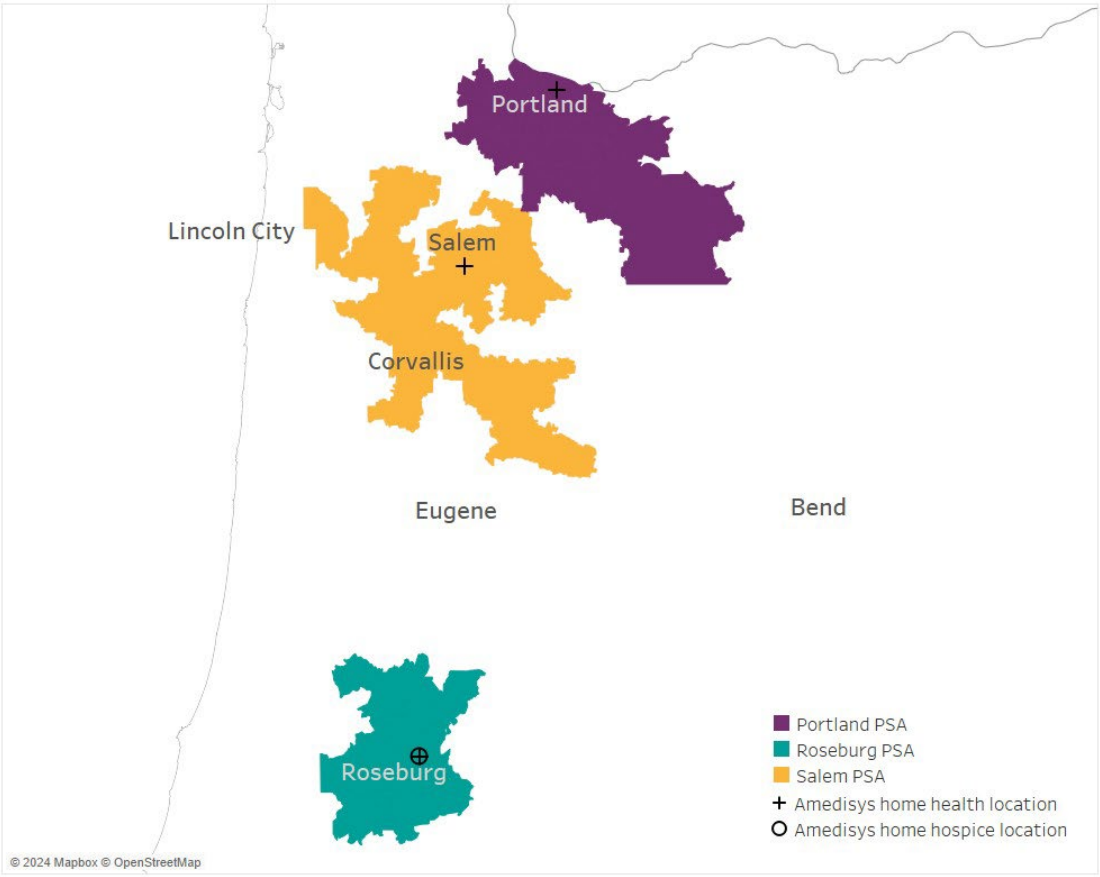
- HCMO notice and related submissions,
- Documents and data provided by the entities in responses to RFIs,
- OHA databases,
- Public comments,
- Publicly available data, research, and reports.

OHA also relied on legal analysis provided by ODOJ and consultation provided by outside advisors. OHA's analysis was guided by the approval criteria outlined in OAR 409-070-0060(5). For OHA to approve this transaction, the transaction must meet the criteria for A. and B. or C. listed below:

D. There is no substantial likelihood that the transaction would: • Have material anti-competitive effects in the region not outweighed by benefits in increasing or maintaining services to underserved populations; • Be contrary to law; • Jeopardize the financial stability of a health care entity involved in the transaction; or • Otherwise be hazardous or prejudicial to consumers or the public	***and***	**E.** The transaction will benefit the public good and communities by: • Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is in the best interest of the public; • Increasing access to services in medically underserved areas; or • Rectifying historical and contemporary factors contributing to a lack of health equity or access to services.
		or
		F. The transaction will improve health outcomes for residents of this state.

Amedisys Service Areas

To understand the geographic regions and populations served by Amedisys in Oregon, OHA used historical claims data to identify a Primary Service Area (PSA) around each Amedisys home health and hospice agency location in the state. PSAs reflect the zip codes of patients making up 75% of care episodes provided historically by each home health or hospice agency location. (See Appendix B, "Primary Service Area Analysis" for details on OHA's methodology.) The map below shows Amedisys' PSAs in Oregon. Cities and counties included in each PSA are listed in the accompanying table.



Amedisys PSA	Counties	Cities
Portland (Home Health)	Washington, Multnomah, Clackamas	Portland, Gresham, Beaverton, Tigard, Milwaukie, Troutdale, Lake Oswego, Hillsboro, Wilsonville, Sherwood, Tualatin, Oregon City, Boring, Sandy, Happy Valley, Estacada, Fairview, Damascus, Canby, Clackamas, West Linn, Gladstone, Eagle Creek, Beavercreek, Mulino, Colton, Marylhurst
Salem (Home Health)	Marion, Polk, Yamhill, Linn, Benton	Salem, Silverton, Stayton, McMinnville, Woodburn, Albany, Lebanon, Sheridan, Dallas, Lebanon, Corvallis, Sweet Home, Monmouth, Turner, Grand Ronde, Sublimity, Mount Angel
Roseburg (Home Health and Hospice)	Douglas	Roseburg, Myrtle Creek, Sutherlin, Winston, Oakland, Winchester, Tenmile

Demographics

According to American Community Survey (ACS) survey estimates for 2022, nearly 2.5 million people live in the combined Amedisys service area (Portland, Salem, and Roseburg PSAs).

Amedisys service areas in Oregon are home to nearly **2.5 million** people.

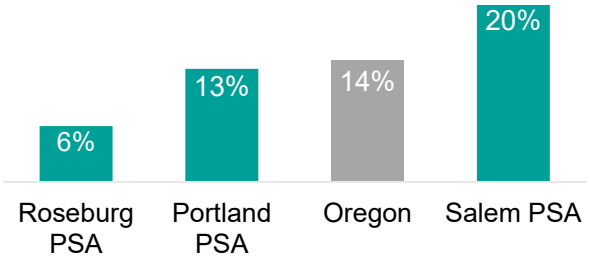
Rural/urban areas

Approximately 29% of zip codes in the combined Amedisys service area are designated as rural, and 14% of the service area population lives in a rural zip code.The Roseburg PSA population is 100% rural, compared to 4% for the Portland PSA and 32% for the Salem PSA. Patients within these zip codes account for 39% of the home health episode volume within the service area.

Race/ethnicity

The majority (74.6%) of service area residents identify as white, followed by 10% who identify as two or more races and 6.6% identifying as Asian.[vi] Approximately 15% of service area residents (compared to 14% statewide) identify as Hispanic/Latino (of any race). The percentage of service area residents who identify as Hispanic/Latino varies across Amedisys PSAs, ranging from 20% in the Salem PSA to 6% in the Roseburg PSA.

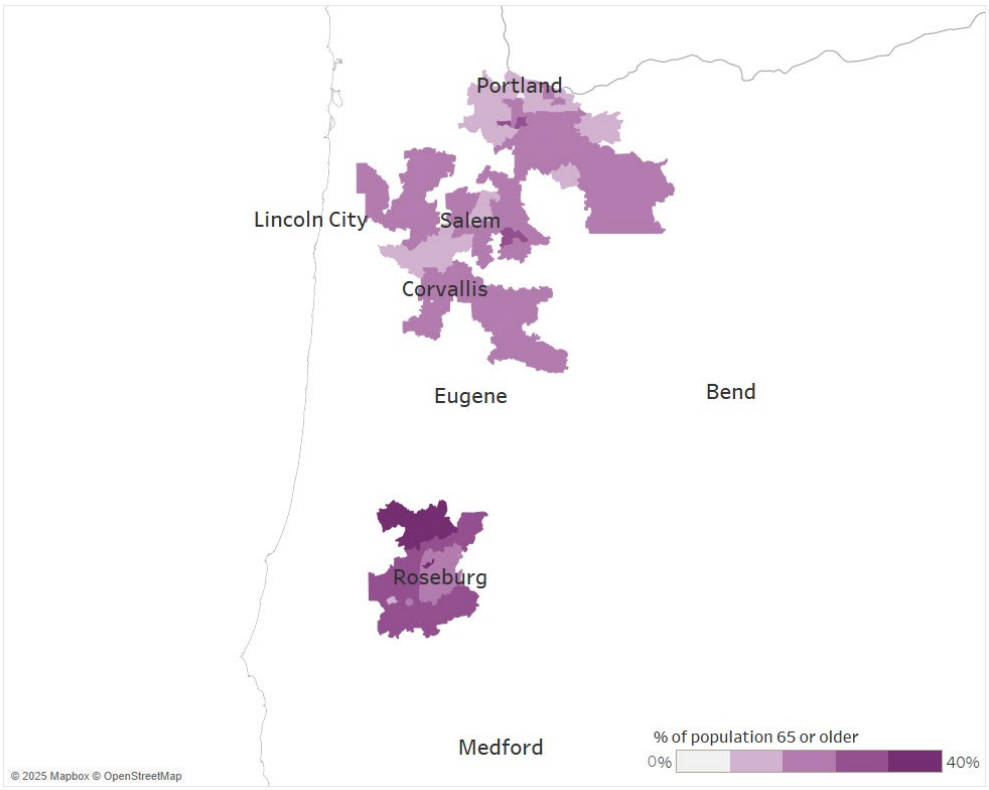
The share of residents identifying as Hispanic/Latino ranges from 20% in the Salem PSA to 6% in the Roseburg PSA.



Age

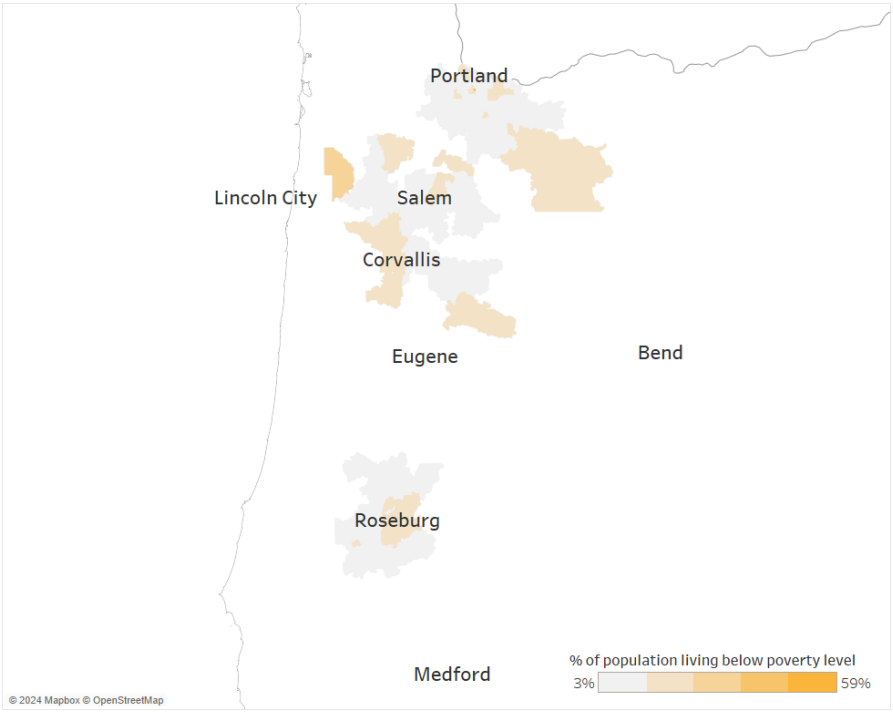
Approximately 16% of people living in the combined Amedisys service area are age 65 or over, compared to 18% statewide. The older (65+) adult population is most concentrated within the Roseburg PSA. Older adults represent 25% of the population within the Amedisys Roseburg PSA, 17% in the Salem PSA, and 15% in the Portland PSA. The population of individuals ages 65 and older varies across PSA zip codes, from 9% to 37% of individuals within a single zip code (see map below).

[vi] *Race and ethnicity categories are consistent with federal OMB (Office of Management and Budget) standards and do not comply with Oregon's REALD (race, ethnicity, language, and disability) and SOGI (sexual orientation and gender identity) standards.*



Poverty

About 11.2% of the combined service area population has incomes at or below the federal poverty level, compared with 5.6% statewide. Low-income populations are concentrated in the Salem PSA, where 14.2% of residents have incomes at or below the federal poverty level, compared to 9.9% and 14.1% for the Portland and Roseburg PSAs, respectively.



Health Care Access and Workforce

Medically underserved areas & populations

Amedisys PSAs include several geographic areas that have been designated by the federal Health Resources & Services Administration (HRSA) as Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs). MUA/MUP designations reflect lack of access to primary care services. (See callout box for details.[63])

The MUAs and MUPs that overlap with Amedisys PSAs are listed in the table below.

MUA/P Service Area Name(s)	MUA	MUP	Amedisys PSA
Clackamas	x		Portland
Hillsboro	x		Portland
Low Income/Migrant Seasonal Farm Workers - Beaverton		x	Portland
Low Income Population (Douglas County)	x		Roseburg
Marion	x		Salem
Migrant Farm Workers – Monmouth/Dallas		x	Salem
Multnomah	x		Portland
Seasonal Farm Workers - Sherwood		x	Portland

Medically Underserved Areas & Populations

A Medically Underserved Area (MUA) is a geographic area with a shortage of primary health care services. MUAs may be defined as counties, census tracts, or other geographic divisions.

A Medically Underserved Population (MUP) is a geographic area where a subset of residents lack access to primary care due to factors such as economic, cultural, or language barriers to health care. MUPs may include people experiencing homelessness, people who are low-income, Native Americans, or migrant farm workers.

Population-to-provider ratios

The table below shows population-to-provider ratios (number of people per provider) for each county in the Amedisys service area for physicians, registered nurses, and physical therapists. Higher ratios indicate lower availability of providers relative to county population.

All counties in the service area except for Multnomah and Benton Counties are above the state average population-to-provider ratio for physicians, registered nurses, and physical therapists. Polk County stands out among the PSA counties; for example, Polk has eight times more people (1,199) for each registered nurse compared to the statewide average (151).[64]

Population-to-provider ratios, 2022

County	Physician Ratio	Registered Nurse Ratio	Physical Therapist Ratio
Benton	297	149	1,299
Clackamas	436	209	1,571
Douglas	509	196	1,997
Linn	777	265	2,171
Marion	397	150	1,700
Multnomah	206	93	1,210
Polk	2,254	1,199	4,555
Washington	399	172	1,464
Yamhill	620	271	1,460
Oregon	**358**	**151**	**1,413**

Competitive Effects

HCMO approval criteria: *There is no substantial likelihood that the transaction would result in material anticompetitive effects in the region not outweighed by benefits in increasing or maintaining services to underserved populations.*

During preliminary review, OHA analyzed the impacts of the transaction on concentration in Oregon's home health and hospice markets. OHA updated and refined this analysis as part of comprehensive review. Additionally, OHA's preliminary review identified the potential for anti-competitive effects due to UHG being a vertically integrated insurer-provider. OHA's comprehensive review assessed whether further vertical consolidation of UHG could be expected to reduce competition in Oregon's markets for home health or Medicare Advantage insurance.

The transaction will not materially increase concentration in Oregon's home health or hospice markets.

Concentration measures the degree of competition in a market; a market is generally "concentrated" when there are a few large competitors selling products or services and "unconcentrated" when there are many smaller competitors. Amedisys and UHG-owned LHC are competitors in the provision of home health and hospice services in Oregon. They also each compete with other providers, including publicly and privately owned and hospital-owned providers as well as non-profits. Amedisys' annual report states:[65]

> *We compete based on the quality of services, the availability of personnel, expertise of visiting staff, and, in certain instances, on the price of our services.*

OHA used claims data for the years 2017 through 2023 from the APAC database to calculate market shares of home health and hospice agencies in Oregon. Each agency's market share was computed as its percentage of total episodes of care. OHA used these market shares to obtain the Herfindahl-Hirschman Index ("HHI") in each market pre-and post-transaction. OHA measured concentration in two ways: statewide and at the service area level. Findings from OHA's updated analysis are reported below.[vii] (See **Appendix B: Data & Methodology** for details on OHA's methodology.)

Herfindahl-Hirschman Index (HHI)

HHI is a measure commonly used by federal and state antitrust regulators to measure concentration in a market The higher the HHI, the more concentrated (and less competitive) the market is presumed to be. HHI is calculated as the sum of squared market shares and therefore has a maximum value of 10,000.

Under federal antitrust guidelines, an HHI of more than 1,800 indicates a "highly concentrated" market, and mergers involving an increase in HHI of more than 100 and post-merger HHI of more than 1,800 are presumed to be anti-competitive.

[vii] These numbers are not materially different from those included in OHA's preliminary review report.

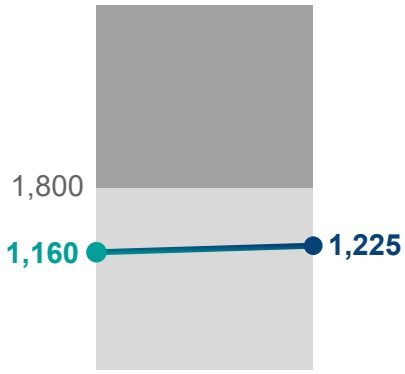
Home Health Concentration

With the addition of Amedisys, OHA estimates that UHG's share of the statewide market for home health services doubled from approximately 5.7% to 11.4%, making UHG the third largest provider of home health care in Oregon.

Before the transaction, **UHG** and **Amedisys** each had a 6% share of the statewide home health market. After the transaction, OHA estimates that **UHG's** market share is approximately 11%.

At the state level, Oregon's market for home health services is unconcentrated (HHI=1,160). OHA estimated that the combination of UHG and Amedisys increases state-level HHI by 65 points to 1,225, which is below the federal threshold for presumed anti-competitive effects.

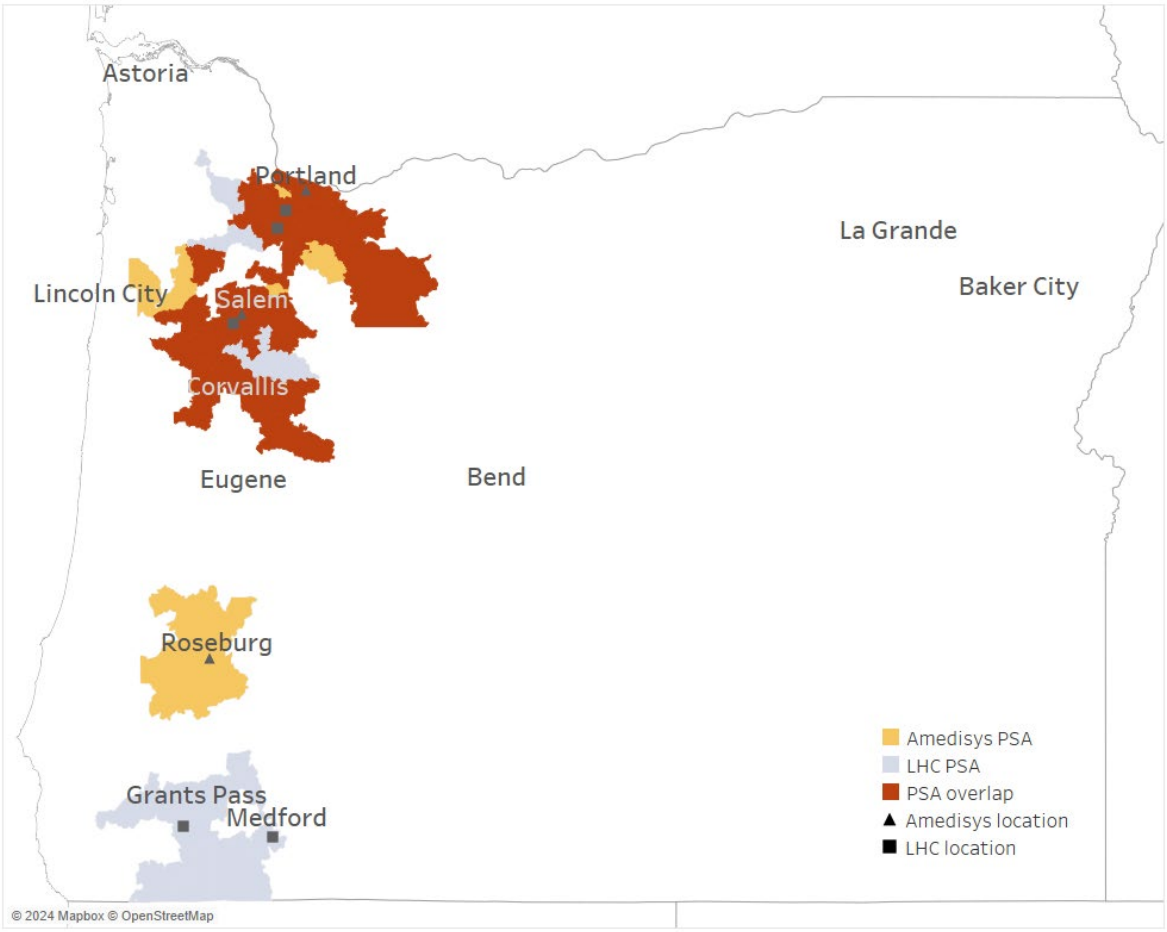
Pre-transaction HHI shows that the home health care market in Oregon is not concentrated. **Post-transaction**, HHI increases by 65 points.



Primary Service Areas

OHA defined a primary service area (PSA) around each Amedisys and UHG home health location, representing the geographic location of patients making up 75% of each location's episode volume for the years 2017 through 2023. (See **Appendix B: Data & Methodology** for more information on OHA's methodology.)

Amedisys PSAs are shown in yellow in the map below, and PSAs of UHG home health agencies are shown in light blue. The brown shading represents areas of overlap between Amedisys and UHG home health PSAs in the Portland and Salem regions.



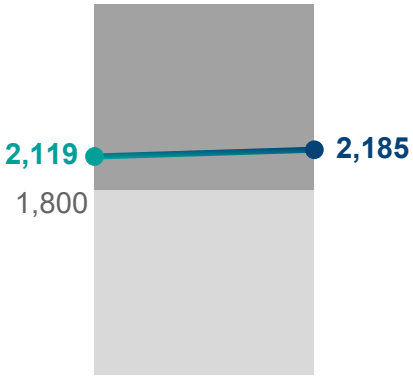
OHA analyzed how the transaction affects home health concentration in each Amedisys PSA. In Amedisys' Portland PSA, the transaction increases UHG's market share from approximately 6% to 12%. This PSA is highly concentrated (HHI=2,119), but the transaction does not materially increase concentration (HHI change=66 points).

For the Amedisys Salem PSA, UHG's market share increases from approximately 6% to 14%. Concentration among home health providers serving the Amedisys Salem PSA increases by 91 points from 1,968 to 2,059.[viii] These changes do not meet thresholds defined in the FTC/DOJ merger guidelines (post-transaction HHC exceeding 1,800 and HHI change of more than 100 points) for presumed anti-competitive effects.[66]

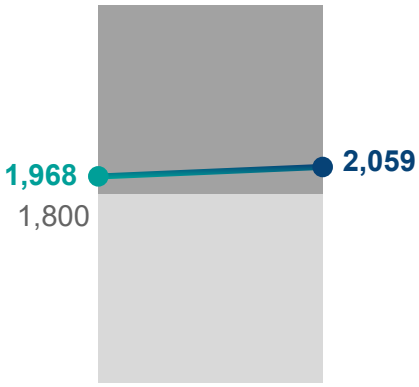
[viii] OHA's preliminary analysis found an HHI increase over 100 points. OHA's updated numbers more accurately reflect market structure, because the data used here are more current. (See Appendix B, "Market Share and Concentration Analysis" for details.)

The home health markets in Portland and Salem are already highly concentrated with **pre-transaction HHI** exceeding 1,800. **Post-transaction**, HHI increases by 66 points and 91 points, respectively.

Portland PSA



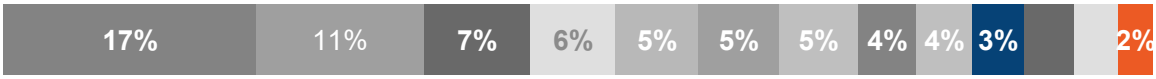
Salem PSA



Hospice Concentration

With the addition of Amedisys, OHA estimates that UHG's share of the market for hospice services in Oregon increases from approximately 3% to 6%, making UHG the fourth largest provider of hospice care in Oregon, tied with one other provider. At the state level, Oregon's market for hospice services is unconcentrated (HHI=670); post-transaction, HHI would increase by 15 points to 685, which is well below the federal threshold for presumed anti-competitive effects.

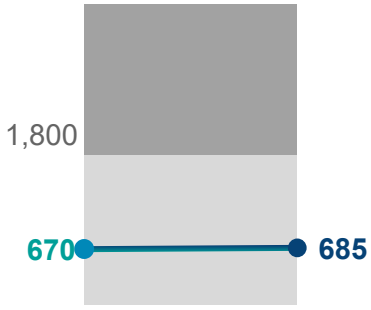
Before the transaction, **UHG** and **Amedisys** shares of the statewide home hospice market were 3% and 2% respectively. After the transaction, OHA estimates that **UHG's** market share is approximately 6%.

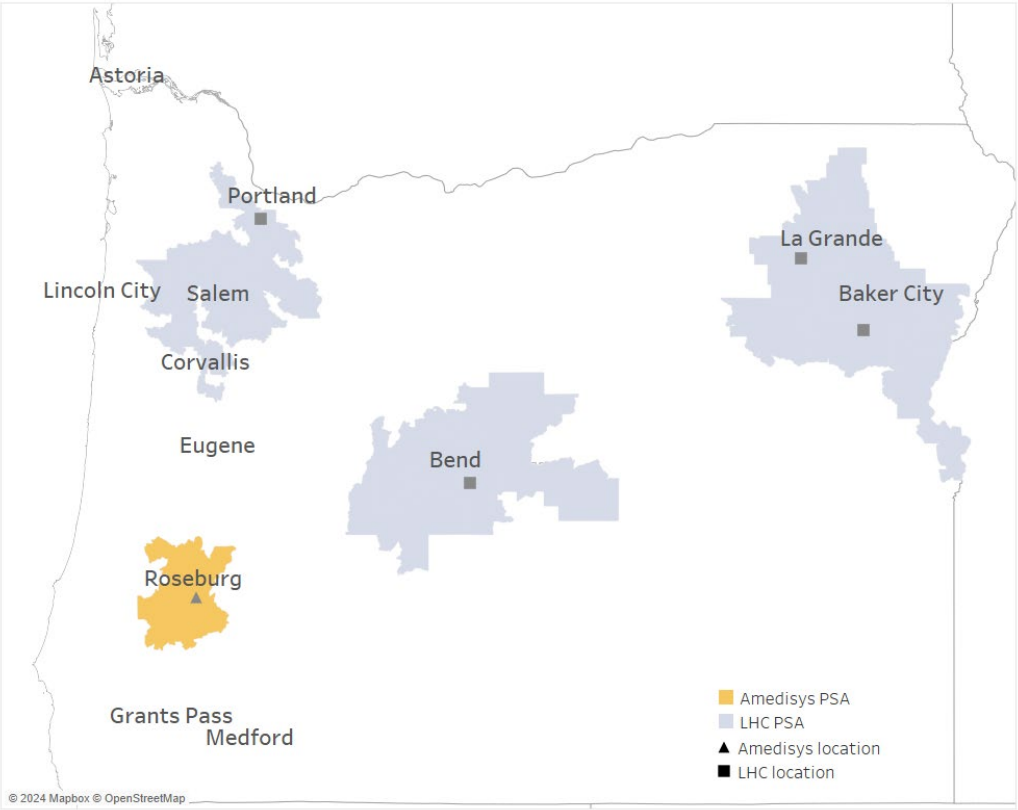


OHA defined a PSA around the Amedisys hospice location in Roseburg and the UHG locations in Bend, Baker City, La Grande and Portland, representing the geographic location of patients making up 75% of episode volume for each location in the years 2017 through 2022. (See **Appendix B: Data & Methodology** for more information on OHA's methodology.)

The Amedisys Roseburg PSA is shown in orange in the map below, and PSAs of UHG hospice agencies are shown in blue. As shown, there is no overlap in the service areas of Amedisys and UHG hospice agencies in the state.

Pre-transaction HHI shows that the home hospice market in Oregon is not concentrated; **post-transaction**, HHI would increase by 15 points.





The Roseburg PSA is very highly concentrated (HHI=5,816) with Amedisys being the dominant competitor accounting for 74% of hospice episodes in the years 2017 through 2023. Pre-transaction, UHG's presence was minimal (less than 0.5% of hospice episodes), and thus the transaction does not materially increase concentration (HHI change=58 points).

Before the transaction, **Amedisys** accounted for 74% of home hospice episodes in the Roseburg PSA, whereas **UHG** had a market share of less than 0.5%.

Anti-competitive effects associated with provider-insurer vertical integration are unlikely in Oregon.

What is provider-insurer vertical integration and how could it impact competition?

UHG is a "vertically integrated" insurer in that it provides both health insurance and a wide array of health care services through its Optum business. The transaction would further increase UHG's vertical integration into home health and hospice service delivery.

In Oregon, UHG offers commercial group, self-insured, and Medicare Advantage plans as well as primary care, specialty care, behavioral health, home health, hospice care, and various other

services.) OHA's preliminary review report described UHG's history of mergers and acquisitions of health care providers and other health care companies nationally and in Oregon.

UHG's acquisitions, including this transaction, are part of a broader trend of vertical consolidation between commercial insurers and provider organizations. Economists, antitrust scholars, and regulators have raised concerns that such deals may reduce competition in health care markets.[67]

A key concern is that companies that are both health insurers and providers may have the incentive and the ability to unfairly disadvantage competing providers or health insurers by limiting their access to products or services needed to compete effectively.[68] This type of anti-competitive conduct is known as "vertical foreclosure" (see callout box). Under federal antitrust guidelines, mergers that create a firm that controls products or services that its rivals may use to compete may substantially reduce competition.[69]

Vertical foreclosure

Vertical foreclosure is when a vertically integrated firm (one that has both an upstream and a downstream business) uses its position in one business to unfairly disadvantage rivals in the other. Federal antitrust agencies have generally distinguished between two "types" of vertical foreclosure:

Input foreclosure is when a vertically integrated upstream firm either refuses to supply or otherwise limits downstream rivals' access to a critical input.

Customer foreclosure is when a vertically integrated downstream firm switches from other suppliers to its own upstream supplier, depriving the other suppliers of an important customer.

Customer foreclosure

Vertically integrated insurers may have the ability to steer patients to and otherwise favor their owned providers via referral requirements, by placing their own providers in a lower cost-sharing tier in their plans' provider networks, by offering less favorable reimbursement rates or other contract terms to third-party providers, or by outright excluding third-party providers from their networks.[70] This would represent a form of "customer foreclosure." (See callout box.) If the insurer has a sufficiently large enrollment in an area, this could deprive third-party providers from an important "customer," making it more difficult for those providers to achieve the scale needed to remain financially viable.

Input foreclosure

Vertically integrated providers may limit other insurers' access to their services, for example, by refusing to contract with third-party insurers, or by demanding prohibitively high reimbursement rates or other unreasonable contract terms, such that third-party insurers have little choice but to cease contracting with the vertically integrated provider. This may hamper third-party insurers' ability to offer a competitive provider network, particularly if there are few alternative providers in the area.

Are anti-competitive effects a concern for this transaction?

UHG/Optum has faced multiple accusations of violating antitrust laws by using its market power to prevent other health care providers from competing effectively against Optum in other states.[71] In 2024, federal antitrust regulators reportedly opened an investigation into UHG's ownership of provider groups.[72] Nevertheless, OHA's state-level analysis found no evidence of there being a substantial likelihood that the transaction will have such anti-competitive effects in Oregon.

Per the federal merger guidelines, for anti-competitive effects to be a concern in vertical transactions, the vertically integrated entity must have both the *ability* and the *incentive* (e.g., higher profits) to engage in anti-competitive behavior.[73]

UHG is unlikely to engage in input foreclosure in Oregon

It is unlikely that excluding third-party insurers from contracting with UHG home health providers in Oregon would be profitable for UHG. Based on 2022 data from APAC, the majority (84%) of Amedisys patients with Medicare Advantage (MA) plans had coverage through a third-party insurer. Similarly, 70% of LHC home health patients with MA insurance were covered by another insurer. UHG would therefore stand to lose a significant portion of its home health revenue base if it stopped accepting insurance from third-party insurers.

As noted earlier, Oregon's home health market is relatively unconcentrated, and third-party insurers would generally have other options for home health services if they were no longer able to contract with UHG. It's therefore unlikely that enough patients would switch to a UHC MA plan (and continue receiving home health services from UHG providers) to offset the decline in UHG's home health revenues. OHA's one-year follow-up review of UHG's acquisition of LHC found that in the year following closing, the number of MA and commercial health plans contracted with LHC home health locations in Oregon increased overall.[74]

UHG is unlikely to engage in customer foreclosure in Oregon

Similarly, excluding other home health providers from UHC's network (e.g., customer foreclosure) is unlikely to be profitable for UHG in Oregon. Even with the addition of Amedisys, the capacity and geographic reach of UHG home health agencies in Oregon are limited. Among UHC MA members in Oregon who received home health care services in 2022, over 90% received services from a third-party provider.

Going forward, UHC will need to continue contracting with third-party home health providers to maintain a provider network that adequately serves the home health needs of the more than 100,000 UHC MA beneficiaries in the state. UHG's MA enrollment may be negatively impacted if members are unable to obtain home health services in a timely manner. OHA's one-year follow-up review of UHG's acquisition of LHC found that in the year following closing, UHC continued to contract with its existing third-party home health providers in Oregon.[75]

► Will the transaction result in anticompetitive effects?

OHA's analysis did not find evidence that the transaction would create a substantial risk of material anti-competitive effects in Oregon. However, given the high levels of concentration among home health providers in Amedisys' PSAs, complaints raised by providers in other states about UHG's anti-competitive behavior, and reported concerns among federal antitrust regulators, OHA has placed conditions on the entities intended to mitigate any such risk.

Lawfulness of the Transaction

***HCMO approval criteria**: There is no substantial likelihood that the transaction would be contrary to law.*

OHA worked with legal counsel from ODOJ to evaluate whether the transaction is contrary to law and identify any legal concerns or risks. The legal analysis included assessing compliance with applicable state and federal law including the following:

- Anti-Kickback Statute (AKS), which prohibits payments for referrals involving federal healthcare programs.
- Stark Law, which prohibits physicians from referring Medicare patients to entities they have a financial relationship with unless an exception applies.
- Health Insurance Portability and Accountability Act (HIPAA), which protects individually identifiable health information (PHI).

To conduct the analysis, the ODOJ reviewed information and documents submitted by the entities to OHA as part of the notice and in response to RFIs. The analysis included a thorough review of the definitive agreements and all filings as of the date of this report to identify any potential legal issues. ODOJ also evaluated healthcare licenses, certifications, and accreditations related to the transaction, the effect on local market competition, past data breaches regarding handling of PHI, investigations related to billing and coding concerns (including allegations of “upcoding” and improper claim denials), and any pending lawsuits against the entities.

Findings

The transaction complies with Oregon and applicable federal law

The terms of the transaction as presented by the entities do not appear to violate federal or Oregon law. OAR 409-070-0060(5)(a)(B) is therefore satisfied.

Financial Stability

HCMO approval criteria: *There is no substantial likelihood that the transaction would jeopardize the financial stability of a health care entity involved in the transaction.*

To assess potential impacts of the transaction on the entities' financial stability, OHA reviewed audited financial data for Amedisys and UHG for the years 2021 through 2024. OHA obtained data from entities' public filings with the Securities and Exchange Commission (SEC) and earnings releases posted to the entities' websites. OHA also reviewed financial reports for Amedisys Oregon, LLC provided by the entities, covering the years 2020 through 2023.[ix]

Amedisys is profitable and solvent

Financial performance

In 2024, Amedisys earned $2.3 billion in service revenues, up from approximately $2.2 billion in 2023.[76] Despite the improvement in revenues, Amedisys' operating profits declined approximately 40% from $156 million in 2023 to $94.5 million in 2024. This decrease was driven by merger-related expenses and a reduction in the value of assets associated with the high acuity care segment.[77]

After taking into account non-operating income and expenses, Amedisys recorded a net profit of $43 million in 2024. In 2023, Amedisys recorded a net loss of $9.7 million; this was largely due to the $106 million fee incurred from terminating the OptionCare merger agreement, which Amedisys recorded as an expense. This fee was ultimately paid by UHG.

Amedisys reported net assets of $1.12 billion in 2023 and $1.18 billion in 2024. Total debt as a percentage of assets has hovered around 44-46% in the past three years. As of December 31, 2024, Amedisys' short-term ("current") assets were valued at $632 million, exceeding the value of its short-term debt by 23% (current ratio of 1.23). A current ratio above 1 indicates solvency, as the company can pay short-term debts as they come due.

Revenue is the money received from providing goods and services.

Income is what remains of revenue after subtracting expenses (also referred to simply as "profit").

Operating income/profit is the amount of revenue left after paying things like staff wages and other operating expenses.

Net income/profit is operating income plus other income (e.g. investment earnings), minus other expenses (e.g. interest payments).

Margin is income expressed as a percentage of revenues.

Assets are resources owned or controlled by a company that have monetary value. These include cash, money owed by customers, property, equipment, and goodwill.

Liabilities refer to debts or obligations owed to another entity, payable in money, services, or goods.

Net assets means the value of assets minus liabilities.

Solvency is when an entity has enough money to pay its liabilities as the payments are due.

Board and shareholder approval of the merger

Mergers and other transactions involving publicly traded companies must first be approved by the board of directors of the entity that is being acquired, and then separately approved by the company's shareholders. While generally, this shareholder vote requires approval by a majority of the shareholders, depending on a company's

[ix] In submitting these data to OHA, UHG asserted them to be confidential and exempt from release to the public under Oregon law (ORS 415.501(13)(c) and ORS 192.345(2)).

organizational documents or laws where the company is incorporated, a higher vote may be required.

On August 10, 2023, Amedisys notified its shareholders of a Special Meeting to be held on September 8, 2023, to vote on the UHG merger agreement. In a letter to shareholders announcing the meeting, the Chair of the Amedisys Board of Directors noted that the Board was "unanimously" recommending a vote in favor of the merger:[78]

> *"The Amedisys Board of Directors (the 'Amedisys Board') has carefully considered and unanimously approved and declared advisable the Merger Agreement and the transactions contemplated thereby […] and determined that the Merger Agreement and the transactions contemplated thereby, including the Merger, are fair to, and in the best interests of, Amedisys and its stockholders."*

Amedisys shareholders voted almost unanimously to approve the merger (99% voted yes).[79]

UnitedHealth Group is also in a strong financial position

UHG is the largest health care company in the United States by revenue.[80] The company generated revenues of $400.5 billion and operating profits of $34.4 billion in 2024. UHG's operating results weakened in 2024 compared to 2023, with revenues growing 8% in 2023-2024 compared to 15% growth in 2022-2023. The company saw a slight (0.2%) decline in operating profits in 2024 compared to 2023, but it nevertheless achieved a healthy operating margin of 8.1%.[81]

Revenues for the UHC and Optum businesses grew by 6% and 12%, respectively, in 2024. Revenues for the Optum Health business segment within Optum grew by 11% from $95 billion in 2023 to $105 billion in 2024.[82] Per UHG's press release, Optum Health's growth was "driven by patients served under value-based care arrangements and continued expansion of the types and level of care provided".[83]

UHG generated $24.2 billion in cash flows from operations in 2024, down from $29.1 billion in 2023. UHG reported the decrease was driven by "CMS Medicare funding reductions, Change Healthcare cyberattack response actions, increased medical costs and changes in working capital accounts."[84] The company's 2024 annual report stated:[85]

> *We expect the cash required to meet our long-term obligations to be primarily generated through future cash flows from operations. However, we also have the ability to generate cash to satisfy both our current and long-term requirements through the issuance of commercial paper, issuance of long-term debt, or drawing under our committed credit facilities or the ability to sell investments. We believe our capital resources are sufficient to meet future, short-term and long-term, liquidity needs.*

In April 2025, UHG revised its 2025 performance outlook, adjusting expected net earnings from approximately $28 per share to $25 per share.[86] UHG's press release cited "heightened care activity" within the Medicare Advantage business leading to higher spending on physician and outpatient services.[87] UHG also pointed to "unanticipated changes in the profile of Optum Health members" and impacts from "ongoing Medicare funding reductions."[88]

In July 2025, UHG further dropped its earnings outlook, saying it faced "challenges across our lines of business" but was implementing a plan to improve financial performance.[89] The Optum subsidiary was also falling short of earnings expectations due to increased medical costs, lower services volume, and an underestimation of new members' risk status.[90]

Although the decrease in UHG's 2025 expected earnings negatively impacted UHG's stock price and shareholder returns, UHG generally maintains a strong financial position relative to other major insurers. For example, UHG reported the highest net income of any insurer in the second quarter of 2025, at $3.4 billion, twice the amount earned by the next-highest performer Elevance Health.[91] Other insurers are facing similar financial challenges driven by rising healthcare costs and regulatory changes, among other factors.[92]

UHG also holds strong credit ratings across all the major rating agencies.[93] UHG's credit ratings held steady in 2025 amid the company's weakening financial performance, although several rating agencies downgraded UHG's credit outlook from "stable" to "negative."[94]

► Will the transaction jeopardize the financial stability of Amedisys or UHG?

The transaction is unlikely to jeopardize the financial stability of Amedisys or UHG. Amedisys' recent financial reports demonstrate that the company is both profitable and solvent. Amedisys' board reviewed and approved the merger agreement, and its shareholders approved it almost unanimously. Despite headwinds, UHG, as the largest health care company in the country, continues to grow its revenues, achieve profitability, and maintain a strong financial position. UHG is not assuming any additional debt to finance the transaction. As a subsidiary of UHG, Amedisys will likely be able to reduce its expenses (e.g., by relying on Optum's corporate and administrative resources) while further growing its revenues by serving more Optum patients.

Impact on Consumers and the Public

HCMO approval criteria: *There is no substantial likelihood that the transaction would otherwise be hazardous or prejudicial to consumers or the public.*

OHA's comprehensive review explored how previous UHG/Optum acquisitions in Oregon, including LHC, Oregon Medical Group, and other physician groups, have affected health care service delivery in the state.

LHC agencies in Oregon saw two relocations, one closure, and other changes in the months after they were bought by UHG

The transaction is UHG's second purchase of a publicly traded for-profit home health and hospice company. As noted earlier, in February 2023, UHG completed its purchase of LHC, whose nationwide network of post-acute health care services included five home health and five hospice agency locations in Oregon.[x] Given the similarities between LHC and Amedisys, any changes seen after LHC's transition to UHG ownership may provide an indication of expected changes at Amedisys locations following close of the transaction. OHA therefore sought more information from the entities about the operation of LHC's Oregon agencies post-acquisition. Key findings from this analysis are summarized below and in OHA's One-Year Follow-Up Report of the UHG-LHC transaction.

Closure and relocations

LHC's hospice agency location in La Pine (Heart 'n Home Hospice and Palliative Care) closed in April 2023, two months after the UHG acquisition. All patients and employees were re-assigned to LHC's Bend location. UHG stated the reason for the move was "to improve retention of staff located near the Bend location and to improve collaboration of care."[95]

In June 2023, the Bend location of Heart 'n Home Hospice and Palliative Care relocated to a new larger space in Bend (approximately 5 miles away). Additionally, in January 2024, Three Rivers HomeCare in Grants Pass moved to a new location (less than 2 miles away) to provide "additional room for growth."[96]

UHG told OHA that "[n]o service areas changed because of any closure or relocation." Per Oregon's licensing rules, geographic service areas of home health and hospice agencies are limited to a 60-mile radius of the parent agency location. While this provides an outer boundary for where the agency's patients can reside, it does not prevent an agency from reducing services to any area within that boundary. The current location of LHC's hospice agency in Bend is over 30 miles from the previous La Pine location. The closure of the La Pine location thus raises concerns about potential reductions in access to hospice services for patients in this area. Areas in and around La Pine are medically underserved, and residents (many of whom are low-income) have limited local options for home hospice services.

Analysis of entity-reported data

To inform its analysis, OHA requested various data from UHG on the operation of each LHC home health and hospice agency in Oregon. Specifically, OHA requested annual data for the years 2021 through 2023 in the following areas:

- **Patient volume:** Total admissions, total patient volume, total episode volume, total patient days, and average daily census. OHA also asked for episode counts by primary payer type.

[x] OHA reviewed and approved this transaction on September 1, 2022. See OHA's Order and Review Report.

- **Staffing:** Number staff, number of full-time-equivalent (FTE) employees, unfilled/open FTE, number of in-person visits, and number of direct patient care hours. OHA requested these data be provided for the month of January 2021 through 2024 and reported separately by staff position or category (e.g., registered nurse, social worker, home health aide, etc.)
- **Patient demographics:** Episode counts by patient sex, age group, race, ethnicity, and language service needs. OHA also requested episode counts by referral source.
- **Services rendered:** Number of visits (broken down by nursing, social worker, and home health/home hospice aide) and minutes of care provided (nursing, physical therapy, occupational therapy, and speech-language pathology).
- **Payments:** Total payment amounts received annually by payer, amount of financial assistance provided, payments received from alternative payment arrangements (not fee-for-service), and average payment per episode of care.
- **Service areas:** Number of episodes by zip code of patient residence.

OHA analyzed these data to measure changes over time, paying particular attention to any changes from 2022 ("pre-transaction") to 2023 ("post-transaction"). Given that the study period for this analysis (2021-2023) included only ten months of post-transaction data, the results of this analysis are preliminary and should be cautiously interpreted.

In submitting these data to OHA, UHG asserted them to be confidential and exempt from release to the public under Oregon law.[xi] While OHA has obtained permission from the entities to report certain findings from its analysis of these data below, OHA is prohibited by law from publicly sharing the full results from its analysis. OHA will continue to monitor trends in these data as part of its statutorily mandated follow-up reviews of the UHG-LHC transaction.

For home health, some LHC locations saw increases in patient and service volume from 2022 to 2023, whereas others saw decreases. At the majority of LHC home health agency locations, clinical and non-clinical FTE increased, and patient load (number of patients per 1 FTE of clinical staff) decreased. There were some changes in the types of clinical staff (e.g., home health aide, nurse, or social worker), but no clear trends across LHC locations. For all locations but one, the share of payments from Original Medicare decreased, whereas the share of payments received from Medicare Advantage plans increased.

OHA's analysis of LHC hospice agency locations in Oregon found changes in various metrics from 2022 to 2023. However, the direction of these changes varied across locations, and OHA did not find evidence of any overarching trends affecting all locations in this period. A contributing factor to this variability was the closure of the La Pine hospice location and subsequent re-assignment of those patients and staff to the Bend location. Among the LHC hospice locations not affected by closures or relocations, the percentage of care episodes where the patient was referred from an institution increased.[xii]

Summary

Since UHG's acquisition of LHC in early 2023, two LHC agency locations in Oregon have been relocated and one has closed entirely. Across the health care system, closures and service reductions usually impact people with low incomes, rural residents, and people of color more deeply than other groups, contributing to growing health inequities. These and other changes at

[xi] ORS 415.501(13)(c) and ORS 192.345(2).
[xii] An institution may be an acute care hospital, inpatient psychiatric facility, skilled nursing facility, inpatient rehabilitation facility, or long-term care home.

LHC suggest the need for conditions to prevent similar changes at Amedisys following close of the transaction.

UHG's physician practice acquisitions in Oregon brought significant disruptions and reduced access to care

OHA also assessed changes in care delivery following Optum's physician group acquisitions in Oregon, including Oregon Medical Group (acquired in 2020), GreenField Health (acquired 2021), Family Medical Group NE (acquired in 2021), and The Davies Clinic (acquired in 2023). OHA requested information and data from UHG and obtained additional information from media coverage and public comments submitted to HCMO. (OHA's analysis did not include Optum's acquisition of The Corvallis Clinic, as this acquisition closed just four months before OHA issued its information request.[xiii])

For each physician group, OHA obtained pre- and post-acquisition data on practice locations, number of patients served, clinical and non-clinical FTE, staff turnover/departures, and geographic service areas (patient zip codes). While OHA has carefully analyzed these data and considered the findings, UHG marked the files as confidential trade secrets, and therefore OHA is prohibited by law from publicly sharing its findings.

When asked about the strategy behind physician practice acquisitions in Oregon, UHG responded:[97]

> *"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 payers and patients."*

After Optum acquired these practices, the management of critical practice functions moved to Optum Care Delivery, a division Optum Health.[98] These functions included:

- Staffing and hiring (for clinical and administrative staff).
- Compensation and benefits of clinical staff.
- Payer contracting.
- Billing and payment.
- Patient care practices.
- Patient enrollment practices.
- Financial assistance policies.
- Sourcing of supplies and technology.

Oregon Medical Group

Optum acquired Oregon Medical Group ("OMG"), a Eugene-based physician group offering primary and specialty care, in late 2020. OHA's July 2024 information request asked UHG to describe any changes at OMG following the acquisition related to services offered, insurance plan contracts, referral practices, patient enrollment or discharge policies, administrative responsibilities of clinical staff, billing, payment, or diagnosis coding. UHG's response was limited to the following statement:

[xiii] OHA issued its information request in July 2024 and The Corvallis Clinic acquisition closed in March/April 2024. Any data obtained for TCC would not have provided sufficient basis for assessing post-transaction changes in care delivery.

"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."

OHA received numerous comments from members of the public in connection with Optum's acquisition of The Corvallis Clinic.[xiv] Many commenters cited adverse experiences as patients and providers after Optum acquired OMG, including physician departures, difficulty getting appointments, patients being turned away, billing and administrative issues, changes in insurance plans accepted, and price increases.[99] See the callout box for examples.

The OMG acquisition has been extensively covered in local media, with reports of significant disruptions and loss of patient access to care associated with clinician departures and management changes.

The Oregonian reported that beginning in late 2022, Optum had instituted changes to OMG physicians' employment contracts, introducing new productivity quotas and requiring them to perform additional administrative work, such as medical coding, which had previously been handled by support staff.[100]

Examples of public comments on Optum's acquisition of OMG

"OMG has lost a substantial fraction of their providers since the merger (30-40%). Physician morale plummeted. Patients have lost access to primary care."

"After Optum took over Oregon Medical Group in Eugene, they went to only accepting Medicare Advantage plans."

"We have personally experienced enormous increases in costs of our health care there within the year that it [OMG] was acquired."

"I experienced significant obstacles with Optum/Eugene OMG in getting my disabled son, an OHP, access to the healthcare he needed […]."

One former OMG physician said Optum's takeover had brought "a frustrating mix of bureaucratic paperwork and unrelenting pressure to produce." In addition to "absurd" patient quotas (caring for 2,800 patients), he was expected to do billing and code entry work. [101] (By contrast, in submissions to OHA, UHG cited no changes in administrative responsibilities of clinical staff at OMG following the acquisition.[102])

In March 2024, The Oregonian reported that 32 doctors had left OMG over the last two years.[103] The piece included multiple reports of patients who had been informed that they could no longer receive care at OMG due to their physician leaving. According to OPB, thousands of OMG patients had been dropped, and OMG's Southtowne Clinic was closed in March 2024.[104] A former patient interviewed by OPB was reportedly told that "if he switched back to an insurer owned by OMG's parent company, he would be able to continue seeing his doctor." Another patient was reportedly told she was no longer a patient because her primary care provider had left OMG.[105] In 2025, OMG reported that they would close their Obstetrics/Gynecology service line in November 2025. OMG stated the planned closure was due to providers leaving the practice and the inability to recruit new physicians.[106]

[xiv] This transaction was exempted from HCMO review and closed in March 2024.

Other Provider Groups Acquired by Optum

OHA's July 2024 information request asked UHG to describe any changes at OMG, GreenField Health, The Davies Clinic, and Family Medical Group NE following their acquisition. OHA specifically asked about changes related to services offered, insurance plan contracts, referral practices, patient enrollment or discharge policies, and various other categories. UHG's responses are summarized in the table below. Two of these four physician groups (GreenField Health and Family Medical Group NE) have now closed, as discussed below.

UHG-reported changes following Oregon physician group acquisitions (as of August 2024)

Category	Oregon Medical Group	GreenField* Health	The Davies Clinic	Family Medical Group NE*
Range of services offered	Changes driven by clinician departures.			
Contracted insurance plans	No changes.	Terminated Devoted MA, Humana MA, and Regence Alliance contracts.		
Patient referral policies or practices	No changes.			
Administrative responsibilities of clinical staff	No changes.			
Patient enrollment policies	Adult primary care enrollment closed to new patients due to clinician capacity limitations.			
Practices for coding/documentation of patient diagnoses	No changes.			
Financial assistance	No changes.	OMG policies adopted in February 2023.		
Billing and payment practices or policies	No changes.	OMG policies adopted in February 2023.		
Branding or practice names	No changes.			
Electronic health records systems	Moved to Epic system.	Moved to Family Medical Group instance of Epic.	Moved to Epic system.	No changes.

Source: UHG Responses to OHA's July 11, 2024 Request for Information, pp. 28-33.

* GreenField Health closed in January 2024. Family Medical Group NE closed in March 2026.

As shown in the table, UHG reported that all four clinics saw service changes that were "driven by clinician departures" and have closed enrollment of adult primary care patients "due to clinician capacity limitations." Optum also terminated several insurance plan contracts for GreenField Health, The Davies Clinic, and Family Medical Group NE. UHG noted that these contracts were all associated with Legacy Health Partners, and that Optum terminated the contracts "because Legacy Partners was unwilling to contract in specific locations only."[107] Optum also adopted new financial assistance policies and transitioned to new electronic health records (EHR) systems for three of the practices.

GreenField Health closure

In December 2023, Optum began informing patients that it planned to close the GreenField Health clinic in Northwest Portland and relocate all GreenField Health providers to the Family Medical Group location in NE Portland.[xv] Patients with scheduled appointments were told their appointment would be moved to the new location.[108] Optum framed the closure as bringing "benefits" such as "increased clinician and staff pools" and "less lead time for appointments" but acknowledged that the new location (approximately 10 miles away) might not work well for all patients.[109]

In response to OHA information requests, UHG confirmed that the Northwest Portland GreenField Health location closed effective January 29, 2024. UHG initially said the reason for the closure was "to provide better support and coverage for patients, staff, and clinicians."[110] When prompted for more information, UHG stated:[111]

> *"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."*

Family Medical Group NE closure

In February 2026, Optum sent letters to patients of Family Medical Group NE notifying them that the clinic was closing due to "several unavoidable factors."[112] The closure was effective March 13, 2026.[113] The majority of Family Medical Group NE's clinicians are reported to have left in 2025, as the number of clinicians working at the practice declined from eight or nine in January 2025 to just two in early 2026.[114] Optum issued the following statement in response to media questions:[115]

> *"We understand how important access to care is for our patients; however, due to ongoing provider shortages and recruitment challenges affecting health care organizations nationwide, we have made the difficult decision to close the Family Medical Group."*

Summary

In the years after UHG acquired Oregon Medical Group, GreenField Health, The Davies Clinic, and Family Medical Group NE, numerous doctors and other clinicians left these practices. Many of these departures were reportedly driven by a deteriorating work environment and changes in compensation terms. As a result, Optum scaled back its services, stopped accepting new primary care patients, and ultimately closed two of the four practices.

It is uncertain whether similar impacts can be expected at Amedisys. Notably, Amedisys is *not* an independent local provider; it is a corporate, publicly owned national company. It also has different operating and staffing models; it provides very different services, and the composition of its workforce is different.[xvi] However, given Optum's track record on physician group acquisitions in Oregon, conditions are warranted to mitigate any potential harms to employees, patients, or communities in Oregon.

► Will the transaction otherwise be hazardous or prejudicial to consumers or the public?

OHA's review found that previous UHG acquisitions were followed by disruptions and reductions in access to health care services for people in Oregon. OHA has imposed approval conditions to

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[xv] When Optum acquired GreenField Health in 2021, the practice included two clinic locations in Portland. It is unclear when the first location was closed.

[xvi] See **The Home Health & Hospice Workforce** (Appendix C), for more information on home health and hospice workforce composition, demographics, compensation, and working conditions nationally and in Oregon.

mitigate the risk of similar changes following close of the transaction. Under OHA's conditions, the transaction is unlikely to be hazardous or prejudicial to consumers or the public in Oregon.

Potential to Benefit the Public Good and Communities

HCMO approval criteria: *The transaction will benefit the public good and communities by:*

- *Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is in the best interest of the public;*
- *Increasing access to services in medically underserved areas;*
- *Rectifying historical and contemporary factors contributing to a lack of health equity or access to services.*

or

Improve health outcomes for residents of this state.

In their submissions to OHA, the entities have described various ways in which the transaction would benefit people in Oregon. Specifically, entities have argued that the transaction would "increase access to home health and hospice services" and "improve health outcomes for Oregon residents."[116] In summary, these claimed benefits would be achieved by:[117]

- Allowing Optum to provide Amedisys' services to more patients;
- Contributing to a faster transition by home health care providers in Oregon from fee-for-service to value-based care reimbursement models, which may improve access to home health for OHP members;
- Making hospice services available to pediatric patients in Roseburg;
- Adopting clinical programs for home health and hospice care that have been shown to improve patient outcomes;
- Reducing the time Amedisys and LHC nursing staff spend traveling to see patients, allowing them to treat more patients.

OHA assessed the likelihood that each of these claimed benefits would materialize for people in Oregon. OHA's assessment relied on information and documentation provided by the entities in response to OHA's information requests as well as consultation with internal experts on home health and hospice licensing.

Clinical program integration can be expected to improve care quality and outcomes for home health patients.

OHA's review found that integration of clinical programs at LHC and Amedisys home health agencies is likely to contribute to improved health outcomes for home health patients in Oregon.

Amedisys and LHC clinical programs for home health

Both LHC and Amedisys home health agencies nationwide use specialized clinical programs that provide protocols and best practices for treating patients with specific diseases or conditions. These programs typically include care protocols, clinician training, and patient education components that guide clinical staff and help patients manage their disease, with the goal of avoiding hospitalization or admission to a long-term care facility. The table below summarizes programs offered nationally by LHC and Amedisys.

Disease/Condition	LHC Program	Amedisys Program
Diabetes	Choose Control	Home Health Diabetes Program
Chronic Obstructive Pulmonary Disease (COPD)	ClearWay	COPD Program
Congestive Heart Failure	VentriCare	Heart Failure Program
Alzheimer's & dementia	Active Minds	N/A
High risk of falling in the home	N/A	Fall Reduction Program
Complex or chronic wounds	N/A	Wound Care Program

LHC and Amedisys both offer programs for managing diabetes, COPD, and congestive heart failure. LHC does not currently have a program to address risk of falling or complex wound care, whereas Amedisys does not currently have a program in place to care for Alzheimer's or dementia patients.

LHC's clinical programs are typically developed over several years and based on both in-house research and guidance on evidence-based practices issued by organizations such as the Centers for Disease Control (CDC), American Diabetes Association, the Mayo Clinic, and the American Heart Association. For example, LHC's heart failure program, VentriCare, was developed in collaboration with the American Heart Association.[118]

Before adopting new clinical practices across its agencies, LHC conducts a "pilot" study to test whether the program leads to measurable improvement in patient outcomes. LHC's pilot study of the Choose Control program found a reduction in hospitalization among participating diabetes patients.[119] Similarly, the ClearWay COPD pilot study found a decrease in hospital readmissions for patients who received care under the program.[120]

Plans for clinical program deployment post-close

UHG has stated that following the transaction, it plans to make the Active Minds program available to Amedisys home health patients in Oregon. Additionally, UHG plans to make the Amedisys Fall Reduction and Wound Care programs available to patients of LHC's Portland, Salem, and Medford agencies.[121]

For COPD, heart failure, and diabetes, where LHC and Amedisys each have their own programs, UHG plans to integrate and harmonize clinical protocols based on input from LHC medical staff. UHG's responses state:[122]

> *"[…] 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 […]."*

Targeted implementation

UHG's responses to OHA indicate that UHG intends for its LHC subsidiary to take the lead in integrating and harmonizing clinical programs across LHC and Amedisys following the close of the transaction.[123] Per UHG's responses to OHA, prior to implementing a new clinical program at a home health agency, LHC will assess whether the agency is likely to benefit from the program by assessing the needs of its patient population, the stability of the agency's leadership and clinical staff, and the agency's performance on quality of care.[124]

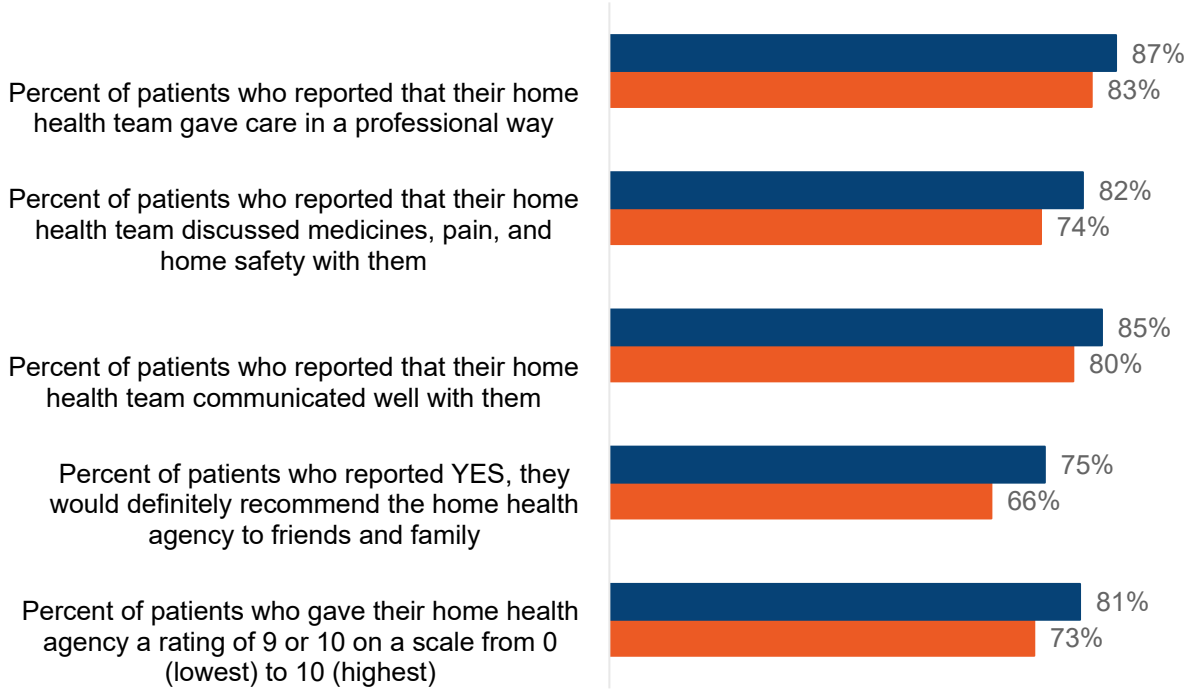
To implement new clinical programs at a home health agency, LHC provides remote and on-site training for clinical staff. The agency's Electronic Health Record (EHR) system is then updated to include prompts and templates that guide staff in caring for patients.[125] UHG stated it anticipates making only "limited changes" to Amedisys' EHR system when deploying new clinical programs, because Amedisys and LHC currently both used the Homecare Homebase EHR system.[126]

Quality of care

OHA used data from CMS CareCompare for the third quarter of 2024, including data from the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey, to compare quality measures for Amedisys home health agencies to LHC agencies in Oregon. (See **Appendix B: Data & Methodology** for more information on the data used.) OHA's analysis found that LHC's home health agencies in Oregon have historically performed better than Amedisys' home health agencies in the state.

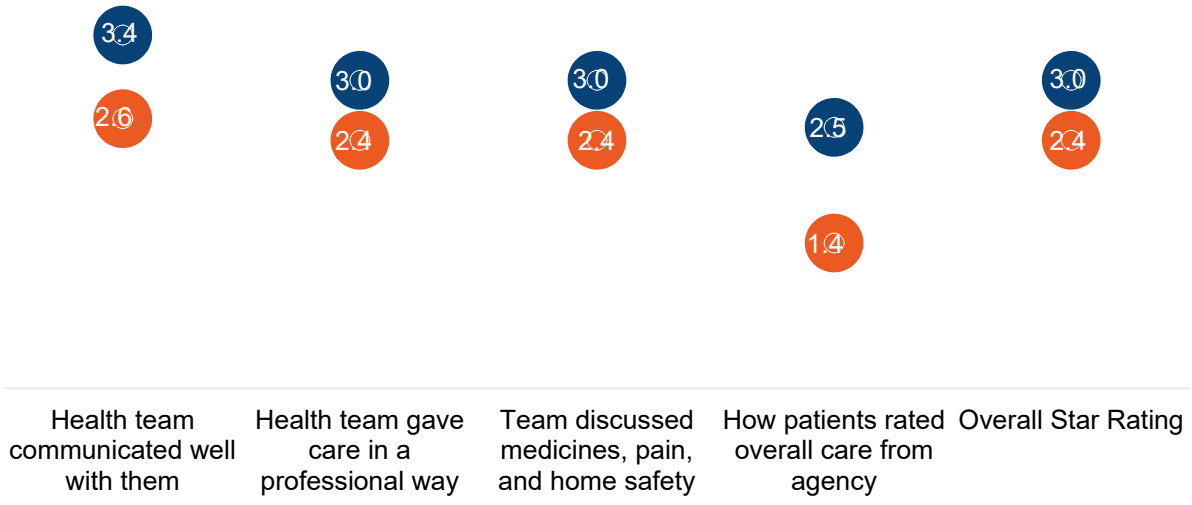
LHC home health locations outperformed the Amedisys locations in terms of patient satisfaction as measured by CAHPS survey. LHC home health locations were rated highly for discussing medicines, pain, and home safety with patients.[127] Patients also rated LHC home health agencies higher in terms of overall care.

Surveyed patients were generally more satisfied with **LHC** home health agencies in Oregon than **Amedisys** agencies in the state.



LHC home health agencies also tended to outperform Amedisys on measures of care process and patient outcomes. Amedisys home health locations tended to be less consistent in rendering functional assessments and care plans to address function concerns and less consistent in addressing physician-recommended actions about medication issues in a timely manner. The Amedisys location in Salem also saw a particularly high rate of patients needing urgent, unplanned care from emergency departments and a high rate of patients who experienced falls with major injury. The LHC locations tended to see higher rates of patient improvement compared to the Amedisys locations and to state averages.[128]

Surveyed patients rated **LHC** home health agencies in Oregon higher, on average, than **Amedisys** home health agencies across multiple quality measures.



These differences in quality between LHC and Amedisys home health agencies in Oregon suggest an opportunity, through clinical integration, to improve performance of Amedisys home health agencies on measures of patient satisfaction, care process, and patient outcomes.

In summary, OHA expects that expanded availability of the Active Minds, Fall Reduction, and Wound Care programs, as well as efforts to clinically integrate Amedisys with LHC, will contribute to improved health outcomes for home health patients in Oregon.

The transaction is expected to increase the availability of pediatric hospice care for underserved communities in and around Roseburg

LHC currently offers hospice services to children (pediatric patients) nationally, whereas Amedisys does not.[129] UHG has stated that following the acquisition of Amedisys, it plans to expand the LHC pediatric hospice program to Amedisys locations nationwide. In Oregon, this would mean that Amedisys' hospice agency in Roseburg will be able to offer hospice services to children:[130]

> *"[A]s a result of this acquisition, children in Roseburg who require hospice care will gain access to a pediatric hospice provider in their community for the first time."*

LHC's pediatric hospice program, Kids at Heart, provides palliative and hospice care to children with life-threatening illnesses. The program was developed in collaboration with Dr. Conrad Williams, a specialist in pediatric palliative care at the Medical University of South Carolina's Children's Hospital.[131] Dr. Williams currently directs LHC's pediatric clinical services nationally. LHC has developed its own internal training materials for pediatric hospice care, and all members of the care team are trained on the unique needs of children at the end of life. LHC's program is consistent with the "concurrent care" model (see callout box[132]). In 2023, LHC served 128 hospice patients nationwide aged under 21.[133]

Hospice services for children

Pediatric hospice care differs from adult hospice care, because children's needs are typically different from those of adults, family members are more involved in the development of the care plan, and because for many children, curative care is provided alongside hospice care.

Prior to the Affordable Care Act (ACA) enacted in 2010, children had to forego any life prolonging treatments when enrolling in hospice care. The ACA required Medicaid programs nationwide to pay for **concurrent care**, meaning curative, life prolonging treatment *in addition* to hospice services, for children under the age of 21. Commercial insurers are not subject to this requirement, but many do cover concurrent care.

UHG's responses to OHA indicate that UHG intends for its LHC subsidiary to take the lead in implementing pediatric hospice services at acquired Amedisys locations following the close of the transaction. To enable this, LHC's pediatric hospice training materials will be shared with Amedisys nursing staff, and LHC's Hospice Clinical Operations Coordinator will be responsible for overseeing and providing additional training as needed. UHG also stated it does not expect to increase staffing at the Roseburg location to support pediatric hospice care. However, it intends for LHC to engage an Oregon-based pediatrician to provide "local support" and "act as a liaison with patients' existing pediatricians." Per UHG's responses, LHC expects to be able to begin serving pediatric hospice patients in Douglas County within 6-12 months of closing.[134]

LHC's hospice agencies do not currently serve the Roseburg area; the closest LHC hospice agency location is in Bend, over 150 miles from Roseburg. OHA is not aware of any hospice agencies with locations in Roseburg or Douglas County that currently offer pediatric hospice services. While the demand for pediatric hospice services may be limited[xvii], the presence of a

[xvii] Based on OHA's analysis of APAC claims, hospice agencies in Oregon provide fewer than 50 care episodes annually to pediatric patients. This includes hospice episodes with start dates between 2015 and 2022. It is likely an undercount, as APAC data does not include all episodes paid for by self-funded employer-sponsored plans.

locally based agency with capacity for and expertise in pediatric hospice care would mean increased access to services for residents of this underserved area.

► Will the transaction benefit the public good and communities in Oregon?

OHA expects that the transaction will improve care quality and health outcomes for home health patients in Oregon through the integration of LHC and Amedisys clinical programs. OHA also expects that the transaction will increase access to hospice services for pediatric patients in the medically underserved Roseburg area.

OHA has imposed a condition on its approval of the transaction requiring that UHG's hospice agency in Roseburg have the capacity and expertise to offer hospice services to pediatric patients within one year of the order date. UHG must also provide a report to OHA on implementation of the pediatric hospice program at the Roseburg hospice agency, including information on training efforts and staffing.

Public Comments

OHA started accepting public comments about the transaction in December 2023. OHA has received 16 comments. Public comments related to this transaction are posted to the HCMO website.

Public comments raised concerns about UHG's potential ownership of another provider group in Oregon. Commenters cited the departure of physicians from Oregon Medical Group after its acquisition by UHG/Optum, UHG's status as a large for-profit corporation, and the risk of anti-competitive practices that could harm competing providers. Commenters also raised concerns about potential price increases, the multitude of lawsuits filed against UHG, and potential for the transaction to dampen wage growth for nurses and other health care professionals.

Public comments for the transaction are reproduced in this report for reference only. Where applicable, OHA has used public comments to inform its analysis of the transaction. OHA expresses no views on the substance of the comments and their inclusion in this report does not constitute an endorsement by HCMO of the views expressed therein.

"If this transaction is approved will the clinic doctors be referring patients to the former Amedisys services to the exclusion of other service providers in the area?"

"Please do not allow any more purchases by the United Health Care group as well as all of their divisions. Their record of care for patients is terrible. Their main concern is always profit over care for people."

"I was a home health nurse for [Amedisys] somewhere around 2014. They treated employees poorly, often shorting them on mileage reimbursement, and there was constant time pressure."

"UHG's track-record of driving up profit margins at the expense of patients is not in alignment with Oregon values."

Conclusions

Based on comprehensive review findings, **OHA approved the transaction with conditions on June 12, 2026.** See Findings of Fact, Conclusions of Law, and Proposed Order in the Matter of the Proposed Material Change Transaction of UnitedHealth Group Incorporated and Amedisys, Inc. dated June 12, 2026 ("Comprehensive Review Order").

The transaction was approved, because OHA determined the transaction satisfies the criteria for approval under ORS 415.501(9) and OAR 409-070-0060(5).

Consistent with ORS 415.501(18) and OAR 409-070-0060(3), OHA has decided to provide members of the public 15 calendar days to provide written exceptions to the Comprehensive Review Order. Comments should be emailed to hcmo.info@oha.oregon.gov or submitted by filling out the 014 UHG-Amedisys Written Exceptions Form no later than June 27, 2026. All comments received will be made publicly available on OHA's website.

Criteria for Approval

For OHA to approve a transaction following comprehensive review, the transaction must meet criteria A. and B. or C. listed below. These criteria are specified in administrative rules for the HCMO program and are consistent with Oregon law.

A. There is no substantial likelihood that the transaction would: • Have material anti-competitive effects in the region not outweighed by benefits in increasing or maintaining services to underserved populations; • Be contrary to law; • Jeopardize the financial stability of a health care entity involved in the transaction; or • Otherwise be hazardous or prejudicial to consumers or the public	***and***	**B.** The transaction will benefit the public good and communities by: • Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is in the best interest of the public; • Increasing access to services in medically underserved areas; or • Rectifying historical and contemporary factors contributing to a lack of health equity or access to services.
		or
		C. The transaction will improve health outcomes for residents of this state.

OHA determined that, under the approval conditions outlined below, the transaction meets criterion A, because there is no substantial likelihood that the transaction would have material anti-competitive effects in Oregon, be contrary to law, jeopardize the financial stability of either UHG or Amedisys, or be otherwise harmful to consumers or the public.

OHA further determined that subject to approval conditions outlined below, the transaction will benefit the public good and communities by increasing access to hospice services in a medically underserved area, therefore satisfying criterion B. While not needed for OHA to approve the

transaction, OHA further determined that the transaction also satisfies criteria C by improving health outcomes for home health patients in Oregon.

Approval Conditions

Conditions for approval of the transaction are summarized below. Approval conditions apply for a period of five years from the date of the Comprehensive Review Order ("order date"). Please see the Comprehensive Review Order for the legal wording of these conditions.

1. UHG must adhere to the representations made in the notice and subsequent filings with OHA.
2. For any future UHG transaction not subject to HCMO review that involves a home health or hospice agency licensed in Oregon, UHG must notify OHA at least 60 days prior to completing the deal.
3. If UHG anticipates making changes that would lead to non-compliance with any condition, UHG may petition OHA to waive or modify the relevant condition(s). UHG must submit the petition to OHA at least 60 days before making the change(s). OHA may approve or deny the petition.
4. Within six months of the date of the order date, UHG must administer an anonymous survey to clinical caregivers at UHG home health and hospice agencies in Oregon. UHG must administer a second survey within one year of the Order date, followed by annual surveys. Survey questions are listed in Exhibit A to the Comprehensive Review Order and cover topics such as care quality, workload, and job satisfaction. UHG must use an independent, third-party platform to administer the annual survey.
5. Within 180 days of the order date, UHG must establish a Home Health Committee composed of staff working at UHG's home health agencies in Oregon. The committee must meet quarterly and will be tasked with establishing benchmarks for the Oregon home health agencies, which must be tied to annual survey responses, and tracking performance on those benchmarks. UHG must provide the Home Health Committee with quarterly reports including data on survey responses, benchmark performance, and other metrics specified in Exhibit B-1 to the Comprehensive Review Order. If UHG home health agencies fail to meet a benchmark, UHG must develop a plan to improve performance, which will be subject to the Home Health Committee's approval. UHG must provide quarterly reports to the Home Health Committee on implementation of the plan.
6. Within 180 days of the order date, UHG must establish a Hospice Committee composed of staff working at UHG's hospice agencies in Oregon. The committee must meet quarterly and will be tasked with establishing benchmarks for the Oregon hospice agencies, which must be tied to annual survey responses, and tracking performance on those benchmarks. UHG must provide the Hospice Committee with quarterly reports including data on survey responses, benchmark performance, and other metrics specified in Exhibit B-1 to the Comprehensive Review Order. If UHG hospice agencies fail to meet a benchmark, UHG must develop a plan to improve performance, which will be subject to the Hospice Committee's approval. UHG must provide quarterly reports to the Hospice Committee on implementation of the plan.
7. UHG must use commercially reasonable efforts to continue to operate and maintain all Amedisys home health and hospice agencies in Oregon and maintain the capacity, services, and programs of these agencies. UHG may not close, consolidate, or relocate any agency if the relocation would substantially change the agency's geographic service area. If UHG believes that closures or service reductions are necessary based on changes in

community need, quality/safety concerns, significant financial losses, or other reasons, UHG must apply to OHA for approval at least 60 days before taking any action.

8. Within one year of the order date, UHG must have built the capacity and expertise to provide pediatric hospice services at its Roseburg hospice agency.
9. UHG must not unreasonably favor its own home health agencies over third-party providers that are not affiliated with UHG. This extends to network participation, reimbursement and other contracting terms, prior authorization processes, and health plan member communications or incentives. UHG will be allowed to implement policies or programs designed to increase quality or improve patient outcomes.
10. UHG home health agencies must not unreasonably favor UnitedHealthcare ("UHC") health insurance plans or their members over third-party insurers that are not affiliated with UHG. This extends to network participation, reimbursement and other contracting terms, patient admissions/discharge, and marketing activities. UHG will be allowed to implement policies or programs designed to increase quality or improve patient outcomes.
11. UHG must continue to participate in all public health insurance programs in which Amedisys home health and hospice agencies participated as of the closing date, including Medicare and Medicaid (OHP).
12. UHG must submit an annual compliance report to OHA certifying and substantiating its compliance with all conditions.

OHA will conduct follow-up analyses one year, two years, and five years after the order date to monitor compliance with these conditions and assess the impact of the transaction on health care costs, quality of care, access to care, and health equity in Oregon.

Abbreviations & Terminology

APAC	All Payer All Claims database
CAHPS	Consumer Assessment of Healthcare Providers & Systems
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Plan
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
COPD	Chronic Obstructive Pulmonary Disease
DCBS	Department of Consumer and Business Services
DOJ	Oregon Department of Justice
D-SNP	Dual-Eligible Special Needs Plan
EHR	Electronic Health Record
FTC	Federal Trade Commission
FTE	Full time equivalent
HCMO	Health Care Market Oversight
HHA	Home Health Aide
HHI	Herfindahl-Hirschman Index
LHC	LHC Group, Inc.
LPN	Licensed Practical Nurse
LTSS	Long Term Services and Supports
LVN	Licensed Vocational Nurse
MA	Medicare Advantage
ODOJ	Oregon Department of Justice
OAR	Oregon Administrative Rule
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OMG	Oregon Medical Group
ORS	Oregon Revised Statute
PBM	Pharmacy Benefit Manager
PDGM	Patient-Driven Groupings Model
PSA	Primary service area
RFI	Request for information
RHC	Routine Home Care
RN	Registered Nurse
SEC	U.S. Securities and Exchange Commission
UHC	UnitedHealthcare
UHG	UnitedHealth Group
USDOJ	U.S. Department of Justice

Glossary

Competition: A situation in a market in which firms or sellers independently strive to attract buyers for their products or services by varying prices, product characteristics, promotion strategies, and distribution channels.

Concentration: A measure of the degree of competition in the market; highly concentrated markets are generally characterized by a smaller number of firms and higher market shares for

individual firms. Concentration is typically measured using the Herfindahl-Hirschman Index (HHI); see below.

Consolidation: The combination of two or business units or companies into a single, larger organization. Consolidation may occur through a merger, acquisition, joint venture, affiliation agreement, etc.

Coordinated Care Organization: OHA contracts with coordinated care organizations (CCOs) to provide benefits to people on the Oregon Health Plan. CCOs are locally based organizations that are accountable for the physical, mental, and dental health of the population they serve. CCOs create a network of providers and are governed by a partnership among health care providers and community members.

Health equity: OHA defines health equity as follows:

> Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
>
> - The equitable distribution or redistribution of resources and power; and
> - Recognizing, reconciling, and rectifying historical and contemporary injustices.

Herfindahl-Hirschman Index (HHI): A measure commonly used by federal and state antitrust enforcement agencies to measure market concentration. HHI is calculated as follows:

$$HHI = (S_1^2 + S_2^2 + S_3^2 + \cdots S_n^2)$$

Where S1 is market share (in percentage points) of firm 1 and n is the total number of competitors in the market. By summing the squared values of market shares, the HHI gives greater weight to firms with larger market shares. Transactions occurring in concentrated markets and those involving a significant change in concentration are more likely to have adverse effects on competition and lead to price increases.

Horizontal consolidation: The combination of two companies or organizations that offer similar products or services. In health care, the acquisition of a hospital by a health system or the merger of two physician groups would be considered horizontal consolidation.

Limited liability company: Refers to a basic type of business entity that allows its owners to separate the financial assets and liabilities of the business from personal finances. A limited liability company can have multiple owners, called members, who have the discretion to manage the business's operations and distribute any profits how they choose. A limited liability company is characterized by limited liability, management by members or managers, and limitations on ownership transfer.

Medicaid: Medicaid provides public health insurance coverage for people who meet certain criteria, such as low-income, disability, and/or pregnancy.

Medicare Advantage: Medicare is federal health insurance for older adults and younger people with disabilities or specific illnesses. Medicare Advantage plans are health plans that provide

Medicare Part A and Part B benefits. The federal government contracts with private companies to offer Medicare Advantage plans.

Oregon Health Plan: The Oregon Health Plan (OHP) is Oregon's Medicaid program. OHP provides free health coverage to people who meet income and other requirements.

Professional corporation: Refers to a corporation that provides services of a type that requires a professional license. In Oregon, a professional corporation is organized and regulated under the Oregon Professional Corporations Act. Typically, professional corporations are formed by members of a certain profession, such as doctors, to offer professional services.

Value-based care: refers to how a service is paid for by a health insurance company. Traditionally, health care is paid on a per-service basis (e.g., for a given procedure, the health insurance company pays the doctor a set dollar amount. Value-based care is different because it could include quality metrics or health outcomes as a factor in payment amount. Some value-based care allows for more flexibility and incentives for health care providers to deliver patient-centered, whole person care.

Vertical consolidation: Also referred to as "vertical integration;" the combination of two companies or organizations in different lines of work or operating at different levels of the supply chain. In health care, the acquisition of a physician practice by a hospital or the merger of a health plan with a hospital system would be considered vertical consolidation.

Appendix A: OHA's Review

OHA performed a review of the transaction to assess its potential impact on Oregon's health care delivery system.

Background Research and Literature Review

OHA conducted background research on the entities involved in the transaction to understand more about the transaction, the entities involved, and market trends. OHA consulted publicly available sources, including press releases and media reports; IRS filings; business filings with the Secretary of State in Oregon and other states; entity websites; state agency, professional association, and third-party entity reports; reports commissioned by local, state, and federal government; and other relevant governmental communications.

Requests for Information

In addition to the information provided in the notice, HCMO requested information from the entities to clarify and supplement the notice. The entities responded to these requests by providing narrative responses, as well as data, business documents, presentations, and consultant analyses.

Public Input and Engagement

HCMO solicited public comments to gather input on the transaction throughout the review period. HCMO accepted written comments via email at hcmo.info@oha.oregon.gov, by calling 503-945-6161 to leave a voicemail, or by completing a public comment form. HCMO posted all public comments received to its website.

Outside advisors

OHA engaged Health Management Associates to provide advice on economic analyses to OHA for this transaction.

Analysis

OHA's analysis assessed the likely impact of the transaction on people and communities in Oregon. OHA's analysis followed the guidelines and methods set out in the HCMO Analytic Framework published in January 2022 and updated in May 2025.[135] The framework is grounded in the goals, standards and criteria for transaction review and approval outlined in OAR 409-070-0000 through OAR 409-070-0085.

The table below describes the types of analysis HCMO typically performs in the domains of market share, cost, access, quality, and equity.

Domain	Analysis
Market Share	Market share analyses explore how the transaction may impact the competition and concentration in the market. For this review, OHA looked at the total share of home health and hospice episodes for the entities in Oregon, current market concentration, and how the transaction is likely to impact market shares.
Cost	Analyses under the cost domain explore how the transaction could affect the cost of care, impact on the entities' ability to meet cost growth targets, and the financial condition of the entities. For this review, OHA looked at changes in average payment per episode following UHG's acquisition of LHC. OHA also analyzed potential anti-competitive effects associated with insurer-provider vertical integration. To understand the financial condition of UHG and Amedisys, OHA reviewed publicly available financial reports and additional financial information obtained from the entities.
Access	Analyses in the access domain explore how the transaction may affect the range of services available in the market, types of providers, characteristics of the patient population, and any barriers to access. Consolidation and change of ownership in the health care market can impact the range and type of services offered in the service area. For this review, OHA looked at potential anticompetitive effects related to the transaction, the financial stability of the entities, and operational changes following prior UHG acquisitions.
Quality	Analyses in the quality domain explore how the transaction may affect patient outcomes and the experience of care. Consolidations and ownership changes in health care can impact clinical practice, including staffing ratios, time spent or number of visits with patients, timeliness of care, and the patient's experience of care, all of which can have adverse effects on patient outcomes. Analyses in the quality domain consider current indicators of quality and assess potential impacts of the transaction on quality of care. For this review, OHA looked at LHC and Amedisys quality metrics reported by CMS.
Equity	Analyses in the equity domain explore how the transaction may affect the entity's ability to assess for and equitably meet the needs of the population it serves. Consolidations and ownership changes in health care can disproportionately impact availability of health services for populations who already experience health inequities, including people of color, low-income families, and residents of rural areas. Equity-focused analysis considers the entities' ability to serve a patient population that is representative of the community in which they operate. OHA also looks for evidence that the entity is actively identifying and addressing inequities in access to or quality of care across their patient population.

Appendix B: Data & Methodology

Data Sources

All Payers All Claims (APAC)

The Oregon All Payer All Claims Database (APAC) houses administrative health care data for Oregon's insured populations. It includes medical and pharmacy claims, non-claims payment summaries, member enrollment data, billed premium information and provider information for Oregonians who are insured through certain commercial insurance, Medicaid and Medicare. Information about APAC is available on OHA's website. The APAC study period for this review was based on claims rendered between 2017 and 2023. OHA's analysis is based on claims for services rendered to residents of Oregon based on the state of their home address at the time of service as reported to APAC.

APAC claims data do not capture services for which no claim was generated, which includes services provided under certain types of alternative payment arrangements, e.g. capitation. Therefore, APAC does not reflect all home health and hospice services delivered to people in Oregon at any given time.

American Community Survey (ACS)

The American Community Survey (ACS) is an ongoing, nationwide survey conducted by the US Census Bureau. The survey generates data about a variety of topics like occupation, housing, education and demographics. For this report, OHA used 2022 ACS 5-Year Estimate data. Additional information about the ACS can be found on the US Census website.

CMS Hospice and Home Health Care Compare

The CMS Care Compare tool enables the public to find and compare providers of different types of Medicare services. CMS Care Compare aggregates quality measures used across the Center including clinical process measures, patient outcome measures, and patient/caregiver satisfaction measures. For this report, OHA used the 2024 third quarter Care Compare data for home health and hospice which can be accessed as archives on the CMS provider data website.

Home Health and Hospice Claims Analysis

Claims Identification

OHA's identification of home health PSA and analysis of market share and HHI are based on home health agency and home hospice claims data from APAC. To find relevant claims for these uses, OHA utilized bill type codes for home health and for home hospice. All analyses in this report are based on claims incurred by Oregon residents and rendered by or billed to Oregon providers.

Episode Definition

OHA's PSA and market analyses use 'episodes' of home health and home hospice care for the unit of measurement. Instances of home health or home hospice care are considered one episode if the same home hospice or home health agency provides care to the same patient for any time period without a gap in care longer than 60 days. Instances of care with gaps longer than 60 days are considered separate episodes.

Primary Service Area Analysis

To define the Primary Service Area (PSA) for this transaction, OHA followed four steps:

1. Summarize the claims rendered by or billed to the provider(s) involved in the transaction during the study period by patient zip code and episode count. OHA uses National Provider Identifiers (NPIs) to identify relevant claims for each provider in the transaction. OHA typically defines a transaction PSA using the claims rendered by or billed to the provider(s) being acquired.
2. Rank the patient zip codes in descending order of episode count (volume).
3. Identify contiguous zip codes that account for at least 75% of the provider's total episodes. This identifies the contiguous, volume-driven PSA.
    a. To do this, OHA starts with the provider's office zip code and adds other zip codes to the map based on volume rank only if they are contiguous to the provider's office zip code. When an NPI is associated with more than one address, OHA uses the zip code of the primary practice address listed for the NPI in the NPPES NPI Registry as the starting zip code.
    b. Zip codes that are not immediately contiguous with the provider's office location may be permanently excluded from the PSA or only temporarily excluded until interim zip codes are added that fill in the geographical gap. Adding a new zip code that then pulls in previously excluded zip codes can result in a PSA volume over 75%.
4. Add zip codes that are fully encompassed by the zip codes identified in step 3. This may result in a PSA volume over 75%.

Market Share and Concentration Analysis

Consolidation, or concentration, is a measure of the degree of competition in a market; highly concentrated markets are generally characterized by a smaller number of firms and higher market shares for individual firms. When a transaction involves health care entities offering similar products or services (a "horizontal" transaction), the level of concentration in the market and the change in concentration resulting from the transaction is useful as an initial screen for potential anticompetitive effects.

OHA measured market concentration using the Herfindahl-Hirschman Index (HHI), a measure commonly used by federal and state antitrust enforcement agencies.

HHI is calculated as follows:

$$HHI = (S_1^2 + S_2^2 + S_3^2 + \cdots S_n^2)$$

Where S_1 is market share (in percentage points) of firm 1 and n is the total number of competitors in the market. By summing the squared values of market shares, the HHI gives greater weight to firms with larger market shares. The unit of measurement for each firm's market share may be the number of products sold or services rendered, or the associated dollar revenues. For this analysis, OHA used APAC claims to measure market shares as each provider's percentage of total home health or hospice episodes rendered in 2017-2023 by Oregon providers to Oregon residents.

OHA's methodology for calculating market shares differed from that underlying the USDOJ 's antitrust lawsuit.[136] Based on OHA's reading of the USDOJ's complaint, federal investigators' market share analysis relied on Medicare claims data only and used dollar payments or revenues (as opposed to episodes) as the unit of measurement. The market shares and HHIs presented in this report are therefore not directly comparable to those presented in the USDOJ's complaint.

Transactions occurring in concentrated markets and those involving a significant change in concentration are more likely to have adverse effects on competition and lead to price increases. OHA uses the HHI thresholds specified in the U.S. Department of Justice and Federal Trade

Commission Horizontal Merger Guidelines to determine whether a transaction can be presumed to have anti-competitive effects. These thresholds are summarized in the table below.[137]

HHI Thresholds for Presumed Anti-Competitive Effects:

Indicator	Threshold for Presumed Anti-Competitive Effects
HHI change	HHI increase of more than 100
	AND:
Post-merger HHI	HHI greater than 1,800
	OR
Merged firm's market share	Market share exceeds 30%

Given limitations in the APAC data used for market share calculations, home health and hospice services paid for through alternative payment arrangements such as capitation-based reimbursement models are not fully captured in OHA's analysis. To the extent that some providers rely more on alternative payment arrangements than others, market shares may be under- or overstated.

Updates and refinements to preliminary review analysis

During comprehensive review, OHA updated and refined its preliminary review analysis of market shares and concentration/HHI as follows:

- Whereas the preliminary review analysis incorporated claims for the period 2017-2022, the comprehensive review also included claims for 2023.
- OHA's comprehensive review analysis included denied claims; these were excluded from the preliminary analysis due to time constraints.
- OHA conducted further research into the parent ownership of each provider location and aggregated services provided by different hospice and home health agencies owned by the same parent company.

Appendix C: Home Health & Hospice

What is home health?

Home health care includes a range of services to treat an illness, injury, or medical condition that are provided in a patient's place of residence. Services include skilled nursing care (such as medication management, pain management, injections or intravenous treatments, wound care and post-operative care), physical therapy, occupational therapy, speech therapy, and non-medical services such as social services or assistance with daily living.

Eligibility requirements for home health vary depending on insurance type. For Medicare, enrollees must need intermittent skilled care for an illness or injury and be "homebound," meaning they cannot leave their residence without considerable help. Patients in assisted living facilities (e.g., group homes and personal care homes) also qualify for home health.

Home health & skilled nursing

The term "home health" is often used interchangeably with "skilled nursing care." While both offer similar services delivered by similar providers, there are some important distinctions:

Home health refers to medical and non-medical care provided in a person's home (or place of residence) to treat an illness, medical condition, or injury. Services may aim to improve or maintain the patient's condition, maintain functionality, build self-sufficiency, or slow decline.

Skilled nursing refers to skilled medical care (for example, intravenous injections) provided by licensed health professionals, such as doctors, registered nurses, or physical therapists. Services may be provided a hospital, skilled nursing facility, nursing home, or in the home (in which case they are also considered "home health" care).

Who provides home health care?

CMS certifies home health agencies for all states and territories. In order to receive payment from Medicare, the agency must demonstrate they are in full compliance with Medicare quality and safety requirements. The accreditation is accomplished through an onsite survey with a CMS approved accreditation organization.[138] Home health agencies operating in Oregon must also be licensed by the state of Oregon. Home health agencies are surveyed no less frequently than every three years. During a survey the licensing team may investigate a complaint, recertify the agency, relicense the agency, or do initial license or certification surveys. In Oregon, home health agencies are only licensed to serve patients within a 60-mile radius from their office location.[139] There are currently no clinical staffing requirements for home health agencies in Oregon that dictate the number of patients nurses, home health aides, or other clinical staff see.

Home health agencies may be for-profit, or non-profit companies. Licensing requirements are the same for non-profit and for-profit agencies. Research has shown there are quality and cost differences between for-profit and non-profit agencies. Non-profit home health agencies generally had better quality metrics compared to for-profit agencies. For-profit companies also had significantly higher costs and profits compared to non-profits.[140] Home health agencies hire licensed medical professionals such as nurses, licensed professional (or vocational) nurses (LPN/LVN), home health aides, physical therapists, occupational therapists, speech pathologists, and other clinical staff to care for patients.

How do payments work for home health care?

Medicare currently pays for most home health care services nationwide, and there are two options for individuals eligible for Medicare: Original Medicare and Medicare Advantage. In 2022, 55% of individuals in Oregon eligible for Medicare were enrolled in a Medicare Advantage plan.[141] Medicare Advantage plans pay for home health care services differently than Original Medicare.

Original Medicare

Home Health services are covered under Medicare Part A.[142] Patients enrolled in Original Medicare do not have copayments or payments towards a deductible for home health services. Home health agencies receive payment from the federal government. To obtain payment from Original Medicare, home health agencies must submit a certification by a physician or other clinician that the patient is eligible for home health care along with an assessment of the patient's condition and service needs. The certification is valid for 60 days, after which another assessment is required. There is no limit to the number of continuous 60-day certifications for home health eligible patients.

Original Medicare currently reimburses home health providers according to the Patient-Driven Groupings Model (PDGM), which went into effect on January 1, 2020. CMS determines a national base payment rate, updated annually, for each 30-day period of care.[18] For 2025, the base rate was set to $2,057.[143] Under the PDGM, payments are adjusted based on patient severity (case mix) and geographic differences in wages.[19] To adjust for case-mix, each 30-day period of care is placed into different subgroups based on admission source (community vs. institutional), timing of the 30-day period, clinical grouping (based on principal diagnosis), and degree of patient comorbidity. Agencies may receive extra ("outlier") payment for patients requiring unusually costly care.

Under the PDGM, institutional admissions to home health are reimbursed at a higher rate by CMS, because they tend to be more resource intensive. To qualify as an institutional referral, the patient must have been discharged from a facility (acute care hospital, inpatient psychiatric facility, skilled nursing facility, inpatient rehabilitation facility, or long-term care home) in the 14 days preceding the admission.

Medicare Advantage

Medicare Advantage (MA) plans differ from Original Medicare, because MA plans encompass all benefits of Medicare into one plan, and generally include benefits that Original Medicare do not, such as vision and dental coverage.[144] MA plans are generally administered by health insurance companies and can have lower premiums for patients compared to Original Medicare. MA premiums cost less than Original Medicare, because these plans may require copays, limit the networks of providers patients can see, and require prior authorization for services. MA plans have more flexibility in limiting costs by requiring prior authorization, frequent recertifications for home health patients, constraining the number of home health visits, or limiting the length of the home health stay.[145] Depending on their plan, MA patients may be required to make copayments for home health services.

[18] 30-day periods of care that do not meet a threshold number of visits are paid on a per-visit basis for the discipline providing care.
[19] Prior to 2020, the number of in-person therapy visits provided during the period of care was also factored into the payment adjustment.

Unlike Original Medicare, home health providers negotiate with MA plans to determine payment amounts. These payment amounts, however, are constrained by the fact that MA plans receive funding from the federal government at predetermined rates. CMS pays MA plans at a capped annual amount equal to the amount of health care that seniors with similar health conditions consume each year. MA plans make money by keeping the costs of care below the average amount. MA plans receive a higher annual rate for patients with chronic conditions or other conditions that are generally more expensive to care for.[146]

What is hospice?

Hospice services focus on comfort and quality of life for people with serious medical conditions who are approaching the end of their lives. Rather than attempting to cure a medical condition or slow its progress, hospice care aims to reduce pain and suffering and provide comfort and support patients and their caregivers.

People covered by Medicare who have a terminal illness and a life expectancy of six months or less are eligible for Medicare's hospice benefit. When a patient opts for hospice care, they stop all curative treatment for their terminal illness and instead receive care intended to relieve pain and provide comfort and support as they near end of life.

Hospice care encompasses a range of supportive services, including physician and nursing services, pain management, physical or occupational therapy, medical social services, spiritual and grief counseling, and home maintenance support. Services align with a plan of care that is designed collaboratively with the patient and caregiver(s).

Hospice services can be provided in a person's home, in other care settings (e.g., skilled nursing or assisted living facilities), in an inpatient hospital, or in a specially designated inpatient hospice facility. As a patient's illness progresses, they may need to transition to or from any of these settings, but the hospice staff can continue to provide supportive care.

Hospice & palliative care

The term "hospice" is often used interchangeably with "palliative care." While both offer similar services delivered by similar providers, there are some important distinctions:

Hospice care focuses on pain relief and comfort at the end of life. Hospice is provided for patients who forgo attempts to cure illness and who are expected to have six months or less to live. Hospice care can take place in home or at a facility.

Palliative care focuses on pain relief and comfort, regardless of life expectancy. Patients may receive palliative care along with treatment intended to cure serious illness. Palliative care can take place in home or at other care locations.

An episode of hospice care begins when a patient elects hospice care and ends when the patient dies, is discharged to another kind of care facility, or opts out of hospice care.

Palliative care is billed and delivered similarly to hospice care and is often offered by licensed hospice facilities but is not limited to patients with a 6-month life expectancy.

Who provides hospice care?

Hospice agencies must meet specific requirements to receive Original Medicare payments from the federal government, as outlined in CMS regulations. The State of Oregon further requires hospice agencies to be licensed under ORS 443.850-443.869. As of July 2024, there were 75 licensed hospice agencies in Oregon. Like home health agencies, hospice agencies are restricted to providing care to patients within a 60-mile radius from their agency office.[147] Hospice agencies need to be certified by CMS that they meet all federal quality and safety guidelines. Hospice

agencies operating in Oregon must also be licensed by the state of Oregon. Hospice agencies are surveyed no less frequently than every three years. During a survey the licensing team may investigate a complaint, recertify the agency, relicense the agency, or do an initial license or certification surveys.[148] There are separate licensing and Medicare certification processes for agencies that provide home health care, but some agencies obtain both licenses and offer both home health and hospice services, given the overlap in types of care and required staff qualifications.

Hospice agencies hire licensed medical professionals including nurses, doctors, nurse practitioners, hospice aides, social workers, counselors, and pastoral care providers to care for patients. Hospice agencies also rely on volunteers to provide services for patients as well including music or pet therapy. There are currently no clinical staffing requirements for hospice agencies in Oregon that limit the number of patients nurses, hospice aides, or other clinical staff see.

Hospice agencies may be for-profit or non-profit companies. Similarly to home health, research has found that for-profit hospice agencies generally score lower than non-profit agencies on quality metrics.[149] Additionally, for-profit hospice companies are more likely to adopt profit-maximizing strategies that jeopardize care quality.[150] For example, hospice companies can reduce the number of visits by a health care professional or use less skilled staff to visit patients (i.e. sending a home hospice aide instead of a nurse).[151] For-profit hospice companies have also been found more likely to admit patients with a longer expected length of stay and patients who require less intensive care, such as dementia patients.[152]As payment is received each day that the patient is in hospice, it is more profitable to enroll patients who are expected to live longer and require less intensive care.[153] Conversely, for-profit hospice companies have a lower enrollment of cancer patients that require more intensive services but have shorter life expectancy.[154]

How do payments work for hospice services?

Original Medicare pays for all hospice services for people eligible for Medicare. MA patients who elect hospice services are transitioned to Original Medicare which pays for any services related to the person's terminal illness. Patients can continue to be enrolled in their MA plan as long as they continue paying their premiums, allowing them access to additional services such as dental and vision benefits.[155] Each year the Centers for Medicare and Medicaid Services (CMS) sets reimbursement rates for hospice services for Original Medicare recipients. Rates are set nationally based on the intensity of services provided and adjusted to account for regional differences in staffing costs. CMS publishes annual wage index adjustments for rural and urban regions across the country.[156]

Original Medicare pays a daily rate for each patient enrolled in hospice care. CMS also sets a per-person cap on annual payments; the cap for fiscal year 2025 is $34,465.[157] The daily rate varies based on level of care and services provided, as shown in the table below.

CMS daily rates for hospice services, 2025

Level of Care	Payment*	Requirements
Routine Home Care	First 60 days (high RHC rate): $224.62 per day Subsequent days (low RHC rate): $176.92 per day	Paid each day patient is in routine hospice care, regardless of service delivery
Continuous Home Care	$67.44 per hour, maximum of $1,618.59 per day	Provided only in crisis to keep patient at home; must deliver 8 hours of services each 24-hour period
Inpatient Respite Care	$518.78 per day	Paid a maximum of consecutive 5 days, additional days paid at RHC rate; patient must be at a certified inpatient hospice facility, hospital, or skilled nursing facility
General Inpatient Care	$1,170.04 per day	Patient must receive care at a certified inpatient hospice facility, hospital, or skilled nursing facility

* FY2025 CMS Hospice Payment rates[158]

With Original Medicare, patients pay a coinsurance (maximum of $5) for drugs received in the home and 5% of inpatient respite care days (taken when caregivers require a rest from ongoing home care).

Patients without Medicare can have hospice services covered by Oregon's Medicaid program or commercial health insurance. Benefit coverage for the patient and reimbursement rates to providers may vary by commercial plan but are likely indexed to the Medicare rate.

The Home Health & Hospice Workforce

Employment trends

As more Americans age and require in home care, the demand for services will outpace the current homecare employment landscape. Oregon has a slightly older population than the US overall, making the projected need for homecare higher. In 2020, the percent of adults 65 or older was 18%, and by 2040 it is projected to increase to 24%.[159] There is currently a shortage of home health nurses and aides, and this shortage is projected to grow over time.[160] These shortages have been exacerbated by high levels of stress and burnout and low pay among home health and hospice workers.[161] (See **Working conditions** below.)

Home health agencies and nursing homes generally compete for nurses.[162] Home health agencies have expressed concern that recruitment and retention of nurses may get more difficult due to recent changes in federal rules that mandate more nursing hours for patients in a nursing home.[163]

In 2018, the vacancy rate for home health/hospices nurses in Oregon was 12.2%, the second highest vacancy rate among nursing specialties behind long-term care.[164] Home health/hospice nurses were among the most experienced nurses in the Oregon workforce. The average home health/hospice nurse has been working as a nurse for 15 years. More experienced nurses move to different settings in various times of their career. Many nurses start in hospital settings and move to an outpatient setting like home health or hospice later in their career. As more experienced nurses

are working in home health and hospice, retirements could further exacerbate the shortage of home health/hospice nurses. The most difficult positions to fill for home health agencies are RNs.[165]

Wages and compensation

Home health and hospice agencies employ Registered Nurses (RNs), Licensed Practical/Vocational Nurses (LPN/LVN), Home Health/Hospice Aides, Physical Therapists, Occupational Therapists, and Social Workers. The table below describes what each profession would do in a home health or hospice setting. RNs, LPNs, and Home Health/Hospice Aides are the most common workers employed by agencies. RNs and LPNs

	Education[166]	Duties[167]	Average home health pay nationwide as of May 2023
Registered Nurse (RN)	Registered nurses complete an education program at a community college, diploma school of nursing, or university, and pass a national licensing exam (NCLEX-RN)	RNs provide essential nursing services including patient assessment and monitoring, administering treatments and medications, educating patients and family members, and coordinating care.	$42.04 per hour[168]
Licensed Practical/Vocational Nurses (LPN/LVN)	LPNs complete 12 to 18 months of education at a community college or vocational/technical school and pass a national certification exam (the NCLEX-PN)	Provide basic nursing care including monitoring vital signs, administering medications, and performing other tsks such as would dressing changes.	$34.22 per hour[169]
Home Health Aides (HHAs)	Many home health aides are Certified Nursing Assistants (CNAs). CNAs licensure requires 75 hours of state-approved training. Not all HHA have a CNA license as not all agencies require it. Some go through a training program.	Provide basic care like supporting activities of daily living such as bathing, dressing, mobilization, toileting, and eating.	$15.44 per hour[170]

Nationally, wages have been increasing since the COVID-19 pandemic, but wages remain low in the home health aide field, leading to increased turnover and workforce shortages.[171] Sign on

bonuses were are common incentive to hire home health staff. The pay at non-profit home health agencies is generally higher than pay at for-profit home health agencies.[172]

Working conditions

Home health and hospice nurses have the second highest turnover rate among nurses at 30.2%, behind long-term care.[173] Based on an assessment of Oregon's workforce from 2023, 83% of nurses reported stress and burnout, with the highest reports coming from nurses practicing in long-term care and hospital settings.[174]

Turnover and inefficiencies in hiring lead to agencies being unable to accept patients and shortages in patient care.[175] In 2023, 63% of agencies in the US turned down referrals to home health because of staffing capacity. Home health staff that are paid in the 75th percentile saw a 35% decrease in turnover rate, leading to better agency staffing and the ability to take on more patients.[176]

For home care workers, including home health and hospice aides, the turnover rate is 64% nationally, with a high percentage occurring in the first 90 days.[177] The high turnover rate can be attributed to low pay, insufficient training, burn out, and insufficient management support and communication.[178] In addition, the injury rate for home care workers is higher than that of the mining, oil and gas industries. Job injuries cause home care workers to miss work at twice the rate of the US labor force overall.[179]

Home care workers are more likely than the average worker to experience labor violations, and labor standards are poorly enforced in the home care industry.[180] Based on a 2009 national study, 83% of non-union home care workers have experienced overtime violations, 90% experienced off-the-clock work violations where they worked outside of their regularly scheduled hours without additional pay, 79% experienced meal break violations where they did not receive adequate time for paid meal breaks, and 18% experienced minimum wage violations.[181]

Workforce demographics

Direct care workers, which include home health and hospice aides, are generally women, people of color, and people living below the federal poverty line. Among direct care workers in Oregon in 2021:

- 8 in 10 are female
- 1 in 3 is a person of color
- 1 in 6 is an immigrant
- 2 in 5 live in households with incomes less than 138% of the Federal Poverty line
- 1 in 3 receive some sort of public food and nutrition assistance
- 1 in 4 is insured by Medicaid, 1 in 8 (3x the statewide average) are uninsured[182]

Oregon's CNAs and LPNs are more racially/ethnically diverse than RNs.[183] 77% of Oregon RNs identify as white compared to 57% of CNAs and 68.3% of LPNs who identify as white.[184] Oregon's home health RNs are generally older and more experienced compared to nurses who work in other settings such as hospitals.[185]

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