POLICY SUBJECT:

Arkansas Health Network's (AHN) Structure and Operations

I. Scope

This document describes the requirements for clinically integrated network structure and operations and its business relationship between Arkansas Health Network (AHN), and its sponsors, Catholic Health Initiative (CHI) St. Vincent and its parent company CommonSpirit Health (CSH). AHN is a physician-led clinically integrated network wholly-owned by CHI St. Vincent. Arkansas Health Network (AHN) is the largest physician-led clinically integrated network in Arkansas. Established in 2013, AHN is committed to driving measurable improvement in quality, health, and financial sustainability for patients and providers through value-based care. CHI St. Vincent is a nonprofit, faith-based health system formed in 1996, and is part of a national Catholic health system. In February 2019, CHI merged with Dignity Health, forming CSH.

II. Purpose

The purpose of this Policy and Procedure is to describe the requirements and processes for clinically integrated network structure and operations.

III. Policy

Written agreements: Arkansas Health Network (AHN) maintains signed written legal agreements with integrating parties that describe the structure, scope, and objectives of the CIN business arrangement. AHN also has written agreements with clinically integrated providers that address obligations, responsibilities, and conditions of their business relationship. AHN will utilize policies and procedures from both organizations, CHI St. Vincent and CSH as necessary to accomplish stated goals.

Business documentation: AHN maintains documentation that demonstrates the rationale and value to the consumer for improvement of clinical quality, health outcomes, and cost efficiency, and how community and other relevant stakeholders had and continues to have input in the planning and evaluation of the effectiveness of the CIN business model.

Leadership structure and oversight: AHN has a clearly defined leadership and organizational structure outlining responsibility throughout the CIN. AHN maintains documents that address required elements of the business. AHN has a physician-led leadership team, which includes clinically integrated providers and administrative personnel. The leadership (Governing Body) that accepts risk

under payer contracts oversees maintenance of fiscal solvency for both short and long term. The leadership team establishes organizational goals and desired outcomes of the organization related to efficiency, cost control, and quality improvement. AHN has management practices and policies that define transparent organizational relations between clinically integrated providers. AHN has financial incentive programs between integrating parties for the purpose of improved clinical outcomes and health care cost trend mitigation.

Qualification and training requirements: AHN establishes roles, qualifications and ongoing training programs for its staff. AHN also has training programs and provides overviews of ongoing qualification requirements to clinically integrated providers.

Consumer safety mechanisms: Clinically integrated providers have consumer safety mechanisms to prepare to respond and address potential threats to its consumers' health and safety. Identified potential threats may include, but are not limited to:

A. Harm to oneself (including suicide threats);
B. Harm to others (including abuse, actual or potential violence, and gross negligence); and
C. Clinical distress/medical emergencies;

IV. Definitions[1]

See AHN Glossary for definitions.

V. Procedure

Written Agreements

A. Written business agreements
   1. AHN's Amended & Restated Operating Agreement is a signed written legal agreement between the integrating parties describing the:
      a) Structure
      b) Scope of the business agreement
      c) Objectives and goals are value driven and consumer-oriented. Objectives include, but are not limited to effects on consumers from improvements in the following:
         (1) Clinical quality
         (2) Health outcomes

[1] Unless the source is otherwise documented, definitions are derived from the URAC Programs Glossary, 2018.

(3) Cost efficiency

2. The nature of the legal agreements depends on the type of business model for AHN.
3. Business agreements meet FTC guidelines.

B. Arkansas Health Network, LLC Clinically Integrated Network Participation Agreement and Arkansas Health Network, LLC Clinically Integrated Network Administrative Policy and Procedure are written agreements between clinically integrated providers. These agreements include the following elements:
   1. Arkansas Health Network, LLC Clinically Integrated Network Participation Agreement will list all individuals or entities who are party to the written agreement.
   2. Conditions for participating as a clinically integrated provider. Conditions are to be confirmed via primary source verification. Conditions include the following:
      a) Verification of required credentials (e.g., licensure, board certifications, DEA registration)
      b) History of sanctions by federal or state agencies
      c) Liability insurance coverage
      d) Be in good standing with the medical staff and have unrestricted clinical privileges as appropriate to their specialty at one of the CIN affiliated hospitals or be credentialed by a Payer participating in a CIN program
      e) Agreement to provide all services to AHN or Covered Persons as required by the Agreement and in accordance with all applicable state and federal laws
      f) Consent and agree to AHN's disclosure and submission of your TIN and each Provider/Suppliers' provider identifiers (i.e., Medicare NPI) to Payers
      g) Bill for Covered Services furnished to Covered Persons solely through the billing number assigned to your TIN
      h) Meet quality standards imposed by any Payer under a CIN Agreement
      i) Implementation and maintenance of required IT capabilities
   3. Obligations and responsibilities of AHN and the clinically integrated providers.
      a) These include obligations for the clinically integrated provider to participate in and adhere to AHN's defined:
         (1) Clinical practice and/or evidence-based guidelines
         (2) Quality standards and care coordination programs
         (3) Performance measurement and reporting procedures
         (4) Requirements to contribute to the core goals of AHN.

   4. Events that may result in the reduction, suspension, or termination of CIN participation privileges are noted in the above documents. These include, but are not limited to, violations of compliance with and implementation of all CIN evidence-based medicine, efficiency, care coordination, quality improvement, and performance reporting requirements. Providers may

also be terminated for noncompliance with Arkansas Health Network, LLC Clinically Integrated Network Participation Agreement or if they pose a risk to patient care or disrupting AHN operations. AHN will act upon all noncompliance and violations, by:

a) The Board of Managers will review all reports of alleged violations by clinically integrated providers.

b) Noncompliance with performance standards will result in corrective action, up to and including remediation. Clinically integrated providers failing remediation will result in termination for non-performance.

c) Rights of clinically integrated providers. Rights include:

(1) An opportunity for dispute resolution, remediation, and to correct identified performance deficiencies in meeting responsibilities of network participation.

(2) These rights are balanced by CIN's mandate to achieve quality, effectiveness, and efficiency goals.

5. Explicit description of the requirements for provider participation in CIN activities, investment of time or finances and/or other resources required to participate in the CIN.
   a) The description of the requirements for provider participation is the following:
      (1) Create and maintain a physician/patient or other applicable relationship with each Covered Person receiving Covered Services
      (2) Agree to use and comply with Marketing Materials and Activities as provided in the applicable CIN Agreement
      (3) Maintain medical and other records, and collect data and information relating to services furnished in connection with the Programs in accordance with applicable state and federal laws and AHN Policies.
      (4) Agree to provide AHN with access, without charge, to all medical, claims and other data and information deemed necessary and appropriate for management of individual or population health management purposes to allow AHN to perform CIN Activities and meet Performance Standards in accordance with AHN Policies.
      (5) Prepare and submit electronically in accordance with each applicable Program as specified by AHN: (a) claims and Encounter Data for Covered Services rendered to Covered Persons along with information necessary to process and/or to verify such claims; and (b) all data and information, including quality data, required by AHN Policies and applicable Programs.
6. Conditions for use of incentives and penalties by AHN related to CIN and provider performance, in accordance with AHN clinical practice or evidence-based guidelines, quality or efficiency standards and agreed upon expectations for individual and CIN group performance. These conditions include the following:

a) AHN may be eligible for Shared Savings Incentive Awards in accordance with the terms of individual CIN Agreements.
b) AHN will use and/or distribute each Shared Savings Incentive Award in accordance with the applicable Shared Savings Incentive Award Methodology.

7. Mechanisms for dispute resolution between AHN and clinically integrated providers. These mechanisms include the following:
   a) Providers have the ability to bring a dispute before the Board of Managers
8. Term of the contract and conditions and procedures for terminating the contract.
   a) Subject to obtaining Board of Managers Approval, the Initial Term will continue in effect for an initial term of three (3) years from the Effective Date. Upon expiration of the Initial Term, this Agreement will automatically renew for successive three (3) year Renewal Terms thereafter unless either party provides notice to the other of non-renewal at least sixty (60) days prior to the end of the Initial or any Renewal Term.
   b) Either party may terminate the Participating Provider Agreement for any or no reason, without penalty, upon providing the other with sixty (60) days' prior written notice. The participation of each Provider/Supplier within a group will automatically terminate upon such termination.
   c) AHN may terminate a Provider for:
      (1) failure to meet and maintain the Participation Requirements
      (2) engaging in conduct inconsistent with or potentially detrimental to the delivery of good quality patient care or contrary to the best interests of AHN;
      (3) material non-compliance with the Participating Provider Agreement;
      (4) provided that in lieu of terminating the Participating Provider Agreement AHN may terminate the participation of a Provider in select Programs only. The Provider will be provided thirty (30) days advance written notice prior to termination under this Section and given the thirty (30) days following such notice to cure.
   d) The Board of Managers may immediately suspend a Provider in any or all Programs pending completion of termination proceedings if the Board of Managers has a reasonable basis for concluding that noncompliance with the Participation Requirements or the Participating Provider Agreement poses a risk to patient care or disrupts AHN operations.
9. Business associate requirements with respect to preserving the confidentiality of protected health information and individually identifiable health information as required by HIPAA and HITECH, including the March 2013 Omnibus Final Rule.

Business Documentation

A. AHN maintains business documentation

POLICY SUBJECT:

Arkansas Health Network's (AHN) Structure and Operations

1. Business documentation demonstrates the rationale and value to the consumer for the CIN business model to improve clinical quality, health outcomes, and cost efficiency. These include, but are not limited to, the following:
   a) Rationale: AHN believes the traditional model of healthcare relies on treating illness versus preventing it, is fragmented in its approach, lacks true coordination of care without input from RN Population Health Coaches and Social Workers and limited provider input. AHN's innovative model takes a holistic approach in caring for patients, by promoting wellness within the community and providing high quality, accessible care in a coordinated, safe and efficient manner.
   b) Value to the consumer: AHN's CIN provides each patient with the following:
      (1) Better access, quality and experience for patients and providers
      (2) A high value and robust provider network
      (3) Advanced care management, and
      (4) Proactive data and analytics

      Together these initiatives aim towards preventing illness through coordinated care by RN Population Health Coaches and physician-led medicine to achieve better outcomes and lower medical expenses for consumers, providers and payers.
2. Business documentation demonstrates community and other relevant stakeholders having input into the planning phase and ongoing effectiveness evaluation of the CIN business model.
   a) Input from community or other relevant stakeholders include but not limited to:
      (1) AHN Board members
      (2) Clinical Care Committee members
      (3) AHN staff and leadership
      (4) Independent physicians
      (5) Consumers
   b) Input into the planning phase and ongoing effectiveness evaluation of the CIN starts with the Board members and various Committees, but also includes suggestions from independent providers as well as consumers. Providers and consumers can provide input via direct contact with Board members, AHN's full-time staff, AHN Connect app, AHN website, or directly by phone or email.

c) The AHN Board of Managers meets every other month. The meeting frequency of the AHN Chapter Advisory Boards and AHN Committees varies from monthly to annually depending on the Board/Committee.

3. Business documentation may be in various forms including:
   a) All executed legal agreements are stored in MediTract, a contract management platform that helps organize and manage contracts.
   b) Arkansas Health Network maintains documentation on the following items electronically or in MediTract: business and provider agreements, policies and procedures, meeting agendas and minutes, copies of newsletters. Additionally, all providers/participants/partners receive copies of the business documentation via electronic or paper methods. AHN monitors provider participation via meeting minutes and attestation to various documents. AHN's website and newsletter provides rationale and outcomes/value for business models for providers and consumers. Additionally, AHN maintains Board and Committee minutes detailing input from stakeholders along with outcomes on various topics.

Leadership Structure and Oversight

A. AHN has clearly defined leadership and organizational structure outlining responsibility throughout the CIN. AHN maintains a copy of the documents that address the following:
   1. Mission statement with the goals of establishing mechanisms to monitor and control utilization of health care services. Goals are designed to benefit the consumer through controlling costs and assuring quality care and improved outcomes.
      a) As a ministry of CommonSpirit Health, Arkansas Health Network is a part of a community of healers and leaders across Arkansas committed to driving meaningful, measurable improvement in quality, health, and financial sustainability for our patients and provider community in Arkansas through excellence in value-based care.
      b) We achieve this through our comprehensive model of care built upon three foundational pillars:
         (1) Multidisciplinary Care Management,
         (2) A Robust Provider Network, and
         (3) Proactive Data and Analytics.
   2. Organizational charts

POLICY SUBJECT:

Arkansas Health Network's (AHN) Structure and Operations

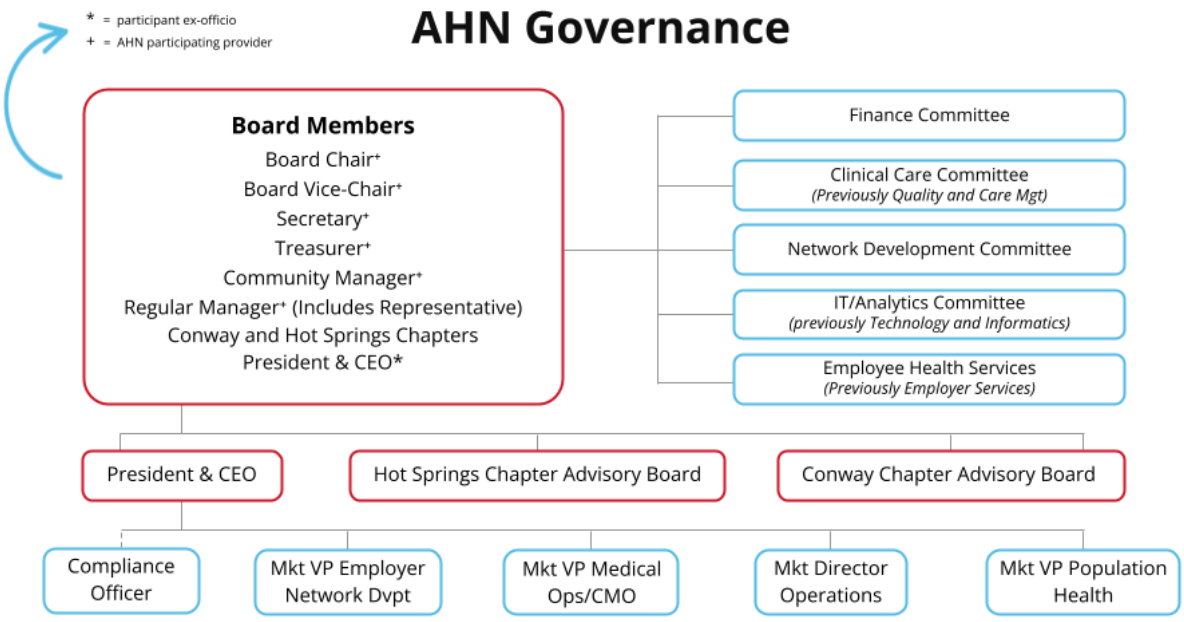
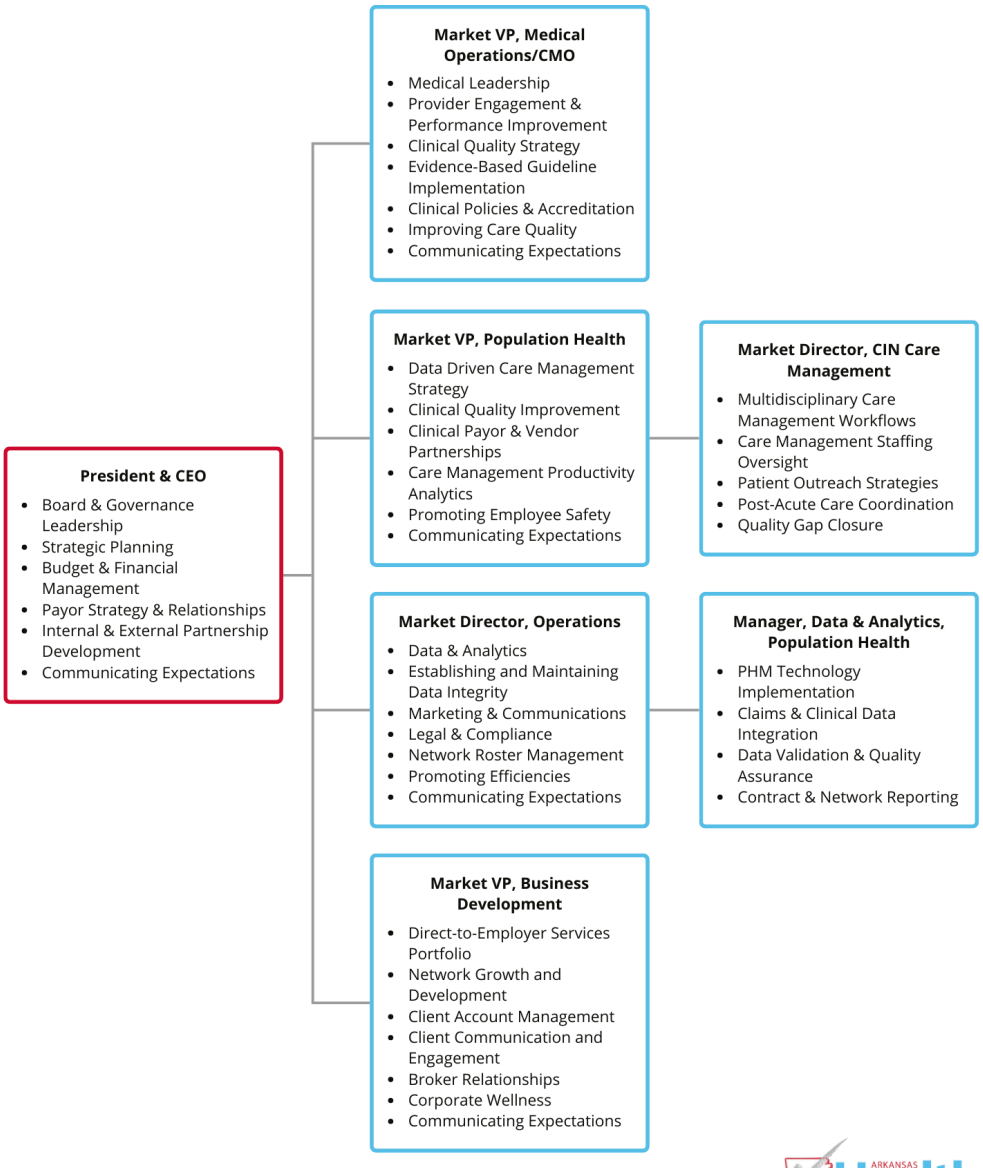


Chart 1: AHN Governance Org Chart

POLICY SUBJECT:

Arkansas Health Network's (AHN) Structure and Operations

AHN Leadership Responsibilities



24.01.18

POLICY SUBJECT:

Arkansas Health Network's (AHN) Structure and Operations

Chart 2:AHN Leader Responsibilities Chart

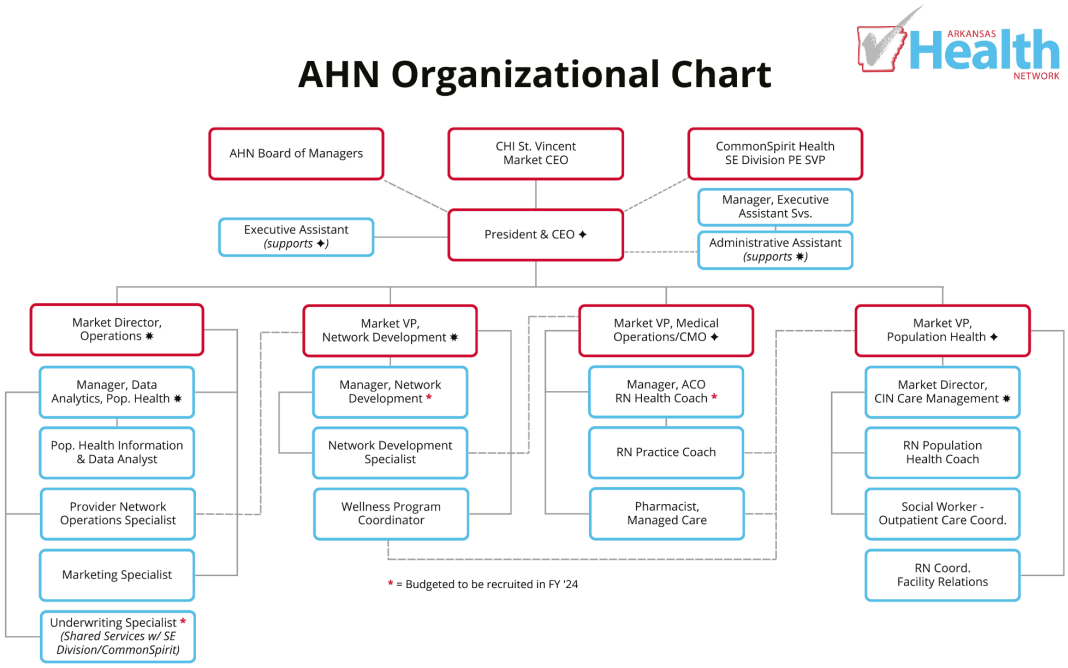


Chart 3: AHN Staff Organizational Chart

Organizational charts are updated as needed when a change to the organization is authorized by the President and duly approved by the Board of Managers. AHN's President will ensure changes are updated in a timely manner. AHN maintains a current list of the AHN leadership with their respective area of responsibilities and the current board members on AHN's website https://arkansashealthnetwork.com/about/board-of-managers/.

3. CIN guiding principles and goals are developed by AHN's Board of Managers.
   a) Guiding Principles:
      (1) Provide physicians with a strong governance and leadership roles; AHN will be physician-led and physician-governed.
      (2) Build on the capabilities of existing providers to improve the overall health of the patient populations AHN serves.
      (3) Involve and support a strong network of excellent primary-care clinicians.

(4) Capitalize on the existing strengths and cost efficiency of AHN providers to be attractive to payers, employers and patients based on cost, quality and other key variables.

(5) Use a flexible vehicle to align physicians in independent community practices and those in hospital-affiliated practices.

(6) Provide participating physicians with network ownership opportunities.

(7) Partner with other physician practices, hospitals and networks locally and across Arkansas to meet payer needs.

(8) Remain flexible to adapt to changes occurring in the market and health care reform.

b) Goals

(1) Active participation of providers in practice improvements through guideline and protocol adherence and utilization and cost efficiencies that benefit consumers in the population served.

(2) CIN goals are the following:

(a) Improve patient health through education and higher quality care
(b) Improve efficiency
(c) Monitor and improve utilization
(d) Decrease cost
(e) Enable physicians to succeed in changing healthcare payment and delivery environments

c) Guiding principles and goals are adopted by the leadership/governing body that seek to provide clinically integrated patient care services.

4. AHN has leadership structures and processes, which include the following:

a) Clinically integrated providers in leadership roles and decision-making roles about clinical aspects of the CIN program, practices, and policies. These providers are of the types required to meet quality and performance measures.

(1) Types of providers required to meet quality and performance measures include

(a) The AHN Board of Managers, Chapter Advisory Boards, and Committees are physician led. AHN Boards and Committees are led and populated with CIN providers of varying specialties (including both primary care and specialty) and

representative of the multidisciplinary makeup of the larger AHN provider network.

b) Administrative staff manage day-to-day CIN operations, including financial management.

(1) The financial responsibilities are the collective responsibility of the network to manage individual value based agreements. The accounting responsibilities are "purchased" services by AHN from its Sponsors.

c) Board nominating processes and by-laws.

(1) By-laws, The Amended and Restated Operating Agreement, will be maintained electronically and in MediTract. A copy is provided to each board member.

(2) The Amended and Restated Operating Agreement describes in detail the selection of the initial board members and the selection criteria and nominating process of additional board members. Board members include appropriate subject matter experts of high volume services within the served market.

d) The scope of its services with respect to the types of health care services offered by AHN.

(1) Arkansas Health Network, LLC Clinically Integrated Network ("CIN") Participation Agreement and AHNs Amended and Restated Operating Agreement describe the scope of services and types of health care services to be provided.

e) Other requirements: The Board of Managers' powers and responsibilities are outlined in AHN's Amended and Restated Operating Agreement Article VII. Some of the examples are listed below.

(1) Organizational governance

(2) Management

(3) Oversight

(4) Evaluation

(5) Reporting

B. Leaders at Arkansas Health Network pursue specific goals and strategies including the following:

1. Promoting employee safety

a) All AHN leaders show a visible commitment, and they act on opportunities to identify and resolve unsafe conditions and practices.

b) Leaders may reference or use resources to help develop a culture of safety: An example source of such resources is the Institute for Healthcare Improvement [http://www.ihi.org] (go to "Improvement Areas tab")

c) AHN's Market VP of Population Health will have oversight of employee safety responsibility and monitoring compliance. See Section A. 2. Chart 2 (AHN Leader Responsibilities Chart) for AHN Market VP of Population Health position responsibilities description. As a member of management staff, the AHN Market VP of Population Health promotes employee safety through adherence to the CommonSpirit Health Standards of Conduct as described in the CommonSpirit Health Standards of Conduct: Our Values in Action Policy and Reference Guide and the CHI St. Vincent Code of Conduct.

2. Establishing and maintaining data integrity (refer to AHN's HIT policy for details)

a) AHN staff and CIN participants must maintain medical and other records, and collect data and information relating to services furnished in accordance with applicable state and federal laws and ANH Policies.

b) AHN's Market Director of Operations is the responsible person working toward this goal. See Section A. 2. Chart 2 (AHN Leader Responsibilities Chart) for AHN Market Director of Operations position responsibilities description.

3. Communicating expectations

a) Leaders communicate expectations with staff during new coworker orientation and during staff conference calls. Leaders communicate these expectations via written materials, policies and procedure, on-line web applications, various publications, committee and staff meetings.

b) Types of expectations communicated may include:

(1) current initiatives

(2) individual expectations/goals

(3) AHN goals including KPI and quality goals.

c) All leaders, to include AHN board members, are responsible for communicating AHN expectations. See Section A. 2. Chart 2 (AHN Leader Responsibilities Chart) for AHN leadership position(s) responsibilities description.

4. Promoting efficiencies

   a) Leaders promote efficiencies by tracking and trending efficiency metrics as outlined in various contracts.

   b) AHN will leverage its own data analytics assets along with any other mutually agreed upon system to determine efficiency metrics.

   c) AHN's Market Director of Operations is the responsible person aggregating this data; however, all leaders are responsible for developing strategies to improve various metric efficiencies. See Section A. 2. Chart 2 (AHN Leader Responsibilities Chart) for AHN Market Director of Operations position responsibilities description.

5. Promoting employee privacy

   a) CIN participants are responsible for ensuring their respective employees follow all state and federal laws regarding employee privacy. AHN staff will additionally adhere to all CSH privacy policies.

   b) AHN's Market Director CIN Care Management, ACO will have oversight for ensuring employee privacy. See Section A. 2. Chart 2 (AHN Leader Responsibilities Chart) for AHN Market Director CIN Care Management, ACO position responsibilities description. As a member of management staff, the AHN Market Director CIN Care Management, ACO promotes employee privacy through adherence to the CHI Information Security Principles and Requirements policy.

6. Improving care quality

   a) AHN's Market VP of Medical Operations/Chief Medical Officer (CMO) and the Clinical Care Committee will develop metrics for measuring clinical quality, patient satisfaction, resource utilization, and cost effectiveness with regard to the delivery of covered health care services. The Clinical Care Committee will make recommendations for improving any metric or goal not being met.

b) AHN's CMO is responsible for reporting care quality goals to the Clinical Care Committee.

See Section A. 2. Chart 2 (AHN Leader Responsibilities Chart) for AHN Market VP of Medical Operations/CMO position responsibilities description.

C. Delegation

1. Criteria and Processes for the Selection of Contractors.

a) Background

(1) AHN has entered into formal agreements with other CINs to manage various populations based on geography and age. The Memorandum of Understanding (MOU) outlines a joint collaboration between the Parties to assist one another in performing high quality and efficient care to beneficiaries of self-insured health plans in the state of Arkansas. The MOU details each Parties' obligations to establish joint advisory boards who will meet on a bi-montly basis but no more than a quarterly basis to provide input to each Parties' respective governing board and quality and performance committees.

b) Development of criteria and processes

(1) Before delegating functions under the scope of URAC Employer-Based Population Health standards, a department or office within Arkansas Health Network must first develop criteria and processes for the assessment of contractors for such delegation. At a minimum, such criteria and processes shall include an assessment of potential contractors' policies and procedures and capacity to perform the delegated functions in accord with the delegation agreement. Contractors must be able to demonstrate the ability to perform functions within the scope of URAC standards in accordance with the expectations for compliance found in the Program Guide. Such criteria also shall address the circumstances, if any, under which a site visit would be conducted as a part of the documented assessment.

c) Approval of criteria and processes

(1) Before use in the selection of a contractor for delegation of functions, such criteria and processes must first be reviewed and approved by Arkansas Health Network leadership and the AHN Board of Managers. Such approval must be memorialized in a written document such as an email, memorandum, or committee minutes.

2. Delegation Review

a) Before entering into a delegation under this policy, the delegating department or office of AHN shall conduct a documented assessment consistent with the approved criteria and processes referenced in Section 1 above, which will include:

(1) A review of the potential contractor's written policies and procedures, and

(2) The potential contractor's capacity to adequately perform delegated functions consistent with URAC standards.

3. Delegation Agreement

a) After selection under the above-described criteria and processes, and before the selected contractor begins work as a delegate of Arkansas Health Network, AHN shall execute a formal written agreement with the contractor that:

(1) Specifies the functions to be performed by the delegated contractor.

(2) Lists any performance standards that the delegated contractor must meet; and

(3) Specifies the applicable URAC standards that the delegated contractor must meet.

(4) In addition, if the delegated contractor is URAC-accredited or URAC-certified, AHN shall include in the agreement a provision requiring the delegated contractor to report to AHN if there is any change to its accreditation or certification status.

4. Delegation Oversight

a) Oversight of URAC-Accredited or URAC-Certified Organizations

(1) For delegation arrangements with organizations that are URAC-Accredited or URAC-Certified in programs relevant to the functions delegated, AHN shall conduct a validation of the contractor's relevant accreditation or certification no less frequently than annually by printing a screenshot of the contractor's page in URAC's directory. The AHN Market VP of Population Health will be responsible for ensuring this is completed annually.

(2) For all delegation to contractors not URAC-Accredited or URAC-Certified for the functions delegated to the contractor, AHN shall conduct such oversight as described in the executed MOU between Parties. AHN will review the MOU annually to identify any updates that may be necessary. AHN will document compliance utilizing

the AHN Contractor Performance Oversight Evaluation tool. This tool will be completed annually on all contractors by the Market VP of Population Health and reviewed annually by the Collaborative Steering Committee. A definition of the Collaborative Steering Committee, including membership and goals, is included in the MOU (ACCN_AHN_NextHealth_MOU Exhibit B).

b) AHN's Market VP of Population Health will review the quality of performance annually to confirm compliance with pertinent URAC standards for both URAC accredited and non-accredited contractors. These AHN coworkers are accountable for oversight of the contractor's compliance with URAC standards.

(1) AHN's Market VP of Population Health will use a compliance rating scale (met or not met) to determine if the contractor is compliant with performance measures. The AHN Contractor Performance Oversight Evaluation tool will be utilized for this purpose and will be completed annually on all contractors.

(2) Oversight of compliance with URAC standards may not be assigned to the contractor.

D. Leadership oversight (Governing Body)

1. AHN has a physician-led Board of Managers, which includes clinically integrated providers and administrative personnel. The Board of Managers establishes organizational goals and desired outcomes of the organization related to efficiency, cost control, and quality improvement.
2. The Board of Managers is made up of the following members: (See Section 2 AHN Governance Chart)
   a) Board Chair
   b) Board Vice-Chair
   c) Secretary
   d) Treasurer
   e) Community Manager
   f) Regular Managers
   g) President/CEO
3. The leadership team has oversight of the following:
   a) Regulatory compliance with all applicable federal and state laws and regulations. This includes at a minimum compliance with states' scope of practice laws, HIPAA and HITECH laws and regulations including the March 2013 Omnibus Final Rule, the DOJ/FTC

guidance, all necessary state licenses in accordance with state laws, and filing of all state and federal reports required.

b) Performance monitoring to confirm that established goals related to improved health, enhanced efficiency, and controlled health care costs in the population served are being met.

(1) The Clinical Care Committee is responsible for performance monitoring and reviews performance goals during meetings scheduled at least quarterly. Additionally, AHN provides an Annual Value Report detailing performance annually. The Annual Value Report is accessible to all CIN participants through the AHN website (www.arkansashealthnetwork.com).

c) Systems for assuring provider acceptance of performance goals. Performance goals are defined in each individual value-based contract. Per the AHN, LLC Clinically Integrated Network (CIN) Administrative Policy and Procedure, all CIN participants authorize the CIN to contract on their behalf with payors. CIN Participants have the option to opt out for specifically approved reasons under the supervision of the AHN Board of Managers. If participants do not request to opt out, they are agreeing to the terms and conditions of the contract. See Section D.3.b above for monitoring and sharing of performance goals with CIN providers.

d) Use of health information technology as appropriate to support clinical integration within the network.

(1) AHN will maintain a HIT system to integrate provider data for monitoring and quality assurance.

e) Promotion of clinical practices consistent with AHN goals, based on evidence-based medicine.

(1) Providers are expected to comply with evidence-based medicine in accordance with value based programs through processes that cover diagnoses with significant potential for AHN to achieve quality improvements taking into account the circumstances of individual beneficiaries.

(a) The Clinical Care Committee reviews and approves the quality measures for various contracts.

(b) Quality measures/targets will be reviewed and disseminated to providers annually.

(c) Quality measures/targets will be posted on the AHN website and AHN Connect app.

(d) The data analytics platform generates provider quality measure scorecards.

(e) Manual audits of selected quality measures are completed for providers whose EMRs are not captured in the data analytics platform.

f) Conservation of health care resources through oversight of appropriate utilization as necessary.

(1) The Clinical Care Committee is responsible for oversight of appropriate utilization.

The Clinical Care Committee meets at least quarterly to review data. Measures for performance include: Mutually agreed upon, validated quality, cost, efficiency key performance indicators and measures which are outlined in each individual value-based contract.

g) Transparent internal reporting on quality, cost, and outcomes metrics as required to meet AHN goals.

(1) AHN leadership is responsible for ensuring internal reporting occurs within the appropriate committees/boards.

h) Transparent external reporting on quality, outcomes and cost metrics as required to demonstrate AHN goals.

(1) AHN reports externally as required by regulators, contracted payers, and employer group purchasers.

(2) AHN leadership is responsible for ensuring external reporting occurs as determined by each value based contract.

i) Compensation plan among CIN clinically integrated providers based on meeting performance metrics.

(1) Under the supervision of the AHN Board of Managers and/or the Finance Committee (or other applicable committees) the CIN will develop pay-for performance/incentive distribution models that reward Participants for efficient and effective performance under the CI Program, annually.

j) Establishment of appropriate clinical and administrative systems to manage the CIN.

(1) Clinical systems: AHN maintains a data and analytics platform. The IT/Analytics Committee is responsible for oversight of the data and analytics platform and meets

at least annually. The AHN Clinical Care Committee meets at least quarterly and reviews performance reporting from the data and analytics platform for ongoing CIN performance monitoring.

(2) Administrative systems: AHN purchases Administrative systems from our sponsors.

k) Periodic evaluation of the success of the CIN in meeting its performance metrics.

(1) The AHN Board of Managers meets every other month, Clinical Care Committee meets at least quarterly, and other AHN Chapter Advisory Boards meet once a quarter to evaluate progress toward meeting performance metrics.

4. The leadership (Governing Body) that accepts risk under payer contracts oversees maintenance of fiscal solvency for both short and long term.
   a) This is important to ensure uninterrupted services to consumers.
   b) Contracts with payers define the following parameters:
      (1) Financial risk model does not incentivize or influence a limitation or restriction in the rendering of medically necessary care.
      (2) Practitioner contracting/compensation model does not create patient steerage towards non-risk benefits or delivery systems.
      (3) Nature and level of risk is defined or described.
   c) AHN meets all federal and state regulations and statutes to enable downstream risk. AHN value-based contracts/Care Service Agreements stipulate which federal and state regulations to follow.
      (1) AHN Sponsors' Legal and Compliance departments ensure compliance with federal and state regulations and statutes to enable AHN to participate in downstream risk value based contracts.
   d) Where required, AHN holds all necessary state licenses in accordance with State laws. AHN value-based contracts/Care Service Agreements stipulate which federal and state regulations to follow.
      (1) AHN Sponsors' Legal and Compliance departments ensure compliance with federal and state regulations and statutes to enable AHN to participate in downstream risk value based contracts.
   e) AHN has fiscal solvency protections in place. AHN value-based contracts/Care Service Agreements will stipulate the amount of reserves needed and any stop loss protections.

f) AHN completes all State statutory financial filings related to incurred health care expenses. Reports are submitted in a timely manner and retained on file.

(1) AHN is a Non-Profit LLC., and files appropriate tax documents through its sponsors.

g) AHN maintains the following:

(1) Board governance and decision-making over risk management decisions.

(a) AHN Finance and Contracting Committee shares with the Board of Managers monthly Financial Position Statements. The Board of Managers approves an Annual Operating Budget. The Board of Managers is responsible for the financial risk management related to incurred health care expenses.

(2) AHN Board of Managers with support of the AHN Finance and Contracting Committee oversees financial matters related to risk assumptions.

(3) Financial accounting systems and procedures to manage financial risk are a "purchased" service by AHN from AHN Sponsors.

(4) Internal and External Financial Controls to manage risk include:

(a) The financial accounting systems are a "purchased" service by AHN from AHN Sponsors.

(b) The AHN Finance and Contracting Committee maintains internal controls to manage risk.

(c) As directed by value based contracts, AHN maintains repayment mechanism(s) to ensure solvency and compliance with the value-based contract.

h) Short and long term strategies are outlined in the Long Range Strategic and Financial Plan.

5. Fiscal solvency reports are provided to the CIN governing body as described in g) (1) (a) above.

E. AHN has financial incentive programs between integrating parties for the purpose of improved clinical outcomes and health care cost trend mitigation. The goal of financial integration is to ensure that all integrating parties have a financial investment in the CIN systems and processes that motivate the contracted parties to improve quality and mitigate costs. Financial integration programs do the following:

1. Offer applicable incentives and/or disincentives for compliance with clinical guidelines and integration systems and processes.

a) Incentives include:

(1) Shared Savings Incentives

b) Disincentives include:

(1) Risk of staff relationship or contractual termination for non-compliance.

2. Align with AHN's goals. AHN goals include the following: improve patient health through education and higher quality of care, improve efficiency, monitor and improve utilization, decrease cost, and enable physicians to succeed in changing healthcare payment and delivery environments. AHN has management practices and policies that define transparent organizational relations between clinically integrated providers (as referenced in Section Leadership Structure and Oversight, subsection C). These include the following:
   a) Care management and coordination
   b) Use of locally adopted, nationally-accepted, validated clinical measures for performance, efficiency, and patient experience as necessary to meet CIN goals
   c) Operational capability that facilitates communication and cooperation among CIN participants
   d) Supporting organization, operational, and technical capabilities to assist with clinical decision-making and performance monitoring
   e) Health care services to improve measures of the health of persons with selected conditions for quality improvement
   f) Monitoring gaps in care aimed to prevent adverse unintended consequences for medically complex/difficult to treat patients and to improve patient compliance with preventative care and chronic disease management
3. Documented in applicable contracts between parties, including explicit documentation of integration methods. This documentation can be found in the Arkansas Health Network, LLC Clinically Integrated Network (CIN) Participation Agreement.

(1) Tracked and reported to the individuals and organizations that are contracted to participate in the financial integration programs. The Clinical Care Committee is responsible for performance monitoring on a quarterly basis and reviews performance goals. The Clinical Care Committee reports to the Board of Managers. The AHN data and analytics platform is utilized to monitor and track utilization, cost, and quality performance across all AHN value-based contracts. Dashboards allow for ongoing monitoring and quick identification of opportunities that can be reported to stakeholders.

POLICY SUBJECT:

Arkansas Health Network's (AHN) Structure and Operations

Qualification and Training Requirements

A. AHN establishes roles and qualifications for its CIN staff. Staff meet qualifications as required in written job descriptions. Staff is required to adhere to a scope of work consistent with licensure/certification and/or documented training and experience. AHN contracts with CHI St. Vincent HR department to perform vetting of internal/external candidates against the job description for the role that is being applied for. Listed below are some of the contracted responsibilities:
   1. Job is posted with job description requirements listed.
   2. When a candidate applies, the Recruiter carefully reviews the resume/application to ensure that all experience, education, and licensure requirements are satisfied.
   3. All non-qualified candidates are rejected at the Recruiter level and a regret email is initiated to the candidate.
   4. In many cases, CHI St. Vincent HR also conducts further checks. If the applicant is applying for a licensed position, CHI St. Vincent HR verifies their credentials with the appropriate licensing board.
   5. If all of those checks are satisfactory, CHI St. Vincent HR will forward the candidate to the hiring manager so an interview can be conducted.
   6. If the manager asks CHI St. Vincent HR to proceed with an offer, they then initiate a background check, a reference check, and a drug screen.
   7. All of those checks have to have satisfactory results before CHI St. Vincent HR will move forward with the hire.
   8. Further, CHI St. Vincent HR background checks include the following components:
      a) SSN Verification
      b) GSA/OIG Sanction Review
      c) Public Criminal History (state, county, and federal)
      d) Sex Offender Registry
      e) Professional License Verification
      f) Employment Verification
      g) Education Verification
      h) Professional Reference Check
      i) Motor Vehicle Report (only in cases here the employee drives a company car as part of their job duties)

B. AHN has training programs for its CIN staff.
   1. New Hire Orientation.

a) Corporate Orientation

(1) All employees will attend Hospital Orientation. Hospital Orientation is provided by the CHI St. Vincent Human Resources department prior to staff assuming assigned roles and responsibilities. It is designed to acquaint newly-hired employees with various aspects of working within the sponor's organization including its mission statement, values, organizational structure, privacy and security of information protections, ethics in health care, code of ethical business conduct, compliance, fire and safety procedures, incident and accident reporting procedures, and general policies and procedures necessary for the safe and effective performance of their responsibilities.

b) Department Level Orientation

(1) Upon completion of Hospital Orientation, all staff will complete department level training to learn their specific roles and duties and role performance expectations prior to assuming their responsibilities. Staff will receive the most current policies and procedures, guidelines, and workflows for their duties. Staff will also receive education covering topics including, but not limited to, CIN program overview, goals and approach of the CIN, clinical management roles and responsibilities, CIN technology and tools, program specific quality and cost goals and improvement standards.

(2) Managers will be responsible for providing department level orientation for staff members and documenting completion of department level training using the AHN department training log.

c) Goals and approach of the CIN for clinical integration

(1) During department level orientation, managers will provide staff with education around goals and approach of the CIN for clinical integration.

d) CIN policies and procedures and use of CIN health information technology software pertinent to their roles and responsibilities.

(1) During department level orientation, managers will provide staff with education on where to access CIN policies and procedures and the use of CIN health information technology and software pertinent to their roles and responsibilities. Managers will arrange for training on any pertinent CIN health information technology and tools.

e) Compliance training including:

(1) Privacy and security of individually identifiable health information in accordance with HIPAA and HITECH, and including March 2013 Omnibus Final Rule. AHN's Sponsor requires that all employed members of its workforce receive education related to confidentiality of information. This education is required to be completed by all employees during their new hire onboarding period, whenever material changes to related policies are made and education on these changes is offered, and as otherwise assigned.

(2) Regulatory compliance with applicable state and federal laws.

(a) Training includes state licensure, scope of practice laws and regulations as outlined by the sponsor's organization policy and procedures.

(3) Have access to methods of reporting legal and regulatory breaches and/or violations, as well as nonconformance to the Code of Conduct.

f) Clinical management, efficiency, and quality improvement standards of the CIN.

(1) Staff will be provided with education covering clinical management, efficiency, and quality improvement standards of the CIN. Managers are responsible for providing this education to staff members and arranging for any additional job shadowing opportunities that may be needed to enhance understanding.

2. Ongoing training to maintain competency in assigned roles and responsibilities
   a) On-going training is provided as needed when there are changes to policies, laws and regulation shifts in business functions or strategy or changes in accreditation standards. The need for such training will be evaluated annually and communicated to staff through monthly AHN staff meetings and/or via email correspondence.
   b) Staff must have access to the most current policies and procedures applicable to their duties on an ongoing basis. Current policies and procedures are located online and can be accessed at any time through the CHI St. Vincent intranet - Policies and Procedures Manager platform.
3. Documentation of training
   a) The CommonSpirit Health Pathways tool will track and log the training of staff at the time of Hospital Orientation and for ongoing training. Department level ongoing training occurring outside of the CommonSpirit Health Pathways tool will be documented using a department training log. Documentation of training will include, but not be limited to the topics outlined in section B.1.b).(1) of this policy. Staff receiving emails are: (I)

responsible for knowing content; (II) able to ask questions for clarification; and (III) accountable for implementing changes as appropriate to their roles.

POLICY SUBJECT:

Arkansas Health Network's (AHN) Structure and Operations

ATTESTATION OF LEADERSHIP REVIEW:

By signing this document, I do hereby attest that I have read and agree with the contents of this policy.

DocuSigned by:
F913417B0F03460...
Bob Sarkar, President & CEO

DocuSigned by:
Camille Wilson
0F44C913787F49C...
Camille Wilson, Market VP, Population Health

DocuSigned by:
Dr. Lubna Maruf
ABA7EBEA27BE416...
Lubna Maruf, Market VP Medical Operations/Chief Medical Officer

DocuSigned by:
Amy Ward
B5860158B4404F8...
Amy Ward, Market Director Operations

DocuSigned by:
Chris O'Dwyer
EFA3236332BC4EF...
Christopher O'Dwyer, Market VP Employer Business/Network Development

DocuSigned by:
Priyanka Muppidi
4303038FC71E42F...
Priyanka Muppidi, Manager, Data Analytics/Population Health

DocuSigned by:
AAECF180B1B5431...
Hafeezah Brooks, Market Director CIN Care Management