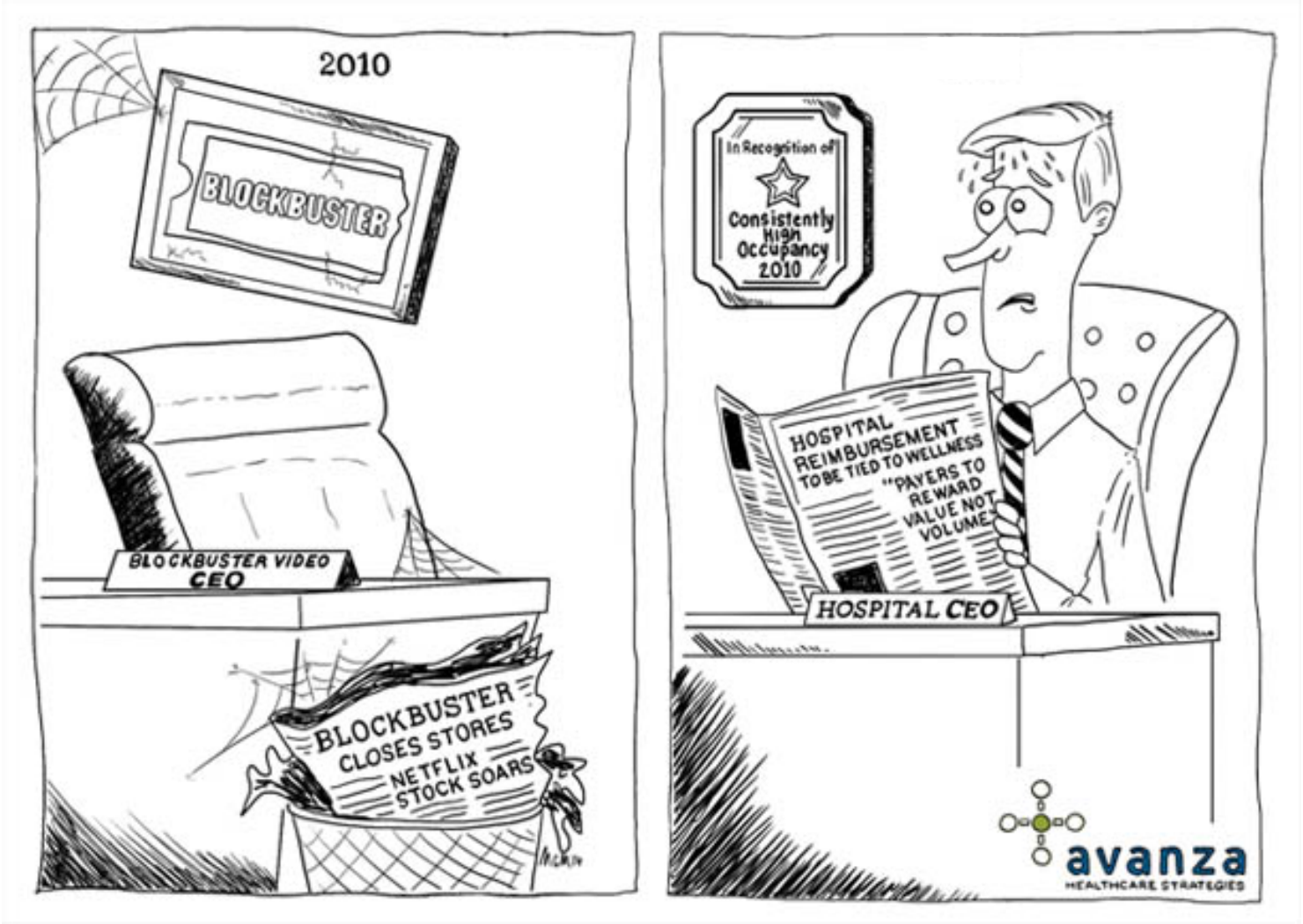
American Hospital Association™

Advancing Health in America

AHA Events

Can a Rural Community Be Financially Successful in Value-Based Care?

Paul R. Stewart, MHSA
President and CEO
Sky Lakes Medical Center
Klamath Falls, Oregon

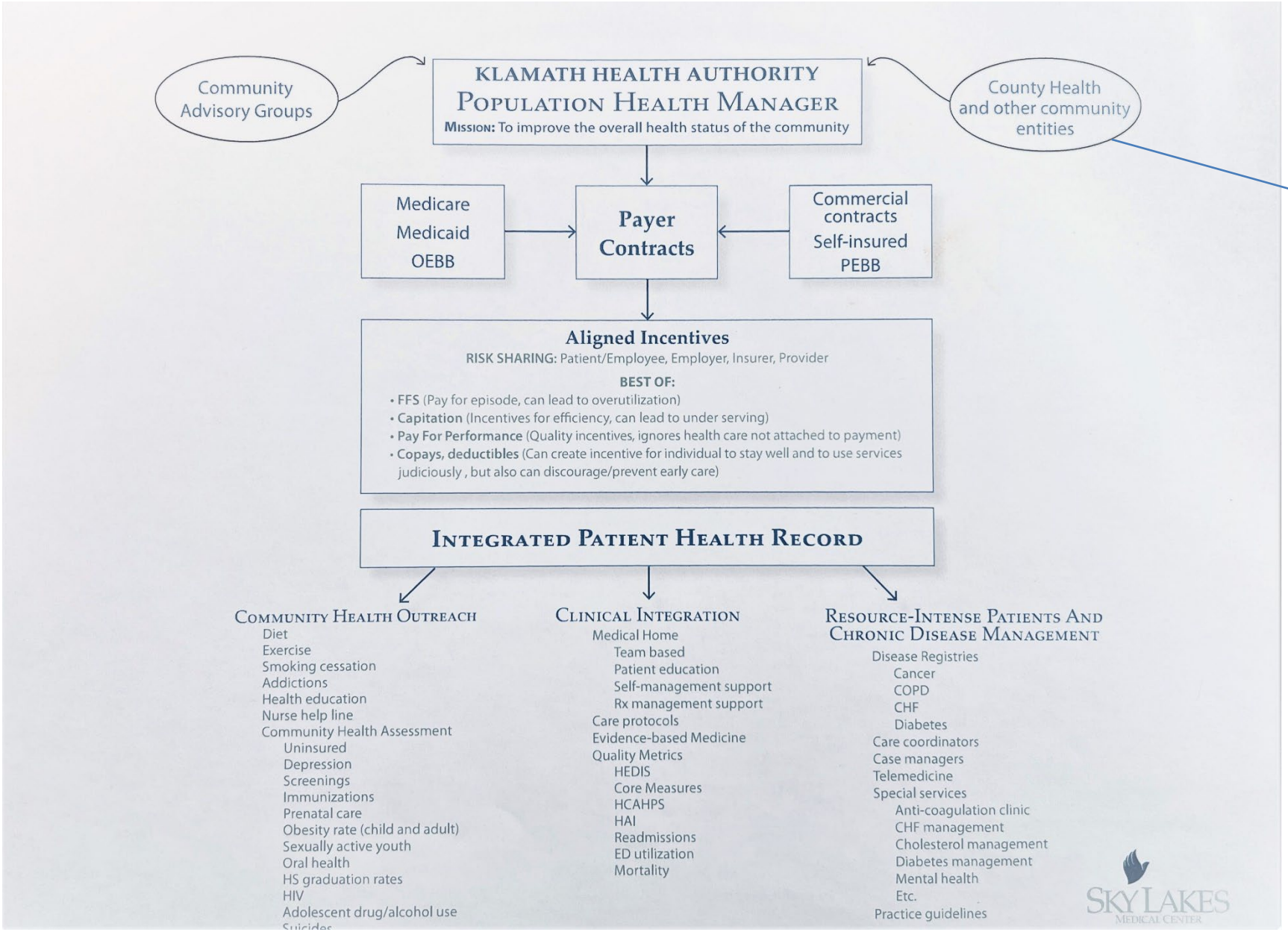

2010
BLOCKBUSTER
BLOCKBUSTER VIDEO CEO
BLOCKBUSTER CLOSES STORES
NETFLIX STOCK SOARS
In Recognition of
Consistently High Occupancy 2010
HOSPITAL REIMBURSEMENT TO BE TIED TO WELLNESS
"PAYERS TO REWARD VALUE NOT VOLUME"
HOSPITAL CEO
avanza
HEALTHCARE STRATEGIES


BUT WHY ARE OUR HEALTH CARE COSTS HIGHER THAN OTHER COUNTRIES?..
...WHO SAID THAT?..
USA
SUPER GULP
WHAT PANDEMONIUM
Newsday


SMOKING
DIET
PHYSICAL ACTIVITY
ALCOHOL

Patient Engagement in Healthy Behavior

- Poverty leads to
  - higher rates of smoking and alcohol use
  - Poor dietary choices
  - Lack of exercise
- Medicaid programs have no cost sharing
  - No skin in the game to manage health
  - And make wise choices



Includes HEALTHY KLAMATH – A Blue Zones Certified Community:

- Blue Zones Project
- Homeless shelter
- Sobering station
- Non-emergent medical transportation
- Klamath Works - Employment/Work training programs
- High School graduation initiatives
- Food banks
- Parks, recreation, youth programs
- Etc.

VALUE BASED CARE

What is it?

A new way forward – a structure in which **provider payments** reflect the quality of care and outcomes for members rather than the traditional fee for service payments (based on volume).

THE BALANCE OF COST, ACCESS, AND OUTCOMES

Value-Based Payments Objectives

- Rewards patient-centered, high-quality care.
- Incentivizes excellent health plan and system performance.
- Ensures consideration of health disparities and members with complex needs.
- Supports the triple aim of better care, better health and lower healthcare costs.

Key Principles

APM/VBP Framework–Summary of Key Principles

1

Empower Patients to be Partners

Changing providers' financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in health care transformation.

2

Shift to Population-Based Payments

The goal is to shift U.S. health care spending significantly toward population-based payments.

3

Incentives Should Reach Providers

Value-based incentives should ideally reach the providers who deliver care.

4

Payment Models & Quality

Payment models that do not take quality into account will be classified within the appropriate category and marked with an "N" to indicate "No Quality" and will not count as progress toward payment reform.

5

Motivate Providers

Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6

Dominant Form of Payment

APMs will be classified according to the dominant form of payment, when more than one type of payment is used.

7

Examples in the Framework

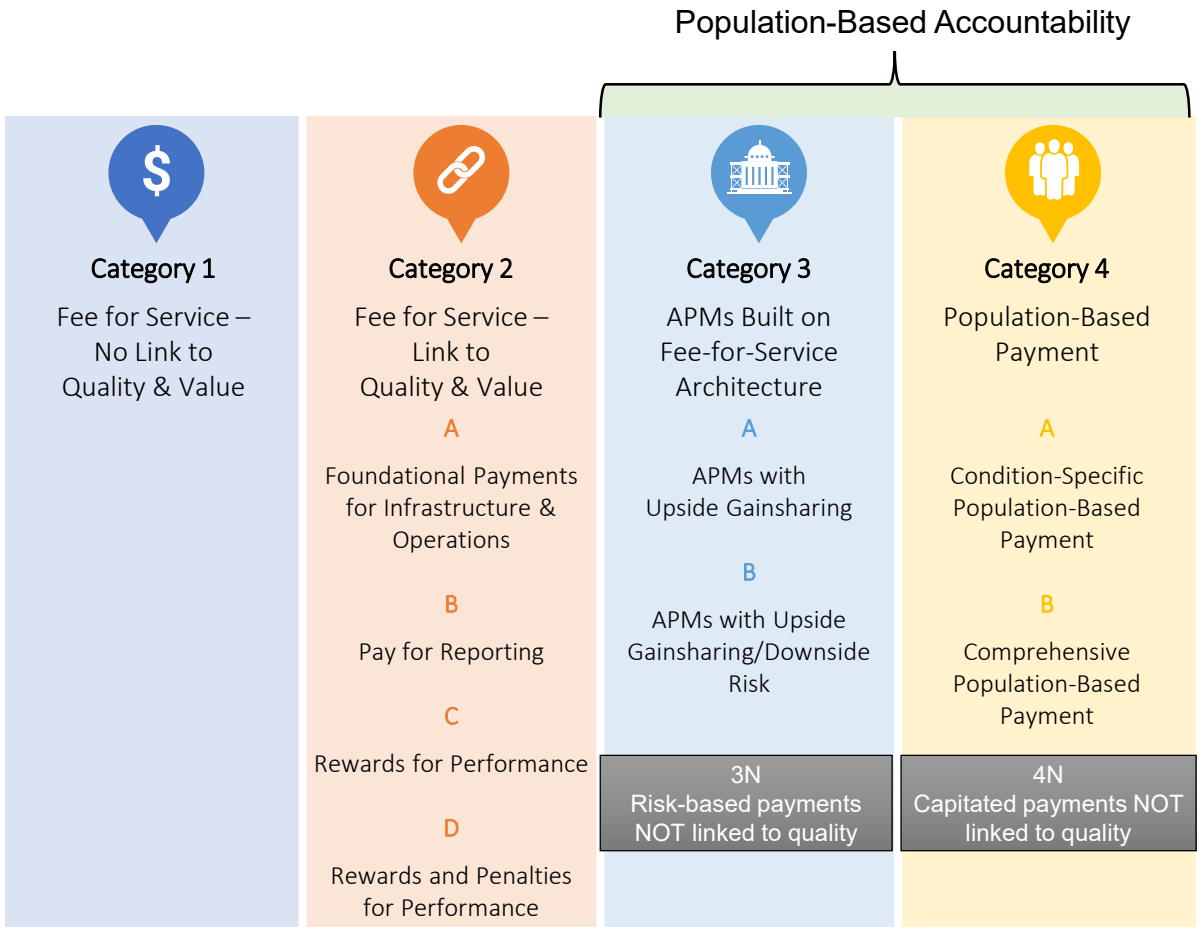
Centers of Excellence, Accountable Care Organizations, and Patient-Centered Medical Homes are examples in the Framework, rather than categories, because they are delivery systems that can be applied to and supported by a variety of payment models.

APM/VBP Framework

- At-a-Glance

The Framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- Serves as the foundation for generating evidence about what works and lessons learned
- Provides a road map for payment reform capable of supporting the delivery of person-centered care
- Acts as a "gauge" for measuring progress toward adoption of alternative payment models
- Establishes a common nomenclature and a set of conventions that will facilitate discussions within and across stakeholder communities

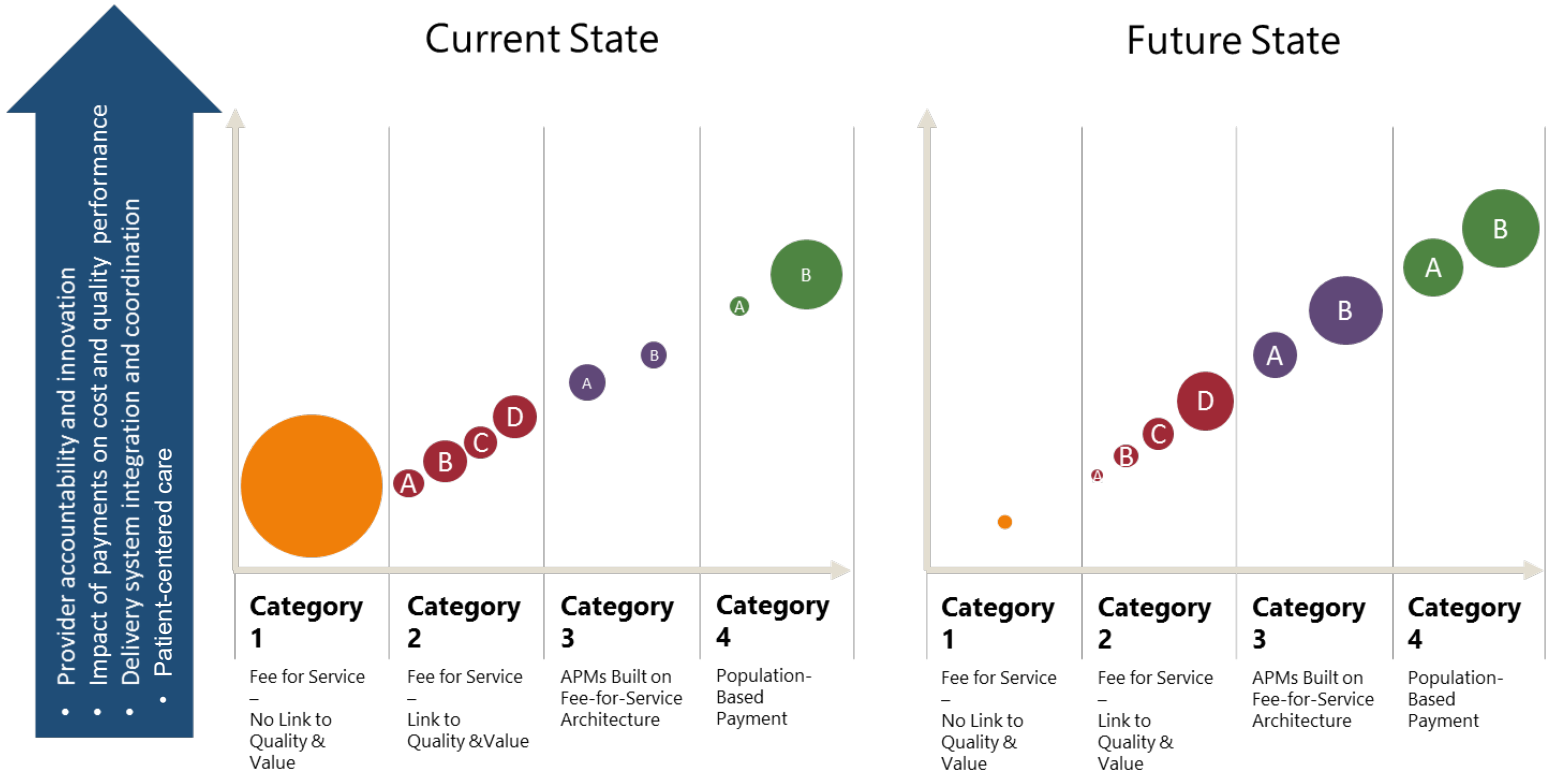


The framework situates existing and potential APMs into a series of categories.

N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

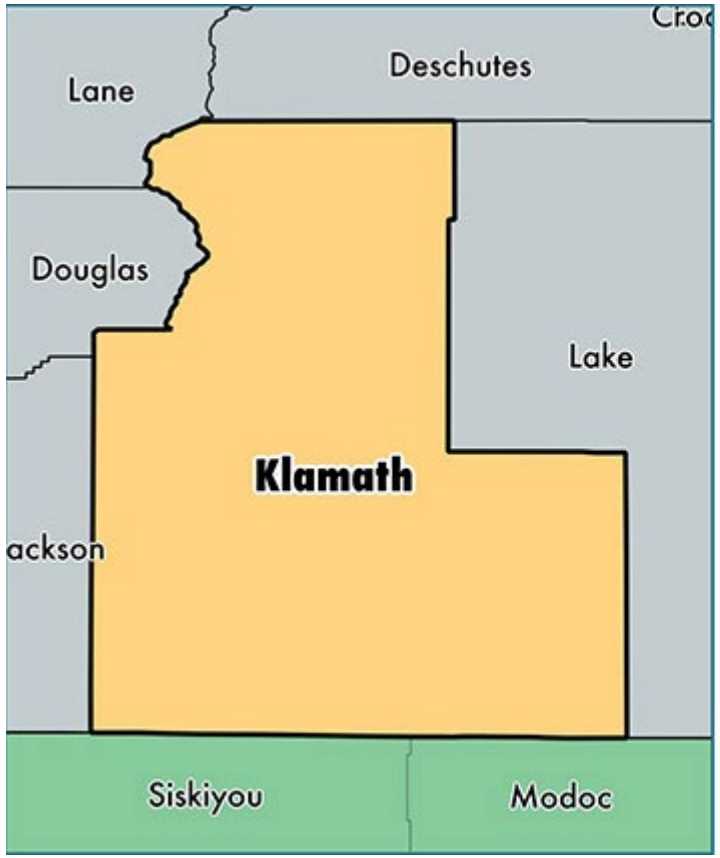
= example payment models will not count toward APM goal.

Our future state goal around population health aligns with our value-based payment model.

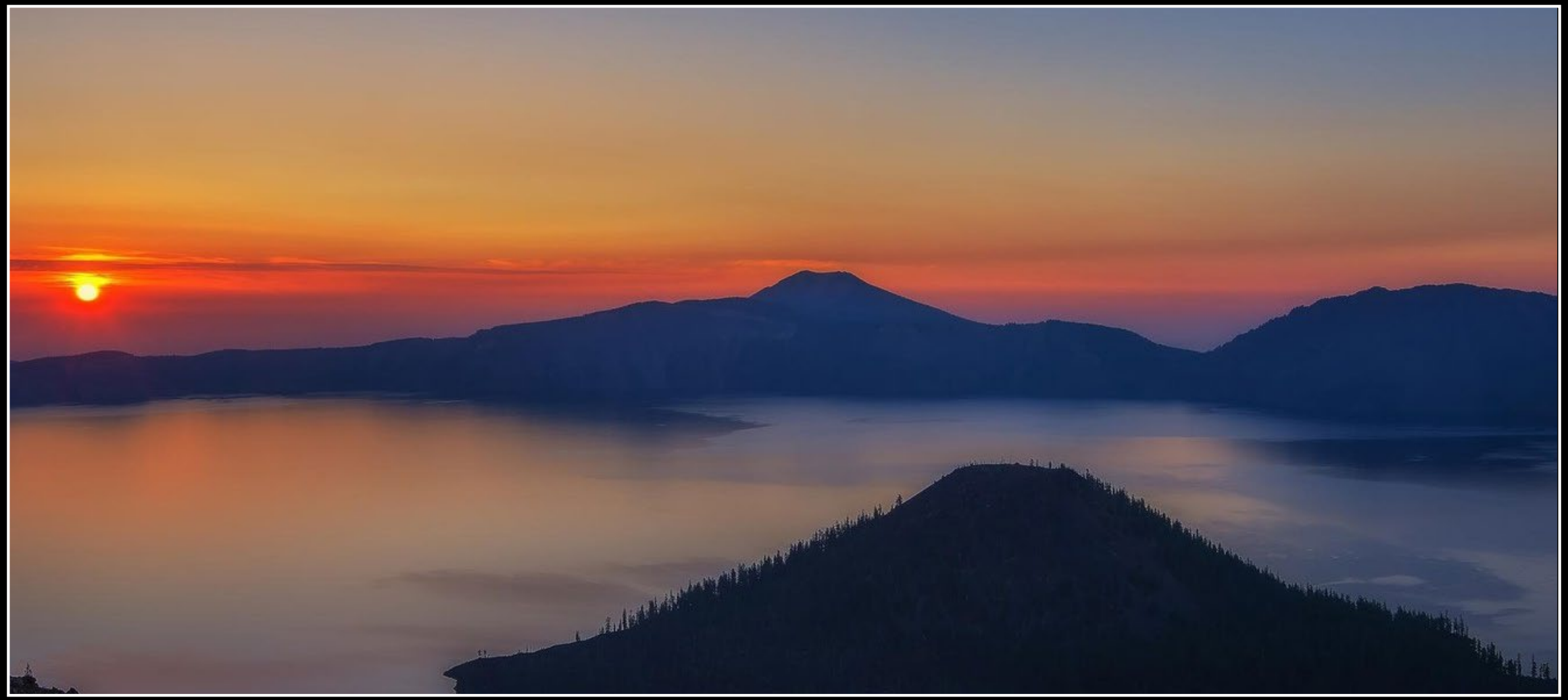


Community Background

- Klamath Falls Population: ~45,000
- Remote – high desert, east Cascades
- 75 miles over Cascade Mountains to nearest larger community
  - ~4.5 hours south of Portland on California border
  - ~5 hours north of San Francisco
- Klamath County - 6100 Square miles ~68,000 residents
- Agrarian economy
- Oregon Institute of Technology – Oregon’s only polytech univ.
- Klamath Community College



The median household income for the Klamath County Oregon area was $56,348 in 2019, the latest figures available. Klamath County median household income is $10,710 (-19%) lower than the median Oregon household income and $9,364 (-16.5%) less than the US median household income.



Home to Oregon’s only National Park –
Crater Lake

Private Independent NFP Community Hospital

Minor teaching hospital – Family Medicine Residency Program

$300 Million Net Revenues

1500 employees – self insured

Employ/Under Arrangement ~75% of providers

Part Owner of Medicaid Managed Care Plan and Medicare Advantage Plan

Also participate in Caravan ACO

Historical Context

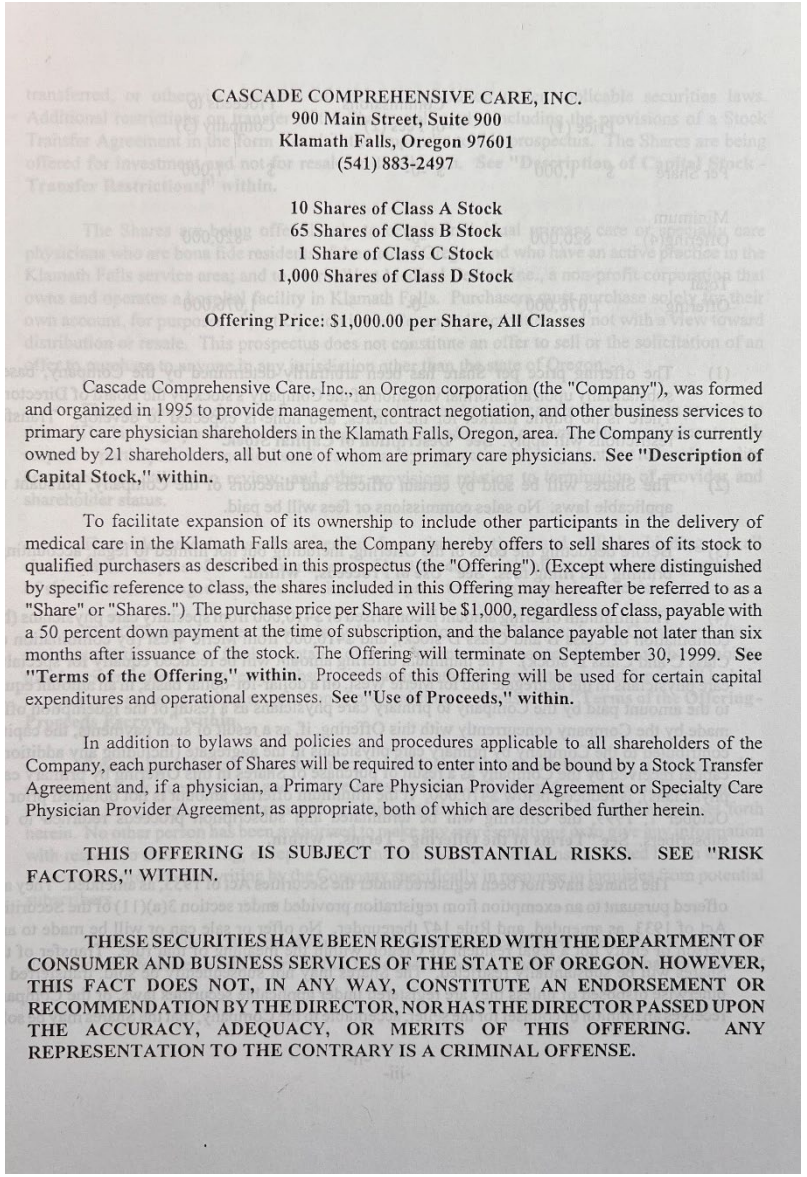
- 1994 – 4 pediatricians
  - ~70% Medicaid practice
  - Very poorly reimbursed FFS
  - Unsustainable business model
  - Considering dropping Medicaid altogether
- Approached state requesting change in reimbursement
- New model being developed by then-Governor Kitzhaber – a physician by training
- Creation of a Primary Care Organization (PCO)

Historical Context Continued

- Group was invited to take capitated risk for all primary care for Medicaid adults and children
- Complicated negotiation with hospital and primary care docs
  - Led to creation of Klamath Comprehensive Care
- 1996 “fully capitated Medicaid health plan” – among the first in Oregon
  - Cascade Comprehensive Care (CCC)
- 1999 Specialist physicians invited to join
  - Creation of new ownership model - LLC
    - 1/3 PCPs
    - 1/3 Specialists
    - 1/3 Medical Center
  - Direct contract with state for Medicaid enrollees

Stock Offering

- Primary Care Physicians
  - 1 share Class A and minimum 4 shares Class D
- Specialty Care Physicians
  - 1 share Class B and minimum 4 shares Class D
- Sky Lakes Medical Center
  - 1 share Class C and 409 shares Class D



CASCADE COMPREHENSIVE CARE, INC.
900 Main Street, Suite 900
Klamath Falls, Oregon 97601
(541) 883-2497

10 Shares of Class A Stock
65 Shares of Class B Stock
1 Share of Class C Stock
1,000 Shares of Class D Stock

Offering Price: $1,000.00 per Share, All Classes

Cascade Comprehensive Care, Inc., an Oregon corporation (the "Company"), was formed and organized in 1995 to provide management, contract negotiation, and other business services to primary care physician shareholders in the Klamath Falls, Oregon, area. The Company is currently owned by 21 shareholders, all but one of whom are primary care physicians. **See "Description of Capital Stock," within.**

To facilitate expansion of its ownership to include other participants in the delivery of medical care in the Klamath Falls area, the Company hereby offers to sell shares of its stock to qualified purchasers as described in this prospectus (the "Offering"). (Except where distinguished by specific reference to class, the shares included in this Offering may hereafter be referred to as a "Share" or "Shares.") The purchase price per Share will be $1,000, regardless of class, payable with a 50 percent down payment at the time of subscription, and the balance payable not later than six months after issuance of the stock. The Offering will terminate on September 30, 1999. **See "Terms of the Offering," within.** Proceeds of this Offering will be used for certain capital expenditures and operational expenses. **See "Use of Proceeds," within.**

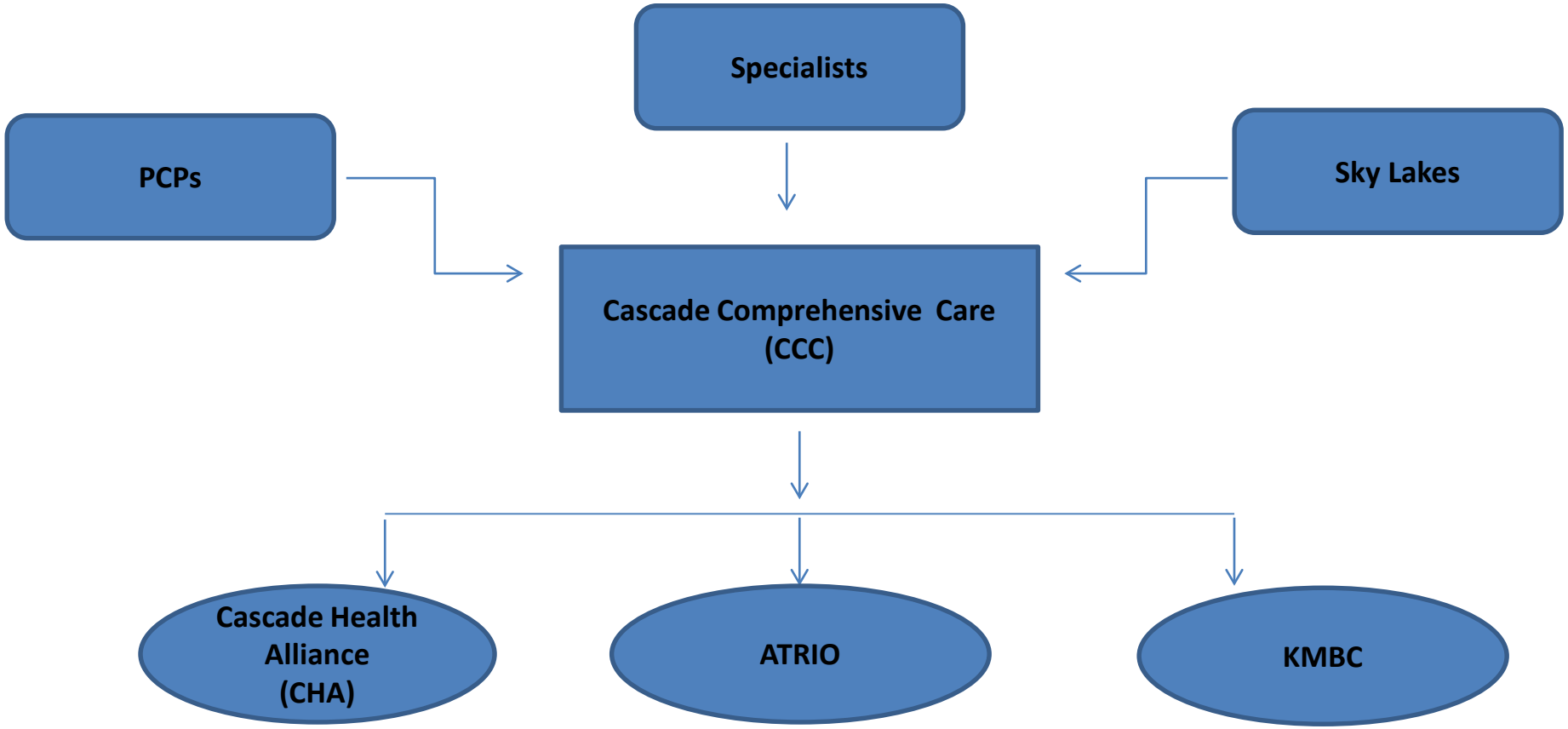
In addition to bylaws and policies and procedures applicable to all shareholders of the Company, each purchaser of Shares will be required to enter into and be bound by a Stock Transfer Agreement and, if a physician, a Primary Care Physician Provider Agreement or Specialty Care Physician Provider Agreement, as appropriate, both of which are described further herein.

THIS OFFERING IS SUBJECT TO SUBSTANTIAL RISKS. SEE "RISK FACTORS," WITHIN.

THESE SECURITIES HAVE BEEN REGISTERED WITH THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES OF THE STATE OF OREGON. HOWEVER, THIS FACT DOES NOT, IN ANY WAY, CONSTITUTE AN ENDORSEMENT OR RECOMMENDATION BY THE DIRECTOR, NOR HAS THE DIRECTOR PASSED UPON THE ACCURACY, ADEQUACY, OR MERITS OF THIS OFFERING. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

GOVERNANCE STRUCTURE & COMMUNITY ADVISORY COUNCIL (CAC)

Cascade Comprehensive Care Is a Provider-Owned Company
9-Person Board of Directors



CHA's Governance Structure – Board Committees

Community Advisory Council

Cascade Health Alliance Board of Directors

- Alternative Payment Method Committee
- Pharmacy & Therapeutics Committee
- Finance Committee
- Quality Management Committee
- Compliance Committee
- Community Projects Advisory Committee
- Utilization Review Committee/ Clinical Advisory Panel

CHA's Community Advisory Council (CAC)

PURPOSE:

Serves as the voice of our members and provide input into our strategies, and to ensure the healthcare and community needs are being addressed for our members.

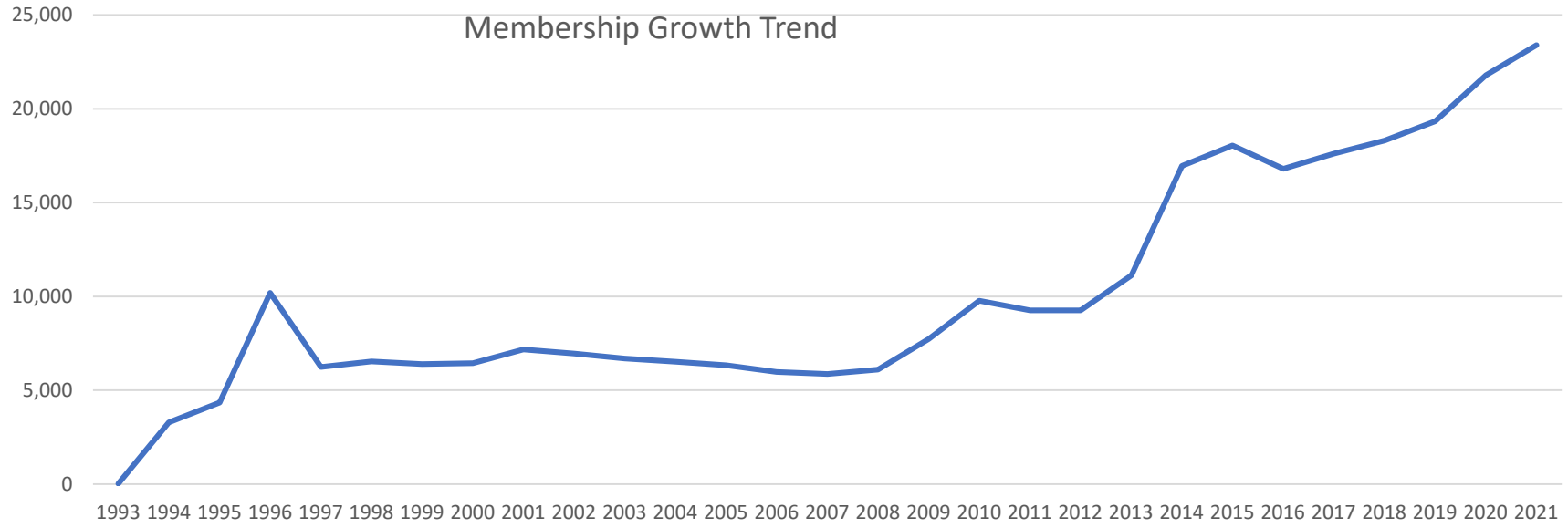
DUTIES:

- ✓ Identify and advocate for preventative care practices
- ✓ Input on SDOH-HE projects that are considered by CPAC
- ✓ Oversee a Community Health Assessment and adopt a strategic Community Health Improvement Plan
- ✓ Publish an annual progress report on the Community Health Improvement Plan

MEMBERS: represent the community, government entities, and behavioral health. Over half of the CAC are CHA members or caretakes of members.

BOARD REPRESENTATION: CAC Chair and Vice-Chair sits on CHA's Board of Directors

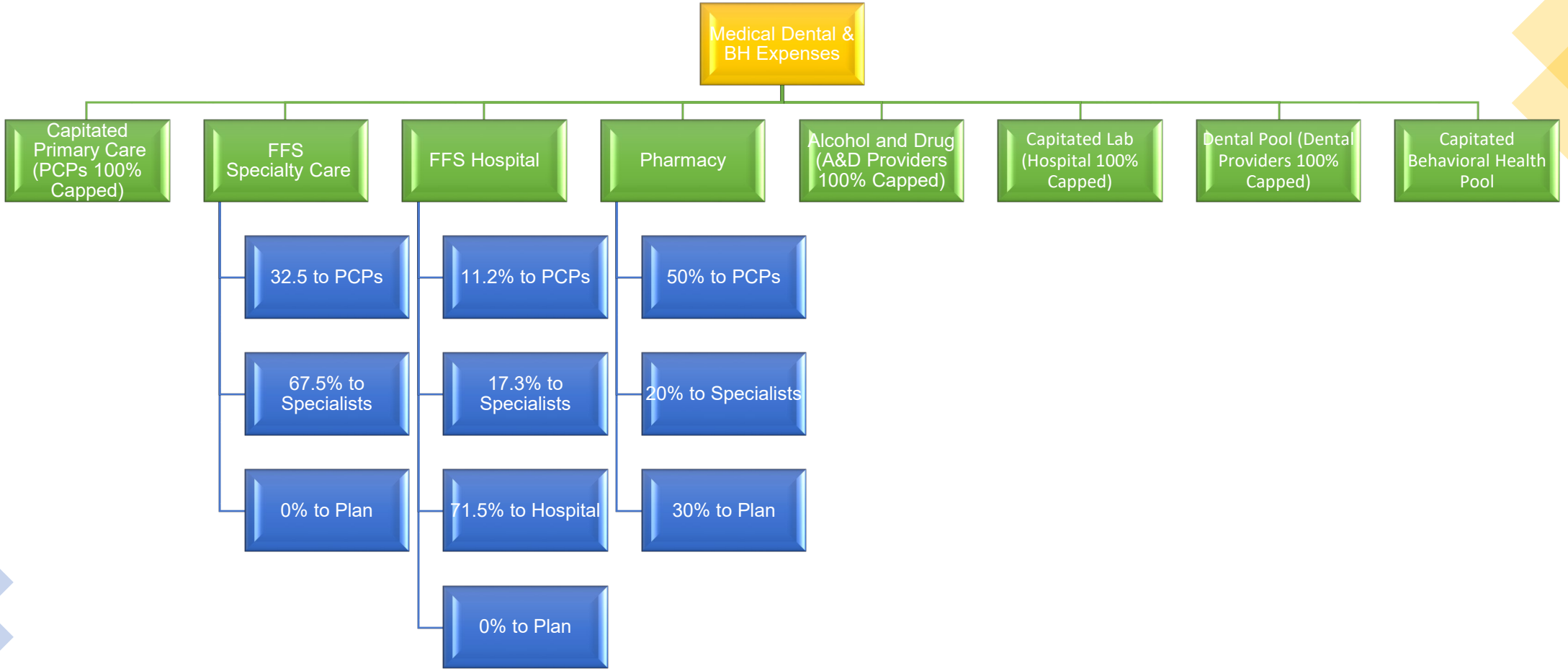
CCC Beg Month Enrollment



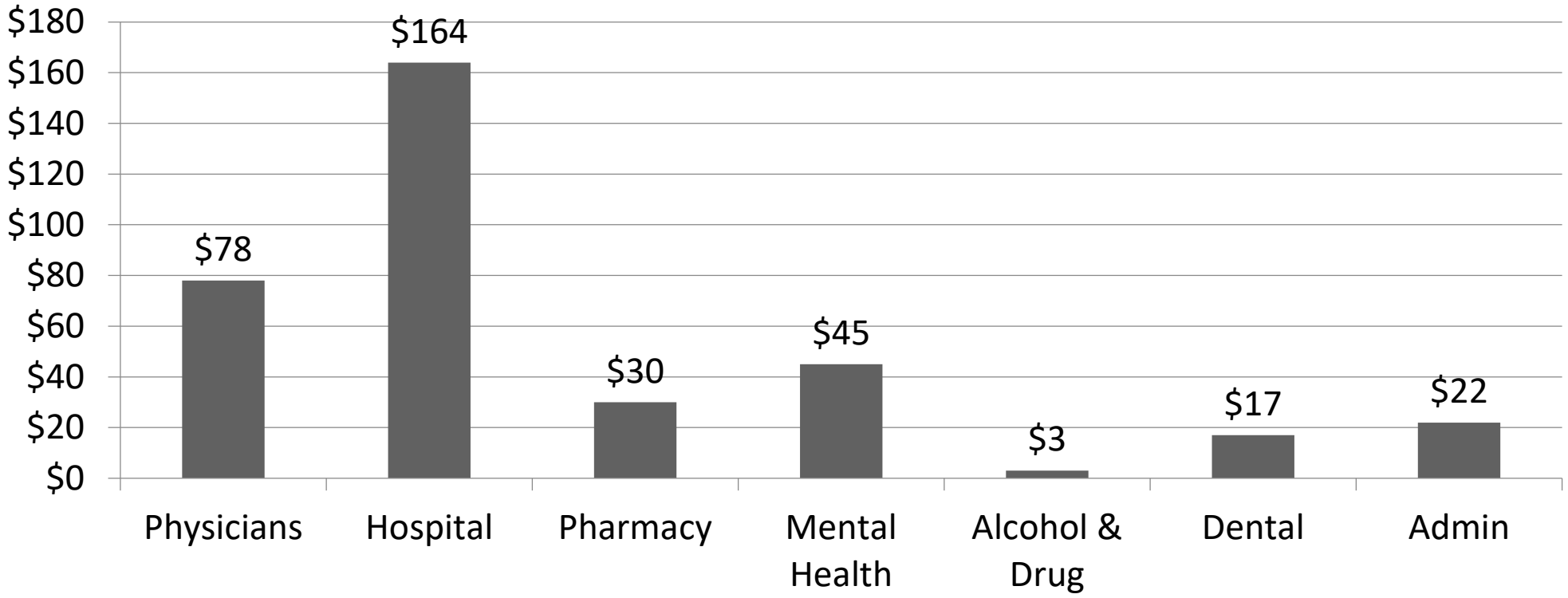
- Note: CHA became a Coordinated Care Organization in 2013. The Affordable Care Act was signed into law on March 23,2010.

CHA Membership Growth Trend since 1993

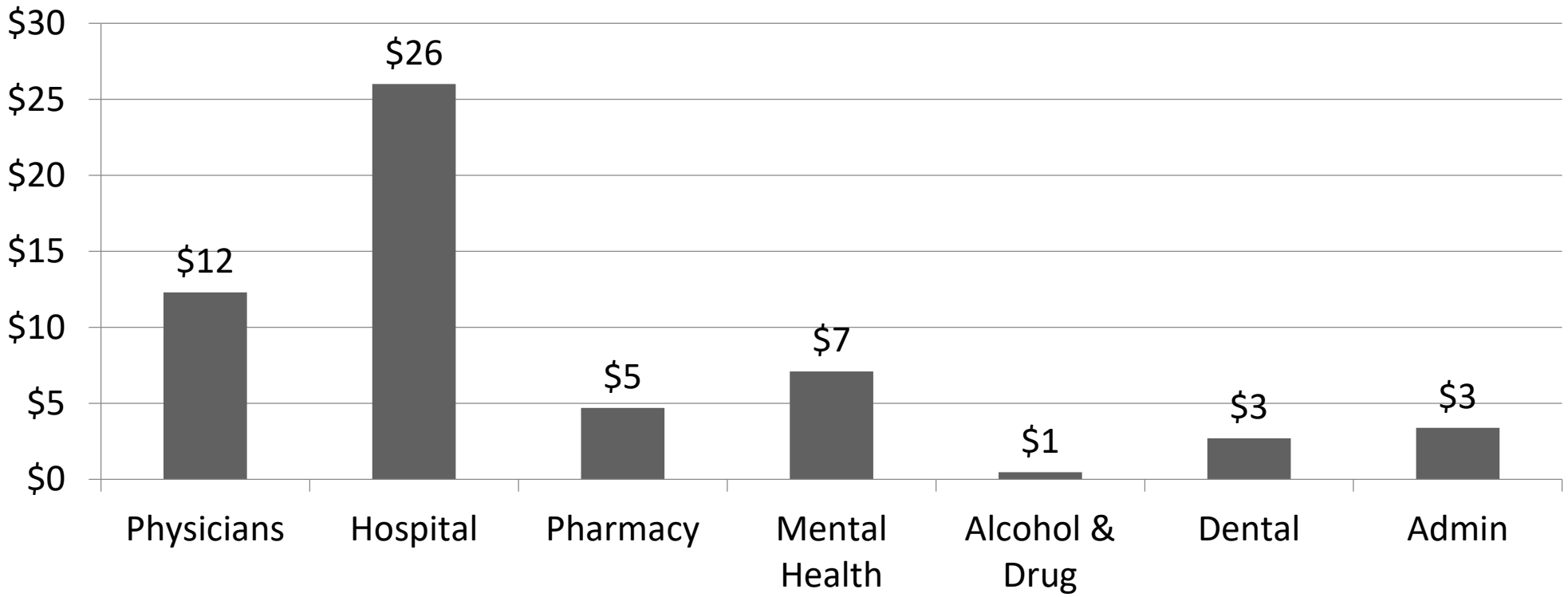
Risk Pool Sharing



CCO Financial Risk by Group (Cost Per Enrollee Per Month)



Annual Financial Risk by Group (Millions)



A Hypothetical Value-Based Payment Risk-Sharing Framework

This example assumes the medical budget allocated for this risk-sharing example is $40M. If the provider partners manages the medical spent judiciously, the group will have a surplus. Otherwise, they will have a deficit and will be responsible for the payback to the plan.

Valube-Based Payment (Paid throu	Capitated	Service	Institutional	Pharmacy	Lab Pool	Total
Revenue Allocation	17.0%	22.0%	40.0%	16.0%	5.0%	100.0%
Physical Revenue	$6,800,000	$8,800,000	$16,000,000	$6,400,000	$2,000,000	$40,000,000
Expenditures	($4,875,000)	($8,450,000)	($14,200,000)	($5,650,000)	($2,500,000)	($35,675,000)
Residual	$1,925,000	$350,000	$1,800,000	$750,000	($500,000)	$4,325,000
						$0
Residual Available for Bonus	$1,925,000	$350,000	$1,800,000	$750,000	($500,000)	$4,325,000

Payment Grid		Fee For				Total Physical
	Capitated	Service	Institutional	Pharmacy	Lab Pool	Svc Pool
PCPs	100.00%	30.00%	11.00%	70.00%	33.34%	
Specialists	0.00%	70.00%	18.00%	30.00%	33.30%	
Hospital	0.00%	0.00%	71.00%	0.00%	33.30%	
				0.00%		
Total	100.00%	100.00%	100.00%	100.00%	99.94%	
BH Providers						

Payout - Surpluses		Fee For				Total Physical
	Capitated	Service	Institutional	Pharmacy	Lab Pool	Svc Pool
PCPs	$1,925,000	$105,000	$198,000	$525,000	($166,700)	$2,586,300
Specialists	$0	$245,000	$324,000	$225,000	($166,500)	$627,500
Hospital	$0	$0	$1,278,000	$0	($166,500)	$1,111,500
Total	$1,925,000	$350,000	$1,800,000	$750,000	($499,699)	$4,325,301
Sub-total to Providers						
BH Providers						

Payout - Surplus & Withholds		Fee For				Total Physical
	Capitated	Service	Institutional	Pharmacy	Lab Pool	Svc Pool
PCPs	$1,925,000	$205,000	$198,000	$525,000	($166,700)	$2,686,300
Specialists	$0	$645,000	$324,000	$225,000	($166,500)	$1,027,500
Hospital	$0	$0	$2,828,000	$100,000	($166,500)	$2,761,500
Total	$1,925,000	$850,000	$3,350,000	$850,000	($499,699)	$6,475,301

Clinical Highlights

Utilization Review Techniques

- OB – Risk Management
  - Incentive Programs ($50 for Car Seat/Diapers if member a) WIC b) Dental Eval c) OB visits @ 13 and 28 weeks d) Three Case Mgt Contacts
- Hep C Program (Monthly Committee… Protocol adopted by providers for non OMAP patients)
- Early Childhood Cavities Prevention
- Emergency Room (Daily ER Rpt from Hospital)
- Clinical Information Sharing/Access
- Case Conferences
  - Community Involvement
- Hospital Discharge Planning

Collaborations

- Klamath County Mental Health Advisory Board
- Disabled Services Advisory Committee
- Head Start
- Health Advisory Committee
- Detox Task Force
- Dual Diagnosis Task Force
- CCC Med Dir also Med Dir of local A&D Programs
- OMPRO Diabetes Collaborative
- Mental Health Weekly Case Planning
- Mental Health Quality Improvement Committee
- Community Connections Network
- Food Stamp Advisory Board
- Klamath Basin Diabetes Collaborative
- Hospital Util Review

Member Contacts

- Durable Medical Taken In-house
  - Diabetic (Strips, Meters, Syringes)
  - Asthma (Peak Flow Meters, Spacers, Nebulizers)
  - Ordering Incontinent Supplies
- Smoking Cessation
  - Own in-house class…only one in community
  - Encouragement & Support
- Pharmacist
  - Education of Members (recommendations for BTL diagnoses, encouraging adherence, compliance and persistence)

Member Contacts (continued)

Case Management:

- New Member Health Status Survey (Prizes for responding… 40%)
- Easy Access to Staff
- Follow-up Inpatient Hospital Calls
    - “How are you doing?”
- Follow-up Oxygen Utilization
    - “Still using it?”
    - “Still meeting needs”
- Follow-up Pap Smears
    - Tracking recent change in utilization

Pharmacy Management

- In House Pharmacist (since Jan 2002)
- Collaborative effort with FQHC for 340B- will money and supports FQHC
- Improved generic utilization (from low 60's to 80%)
- Small Plan with a pharmacist
  - Pharmacy Reviews (i.e. adherence, persistence, under-utilization)
  - Participates on Disease Mgt Team

Disease Management

- Team Approach
- Rapid Cycling QI Process
- Primary Care Guidelines
- Standards of Care
- Community Trends
- Creativity/Forward Thinking
- Data Used for Prioritization of Resources

2021 TQS Projects	
Component:	Project:
Behavioral Health Integration Serious and Persistent Mental Illness (SPMI)	❖ Continued Project: Community Integrated Risk Reduction and THW Sustainable Capacity
PCPCH: Tier Advancement PCPCH: Member Enrollment	❖ Comprehensive PCPCH Plan to include a Learning Collaborative to facilitate technical assistance toward tier advancement; increase member enrollment in PCPCH
Special Health Care Needs (SHCN)	❖ Chronic Disease Management: Diabetes ❖ Long Term Services and Supports (LTSS) - collaboration with Atrio
Oral Health Integration	❖ Physical health screenings during dental visits ❖ Coordination with PCP, referrals via Health Information Exchange
Utilization Review Access: Timely Access: Quality and Adequacy of Services	❖ Comprehensive Utilization Management Plan ❖ NEMT Comprehensive Plan and improvement in delivery of NEMT services

2021 TQS Projects	
Component:	Project:
Appeals and Grievances HE: Data	❖ Enhance reporting of grievance and appeals (including member reassignment) reports by race, ethnicity, language and disability (REALD) data; ❖ Create process for direct collection of member demographic and SDOH data
CLAS Standards Access: Cultural Considerations Health Equity: Cultural Responsiveness	❖ Acquire NCQA Multicultural Healthcare Distinction designation ❖ Meaningful Language Access: standardize real time communication among the provider network of members' preferred spoken and written language ❖ Bilingual workforce development; increased frequency and amount of member education materials on language access and availability of services
Social Determinants of Health and Equity (SDOH-E)	❖ Mills Neighborhood Food Hub

- 8 Projects total
- Initiatives align across the organization as well as community and provider initiatives
- Initiatives align with current CHIP projects and domain areas
- Initiatives aim to improve member experience and satisfaction and health outcomes

What are some of our results?

Community – Quality - Financial

COMMUNITY HEALTH ASSESSMENT & COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

Klamath County Community Health Improvement Plan (CHIP)

Healthy Klamath is the organization that drives the development of our CHIP program. The four organizations that make up Healthy Klamath are:

CASCADE HEALTH ALLIANCE

KLAMATH COUNTY PUBLIC HEALTH

KLAMATH HEALTH PARTNERSHIP

SKY LAKES MEDICAL CENTER

Priority Areas:

Suicide Prevention
You Matter to Klamath Coalition.

Physical Health/Physical Activity
Blue Zones Project.

Oral Health
Cascade Health Alliance.

Infant Mortality
Klamath County Public Health.

FOOD INSECURITY
Blue Zones Project.

HOUSING
Cascade Health Alliance

QUALITY METRICS

Examples of Quality Metrics Measures

- Most of these quality measures are performed by the primary care physicians.

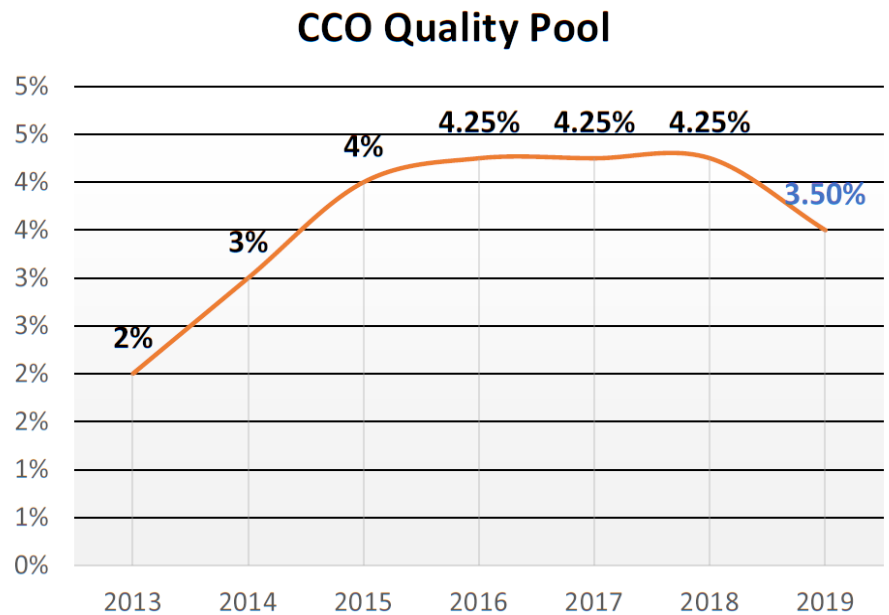
2020 – 2021 Measure Reporting Comparison

Measure	Source	2020	2021
Adolescent Immunizations^^	Alert	Reporting Only	MUST MEET TARGET: 40.4%
Childhood Immunizations	Alert	Reporting Only	MUST MEET TARGET: 79.5%
Depression Screening	EHR	Reporting Only (70% of Population; MUST PASS)	Reporting Only (70% of Population; MUST PASS)
DHS Assessments^^	Claims	Reporting Only	MUST MEET TARGET: 86.9%
Diabetes HbA1c: Poor Control	EHR	Reporting Only	MUST MEET TARGET: 23.4%
ED MI Utilization	Claims	Reporting Only	MUST MEET TARGET: 96.9
Initiation and Engagement in Alcohol or Other Drug Treatment^^	Claims	Reporting Only	MUST MEET TARGET: Initiation: 41.3% Engagement: 10.3%
Oral health evals for diabetics	Claims	Reporting Only	MUST MEET TARGET: 26.8%
Preventive Dental Services Children ages 1 – 5; 6 - 14	Claims	Reporting Only	MUST MEET TARGET: 1-5: 42.5% 6-14: 58.8%
SBIRT	EHR	Reporting Only (20% of Population; MUST PASS)	Reporting Only (20% of Population; MUST PASS)
Smoking Prevalence	EHR	Reporting Only	MUST MEET TARGET: 26.6%
Timely Postpartum Care	Claims	Reporting Only	MUST MEET TARGET: 61.3%
Well Child Visits 3-4-5-6 years^^	Claims	Reporting Only	MUST MEET TARGET: 61.5%
Meaningful Language Access	N/A	N/A	Attestation (MUST PASS)

^^Challenge Pool Measure 2021

2019 Changes to the Quality Pool Percentage (cont'd)

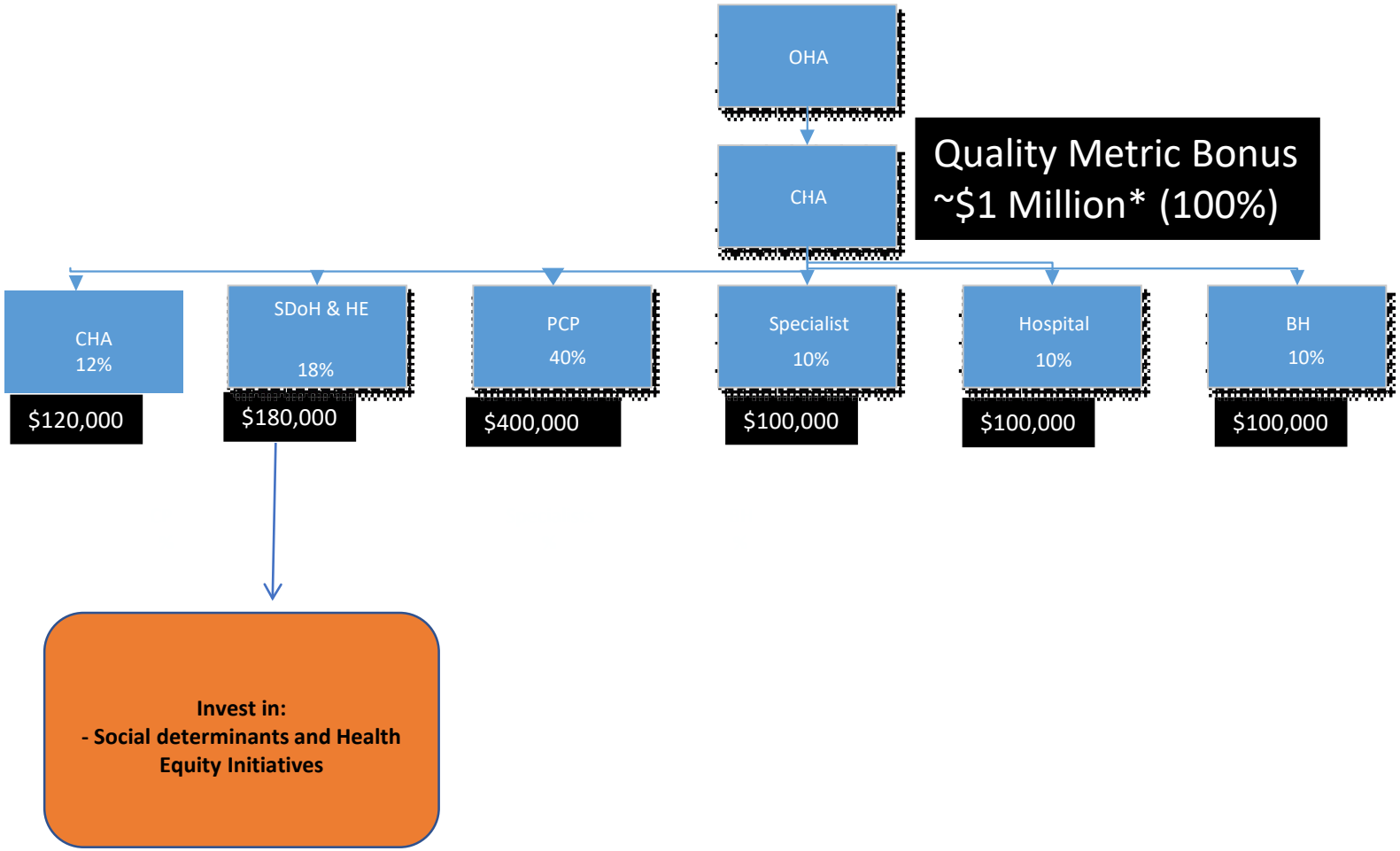
The 2019 Quality Pool (QP) will decrease to 3.5% (or lower). The percentage available to each CCO will be based on the individual CCO's sustainable rate of growth performance against the **3.4% growth target** from CY2018 to CY2019.



Anticipated payouts range from approximately 3% to 4.25%.

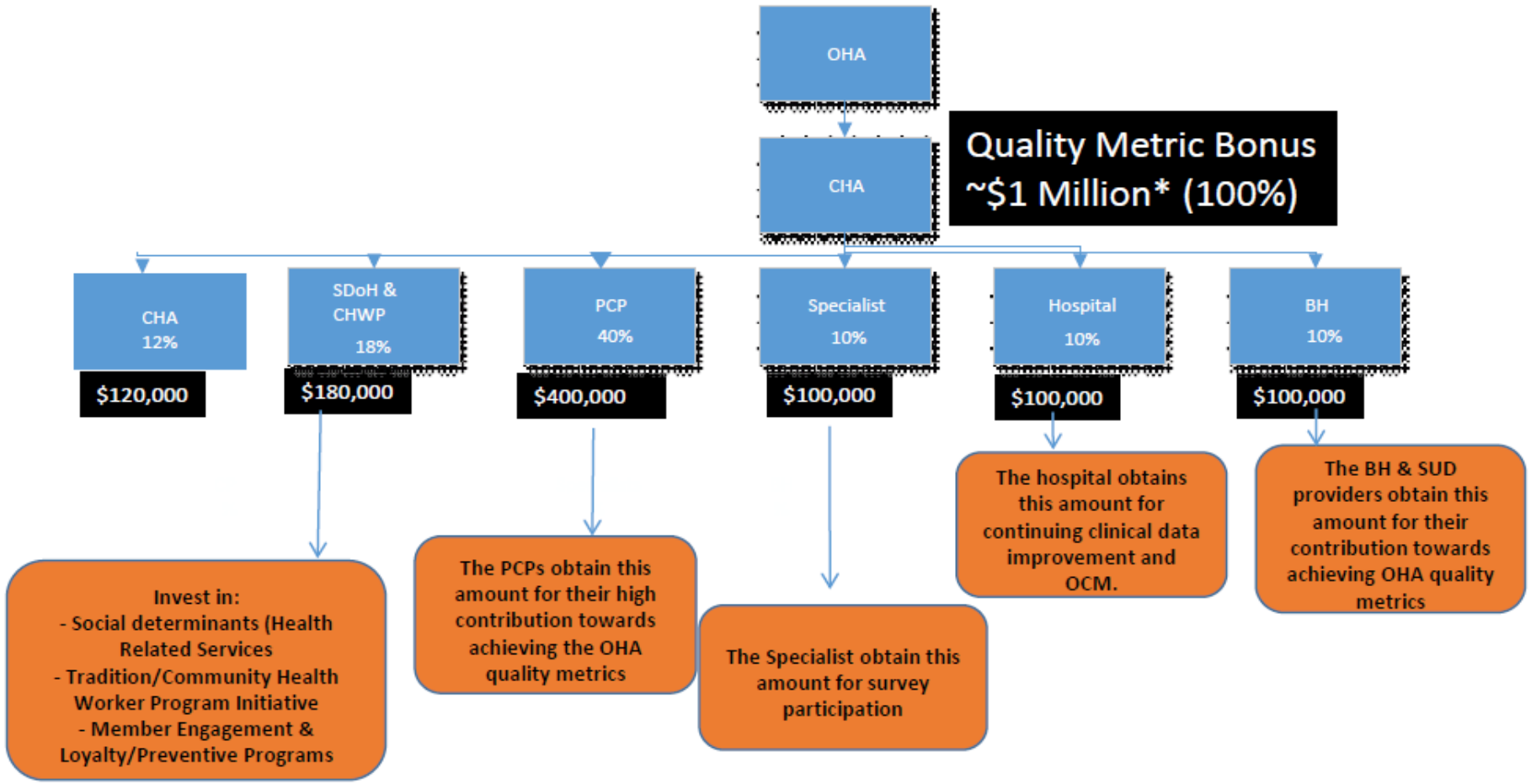
Example of Quality Metrics Payout to Provider Partners

A portion of our quality payment carves out a percentage to address our Social determinants of health and health equity initiatives.



2020 Quality Metrics Proposal – (Payout in 2021 at 100%)

The approved distribution for the 2020 OHA quality metrics allocation.



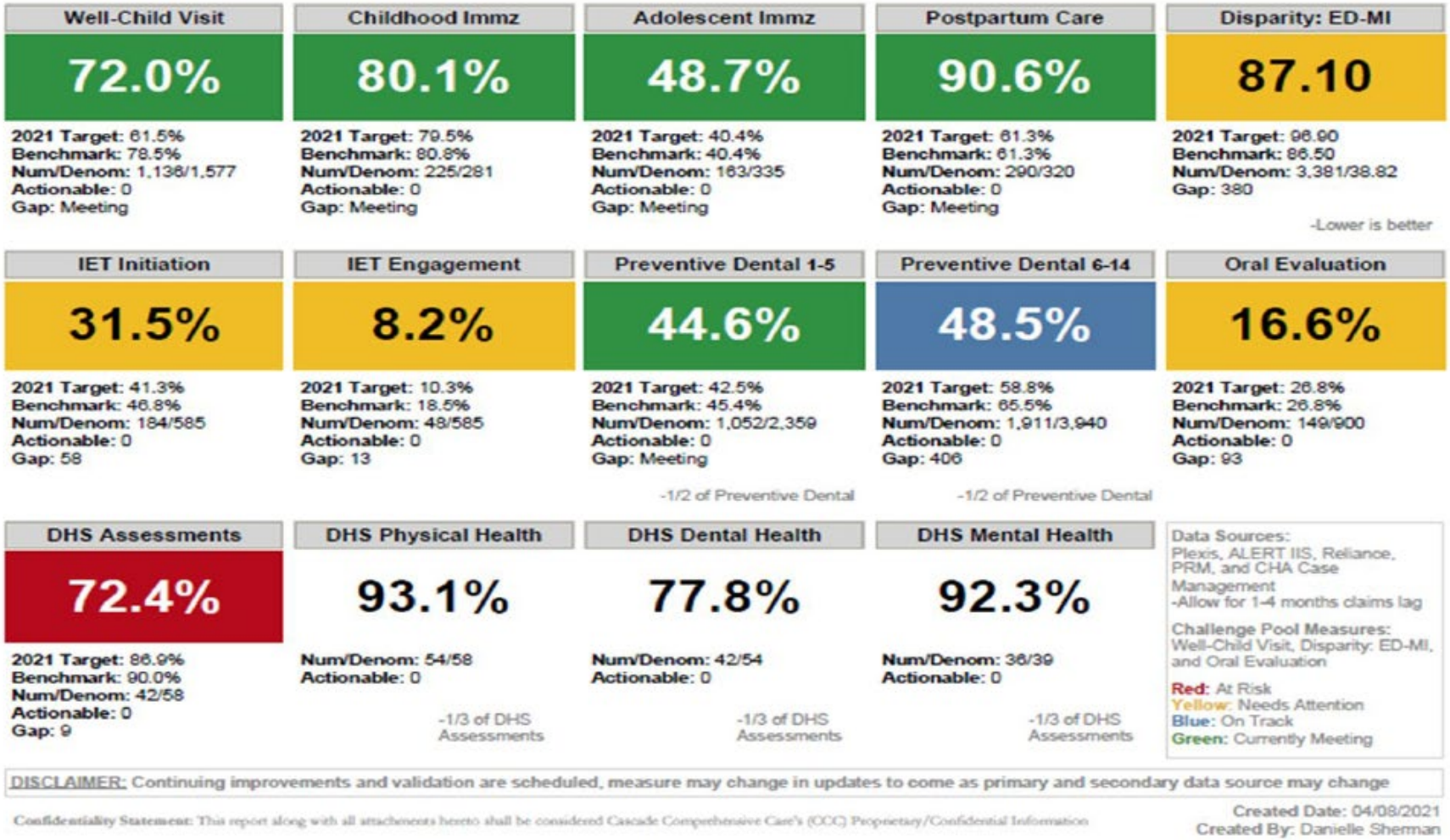
2019 INCENTIVE METRIC PERFORMANCE OVERVIEW

■ CCO achieved BENCHMARK in 2019
■ CCO achieved IMPROVEMENT TARGET in 2019
✱ Top performing CCO in each measure

Bolded CCOs earned 100% quality pool
^ indicates challenge pool measure

	Advanced Health	AllCare	Cascade	Columbia Pac.	EOCCO	Health Share	IHN	Jackson	PacSource Central	PacSource Gorge	PrimaryHealth	Trillium	Umpqua	WVCH	Yamhill
Access to care (CAHPS) - adults							■	✱		■	■	■			
Access to care (CAHPS) - children							■			■	✱		■		
Adolescent well-care visits			■	■	■	■	■		■	✱			■	■	
Ambulatory care - ED utilization		■						■		■	✱		■	■	■
Assessments for children in DHS custody^	■	■		■	■	■		■	■		✱		■	■	■
Childhood immunization status^	■			■	■		■		■	✱	■		■		■
Cigarette smoking prevalence (EHR)	■	■	✱	■	■	■		■	■	■	■	■	■	■	■
Colorectal cancer screening		■		■	■		■	■	✱	■	■	■	■	■	
Controlling high blood pressure (EHR)	■		■	■	■	■		■			■	✱		■	■
Dental sealants for children	✱		■	■		■		■	■	■	■	■	■		■
Depression screening and follow up (EHR) - must pass	■	■	✱	■	■	■	■	■	■	■	■	■	■	■	■
Developmental screening ^	■	■	■	■	■	■	■	■	■	✱	■		■		■
Diabetes HbA1c poor control (EHR)		■			■			■	■		■	✱		■	■
Disparity measure: ED util for members w mental illness	■	■		■							✱		■	■	■
Effective contraceptive use (ages 15-50)	■	■			■		✱		■	■			■		■
Oral evaluation for adults with diabetes	■	■	■			✱	■	■	■	■	■	■	■	■	■
Prenatal and postpartum care: Postpartum care rate^	■	■	✱	■	■			■	■	■	■	■	■	■	■
Patient-Centered Primary Care Home (PCPCH) enrollment - must pass	■	■	■	■	■	■	■	■	✱	■	■	■	■	■	■
SBIRT (EHR) - must pass	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Weight assessment, nutrition, and activity counseling kids (EHR)	■	■	■	■	■	■	■	■	■	■	■	■	■	■	✱

2020 Measurement Year Preliminary Performance – OHA Incentive Measures – Claims Measures



Reflective of claims received through April 2, 2021. EHR data and hybrid measure submission to OHA occurred on March 30. Final data review and validation will be conducted in May pending receipt of OHA's final performance dashboard at the end of April.

PCP Utilization/Access/Acuity Measures

- *In year 1, 50% of surplus will be distributed on old methodology and 50% on new*
- Measures:

✓ % of visits of PCP panel size (at least 72%) → 40%
  - At least 1 visit per year per member on the panel, which includes preventive visit
    - Panel size of each clinic on January 1st multiplied by 72% to obtain target for each clinic
    - Bonus awarded only to clinics who see 72% or more of the established target
    - Bonus calculated based on each clinics percentage of visits compared to all visits of all clinics (see next slide)

✓ Risk Adjusted Capitation Acuity of the PCP panel size → 50%
  - Capitation will be risk adjusted based on the risk factor for each member
    - Risk adjustment captured on a monthly basis to prevent churning factor
    - Calculated monthly and paid annually (see next slide)

✓ Net new patient increase of the PCP panel size → 10%
    - Panel size calculated based on member months and compared to 2018 member months
    - Clinics who have an increase in panel size will share in the bonus
    - Increase will be weighted by total population increased (see next slide)

Measure	Weight
% of visits of PCP Panel Size	40%
Panel Size Risk Adjustment	50%
Net new Patient increase	10%

Specialist Quality Measures

- *In year 1, 50% of surplus will be distributed on old methodology (fee-for-service) and 50% on new methodology*
- All Specialists *(for illustration purposes only – assumes $1 million total surplus):*

✓ Risk adjusted payment by acuity of the member

  - Total RVU for each specialist will be adjusted by the average annual risk score of each individual member treated

	2019 Net Paid	Average Risk Score	Risk Adjusted Net Paid	% of Risk Adjusted Net	Bonus Earned
Specialist 1	$ 278,511.79	1.20	$ 334,214.15	45.14%	$ 225,723.09
Specialist 2	$ 73,158.48	1.10	$ 80,474.33	10.87%	$ 54,351.12
Specialist 3	$ 66,360.78	0.90	$ 59,724.70	8.07%	$ 40,337.14
Specialist 4	$ 51,591.80	0.95	$ 49,012.21	6.62%	$ 33,102.09
Specialist 5	$ 16,118.05	1.15	$ 18,535.76	2.50%	$ 12,518.77
Specialist 6	$ 22,303.00	1.05	$ 23,418.15	3.16%	$ 15,816.26
Specialist 7	$ 74,090.29	1.40	$ 103,726.41	14.01%	$ 70,055.22
Specialist 8	$ 1,958.30	1.50	$ 2,937.45	0.40%	$ 1,983.91
Specialist 9	$ 8,493.33	0.80	$ 6,794.66	0.92%	$ 4,589.01
Specialist 10	$ 61,481.11	1.00	$ 61,481.11	8.30%	$ 41,523.39
	$ 654,066.93	11.05	$ 740,318.93	100.00%	$ 500,000.00

Facility (Hospital) APM Measures –

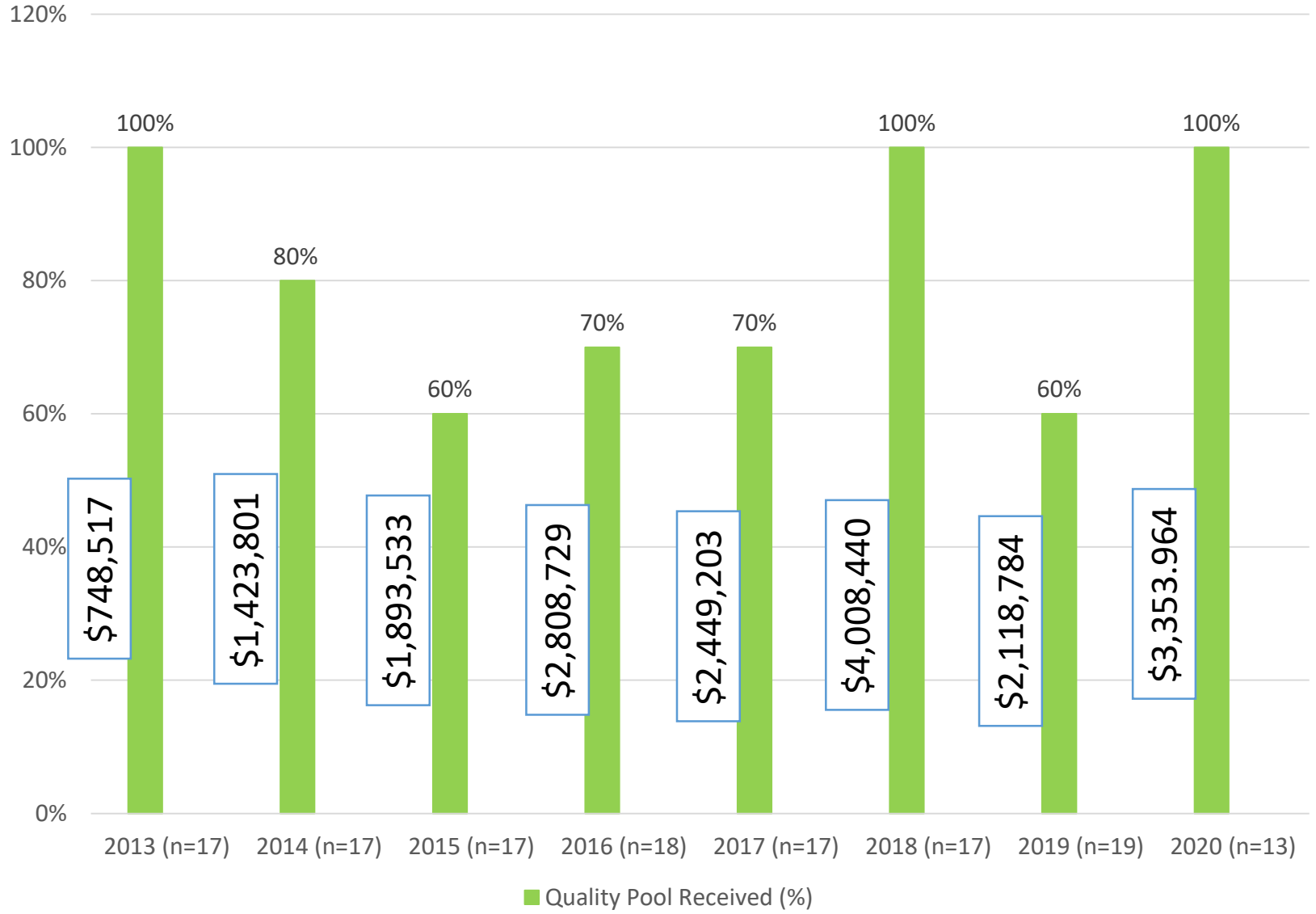
- ✓ SBIRT in the ED > 83% → (40%)
  - Data source— Claims
  - Data definitions—To be discussed

- ✓ Early Elective Deliveries <=5% annualized rate → (40%)
  - Data source— To be discussed (Auditing Charts)
  - Data definitions—To be discussed

- ✓ Adverse Drug Events Associated with Opioids <2%→ (20%)
  - Data source—To be discussed
  - Data definitions– To be discussed

In year 1, 75% of surplus will be distributed on old methodology and 25% on the new

Quality Metrics Performance



Quality metrics payment are made to CCOs as an incentive to encourage CCOs to achieve certain member quality target. Depending on the year, the payment can range from 2% to 4.5% of annual member capitation payment.

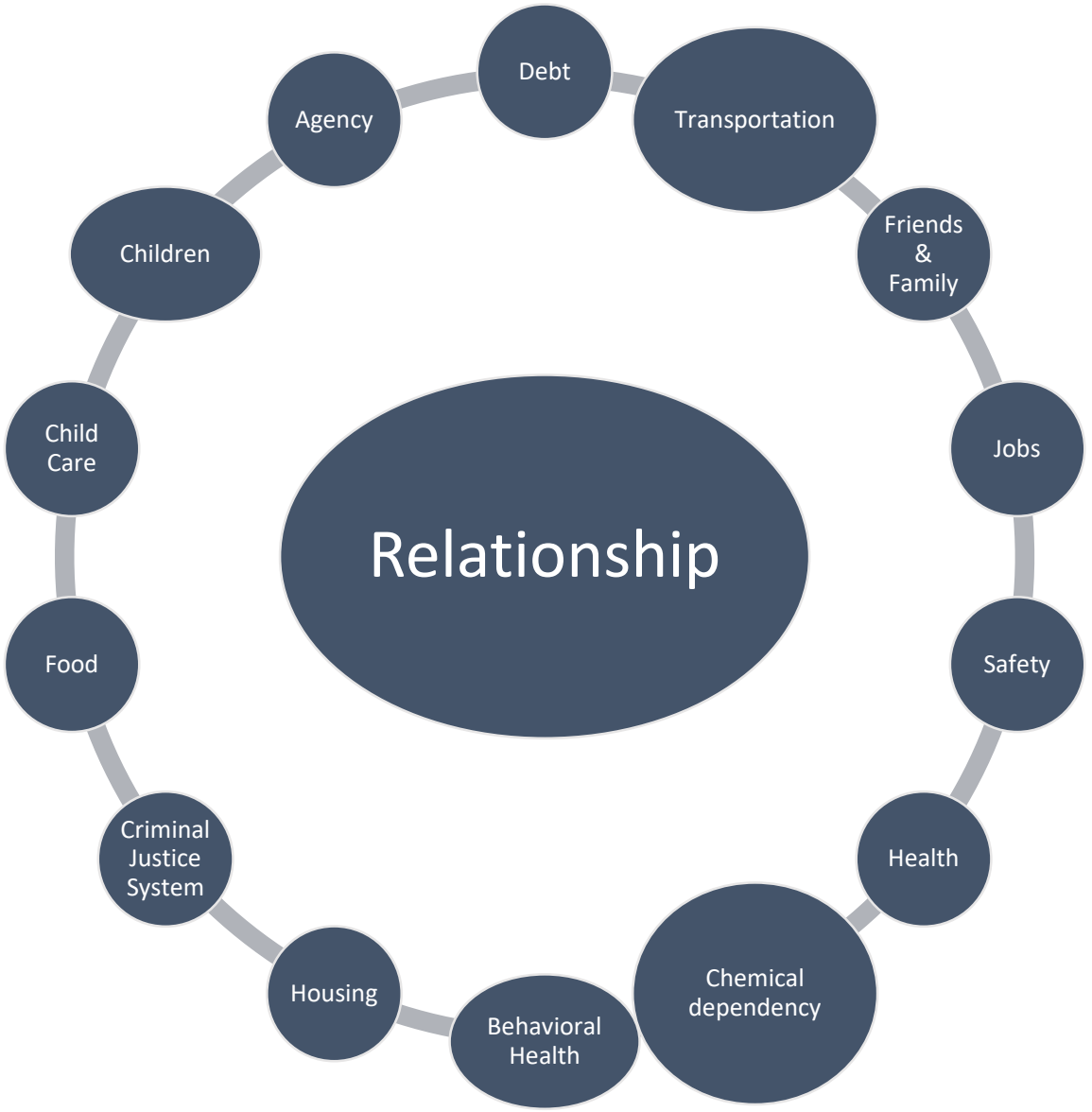
Note: 2020 was a reporting year only due to COVID-19.

COMMUNITY PARTNERSHIP

Community Engagement

Empower the people who live in our community to improve their health and wellbeing.

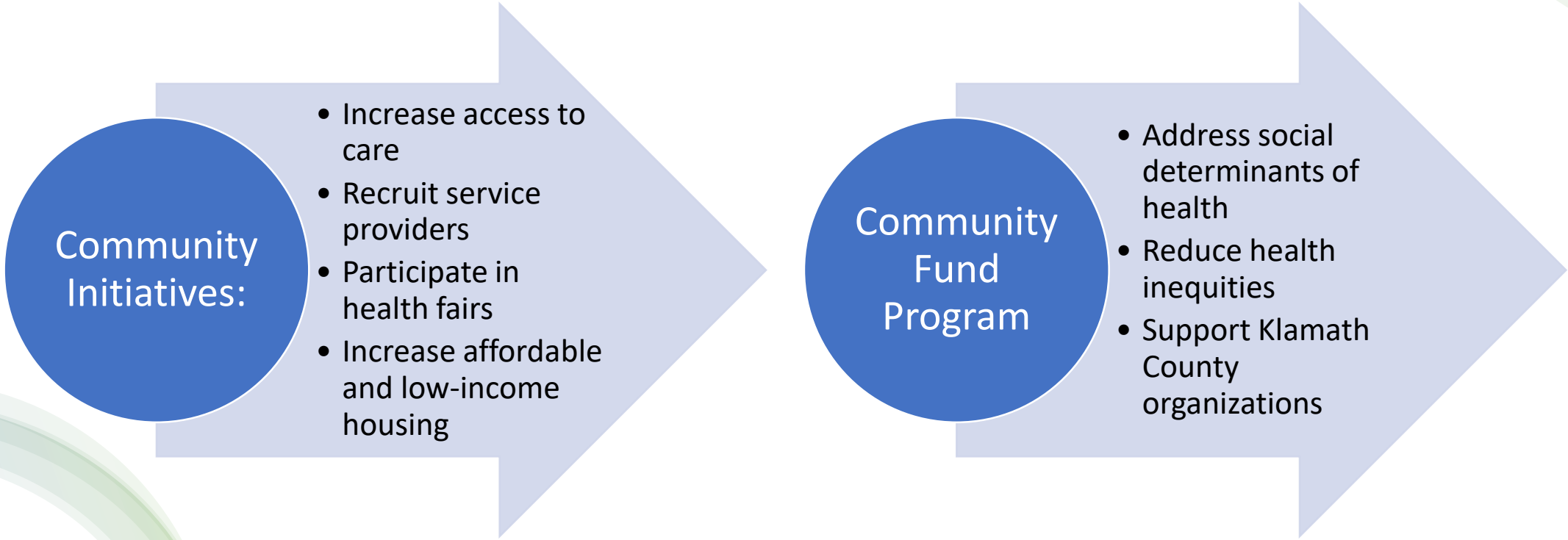
Mental model for poverty and how time is spent



How time is spent impacts your knowledge base and resources.

Source: By Phillip Devol

Community Partnership Opportunities



Oregon's Focus with CCO 2.0

4.Social Determinants of Health & Health Equity

- **SDOH** – The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age

Source: Oregon Health Authority

Social Determinant of Health-Health Equity (SDoH-HE)

SDoH Implementation Framework

OHA Domain Criteria Requirements

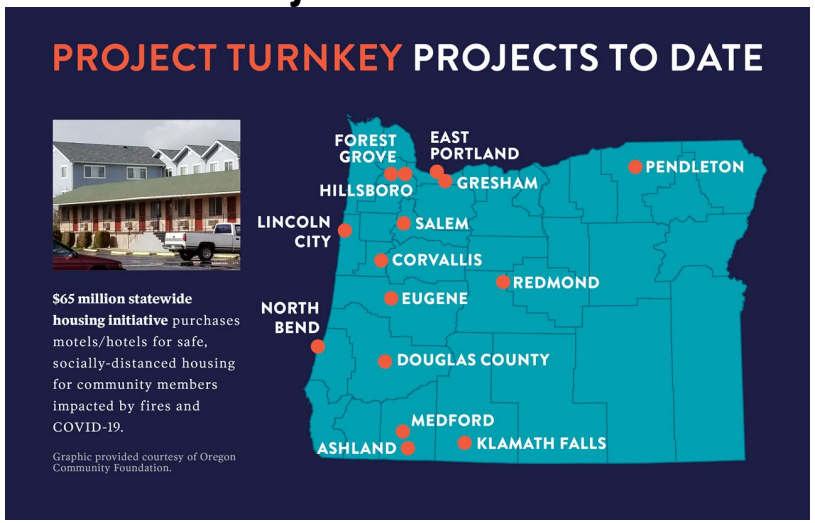
- **Neighborhood and Built Environment:** Income/poverty; Employment; Food security/insecurity; Diaper security/ insecurity; Access to quality childcare; Housing stability/instability (including homelessness); Access to banking/credit.
- **Economic Stability**: Access to healthy foods; Access to transportation (non-medical); Quality, availability, and affordability of housing; Crime and violence (including intimate partner violence); Environmental conditions; Access to outdoors, parks.
- **Education:** Early childhood education and development; Language and literacy; High school graduation; Enrollment in higher education.
- **Social and Community Health:** Social integration; Civic participation/community engagement; Meaningful social role; Discrimination (e.g. race, ethnicity, culture, gender, sexual orientation, disability); Citizenship/immigration status; Corrections; Trauma (e.g. adverse childhood experiences).

Realities for Our Member Base

Social determinants drive health care outcomes

Four Major SDoH Projects We Are Implementing

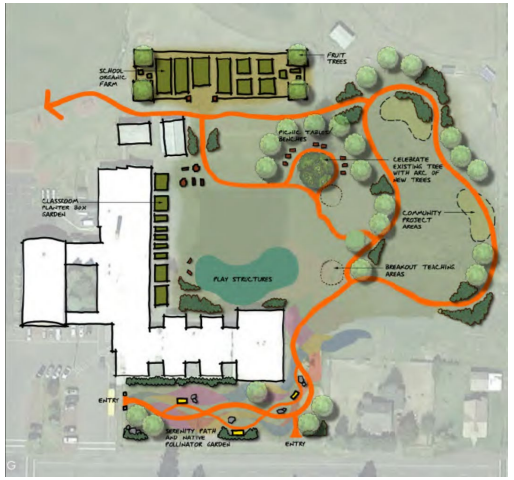
Project Homefront



Pump Track Project

Moore Park Playground Project

Chiloquin Elementary Green Schoolyard

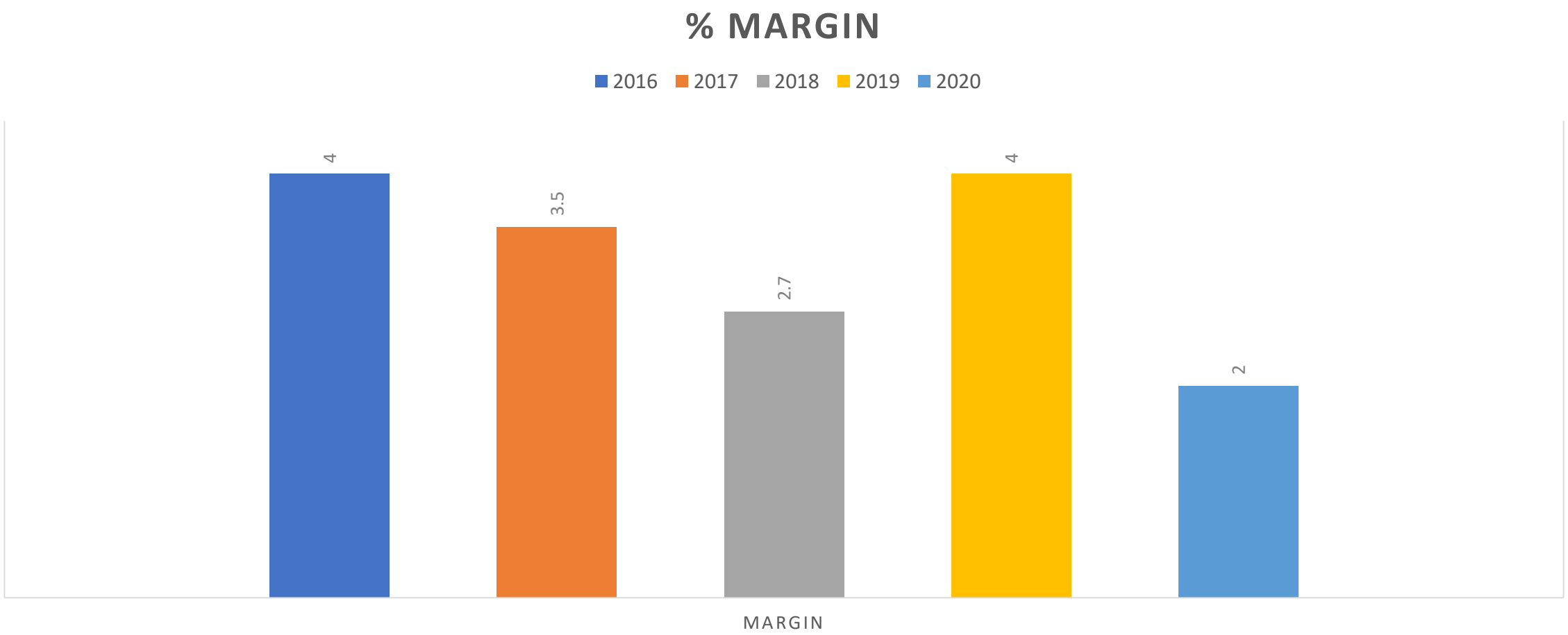


FINANCIAL PERFORMANACE

Some examples of results over the years

Income Statement Proposed 2020 BUDGET	CHA	CCC	Consolidated
Membership	222,408		
Gross Revenue	$119,162,691	$0	$119,162,691
Pass Throughs/Others	($23,464,646)	$0	($23,464,646)
Other State Revenue	$900,000	$0	$900,000
Management Fee Income	$0	$9,673,286	$0
ATRIO Riemburse CCC	$0	$960,000	$960,000
Net Revenue	$96,598,045	$10,633,286	$97,558,045
Physical Health Expenses	($70,347,407)	$0	($70,347,407)
Dental Expenses	($4,460,000)	$0	($4,460,000)
Community Health Initiatives	($250,000)	$0	($250,000)
Behavioral Health Expenses	($8,806,193)	$0	($8,806,193)
Total Medical Expenses	($83,863,600)	$0	($83,863,600)
Gross Profit	$12,734,445	$10,633,286	$13,694,445
G & A Management Fee	($9,673,286)	$0	$0
General & Adminstrative	($1,368,897)	($10,565,277)	($11,934,174)
Operating Income	$1,692,262	$68,009	$1,760,271
ATRIO Risk Pool - CCC Share	$0	$725,000	$725,000
Interest Income	$148,654	$69,420	$218,074
Interest and Dividend Income - Bonds	$0	$50,998	$50,998
Investment Income - KMBC	$0	$0	$0
Gain/Loss on Sale of Bonds	$0	$0	$0
Gain on Sale of Atrio	$0	$0	$0
Total Other Income	$148,654	$845,418	$994,072
Income Before Taxes	$1,840,916	$913,427	$2,754,343
Less: Income Taxes	($497,047)	($867,550)	($1,364,597)
Net Income	$1,343,869	$45,877	$1,389,746
Unrealized Gain/Loss Atrio & KMBC	$0	$775,000	$775,000
Unrealized Gain/Loss Bonds	$0	$111,000	$111,000
Net Income	$1,343,869	$931,877	$2,275,746
MLR %	87.8%		
G&A	10.4%		11.2%
Operating Income	1.8%		1.8%
Net Income before Taxes	1.9%		2.8%
Net Income	1.4%		2.3%

CCC NET INCOME



Risk Pool Results

Risk Pool - December 2020 DRAFT Paid through 3/31/2021	Capitated	Fee For Service	Institutional	Pharmacy	Lab Pool	Total	%	Mental Health	%
Physical Revenue	$7,768,032	$16,952,965	$32,453,429	$11,349,444	$1,466,741	$69,990,611	100.00%	$11,689,860	100.00%
Expenditures	($6,650,667)	($13,053,418)	($26,610,850)	($9,387,356)	($1,424,806)	($57,127,097)	-82.78%	($10,952,757)	-94.78%
Residual	$1,117,365	$3,899,547	$5,842,578	$1,962,088	$41,935	$12,863,514	18.38%	$737,102	6.31%
Less PCP Cap	($1,117,365)					($1,117,365)			
Residual	$0	$3,899,547	$5,842,578	$1,962,088	$41,935	$11,746,149		$737,102	
Less Withhold		($926,298)	($2,595,471)	($187,918)	$0	($3,709,687)		($1,051,705)	
Residual in Excess of Withhold		$2,973,249	$3,247,107	$1,774,170	$41,935	$8,036,461		($314,602)	
Withhold Not Returned						$0			
Residual Available for Bonus		$2,973,249	$3,247,107	$1,774,170	$41,935	$8,036,461	11.48%	($314,602)	-2.69%

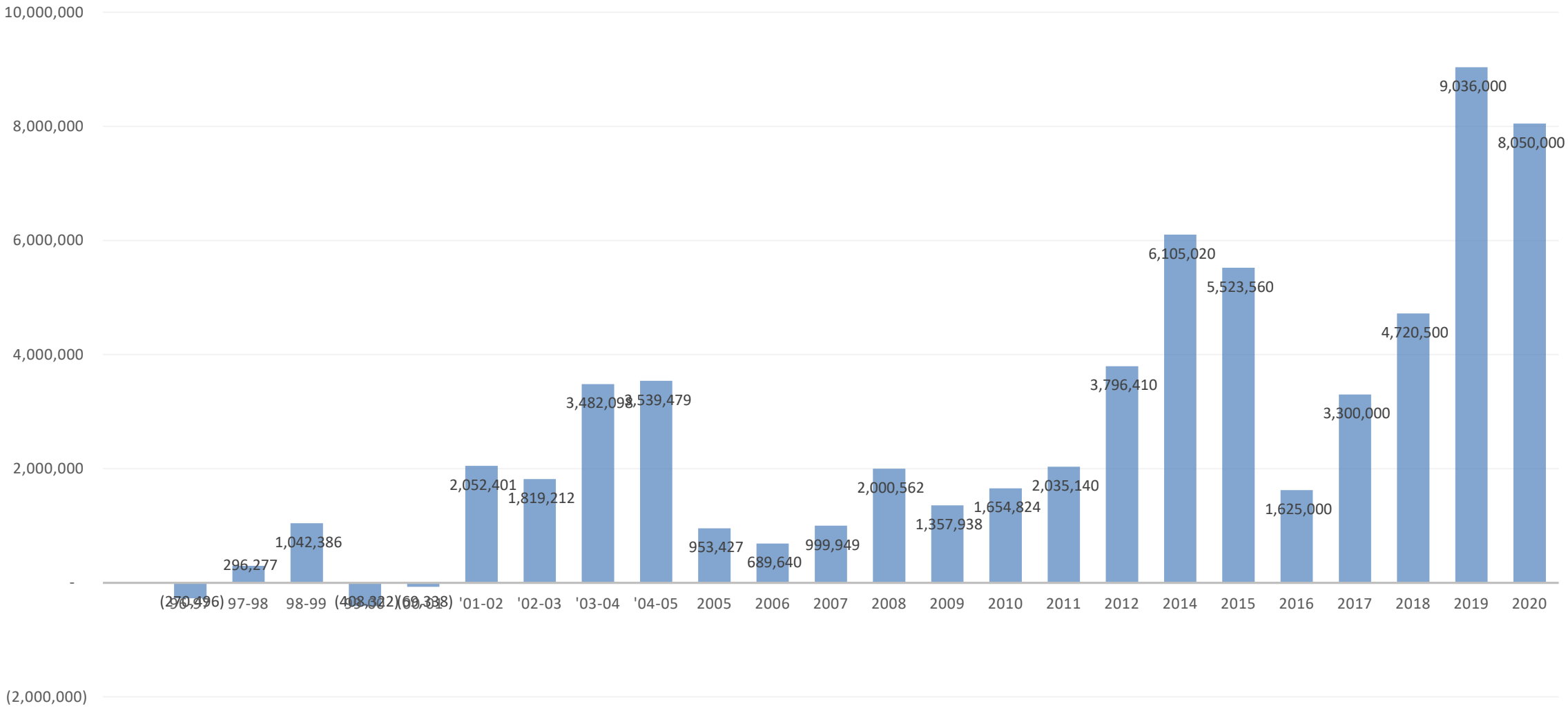
Payment Grid	Capitated	Fee For Service	Institutional	Pharmacy	Lab Pool	Total Physical Svc Pool		Mental
PCPs	100.00%	32.50%	11.20%	0.00%	33.33%			0.00%
KFIPA	0.00%	67.50%	17.30%	0.00%	33.33%			0.00%
SLMC	0.00%	0.00%	71.50%	0.00%	33.33%			0.00%
CHA				100.00%				10.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%			0.00%
Sub-total to Providers								90.00%

Payout - Surpluses	Capitated	Fee For Service	Institutional	Pharmacy	Lab Pool	Total Physical Svc Pool		Mental
PCPs	$1,117,365	$966,306	$363,676	$0	$13,978	$2,461,325		$0
KFIPA	$0	$2,006,943	$561,750	$0	$13,978	$2,582,671		$0
SLMC	$0	$0	$2,321,682	$0	$13,978	$2,335,660		$0
CHA	$0	$0	$0	$1,774,170	$0	$1,774,170		($31,460)
Total	$1,117,365	$2,973,249	$3,247,107	$1,774,170	$41,935	$9,153,826		$0
Sub-total to Providers								($283,142)
Total								($314,602)

Payout - Surplus & Withholds	Capitated	Fee For Service	Institutional	Pharmacy	Lab Pool	Total Physical Svc Pool		Mental
PCPs	$1,117,365	$1,076,917	$363,676	$0	$13,978	$2,571,936		$0
KFIPA	$0	$2,822,630	$561,750	$0	$13,978	$3,398,358		$0
SLMC	$0	$0	$4,917,153	$187,918	$13,978	$5,119,049		$0
CHA	$0	$0	$0	$1,774,170	$0	$1,774,170		($31,460)
Total	$1,117,365	$3,899,547	$5,842,578	$1,962,088	$41,935	$12,863,513		$0
Sub-total to Providers								$768,563
Total								$737,102

Payout - Surpluses Compared to last month	Capitated	Fee For Service	Institutional	Pharmacy	Lab Pool	Total Physical Svc Pool		Mental
Previous month Total	$1,037,275	$3,216,448	$4,696,112	$1,985,120	$38,694	$10,973,650		$775,612
Difference	$80,090	$683,099	$1,146,466	($23,032)	$3,241	$1,889,863		($38,509)

Risk Pool Surplus



December 2020 Dental Risk Pool (DRAFT) – Summary Overview

- KOD is the only entity eligible for shared surplus/loss
- Withhold and any surplus/loss allocations are only paid if contracted metrics are met
- Summary represents claims paid through March 2021 with date of service through December 2020

DENTAL RISKPOOL

1/1/2020 - 12/31/2020

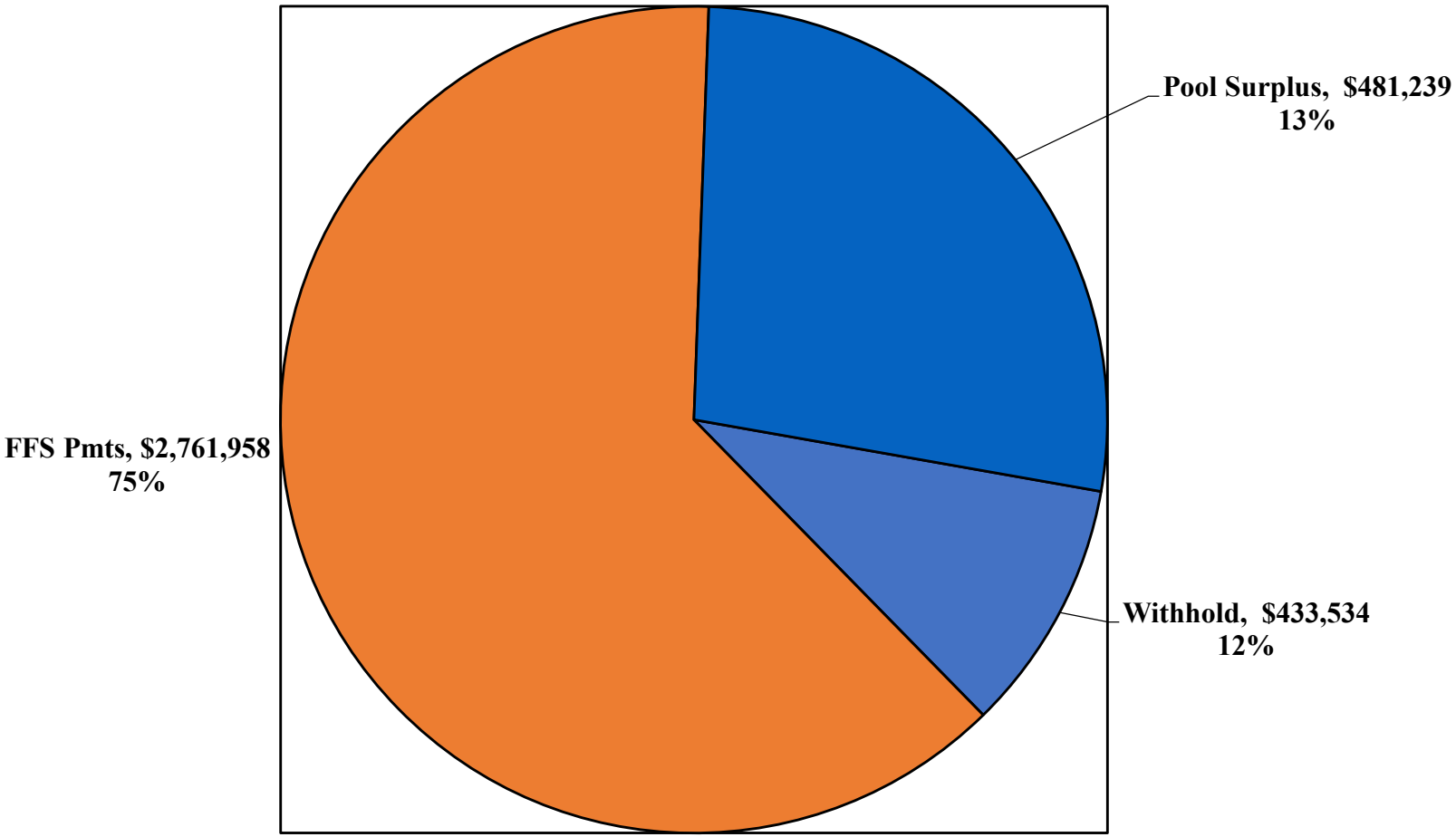
Actual YTD through December 2020 (claims paid through 3/31/2021)

	Gross Revenue	Less Admin	Net Revenue	Paid Cap	Paid FFS	Unassigned Members	Total Expenses
1/31/2020	501,991.84	60,239.02	441,752.82	239,719.90	69,094.72	46,704.00	355,518.62
2/29/2020	506,698.89	60,803.87	445,895.02	236,844.45	71,132.80	46,784.00	354,761.25
3/31/2020	506,967.63	60,836.12	446,131.51	239,119.75	65,383.86	50,512.00	355,015.61
4/30/2020	509,492.90	61,139.15	448,353.75	237,614.55	26,701.03	55,344.00	319,659.58
5/31/2020	524,193.53	62,903.22	461,290.31	240,820.15	38,247.91	55,520.00	334,588.06
6/30/2020	529,396.13	63,527.54	465,868.59	242,839.15	156,866.17	44,464.00	444,169.32
7/31/2020	535,221.26	64,226.55	470,994.71	266,519.75	64,564.06	46,608.00	377,691.81
8/31/2020	542,783.90	65,134.07	477,649.83	257,216.25	34,756.01	49,136.00	341,108.26
9/30/2020	544,050.06	65,286.01	478,764.05	258,458.15	63,920.93	49,168.00	371,547.08
10/31/2020	537,248.03	64,469.76	472,778.27	257,807.90	62,712.16	53,136.00	373,656.06
11/30/2020	534,620.42	64,154.45	470,465.97	258,930.55	75,363.99	56,208.00	390,502.54
12/31/2020	547,534.68	65,704.16	481,830.52	259,814.90	95,484.84	59,424.00	414,723.74
	6,320,199.26	758,423.91	5,561,775.35	2,995,705.45	824,228.48	613,008.00	4,432,941.93

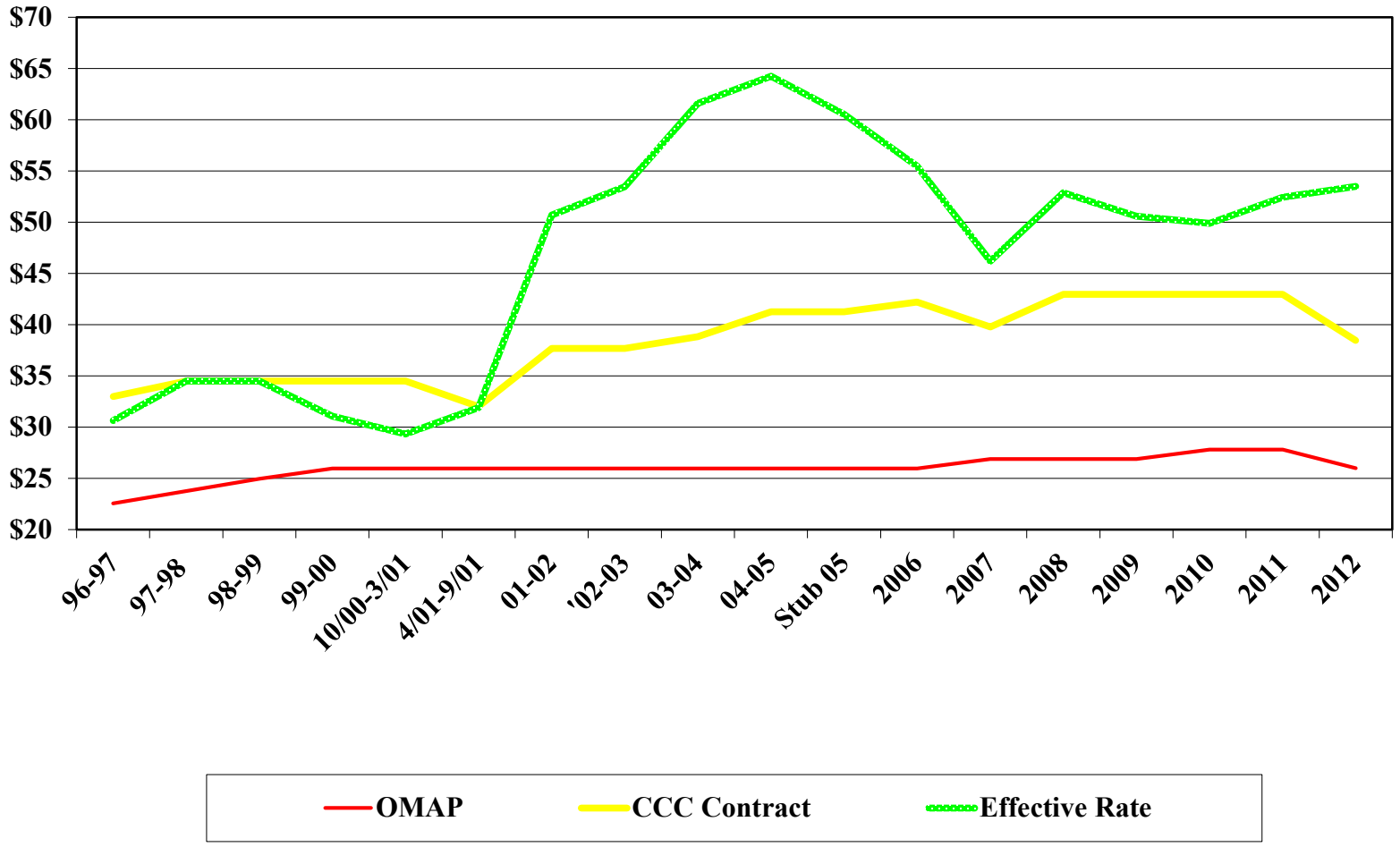
SUMMARY

Total Net Revenue	5,561,775.35
Total Expenses	4,432,941.93
Sur/Def Total	1,128,833.42
Withhold due	(297,397.01)
Net pool surpluses (deficits)	**831,436.41**
Distribution of Surplus/(Deficit)	
KOD	498,861.85
CHA	332,574.56
	831,436.41

KFIPA Reimbursement Breakdown

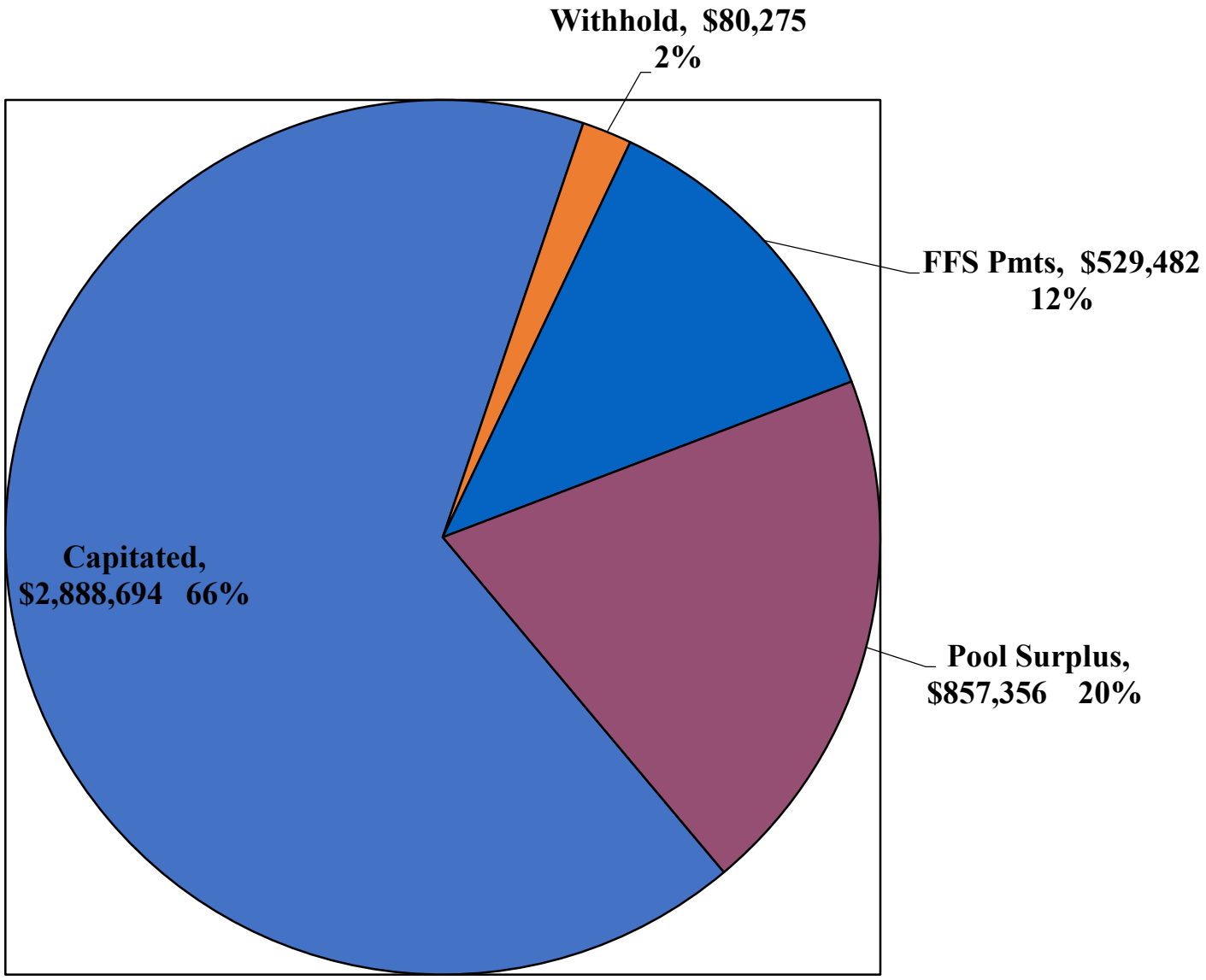


Specialist FFS Rates (Excluding Provider Bonuses) vs. OMAP

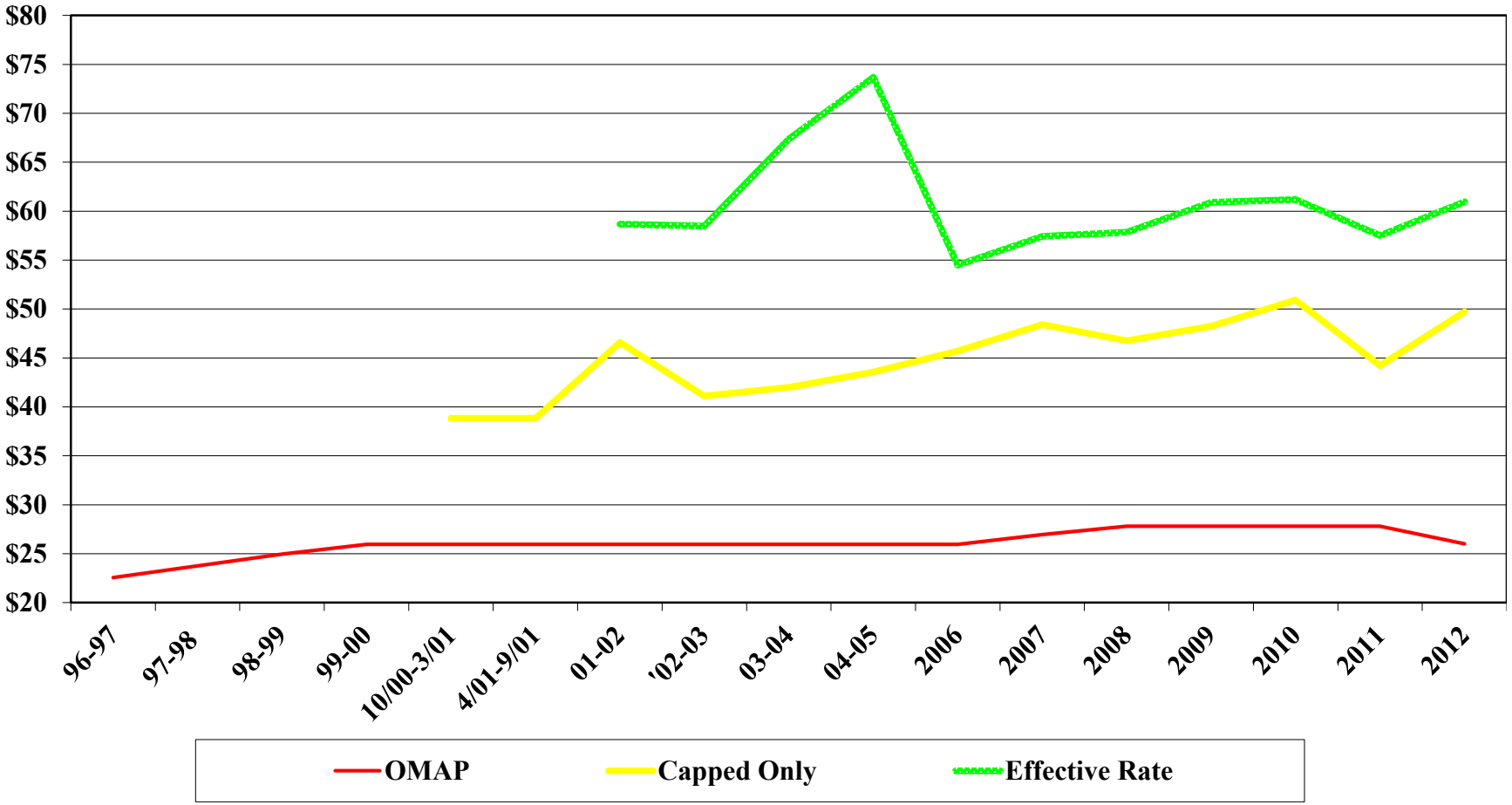


Specialist FFS Conversion Factor vs. OMAP and Medicare

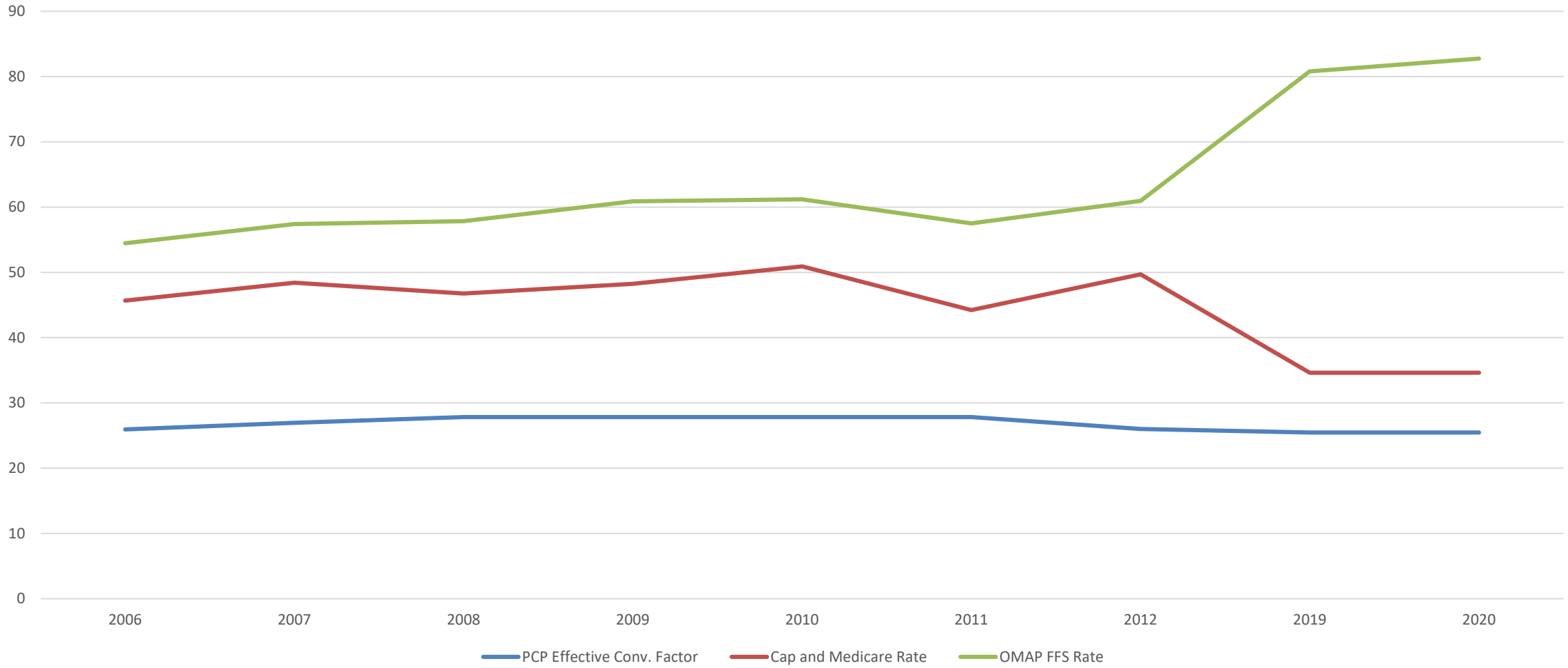
PCP Reimbursement Breakdown



PCP Equivalent Rates (Excluding Provider Bonuses) vs. OMAP



PCP Effective Conversion Rate vs. OMAP and Medicare



Corporate "Tithe"

Sobering Station – challenge grant $100K	$30K C.A.R.E.S. (Child Abuse Assessment Center)	$8K MWMC Benevolence Fund	$150K MWMC Foundation ($100K to Building Fund, $30K for C.A.R.E.S. and $20K Benevolence Fund	$68K MWMC ICAP; $20K to Head Start; $20K to OIT
$25K Sky Lakes Benevolence Fund	$20K C.A.R.E.S.; $10K Klamath Food Bank; Head Start $5K, SkyLakes Benevolent Fund $25K	$10K to Klamath Food Bank	$2,500 each to Salvation Army, CARES, Marta's House, and Klamath Gospel Mission	$25K to Klamath Food Bank;
$10K Cares,	$5K to Humane Society,	$10K to SLMC Foundation/Humanitarian Fund	$20K to Klamath Food Bank; $20K to SLMC Foundation/Humanitarian Fund	$10K to Klamath Basin Senior Center for Meals on Wheels

Why has the local private model been successful since 1994?

- Driven by the local medical community of physicians and local non-profit hospital
- Aligned incentives: The “workers” are also the “owners”
- Community minded, and good community member
- “Skin in the game”