

### 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, 2008, the Contract Term of the contract is extended. The Contract Term language is revised by replacing:

"The period of the Contractor's performance shall begin November 1, 2005 and ends on October 31, 2008."

with:

"The period of the Contractor's performance shall begin November 1, 2005 and ends on October 31, 2010."

2. Effective November 1, 2008, add the following language to Attachment A, Specifications of Work to be Performed:

**"XXI. Additional Clinical Services and Case Reviews**

The Contractor shall assist the State in providing additional clinical pharmacy case review support when more detailed clinical and coverage reviews are indicated. In particular, the Contractor shall provide case reviews to determine if there is sound medical evidence to support the State's coverage decisions with Medicare Part D Prescription Drug Plan (PDP) denials, fair hearings, grievances and appeals, and review of coverage through the medical benefit. This clinical review support may include instances where the dual-eligible Vermont Medicaid beneficiary's Part D prescription drug plan (PDP) does not cover the prescribed medication and the appeal to the PDP and to their Independent Review Entity (IRE) to cover the drug has been upheld. The Contractor shall provide case reviews, conduct a comprehensive literature search, and utilize resources within the University of Massachusetts Medical School to provide the evaluation and documentation of evidence-based medicine to support recommendations sent to OVHA to justify coverage or non-coverage of the prescribed drug. Specific duties may include:

- a) Review of all documentation pertaining to the case, including any information obtained about the denial or appeal
- b) Review of beneficiary's PDP coverage and the PDP's Preferred Drug List and evaluation of alternative clinical selections
- c) Literature searches and reviews
- d) Consultation with providers directly involved in beneficiary care
- e) Development of and recommendations related to case review

f) Documentation of the outcome

3. Effective November 1, 2008, add the following language to Attachment A, Specifications of Work to Be Performed:

**“XXII. Generic Voucher Program**

In the spring of 2007 the Legislature enacted Act 80 of the Vermont General Assembly of the 2007-2008 Legislative Session (S.115), *An Act Relating to Increasing Transparency of Prescription Drug Pricing and Information*. One of the provisions of this act established a generic drug voucher pilot project. This project is a part of a larger evidence-based education program under Act 80 to promote the use of generic drugs among the Vermont Medicaid population by offering denomination-based coupons for payment of generic drugs to prescribers.

- The Contractor will assist with the design and implementation of the voucher program
- Contractor will develop program-specific coding needed on eligibility and claims extracts which may include the development of specific plans that will identify and/or target specific beneficiaries, pharmacies, providers, or drugs and allow claims to process and adjudicate properly for this program.
- Contractor will develop and populate utilization and impact reports to demonstrate the effectiveness of the pilot and post-pilot program.”

4. Effective November 1, 2008, add the following language to Attachment A, Specifications of Work to Be Performed:

**“Section XXIII. Provider Recovery Services**

**A. Overview**

The State of Vermont, Office of the State Auditor, contracted with HWT, Inc. to use specific algorithms to analyze pharmacy claims paid by Vermont Medicaid between January 1, 2004 and December 31, 2005. HWT, Inc. created eight algorithms which identified for the Office of Vermont Health Access (OVHA) an estimated \$2.2 million in potential pharmacy overpayments.

Additionally, in auditing pharmacy claims paid by OVHA for the Medicare Part D wrap program in March – May, 2006, MedMetrics discovered claims that were submitted with an Other Coverage Code of “2” where the Submitted Patient Pay field was either blank or contained a \$0 dollar amount. Because the Medicare Part D wrap program processes claims based on the Submitted Patient Pay (SPP) field, the claims processing system assumed that a blank or \$0 dollar amount in the SPP field reflected a pharmacy oversight. As a result, claims were re-priced to determine the appropriate pharmacy due amount. Upon review, it was determined that the re-pricing was not necessary and that pharmacies correctly sent secondary claims with a \$0 dollar amount in the SPP to indicate that the claim was fully paid by the

primary payer. The claims that were re-priced generated an estimated \$750,000 in erroneous payments to pharmacies.

The Contractor shall perform a provider recovery process as a follow-up on the potential pharmacy overpayments identified. The process would include sending out Initial and Final Notices of Overpayment to providers as well as tracking all provider responses and final determinations. The result of the process shall detail the pharmacies, claims and amounts that should be recouped as overpayments by the State.

### **B. Description and Scope of Service**

This project relates to four distinct groups:

**Group One** (HWT Audit) includes Unreasonable Quantities excluding Tablets and Capsules which identifies claims where the drugs were not dispensed in tablet or capsule form. Also, it includes Unreasonable Quantities/ Tablets and Capsules. Both algorithms detect the possibility of drugs being billed in quantities that “exceed normal or maximum dosages”.

**Group Two** (HWT Audit) includes Near Duplicate Claims for Same and Different Providers. These two algorithms detect two or more claims that appear to be “duplicates by either the same provider or different providers”.

**Group Three** (HWT Audit) includes four separate algorithms that each include different billing errors for various drugs dispensed by providers. They are possible Kit Billing Errors, Zithromax (Antibiotic) Billing Errors, Lovenox (Anti-coagulant) Billing Errors and Inhaler/Nasal Spray Billing Errors.

**Group Four** (Contractor Audit) includes those claims processing errors on 2006 Medicare Part D secondary claims that resulted in overpayments to pharmacies.

The Contractor shall obtain claims data from State for pharmacy claims submitted between January 1, 2004 and December 31, 2005 and use claims data available in paid claims history for 2006. In addition, the Contractor shall work with the State on the approval of any communication(s) developed and distributed by this project. The Contractor staff shall include a pharmacist to be available to review provider responses. After review of the documentation submitted by the provider, the Contractor shall compile overpayment amounts for the Final Determination Letter and make recommendations for the State’s consideration on improvements and changes to provider reimbursement policies, billing instructions and system edits/alerts that apply to pharmacy payments. The Contractor shall routinely update the State of progress throughout the project.

Contractor activities shall include development of initial letter of overpayment, provider extension letter and final determination letter with State approval; preparing claims for provider review; creating initial letter of overpayment and sending to providers with claims listings; creating provider extension letters; tracking and logging provider responses (i.e.

phone calls and/or claims response submission); tracking internal professional review of provider responses; calculating overpayments based on documentation and feedback; creating and sending a final determination letter to the providers with a claims listing; creating a report and a file for the State on providers, claims and overpayment amounts due.

**C. Work Plan**

**Phase 1 – Assessment and Planning**

Task Description	Timeline	Staff Resources	Deliverables
<b>Assessment and Planning</b> <ul style="list-style-type: none"> <li>Finalize project scope</li> <li>Kickoff meeting</li> </ul>	Within the first 15 days of contract amendment	Project Manager	Finalized work plan

**Phase 2 – Preparation and Analysis Phase**

Task Description	Timeline	Staff Resources	Deliverables
<u><b>Step 1</b></u> <ul style="list-style-type: none"> <li>Prepare claims listings</li> <li>Prepare mailing addresses</li> <li>Prepare Initial Notice of Overpayment</li> <li>Merge address with INOP</li> <li>Mail notices with claims listing</li> </ul>	35 Days	Project Manager  Project Coordinator	Initial Notice of Overpayment

<u><b>Step 2</b></u> <ul style="list-style-type: none"> <li>Log and track pharmacy inquiries i.e. phone calls, extension letters</li> <li>Maintain status report</li> <li>Prepare 2<sup>nd</sup> request</li> </ul>	75 Days	Project Manager  Project Coordinator	Status report on notices sent, responses received, inquiries, extensions, second requests
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notices to providers who have not responded <ul style="list-style-type: none"> <li>• Mail extension notices or 2<sup>nd</sup> notices to providers if applicable</li> <li>• Review and process pharmacy responses</li> <li>• Log and track claim status</li> </ul>			
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<b>Step 3</b> <ul style="list-style-type: none"> <li>• Determine final overpayment amount</li> <li>• Prepare and mail FNOP to providers</li> </ul>	30 Days	Project Manager  Project Coordinator	Log of claim status  Log of final determination on claim  File with provider, claim and overpayment amount due
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**Phase 3 – Knowledge Transfer**

Task Description	Timeline	Staff Resources	Deliverables
<b>Debriefing Phase</b> <ul style="list-style-type: none"> <li>• Produce final project status report</li> <li>• Assess time performance</li> <li>• Assess project success</li> </ul>	Within 45 days after the project ends	Project Manager	Final project report

5. Effective November 1, 2008, revise Attachment B, Payment Provisions, Section 1, Payments and Contract Amount, by replacing:

“The maximum amount payable from the date of execution of the Contract through the period ending October 31, 2008 is \$8,318,624.”

with:

“The maximum amount payable from the date of execution of the Contract through the period ending October 31, 2010 is the amount specified on the contract’s State of Vermont Contract Summary and Certification – Form AA-14.”

6. Effective November 1, 2008, revise number 5 of Attachment B, Payment Provisions, Section 2, Cost Structure, by replacing:

“5) Drug coverage management: \$6,125/month”

with:

“5) Drug coverage management: \$6,889.83/month plus up to \$400/month for P&T Committee meeting support costs limited to actual costs.”

7. Effective November 1, 2008, revise number 8 of Attachment B, Payment Provisions, Section 2, Cost Structure, by removing

“8) Rx Track Cognos: \$750/month per user”

8. Effective November 1, 2008, revise number 16 of Attachment B, Payment Provisions, Section 2, Cost Structure, by replacing:

“16) Prior authorizations (Pharmacists and Associates): the greater of \$21,833/month or \$5.20 per prior authorization”

with:

“16) Prior authorizations (Pharmacists and Associates): \$24,559.16 for the first 200 prior authorizations per month and \$5.85 per prior authorization thereafter.”

9. Effective November 1, 2008, revise number 17 of Attachment B, Payment Provisions, Section 2, Cost Structure, by replacing:

“17) Telephone support – pharmacy providers and prescribers: the greater of \$16,666/month, or \$13.22 per call up to 60 calls daily, and \$12.25 for calls over 60 daily”

with:

“17) Telephone support – pharmacy providers and prescribers: the lesser of \$18,746.98/month, or \$14.87 per call up to 60 calls daily, and \$13.78 per call for over 60 calls daily.”

10. Effective November 1, 2008, revise number 19 of Attachment B, Payment Provisions, Section 2, Cost Structure by replacing:

“19) ePocrates contract: actual cost up to \$152,796 per year (\$120,000 per year plus \$2,733/month)”

with:

“19) Epocrates<sup>®</sup> contract: actual cost up to \$50,926 per year for contract year 4 and \$56,018 per year for contract year 5.”

11. Effective November 1, 2008, revise number 20 of Attachment B, Payment Provisions, Section 2, Cost Structure by replacing:

“20) Four (4) on-site dedicated staffing: actual cost up to \$343,200/year beginning January 1, 2006, including fringe benefits plus reasonable expenses no greater than allowed for State employees.”

with:

“20) Four (4) on-site dedicated staffing: actual cost up to \$471,822/year beginning November 1, 2008, including fringe benefits plus reasonable expenses no greater than allowed for State employees including staff procurement costs. Staff procurement costs include but are not limited to advertising, recruitment fees, candidate expenses, and/or reasonable relocation expenses and are subject to the approval of the State.”

12. Effective November 1, 2008, add number 27 to Attachment B, Payment Provisions, Section 2, Cost Structure:

“27) Additional Clinical Services and Case Reviews: Hourly consulting services: \$150 per hour on an “as needed” basis, up to a maximum of \$15,000 per contract year.”

13. Effective November 1, 2008, add number 28 to Attachment B, Payment Provisions, Section 2, Cost Structure:

“28) Generic Drug Voucher Project: One-time Implementation Fee; system coding changes required to eligibility and/or claims’ extracts; and design, development, and testing of reports to assess outcome and success of the Project. The total costs of this section shall not exceed \$150,000.”

14. Effective November 1, 2008, add number 29 to Attachment B, Payment Provisions, Section 2, Cost Structure:

“29) Provider Recovery Services: Total costs not to exceed \$45,000 to be paid in three equal payments after the completion of each of three phases of work as described in the work plan.”

15. Effective November 1, 2008, revise Attachment B, Payment Provisions, Section 3, Development, Implementation and Training, by replacing:

“The Maximum Total Amount of this contract shall not exceed \$8,318,624 for the period from November 1, 2005 through October 31, 2008.”

with:

“The Maximum Total Amount of this contract shall not exceed the amount specified on the contract’s State of Vermont Contract Summary and Certification – Form AA-14 for the period from November 1, 2005 through October 31, 2010.”

16. 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 \$14,734,071. This amount is referenced on Page 1, Number 3, Maximum Amount, and on Page 39, Number 1, Payment and Contract Amount, and in one paragraph on 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. The maximum dollar amount payable under this agreement is not intended as any form of a guaranteed amount. The Contractor shall be paid for the individual services as specified in Attachment A and identified on the chart. The amounts on this chart represent anticipated contract costs based on the individual services identified in Attachments A and B of this contract. As has been the cases since the inception of this contract as indicated on all versions of this chart, line items are subject to a 4% annual increase unless otherwise indicated. The resulting maximum dollar amount payable under this agreement for an individual service line is not intended as any form of a guaranteed amount. It is acknowledged that the individual line item costs are not maximums unless specified as such. It is recognized that certain services may have costs greater or lesser than the referenced line item based on the actual services delivered as specified in Attachment A. Amounts in excess of the referenced line item shall be subject to the approval of the State. However, the total maximum allowable amount as specified on State of Vermont Contract Summary and Certification – Form AA-14 of this contract may not be exceeded without an amendment to the contract.

**STATE OF VERMONT  
AMENDMENT TO CONTRACT FOR PERSONAL SERVICES  
MEDMETRICS HEALTH PARTNERS**

**Contract # 9097  
Change # 3  
Page 9 of 14**

This amendment consists of 14 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 Patricia K. O'Day  
Patricia O'Day

Chief Executive Officer

Date 10/30/08

By the State of Vermont:

By [Signature]  
Joshua Sten

Director

Date 10-31-2008



**STATE OF VERMONT  
AMENDMENT TO CONTRACT FOR PERSONAL SERVICES  
MEDMETRICS HEALTH PARTNERS**

**Contract # 9097  
Change # 3  
Page 11 of 14**

MedMetrics Health Partners Costs- Implementation & Operation Revised													
Item #	Type of Service	Basis of Cost	Costs			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	Operations Year 4 11/01/08 - 10/31/09	Operations Year 5 11/01/09 - 10/31/10	Grand Total
			Unit Costs	Per Month	Annual								
8	RxTrack Cognos (10 Licenses)	Per license per month	\$ 750.00	\$ 7,500.00	\$ 90,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9	RxTrack Showcase (4 licenses)	Per license per month	\$ 200.00	\$ 1,200.00	\$ 4,800.00	\$ -	\$ -	\$ -	\$ 3,328	\$ 865	\$ -	\$ -	\$ 4,193
			Year 2: \$200/month/6 users/4 months			\$ -	\$ -	\$ -	\$ -	\$ 12,980	\$ 14,726	\$ 15,315	\$ 43,022
			\$ 295.00 \$ 1,180.00 \$ 14,160.00 Year 3 and after \$295/month/4 users; plus 4%/year for years 4-5			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10	Supplemental rebate negotiations, rebate management and disputes and collection	Per month cost	N/A	\$ 6,500.00	\$ 78,000.00	\$ -	\$ 65,000	\$ 65,000	\$ 81,120	\$ 84,365	\$ 87,739	\$ 91,249	\$ 409,473
			Plus 4%/year for years 2-5			\$ -	\$ 65,000	\$ 65,000	\$ 81,120	\$ 84,365	\$ 87,739	\$ 91,249	\$ 409,473
11	Non-Medicaid State program rebate negotiations, rebate management and disputes and collections	Per month cost	N/A	\$ 6,500.00	\$ 78,000.00	\$ -	\$ 65,000	\$ 65,000	\$ 81,120	\$ 84,365	\$ 87,739	\$ 91,249	\$ 409,473
			Plus 4%/year for years 2-5			\$ -	\$ 65,000	\$ 65,000	\$ 81,120	\$ 84,365	\$ 87,739	\$ 91,249	\$ 409,473
12	Drug Utilization Review, including DUR Board support for all beneficiaries except AMAP, GA, and HVP	Per month cost	N/A	\$ 8,954.00	\$ 107,448.00	\$ -	\$ 89,540	\$ 89,540	\$ 111,746	\$ 116,216	\$ 120,864	\$ 125,699	\$ 564,065
			Plus 4%/year for years 2-5			\$ -	\$ 89,540	\$ 89,540	\$ 111,746	\$ 116,216	\$ 120,864	\$ 125,699	\$ 564,065
13	Utilization 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	\$ 82,678	\$ 85,985	\$ 385,850
			Plus 4%/year for years 2-5			\$ -	\$ 61,250	\$ 61,250	\$ 76,440	\$ 79,498	\$ 82,678	\$ 85,985	\$ 385,850
14	Clinical detailing	Per month cost	N/A	\$ 6,250.00	\$ 75,000.00	\$ -	\$ 62,500	\$ 62,500	\$ 78,000	\$ 81,120	\$ 84,365	\$ 87,739	\$ 393,724
			Plus 4%/year for years 2-5			\$ -	\$ 62,500	\$ 62,500	\$ 78,000	\$ 81,120	\$ 84,365	\$ 87,739	\$ 393,724
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	\$ 82,678	\$ 85,985	\$ 385,850
			Plus 4%/year for years 2-5			\$ -	\$ 61,250	\$ 61,250	\$ 76,440	\$ 79,498	\$ 82,678	\$ 85,985	\$ 385,850
16	Prior authorization		N/A	\$ 21,833.00	\$ 261,996.00	\$ -	\$ 218,330	\$ 218,330	\$ 272,476	\$ 283,375	\$ -	\$ -	\$ 774,181
			Plus 4%/year for years 2-3			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
			N/A \$ 32,164.16 \$ 385,969.92 \$24,559.16 first 200 PAs per month plus \$5.85/PA over first 200; estimated 1,500 PAs/month; plus 4%/year for year 5			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 385,970	\$ 401,409





**STATE OF VERMONT  
 AMENDMENT TO CONTRACT FOR PERSONAL SERVICES  
 MEDMETRICS HEALTH PARTNERS**

**Contract # 9097  
 Change # 3  
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MedMetrics Health Partners Costs- Implementation & Operation Revised													
Item #	Type of Service	Basis of Cost	Costs			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	Operations Year 4 11/01/08 - 10/31/09	Operations Year 5 11/01/09 - 10/31/10	Grand Total
			Unit Costs	Per Month	Annual								
27	Additional Clinical Services & Case Reviews	Per hour cost	\$150.00	N/A	\$ 15,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 15,000	\$ 15,600	\$ 30,600
			\$150/hour up to a maximum of 100 hours/year; plus 4%/year for year 5										
28	Generic Drug Voucher Program		N/A	N/A	\$ 150,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 150,000	\$ -	\$ 150,000
			One-time initiation implementation fee for eligibility/claims extract coding changes and creation/population of reports										
29	Provider Recovery Services		N/A	N/A	\$ 45,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 45,000	\$ -	\$ 45,000
			Total costs not to exceed \$45,000 to be paid in three equal payments after the completion of each of three described phases of work										
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 Year										
	Grand Total					\$ 478,750	\$ 2,057,417	\$ 2,536,167	\$ 2,794,133	\$ 2,906,591	\$ 3,282,900	\$ 3,214,280	\$ 14,734,071