Organization Structure

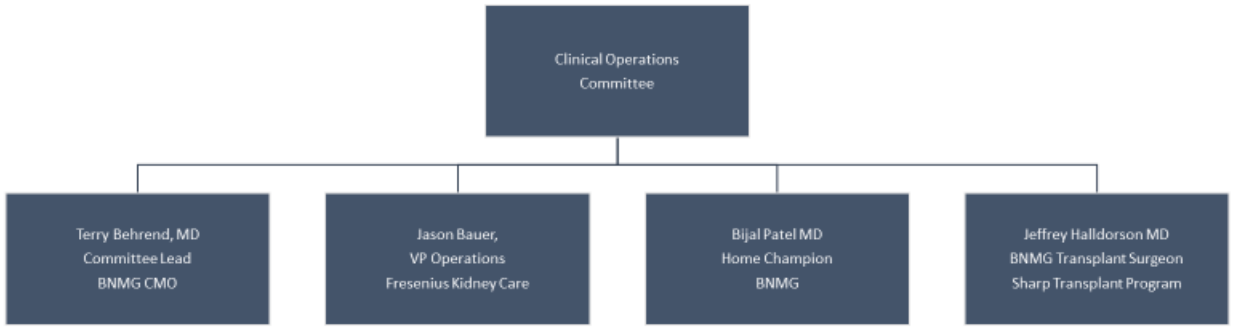
1. Please provide a proposed organizational chart for the KCE. It should depict the legal structure and governing body, the proposed composition of the applicant, and any relevant committees. **(No more than 2 pages)**

Camino Renal Care, LLC is a California Limited Liability Company formed November 26, 2019. TIN #84-3849472. It is a single member LLC that is owned by Balboa Nephrology Medical Group. The following organizational charts detail governance, committees and support that is relevant to our KCE.

GOVERNING BOARD | Camino Renal Care

Balboa UNITED

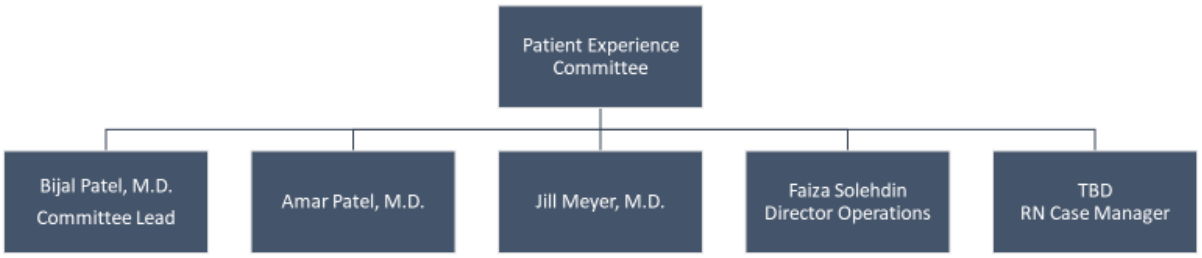
The Governing Board of Camino Renal Care is made up of five members, including one Beneficiary Representative and one executive representative from our Preferred Provider transplant program. Three of the four members represent BNMG when scoring for governance control, giving the KCE Participant 75% control. Three of five total members represent the nephrology practice so that 60% of the total members represent the nephrology practice. The Governing Board will place their fiduciary duty to the KCE ahead of their interests to the KCE Participant or Preferred Provider in all decisions related to the KCE. The Beneficiary Representative we select will be an existing patient with no financial relationships or encumbrances to the KCE or KCE Participant, and with no family member connections. The Governing Board will meet monthly to review the operations and performance of the KCE. A dashboard review of performance measures encompassing quality, outcomes, beneficiary satisfaction and cost goals will be the driver of the monthly meetings. The Governing Board will do a deep dive into each area to ensure that the Mission of the organization is being accomplished, in accordance with our values.



CLINICAL OPERATIONS COMMITTEE | Camino Renal Care

Balboa UNITED

The Clinical Operations Committee will meet quarterly and review the clinical achievement of core quality measures for beneficiaries being tracked in the CKCC models. The Committee includes senior leaders from the primary providers who are touching these patients and encompassing CKD, dialysis in all its forms and transplant. The Committee will make recommendations through the Lead on actions to enhance the achievement of the targeted clinical quality measures in the CKCC model.



PATIENT EXPERIENCE COMMITTEE | Camino Renal Care

Balboa UNITED

The Patient Experience Committee will meet quarterly and review the performance of the company in achieving beneficiary satisfaction with the services being provided, depression scores, and approaches to activate and

engage the patient population to be active participants in their own care. This committee will also make recommendations through the Committee Lead on actions to enhance the achievement of the targeted satisfaction and engagement measures in the CKCC model.

Organization Structure

2. Please provide the information specific to the KCE's proposed leadership team. The leadership team may include, but is not limited to: key executives, finance, clinical improvement, compliance officers, information systems leadership, and the individual responsible for maintenance and stewardship of clinical data. If specific individuals have not yet been identified, please note that in the Name column and provide an anticipated date by which the individual will be identified. Please also include a brief description of the responsibilities associated with that each position/role. **(No more than one page)**

Leader	**Role**	**Responsibilities**
Dylan Steer MD	Chief Executive Officer	Responsible for the overall performance of CRC in achieving the goals of the CKCC Model, and leadership of the management team.
Terry Behrend MD	Chief Medical Officer	Responsible for the oversight of clinical care, care coordination, data integration and utilization, and achievement of key milestones in beneficiary management. In this role the CMO also provides oversite and leadership to the data analytics team and is responsible for stewardship of clinical data.
Shaun Edelstein	Chief Financial Officer	Responsible for financial oversight of CRC and tracking and reporting the financial performance and results of the CKCC Model.
Glenn Davis	Chief Growth & Development Officer	Responsible for managing the operational relationships and shared accountabilities of the Partners and Preferred Providers participating in the KCE.
Machelle Shield	Chief Compliance Officer	Responsible for compliance with all applicable compliance requirements attributable to state, federal and CMS regulations.
TBD RN (Anticipated hire date March 31, 2020)	Care Coordination Director	Responsible for the leadership of the multi-disciplinary care team and their effectiveness and performance within the CKCC Model.

Organization Structure

3. Please provide a narrative explanation of 1) why the KCE wishes to participate in one of the CKCC Options, 2) the KCE's proposed KCE participants, and 3) how the KCE will achieve the goals of better health and better care for Medicare beneficiaries with CKD, ESRD and transplants? **(No more than 2 pages)**

We believe patients do better in outcomes-oriented models of care. We believe communities fare better with coordinated, comprehensive population health approaches to care. We believe total healthcare expenditures decrease with alignment around value. We believe our physicians will enjoy improved sense of purpose and less burnout in patient-centered paradigms of care. These four beliefs drive our "Why." The ultimate product of the CKCC model of kidney care is this "Quadruple Aim" and the CKCC model aligns with our core beliefs.

BNMG – the provider group - created Camino Renal Care, the KCE, to focus our efforts on that Quadruple Aim. As a physician group, we understand all of the factors and drivers that have created the current paradigm of fractured, fragmented, service-oriented kidney care. The result is a cohort of Medicare beneficiaries with sub-optimal outcomes obtained at high cost. Not only do we believe that we can do better, based on our experience with CMS Demo Project and the CEC program, we know we can.

The KCE is focused on five core values: Patient-Centeredness, Accountability, Respect, Innovation, and Data-Driven. We practice what we preach, and BNMG is using these values to transition its core business plan from a service-oriented model to an outcomes-oriented model. To make that transition, the medical group has incorporated internal quality metrics and adjusted our physician compensation around patient outcomes and quality. We have invested in a robust internal data analytics capability and care coordination team. We have our own transplant and dialysis access surgeons. We have established relationships with community organizations, including hospital systems, medical groups, palliative care organizations, and non-profits. We are adding nurse care management and patient education and developing new relationships with service providers to augment our approach.

Our KCE Participants include Balboa Nephrology Medical Group and two BNMG physicians individually named – Dr Guy Lund (Transplant Nephrologist) and Dr Jeffrey Halldorson (Transplant Surgeon). Our care model includes several Preferred Providers with whom we will align in ways that we have not been able to do before. Many of these providers have been working alongside us for years, this is a unique opportunity to create broader relationships that will align care across multiple providers and care settings.

Our Clinical Operations Committee and Patient Experience Committee structure means that these preferred providers are included in our management process around discussions of quality, outcomes, patient experience, and population health management. We are optimistic that these aligned and committed providers will help us find more effective ways to manage this beneficiary population.

We will achieve the goals of better health and care through advancement of our patient centered care model. Our multi-disciplinary team consists of our physicians, PA/NP's, care management RN's, social work, dietician and patient care coordinators based within BNMG, working with our Preferred Providers, to achieve better health and care. The core competencies of our KCE, across the spectrum of CKD, ESRD and Transplant, will be:

- **Patient Empowerment through Education**. Our multi-disciplinary team will be provided the *time* and resources to engage beneficiaries and family members and educate them on kidney disease and therapy options. Educational resources are available, but not presented at the right time, or in the right way for the needs and wants of the beneficiary. We have developed a competency in educating patients regarding financial options, insurance, and access to community resources through our own program, "CovER". Our

doctors and patient educators will be able to provide multi-modal education to "meet the patient where they are." Our team will operate along workflows that collect data at each step so that interventions and education can be matched with outcomes. By iterating both process improvement and content improvement, beneficiaries will get the education that they need and want, when they need and want it. We are also working with Remend, a non-profit patient mentoring organization in San Diego, to connect mentors who are patients with new patients.

- **Data-Driven Decision Making**. We've created relevant dashboards that bring together billing, EHR and Medicare claims data across the population from our enterprise data warehouse. Our internal data platform allows us to move from a population management perspective all the way down to the individual beneficiary level. We believe that accurate data allows us to understand the outcomes that various workflows produce. The data is highly visible across our group and published internally to achieve practice goals.
- **Care Coordination across the care continuum**. We have built, and continue to build, an internal care management team to assist our physicians and advanced practitioners in managing our patient population. Together we will focus and collaborate in these areas:
    - CKD
        - Ensure aligned beneficiaries are seen by nephrologists, dieticians, and social work on the schedule and frequency as dictated by their care plan.
        - Providing and documenting the medical, educational, nutritional, and resources designed to slow the progression of kidney disease.
        - Development of an advanced care plan
        - For those beneficiaries progressing into end stage renal disease, education regarding therapies, including supportive non-dialytic care, and an assessment of patient choice/preference, in order to prevent a crash onto dialysis.
        - For patients that choose transplant and who are candidates, encouragement, support and strategy to find a living donor and obtain a a pre-emptive transplantation
        - Development of care process to ensure that patients who choose dialysis will start with an optimal start, including appropriate dialysis access.
        - Coordination of outpatient dialysis initiation
        - Care coordination of select co-morbid conditions.
    - ESRD
        - Long-term access creation and maintenance using an outpatient vascular access center as the hub
        - Dialysis modality education, including home therapy assessment for in-center beneficiaries
        - Transplant education, including strategy for living donor
        - Hospitalization reduction and readmission reduction
        - Oversight of SNF care through engagement with SNF facilities and SNF physicians
        - Advanced care plan, advanced directives and end of life planning
        - Initiation of dialysis in a transitional care unit, where patients will receive education and training.
    - Transplant and Transplant Listed Beneficiaries
        - To minimize delays in listing, our care coordination resources will focus on keeping beneficiaries on schedule for all transplant evaluation testing
        - Communication with nephrologists and dialysis clinics regarding the listing status of all beneficiaries.
        - For those beneficiaries that are listed for transplant, keeping up to date on all individual requirements to receive a kidney if it becomes available.
        - Beneficiaries with a functioning transplant will be followed per clinical protocols of the transplant program.

Organization Structure

4. Please provide a narrative description of the KCE's plan for engaging with CKD and ESRD beneficiaries and their caregivers. At a minimum, please address the following **(No more than 10 pages)**:

a. Managing the progression of CKD
b. Modality options and Transition onto dialysis
c. Coordination of care with different health care providers and suppliers
d. Transplant process and managing post-transplant care
e. Health I.T. and data interoperability
f. Social determinants of health
g. Prescription drug utilization
h. Shared decision-making, self-management and self-care skill development
i. Managing care for dually eligible beneficiaries

a. Managing the progression of CKD

We will take a systematic approach. Our plan begins with the identification of CKD 4/5 patients/beneficiaries through practice, claims, and lab data. We will then implement a system to encourage these beneficiaries to be seen at least quarterly, and more frequently, as needed. Patients identified at high risk of progressing by our algorithm will be seen more frequently.

Many beneficiaries can fall out of the system after missing even a single appointment. We have a plan to reach out to those beneficiaries to address issues, often related to social determinants of health, transportation, behavioral issues, and even fear, to get them back in to see their physician using a regularly implemented database query done by our patient care coordinators. For those that may have difficulty attending appointments at traditional medical office times, we will have locations with extended hours.

We also plan to continue care in the time between physician visits with outreach from our care coordination team. We are developing a chronic care management program to provide non-face to face care on a more frequent basis. This program will be nurse-driven under physician direction and will also include a dietitian and social worker. We will focus on efforts to delay progression of CKD, including adherence to the medical treatment plan, coaching, dietary counseling, and lifestyle changes. We will also use this program to educate and prepare beneficiaries for transplant and dialysis when appropriate.

For our providers, we are developing standards of care focused on delaying the progression of CKD. Each will be measured and reported to all providers and used in a continuous quality improvement process. Some of these standards will also be used as internal quality measures with financial ramifications for our providers. For example, one such measure being implemented is the percent of beneficiaries with diabetic kidney disease being treated with ACE inhibitors or ARBs.

b. Kidney Disease Education, Modality Options and Transition onto Dialysis

Kidney disease and treatment option education are a cornerstone of achieving the goals of the Advancing American Kidney Health Initiative. Although as an industry we have produced a lot of educational materials and approaches, we have fallen short of providing that education in a personalized, patient-specific manner. Patient activation and engagement were not the primary goals of those approaches, but now are critical if we are to achieve our goal.

For CKD beneficiaries our KCE will provide kidney disease education in the following ways:

- With increased office visits, we will provide our physicians with more time to have meaningful dialogue with individual beneficiaries and family members about their life and therapy goals.

- We are building into our EHR system a certification requirement for our nephrologists that they must certify that they have provided appropriate disease, therapy and transplant education to CKD 4/5 beneficiaries.
- We are using standardized educational materials that include print and video tools to assist our doctors and office staff in conveniently providing educational information.
- Our care coordination team can assist our doctors in providing education.
- Several of our preferred partners have case management systems, including case managers and social workers who are trained in kidney care. For example, Sharp Healthcare has inpatient case managers and social workers who can share educational information with hospitalized beneficiaries and their family members.

For ESRD beneficiaries, our KCE will provide kidney disease education in the following ways:

- We are building into our EHR system a certification requirement for our nephrologists that they must certify that they have provided appropriate therapy and transplant education to newly diagnosed ESRD beneficiaries.
- In cooperation with our dialysis providers, all new beneficiaries have a meeting within the first 30 days of care with the dialysis social worker to evaluate that the beneficiary is on the preferred therapy for the beneficiary and their life and therapy goals. These meetings are verified and logged in the monthly Quality Meetings.
- Our dialysis providers are educating in-center staff and providing education about home therapy options to center staff so that they have some knowledge and can discuss various treatment options with beneficiaries in the course of incenter hemodialysis care.

For transition of new patients onto dialysis, our KCE is doing the following:

- Our care coordination team leads new beneficiaries through their first steps into ESRD treatment. First choice of therapy is documented, access creation surgery (PD catheter or hemodialysis) is scheduled and a preferred dialysis center is identified based on patient needs and therapy selected. Beneficiaries interested in transplantation are referred to the transplant program to begin the evaluation process.
- Along with Fresenius Kidney Care we are building a Transitional Care Unit (TCU) and Home Training Center in a combined location. The transitional care unit will be the first dialysis center for most of the beneficiaries within our primary San Diego market. The TCU will be used to stabilize and assess new beneficiaries coming into dialysis. Initial treatments and dialysis education and home training will be provided. Beneficiaries will be transferred to in-center locations and the home program as they stabilize within the TCU.

For patients that choose supportive, non-dialytic, care for their ESRD:

- Our physicians and care managers will support the needs of the beneficiary who chooses not to receive dialysis. This support will also include work with outpatient palliative care and hospice organizations where needed, our Preferred Provider, Lightbridge has care expertise in this area.

c. Coordination of care with different health care providers and suppliers

We will engage with our KCE Preferred Providers to use data driven tools and clinical resources to proactively address the needs of beneficiaries. We will emphasize the importance of interplay and communication between the beneficiary and their multi-disciplinary care coordination team to facilitate a patient centered approach to care. Our Committee and management structure detailed earlier align the providers delivering care and put them on the same committees to address care coordination and delivery issues as they arise. Our dashboards, quality reporting and claims data analysis will identify gaps and opportunities for improvement in the coordination of care. Along with internally developed web applications, several of our preferred providers have developed back-end infrastructure to coordinate and make these efforts visible to the care team. Our patient care coordinators will work with both high-risk and low-risk beneficiaries to optimize use of these resources.

d. Transplant process and managing post-transplant care

The Sharp Memorial Hospital Kidney Pancreas Transplant program, one of the KCE's preferred providers, is a joint effort between Sharp Memorial Hospital and Balboa Nephrology Medical Group. The administrator, nurse coordinators, financial staff, social workers, pharmacists, and dieticians are employees of Sharp Memorial Hospital. The physicians and surgeons are employees of Balboa Nephrology Medical Group. There are three transplant surgeons and three full time transplant nephrologists who staff the program. All physicians are on the medical staff of Sharp Memorial Hospital.

Beneficiaries are referred to the program by their nephrologist, either when they develop CKD 4/5 or after starting dialysis, and beneficiaries may also self-refer. The initial visit entails a class, called "Transplant 101", which is given in English and Spanish. During this class beneficiaries are given information regarding the transplant process and encouraged to find a living kidney donor. Beneficiaries are then evaluated by a transplant nurse coordinator and scheduled for an initial visit with a transplant nephrologist.

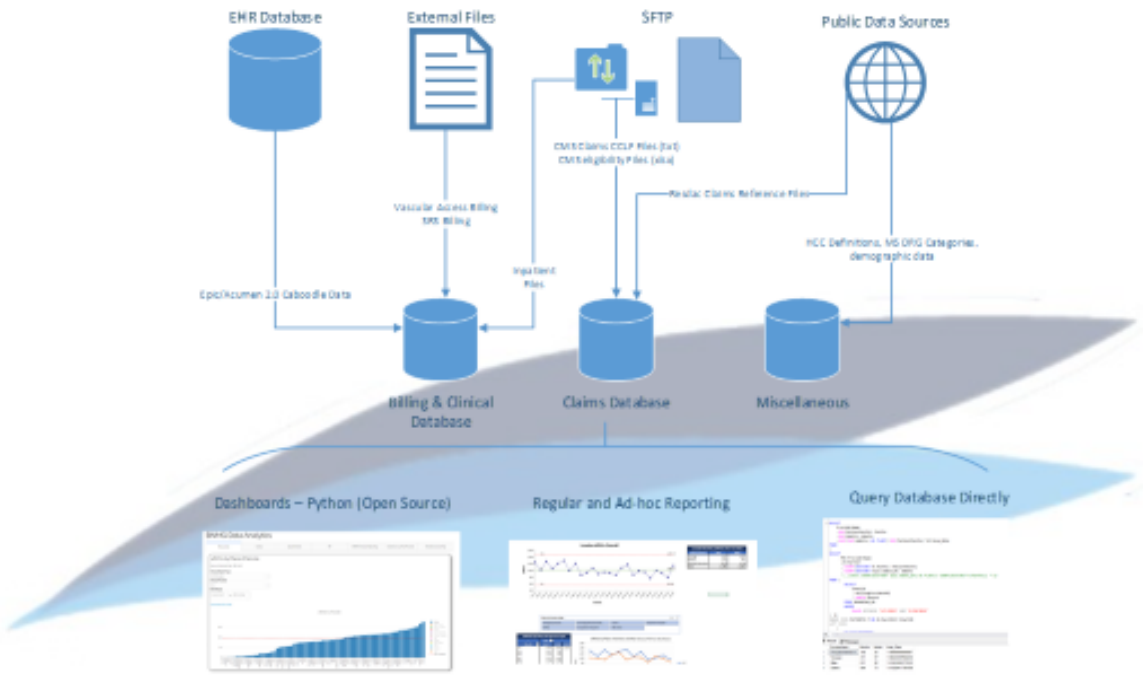
Our KCE has care coordinators who ensure that beneficiaries who are interested in transplant attend the Transplant 101 program. Thereafter, the coordinators will follow up and facilitate the beneficiaries transplant evaluation and communicate with the care team regarding the transplant listing status of the patient.

Beneficiaries are encouraged to find living donors due to the long waiting times for deceased donor kidney transplant in Southern California. They are coached by our patient mentors in how to approach potential living donors.

Routine medical care is provided at the transplant center and in the nephrologists' offices. Our mentors and financial counselor are available post-transplant to assist patients and the care team as needed. Our team encourages interaction with the patient mentors.

e. Health IT and data interoperability

Our certified EHR technology is Acumen 2.0, a nephrology specific implementation of Epic. This technology is incorporated into multiple aspects of our practice, including office-based care, hospital-based care, dialysis clinic care, and our vascular access center. Additionally, it is our practice management software. We also have an internally developed web application used by our care coordination team. We employ 2 full time data analysts and have developed a data warehouse that includes data from our EHR, billing, local health exchanges, other public data feeds, and Medicare Claims data (including CCLF files and eligibility files). We are in the process of adding data from our local transplant center, which will help us understand which beneficiaries have not yet been referred for transplant.



KCE Data Warehouse Detail

f. Social determinates of health

Many beneficiaries within our patient population are vulnerable and adversely impacted by one or more social determinants of health. Within our care model we have these focused resources to help our vulnerable beneficiaries.

Patient Financial Counselor, David Ordaz, serves as patient advocate for our most vulnerable beneficiaries. He helps in filing, submitting, follow through and information on:

Medi-Cal, Medi-Cal Managed Care and PRUCOL applications	Affordable Care Act (ACA/ObamaCare/Covered CA) applications	Medicare, Medicare Advantage plan applications
Medigap Policy applications	Employer Group Health Plans enrollment forms	Food stamps application, food bank locations, nutritional supplements
Education of options, patient's rights and responsibilities	Prescription assistance referrals	Assistance programs, including housing, rental and utility assistance programs.
How to obtain a Lifeline phone	Referrals to other organizations in the Renal Care Community	Disability, including SDI, SSI, SSDI, & SSA-R
Project Access San Diego referrals for patients without insurance	Referrals to Hospice/Palliative care, Home Healthcare, In- Home Supportive Services program	Transportation assistance for beneficiaries who qualify

g. Prescription drug utilization

Medication management for CKD beneficiaries will include medication reconciliation performed by the provider during every outpatient encounter. Our nephrologists leverage e-prescribing solutions embedded within the EHR to send prescriptions electronically to the beneficiary's pharmacy. Medication lists for ESRD patients will be reconciled by providers and by dialysis clinic staff where appropriate, on a monthly basis, and post-hospitalization.

Updating medications within these solutions permits real time clinic decision support and affords our nephrologist a view of medications prescribed by other members of the care team. As noted above, medication reconciliation is a foundational component of the KCEs transition of care strategy for both CKD and ESRD populations.

By having real-time updated medication reconciliation process, a "source of truth" medication list can be reviewed for a number of factors, including drug-drug interactions, dangerous drugs for CKD/ESRD/transplant, and drugs that require therapeutic monitoring.

The care coordination team, social workers within the dialysis centers and transplant program and the BNMG Patient Financial Coordinator will help needy beneficiaries to find financial resources to obtain needed prescriptions.

h. Shared decision making, self-management and self-care skill development

Shared decision making is defined as the process by which physicians and beneficiaries agree on a specific course of action based on a common understanding of the treatment goals, risks and benefits of the chosen course compared with reasonable alternatives. The role of the beneficiary is critical and must be educated regarding their diagnosis, prognosis, treatment options and relevant considerations. It is important that the beneficiary be fully aware of these elements so that they can collaborate with other members of the care coordination team to develop consensus and make informed decisions.

These discussions begin at the onset of CKD and continue as their disease progresses. Our physicians and patients begin a shared decision-making conversation as CKD progresses into CKD stage 4. The majority of patients with late stage CKD never progress to ESRD. They live with multiple comorbid conditions, are hospitalized with disease processes that aren't attributable to CKD and die from conditions other than progressive renal failure. Goals of Care discussions are conducted early on to make sure that patients are receiving care consistent with their goals. Self-determination is a key aspect of our "Patient Centered" approach.

Additionally, where appropriate, the KCE will leverage our partnership with Lightbridge Palliative Care and Hospice. Lightbridge will develop an educational workshop series for the physicians, clinical, and care coordination staff of the KCE to improve our ability to conduct these Goals of Care discussions within a shared decision-making framework.

For the CKD 4/5 population, the care coordination team ensures all beneficiaries and their families understand the progression of kidney disease. Through timely and substantive education and discussion the goal is to foster an engaged beneficiary to take an active role in the direction of their care. Shared decision making is particularly important when the CKD beneficiary is considering available treatment options should their disease progress. Our nephrologist and care coordination team can explain the options of preemptive transplant, home dialysis modalities such as peritoneal dialysis and home hemodialysis, incenter hemodialysis and conservative care. Working collaboratively with our care coordination team we can help empower late stage CKD beneficiaries to make patient centered decisions regarding their care.

This approach to shared decision making ensures transplant candidates also have the resources necessary to consider living related donors, and they are listed at the transplant center in a timely fashion. In addition, this approach provides the foundation for optimal starts for those who progress to ESRD and require dialysis. For those electing to pursue conservative care, shared decision making permits a smooth transition to hospice care when indicated.

For the ESRD population, driven by the dialysis facility care teams, a comprehensive assessment and care plan is developed as a collaborative effort of each center's multidisciplinary care team (nephrologist, social worker, renal nurse, dietitian) and patient. These patient assessments have the comprehensive picture of the patient's status which formulates a patient centered care plan. Information on the assessment is also used by the broader care team to:

- Identify educational and clinical care gaps
- Identify opportunities to change modalities or change goals of care
- Medication access, availability, utilization and compliance gaps
- Psychosocial, behavioral, cognitive, functional, environmental, and financial barriers to care.

This comprehensive care plan ensures that the individuals most directly involved in the patient's care have exchanged critical information, recommendations and potential concerns. The frequency of the meetings promotes the rapid addressing of patient needs. Additionally, applicable accommodations are made for beneficiaries with hearing impairments, language barriers and cognitive deficits to ensure effective communication (e.g. translation services, TTY/TTD, etc.).

Self-care is an important part of patient engagement and patient activation. Within the context of home dialysis therapies, self-care is critical. Our new Transitional Care Unit will teach a variety of aspects of self-care, including self-cannulation of hemodialysis access and PD care. The TCU and our vascular access center will be educational resources for patients who wish to increase their degree of self-care, and indeed, self-care will be promoted by our physicians and staff.

i. Managing care for dually eligible beneficiaries.

For dually eligible Medicare and Medicaid beneficiaries, CRC will collaborate with California Medi-Cal. Our care coordination team will assist with referrals to Medi-Cal to ensure beneficiaries are receiving needed services available to the beneficiary. These services may include transportation to medical appointments, personal care aides or home health care, dental or vision services and financial assistance.