

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, Inc. (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 date last signed by parties ("Effective Date"), as follows:

1. As of the Effective Date, replace first paragraph of Section XI. Prior Authorization (PA), Subsection 2. Requirements (Page 26), which reads as follows:

The Contractor shall recommend drugs for prior authorization to the State consistent with the State's criteria in the OVHA Policy Manual at M106.2; the Preferred Drug List; and, in the case of HIV and AIDS-related medications used by individuals with HIV or AIDS, with the State's criteria as determined by the Vermont Department of Health. The Contractor shall have a process for informing providers and consumers of any additions to the list of drugs requiring PA. This process will be developed in conjunction with the State and may be modified over time as circumstances warrant.

with:

Contractor shall recommend drugs for prior authorization to the State consistent with the State's criteria in the OVHA Policy Manual at M106.2; the Preferred Drug List; and, in the case of HIV and AIDS-related medications used by individuals with HIV or AIDS, with the State's criteria as determined by the Vermont Department of Health. The State may opt to use the requirement of prior authorizations as a method of clinical detailing and disease management in lieu of executing the clinical detailing and disease management programs described in Attachment A, Specifications of Work to be Performed; specifically, sections VIII. Drug Utilization Review and Federal DUR Requirements, IX. Utilization Management (UM), and XI. Disease Management.

The Contractor shall have a process for informing providers and consumers of any additions to the list of drugs requiring PA. This process will be developed in conjunction with the State and may be modified over time as circumstances warrant.

2. As of the Effective Date, replace Paragraph 5 and Paragraph 6 (in their entirety) of *Section XI. Prior Authorization (PA)*, Subsection 2. *Requirements* (Page 26), which reads as follows:

Any medication requiring prior authorization will be entered into the system to reject at the point of sale. This rejection will include messaging describing the reason for the denial and the Contractor's toll-free telephone number for the pharmacist or the prescriber. The prescriber must initiate a prior authorization request. A certified pharmacy associate shall manage initial PA requests. If the information furnished by the prescriber satisfies criteria, the associate may grant an approval.

If there is any doubt that the criteria have been met, the associate will refer the PA to a licensed clinical pharmacist will review the patient specifics with the prescriber. The Contractor shall assist the prescriber in changing to a more appropriate therapy rather than simply denying the initial request. If the prescriber is unwilling to switch the patient to an acceptable therapy, the pharmacist will issue a denial, or as indicated consult with the Contractor's Medical Director or clinical staff for resolution. If still unresolved, the case will be referred to the OVHA Medical Director or clinical staff as directed by the State. If the recommendation of the Contractor is overridden by the State, an authorization will be entered into the system. All clinical decisions remain the final responsibility of the State. If a request for prior authorization is denied, the Contractor shall issue a notice to the beneficiary notifying them of the denial and of their rights to a fair hearing. The format for such notices will be approved in advance by the State. If requested by the State, the Contractor shall provide the clinical criteria and rationale for each denial.

with:

Any medication requiring prior authorization will be entered into the system to reject at the point of sale. This rejection will include messaging describing the reason for the denial and the Contractor's toll-free telephone number for the pharmacist or the prescriber. The prescriber must initiate a prior authorization (PA) request. Initial PA requests shall be managed by staff trained by the Contractor in the administration of the prior authorizations. PA staff shall be assigned responsibility based on skills and expertise ranging from non-clinical tasks such as the administration of a questionnaire to gather information, to the application of knowledge of pharmacy practice and/or clinical judgment. Training of all staff is provided by the Contractor, and staff may include administrative personnel, certified pharmacy associates/technicians, licensed registered pharmacists (RPh), and licensed pharmacists with a doctoral degree (PharmD). Calls will be categorized into four tiers depending on the level of complexity and knowledge required of the call center's staff to properly manage the call. Tier Zero calls are answered by administrative, non-clinical personnel and include calls coming into the technical call center from pharmacy providers in addition to administrative requests coming into the clinical call center from pharmacy and medical providers. The remainder of calls are clinical requests for Prior Authorization coming into the Clinical Call Center, and are classified as follows: Tier One calls are handled by Pharmacy Associates, Tier Two calls are handled by Level II Pharmacists, and Tier Three calls are handled by Level III Pharmacists (more advanced or specialized clinical skills).

If the information furnished by the prescriber satisfies criteria, the prior authorization approval may be granted. If there is any doubt that the criteria have been met, the trained staff may consult with a pharmacy associate/technician. If doubt remains, the PA shall be referred to a licensed pharmacist who shall review the patient specifics with the prescriber. The pharmacist shall attempt to assist the prescriber in changing to a therapy more in keeping with clinical guidelines, rather than simply denying the initial request. If the prescriber is unwilling to switch the patient to a therapy more in keeping with clinical guidelines, the pharmacist will

issue a denial, or as indicated consult with the Contractor's Medical Director or clinical staff for resolution. If still unresolved, the case will be referred to the OVHA Medical Director or clinical staff as directed by the State. If the recommendation of the Contractor is overridden by the State, an authorization will be entered into the system. All clinical decisions remain the final responsibility of the State. If a request for prior authorization is denied, the Contractor shall issue a notice to the beneficiary notifying them of the denial and of their rights to a fair hearing. The format for such notices will be approved in advance by the State. If requested by the State, the Contractor shall provide the clinical criteria and rationale for each denial.

3. As of the Effective Date, replace the first two paragraphs of Section XIX. Post Implementation (Page 32), which currently reads:

The Contractor shall be responsible for routine system maintenance. Routine maintenance shall include changes required because of determinations by the State or by the Contractor that a deficiency exists with the operational system, including deficiencies found after the implementation of any modifications, or that continued efficiency could be maintained or achieved through the proposed activity.

Modifications may be required that are outside routine system maintenance. They would result when the State or the Contractor determines that an additional requirement needs to be met or that a modification of the existing file structures or current processing is needed. If modifications include changes to interfaces, Contractor will work collaboratively with State systems staff and State's MMIS Contractor. Modification costs shall be subject to negotiation.

with:

The Contractor shall be responsible for routine system maintenance. Routine maintenance shall include:

- Changes required because of determinations by the State or by the Contractor that a deficiency or inefficiency exists or is likely to develop within the operational system, including real or potential deficiencies or inefficiencies found after the implementation of any modifications;
- Continued improvements in the efficiency of the plan design structure within the system; and
- Changes that enhance system performance including the plan design and the system's own management.

There are four categories of maintenance:

- Corrective: A change to correct discovered problems
- Adaptive: A change to keep plan design usable in a changed or changing environment.
- Perfective: A change to improve performance or maintainability.

- Preventive maintenance: A change to correct detected or latent faults before they become effective faults.

Maintenance includes, but is not limited to, routine updates to add new drugs to various lists that dictate plan design, formulary structure, and/or utilization management programs. Another example is updating co-pay, deductible, or out-of-pocket maximum levels.

Modifications may be required that coincide with, or are outside of, routine system maintenance when the State or the Contractor determines that a requirement not previously included in the system design needs to be met, or that a change requires a modification to the design's existing operations, interfaces, and/or file structures that is outside the routine. This includes, for example, changes to OVHA's custom claims extract and/or custom eligibility file extract when new fields need to be added, or new logic needs to be incorporated for a new feature or plan design modification. Another example includes setting up new plans for a newly defined group of members or group benefit modification as well as additions and/or changes to an existing benefit plan structure (e.g. creating a new co-pay benefit structure or instituting a mandatory 90 Day Supply Maintenance Drug Benefit). If modifications include changes to interfaces with other systems, the Contractor will work collaboratively with State systems staff and State's MMIS Contractor.

Reimbursement for modification costs shall be subject to negotiation. The State must agree to payment for modifications. Reimbursement for modifications requires the State's prior approval. To consider reimbursement the State shall minimally require a Level of Effort estimate which includes line item details including work to be performed; technical staff necessary to perform the work; hours and projected costs associated with the work, an estimate of the time to complete the work, and any other conditions that affect the work plan. The State must sign off on the Level of Effort estimate provided by the Contractor before work is to proceed.

It shall be understood that final payment for modifications approved for reimbursement will only be made upon demonstration of the complete and successful implementation of the modification, unless other terms have been agreed upon by the State and the Contractor.

4. As of the Effective Date, revise Number 14 of Attachment B, Payment Provisions, Section 2, Cost Structure, Clinical detailing (Page 40) by removing:
 - 14) Clinical detailing: Not to exceed \$75,000 per year. Actual amount to be determined based on program design agreed to with the State.
5. As of the Effective Date, revise Number 15 of Attachment B, Payment Provisions, Section 2, Cost Structure, Disease Management (Page 40) by removing:
 - 15) Disease management: \$6,125/month

6. As of the Effective Date, revise Number 16 of Attachment B, Payment Provisions, Section 2, Cost Structure (Page 40), by replacing:

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

with:

16) Prior authorizations: Tier Zero calls at \$7.00 per call, Tier One Calls at \$10.00 per call, Tier Two calls at \$40.00 per call, and Tier Three calls at \$100.00 per call. Through the term of the contract not to exceed the total of \$809,095 per year, consisting of \$233,962 per year from Telephone Support line item 17, \$401,409 per year from Prior Authorization line item 16, \$87,739 per year from Clinical Detailing line item 14, and \$85,985 per year from Disease Management line item 15

7. As of the Effective Date, remove Number 17 of Attachment B, Payment Provisions, Section 2, Cost Structure, (Page 40) which states:

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.

8. As of the Effective Date, to accommodate the changes made heretofore:

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. 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 shall not exceed \$14,734,071 for the period from November 1, 2005 through October 31, 2010 may not be exceeded without an amendment to the contract.

STATE OF VERMONT
AMENDMENT TO CONTRACT FOR PERSONAL SERVICES
MEDMETRICS HEALTH PARTNERS, INC.

Contract # 9097
Change # 4
Page 6 of 11

This amendment consists of 11 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.

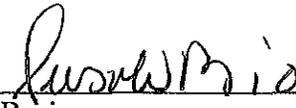
IN WITNESS THEREOF, the parties set forth below agree to execute this Amendment to the State of Vermont Contract for Services with MedMetrics Health Partners, Inc.:

By MedMetrics Health Partners:

By 
Ellen R. Nelson
Managing Director

Date 5/20/10

By the State of Vermont:

By 
Susan Besio
Director

Date 5/26/10

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

**Contract # 9097
Change # 4
Page 7 of 11**

MedMetrics Health Partners Costs- Implementation & Operation Revised														
Item #	Type of Service	Basis of Cost	Costs			Implementation	Operations	Total	Operations	Operations	Operations	Operations	Grand Total	
			Unit Costs	Per Month	Annual	Costs:	Costs:	Year 1	Year 2	Year 3	Year 4	Year 5		
						11/01/05 10/31/06	01/01/06 10/31/06	01/01/06 10/31/07	01/01/07 10/31/08	01/01/08 10/31/09	01/01/09 10/31/10			
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	\$ 778,968	\$ 810,127	\$ 3,635,387	
			Monthly based on 5 M; \$.14 <= 2M; \$.13 >2M <= 3.5M; \$.12 > 3.5M <= 5M; \$.11 > 5M											
			Plus 4%/year for years 2-5											
2	Claims processing – Keying paper claims	Per month cost	N/A	N/A	\$ 7,125.00									
						\$ -	\$ 5,937	\$ 5,937	\$ 7,410	\$ 7,706	\$ 8,015	\$ 8,335	\$ 37,404	
			Annual based on 10,000 Annual; \$.75 <= 4,999; \$.70 >5,000 <= 7,499; \$.65 > 7,500 <= 9,999; \$.60 > 9,999 <= 15,000											
			Plus 4%/year for years 2-5											
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	\$ 25,309	\$ 26,322	\$ 118,117	
			Assumes 15 days on site plus 4%/year for years 2-5											
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	\$ 82,678	\$ 85,985	\$ 385,850	
			Plus 4%/year for years 2-3											
						\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,800	\$ 4,800	\$ 9,600
			Up to \$400/month for additional committee support costs limited to actual costs.											
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	\$ 25,444	\$ 26,462	\$ 118,747	
			Plus 4%/year for years 2-5											
7	Connectivity Fee			\$ 300.00	\$ 3,600.00									
						\$ -	\$ 3,000	\$ 3,000	\$ 3,744	\$ 3,894	\$ 4,050	\$ 4,211	\$ 18,899	
			Plus 4%/year for years 2-5											

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

**Contract # 9097
Change # 4
Page 11 of 11**

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	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	Quantity	Annual								
27	Additional Clinical Services & Case Reviews	Per hour cost	\$150.00	N/A	\$ 15,000.00								
			\$150/hour up to a maximum of 100 hours/year; plus 4%/year for year 5			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 15,000	\$ 15,600	\$ 30,600
28	Generic Drug Voucher Program		N/A	N/A	\$ 150,000.00								
			One-time initiation implementation fee for eligibility/claims extract coding changes and creation/population of reports			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 150,000	\$ -	\$ 150,000
29	Provider Recovery Services		N/A	N/A	\$ 45,000.00								
			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			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 45,000	\$ -	\$ 45,000
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			\$ 478,750	\$ 2,057,417	\$ 2,536,167	\$ 2,794,133	\$ 2,906,591	\$ 3,282,900	\$ 3,214,280	\$ 14,734,071
	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