

**AMENDMENT NUMBER 6 TO HEALTH PLAN SERVICES CONTRACT  
COORDINATED CARE ORGANIZATION  
CONTRACT #143113 BETWEEN  
THE STATE OF OREGON  
OREGON HEALTH AUTHORITY**

**AND**

**EASTERN OREGON COORDINATED CARE ORG., LLC  
601 SW 2<sup>ND</sup> AVE., 24TH FLOOR  
PORTLAND, OR 97204**

1. This is amendment number 6 (“Transformation Amendment”) to Health Plan Services Contract, Coordinated Care Organization, Contract # 143113 (the “Contract”), between the State of Oregon, acting by and through its Oregon Health Authority (“OHA”), and Eastern Oregon Coordinated Care Org., LLC (“Contractor”). This Amendment is effective October 1, 2015, regardless of the date of signature, subject to approval by the US Department of Health and Human Services, Centers for Medicare and Medicaid Services.

2. The Contract is hereby amended as follows:

a. Exhibit K, Opening Paragraph, is hereby deleted in its entirety and replaced with the following:

Contractor shall prepare a “Transformation Plan” that is a specific plan (plans, timeline, benchmarks, milestones, and deliverables) demonstrating how and when Contractor will achieve Health System Transformation, aligned with the quality and incentive specifications established in Exhibit B Part 9. Contractor shall prepare, subject to approval by OHA, DOJ, and CMS, “Areas of Transformation” that are based in substance on the Transformation Plan and in the form of the Transformation Deliverables and Benchmarks described below. Contractor’s Areas of Transformation are in Attachment 1, which is attached to this Exhibit K and hereby incorporated into this Contract with this reference. Contractor’s obligations under the Transformation Amendment are obligations under this Contract. The purpose of this Exhibit K is to set forth the procedure Contractor shall follow to maintain the Transformation Plan and Transformation Amendment required by this Contract.

b. Exhibit K, Section 1, is hereby deleted in its entirety and replaced with the following:

**1. Transformation Plan**

a. Contractor shall maintain a Transformation Plan in effect throughout the term of this Contract. Contractor’s Transformation Plan must include, at minimum, the following eight areas of transformation (the “Transformation Areas”):

(1) Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when Dental Services are included. This plan must specifically address the needs of individuals with severe and persistent mental illness.

- (2) Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).
- (3) Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.
- (4) Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with ORS 414.627.
- (5) Developing a plan for encouraging Electronic Health Records; health information exchange; and meaningful use.
- (6) Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.
- (7) Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects Member diversity).
- (8) Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Contractor's Transformation Plan may include any other elements that are part of Contractor's strategy for Health System Transformation.

If Contractor does not have an OHA-approved Transformation Plan by the Deliverable Date identified in Section 4, Contractor shall continue to negotiate with OHA regarding the Transformation Plan. Contractor's failure to have an OHA-approved Transformation Plan by the Deliverable Date identified in Section 4 is a material breach of this Contract under Exhibit D, Section 10.a(3) of this Contract.

c. Exhibit K, Section 4, is hereby deleted in its entirety and replaced with the following:

**4. Periodic Update of Transformation Plan**

Contractor shall periodically update its Transformation Plan and Areas of Transformation to continue strategic planning and implementation of specific plans (plans, timeline, benchmarks, milestones, and deliverables) demonstrating how and when Contractor will achieve Health System Transformation, aligned with the quality and incentive specifications established in Exhibit B Part 9. Contractor shall provide the following deliverables, and OHA will respond to these deliverables, in accordance with the schedule described below:

<u>Deliverable</u>	<u>Deliverable Date</u>
(1) <u>Draft Plan</u> . Contractor furnishes OHA with a draft of an updated	March 16, 2015

Transformation Plan.

- (2) OHA Comments. OHA furnishes Contractor with written comments on its draft updated Transformation Plan. May 15, 2015
- (3) Final Draft. Contractor submits final draft language of its updated Transformation Plan for approval by OHA. June 10, 2015
- (4) OHA Acceptance. OHA furnishes Contractor with written approval of its draft updated Transformation Plan. July 1, 2015

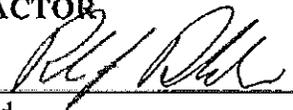
d. Exhibit K, Attachment 1, is hereby deleted in its entirety and replaced with the revised Exhibit K, Attachment 1, a copy of which is attached to this Amendment and hereby incorporated into the Contract with this reference.

- 3. OHA's performance hereunder is conditioned upon Contractor's compliance with provisions of ORS 279B.220, 279B.225, 279B.230, 279B.235, and 279B.270, which are hereby incorporated by reference. Contractor shall, to the maximum extent economically feasible in the performance of this Contract, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in 279A.010(1)(ii)).
- 4. Except as expressly amended above, all other terms and conditions of the initial Contract and any previous amendments are still in full force and effect. Contractor certifies that the representations, warranties and certifications contained in the initial Contract are true and correct as of the effective date of this amendment and with the same effect as though made at the time of this amendment.

5. **Signatures**

**IN WITNESS, THE PARTIES LISTED BELOW HAVE CAUSED THIS AMENDMENT TO BE EXECUTED BY THEIR DULY AUTHORIZED OFFICERS.**

**CONTRACTOR**

By   
Authorized

July 22, 2015

Printed Name: Robin J. Richardson

Date

Title COO

**OHA –Division of Medical Assistance Programs**

By Rhonda Busek  
OHA

8/5/15  
Date

**Approved as to Legal Sufficiency:**

By \_\_\_\_\_  
Deanna Laidler, Sr. Assistant Attorney General

7/20/15  
Date

**Reviewed by OHA/DMAP Contract Administration**

By David Fischer  
David H. Fischer, Contract Administrator

7/27/15  
Date

**Exhibit K - Attachment 1 – Areas of Transformation**

**A. Benchmarks for 2015 – 2017 Transformation Plan Amendment**

- (1) **Area of Transformation:** Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when Dental Services are included. This plan must specifically address the needs of individuals with severe and persistent mental illness.

Benchmark 1	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• Contractor will continue to communicate and collaborate with key stakeholders; Moda, GOBHI, APD, hospital representatives and clinic representatives at county collaborative meetings to achieve optimal member outcomes, e.g. coordinating care between medical, behavioral health and dental through intensive case management, dental case management, behavioral health providers, members, and the county collaborative representatives.</li> <li>• Contractor will continue to work with the APD Innovator Agent(s) to initiate collaboration programs in other Contractor counties to expand the opportunities for communication and to support continuity of care for the members.</li> <li>• Contractor and key stakeholders will continue to explore methods for tracking referrals to APD transition coordinators to ensure appropriate transitions of care for members and to identify potential long term care needs.</li> <li>• Contractor will continue to identify members with complex needs and refer to ICM to provide assistance with navigation, care transitions, and identification of resources for members with complex medical, dental, and/or behavioral health needs; transportation, medical equipment and supplies, and evaluate requests for flexible services. ICM will provide assistance to the providers and will coordinate communication between and among the providers and with the member.</li> <li>• Contractor will use existing fidelity based self-assessments and technical assistance from CCO/OSEACT, et.al, to score program and measurement systems with OHA to report on Early Assessment and Support Alliance, Assertive Community Treatment, Supported Employment, Systems of Care/Wrap around, Rental Assistance, and other Evidence Based Practices</li> </ul>

	<p>currently being used by Contractor. Maximizing the principles contained within the fidelity requirements will ensure appropriate connections with substance abuse, occupational, and physical health providers that support a systematic system wide approach in a culturally appropriate manner.</p> <ul style="list-style-type: none"> <li>• Contractor will count the number of counties with contracts between medical clinics and community mental health program clinics for provision of specific behavioral health services and shared risk management in medical clinics. Focus will be on the shared responsibility for care management between PCPCH and CMHP’s concerning high risk members and those needing placement in higher levels of care.</li> <li>• Contract with OHA/AMH will exist as an early adopter of mental health residential treatment, that transitions into the permanent OHA contract. During the early adopter phase creating connections with community based services, physical health, dental, landlords, substance abuse providers, and others that lead to permanent arrangements that facilitate appropriate and timely discharges from residential levels of care.</li> <li>• Contractor will have established UM guidelines and pre-authorization processes for mental health, addictions, and detoxification facility based care that will be based on processes and connections developed during the early adoption of mental health residential, along with on-going efforts within the SUD/Detox residential community.</li> <li>• Contractor will track and count the number of Contractor members utilizing each of these facility based care services, including successful transitions to lower levels of care. Tracking utilization, discharge and transition to community based care will allow for continual feedback on the appropriateness of community based connections, specialty care availability, and development needs for members.</li> </ul>
<p>Milestone(s) to be achieved as of July 31, 2016</p>	<ul style="list-style-type: none"> <li>• Expand the county collaboratives to at least four of the 12 counties included in the Contractor to achieve optimal member outcomes, e.g. coordinating care between medical, behavioral health and dental through intensive case management, dental case management, and behavioral health providers, members, and the county collaborative representatives.</li> <li>• Develop working MOU for at least four of the 12 counties included in Contractor’s service area to ensure member confidentiality in communication between the collaborative participants.</li> <li>• Develop secure and effective method for tracking</li> </ul>

	<p>referrals to APD transition coordinators.</p> <ul style="list-style-type: none"> <li>• Health risk assessment (HRA) review process will be fully implemented with review of HRAs completed within 30 days of receipt including identifying members in need of referral to medical, dental, and/or behavioral health programs as appropriate.</li> <li>• Fidelity and/or evidence based programs within each service delivery area will create a sustainability plan, and submit either or both a self-assessment and/or OSEACT/EASA/Wrap-around evaluation, that will be submitted and approved by Contractor as appropriate to the members holistic needs for each community.</li> <li>• Contracts with medical clinics in at least 75% of counties that show evidence of shared care management and risk sharing responsibilities for Contractor enrolled members.</li> <li>• 25% of the contracts between CMHP and PCPCH will include a risk management process for Contractor members.</li> <li>• Contractor will have incorporated mental health residential treatment into its' OHA contract.</li> <li>• Contractor will have established UM guidelines and pre-authorization processes in place and operational for facility based care.</li> <li>• Contractor will have an established tracking method for tracking member placement in each category of facility based care (i.e. MH, SUD, and Detox) for the purposes of identifying and benchmarking utilization and evaluating systematic interventions to prevent, retain, and to effectively transition Contractor members back into their communities.</li> </ul>
<p>Benchmark to be achieved as of July 31, 2017</p>	<ul style="list-style-type: none"> <li>• Expand the county collaboratives to at least six of the 12 counties included in Contractor's service area to achieve optimal member outcomes, e.g. coordinating care between medical, behavioral health and dental through intensive case management, dental case management, and behavioral health providers, members, and the county collaborative representatives.</li> <li>• Develop working MOU for at least six of the 12 counties included in Contractor's service area to ensure member confidentiality in communication between the collaborative participants.</li> <li>• Monitor and update as necessary the tool developed for tracking referrals to APD to ensure appropriate identification of members with potential long term care needs.</li> <li>• Complete all new HRA reviews within 30 days of receipt including identifying members in need of referral to medical, dental, and/or behavioral health programs as appropriate.</li> </ul>

	<ul style="list-style-type: none"> <li>• Sustainability for each fidelity and/or evidenced based program will be achieved as evidenced by six consecutive months of self-reports and technical reviews by Contractor.</li> <li>• Contracts with medical clinics in 100% of counties that address shared care management and risk sharing for Contractor members.</li> <li>• 50% of the counties will have included within them a risk management process for Contractor members.</li> <li>• All contracted facility based care providers will have been trained and will be accurately reporting data to Contractor regarding UM and pre-authorization requests.</li> <li>• Contractor will have an established process for tracking member transitions from facility based care in all categories specified within the established UM guidelines.</li> </ul>
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(2) **Area of Transformation:** Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).

Benchmark 2	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• Contractor will continue to measure the number of members assigned to a certified PCPCH at each tier level including 3 STAR participants.</li> <li>• Contractor will have a consistent methodology to reimburse for community health workers employed by PCPCH's.</li> <li>• Contractor will have enhanced tools available to assist PCPCH's with population health.</li> <li>• Contractor will have a consistent methodology to reimburse for behavioral health services provided within PCPCH's.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• At least 70% of Contractor members will be assigned to a certified PCPCH at any tier level.</li> <li>• At least 10% of Contractor members will be assigned to a 3 STAR certified PCPCH.</li> <li>• Contractor will pay for community health worker services in at least two counties within Contractor's service area.</li> <li>• Contractor will provide integrated medical and behavioral health utilization data to PCPCH's to assist in managing member health conditions.</li> <li>• Contractor will pay for behavioral health services provided in at least four PCPCH's.</li> </ul>
Benchmark to be achieved as of	<ul style="list-style-type: none"> <li>• At least 75% of members will be assigned to a certified PCPCH at any tier level.</li> </ul>

July 31, 2017	<ul style="list-style-type: none"> <li>• At least 20% of Contractor members will be assigned to a 3 STAR certified PCPCH.</li> <li>• Contractor will pay for employed community health worker services in at least four counties in Contractor’s service area.</li> <li>• Contractor will provide PCPCHs population health tools via a secure on-line provider portal at consistent intervals that will provide PCPCHs with the information necessary to focus on the most high cost/high risk members within their practice.</li> <li>• Contractor will pay for behavioral health services provided in at least eight PCPCH’s.</li> </ul>
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(3) **Area of Transformation:** Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.

Benchmark 3	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• Contractor will measure the number of primary care practices assuming full risk for primary care services.</li> <li>• Contractor will measure the number of in-area contracted providers and the percentage of the member population being served by in-area contracted providers participating in alternative payment methodologies including risk contracts.</li> <li>• Contractor will continue modifying risk contracts to ensure the majority of healthcare providers have an opportunity for participation.</li> <li>• Contractor will develop a consistent methodology for sharing quality incentive funds with providers that is weighted toward those providers with the best performance.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• At least one primary care practice is taking full risk for primary care services.</li> <li>• At least 75% of in-area utilization spend is to providers participating in alternative payment methodologies and risk contracts.</li> <li>• Contractor will evaluate additional provider categories that could be included in risk contracts.</li> <li>• Contractor’s board will approve a methodology for sharing quality incentive funds with providers that is weighted toward those providers with the best performance.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• At least three primary care practices are taking full risk for primary care services.</li> <li>• At least 85% of in-area utilization spend is to providers participating in alternative payment methodologies and</li> </ul>

	<p>risk contracts.</p> <ul style="list-style-type: none"> <li>• Contractor will modify risk contracts to include additional providers and provider categories within the healthcare system.</li> <li>• Contractor will share a portion of quality incentive funds with hospitals, primary care providers, specialists, GOBHI, DCO's and the local community advisory councils using a methodology that rewards providers based on their performance including their ability to meet the CCO incentive measures.</li> </ul>
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(4) **Area of Transformation:** Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with ORS 414.627.

Benchmark 4	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• Contractor will maintain the number of Local Community Advisory Councils (LCACs) and Regional CAC (RCAC) meetings already established.</li> <li>• Contractor will measure the number of OHP members participating in LCAC activities.</li> <li>• Contractor will measure the number of LCACs that produce an annual report describing implementation of the local CHIP.</li> <li>• Contractor will measure the number of LCACs with a completed update of their Community Health Assessment.</li> <li>• Contractor will measure the number of LCACs with an updated Community Health Improvement Plan.</li> <li>• Contractor will produce a Regional Community Health Improvement Plan.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• 100% of Contractor's counties will have maintained progress in conducting LCAC and RCAC meetings consistent with ORS 414.627.</li> <li>• 100% of LCACs will have increased the proportion of OHP members serving on the committees and will continue to strive toward meeting the goal of OHP consumers representing the majority of the committees. In June of each year the LCAC meeting invitation list will be compared to the official list of LCAC members provided by the county commission/court that appointments them. The percentage of membership who are OHP plan members will be determined and compared to the prior year.</li> <li>• 100% of LCACs and the RCAC will have produced an annual report describing progress for 2015.</li> </ul>

	<ul style="list-style-type: none"> <li>• 100% of LCACs will have begun an updated Community Health Assessment.</li> <li>• 100% of LCACs will have begun to compile a Community Health Improvement Plan.</li> <li>• The RCAC Community Health Improvement Plan will have been reviewed and updated on a semi annual basis.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• 100% of LCACs and the RCAC will be meeting consistently in compliance with ORS 414.627.</li> <li>• 100% of LCACs and the RCAC will have updated their Community Health Assessment and produced an updated Community Health Improvement Plan.</li> <li>• 100% of LCACs and RCAC will have produced annual progress reports on their Community Health Improvement Plans.</li> </ul>

(5) **Area of Transformation:** Developing a plan for encouraging Electronic Health Records; health information exchange; and meaningful use.

Benchmark 5	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• Contractor will measure the number of members assigned to primary care practices which incorporate Electronic Health Records (EHRs).</li> <li>• Contractor will measure the number of primary care practices and EHRs reporting accurate clinical quality measure data.</li> <li>• Contractor will measure the number of primary care practices accessing quality, utilization and member roster data via a secure on-line provider portal.</li> <li>• Contractor will measure the number of members accessing real time health information using an on-line member portal.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• Contractor's vendor will have installed data connectors, extracted clinical quality measure data and performed quality/completeness analysis of incoming clinical data with 15 key hospital/clinic systems.</li> <li>• Contractor will be able to store clinical quality measure data within it's data store for 15 key hospital/clinic systems.</li> <li>• Contractor will provide primary care practices with quality, utilization and member roster data via a secure</li> </ul>

	<p>on-line provider portal</p> <ul style="list-style-type: none"> <li>• Contractor will have launched the on-line member portal.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• 15 key hospital/clinic systems will be able to submit accurate clinical quality measure data to Contractor via a secure connector regardless of the EHR being used at any given clinic.</li> <li>• Contractor will be able to access clinical quality measure data from 15 key hospital/clinic systems on demand.</li> <li>• 90% of Contractor primary care practices will access quality, utilization and member roster data via a secure on-line provider portal on a monthly basis.</li> <li>• 20% of Contractor members will have signed up for the on-line member portal.</li> </ul>

(6) **Area of Transformation:** Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.

Benchmark 6	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• Contractor will track vendor outreach with members identified as chronically ill with psychosocial issues. Tailored communication outreach to be addressed includes social gaps, consciousness raising, cognitive reframing, agenda mapping, patient education, and provider support.</li> <li>• Contractor will measure the number of consumer materials assessed and modified using a health literacy assessment tool.</li> <li>• Contractor will measure the number of LCAC meetings with consumer attendance.</li> <li>• Contractor will measure the number of interventions with integrated consumer feedback.</li> <li>• EOCCO will continue to measure the number of demographic data reports completed and disseminated to Contractor health care providers and staff.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• 50% of population management outreach and communication will be tailored to member’s cultural and linguistic needs.</li> <li>• 100% of Contractor healthcare service department member material will be assessed and modified with a health literacy assessment tool.</li> <li>• Contractor will utilize the teach back consumer feedback method on at least three interventions.</li> <li>• Contractor will create a consistent methodology for disseminating demographic data to providers and CACs.</li> </ul>

<p>Benchmark to be achieved as of July 31, 2017</p>	<ul style="list-style-type: none"> <li>• 75% of population management outreach and communication will be tailored to member’s cultural and linguistic needs.</li> <li>• Contractor will utilize the health literacy tool to assess at least 25% of Contractor enrollment and website consumer material.</li> <li>• At least 50% of LCAC meetings will have a minimum of one consumer in attendance.</li> <li>• Contractor will utilize the teach back consumer feedback method on at least six interventions.</li> <li>• Contractor will list demographic data in clinic-level reports disseminated quarterly.</li> </ul>
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(7) **Area of Transformation:** Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects Member diversity).

<p>Benchmark 7</p>	
<p>How Benchmark will be measured (Baseline to July 31, 2017)</p>	<ul style="list-style-type: none"> <li>• Contractor will measure the number of educational events and informational material on cultural competency and health disparities provided to Contractor providers and staff.</li> <li>• CHW services funded by Contractor will be delivered using culturally competent models and tools.</li> <li>• Contractor will build partnerships with community organizations that advocate, educate, and/or work to improve meeting the needs of culturally diverse members.</li> <li>• Contractor will implement Trauma Informed Care Learning Community recommendations.</li> </ul>
<p>Milestone(s) to be achieved as of July 31, 2016</p>	<ul style="list-style-type: none"> <li>• Contractor will provide at least two educational opportunities to Contractor providers and staff.</li> <li>• CHW staff and Contractor will develop a process to report methods to meet the needs of culturally diverse members.</li> <li>• Contractor will actively participate in two community based events that advocate, educate, and/or work to improve meeting the needs of culturally diverse members.</li> <li>• Contractor will identify one clinic with capacity, and willingness to adopt a Trauma Informed Care policy.</li> </ul>
<p>Benchmark to be achieved as of July 31, 2017</p>	<ul style="list-style-type: none"> <li>• Contractor will implement annual cultural competency educational opportunities.</li> <li>• CHW staff will establish a methodology for reporting service delivery methods to Contractor.</li> </ul>

	<ul style="list-style-type: none"> <li>• Contractor will actively participate in four community-based events that advocate, educate, and/or work to improve meeting the needs of culturally diverse members.</li> <li>• Contractor will implement one Trauma Informed Care clinic level pilot based on recommendations of the Trauma Informed Care Learning Community committee.</li> </ul>
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**(8) Area of Transformation:** Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Benchmark 8	
How Benchmark will be measured (Baseline to July 31, 2017)	<ul style="list-style-type: none"> <li>• Contractor will track utilization pre- and post- Intensive Case Management intervention for members with special health care needs and high utilization history.</li> <li>• Contractor will develop a process to identify health disparities and gaps in care using the annual Oregon Health Authority report on reading language and ethnicity.</li> </ul>
Milestone(s) to be achieved as of July 31, 2016	<ul style="list-style-type: none"> <li>• Contractor will develop a claims analysis process to identify and track members enrolled in ICM.</li> <li>• Contractor will complete an analysis of 2015 CAHPS data for access to care and satisfaction with care.</li> </ul>
Benchmark to be achieved as of July 31, 2017	<ul style="list-style-type: none"> <li>• Intensive Case Management will improve services based on analysis of impact as defined by pre-and-post program utilization.</li> <li>• Contractor will implement an intervention based on the 2015 CAHPS data access to care and satisfaction with care.</li> </ul>