FIRST AMENDMENT
TO AHARO CLINICAL INTEGRATION AGREEMENT

This First Amendment ("First Amendment") to the AHARO CLINICAL INTEGRATION AGREEMENT ("Agreement") dated as of January 1, 2015 among Bay Clinic, Inc., Hamakua Health Center, Inc. (doing business as Hamakua-Kohala Health), Waimanalo Health Center and Waianae District Comprehensive Health and Hospital Board, Incorporated (doing business as Waianae Coast Comprehensive Health Center) (individually, a "Member" and collectively, "Members") is hereby entered into as of July 24, 2017.

The undersigned acknowledge and agree as follows:

1. Formal Joinder of AHARO HAWAII. AHARO HAWAII, a Hawaii nonprofit corporation, is formally identified as "AHARO" within the meaning of the Agreement, added as a signatory to the Agreement, and agrees to observe and perform the terms of the Agreement as of the original date of the Agreement.

2. Appointment of AHARO HAWAII as Negotiating and Contracting Agent. As provided in the Agreement, AHARO is a multi-provider network of separate and independent federally qualified health centers that seeks to create a clinically integrated network and to then engage in joint contracting with third-party payors on behalf of its participating providers. Each Member designates AHARO as its agent for the purpose of negotiating and entering into payor contract(s) generally in the form attached as Exhibit A. Such designation is subject to the board of directors of AHARO reasonably determining that AHARO is sufficiently clinically integrated such that AHARO is permitted by applicable federal and state antitrust laws to negotiate and enter into such payor contract(s) on behalf of the Members. For such period of time that the Agreement is in effect, unless precluded from doing so by law, each Member hereby grants an irrevocable power of attorney and appoints AHARO as its attorney in fact with an irrevocable power to execute, on the Member's behalf, all payor contracts entered into by AHARO and any amendments thereto, and to execute any other appropriate documentation or take any action required by a payor to reflect the Member's agreement to comply with the terms of the payor contracts and amendments. Except where permitted by law, AHARO shall not disclose any information to a Member regarding the fees proposed or accepted by other Members. Except as permitted by law, each Member agrees that it will not discuss or exchange information regarding individual fee schedules with other Members, nor will it take part in any discussions or activities that could be construed as a collective refusal to deal or price-fixing activity with payors or other providers.

3. Contribution to/Funding of AHARO. Each Member shall be liable for a share of operating and capital costs, and any financial liability, of AHARO subject to a "Limit of Liability." The Limit of Liability for a Member shall be the greater of one dollar (1.00) per Member's member per month subject to all AHARO payor contracts.

4. Each Health Center's Continuing Independence and Individual Accountability. Each Member will continue to manage its own patient population and separately and independently observe and perform its rights and obligations with respect to AHARO and all payor contracts. Any right of a

Member to receive any compensation under payor contracts shall not be dependent upon AHARO collectively achieving certain quality metrics and generating savings for the care furnished to patients as described in agreements with payors.

5. Term and Withdrawal. The initial term of the Agreement will continue until and including December 31, 2018 ("Initial Term"). The Agreement shall automatically renew for additional one (1)-year periods ("Renewal Term") subject to the right of any Member to withdraw, with or without cause, from the Agreement by written notice to AHARO and other Members at least ninety (90) days prior to the expiration of the Initial Term or any Renewal Term.

6. Conflicts and Counterparts. As amended by this First Amendment, all of the other provisions of the Agreement shall remain in full force and effect and are hereby ratified and affirmed. In the event of any conflict between the terms and conditions of this First Amendment with the terms and conditions of the Agreement, the terms and conditions of this First Amendment shall control. This First Amendment may be executed in one or more counterparts, and by the Parties hereto on separate counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the undersigned have caused this Agreement to be executed by their duly authorized representatives as of the day and year written above.

AHARO HAWAII

By: _____
Mary Frances Oneha
Its Chief Executive Officer

Bay Clinic, Inc.

By: _____
Harold Wallace
Its Chief Executive Officer

Hamakua Health Center, Inc.
(doing business as Hamakua-Kohala Health)

By: _____
Irene J. Carpenter
Its Chief Executive Officer

Waianae District Comprehensive Health and Hospital Board, Incorporated (doing business as Waianae Coast Comprehensive Health Center)

By: _____
Richard P. Bettini
Its President and Chief Executive Officer

Waimanalo Health Center

By: _____
Mary Frances Oneha
Its Chief Executive Officer

Exhibit A

Form of Contract Between Payor and AHARO

[To Come]

AHARO CLINICAL INTEGRATION AGREEMENT

This Clinical Integration Agreement ("Agreement") is made as of the 1st day of January, 2015 by and among the undersigned federally qualified health centers.

Recitals

A. AHARO is a multi-provider network of separate and independent federally qualified health centers ("FQHCs") that seeks to create a clinically integrated network and to then engage in joint contracting with third-party payers on behalf of its participating providers as described in the Federal Trade Commission's Norman Physician Hospital Organization February 13, 2013 advisory opinion at http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf (see also related letter dated May 26, 2011 from Michael Joseph, McAfee & Taft, to Federal Trade Commission at http://www.ftc.gov/os/2013/02/130213normanphoincomingadvltr.pdf).

B. AHARO will develop contract proposals, negotiate contract terms, and enter into contracts with third-party payers for the provision of the clinically integrated services described in this Agreement. AHARO's proposed activities contemplate horizontal pricing agreements only with respect to its provision of physician services. Its proposed clinical integration program offers the potential to create a high degree of interdependence and cooperation among its participating FQHCs and their physicians and to generate significant efficiencies in the provision of physician services. AHARO's proposed joint contracting on behalf of its participating FQHCs will be both subordinate to the network's integrative activities and reasonably necessary to implement the proposed program and achieve its efficiency benefits.

C. AHARO acknowledges that certain important details of its program are yet to be finalized. Nonetheless, AHARO believes that the driving principles and essential features of its proposed operations have been determined, and that its proposed program will offer payers and their enrollees—that is, AHARO patients—improved quality of care, reduced costs of care, and increased patient satisfaction. AHARO asserts that one of the network's primary goals is to set the standard for efficient and high-quality care in the areas served by the participating providers.

D. Membership in AHARO will remain available to applicants who meet the network's membership guidelines and criteria.

Agreement

1. **Incorporation of Recitals**. The recitals set forth above are true and correct and are incorporated herein by reference.

2. **Non-Exclusivity**. AHARO will operate as a non-exclusive network. In the event a health plan, employer, or other third-party payer does not wish to contract with AHARO (or vice versa), the payer will have the ability to negotiate with the network's individual participating providers or other networks in which they may participate without interference from AHARO. Neither the network nor its participating provides will seek to influence any other participant's independent contracting intentions or strategies, or otherwise confront any payer with the group's aggregate bargaining power.

AHARO specifically represents that, as a partially integrated, non-exclusive network, its participating providers will remain free to contract independent of AHARO with any payer that chooses not to contract with the network. AHARO will clearly inform payers and participating providers that the network is non-exclusive. The network also will provide antitrust counseling and training to its participating providers and will specifically address the antitrust concerns associated with concerted refusals to deal. As such, AHARO anticipates that payers who seek to contract with local providers will have the choice of contracting with AHARO for clinically integrated services, contracting individually with AHARO's participating providers (i.e., outside the network), or pursuing alternate contracting strategies.

3. **Clinical Integration**. AHARO and its participating providers have determined to replace their existing operating model, in which each provider is responsible for individually providing clinical services and setting its own reimbursement rates for those services, with a clinically integrated program in which its providers collectively offer a network of coordinated services. AHARO anticipates that its proposed new operations will result in the delivery of improved quality of care in a more efficient manner than the participating providers could otherwise achieve independently.

AHARO and its participating providers intentionally have moved slowly and deliberately with the objective of carefully constructing a clinical integration program that has strong provider support and is also attractive to health plans, employers, and other third-party payers. AHARO acknowledges that the federal antitrust enforcement agencies have explained that clinical integration may be evidenced when a provider network:

> "implement[s] an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create[s] a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies." Statement 8 Section (B)(1) at http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm

4. **New Infrastructure**. AHARO will establish a new organizational structure for accomplishing the integrative goals of its proposed program. The new structure will be designed to ensure that the participating FQHCs and their physicians work collaboratively to establish clinical practice guidelines, to create a high degree of transparency and visibility with respect to their practice patterns, and to provide mechanisms for monitoring and enforcing compliance with AHARO's clinical practice guidelines. Participating FQHCs and their physicians will be obligated to participate in, and comply with, the network's clinical integration program pursuant to the terms of this Agreement and/or any network participating provider agreement.

Key components of AHARO's new organizational structure include a Specialty Advisory Groups ("SAG"), Mentor's Committee ("MC"), and Quality Assurance Committee ("QAC"). The SAG will be responsible for developing and periodically updating clinical practice guidelines. The MC will oversee global quality improvement planning, including approval of clinical practice guidelines, monitoring of implementation, and enforcement of adherence to the guidelines.

The QAC will be broadly responsible for establishing the measures for individual and group performance benchmarking, monitoring individual and group compliance with the network's standards, and administering corrective actions as necessary. Although specific performance measures have yet to be developed, the QAC will develop measures to identify high-cost providers, inappropriate use of resources, and failures to comply with clinical practice guidelines. The QAC will audit medical records and generate regular reports on individual and aggregate physician compliance rates for clinical measures. These reports will include information such as: (1) individual physician compliance rates under applicable measures; (2) comparisons of the physicians' compliance rates against their previous performance and with that of peer physicians; and (3) cumulative compliance rates for all physicians for whom particular measures are applicable. The reports will be shared with both the participating physicians, individually and as a group, and with payers, to promote transparency, compliance and accountability. The QAC also will make recommendations for improving individual and aggregate compliance performance and assist with risk management. Additionally, the QAC will provide or arrange for medical education and information to promote compliance with network clinical practice guidelines. The QAC will implement and oversee corrective actions when noncompliance or risk concerns are identified, including engaging in physician-to-physician mentoring and other counseling and educational activities. The QAC also may implement financial withholds or penalties, and, in extreme cases of noncompliance, may expel a participating provider from the network.

AHARO will appoint a medical director and will hire new employees to support the clinical integration program. AHARO will contract with a Medical Informatics Officer who specializes in the management and processing of data, information, and knowledge; retain a registered nurse to serve as the Director of Quality Assurance, and hire several full-time staff members for electronic records management and training, data extraction, and other activities relating to the network's use of its electronic platform.

5. **Clinical Practice Guidelines**. AHARO and its participating FQHCs and their physicians expect to develop their own evidence-based clinical practice guidelines for as many as 50 disease-specific conditions, and to periodically review, reassess, and update these guidelines as appropriate. They seek to establish physician-centered processes and procedures for developing, implementing, monitoring, and enforcing clinical practice guidelines. The physicians' involvement in and control over these activities—through the SAG, MC, and QAC—is expected to promote a high degree of confidence in, and adherence to, the network's clinical practice guidelines, as well as the collective achievement of patient care, quality, and cost goals.

AHARO will collect and analyze physician data for purposes of assessing high-prevalence, high-cost, and high-risk chronic conditions that most affect its current patient population. The network plans to identify diseases (including possibly diabetes, anemia, and hypo- and hyperthyroid disease) for which SAG, with oversight from MC, have developed and will be implementing clinical practice guidelines.

6. **Electronic Platforms and Interface**. AHARO will invest time, money and effort in developing an electronic platform and views full use of its electronic platform by participating FQHCs and their physicians as a critical component of its clinical integration program. The electronic platform will include an electronic clinical decisions support system, e-prescribing, electronic medical records system, and an electronic health interface system.

AHARO anticipates that, among other benefits, the network's electronic tools will help participating FQHCs and their physicians to use quality measure parameters in evaluating and treating patients, streamline submission of prescriptions and reduce errors, and facilitate physician-to-physician

communication. Additionally, the network will use the electronic platform both to measure and evaluate physician performance and compliance with the network's own clinical practice guidelines and to facilitate data collection, outcomes measurement, utilization management, and performance reporting required by Medicare and other payers.

To ensure that the network can realize the full potential of its electronic platform, the participating FQHCs and their physicians will be required to both (1) acquire and maintain the necessary computer equipment, software, rights, or licenses (or acceptable alternatives); and (2) make available practice data and medical records for the network's use in connection with developing, reviewing, and enforcing clinical practice guidelines.

7. **Participating FQHCs Commitment, Investment and Involvement**. AHARO and its participating providers recognize that the success of their proposed program rests on the participating FQHCs and their physicians' commitment and motivation—both individually and as a group—to improve quality of care, to reduce costs of care, and to otherwise jointly offer services that payers find to be both attractive and attractively priced. Each participating FQHC and their physicians, therefore, must satisfy the network's eligibility criteria, make certain investments in, and demonstrate a commitment to, AHARO's clinical integration program.

At the outset, and in connection with annual reappointments, each participating FQHC's physicians must satisfy credentialing and medical staff appointment requirements. Each FQHC will pay a $350 membership fee and $150 annual dues to AHARO for each of their respective physicians; enter into and comply with this Agreement and/or any participating provider agreement; and generally commit to the network's clinical integration program. Each participating FQHC and their physicians also must acquire and maintain certain computer equipment, software, rights or licenses, and training as necessary to use the network's electronic platform (or acceptable alternatives).

Each participating FQHC and/or their physicians also must make meaningful ongoing contributions, including commitments of time and effort, to the network's development, implementation, and enforcement of clinical practice guidelines. For example, each participating physician must serve as a member of one or more of the SAG, MC, or QAC. Further, each participating FQHC and/or their physicians must adopt, implement, and adhere to the network's clinical practice guidelines when providing clinical services, patient care, and referrals. In the event of noncompliance or other concerns, a physician must participate in peer education, individualized counseling or proctoring, and corrective action plans as directed by the network. Additionally, as noted above, each participating FQHC and/or their physicians must make practice data and medical records available for the network's review and analysis. Each participating FQHC and/or their physicians also must make ongoing financial contributions, in the form of "withholds" from reimbursements made to them by payers who contract with AHARO, to support the network's clinical integration activities.

AHARO underscores that the ongoing selectivity of only those participating FQHCs and/or their physicians who are committed to AHARO's goals and requirements is essential to the network's success. To ensure that participating FQHCs and/or their physicians' commitment, AHARO will implement comprehensive review processes and may exclude any participating FQHC and/or their physician who is unable or unwilling to comply with the program's requirements. AHARO anticipates that some natural attrition may occur because physicians who are not fully committed to the program will drop out of the network rather than make the substantial time, effort, and other contributions necessary for continued participation. For example, some physicians may not be willing to make the investments necessary to

access the network's electronic platform. In the event of severe or continued noncompliance, the network may impose financial penalties or terminate a physician's participation in the network.

Pursuant to this Agreement and any participating provider agreement, AHARO will require all participating FQHCs and/or their physicians to participate in the development, implementation, and enforcement of the network's clinical practice guidelines, including those requiring use of the network's electronic platform. It also will enable the network to undertake corrective actions, including, in egregious instances of noncompliance, the expulsion of a participating physician.

8. **Payer Contracting**. AHARO intends to establish a contracting committee that will be charged with evaluating payer contract proposals to determine whether the network's goals can be accomplished within the framework of those proposals. AHARO has yet to actively market its new program to payers, but intends to do so once the program is ready to be implemented. AHARO acknowledges that its marketing activities will be successful, and the network will secure payer contracts, only to the extent that it is able to demonstrate the value of its program to payers. In other words, AHARO's proposed new program will be financially viable only to the extent that customers recognize its value and wish to do business with the network.

Pursuant to this Agreement and any participating provider agreement, AHARO will require all participating FQHCs and their physicians to participate in any contract between AHARO and a payer. This requirement will enable the network to provide a stable and identifiable roster of physicians and facilitate in-network referrals, and thereby increase patient volume and harness network effects and economies of scale, while providing efficiencies and reducing transaction costs to payers and participating FQHCs and/or their physicians.

9. **Anticipated Savings, Efficiencies, and Other Benefits**. AHARO acknowledges that it cannot currently quantify the likely overall efficiency benefits of its proposed program, or specify how overall cost or quality efficiency gains will be measured. Nonetheless, AHARO anticipates that its proposed new program will generate meaningful savings and efficiencies that will benefit its patients, payers, and participating providers. For example, AHARO projects the following potential benefits for each:

Patients: improved outcomes; better adherence to preventive screenings and services; reduced medical errors; better infection control rates; shorter hospital stays; lover hospital re-admission rates; earlier disease detection and better disease control procedures; more timely communication of current treatment plans; more timely scheduling of primary and specialty care appointments; and the elimination of unnecessary duplication of tests and repetitive completion of registration paperwork.

Payers: centralized credentialing and contracting; more satisfied beneficiaries; elimination of unnecessary duplication of services; earlier disease detection; avoidance of preventable hospitalizations; reduced medical errors; improved infection control rates; decreased lengths of hospital stay and re-admittance rates; and lower costs of care.

Participating Providers: reduced paperwork; greater ease of scheduling; improved patient diagnosis and treatment plans through timely receipt of diagnostic information and availability of clinical practice guidelines; seamless referrals to specialists and admission to ancillary and hospital providers; reduction of staff time required to duplicate medical records; and timely scheduling of patient care services.

10. **Organizational Protection Against Spillover Effects**. AHARO recognizes that, in a competitive market free of anticompetitive restraints, market forces ultimately will decide if AHARO's product is valuable. Among other activities, AHARO acknowledges that the antitrust laws prohibit the network and its participating providers from collectively exercising market power, including by setting prices or otherwise coordinating the terms on which they will (or will not) contract with payers outside of the network.

AHARO acknowledges that it is responsible for ensuring the network's compliance with the antitrust laws. It specifically represents that it will provide appropriate antitrust training to its administrators and participating providers, and will implement mechanisms to limit opportunities for anticompetitive spillover effects or other unlawful coordination among its participating providers. For example, AHARO will take steps to ensure that competitively sensitive information (e.g., prices, pricing, or negotiating strategies on intentions) is not improperly shared between or among participants.

IN WITNESS WHEREOF, the undersigned have caused this Agreement to be executed by their duly authorized representatives as of the day and year written above.

Bay Clinic, Inc.

By: _____

Hamakua Health Center, Inc. (doing business as Hamakua-Kohala Health)

By: _____

Waimanalo Health Center

By: _____

Waianae District Comprehensive Health and Hospital Board, Incorporated (doing business as Waianae Coast Comprehensive Health Center)

By: _____