

AMENDMENT

It is hereby agreed by and between the State of Vermont, Office of Vermont Health Access (hereinafter called the "State") and MedMetrics Health Partners (hereinafter called the "Contractor") that the personal services contract for the provision of pharmacy benefits management (PBM) services, effective November 1, 2005, is hereby amended, effective on the dates specified upon execution by the parties, as follows:

1. Effective November 1, 2005, revise number 22, c., of Attachment A, Specifications of Work to be Performed, Section II. Claims Processing and Systems, Subsection 3, Systems Requirements, by replacing "FDB" with "Medi-Span".
2. Effective November 1, 2005, revise number 22, d., of Attachment A, Specifications of Work to be Performed, Section II. Claims Processing and Systems, Subsection 3, Systems Requirements, by replacing "First Data Bank" with "First Data Bank and Medi-Span".
3. Effective November 1, 2005, revise number 24 of Attachment A, Specifications of Work to be Performed, Section II. Claims Processing and Systems, Subsection 3, Systems Requirements, by replacing:

"The ability to apply COB edits for Medicare Part D coverage both in terms of benefits and cost sharing to the extent possible according to NCPDP standards. This includes the formularies for each Medicare Part D Pharmacy Drug Provider (PDP) in the State's region; other coverage information billed using the Medicare Part D; and cost sharing details including deductibles, coinsurance, and the application of the coverage gap ("donut hole")."

with:

"The ability to apply COB edits for Medicare Part D coverage both in terms of benefits and cost sharing to the extent possible according to NCPDP standards. This includes other coverage information billed using the Medicare Part D and cost sharing details including deductibles, coinsurance, and the application of the coverage gap ("donut hole")."

4. Effective November 1, 2005, revise numbers 9 and 10 of Attachment A, Specifications of Work to be Performed, Section V. Drug Coverage Management, Subsection 2, Requirements, a., Drug Coverage, by replacing all instances of "First Data Bank (FDB)" and "FDB" with "Medi-Span".
5. Effective November 1, 2005, revise section numbering of Attachment A, Specifications of Work to be Performed, from Section XI. Disease Management to Section X. Disease Management to correct numbering. Section XI simultaneously designated as Prior Authorization (PA).

6. Effective January 1, 2006, revise Attachment A, Specifications of Work to Be Performed, Section XII. Medicare Part D, Subsection 2, Requirements by replacing:

“Subject to final specification from CMS, the Contractor should have the following claims processing capacity relative to Medicare Part D claims.

1. Claims should edit against identified PDPs coverage list to identify what is covered or non-covered by PDP.
2. The system should be able to cost avoid by drug and drug class.
3. The system should be able to edit for subsidy level (the level of beneficiary cost sharing) and set counters for maximums based on subsidy level. (It is anticipated that there will be 5-6 levels).
4. The system should be able to accept transactions from the TROOP coordinator.
5. The system should be able to report on Part D. At a minimum:
 - a. Counter reports for claims review and recovery activity on PDPs
 - b. Fraud/abuse indicators on pharmacies
6. The system should accept changes to PDPs and or cost sharing levels, identify claims erroneously processed, and set the claims for reversal.”

with:

“Post-Medicare Part D Implementation

The Contractor shall have the following claims capability relative to Medicare Part D claims upon the implementation of Part D:

1. Claims should edit against identified Part D coverage to identify what is covered or non-covered.
 2. The system should be able to cost avoid claims with Part D coverage at the State’s direction.
 3. The system should be able to accept claims information from pharmacies including PDP payment amounts and other coverage code indicators.
 4. The system should be able to report on Part D. At a minimum:
 - a. Claims payment information
 - b. Fraud/abuse indicators on pharmacies.”
7. Effective January 1, 2006, add the following language to Attachment A, Specifications of Work to Be Performed, Section XII. Medicare Part D, Subsection 2, Requirements:

“Medicare Part D Implementation Services

The Contractor provided consulting services and systems enhancements required to support the State’s reinstating pharmacy coverage for State programs to pre-January 1, 2006 levels for Medicare Part D eligibles concurrently enrolled in Vermont pharmacy programs. The reinstatement was necessary when the federal implementation of Medicare Part D experienced

failures that resulted in Medicare Part D services being inaccessible to Vermont program beneficiaries.

The Contractor provided consulting services and systems enhancements to accomplish the switch back to the intended design of processing Medicare D claims secondary to the Medicare coverage in April 2006.

The Contractor provided Help Desk services to accommodate pharmacy calls on issues related to the Medicare Part D failure.

Medicare Part D Implementation Claims Recovery Services

The Contractor prepared and submitted Medicare Part D claims billable to the Centers for Medicare & Medicaid Services (CMS) contractor under the terms of the State's participation under the CMS section 402 demonstration, entitled "Reimbursement of State Costs for Provision of Part D Drugs." This demonstration, authorized under section 402 of the Social Security Amendments of 1967, as amended, was authorized to assess the efficiency of reimbursing States for costs not directly reimbursed under Part D plans."

8. Effective November 1, 2005, add the following to Attachment A, Specifications of Work to be Performed, Section XVIII. Security Program:

"The Contractor shall present the State with a copy of the annual Statement on Auditing Standards No. 70 (SAS 70) for Service Organizations of the Contractor's claims processing subcontractor. The SAS 70 provides guidance on two levels:

- Level I – Reports on Policies and Procedures Placed in Operation

A service auditor's report on a service organization's description of the policies and procedures that may be relevant to a user organization's internal control structure, whether such policies and procedures had been placed in operation as of a specific date, and whether they are suitable to achieve specified control objectives.

- Level II – Reports on Policies and Procedures Placed in Operation and Tests of Operating Effectiveness

In addition to the items described in the Level I report, the Level II report states whether the internal control structure policies and procedures that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the related control objectives were achieved during the period specified.

The Contractor shall report to the State any deficiencies found in the SAS 70 report and the actions taken to resolve them."

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9. Effective January 1, 2006, revise number 3 of Attachment B, Payment Provisions, Section 2, Cost Structure by replacing:

“3) Medicare Part D: an additional five (5) cents per claim for each actual Medicare Part D claim processed.”

with:

“3) Medicare Part D: claims involving Medicare Part D will be included in the claims’ count identified in 1 and 2 of this section.”

10. Effective January 1, 2006, revise number 8 of Attachment B, Payment Provisions, Section 2, Cost Structure by replacing:

“8) RxTrack Cognos: \$750/month per user.”

with:

“8) RxTrack Cognos: \$750/month per user. For this purpose, “user” is defined as any State person who signed on in the billable month.”

11. Effective November 1, 2005, revise number 11 of Attachment B, Payment Provisions, Section 2, Cost Structure by replacing:

“11) SPAP rebate negotiations, rebate management and disputes and collections: \$6,500/month.”

with

“11) Non-Medicaid, State program rebate negotiations, rebate management and disputes and collections: \$6,500/month.”

12. Effective January 1, 2006, add number 23 Attachment B, Payment Provisions, Section 2, Cost Structure:

“23) Medicare Part D implementation services: Consulting services: \$150 per hour for 425 hours for a total of \$63,750. Help Desk services: \$50 per hour for 300 hours for a total of \$15,000.”

13. Effective January 1, 2006, add number 24 to Attachment B, Payment Provisions, Section 2, Cost Structure:

“24) Medicare Part D implementation claims recovery services: Consulting services: \$150 per hour for 500 hours for a total of \$75,000. Design, preparation, and

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submittal of first and second pass CMS section 402 demonstration claims files for both Medicaid and SPAP formats for a total not to exceed \$150,000.

14. Effective the dates listed here, to accommodate the changes made heretofore:

- a. Adjust the "Maximum Amount" payable to the contractor for services provided during the contract's term to \$8,622,383. This amount is referenced on Page 1, Number 3, Maximum Amount, and on Page 39, Number 1, Payment and Contract Amount, and in two paragraphs of Page 41, Development, Implementation and Training.
- b. Replace the chart, Implementation and Operating Costs, located at the end of Attachment B, Payment Provisions, with the new and revised version attached hereto.

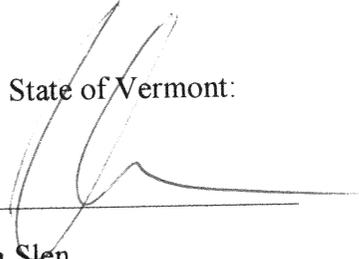
This amendment consists of 9 pages. Except as modified by this amendment and any previous amendments, all provisions of this contract (#9097), dated November 1, 2005, shall remain unchanged and in full force and effect.

IN WITNESS THEREOF, the parties set forth below agree to execute this Amendment as set forth below:

By the Contractor:

By 
Robert D. Wakefield, Jr.
Chief Executive Officer
Date 12-20-07

By the State of Vermont:

By 
Joshua Slen
Director
Date 12-21-2007

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MedMetrics Health Partners Costs- Implementation & Operation Revised											
Item #	Type of Service	Basis of Cost	Upon Proposal - Full Year Cost			Implementation Costs 11/01/05 - 10/31/06	Operations Costs 01/01/06 - 10/31/06	Total Year 1	Operations Year 2 11/01/06 - 10/31/07	Operations Year 3 11/01/07 - 10/31/08	Grand Total
			MM								
			Unit Costs	Per Month	Annual						
1	Claims processing (on-line and batch; with all pricing including MAC; including COB)	Per month cost	N/A	N/A	\$ 692,500.00	\$ -	\$ 577,083	\$ 577,083	\$ 720,200	\$ 749,008	\$ 2,046,291
			Monthly based on 5 M; \$.14 <= 2M; \$.13 >2M <= 3.5M; \$.12 > 3.5M <= 5M; \$.11 > 5M Part D Claims an additional \$.05 per claim for 750,000 claims								
			Plus 4%/year for year 2 and year 3								
2	Claims processing –Keying paper claims	Per month cost	N/A	N/A	\$ 7,125.00	\$ -	\$ 5,937	\$ 5,937	\$ 7,410	\$ 7,706	\$ 21,054
			Annual based on 10,000 Annual; \$.75 <= 4,999; \$.70 >5,000 <= 7,499; \$.65 > 7,500								
			Plus 4%/year for year 2 and year 3								
3	Medicare Part D claims	Per month cost				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
			Claims involving Medicare Part D will be included in the claims' count identified in items 1 and 2 of this section								
4	Auditing	Per on-site audit	\$ 1,500.00	N/A	\$ 22,500.00	\$ -	\$ 18,750	\$ 18,750	\$ 23,400	\$ 24,336	\$ 66,486
			Assumes 15 days on site Plus 4%/year for year 2 and year 3								
5	Drug coverage management (Preferred Drug List), including P & T Committee support	Per month cost	N/A	\$ 6,125.00	\$ 73,500.00	\$ -	\$ 61,250	\$ 61,250	\$ 76,440	\$ 79,498	\$ 217,188
			Plus 4%/year for year 2 and year 3								
6	Analysis and reporting – standard and decision support ad hoc capabilities	Per month cost	N/A	\$ 1,885.00	\$ 22,620.00	\$ -	\$ 18,850	\$ 18,850	\$ 23,525	\$ 24,466	\$ 66,841
			Plus 4%/year for year 2 and year 3								
7	Connectivity Fee			\$ 300.00	\$ 3,600.00	\$ -	\$ 3,000	\$ 3,000	\$ 3,744	\$ 3,894	\$ 10,638
			Plus 4%/year for year 2 and year 3								

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			MM								
			Unit Costs	Per Month	Annual						
8	RxTrack Cognos (10 Licenses)	Per license per month	\$ 750.00	\$ 7,500.00	\$ 90,000.00	\$ -	\$ 75,000	\$ 75,000	\$ 93,600	\$ 97,344	\$ 265,944
			Plus 4%/year for year 2 and year 3								
9	RxTrack Showcase (6 Users)			1200	\$ 14,400.00	\$ -	\$ 12,000	\$ 12,000	\$ 14,976	\$ 15,575	\$ 42,551
			Plus 4%/year for year 2 and year 3								
10	Supplemental rebate negotiations, rebate management and disputes and collection	Per month cost	N/A			\$ -	\$ 65,000	\$ 65,000	\$ 81,120	\$ 84,365	\$ 230,485
			Plus 4%/year for year 2 and year 3								
11	Non-Medicaid State program rebate negotiations, rebate management and disputes and collections	Per month cost	N/A			\$ -	\$ 65,000	\$ 65,000	\$ 81,120	\$ 84,365	\$ 230,485
			Plus 4%/year for year 2 and year 3								
12	Drug Utilization Review, including DUR Board support for all beneficiaries except AMAP, GA, and HVP	Per month cost	N/A	8954	\$ 107,448.00	\$ -	\$ 89,540	\$ 89,540	\$ 111,746	\$ 116,216	\$ 317,502
			Plus 4%/year for year 2 and year 3								
13	Utilization management for all beneficiaries except AMAP, GA, and HVP	Per month cost	N/A	6125	\$ 73,500.00	\$ -	\$ 61,250	\$ 61,250	\$ 76,440	\$ 79,498	\$ 217,188
			Plus 4%/year for year 2 and year 3								
14	Clinical detailing	Per month cost	N/A	\$ 6,250.00	\$ 75,000.00	\$ -	\$ 62,500	\$ 62,500	\$ 78,000	\$ 81,120	\$ 221,620
			Plus 4%/year for year 2 and year 3								
15	Disease management for all beneficiaries except AMAP, GA, and HVP	Per month cost	N/A	\$ 6,125.00	\$ 73,500.00	\$ -	\$ 61,250	\$ 61,250	\$ 76,440	\$ 79,498	\$ 217,188
			Plus 4%/year for year 2 and year 3								

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			MM								
			Unit Costs	Per Month	Annual						
			11/01/05 - 10/31/06	01/01/06 - 10/31/06		11/01/06 - 10/31/07	11/01/07 - 10/31/08				
16	Prior authorization	\$5.20 per each PA	N/A	\$ 21,833.00	\$ 261,996.00	\$ -	\$ 218,330	\$ 218,330	\$ 272,476	\$ 283,375	\$ 774,181
			Plus 4%/year for year 2 and year 3								
17	Telephone support - Pharmacy providers and prescribers	\$13.22 / call up to 60 calls/day; \$12.25 / call over 60 calls; minimum \$16,666/mo	\$ 0.11	\$ 16,666.00	\$ 199,992.00	\$ -	\$ 166,660	\$ 166,660	\$ 207,992	\$ 216,311	\$ 590,963
			Plus 4%/year for year 2 and year 3								
18	ID Cards - Including Mailing	Per Card	\$ 2.10			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
			Plus 4%/year for year 2 and year 3								
19	Epocrates® contract	Cost per month	N/A	\$ 12,733.00	\$ 152,796.00	\$ -	\$ 127,330	\$ 127,330	\$ 158,908	\$ 165,264	\$ 451,502
			Annual Fee \$120,000 and cost per month \$12,733								
20	Required staffing (list by each required staff – separate salary and benefit costs)	Four FTE's		\$ 28,600.00	\$ 343,200.00	\$ -	\$ 286,000	\$ 286,000	\$ 356,928	\$ 371,205	\$ 1,014,133
		Account Mgr	N/A	N/A	N/A						
		Clinical Mgr	N/A	N/A	N/A						
		Program Rep	N/A	N/A	N/A						
		Data Mgr	N/A	N/A	N/A						
			Plus 4%/year for year 2 and year 3								
21	Staff for Dedicated Part D		N/A	\$ 6,666.67	\$ 80,000.00		\$ 66,667	\$ 66,667	\$ 83,200	\$ 86,528	\$ 236,395
			Plus 4%/year for year 2 and year 3								
22	Administrative Fee		N/A	\$ 19,177.00	\$ 230,124.00	\$ -	\$ 191,770	\$ 191,770	\$ 239,329	\$ 248,902	\$ 680,001
			Plus 4%/year for year 2 and year 3								
23	Medicare Part D Implementation Services		N/A	N/A	\$ 78,750.00	\$ 78,750	\$ -	\$ 78,750	\$ -	\$ -	\$ 78,750
			One-time development and implementation								

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			<i>MM</i>								
			Unit Costs	Per Month	Annual						
24	Medicare Part D Implementation		N/A	N/A	\$ 225,000.00	\$ -	\$ -	\$ -	\$ 225,000	\$ -	\$ 225,000
			One-time development and implementation								
Section 3	Other - Development, Implementation, & Training		N/A	\$ 133,333.33	\$ 400,000.00	\$ 400,000	\$ -	\$ 400,000	\$ -	\$ -	\$ 400,000
			One-time development and implementation								
	Grand Total					\$ 478,750	\$ 2,233,167	\$ 2,711,917	\$ 3,011,993	\$ 2,898,473	\$ 8,622,383