Health Care Market Oversight Program
Oregon Health Authority
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Salem, OR 97301-1097

RE: CareOregon/SCAN Merger

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As a Family Nurse Practitioner working for Multnomah County, I have known CareOregon from its inception in 1993 (30 years ago). CareOregon was founded to enhance access to care to local communities. Today, from its own website:

> "We are a nonprofit providing health insurance services to meet the health care needs of low-income Oregonians. We serve about one quarter of Oregon Health Plan members plus members in our Medicare plan.
>
> Our mission is to inspire and partner to create quality and equity in individual and community health. Our vision is healthy communities for all individuals, regardless of income or social factors.
>
> We focus on the total health of our members, not just traditional health care. In teaming up with members, their families and their communities, we help Oregonians live better lives, prevent illness and respond effectively to health issues."

Oregon should not allow over 1 billion dollars and a well performing clinical network to move to out of state management/control. CareOregon manages more than 500,000 Oregon patients. Whether for profit or nonprofit, a move to a multistate company reduces the accountability that an organization has to any one state or even more so to the local community it is supposed to serve.

There is a good chance that a merger with a California based company will disrupt Health Share's (which reports 400,000 patients) mission, vision, values and focus on equity and improvement since Health Share will now be significantly influenced by the out of state company.

From Health Share's website:

> Mission: "We partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual. Oregon is leading on health care transformation and the goal of health equity."

I pose these questions/comments following each of Health Share's Vision beliefs:

- "A healthy community for all." *What will this Oregon community mean to this California organization?*

- “Member voice and experience are at the center of what we do.” *Will the voice of those served in Oregon really matter anymore?*
- “Health equity is achievable and requires deliberate action on our part—this is best done by listening to local communities.” *There is certainly no guarantee of this.*
- “In honoring our commitments”. *This goes against the commitment to local community.*
- “Using continuous improvement is vital to our efforts.” *How much local say will there be in measuring improvements?*
- “In operating transparently and using data to guide our work.” *As information and leadership is swallowed in the larger entity—transparency will be lost.*
- “In working in partnership to maximize our resources.” *There is no way that local partnerships will matter and that resources will be dedicated to Oregon’s communities. Rest assured, the focus will be on the multistate parent company.*

Many unique populations are included in Health Share and CareOregon---tribes, dual eligible (the highest risk Medicaid patients), clinics serving the homeless, clinics serving migrant workers. CareOregon is the dominant delivery system in this market and any change in its governance or financing runs the risk of destabilizing the care of hundreds of thousands of patients. While the rest of the delivery system prioritizes the most profitable patient populations, CareOregon has always stepped up to preserve if not improving health equity, cost, access and quality.

In Erik Hunter’s own words: “We do the work better than anyone else, frankly”. Why would Oregon want to lose this organization to an out of state company? CareOregon’s success makes Oregon a prime target for acquisition and means now is the time for CareOregon executives to monetize that performance for themselves. On the surface, the motivation appears to be a sense on the part of CareOregon that they need to be bigger in order to compete with for profit companies like Centene. In Eric Hunter’s words: ”We have a great relationship with Optum” i.e. United Health Care. So the purported need to be competitive is a false front as CareOregon is already in partnership with the world’s largest insurer. These arrangements NEVER work unless all the executives do well and be assured that is likely happening here. In addition, Mr. Hunter speaks about a “greater scale and geographic reach”. This should make it clear that Oregon will be left behind as in Mr. Hunter’s words: “In the Optum world we’re an afterthought.” Once there is a parent organization, the “CareOregon board” no longer has real meaning as it loses its final authority.

CareOregon should not become a part of the risk that comes with SCAN’s effort to maintain and prosper in a complex environment. SCAN primarily focuses on Medicare Advantage plans---perhaps once a solid strategy given their profitability but their future remains uncertain. Multiple well established MA plans have been notified of CMS concerns that there are problems with population risk reports they have submitted. And many advocacy groups have expressed concern that MA plans succeed because of the marketing and sales strategies they employ. Overall, the Medicare fund is at the time when adjustments are needed by Congress. Given the profitability of Medicare Advantage it is not surprising to see health delivery systems seek out a preferred MA plan. But the risks are substantial in the near term that the federal government may make adjustments that would affect profitability. MA profitability has largely been driven by clever reporting and selection. That approach is not consistent with improving health equity. In addition, hospitals in Oregon are stopping accepting Medicare Advantage and efforts in Oregon are in full swing to but dollars into the healthcare needs of communities and individuals and not profits.

Oregon has seen many health mergers and acquisitions that resulted in key decision-making processes occurring out of state. The weight of the evidence is that such mergers or acquisitions do not result in positive changes when it comes to costs, health equity, access or quality. We have repeatedly seen the importance of key decisions being influenced or made at community levels or regional levels. Health care is local. This transaction heads in the opposite direction.

CareOregon is funded primarily by state of Oregon based Medicaid programs and during that time has accumulated over 1 billion dollars in assets. Those assets are the community's assets that must remain under community control and available for CareOregon's members as conditions change with the federal government ending from the Public Health emergency. Oregon faces a major shift in resources due to the end of the public health emergency. These are the kind of times where CareOregon has led the way in the past. CareOregon's reserves are likely to be needed. Oregon should not risk the progress made by the dominant delivery system in the Portland Metropolitan Medicaid market. The statute calls for the state to evaluate the impact on health equity, cost, access and quality. Given all the factors above, it is more likely these 4 areas will decline if this transaction goes forward. Oregon has too much at risk here. CareOregon is a remarkable organization that has thrived in a difficult market and become the dominant delivery system for good reason. Oregon should not engage in any transaction that might threaten this success.

There is no evidence to support statewide priorities and HCMO responsibility: "Ensure that health care consolidation in Oregon supports statewide goals related to health equity, lower costs, increased access, and better quality."

And finally, as of last November, Oregonians have a constitutional right of access to affordable health care, this transaction will strongly impede Oregon's requirement to deliver this to those living here.

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