AMENDMENT NUMBER 5 TO HEALTH PLAN SERVICES CONTRACT
COORDINATED CARE ORGANIZATION
CONTRACT #143114 BETWEEN
THE STATE OF OREGON
OREGON HEALTH AUTHORITY

AND

FAMILYCARE, INC.
825 NE MULTNOMAH STREET, SUITE 1400
PORTLAND, OR 97232

1. This is amendment number 5 ("Transformation Amendment") to Health Plan Services Contract, Coordinated Care Organization, Contract # 143114 (the "Contract"), between the State of Oregon, acting by and through its Oregon Health Authority ("OHA"), and FamilyCare, Inc. ("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:

Deliverable	Deliverable Date
(1) Draft Plan. Contractor furnishes OHA with a draft of an updated Transformation Plan.	March 16, 2015
(2) OHA Comments. OHA furnishes Contractor with written comments on	May 15, 2015

its draft updated Transformation Plan.

(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

Printed Name: William H. Murray Date 9/18/15

Title COO

OHA –Division of Medical Assistance Programs

By Rhonda Busch _____ 9/22/15
OHA Date

Approved as to Legal Sufficiency:

By _____ 7/20/15
Deanna Laidler, Sr. Assistant Attorney General Date

Reviewed by OHA/DMAP Contract Administration

By _____ 9/21/15
David H. Fischer, Contract Administrator Date

Exhibit K - Attachment 1 – Areas of Transformation

A. Benchmarks for 2015 – 2017 Transformation Plan Amendment

INTRODUCTION: Contractor has been serving Oregon Health Plan Members for more than 30 years as a Managed Care Organization prior to attaining Coordinated Care Organization status. As an organization with an established physical, mental health and dental network, Contractor has built a Transformation Plan that reaches to impact the community in new ways, while also utilizing the strengths of existing best business practices. Within the Transformation Plan, Contractor has paid particular attention to deploying existing best practices while continuing to develop a community based approach to the coordination and delivery of all patient care.

1. **Developing and implementing a healthcare delivery model that integrates mental health and physical healthcare 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)	Baseline- Initiated the member/provider-centric, multidisciplinary service delivery model titled Patient/Provider Oriented Resource Teams (PORTs) to address care delivery to Members with complex healthcare needs. Measurement – P²ORTs CCO Outcome Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the member, practice, and health plan level of care integration: Improved access (CAHPS); Improve satisfaction of care (CAHPS); Decrease ED utilization (CCO measure); and, Decrease hospital readmissions (CCO measure).
Milestone(s) to be achieved as of July 31, 2016	(1) Primary Care Providers receive Screening, Brief Intervention and Referral to Treatment (SBIRT) training. (2) Expand and enhance training of current and new P²ORT Team members in the most effective and efficient use of the HRA. (3) Evaluate partnership with Asian Health and Service Center for replication in other communities/community-based organizations. (4) Implement improvement strategies indicated in Provider Satisfaction Survey which included Plan of Choice indicators. (5) Improve provider training regarding accessing the P²ORT Team services as needed and in a timely manner.

	(6) Share individualized ED Utilization data with Providers to improve appointment availability.
Benchmark to be achieved as of July 31, 2017	(1) Meet or exceed CCO Benchmarks and CAHP improvements: a) Improved access (CAHPS) b) Improve satisfaction of care (CAHPS) c) Decrease ED utilization (CCO Measure) d) Decrease hospital readmissions (CCO Measure). (2) HRA administered to 100% of appropriately identified Members to create individualized care plans for ongoing case management of Members with complex healthcare needs. (3) 100% of PCPs will be trained in SBIRT. (4) Based on evaluation of partnership with Asian Health & Services Center, launch similar partnership with another cultural partner.

2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH)

Benchmark 2	
How Benchmark will be measured (Baseline to July 31, 2017)	Baseline – Providers recognized PCPCH; and/or, increasing their Tier Levels. Measurement - Based on December, 2014 enrollment: (1) 80% of Members were assigned to a PCPCH recognized locations. (2) 79% of Members assigned to a Tier 2 or Tier 3 Level Provider.
Milestone(s) to be achieved as of July 31, 2016	Providers without PCPCH recognition, offered coaching needed to reach the requirements of the PCPCH program. Outreach to at least five clinics per quarter to ensure the PCPCH level is sustained. Monitoring progress of recognized PCPCH clinics monthly and evaluating renewals and levels of Tier recognition.
Benchmark	(1) Based on June, 2017 enrollment, 85% of members assigned to PCPCH recognized

to be achieved as of July 31, 2017	locations. (2) Based on June, 2017, 85% of Members assigned to a Tier 2 or Tier 3 Level Provider.

3. Implementing consistent alternative payment methodologies that align payment with health outcomes.

2015-2017 Narrative: During 2015 – 2017 Contractor will expand alternative payment and reimbursement strategies, including incentives and recognition of PCPCH status, and implementation of knowledge-based reimbursement for Behavioral Health and Dental. In addition, Contractor will provide oversight and training with regard to CCO Quality Metrics; a shared understanding of claims data and coding impact on the Quality Metrics; and, the impact of scheduling and member establishment on attaining the Quality Metrics.

Benchmark 3	
How Benchmark will be measured (Baseline to July 31, 2017)	Baseline – Current Alternative Payment Methodology covers 44% of Primary Care Providers (PCPs); and, 49% of Members. Measurement – (1) Change in PCP, Behavioral Health, and Dental Provider Alternative Payment Methodology coverage. (2) Change in PCP, Emergency Department and Specialist utilization.
Milestone(s) to be achieved as of July 31, 2016	(1) Implement PCP contract that incentives tied to performance on specific quality measures, and PCPCH status. (2) Implement knowledge-based reimbursement methodology for Behavioral Health and Dental providers. (3) Provide provider training on current year CCO Quality Metrics, including correct documentation and coding. (4) Monitor performance on quality metrics and provide feedback to providers.
Benchmark to be achieved as of July 31, 2017	(1) Increase in Primary Care, Behavioral Health, and Dental providers contracted utilizing an Alternative Payment Methodology; targeting 80% coverage for both PCPs and Members. (2) Increase in PCP utilization, and reduction in Emergency Department and Specialist utilization. (3) Continue to achieve CCO Quality Metrics.

4. Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual
Community Health Improvement Plan consistent with 2012 Oregon Laws, Chapter 8 (Enrolled SB 1580).

2015-2017 Narrative:

In 2015-2017, while continuing to focus on Transition Aged Youth service coordination, Contractor will assess the results of the initial pilot project with Outside In; and, review the 2013-2015 strategy in relationship to developing Contractor's 2016 Community Health Assessment and Community Health Improvement Plan (CHIP) update. Contractor will again be partnering on the Community Health Needs Assessment with the Healthy Columbia Willamette Collaborative to inform the 2015-2017 activities.

Benchmark 4	
How Benchmark will be measured (Baseline to July 31, 2017)	(A) Baseline – Increasing care coordination, health delivery and engagement in health and healthcare for the Transitional Age Youth (TAY). Measurement – Effective engagement of TAY in their health and healthcare based upon the following baseline: (1) Adolescent well-child visits; (2) Primary care provider visits; (3) Emergency room visits. (B) Baseline—Completion of a community health needs assessment and community health improvement plan. Measurements- (1) Partner with Healthy Columbia Willamette Collaborative to develop and complete community health needs assessments report; (2) Completion of community health improvement plan.
Milestone(s) to be achieved as of July 31, 2016	(A) Assessment of care coordination, health literacy, health delivery, population- based care management initiatives will be conducted and baseline established as well as the identification of improvement opportunities: (1) Internal critical analysis of current care coordination and health delivery to transition age youth Members and report of the findings. (2) Community listening sessions with transition age youth will be held. At least one session in each county served. (B) Community health needs assessment is completed: (1) Review and build on existing and ongoing health assessment; (2) An examination of the health status and health needs of community; (3) Prioritize health indicators.

Benchmark to be achieved as of July 31, 2017	(A) Implementation at two projects -- informed by the listening sessions and the pilot project results—that will improve Contractor's ability to effectively serve transition age youth. As follows, improved access and utilization of appropriate levels of care for high-risk, high-need TAY will be achieved and reported by Providers and Community-Based Organizations facilitating TAY targeted strategies funded by Contractor: a. From baseline to post-intervention evaluation, achieve at least a 10% increase in measured health literacy among transition age youth served by Contractor; b. From baseline to post-intervention evaluation, achieve at least a 10% increase in measured engagement among transition age youth served by Contractor; a. Increase in primary care utilization; b. Increase in adolescent well child visits; and c. Decrease in ER visits. (B) Community health needs assessment/ community health improvement plan: (a) Community health needs assessment report is presented to Community Advisory Council and used to prioritize health indicators and community needs; (b) Community health improvement plan is adopted by Contractor's Health Board of Directors.

5. Developing a plan for encouraging Electronic Health Records; health information exchange; and, meaningful use.

Benchmark #5	Developing a plan for encouraging Electronic Health Records, health information exchange, and meaningful use.
How Benchmark will be measured (Baseline to July 31, 2017)	Baseline- Exchange of structured data between Contractor and provider practices demonstrates both successful adoption of Electronic Health Records and achievement of the goals of Meaningful Use. Current baseline measures include: a) 50% of members have electronic data exchanged between providers' EHRs and Contractor. b) 4% of Primary Care Providers receive electronic emergency department and/or inpatient visit notifications through EDIE Pre-Manage. Measurements- (1) Percentage of members whose clinical information is electronically shared between Contractor and its provider network as of the end of each calendar year. (2) Percentage of Primary Care Providers receiving emergency department and/or inpatient visit notifications electronically through EDIE Pre-Manage.
Milestone(s) to be achieved as of July 31, 2016	(1) Collecting patient level data in accordance with OHA CCO Technology Plan. (2) 20% of Primary Care Providers will receive electronic emergency department and/or inpatient visit notifications through EDIE Pre-Manage.
Benchmark to be achieved as of July 31, 2017	(1) Exchange clinical data with providers totaling 65% or more of the member population. (2) 40% of Primary Care Providers will receive electronic emergency department and/or inpatient visit notifications through EDIE Pre-Manage.

6. 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)	Baseline – Written communication; Member engagement; employee recruitment, and training; and, community health initiatives are appropriate to unique Member language, race, ethnicity, cultural and literacy.

	Measurements – (1) Written communication with Members, and Providers is based on OAR 410-141-3300, Member Educational Requirements; (2) Diversity of the P²ORTs multidisciplinary teams reflect the diverse Member population served. (3) Consumer Assessment of Healthcare Providers and Systems (CAHPS) improvements based on OHA 2013 Final Report: Access to Care, 81.2%; and, Satisfaction with Care, 84.3%.
Milestone(s) to be achieved as of July 31, 2016	(1) Create Medicaid Member Materials Catalog/Matrix to ensure readability; linguistic and cultural appropriateness for all written communication. (2) Hiring practices are guided by the Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. (3) P²ORTs teams and staff receive new employee orientation and ongoing education and training in culturally and linguistically appropriate service delivery.
Benchmark to be achieved as of July 31, 2017	(1) On an annual basis, review and revise, as needed, the Medicaid Member Materials Catalog/Matrix process to ensure that all written materials comply with readability; linguistic and cultural appropriateness; and OAR regulations and requirements. (2) On an annual basis, review the ratio of Member to the P²ORTs and other staff diversity to assess the effectiveness of hiring practices; and, revise as indicated by the identified gaps in the ratio. (3) Human Resource Records of pre-and post-training survey results demonstrate employee orientation and ongoing education is culturally and linguistically appropriate. (4) CAHPS Access to Care, and overall member satisfaction improvement meet or exceed current CCO Benchmark.

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).

Benchmark 7	
How Benchmark will be measured (Baseline to July 31, 2017)	Baseline - Innovative healthcare delivery model supported by Providers who are culturally competent and understand the unique needs of their patient population; and, community safety-net partners which may utilize Community Health Workers. Measurement – (1) Diversified contracted provider network which includes small- to medium-sized practices which are culturally unique, and neighborhood-centered; and, (2) Grant funded community-based projects to address population health issues. (3) Consumer Assessment of Healthcare Providers and Systems (CAHPS) improvements based on OHA 2013 Final Report: Access to Care, 81.2%; and, Satisfaction with Care, 84.3%.
Milestone(s) to be achieved as of July 31, 2016	(1) Based on new Member assignments, assess the need for additional diversified contracted provider network with small- to medium-sized practices, particularly small, culturally unique, and neighborhood-centered practices. (2) Initial On Boarding and ongoing Provider education and support includes technical assistance, and relevant Member data to address the culturally diverse and disparate health needs of Members is provided by FC Provider Education Services, based on PORT assignment. (3) Broad spectrum of community-based projects implemented to address specific population health needs.
Benchmark to be achieved as of July 31, 2017	(1) Provider Education Services Plan includes a regular review process based on Provider Satisfaction Survey. (2) On an individual basis, the effectiveness of community-based projects, including those utilizing CHWs and THWs, will be evaluated based on program outcomes. (3) CAHPS Access to Care, and overall member satisfaction improvement meet or exceed current CCO Benchmark.

8. 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)	Baseline -Integrated Quality Improvement Plan addresses identified racial, ethnic and linguistic disparities in member access, care and outcomes. Measurements: (1) Analyze quality measures and metrics by race, ethnicity and language.
Milestone(s) to be achieved as of July 31, 2016	(1) Identify disparities and develop a plan to reduce them, including community based initiative and metrics.
Benchmark to be achieved as of July 31, 2017	(1) Evidence of reduction in disparities based on implementation of plan.