I. CONSIDERATION AND APPROVAL OF THE SCAN TRANSACTION BY THE CO BOARD.

INQUIRY I.9: Produce all board minutes, agendas, materials distributed to the CO Board, analyses prepared by the CO Board, CareOregon or its advisors, emails or other correspondence among CO Board members or with members of management concerning the SCAN Transaction or alternatives to the SCAN Transaction.

INQUIRY I.10.a and b: The parties responded to this inquiry in the letter dated July 5, 2023 (the "July 5th Response Letter").

c. Produce any analyses, correspondence or documents evidencing the CO Board's consideration of the CO Corporate Purpose and how the SCAN Transaction fulfills it.

d. Produce the materials claimed to be proprietary in Inquiry 9 in our letter dated January 30, 2023.

[redacted]

INQUIRY I.14: Produce copies of the Hart-Scott-Rodino filing and the California Department of Managed Health Care filing.

[redacted]

INQUIRY II.1.e: Produce all CO Board minutes and internal communications concerning the establishment of the CO Foundation by CareOregon prior to the proposal of the SCAN Transaction and in connection with the proposal and approval of the SCAN Transaction.

[redacted]

INQUIRY V.B.3:

a. The parties responded to this inquiry in the July 5th Response Letter.

b. The spreading of costs over a larger membership. Produce any analyses, reports or other documents that explain and quantify the increased membership over which costs would be spread, the incremental costs of servicing the increase in membership, the benefits to CareOregon of spreading costs over the increased membership, and the types of costs contemplated.

   Response: This affiliation is not motivated by cost synergies. Nonetheless, in August 2021, PricewaterhouseCoopers (PwC) estimated that the base administrative spend for HealthRight could be 2-7% lower than our separate administrative costs. See Exhibit D of the July 5th Response Letter. Houlihan Lokey produced financial projections that incorporated projections of both membership and overall administrative costs for the combined HealthRight organization. See Exhibit E of the July 5th Response Letter.

   As noted in response to Inquiry V.A.4 in the July 5th Response Letter, we have not conducted analyses to quantify cost impacts related to membership under HealthRight. Much of this type of analysis would require sharing of cost and other contract details that is not permitted prior to closing. Please also see our response to Inquiry V.A.3 in the July 5th Response Letter for a description of the savings that the parties would expect if the combined entity pursued a Customer Relationship Management (CRM) system.

c. Implementing the access and complex care platform.

Response: CareOregon and SCAN have discussed our shared belief that by working together we can do more for our members. We believe having a more robust complex care program that incorporates whole person demographic information and supports a more complete view of an individual's care would support our ability to identify member needs and mitigate disparities in care. We have not yet developed specific proposals for an access and complex care platform; however, we have had high level conversations about our desire to build on our collective strengths to develop or improve programs in Oregon.

Please see Exhibit K to the July 5th Response Letter, which illustrates our approach to integration as well as the functional areas that we identified as potentially benefiting from integration.

CareOregon and SCAN anticipate that we will develop, expand or improve programs in Oregon and elsewhere, but have not yet developed specific proposals, associated timelines or projections for costs, financing, benefits or populations served. In our current work we focus on populations with high levels of need and those that have been ill-served by the health care system overall. We anticipate that we will continue to build programs and improve services for these populations, including those with complex comorbidities, including mental health and substance use disorder, in addition to members facing social barriers to care.

d. Independence at Home

Response: Independence at Home (IAH) is the community benefit arm of SCAN Health Plan of California that provides vitally needed services and support to seniors and their caregivers. Recent studies show that an increasing amount of health care services are being delivered in the home and while CareOregon and SCAN have not discussed how to draw on the success of SCAN's Independence at Home programs or developed any proposals for changing or expanding the programs into Oregon, the parties have identified these types of programs as an area for future consideration. We have not discussed making any changes to CareOregon's charitable giving or other community benefit programs.

e. Healthcare in Action

Response: CareOregon and SCAN have not specifically discussed how to draw on the success of SCAN's Healthcare in Action, developed any proposals for expanding Healthcare in Action into Oregon, or considered how to build Oregon-specific programs based on learnings from Healthcare in Action's provision of direct medical care to patients experiencing homelessness in California.

However, homelessness is a recognized issue in Oregon and implementing some form of "street medicine" could benefit many of the over 6,400 Oregonians experiencing homelessness, including those who are CareOregon members, OHP members of other

CCOs, and non-covered Oregonians. Benefits could include improved access to care and health outcomes for homeless individuals and reduced costs for payers. The Providence Center for Outcomes Research and Education (CORE) used Medicaid claims data to determine:[1]

- Health systems costs dropped 12 percent overall for individuals who entered affordable housing. Costs were reduced for all populations, including families, individuals in permanent supportive housing, and seniors and people with disabilities.
- Site of care shifted for newly housed individuals, with primary care use increasing by 20 percent and emergency department visits dropping 18 percent.
- Residents reported that access to care and quality of care improved once they were housed.
- Health care services integrated into housing was a driver of lower health care costs and decreased use of emergency department services.

In another CORE study, recuperative and recovery housing were associated with reduced inpatient readmissions and increased use of primary care for Portland-metro area Medicaid populations recovering from substance use disorders.[2]

f. MyPlace Health

Response. As discussed in response to Inquiry V.B.3.a, CareOregon became aware of a potential PACE opportunity in January 2022, when DHS indicated that it planned to release an RFP. Over the next few months, CareOregon met with several PACE entities, including myPlace Health (SCAN's joint venture with Commonwealth Care Alliance).

The first step for implementing a PACE program is to respond to a DHS RFP. DHS has not indicated a date for the release of this RFP, so CareOregon has been planning ahead of such a release with the goal of being prepared to respond whenever the RFP becomes available. DHS has also not yet released timeframes for interested parties to respond or for DHS to review responses, negotiate with selected entities or for the time between contracting and enrolling members in a PACE entity. We anticipate that it will take 18-24 months from contracting with DHS to serving the first PACE members.

The base case pro forma for a myPlace administered PACE program in Oregon, which includes cost and expense projections, were attached as Exhibit E to the

[1] https://www.enterprisecommunity.org/sites/default/files/2021-06/Health%20in%20Housing%20Exploring%20the%20Intersection%20between%20Housing%20and%20Healthcare.pdf

[2] https://blog.providence.org/center-for-outcomes-research-education/core-study-shows-benefits-of-major-local-housing-for-health-initiative

response letter dated May 23, 2023. We expect this program to directly benefit Oregonians who are age 55 or older, living in a PACE service area and certified by the state to need a nursing home level of care.

DHS has indicated that it will not entertain proposals for PACE in areas that already have a PACE entity. Two of our three regions (the three-county Portland metropolitan area and Jackson County) are already served by PACE and our third region (Columbia/Clatsop/Tillamook Counties) does not have the density of population to support a PACE at this time. Given this, we chose to investigate locations not currently in our service areas that would benefit from PACE access.

Providing a comprehensive suite of services to members with complex needs is consistent with CareOregon's mission. In addition to directly serving high need individuals in a new geography, we see this as a means to bolster a longer-term argument that our model would benefit PACE eligibles in the Portland Metro area. Depending on CareOregon's ownership stake, we will benefit proportionally as the PACE entity is financially successful.

g. The Residentialist Group

Response: The Residentialist Group was acquired by SCAN and renamed Homebase Medical in 2022. Homebase Medical provides palliative care, chronic disease management, care transition management, and in-depth personal health assessments to people in their homes. CareOregon owns Housecall Providers, which provides primary care, advanced illness care and hospice services in patients' homes, residential settings and adult care homes. CareOregon and SCAN have not discussed combining these entities or bringing Homebase Medical into Oregon.

CareOregon and SCAN are not anticipating bringing Homebase Medical to Oregon. The CareOregon-owned Housecall Providers currently provides in-home care to adults living in the Portland-metro area (Clackamas, Multnomah and Washington counties) who have difficulty accessing care due to complex medical conditions. Housecall Providers currently serves an average of 1,785 Oregonians at a time (average daily censuses: 1,510 in home-based primary care; 130 in home-based advance illness palliative care; 125 in home-based hospice). The average participant is in their mid-70s, although we serve individuals from age 19 to 110. Approximately 32 percent of Housecall Providers patients are CareOregon members (63% of those are dual Medicare-Medicaid members, while the other 37% are Medicaid-only members). Housecall Providers also sees other Medicare members, including those in fee-for-service and individuals enrolled in non-CareOregon Medicare Advantage plans.

h. Value based payment methodologies

Response: Value-based care is a critical tool for working with providers to establish meaningful quality and cost controls. SCAN has a long history working with their

network on value-based care metrics and management, which could enhance CareOregon's ability to empower our network partners to serve our membership. CareOregon and SCAN have identified value-based payment methodologies as a potential area of future collaboration. However, it would be premature to have discussions regarding the development or implementation of specific value-based payment methodologies in Oregon or elsewhere, as the integration work is still in its preliminary phases.

i. Health equity programs and initiatives

Response: While CareOregon and SCAN have not jointly established any specific programs or initiatives related to health equity matters, health equity is very important to each organization. Even as separate organizations, CareOregon and SCAN have together taken action to respond to the issues facing low-income consumers. In June, both CareOregon and SCAN made grants to RIP Medical Debt, a national nonprofit that acquires medical debts belonging to people who are financially burdened and then abolishes those debts. All the recipients of the debt relief have a household income at or below 400% of federal poverty guidelines or have medical debt representing 5% or more of their annual household income. SCAN's grant to RIP Medical Debt was in the amount of $285,000 and CareOregon's grant to RIP Medical Debt was $60,000, and the organizations designated their funding to abolishing medical debt in the geographies that each organization respectively serves. RIP Medical Debt used the grants from CareOregon and SCAN to purchase and abolish $110 million in medical debt that previously burdened nearly 70,000 people across Arizona, California, Nevada, Oregon and Texas. CareOregon and SCAN's joint grants to RIP Medical Debt is an example of the type of work that the organizations will seek to do together under HealthRight as part of their shared commitment to health equity and to removing barriers that prevent people from accessing healthcare.

j. IT system integration for human resources, financial planning and budgeting

Response:
*HR***:** CareOregon and SCAN have agreed to move to a centralized human resources function with a single human resources information system (HRIS) for all parts of HealthRight Group. CareOregon and SCAN plan to begin operating on a single HRIS by January 1, 2025. We have not developed cost projections or financing details, as we are not in a position to exchange pricing information prior to the close of the transaction. Implementing an HRIS for HealthRight will not impact medical expenses for any of our lines of business. CareOregon and SCAN anticipate that any system changes will benefit their collective employees, as well as result in administrative cost savings.

*Finance/Budget***:** We have had high level conversations about financial planning and budgeting technology needs but have not yet developed specific proposals, associated timelines or projections for costs, financing, benefits or populations served.

k. Customer relationship management platform

Response: Please see our response to Inquiry V.A.3 in the July 5th Response Letter.

l. New investments in health care delivery and supports that will allow CareOregon to serve more Oregonians in underserved geographies and/or populations.

Response: Other than PACE, which is discussed in subsection (a), CareOregon and SCAN have not made decisions related to new investments in health care delivery or supports under the HealthRight Group banner.
Timeline Projection

m. Any other programs or plans to invest significant funds in Oregon to continue and expand upon the missions of CareOregon and HealthRight and promote access to quality health care, improve health outcomes and health equity in Oregon.

Response: Please see response Inquiry V.B.1 of the July 5th Response Letter.

INQUIRY VI.12: Provide the schedules to the Affiliation Agreement, which you have withheld on the basis that they are "confidential and proprietary."

[redacted]

INQUIRY VI.13: Inquiry 10 in our letter dated March 9, 2023, pertained to the broad risk management processes maintained by both SCAN and CareOregon/HPCO, not the limited information disclosed in the Form F filings.

a. Please advise us if the Parties plan to consolidate risk-management processes, or manage risks separately.

Response: The parties intend to consolidate enterprise risk management (ERM) programs at the HealthRight level. At this time, the parties have agreed that there will be a Chief Risk Officer (CRO) at HealthRight and that separate compliance officers will be appointed for the Medicare and Medicaid lines of business The Medicaid compliance officer will serve as the compliance officer for both CareOregon's CCOs. The parties have further agreed that selected enterprise risk management activities such as Internal Audit, Special Investigations related to fraud, waste, and abuse, and Information Privacy will be managed as shared services within HealthRight. The compliance officers will operate in a matrixed management structure with accountability to both the CRO and to the Presidents of the Medicare and Medicaid divisions. They will be responsible for their respective compliance programs and attendant staff within their respective business lines and will act as liaisons to the shared ERM functions at HealthRight.

b. Where will the Chief Risk Officer(s) reside?

Response: The CRO will be an employee of HealthRight.

b. Which Boards will be responsible for overseeing risk management?

Response: The Audit Committee of the HealthRight board of directors will be ultimately responsible for overseeing risk management, with appropriate delegation of selected oversight responsibilities to the governing boards of CareOregon, the CCOs, or other subsidiary business units, as required. The CO Board will receive regular reports from the HealthRight CRO, Medicaid compliance officer and/or their respective designees on the risk management program and oversight of CareOregon and the CCOs.

d. What will the scope of their responsibilities be?

Response: The Audit Committee of the HealthRight board of directors will be responsible for overseeing the organization's risk management programs and ensuring that such programs address and manage the full scope of strategic, financial, operational, and compliance risks relevant to the work of HealthRight and its subsidiaries. The Audit Committee will delegate certain of its responsibilities to the CO Board, CCO boards, or other subsidiary boards as is appropriate and/or required to assure good governance and full compliance with all laws and regulations.