Samaritan Health Plans

InterCommunity Health Network CCO

InterCommunity Health Plans Board of Directors Meeting - Public
December 17, 2025, 1:00 pm – 3:00 pm
in person SHS Walnut Board Room
2300 Walnut Blvd, Corvallis, OR
or

Microsoft Teams
Join the meeting now
Meeting ID: 226 900 861 066
Passcode: XZzjXx
Dial in by phone
+1 971-254-1254,,209271035# United States, Portland
Find a local number
Phone conference ID: 209 271 035#
For organizers: **Meeting options** | **Reset dial-in PIN**
Please remember to join with the Phone Audio button if you don't have adequate computer audio/headset
Org help

Board Members		
☐ Marty Cahill, Chair	☐ Dick Knowles	☐ Kristy Jessop, MD
☐ Brecca Claitor	☐ Gabe Shepherd	☐ Todd Noble
☐ Bruce Madsen, MD		☐ Will Tucker

Presenters		
☐ Andi Easton	☐ Dan Smith	☐ Matt Farmer
☐ Bruce Butler	☐ Jennifer Hatchett	☐ Todd Jeter
	☐ Kelley Burnett, DO	☐ Trent Began

Invited and Other Attendees		
☐ Members of the Public	☐ Jan Chambers	☐ Rachel Arnold
☐ Anne Daly	☐ Kristty Polanco	☐ Rebekah Fowler, Ph.D
☐ Annette Fowler	☐ Melissa Bates	☐ Tom Loach

Agenda

	Time	Item	Presenter	Purpose
1.	**1:00** 5 min	**Call to Order and Welcome**	Marty Cahill	Informational
2.	**1:05** 5 min	**Reliability Moment**	Dr. Kelley Burnett	Informational

	Time	Item	Presenter	Purpose
3.	**1:10** 5 min	**Introductions and Announcements** • *Dexter Thomas, Dir Claims & Enrollment*	Bruce Butler Annette Fowler	Informational
4.	**1:15** 5 min	**Public Comments**	Marty Cahill	Informational
5.	**1:20** 5 min	**IHP Board Minutes of August 20, 2025** • *Request motion* • *Call for vote*	Marty Cahill	**Action**
6.	**1:25** 20 min	**CEO Report**	Bruce Butler	
7.	**1:45** 15 min	Finance Report • **Financials Review** • **2026 IHN Budget & Overview**	Dan Smith Trent Began	Informational **Action**
8.	**2:00** 10 min	**Compliance Officer Report**	Jennifer Hatchett	Informational
9.	**2:10** 20 min	**Government Relations Report**	Andi Easton	Informational
10.	**2:30** 10 min	Health Equity & Community Benefit Report	Todd Jeter	Informational
11.	**2:40** 10 min	**Chief Medical Officer (CMO) Report** • DSNP	Kelley Burnett, DO	Informational
12.	**2:50** 10 min	Operations Report • Metrics Update	Matthew Farmer	Informational
13.	**3:00**	**Good of the Order - Adjournment**	Marty Cahill	
		Executive Session (if needed)		

**SHS Strategic Priorities:*

Quality and Service Excellence (QSE) *Community Partnerships (CP)*

Sustainability (S) *Employee Engagement (EE)*

Next meeting: February 18, 2026, 1:00-3:00pm
SHS Board room, Walnut – In person

Note: Quorum is 50% of the current number of Board Directors, and actions require a ¾ vote of quorum.

New Staff

Bruce Butler, CEO

Annette Fowler, COO

Dexter Thomas

Director, Claims & Enrollment

Over 20 years of experience in healthcare operations

Expertise in:

- Operational efficiency
- Team leadership
- Performance improvement

Led large multi-state and global teams

Built strategic partnerships with providers and payers

Drove initiatives to enhance KPIs, quality, and industry standards

InterCommunity Health Network CCO

Matthew (Matt) Farmer

Clinical Data Ops Program Director

- Nurse with 13 years of healthcare experience
- **Leadership roles in:**
- Education
- Emergency and critical care
- Population Health
- Last 5 years: Director of Clinical Operations, CoxHealth PHSO Population Health
- Served over 100,000 lives
- Managed Medicare Advantage, Medicaid, commercial,
and employer-funded plans

InterCommunity Health Network CCO

InterCommunity Health Network CCO

InterCommunity Health Plans Board of Directors Meeting - Public
August 20, 2025, 1:00 pm – 3:00 pm
in person SHS Walnut Board Room
2300 Walnut Blvd, Corvallis, OR

Board Members		
☐ Marty Cahill, Chair	☒ Dick Knowles	☒ Kristy Jessop, MD
☐ Brecca Claitor	☒ Elijah Stucki	☒ Todd Noble
☒ Bruce Madsen, MD	☒ Gabe Shepherd	☐ Will Tucker
☐ Claire Hall		

Presenters		
☒ Andi Easton	☒ Dan Smith	☒ Todd Jeter
☒ Bruce Butler	☒ Jennifer Hatchett	☒ Trent Began
☒ Chris Peters	☒ Kelley Burnett, DO	

Invited and Other Attendees		
☐ Members of the Public	☒ Jan Chambers	☐ Rachel Arnold
☒ Anne Daly	☒ Kristty Polanco	☒ Rebekah Fowler, Ph.D
☒ Annette Fowler	☒ Melissa Bates	☒ Tom Loach

Agenda

Item	Discussion/*Action*
Call to Order and Welcome	The meeting was called to order by Kristy Jessop at 1.01pm, who served as acting chair in Marty's absence. She welcomed attendees and introduced Christopher Peters for the "Reliability Moment.
Reliability Moment	Chris Peters, Director of the Center of Performance Excellence, shared a recent example of proactive compliance improvement. A discrepancy in data mapping for a regulatory report was caught before submission, prompting a cross-functional review. The team identified root causes and implemented automated validation checks, exemplifying High Reliability Organization (HRO) principles.

Item	Discussion/*Action*
Introductions and Announcements • ***Kelley Burnett, DO- New Chief Medical Officer, Health Plans***	Bruce Butler formally introduced Dr. Kelly Burnett as the new Chief Medical Officer (CMO) for Samaritan Health Plans and InterCommunity Health Network CCO. Dr. Burnett succeeds Dr. Brent Goedek, who transitioned to a system-wide role. Her prior experience as CMO at AllCare in Southern Oregon was highlighted, and the board expressed confidence in her leadership.
Public Comments	Melissa Bates read a public comment submitted by Brittany Anglo, a patient expressing frustration with the prior authorization process for diabetes care. Anglo described delays caused by Samaritan's reliance on fax-based systems, despite insurers offering faster electronic portals. The board discussed the case, noting that most contracted providers already use electronic portals and that the issue may stem from a disconnect between systems or insurance providers. The board committed to further offline investigation and noted upcoming portal upgrades in September.
IHP Board Minutes of June 18, 2025 • ***Request motion*** • ***Call for vote***	***A motion to approve the June 18, 2025, minutes was made by Dick Knowles and seconded by Todd Noble. There were no objections or corrections. Unanimous approval by all Directors present.***
2026 Proposed Board Meeting Schedule • ***Request motion*** • ***Call for vote***	***A motion to approve the 2026 board meeting schedule was made by Dick Knowles and seconded by Todd Noble. There were no objections or corrections. Unanimous approval by all Directors present.***
Finance Report • **Financials Review** • **IHN Forecasting & Trends Update**	Trent Began presented the financial report, noting a year-to-date net loss of $11 million and a medical loss ratio (MLR) of 93%, significantly above the budgeted 88.9%. While revenue exceeded expectations due to higher membership, claims expenses were $26.6 million over budget. Salaries were under budget due to open positions, but purchase services were over budget, largely due to community reinvestments. Investment income was also down. The balance sheet showed stable assets but increased liabilities, particularly in claims reserves. Trent Began provided a detailed analysis of cost trends across Medicare, commercial, and IHN lines of business. He explained that post-pandemic cost increases have plateaued but remain elevated, especially for IHN, which is now entering its growth phase. He outlined three financial scenarios for 2026, ranging from break-even to significant losses, depending on cost trends and state rate adjustments.

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Item	Discussion/*Action*
Compliance Officer Report	Jennifer Hatchett reported on internal and external audits. Internal audits by Protiviti revealed issues with turnaround times in appeals and utilization management, though some findings were based on incorrect standards. External audits included a financial audit, HSAG compliance review, and fraud, waste, and abuse investigations. Hatchett noted progress in resolving past findings and outlined efforts to improve policy management and compliance tracking. She also discussed hotline reporting trends, with most issues related to HIPAA misdirected PHI.
CEO Report • **Market Conditions**	Bruce Butler expanded on the financial challenges, emphasizing that IHN is not alone—many Coordinated Care Organizations (CCOs) in Oregon are experiencing unsustainable losses. Mr. Butler presented data showing that some CCOs are spending more on claims than they receive in revenue. He warned that without intervention, some CCOs may exit the market. Mr. Butler also highlighted the unprecedented alignment of financial stress across both health plans and hospitals.
Government Relations Report	Andi Easton provided a policy update, describing a “perfect storm” of pressures from both state and federal levels. She discussed the delayed CCO reinstatement contract and the challenge of reconciling OHA’s proposed 6.8% rate increase with the legislature’s 3.4% budget allocation. Easton also addressed the implications of federal legislation (HR1), including future reductions in Medicaid funding and the potential loss of coverage for thousands of IHN members. Ms. Easton noted ongoing litigation and injunctions related to Planned Parenthood funding and emphasized the importance of proactive planning.
Health Equity & Community Benefit Report	Todd Jeter shared updates on health equity initiatives, including the launch of a dual-track program: NCQA Health Equity Accreditation and a deeper organizational assessment with the Linn-Benton-Lincoln Health Equity Alliance. Mr. Jeter also described a promising regional collaboration with school districts to create a payer-blind behavioral health system in schools. This initiative aims to ensure all children, regardless of insurance status, have access to year-round mental health services.
Chief Medical Officer (CMO) Report	Dr. Kelley Burnett outlined her responsibilities as CMO, including oversight of prior authorizations, utilization management, care coordination, and pharmacy. Dr. Burnett emphasized the upcoming regulatory change that will halve prior authorization turnaround times in January 2026. Burnett also discussed efforts to improve workflows and align processes for greater efficiency.
Operations Report • **Project Portfolio Review**	Chris Peters provided an update on the health plan’s project portfolio. Of the 21 active projects, 62% directly support IHN. The top three projects—EDM transformation, care coordination redesign, and portal implementation—received the majority of project resources. Peters highlighted the successful early launch of the member portal and the strategic use of vendor

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	partnerships to reduce internal workload. He noted that resource availability is improving, allowing for continued progress on lower-priority projects.
Good of the Order - Adjournment	Kristy Jessop, MD adjourned the meeting at 2:43pm.
Executive Session (if needed)	

**SHS Strategic Priorities:*

Quality and Service Excellence *(QSE) Community Partnerships (CP)*

Sustainability (S) *Employee Engagement (EE)*

Next meeting: October 15, 2025 - in- person option: Boysen Board Room
Walnut Building – Corvallis, Oregon

Note: Quorum is 50% of current number of Board Directors. Actions require a ¾ vote of quorum.

Respectfully submitted,
Bruce Butler

____
Marty Cahill, President and Chair,
Samaritan Health Plans Board of Directors
Date:

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October Financials

Dan Smith SHS- CFO

Samaritan Health Services
INTERCOMMUNITY HEALTH NETWORK
Income Statement

	Y-T-D		
	Oct 2025 Actual	**Oct 2025 Budget**	**Act - Bud Variance**
Revenues:			
Premium revenue	$ 510,985,505	$ 493,606,243	$ 17,379,262
Other operating revenue	198,079	172,500	25,579
Total revenue	511,183,584	493,778,743	17,404,841
Expenses:			
Salaries	15,256,940	17,134,538	1,877,597
Employee benefits	5,238,681	5,950,966	712,285
Supplies	492,469	365,786	(126,683)
Purchased services	18,047,009	16,599,636	(1,447,373)
Agency	884,272	1,550,255	665,983
Depreciation	58,953	58,953	0
Insurance	2,951,750	4,357,171	1,405,421
Claims expense	476,074,001	437,471,313	(38,602,688)
Other	12,230,845	9,782,801	(2,448,045)
Total expenses	531,234,919	493,271,418	(37,963,501)
Excess of revenues over expenses from operations	(20,051,335)	507,325	(20,558,660)
Non-operating income:			
Investment income	4,813,129	6,661,591	(1,848,462)
Total non-operating income	4,813,129	6,661,591	(1,848,462)
Excess of revenues over expenses	$ (15,238,206)	$ 7,168,916	$ (22,407,122)
Net operating margin	-3.9%	0.1%	
Total margin	-3.0%	1.5%	
Administrative % (Admin Costs/Total Prem Revenue)	8.0%	8.7%	
Medical Loss Ratio (Claims/Premium Revenue)	93.6%	89.3%	

Samaritan Health Services
INTERCOMMUNITY HEALTH NETWORK
Balance Sheet
As of October 31, 2025

	10/31/25	***12/31/24***
Assets		
Cash and cash equivalents	$ 29,932,187	$ 43,516,204
Short-term investments	518,755	4,439,131
Intercompany receivables (payables)	4,961,668	-
Other receivables	9,143,397	9,543,306
Total current assets	$ 44,556,007	$ 57,498,641
Long-term investments	$ 95,004,324	$ 87,164,669
Statutory deposits	21,939,397	20,082,690
Total other assets	$ 116,943,721	$ 107,247,360
Property, plant and equipment, net	$ 3,176,198	$ 3,235,152
Total assets	$ 164,675,926	$ 167,981,152
Liabilities and net assets		
Accounts payable	$ 16,008,526	$ 19,129,807
Intercompany payables	-	601,298
Liability for unpaid medical claims	43,177,376	44,790,156
Other current liabilities	29,564,624	13,560,270
Total liabilities	$ 88,750,526	$ 78,081,531
Total net assets	$ 75,925,401	$ 89,899,621
Total liabilities and net assets	$ 164,675,926	$ 167,981,152

Compliance Report

December 17, 2025
Jennifer Hatchett
Health Plans Interim Compliance Officer

Audits

External

- **HSAG 2025 Compliance Monitoring Review**
  - Vast improvement
    - All standards scored 90% or greater
    - 100% for :
      - Disenrollment, Confidentiality, Health Information Systems
    - 93.8% Quality Assurance and Program Integrity
    - 90% Member Information and Member Rights & Protections
  - Nine Improvement Plans required (6 partially met)
  - Closed 13/17 Improvement Plans from 2023 and 2024 CMRs
- **Qlarent UPIC Audit IHN Fraud Waste & Abuse**
  - In process; final files submitted December 5, 2025
- **IHN Financial Audit**
  - Two findings: Formal Board Review of Intercompany Agreements, Restricted Reserve Deficits Reporting
  - Management Letter Response Submitted on November 14, 2025

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OHA Review

Deliverables

- **Vendor Oversight**
    - Request for Additional Information regarding Corrective Action Plan for a delegated vendor, Teladoc (Provider Credentialing)
    - Response submitted November 25, 2025

Update: FWA Annual Reporting Suite Reported at August meeting is now closed

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Compliance Organization

Pathway to Enhanced Compliance

1. Delegated Vendor Oversight Committee

   Relaunched DVOC on December 1, 2025

   Coordinating with new operations liaison that oversees DV process

2. Policies & Procedures Process and Committee

   Relaunch on hold pending onboarding of new Compliance Officer

   New materials drafted to support new process and education of committee members on their roles

3. Corrective Action Plans

   TIGER team formed in November 2024; work of team and new compliance lead reviewed, categorized and closed those CAPs completed and established clearer guidelines on the role of the business owner, Compliance and Government Programs in the process

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Dashboards

Beta Version

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Open Lines of Communication

- Transitioned from two intake points to EthicsPoint
- Began transitioning responsibility for “compliance incidents” back to business owner to respect the three levels of responsibility
- Marked improvement on closure rates
- Collaboration with SHS compliance on shared services (Privacy, Security, HR issues)
- Some key points
- YTD closure rate as of end of Q3 is 74.7%; Q3 closure rate was 82.1%
- Improved responsiveness
- Privacy issues still dominate

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Hotline Metrics

Case Categories

Category	YTD 2025	Q3 2025
Privacy	95	34
Operations	38	4
HR/Legal/Other	4	0
Compliance	4	1
FWA	6	0
Unspecified	3	—

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Case Closure Timeliness

Period	1-14 Days	15-30 Days	31+ Days
YTD 2025	49 (43.8%)	27 (24.1%)	34 (30.4%)
Q3 2025	19 (59.4%)	11 (34.4%)	2 (6.3%)

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Corrective Action Plans

Category	YTD 2025	Q3 2025
Subcontractor/Vendor	5	4
Regulatory	1	0
Internal	3	1

Department	YTD 2025	Q3 2025
Network	5	4
Appeals & Grievances	2	0
Compliance	1	0
Care Coordination	1	1

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In Process

- Fraud Waste & Abuse
- Policies & Procedures
- Training

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Annual Board of Directors and Leadership Training

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Government Relations Update

Navigating the Headwinds Ahead

Andi Easton, Government Relations Director

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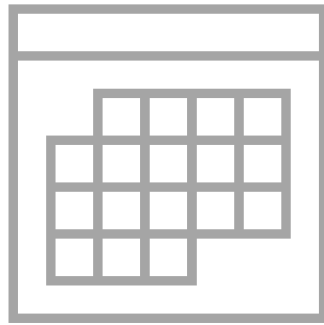
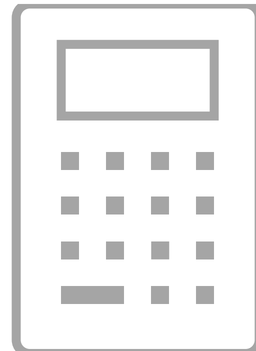
The 2026 Session

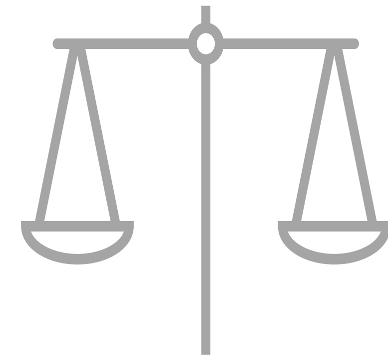
The pressures of the short session



Dynamics



State Budget & Policies



Elections & Real-World Problems

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State Budget

State revenue down, costs up & reductions are proposed

- Recent forecast projected a **shortfall of $63M**.
    - Includes 1x increase in corporate tax revenues
    - Zero ending balance
    - Does not account for H.R. 1 implementation cost
- Agencies put forth **5% reductions for consideration**; deference given to Governor priorities (i.e., Behavioral Health and State Hospital)

- **Bottomline**: Oregon facing a structurally weaker revenue position, making fiscal management more challenging for the Legislature.

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OHA Budget

OHA's target = $916M in reductions

- Designed to minimize harm while maintaining core health and equity functions
- Prioritize and protect maternity rate increases and behavioral health investments
- No reductions to the Oregon State Hospital
- What's at stake:
  - **GME** $8.2M GF, $16,9M FF or **$29M at risk**
  - **DSH3 reductions** $34.1M GF, $47.22M FF or **$81.3M at risk**
  - **Hospital discharge** $1.9M GF, $2.4M FF or **$4.3M at risk**
  - **Quality Incentive Pool (QIP)** $34.4M GF,$81.2M FF or **$115.6M reduction**

- **Bottomline:** Real dollars from the Medicaid system are at stake and that will impact access to care.

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Financials

Its no long only one sector, it's the entire system that is struggling

- Nearly half of Oregon hospitals are operating at a loss, while others barely broke even. Hospitals are shuttering services and even doors.
- Insurance companies are asking for double digit rate increases.
- The statewide CCO current ratio of assets to liabilities is .87; a healthy ratio is at least 1. Furthermore, CCOs on average have a MLR of 94.6%.

- **Bottomline:** Costs are outpacing revenues and threatening the safety net system.

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2026 CCO Rates

Sustainable rates and a transparent process

- Sustainability rates are key to maintaining access to health care.
  - Reduces uncertainty to members and increases confidence to providers
  - Allows for value-based payment arrangements and planning for community benefit
  - Sets a foundation on which state can collectively address the challenges coming (H.R. 1 and Economics)
- Need for year-over-year consistency and alignment with actual cost growth
- Tools available to CCOs to manage costs have been curtailed

- **Bottomline**: 2026 rate increase came at a cost to the QIP at a time of significant instability.

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What's on the Horizon

Hard Conversations about the future of Medicaid

- How to pay for Medicaid in a resource restraint environment
- Exam the 3 levers: Coverage, Benefits and Reimbursements
- Prepare for enrollment volatility
- Great need for eligibility support and outreach
- Change does not bring additional complexity to an over complex system

- **Bottomline**: Asked to do more with far less

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Health Equity & Community Benefit Report

Todd Jeter
AVP, Health Equity & Member Advocacy

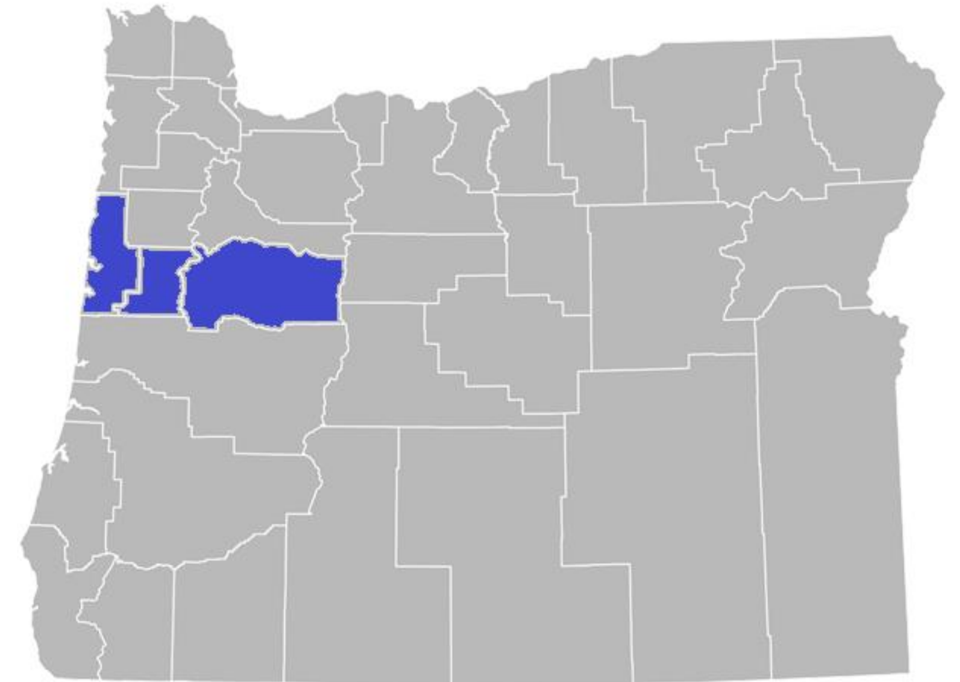
Dual Special Needs Plan (DSNP)

Kelley Burnett DO
SHP Chief Medical Officer

InterCommunity Health Network CCO

Who Are Our SNP Members

Who Are Our SNP Members



Members must meet "means tested eligibility requirements" for the Oregon Health Plan (Medicaid) **and** be enrolled in Medicare Part A and Part B due to age and/or disability.

SNP members thus represent one of the most economically disadvantaged and medically vulnerable groups in our tri-county service area

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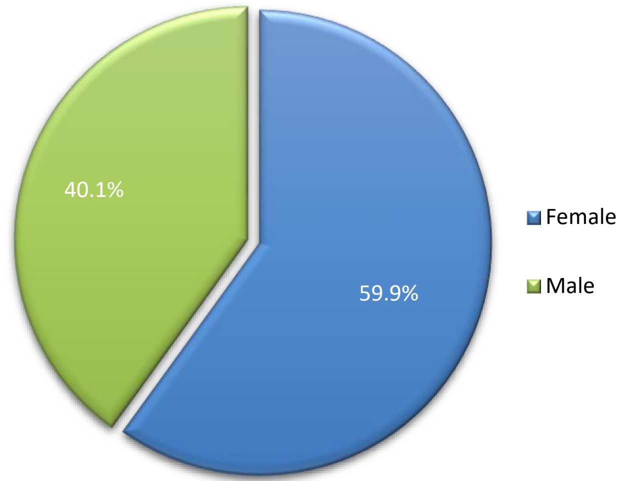
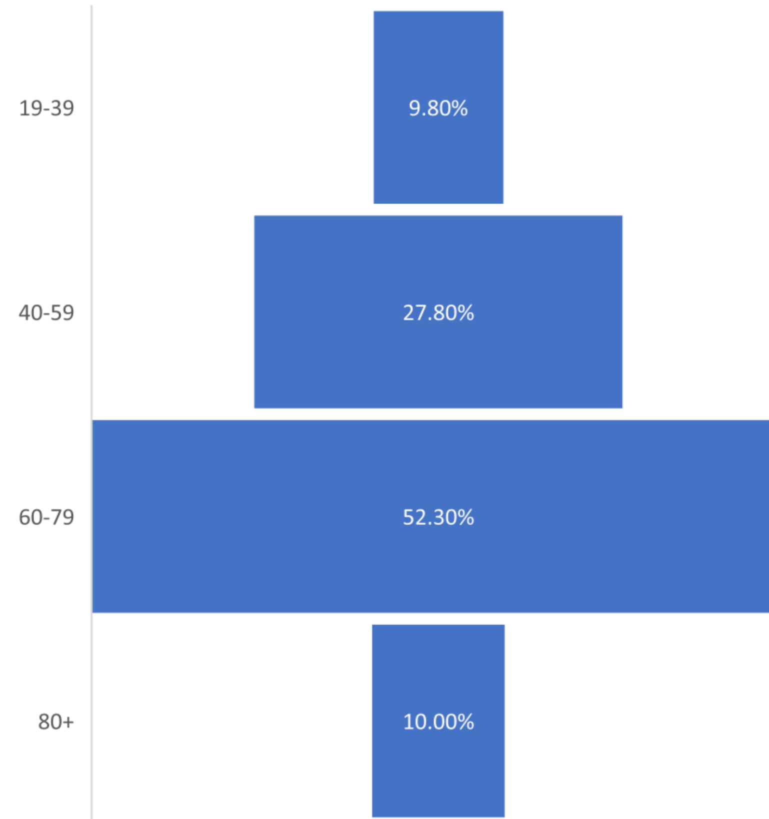
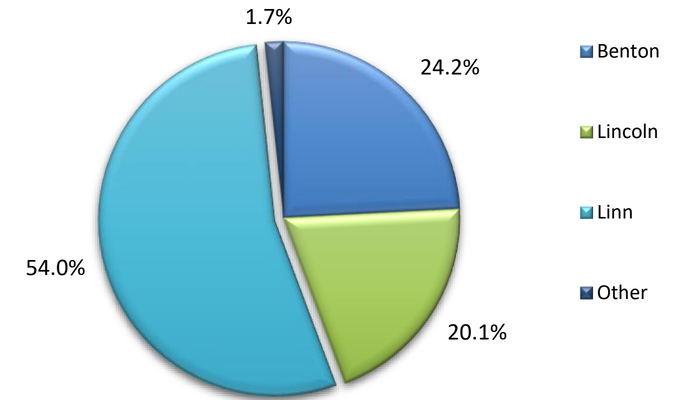
Who Are Our SNP Members — Continued



Approximately 60% identify as women.

SNP members by age group





SNP members by county

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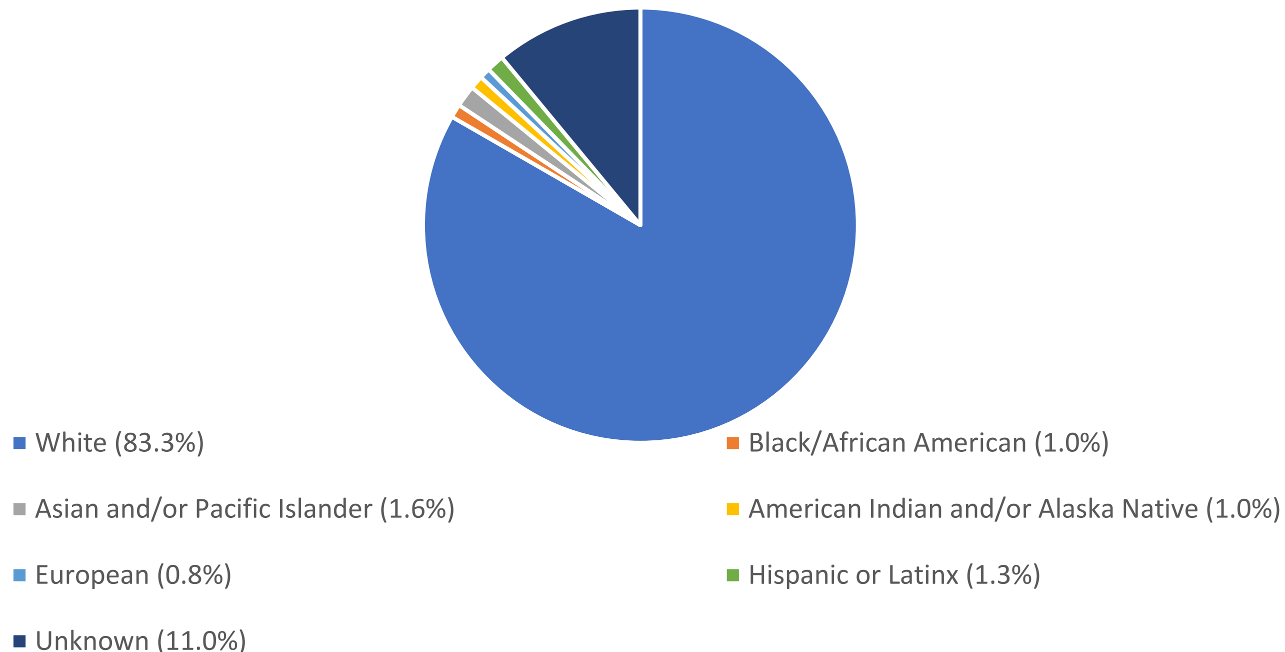
Who Are Our SNP Members — Continued

While SNP members may predominantly speak English and be classified as Caucasian, providing **culturally** and **linguistically** appropriate services is essential.

Cultural and Linguistically Appropriate Services (CLAS) are **respectful of** and **responsive to** an **individual's culture and communication needs**.



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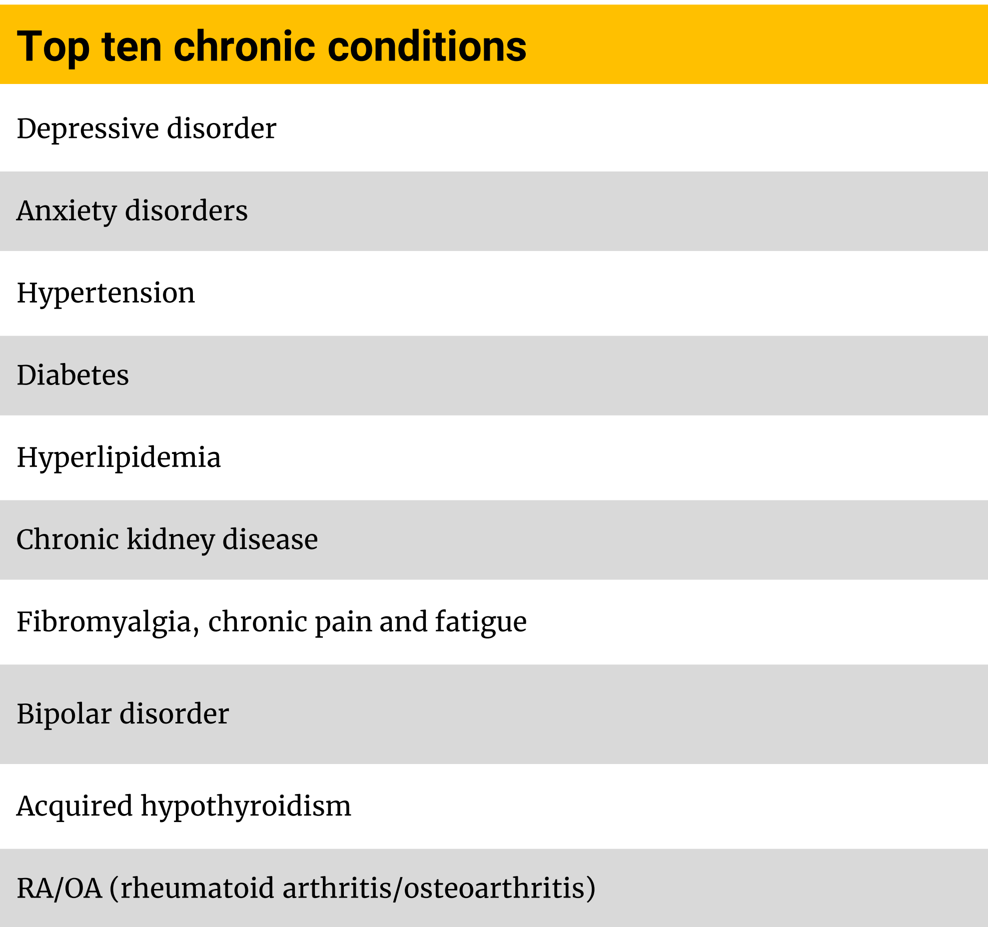
Who Are Our SNP Members — Continued

In 2021, SHP completed a claims data study to determine the prevalence of chronic conditions among our Special Needs Population.

Approximately 86.8% of SNP members were identified as having a chronic condition that impacts them mentally, physically or behaviorally.



Top ten chronic conditions
Depressive disorder
Anxiety disorders
Hypertension
Diabetes
Hyperlipidemia
Chronic kidney disease
Fibromyalgia, chronic pain and fatigue
Bipolar disorder
Acquired hypothyroidism
RA/OA (rheumatoid arthritis/osteoarthritis)

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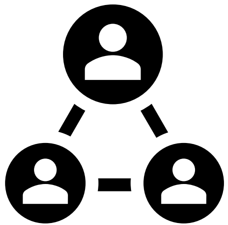
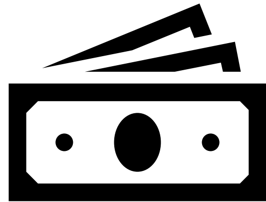
Challenges

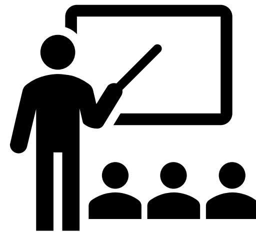
In addition to chronic health conditions, our SNP members may experience additional challenges which impact overall health.



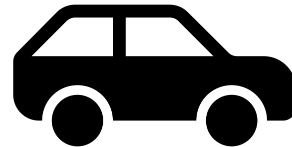
Social support



Economics

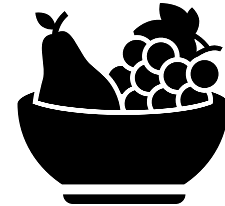


Educational attainment



Transportation

Housing



Food insecurity

InterCommunity Health Network CCO

Care Coordination

Each member's care management is predicated on standard SNP MOC elements.

Health Risk Assessment	Individualized Care Plan	Interdisciplinary Care Team	Face-to-Face Encounter
HRA	**ICP**	**ICT**	

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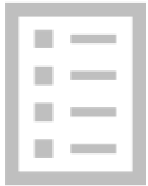
Care Coordination — Continued

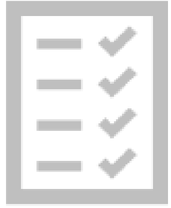


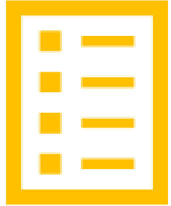
Health Risk Assessment

- Performed by an SHP staff member.
- Conducted within 90 days of enrollment, annually and anytime there is a change in health status or transition of care. HRAs are completed in person, by phone, mail or online.
- Questions centered around medical, functional, cognitive, oral and psychosocial health, social determinants of health and safety of the member's environment.
- Assists in identifying barriers to care.

InterCommunity Health Network CCO

Care Coordination — Continued





Individualized Care Plan

- Member, caregivers, providers and/or family participate in creation, which is conducted in a trauma-informed, culturally and linguistically appropriate manner.
- Maintained and monitored by the care manager.
- Dynamically updated within ICT meetings and member's progress toward goals documented.
- It is updated annually or as transitions of care or diagnosis warrant.
- Individual care plans are mailed to the member and shared with PCP, ICT and caregivers and stored in SHP's care management platform.
- Barriers to care are addressed through goals, interventions and plans for follow up.

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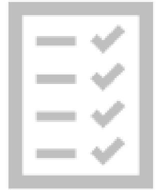
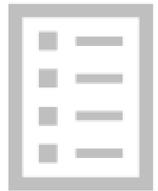
Care Coordination — Continued

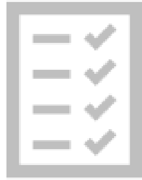




Interdisciplinary Care Team

- Facilitated by and overseen by the Care Management team.
- Meeting cadence determined by member's unique needs.
- All ICTs include a minimum of an SHP care manager, member and member's PCP.
- ICT participants may include specialist providers, community-based organizations and family members.
- ICTs works to share information that modifies the care plan and potential health outcomes for the member.

Care Coordination — Continued



Face-to-face Encounter

- Ensure the member has a face-to-face encounter with a provider within the first 12 months of enrollment and at least annually thereafter.
- May be conducted in-person, or through a visual, real-time, interactive telehealth encounter.
- Wellness visits, annual physical, care plan review, health related education, encounter to manage, treat and oversee health care represent activities conducted for the qualifying face-to-face encounter.
- A vendor may perform these face-to-face encounters for some members. The vendor will send a copy of their assessment/recommendations to the member's provider of record.
- A face-to-face encounter informs the care plan.
- Care coordination activities are driven by the face-to-face encounter to follow up on needed care or services.

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Transitions of Care

A **transition of care** occurs when a member moves from one care setting to another — such as returning home from inpatient hospitalization or outpatient surgery, changing PCPs or the initiation of home-based services.

When a transition of care event is identified, the care manager coordinates between the member, PCP and Interdisciplinary Care Team.

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Transitions of Care — Continued

Following a transition of care event, the care manager contacts the member to assess the following:

- Assesses member's understanding of discharge instructions.
- Ensures member has a post-hospital follow-up appointment.
- Identifies potential barriers.
- Reviews any new care needs.
- Links member with all needed services.
- Educates for post-transition care.
- Collaborates with provider.
- Updates individualized care plan.

Finally, the care manager updates and redistributes the individual care plan to all parties by mail and/or fax.

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Questions?

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Metrics Update & Demo

Matt Farmer

SHP Data Sci-Analytics Program Director