RESOLUTION OF THE BOARD OF DIRECTORS

OF

QUEEN'S MSSP ACO, LLP

Adopted: _____

A. WHEREAS, the Secretary of the United States Department of Health and Human Services has promulgated waivers of certain federal laws in connection with certain activities and arrangements involving Accountable Care Organizations (ACO) and participation in the Medicare Shared Savings Program (MSSP), including a pre-participation waiver (Waiver);

B. WHEREAS, the Queen's MSSP ACO, LLC ("Queen's MSSP ACO"), was formed to serve Medicare fee-for-service beneficiaries as allowed and supported under the MSSP structure;

C. WHEREAS, the goal of the Queen's MSSP ACO is to develop a model of coordinated care to ensure that all Medicare fee-for-service patients will receive better care individually, receive better health as a population, and lower growth in expenditures;

D. WHEREAS, the Board of Directors (Board) of Queen's MSSP ACO will carefully assess a list of providers to determine which providers will be invited to participate in the Queen's MSSP ACO based on individual physician engagement, quality, and commitment to collaborative endeavor;

E. WHEREAS, the Board of the Queen's MSSP ACO will use the Waiver to create and develop governance, infrastructure, services, goods, facilities, and all activities allowed under the Waiver.

F. WHEREAS, the Board is fully aware of and committed to its responsibility to identify and evaluate all start up arrangements as reasonably related to one or more purposes of the MSSP;

G. WHEREAS, all arrangements proposed by the Board aim to increase the quality of care, improve the patient experience, and significantly reduce Medicare costs or support the infrastructural and organizational needs of the prospective MSSP ACO;

H. WHEREAS, the Board believes that the development of a solid Queen's MSSP ACO will support advanced health information exchange, patient co-management, and population health management.

THEREFORE, BE IT RESOLVED, that the arrangements listed on Exhibit A are being considered, developed or meaningfully expanded at the direction of and after careful deliberation by the Board.

FURTHER RESOLVED, that the Board has determined that the arrangements listed are reasonably related to the purposes of the Queen's MSSP ACO.

FURTHER RESOLVED, that the Board has approved infrastructural, governance, and operational activities (Additional Activities) as specified in Exhibit A, that are intended to meet the bona fide prospective ACO's startup needs and that support the progression of an organization prepared to increase quality of care and reduce costs for Medicare fee-for-service patients.

FURTHER RESOLVED, that the Queen's MSSP ACO may also bear organization and staff training costs, provide allowable incentives to attract primary care physicians, and attain capital investments including loans, capital contributions, grants, and withholds in furtherance of the development of an MSSP ACO.

EXHIBIT A

A) Information Technology (IT).

Arrangements for IT and related services created or developed under the Queen's MSSP ACO will address MSSP IT requirements for performance, sustainability, and growth. The Board recognizes that significant advances in healthcare quality can come from optimizing technology to assist provider teams, patients, and the healthcare system. IT solutions can help resolve issues such as poor provider communication due to electronic health records (EHR) that cannot share information bi-directionally; underused analytics to identify risks and care opportunities; and a lack of provider and patient engagement to use available IT to improve care. The following describes the Queen's MSSP ACO's IT objectives and purpose for its participants:

- Adopt, at a minimum, the certified health IT needed to meet the certified EHR technology (CEHRT) definition required by the Medicare EHR Incentive program.
- Adopt and develop effective IT and population management solutions, to include
    - IT-enabled, patient-centered care planning tools that support holistic care and a focus on beneficiary goals and preferences.
    - Tools to empanel and risk stratify patients, identifying complex care populations to address their special care needs.
    - Tools to develop actionable registries for population management.
    - Tools to systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs.
    - Solutions that enable providers to electronically capture the following care plan elements: advance directives and preferences for care; patient health concerns; goals and self-management plans; action plans for specific conditions; interventions and health status evaluations and outcomes; identified care gaps.
    - Electronic health information exchanges that allow for electronic data exchange across multiple platforms including, but not limited to, a community health record and/or a referral platform which may facilitate closed loop referrals.
    - Clinical data exchange: sharing of clinical information to create integration and coordination of care-delivery across the continuum of care.
    - Methods of collecting, sorting, and reporting data from/across multiple platforms to include clinical and payer data.
    - Financial capabilities: efficient payment allocation and tracking systems that can be integrated with the performance management systems to quantify cost of care.
    - Reporting capabilities: comprehensive and need based reporting systems to share the performance data with the other stakeholders internally and externally.
    - Data aggregation capabilities: accountable care organizations data from payers, hospitals, physicians, and other ancillary providers to create holistic view of a populations' care experience.
    - Data analytics, including staff and systems, such as software tools, to perform such analytic functions.
    - Performance management capabilities: ACO performance management capabilities like scorecards, dashboards, and summary reports for continuous improvement.

- Data collection and integration.
- Data organization into standardized vocabulary and registries.
- Predictive analytics.

B) Quality Improvement Systems Development

Inadequate healthcare quality occurs when providers do not agree and/or consistently use evidence-based best practices; critical information is not shared among providers; services are duplicated; and patients/caregivers are not engaged or their needs are unknown and/or unmet. The results cause decreased patient satisfaction and outcomes and may result in wasted resources and unnecessary costs. This is the system we currently have for many Medicare beneficiaries.

The Queen's MSSP ACO will use collaborative, evidence-based approaches to develop, expand, fine-tune, and execute innovative new programs and proven strategies and workflows specifically effective and efficient for Hawaii's Medicare fee-for-service population.

- Retain experts to assist the network at large and individual participating practices in improving quality and competence by educating providers and practice staff on quality improvement processes.
- Retain experts to provide analytics to participating practices to illustrate performance and trends. These staff will help practices identify high-risk/at-risk populations and high-utilizers; stratify the population; and make recommendations to manage populations internally or within the Queen's MSSP ACO to ensure patients get the right care at the right time.
- Hire and retain experts who will assist participating physicians with the process of transitioning to value-based care system from fee-for-service by:
    - Coaching on quality measures/improvement specific to MSSP measures.
    - Helping deploy and integrate systems and solutions including technologies to improve care delivery.
    - Helping practice maximize use of EHR and reports/analytics.
    - Helping practices optimize performance in value-based-payment models.
    - Helping practices who are aiming to capture appropriate risk within their panel.
    - Helping practices engage patients.

C) Clinical Services

Medicare beneficiaries with complex needs often receive care at various sites. Without coordination between and among these sites, a multitude of challenges are created for the healthcare system and for the patient and caregiver. The Queen's MSSP ACO will work specifically with clinical teams that care for patients in the hospital, ambulatory setting, skilled nursing facility, and home setting. Care coordination can expand the capability of geriatrics and palliative care team members. This will offer better coordination and communication among team members, patients, and caregivers. As patients require increased services and support, the infrastructure will be in place for the healthcare system to meet patient needs in a seamless manner. Exploration of how these teams will be structured and collaborate will be part of the

work that will occur to improve the quality of care, quality of the patient experience, and decrease gaps and unnecessary costs of care.

1) Clinical Care Coordination Services

Medicare beneficiaries are often the highest risk, most frail patients that providers serve. Without adequate support and care coordination in the home and community setting, patients return to emergency departments, hospitals, and/or other high-cost settings to seek care. The Queen's MSSP ACO will develop an improved care coordination system that provides the necessary support and coordination for Medicare fee-for-service beneficiaries during transitions of care; in the community; and throughout the health care system.

The Queen's MSSP ACO will work with a broad range of partners to streamline care across the continuum. The Board will ensure a care coordination team is assembled that can best serve Medicare patients. Services will be developed or (if existing in a limited capacity) will expand to focus on high risk, frail elderly Medicare patients, with a goal of improving quality of care and lowering total costs of care. Care coordination models may morph as the program expands, but will focus primarily on high-risk patients, patients with chronic conditions, and patients with behavioral health needs as these are the patients that need the most support to improve their care and reduce unnecessary costs.

Additionally, the Board commits itself and authorizes the Queen's MSSP ACO staff involved with this startup arrangement to conduct regular assessments with respect to services provided and with respect to member satisfaction with the governance, structure, and arrangements relative to the development of this Queen's MSSP ACO.

2) Mental Health Integration for Primary Care Practices.

Psychiatric resources in Hawaii are limited. However, mental/behavioral needs, such as those relating to dementia, continue to be of concern for patients with Medicare. The Queen's MSSP ACO will develop a Mental Health Integration program available to participating primary care practices using the University of Washington's Collaborative Care Model.

The Queen's MSSP ACO will use this model, developed in conjunction with the support of the Hawaii Psychiatric Association, and develop:

- Standardized use of screening to identify individuals at risk and in need of services.
- ACO employed care managers to act as a resource for the primary care provider and help patients be successful with the plan of care. Care managers also ensure regular communication and coordinated workflows between behavioral health and primary care clinicians.

- The PCP remaining as the prescribing provider with support of a contracted psychiatrist.
- Regularly conducted case reviews for those patients not responding to treatment.
- Utilization of telehealth as needed.

Additionally, the SBIRT (Screening, Brief Intervention, and Referral to Treatment) program will support Queen's MSSP ACO providers in the development and delivery of quality substance abuse prevention and treatment services for at-risk individuals using an integrated model of care. The Queen's MSSP ACO may provide practices with training to use proper SBIRT screening and implementation, including training of primary care staff on brief intervention, and may provide practice staff with training and community engagement for referral to treatment.

3) Advance Care Planning (ACP) and Palliative Care

ACP enables Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it.

- Queen's MSSP ACO ACP team aims to facilitate goals of care conversations with patients and families to allow wishes about wanted and unwanted care to be made known. We will sponsor a group ACP clinic with a palliative care RN facilitator and offer a home-based ACP program that includes a palliative care RN/LSW.
- Queen's MSSP ACO ACP team plans to facilitate the appropriate completion and community distribution of the POLST (provider order for life sustaining treatment) form to assure that patients' wishes will be honored in the community setting.
- Queen's MSSP ACO ACP team will explore multidisciplinary home-based palliative care programs to manage high-needs patients in the home setting particularly for the frail elderly and people with chronic conditions, metastatic cancer, and severe dementia.

4) Additional Care Management Services.

The Queen's MSSP ACO will expand its team of transitional care managers to provide high risk or complex care management services to Medicare patients in the Queen's MSSP ACO. We plan to address health needs such as behavioral health issues, dementia, and poorly controlled chronic conditions through the use of a clinical care management team. The following processes will be developed and/or expanded to specifically service Queen's MSSP ACO patients:

- High-risk patients will be identified strategically through registries and risk-stratification tools or identified by the provider based on his/her concern about

the clinical complexity of the patient. Patients will be managed at transitions of care as appropriate.

- Queen's MSSP ACO care management team will provide a social worker and/ or RN initial assessment and support for the patient and family/care giver via the Clinical Care Coordination Team and Transitional Care Coordination Program. This may be telephonic and/or home based.
- The care management team shall, collaborating with the PCP and consistent with the patient's goals, implement a care plan and provide coordination of care across multiple providers and sites of care.
- The clinical care management team will provide additional behavioral health/clinical resources and patient education to high-risk patients who need support.
- The care management team may in the future proactively identify and provide outreach to appropriate high risk patients based on future-risk, such as predictive modeling tools that consider social determinants of health as predictors of risk and high-cost, high-utilization.
- The clinical care management team will provide additional behavioral health/clinical resources and patient education to high-risk patients who need support.
- The care management team may in the future proactively identify and provide outreach to appropriate high risk patients based on future-risk, such as predictive modeling tools that consider social determinants of health as predictors of risk and high-cost, high-utilization.
- The care management team will conduct regular reviews of the targeted patient population for purposes of identification of the most vulnerable patients.
- The clinical care management team will help identify and collaborate with community resources and will engage community partners, such as the Queen's geriatrics ambulatory clinic and house calls program, hospice and palliative care, skilled nursing and rehab facilities, and community health workers to help patients navigate the continuum of care.
- The clinical care management team will partner with allied health professionals such as pharmacists, dieticians and disease specific educators as well as other specialists to meet the needs of the most complex and vulnerable Medicare patients.

5) Telehealth

- The use of telehealth by participating providers offered by the Queen's Clinically Integrated Physician Network (QCIPN) and Queen's MSSP ACO in efforts to increase quality and decrease total cost of patient care; especially where there is an absence of options for "live referrals" due to geographic limitations or network inadequacy, and/or in instances where the patients' needs or limitations call for telehealth services.
- There would be no requirement on the participating physicians to refer to Queen's services.

- The Board has determined this is a bona fide attempt to meet unmet community needs and to improve quality and decrease cost of care of Medicare patients in the State of Hawaii.

D) Additional Activities.

Additional Activities approved by the Board include:

- Infrastructure creation and provision.
- Network development and management, including the configuration of a correct ambulatory network and the restructuring of existing providers and suppliers to provide efficient care.
- Creation of governance and management structure.
- Creation of incentives for performance-based payment systems and the transition from fee-for-service payment system to one of shared risk of losses.
- Hiring of new staff, including:
    - Care coordinators, including nurses, technicians, physicians, pharmacists, nutritionists, and/or non-physician practitioners;
    - Umbrella organization management;
    - Quality leadership;
    - Analytical team;
    - Liaison team;
    - IT support;
    - Financial management;
    - Contracting; and
    - Risk management.
- Consultant and other professional support, including:
    - Market analysis for antitrust review;
    - Legal services; and
    - Financial and accounting services.