

AMENDMENT

It is hereby agreed by and between the State of Vermont, Office of Vermont Health Access (hereinafter called the "State") and Innovative Resource Group LLC d/b/a APS Healthcare Midwest (APS) (hereinafter called the "Contractor") that the personal services contract for health and disease management services for the OVHA Chronic Care Management Program, which includes Intervention Services and Assessment Administration, effective June 15, 2007, is hereby amended as a result of the State's budget rescission announced August 21, 2008. The amendment is effective October 1, 2008 upon execution by the parties, as follows:

1. Revise Attachment A, Specifications of Work to be Performed, I. OVERVIEW, page 5 of 45, by replacing:

"The contractor will operate a Chronic Care Management Program (CCMP) for Medicaid beneficiaries with chronic health conditions. This includes Provider Engagement and Education, Population Stratification, Health Risk Assessment Administration, Targeted Disease-Specific Self-Management Consumer Mailings, Telephonic Nurse Support, and Face-to-Face Care Management.

All terms and conditions included in the Request for Proposals (RFP), APS's proposal in response to the RFP, subsequent written questions prepared by the State and answers submitted by APS to the State between January 4, 2007 and April 5, 2007, and the subsequent amended HRA proposal are binding and considered part of this contract. These documents are included as Attachment G of this contract.

with:

"The Contractor shall collaborate with the State in the management of a Medicaid chronic care initiative. This includes Provider Outreach, Engagement and Education, Population Stratification, Health Assessments, Targeted Disease-Specific Self-Management Consumer Mailings, Telephonic Nurse Support, and Face-to-Face Disease Management.

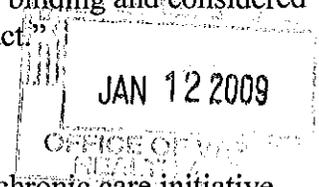
Unless otherwise specified in this amendment, all terms and conditions included in the Request for Proposals (RFP), APS's proposal in response to the RFP, subsequent written questions prepared by the State and answers submitted by APS to the State between January 4, 2007 and April 5, 2007, and the original Contract #11303 are binding and considered part of this contract. These documents are included as Attachment G of this contract."

2. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, A. APS CareConnection® System, page 5 of 45, by adding:

"At a minimum, patient level information shall include Medicaid identification information: number, name, address, telephone and/or cell number (as available); claims data: claim type, provider, date of service, and service; clinical data: diagnosis code(s) on qualifying conditions; and assessment/intervention services information. At a minimum, capability must exist to readily input and retrieve assessment/intervention services information.

Input capability of assessment/intervention services information must include the ability to group options in a meaningful manner that clearly identifies the specific information. This capability is achieved by CareConnection® functionality enhancements for assessment and education module integration.

Retrieval capability shall include the minimum set of monitoring reports described in the Performance



Standards of this contract. Additionally, retrieval capability shall include direct State access to the same data that is used by the Contractor in producing reports from the CareConnection® system. Contractor shall have the right to authorize any State user.

3. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, B. Risk Stratification, page 5 of 45, by replacing:

“The initial target population is estimated to be 25,000 Medicaid eligible beneficiaries identified to have specified chronic health conditions. Medicaid eligibles include beneficiaries eligible with approval by the Centers for Medicaid and Medicare Services (CMS) under the Vermont Health Access Program (VHAP). During the course of this contract, the target population may expand if additional health conditions are specified or if the State opts to offer select services to Medicaid eligible beneficiaries to identify situations that might affect their health. If the target population is expanded the State and the Contractor will work together to identify who will be added, what services will be offered, and what resources would be needed to provide those services. At that time, the State and Contractor will amend the contract to reflect the necessary changes including the costs required to support them.”

with:

“Potential beneficiaries of the chronic care initiative are Medicaid eligible beneficiaries identified to have specified chronic health conditions. Medicaid eligibles include beneficiaries eligible with approval by the Centers for Medicaid and Medicare Services (CMS) under the Vermont Health Access Program (VHAP). Medicaid beneficiaries specifically targeted for enrollment in the Programs who are not Medicare eligible and have at least one chronic condition including, but not limited to: arthritis, asthma, COPD, chronic renal failure, CHF, depression, diabetes, hyperlipidemia, hypertension, ischemic heart disease, or low back pain or who have a condition that otherwise has been designated by OVHA as appropriate. Within these conditions, five (5) risk levels are identified – low, medium, high, very high assigned to disease management, and very high assigned to care coordination. These beneficiaries are at risk for significant clinical events that may result in high cost services.

Selection of beneficiaries for the chronic care initiative, and assignment of beneficiaries for care coordination, shall be the responsibility of the OVHA, the Population Selection and Program Monitoring partner, and/or any other OVHA designee. Contractor services under the initiative shall potentially be available to beneficiaries identified as those in the “very high” and “high” risk categories. Those in the “medium risk” and “low risk” categories may also be considered for services if caseloads permit or to accommodate referrals, provided those in the two highest risk categories are targeted first. The State and Contractor will determine the final methodology to assign the categories, which may include but not be limited to APS’ Total Risk Score (TRS) and/or Johns Hopkins’ Adjusted Clinical Groups (ACGs). The methodology will be documented in writing, including risk level cut-off scores, as applicable. The population receiving health coach and/or care coordination services shall be no fewer than 4,000 Medicaid eligible beneficiaries from July 1, 2008, through June 30, 2009 and no fewer than 4,000 from July 1, 2009 through June 30, 2010. The goal is for eligible beneficiaries to be self-managing or referred to appropriate support services within 12 months.”

4. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, C. Rollout, page 5 of 45, by replacing:

“C. Rollout

Prioritization of the Health Risk Assessment (HRA) administration will be proposed by the vendor and approved by the State. The prioritization will be reviewed on a monthly basis.

The Contractor agrees that Intervention Services (IVS) participants be enrolled in a randomized order. This will be done statewide or within counties or other geographic units chosen by the State if the program is available in some areas sooner than in others.”

with:

“C. Selection and Transfer

The Contractor and State shall establish a written plan and methodology by December 31, 2008, and work in collaboration to provide intervention services to no fewer than 4,000 Medicaid eligible beneficiaries between July 1, 2008 and June 30, 2009 and no fewer than 4,000 beneficiaries between July 1, 2009 and June 30, 2010. Individuals participating shall be predominantly selected from identified “high” and “very high” risk categories. Services during the period may be provided by State and/or Contractor Program staff. It shall be assumed that transitioning of beneficiaries shall occur routinely and that beneficiaries may transition out of intervention services entirely when they demonstrate their ability to generally self-manage their conditions. Beneficiaries may also transition from self-management to care coordination or disease management, if necessary. The protocol for transition of beneficiaries shall be established by mutual agreement no later than December 31, 2008, and shall be documented in writing. The Contractor shall provide monthly monitoring reports to include but not be limited to selection, engagement, and transitions. They must minimally provide beneficiary and summary level reports including descriptions of services provided and service frequency by Contractor and/or State staff, the basis of services on national best practice standards, the specific criteria used to determine appropriate transfers, and the number of transitions as described in the Performance Standards of this contract.”

5. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, D. Health Risk Assessments (HRAs) Administration, page 6 of 45, by replacing:

“The Contractor shall complete all steps necessary to administer by mail, telephone, or in-person Health Risk Assessment questionnaires. Steps shall be defined as agreed upon by the parties.”

with:

“As of October 1, 2008, HRAs (SF8) shall no longer be required for all beneficiaries with identified chronic conditions. However, due to concern that some people may have an acute need for services that would have been identified using a health risk assessment, the Contractor shall use an Interactive Voice Recognition (IVR) system to attempt to contact two times per year people with identified chronic conditions in the medium and low risk categories as agreed upon by the State and Contractor. People contacted who request immediate assistance shall be provided a warm transfer to appropriate Contractor staff to respond to questions and/or complete a general assessment for consideration for intervention services.”

and:

“The contractor shall transfer to the State in a dataset, the raw HRA data collected on beneficiaries. The transfer shall occur as frequently as weekly. The period reported may vary. The content and format of this

data will be mutually agreed upon.”

with:

“The contractor shall transfer to the State in a dataset, the final raw HRA data collected on beneficiaries.

6. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, E. Consumer Mailings, page 6 of 45, by replacing:

“The Contractor shall produce and distribute general mailings to all eligible beneficiaries with disease-specific self management information. The content of mailings (subject to approval from the State) will be generated by the Contractor and will represent Vermont Medicaid and the original source of information (e.g., American Heart Association), and be free from commercial bias. Mailings with disease-specific, self-care information, will comply with established State disease-specific best practice standards when available. Contractor will provide all functions related to the mailings.”

with:

“The Contractor shall produce and distribute general mailings. Welcome mailings shall be sent to the households of all beneficiaries with identified chronic conditions on or after October 1, 2008, and shall contain basic information about the Medicaid chronic care management initiative, including the toll free number to call for additional information. Welcome mailings shall be sent to the households of those beneficiaries newly identified with the specified chronic conditions in the quarter and will be mailed within 30 days of Contractor receiving a population list update. Quarterly newsletters shall be discontinued. Mailings with disease-specific self management information shall minimally be sent to those beneficiaries, primarily identified as “high” and “very high” risk, as determined by Contractor staff. The content of mailings (subject to approval from the State) will be generated by the Contractor and will represent Vermont Medicaid and the original source of information (e.g., American Heart Association), and be free from commercial bias. Mailings with disease-specific, self-management information will comply with established State disease-specific best practice standards when available. Contractor will provide all functions related to the mailings.”

7. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, F. Call Center and Telephonic Nurse Support/Telephonic Interventions, page 6 of 45, by replacing:

“The Contractor shall provide a call center for the target population with capability of incoming and outgoing nurse telephone contact with both patients and providers during both business hours (i.e., 8 AM-5 PM non-holiday Monday-Friday) and limited extended hours (i.e., 5-7 PM non-holiday Monday-Friday). The call center shall be staffed by licensed nurses minimally holding an LPN certification. The evidence-based clinical content of the advice and counseling (subject to approval from the State) provided by the nurses shall be generated by the Contractor. The call center shall be located in Vermont, and have warm-transfer capability. After hours calls shall be responded to by the APS call center located outside of Vermont with warm-transfer capability to on-call staff in Vermont for the period 7:00 PM – 10:00 PM non-holiday Monday-Friday. For hours outside of these specified hours, calls will be handled by an automated response system that will record messages for follow up the next business day.”

With

“The Contractor shall provide a call center for the target population with capability of incoming and outgoing nurse telephone contact with both patients and providers between 8 AM and 7 PM non-holiday Monday-Friday. The evidence-based clinical content of the advice and counseling (subject to approval from the State) provided by Contractor staff shall be generated by the Contractor. The call center shall be located in Vermont, and have warm-transfer capability. For hours outside of these specified hours, calls will be handled by an automated response system that will record messages for follow up the next business day.”

8. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, G. Face to Face Interventions, page 7 of 45, by replacing:

“As approved by the State, the Contractor shall provide for face-to-face interventions in various locations in Vermont as outlined in performance measures, though most contacts are expected to be performed telephonically. Home visits by APS are not provided for under this contract.”

with:

“Most intervention contacts are expected to be performed telephonically. The Contractor shall provide for some face-to-face interventions with beneficiaries designated as “very high” or “high” risk through 5.0 FTE Community Health Coaches in the following locations: Northeast Kingdom Community Action Agency, Central Vermont Medical Center, Rutland Regional Medical Center, Fletcher Allen Health Care, and a Southeastern Vermont host site to be identified yet as outlined in performance measures. The State and Contractor shall monitor this activity and determine whether it adversely impacts the ability to meet the minimum intervention services requirements for the number of beneficiaries managed and the targets for medical service savings expected through the Medicaid chronic care initiative. The State and Contractor may mutually agree to make changes in community placements, if indicated.”

9. Revise Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, H. Provider Outreach and Education, page 7 of 45, by replacing:

“The State shall approve all plans for provider outreach.

The Contractor shall coordinate all provider outreach activity with the OVHA Care Coordination Program.

Efforts must be coordinated, to the extent possible, with the Vermont Banking, Insurance, Securities and Health Care Administration’s (BISHCA) Rule 10 requirements and activities (<http://www.bishca.state.vt.us/RegsBulls/hcaregs/HCARule10.pdf>) and with the related activities of commercial payers, the OVHA Care Coordination Program, the Vermont Blueprint for Health, and other State initiatives.”

with:

“A revised provider outreach and engagement plan shall be developed by the Contractor no later than December 31, 2008, in coordination with designated State staff and units including but not limited to the OVHA’s Medical Director and/or Associate Medical Director, the Care Coordination Field Director, the OVHA Communications Unit, and the OVHA Health Program Integration Unit. Efforts must be coordinated, to the extent possible, with the Vermont Banking, Insurance, Securities and Health Care Administration’s (BISHCA) Rule 10 requirements and activities

(<http://www.bishca.state.vt.us/RegsBulls/hcaregs/HCARule10.pdf>) and with the related activities of commercial payers, the Vermont Blueprint for Health, and other Agency of Human Services and State initiatives. The plan will include specific goals and measurable objectives. The plan shall rely on the services of Contractor staff including but not limited to the Executive Director and Medical Director.”

and:

“The Contractor shall inform primary care providers in advance of all proposed interventions to be conducted with their patients, and timely patient-level information resulting from those interventions will be posted in the care plan maintained with APS CareConnection®.”

with:

“The Contractor shall provide written notification to primary care providers of patients’ enrollment in Contractor-provided intervention services. A written letter will be sent to the primary care provider with the beneficiary’s name, the Health Coach’s contact information, and step-by-step instructions to utilize APS CareConnection®. Timely patient-level information resulting from interventions will be posted in the care plan maintained with APS CareConnection®. At a provider’s request, Contractor shall provide patient-specific information to the provider via alternative method. Contractor shall provide quarterly summary reports to physicians that include but are not limited to information on member demographics, members by disease, member risk level, clinical outcome metrics by disease, and member utilization of hospital and/or emergency department, and will include beneficiaries managed by either State or Contractor staff.

10. Revise Attachment A, Specifications of Work to be Performed, III. QUALITY ASSURANCE AND QUALITY IMPROVEMENT REQUIREMENTS, page 8 of 45, by replacing:

“The Contractor shall identify barriers and propose interventions to improve chronic care management for children with special health care needs and adults with severe and persistent mental illness.”

with:

“The Contractor shall identify barriers and propose interventions to OVHA to improve chronic care management for children with special health care needs and adults with severe and persistent mental illness.”

11. Revise Attachment A, Specifications of Work to be Performed, IV. ADMINISTRATIVE PROVISIONS, page 8 of 45, by replacing:

“The Contractor shall manage regular advisory committee meetings. At the State’s request, the Contractor shall be on site to meet with State staff, consultants, contractors, providers, and other State or Legislative officials.”

with:

“The Contractor shall manage regular advisory committee meetings in collaboration with OVHA. At the State’s request, the Contractor shall be on site to meet with State staff, consultants, contractors, providers, and other State or Legislative officials.”

and:

“At a minimum, the contractor shall collaborate and integrate activities with the State’s initiatives and partners:

- Medicaid Management Information System (MMIS) contractor – Claims processing, fiscal agent services, and provider relations
- PBA – Pharmacy Benefits Administrator
- Member services contractor
- OVHA’s Care Coordination (CC) Program
- Blueprint for Health Goals and Activities
- Population Selection and Program Monitoring partner”

with:

“At a minimum, the contractor shall collaborate and integrate activities with the State’s initiatives and partners:

- Medicaid Management Information System (MMIS) contractor – Claims processing, fiscal agent services, and provider relations
- PBA – Pharmacy Benefits Administrator
- Member services contractor
- OVHA’s care coordination services
- OVHA’s Program Integration Unit
- OVHA’s Program Integrity Unit
- OVHA’s Communications Unit
- Blueprint for Health Goals and Activities
- Any OVHA Population Selection and Program Monitoring partner
- Any other OVHA designee”

and:

“The Contractor will subcontract with the Morehouse School of Medicine, National Center for Primary Care for consultation and assistance services. The following will be the areas of focus and scope for the Morehouse subcontract:

1. Assist in the development of Continuing Medical Education (CME) programs for providers who are working with the CCMP population.
2. Assist in the development of standards and best practices for target conditions and co-morbid conditions (ABCD Model).
3. Assist with the screening of Medical Director candidates.
4. Assist in educational and training programs for health coaches and program staff.”

with:

“The Contractor shall collaborate with relevant partners, including but not limited to the Morehouse School of Medicine, National Center for Primary Care, for consultation and assistance services. The following will be the areas of focus and scope of this collaboration:

1. Assist in the development of standards and best practices for providers for target conditions and co-morbid conditions (ABCD Model).
 2. Assist with the screening of Medical Director candidates.
 3. Assist in educational and training programs for health coaches and other program staff.
 4. Assist in the development of educational programs for providers working with the Medicaid chronic care population, which may include a pilot Continuing Medical Education (CME) program for providers. If implemented, this CME program will be a subject of a Quality Assurance and Quality Improvement activity. The State and Contractor would do a "Plan Do Study Act" (PDSA) cycle on the CME pilot program to assess the effectiveness of this strategy in furthering the goals of the chronic care initiative."
12. Revise Attachment A, Specifications of Work to be Performed, V. ELECTRONIC DATA REQUIREMENTS, page 9 of 45, by replacing:

"The Contractor shall accept data in a mutually acceptable electronic format using secure transfer processes. Data sources include the State, the MMIS contractor, the PBA, and the Population Selection and Program Monitoring partner."

with:

"The Contractor shall accept data in a mutually acceptable electronic format using secure transfer processes. Data sources include the State, the MMIS contractor, the PBA, the Population Selection and Program Monitoring partner, and/or any other OVHA designee."

13. Revise Attachment A, Specifications of Work to be Performed, VIII. CONTRACT MONITORING REQUIREMENTS, page 9 of 45, by replacing:

"The Contractor recognizes that the State will monitor the implementation, operations, and results and outcomes of this contract. For periods of time during the operations of this contract, the State has chosen a vendor for portions of this monitoring. For the purpose of this contract this vendor will be referred to as the Population Selection and Program Monitoring partner.

All records or information described below shall be captured and maintained as described in Attachment C, #8:

1. Data on provider outreach and education activities at the physician/provider level including participation by providers (e.g., physician name, practice name, practice address, federal tax id, Medicare and/or Medicaid provider numbers, date contacted, etc.).
2. HRA data (e.g., numbers of beneficiaries selected for specified periods, sources of referrals, number of HRAs sent, numbers returned to beneficiaries for additional information, number of telephone contacts, etc.)
3. Uniform records of cases with completed and non-completed Health Risk Assessments (HRAs) (e.g., those who have been sent an HRA but who have not returned it, etc.).
4. Uniform records of who has been contacted for enrollment at each level of the intervention.
5. Uniform records of cases enrolled and not enrolled at each level of the intervention.
6. Information needed to link participants with their primary care provider and any specialty providers (e.g., name and address of provider, provider ID numbers, etc.).

7. Reason for non-participation (e.g., unable to contact, mail returned to sender, incorrect diagnosis, ineligible to participate, moved out of state, refused to participate, etc.), at each level of the intervention.
8. Reason for attrition from the program (e.g., “graduated”, moved out of state, no longer able to contact, no longer eligible for Medicaid, refused further participation, etc.) for participants at each level of the intervention.
9. Participant progress during the intervention, including correction of claims-based diagnosis information, changes in disease and overall health status, progress to a lower or higher level of intervention, plus any other relevant data.
10. Information on intervention activities at the case-level for each level of the intervention. (e.g., records that a person was sent disease-specific self-management materials, the number/timing of telephone and in-person contacts, etc.).

These records or information shall be available to the State or to the Population Selection and Program Monitoring partner in report format or database formats at regular agreed upon intervals and upon request. These records and information shall generally be provided to the State in either format and to the Population Selection and Program Monitoring partner in database format. The Contractor shall consult with the State and the Population Selection and Program Monitoring partner on the creation of appropriate data collection instruments and coding of responses for assessments, APS CareConnection®, and other data collection instruments. Comprehensive report formats, data dictionaries, file specifications and code books shall be provided to the State and the Population Selection and Program Monitoring partner as soon as they are available and in advance of any related data transfer. Data shall be provided upon request and/or at regular, agreed-upon intervals.”

with:

“The Contractor recognizes that the State will monitor the implementation, operations, and results and outcomes of this contract. For periods of time during the operations of this contract, the State has chosen a vendor for portions of this monitoring. For the purpose of this contract this vendor may be referred to as the Population Selection and Program Monitoring partner. The Contractor recognizes that the State may designate other entities to act as its agent(s) to assist in any and all monitoring activities.

All records or information described below shall be captured and maintained as described in Attachment C, #8:

1. Data on provider outreach and education activities at the physician/provider level including participation by providers (e.g., physician/provider name, practice name, practice address, Medicaid provider number, date contacted, etc.).
2. Uniform records of who has been contacted for enrollment at each risk level for intervention.
3. Uniform records of cases enrolled and not enrolled at each risk level for intervention.
4. Information needed to link participants with their primary care provider and any specialty providers (e.g., name and address of provider, provider ID numbers, etc.).
5. Data on providers linked with successful engagement of beneficiaries, number of patients enrolled in chronic care management services, and progress of participants.
6. Reason for non-participation (e.g., unable to contact, mail returned to sender, incorrect diagnosis, ineligible to participate, moved out of state, declined participation, etc.), at each risk level for the intervention.
7. Action plans to increase success with beneficiary engagement.

8. Reason for attrition from the program (e.g., “graduated”, moved out of state, no longer able to contact, no longer eligible for Medicaid, declined further participation, non-compliant/readiness for change, etc.) for participants at each risk level of the intervention.
9. Participant progress during intervention services, including Plan of Care, health coach interventions to address problems/goals by diagnosis, problems addressed/goals achieved, changes in patient behaviors linked with intervention services, changes in disease diagnoses and overall health status, changes in claims, emergency department visits, preventable inpatient hospitalizations and length of stay, transition to a lower or higher level of intervention services, plus any other relevant data.
10. Information on intervention activities at the case-level for each risk level for beneficiary population intervened upon (e.g., records that a person was sent disease-specific self-management materials, the number/timing of telephone and in-person contacts, the intervention provided for the specific condition being addressed, etc.).
11. Data on case duration by diagnoses and case duration by risk level.

These records or information shall be available to the State, the Population Selection and Program Monitoring partner, or any other OVHA designee in report format or database formats at regular agreed upon intervals and upon request. These records and information shall generally be provided to the State in either format and to the Population Selection and Program Monitoring partner or any other OVHA designee in database format. The Contractor shall consult with the State, the Population Selection and Program Monitoring partner, or any other OVHA designee on the creation of appropriate data collection instruments and coding of responses for assessments, APS CareConnection®, and other data collection instruments. Comprehensive report formats, data dictionaries, file specifications and code books shall be provided to the State, the Population Selection and Program Monitoring partner, or any other OVHA designee as soon as they are available and in advance of any related data transfer. Data shall be provided upon request and/or at regular, agreed-upon intervals.”

14. Revise Attachment A, Specifications of Work to be Performed, IX. STATE RESPONSIBILITIES, #5, page 10 of 45, by replacing:

“Provide the Contractor with electronic files according to frequency schedule, transmission method, and file formats and specifications defined by State and the Contractor. These files will include:

- a. Monthly eligibility files of all Vermont Medicaid program enrollees.
- b. Monthly roster of potential CCMP program enrollees as identified by the State or the Population Selection and Program Monitoring partner.
- c. Claims files on all Vermont program enrollees.
- d. Reference files identifying data on all Vermont claims (e.g., procedure codes, national drug codes, diagnosis codes, etc.)
- e. Vermont Medicaid enrolled provider lists.”

with:

“Provide the Contractor with electronic files according to frequency schedule, transmission method, and file formats and specifications defined by the State and Contractor. These files will include:

- a. Monthly eligibility files of all Vermont Medicaid program enrollees.
- b. Quarterly roster of potential enrollees in the chronic care initiative as identified by the State, the Population Selection and Program Monitoring partner, or any other OVHA designee.

- c. Monthly claims files on all Vermont program enrollees.
 - d. Up-to-date reference files identifying data on all Vermont claims (e.g., procedure codes, national drug codes, diagnosis codes, etc.).
 - e. Monthly Vermont Medicaid enrolled provider lists.”
15. Eliminate in its entirety Attachment A – Scope of Work Appendix II Performance Standards & Operational Metrics: Health Risk Assessment Administration, pages 19 through 21 of 45.
16. Replace in their entirety Attachment A – Scope of Work Appendix I Performance Standards & Operational Metrics: Intervention Services, pages 12 through 18 of 45, and Attachment A – Scope of Work Appendix III Performance Standards & Operational Metrics: Chronic Care Management Intervention Standards, pages 22 through 24 of 45, with the following:

Attachment A – Scope of Work Appendix I Performance Standards & Operational Metrics: Intervention Services

	Requirement	Standard	Report
1.	<p>Design and implement a comprehensive outreach and engagement plan and ongoing education campaign reaching all Vermont Medicaid providers utilizing current guidelines for prevention and treatment of chronic diseases in support of the Chronic Care Model.</p> <p>The plan shall focus on engagement of the provider community.</p> <p>The plan may include provisions for a Clinical/Professional Advisory Committee, including mission, goals, and meetings.</p> <p>The Contractor shall collaborate and integrate outreach, engagement, and education activities with the OVHA’s Care Coordination (CC) staff, OVHA’s Communications Unit, OVHA’s Health Program Integration Unit, and any other OVHA designee.</p>	<p>The Contractor shall develop and update annually an ongoing provider outreach and engagement plan subject to the approval of the State.</p> <p>The Contractor shall administer the outreach and engagement program.</p> <ul style="list-style-type: none"> ▪ The plan shall contain provisions to contact and engage high volume Medicaid providers who serve the identified population, including ongoing meetings with providers that have been identified by the State and the Contractor as the high volume Medicaid providers to the target population. ▪ The plan shall include provisions for primary care providers to be notified of the engagement of one of their patients in Contractor-provided intervention services. ▪ The Contractor will document individually and on the aggregate level, the number and type of providers contacted, date, method of outreach (e.g., mail, email, telephone, fax, presentation, training, etc.), description of materials provided, the number of providers notified of new cases engaged in intervention services, and number of providers using APS CareConnection®. ▪ The plan shall include goals, outcomes, and measureable objectives. ▪ Provider outreach, engagement, and education will be planned and implemented in collaboration with OVHA’s Care Coordination staff, OVHA’s Communications Unit, OVHA’s Health Program Integration Unit, and any other OVHA designee. Care Coordinator and Community Health Coach roles and responsibilities will be clearly delineated, and criteria for each type of service (care coordination vs. disease management intervention services) will be 	<p>Monthly Provider Outreach Report</p>

		<p>clearly described for providers and other community partners.</p> <ul style="list-style-type: none"> ▪ The Contractor may develop and jointly evaluate with the OVHA the effectiveness and efficiency of a test CME campaign for primary care providers. 	
<p>2.</p>	<p>Perform risk stratification to pro-actively identify the specific intervention populations.</p> <p>Provide results from stratification.</p> <p>Selection of beneficiaries for the Medicaid chronic care initiative, and assignment of beneficiaries to care coordination or disease management, will be done by OVHA, its Population Selection and Program Monitoring partner, or other designee. Generally, beneficiaries in the “high” and “very high” risk categories (and not assigned to care coordination) will be eligible to receive intervention services with a Contractor health coach. By referral, and provided caseloads permit and efforts to first engage high and very high risk individuals have been exhausted, medium and low risk individuals may be considered for intervention services.</p> <p>Contractor will use an Interactive Voice Recognition (IVR) system to reach out two times per year to people in the medium and low risk categories. For people who wish immediate assistance, the IVR will provide a warm transfer to an appropriate Contractor staff person, so the beneficiary may respond to questions and/or complete a general assessment and be considered for intervention services.</p>	<p>Employ consistent method of ongoing population stratification, which utilizes Medicaid claims and which is replicable by other programs. The State and Contractor will determine the final methodology to assign the categories, which may include but not be limited to APS’ Total Risk Score (TRS) and/or Johns Hopkins’ Adjusted Clinical Groups (ACGs). The methodology will be documented in writing, including risk level cut-off scores, as applicable.</p> <p>Individual patient-level data from stratification shall be provided to the State in mutually-acceptable easily-accessible data base or flat file formats.</p> <ul style="list-style-type: none"> • Individual level risk scores (TRS) shall appear on CareConnection®. • The Contractor shall provide aggregate results of the risk stratification on a quarterly basis, including data on cases for which risk levels have changed. 	<p>Aggregate risk results and analyses provided quarterly in relevant monthly report.</p>

	<p>The Contractor will produce, in collaboration with OVHA's care coordination staff, a written plan and methodology by December 31, 2008, to jointly serve a minimum of 4,000 individuals during Contract Year 2. Individuals participating in Contractor-provided IVS will predominantly be drawn from the "high" and "very high" risk categories. The capacity to transition beneficiaries between State care coordination staff and Contractor IVS staff must be built into the system. Annual Contractor case turnover is estimated to be at least 35%. The Contractor will propose, and OVHA will approve, monthly monitoring reports for use by the State. Monthly monitoring must include metrics of health coach/care coordinator intervention services provided, service frequency, goals in POC achieved, the basis of IVS on national best practice standards, the criteria used to determine appropriate transfers/transitions, the number of transitions in order to serve the minimum of 4,000 individuals in Year 2, and data available to track savings/ROI.</p>		
<p>3.</p>	<p>Provide a call center for the target population with capability of incoming and outgoing nurse telephone contact with both patients and providers during both business hours (8 AM-5 PM non-holiday Monday-Friday) and limited extended hours (i.e., 5-7 PM non-holiday Monday-Friday).</p> <p>The call center shall be located in Vermont, and have warm-transfer capability. After hours calls shall be handled by an automated response system that will record messages for follow up the next business day.</p>	<p>The Contractor will employ local nursing staff and other staff to provide call center functions during the required hours of coverage. A nurse will be present during all business hours.</p> <p>Call response standards are:</p> <ul style="list-style-type: none"> • 100% of all incoming calls must be answered within 25 seconds. • 95% of held calls must be transferred to a live operator within 2 minutes. • 100% of held calls are transferred to a live operator within 4 minutes. • Abandonment rate of less than 10% for all calls abandoned. <p>See Chronic Care Management Intervention Standards below.</p>	<p>Monthly Contact Report</p>

4.	<p>Report intervention metrics (e.g., number and type of mailings and telephone calls, number, type, and mode of interventions provided, etc.) with documentation of activities. Intervention activities must be documented in CareConnection® in a manner that provides the ability to aggregate, track and summarize quantitatively, as well as link interventions with changes in behaviors and health outcomes. Reports must demonstrate that Care Plans and intervention activities are based upon national best practice standards (e.g., APS' "touch levels") for each disease and level of patient risk.</p>	<p>See Chronic Care Management Intervention Standards below.</p>	<p>Monthly Contact Report</p>
5.	<p>Use tools (e.g., stratification methods, call scripts, etc.) that are nationally recognized.</p>	<p>Tools that are nationally recognized and commercially available will be considered.</p> <p>Tools selected must be approved by the State prior to use.</p> <p>Approved exceptions may include products that are proprietary to APS or that have been customized. These may be available via contract or agreement with APS.</p>	<p>Written requests for approval of Tools</p>
6.	<p>Request approval from the State in advance of distribution of clinical content.</p>	<p>Allow a minimum of 14 working days for State to review materials prior to distribution.</p>	<p>Written requests for approval of Clinical Materials</p>
7.	<p>Collaborate and integrate activities with:</p> <ul style="list-style-type: none"> • OVHA's Population Selection and Program Monitoring partner • OVHA's Care Coordination (CC) staff • OVHA's Communications Unit • The State's initiatives 	<p>Exhibit a cooperative and collaborative approach to working with the State and its partners.</p> <p>The Contractor shall minimally meet the following standards:</p> <ul style="list-style-type: none"> • The Contractor shall participate in State Medicaid orientation training sessions. 	<p>Annual Report</p>

	<ul style="list-style-type: none"> • Vermont's Blueprint for Health goals and activities • OVHA's Medicaid Management Information System (MMIS) and Fiscal Agent vendor • OVHA's Pharmacy Benefits Administrator (PBA) • OVHA's Member Services vendor • State and local providers to advance understanding of chronic care • Commercial carriers, whenever possible, to promote consistency across payers. 	<ul style="list-style-type: none"> • The Contractor shall participate in chronic care initiative workgroups that include the OVHA's Population Selection and Program Monitoring partner, the OVHA's Care Coordination (CC) Program staff, the OVHA's program and administrative staff, the OVHA's Medicaid Management Information System (MMIS) and Fiscal Agent vendor, the OVHA's Pharmacy Benefits Administrator (PBA), and/or the OVHA's Member Services vendor upon request of the State. • The Contractor shall accommodate reasonable requests of the State's vendors. The Contractor may not dictate terms of collaboration. • The Contractor shall participate in Blueprint for Health meetings at the State's direction. • The Contractor shall participate in Agency of Human Services Medicaid and health reform meetings at the State's direction. 	
8.	Comply with the State's IT requirements.	The Contractor shall fully comply with the IT requirements in section 7.1.6.1 of the RFP at pp. 40-42; APS proposal in response to the RFP pp. 30-33, with the exception that only 1 reporting analyst will be on site in Vermont and other IT support is provided via APS centralized IT capacity; APS' submitted Overview of APS's Technology Infrastructure; and APS' combined response to OVHA's questions regarding APS's proposal pp. 35-50. Questions and answers are between the State and the Contractor between January 4, 2007 and April 5, 2007. These documents are included as Attachment G the CD.	Annual Report
9.	<p>Accept data from the State or its vendors for names, identification numbers, addresses, and phone numbers on all Vermont Medicaid program enrollees.</p> <p>Accept data from the State or its Population Selection and Program Monitoring partner or other designee that represents the quarterly roster of potential chronic care initiative enrollees as identified.</p>	The Contractor shall accept data through suitable, mutually acceptable electronic format and secure transfer processes.	<p>Monthly Report</p> <p>Quarterly Report Includes:</p> <ul style="list-style-type: none"> ▪ State and Contractor case assignments ▪ Number who

			became Medicaid ineligible
10.	Accept claims data, reference files identifying data on all Vermont claims (e.g., procedure codes, national drug codes, diagnosis codes, etc.), and Vermont Medicaid enrolled provider files from the State or its MMIS vendor for use in the patient-level electronic records and in contract operations.	The Contractor shall accept data through suitable, mutually acceptable electronic format and secure transfer processes.	Monthly Data Report
11.	Accept pharmacy claims data from the State, its MMIS and/or PBA vendors for use in the patient-level electronic records.	<p>The Contractor shall accept data through suitable, mutually acceptable electronic format and secure transfer processes.</p> <p>The Contractor shall use pharmacy claims data to report on the chronic care management population in areas to include:</p> <ul style="list-style-type: none"> • Identifying and reducing polypharmacy usage • Recommending dose consolidation as appropriate • Increasing the use of preferred and generic medications by participants • Increasing drug therapy compliance • Reducing duplicate drug therapy 	<p>Monthly Data Report</p> <p>As requested by the State</p>
12.	Use APS CareConnection® to collect self-reported patient level information.	The Contractor shall use APS CareConnection® to capture self-reported individual level data.	N/A
13.	Provide patient-specific information to appropriate healthcare providers, including the Blueprint's chronic care information system.	<p>The Contractor shall provide data through suitable, mutually acceptable electronic format and secure transfer processes.</p> <p>The Contractor shall maintain individual-specific information in CareConnection® and provide access to it to appropriate healthcare providers.</p> <p>Upon provider's request, the Contractor shall provide patient-specific information to the provider via alternative method.</p> <p>Upon request of the State, the Contractor shall provide individual-</p>	Quarterly Report

		specific information to the Blueprint's chronic care information system.	
14.	<p>Provide an easily-accessible database format for individual patient-level: results from stratification, data gathered from HRA's prior to 10/1/08, Care Plans, problems/goals, interventions based on national best practice standards, results from interventions including changes in patient goals accomplished, and transfers among service levels.</p> <p>OVHA designated staff, as authorized by Contractor, will have access to the same data that is used by the Contractor in producing reports from the CareConnection® system. The reporting analyst at APS will continue to be available and primarily responsible for report creation and modification.</p>	The Contractor shall provide data through suitable, mutually acceptable electronic format and secure transfer processes.	Monthly Data Report
15.	Develop best practice quality indicators for targeted conditions and co-morbid conditions.	The Contractor shall develop and distribute quality indicators for OVHA review for target conditions. The Contractor shall collaborate and cooperate in participating in PDSA cycles with the State and its partners. What is learned from the PDSA cycles shall be documented and shared. Contractor shall report results of the quality indicators.	Annual Report of results
16.	Identify barriers and propose interventions, outcomes and measurements that support and integrate with the State's quality assurance performance improvement (QAPI) goals as a Medicaid Managed Care Organization (MCO).	Upon request of the State, the Contractor shall collaborate and cooperate in participating in PDSA cycles with the State and its partners. What is learned from the PDSA cycles shall be documented and shared.	Annual Report
17.	Identify barriers and propose interventions to improve chronic care management for children with special health care needs and adults with severe and persistent mental illness.	Upon request of the State, The Contractor shall collaborate and cooperate in participating in PDSA cycles with the State and its partners. What is learned from the PDSA cycles shall be documented and shared.	Annual Report
18.	Manage and participate in regular advisory committee meetings.	The Contractor shall manage regular professional advisory committee meetings in collaboration with OVHA.	Quarterly Report
19.	Be on site to meet with State staff, consultants,	The Contractor shall exhibit a cooperative and collaborative approach to	Annual Report

	vendors, providers, and other State or Legislative officials at the State's request.	working with the State and its partners.	
20.	<p>Minimum Staffing Levels</p> <p>The Contractor's Executive Director and Medical Director will be approved by the Director of OVHA in writing, and the Director of OVHA will have veto authority over candidates for these positions.</p>	<p>The Contractor shall employ an Executive Director, Medical Director, Program Managers, Nurse Health Coaches, Disease Management Coordinators, Social Worker, and Reporting Analyst in keeping with its proposal to meet the needs of the chronic care initiative enrolled Medicaid population and the outreach and educational needs of Medicaid primary care providers throughout Vermont.</p> <p>The Contractor shall provide organization charts reflecting onsite and offsite staff. Updates will be provided within 10 business days of any changes throughout the course of this contract.</p> <p>The Contractor shall not hire any individual who is excluded from participation in the Medicaid program by the United States Department of Health and Human Services Office of Inspector General as described at http://www.oig.hhs.gov/fraud/exclusions.html.</p>	Annual Report and Organization Chart
21.	Secure and manage office space in Williston, Vermont with reasonable proximity to OVHA offices to maintain a productive work environment for the Contractor staff persons who will be centrally located and for the convenience of OVHA to allow for OVHA personnel to hold meetings and other business activities.	The Contractor shall exhibit a cooperative and collaborative approach to optimize the interaction of APS and OVHA staff to promote the goals of the OVHA.	N/A
22.	Transfer capital equipment purchased under this contract to the State at the time of the termination of the contract.	<p>The Contractor shall transfer all capital equipment to the State at the time of the termination of the contract.</p> <p>In regards to computer equipment, all hardware will be amortized over the expected life of the contract. If the contract ends substantially before the equipment is amortized, equipment equal in value to the amortized amount as determined by the State will become the property of the State. Included will be:</p> <ul style="list-style-type: none"> • Personal computers 	N/A

		<ul style="list-style-type: none">• Local printers• Local network equipment	
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Attachment A – Scope of Work Appendix III Performance Standards & Operational Metrics: Chronic Care Management Intervention Standards

Risk Level	Standard	Report
N/A	<ul style="list-style-type: none"> ▪ One time welcome mailing is sent to all newly identified individuals, in all risk categories, from the periodic population refreshes. <ul style="list-style-type: none"> ○ Mailing sent within thirty (30) days of receipt of population refresh ○ Mailing will include a healthy living action plan/information sheet ▪ Disease-specific information will be sent to beneficiaries as determined by Contractor program staff. 	<p>Monthly Report for the Relevant Month</p> <ul style="list-style-type: none"> ▪ Includes number of individuals sent welcome mailing and number of days post population refresh when accomplished
N/A	<ul style="list-style-type: none"> ▪ Number of unduplicated people served in the Medicaid Chronic Care Initiative between the State and Contractor = 4,000/year. Contractor annual case turnover is estimated at 35%. ▪ Beneficiaries at very high risk who are identified by OVHA or its designee for care coordination are managed by OVHA staff. ▪ Beneficiaries at high, medium and low risk are managed by Contractor staff; additionally, beneficiaries at very high risk not assigned to care coordination are also managed by Contractor. ▪ OVHA and Contractor will work together to clearly define, in writing, operational protocols for co-management of entire population including, but not limited to: <ul style="list-style-type: none"> ○ Definition of “served” ○ Need for assessment ○ Care plan development and documentation procedures ○ Protocols for transitioning beneficiaries among levels of care ○ Case closure protocol 	<p>Complete by December 31, 2008</p>
N/A	<ul style="list-style-type: none"> ▪ Contractor Health Coach and Disease Management Coordinator intervention services as described below will be prioritized to individuals who present very high risk (and not assigned to care coordination) and high risk; medium or low risk individuals may be served secondary to the priority populations. ▪ Individuals who present medium and low risk will receive Interactive Voice Response (IVR) twice/year to outreach and provide access to a Health Coach or Disease Management Coordinator to respond to questions or complete a general assessment. 	<p>Monthly Report</p> <ul style="list-style-type: none"> ▪ Includes activities and interventions by risk level <p>Monthly Report for the Relevant Months</p> <ul style="list-style-type: none"> ▪ Includes number of calls; response rate; number requesting warm transfer to Contractor IVS staff

<p>Very High (not assigned to care coordination)</p>	<ul style="list-style-type: none"> ▪ Welcome mailing (see above) ▪ Completion of appropriate General Assessment <ul style="list-style-type: none"> ○ General assessment completed or no contact letter sent within 21 days of initial attempt to contact member <ul style="list-style-type: none"> ○ Member brochure sent within 7 days of completion of relevant General Assessment ▪ Completion of Relevant Co-Morbid Assessment(s) ▪ Access to RN Health Coach telephonic education and support ▪ Access to Disease Management Coordinator and/or Social Worker telephonic education and support ▪ Disease specific information mailed, as determined appropriate by program staff ▪ Provide face-to-face interventions if essential to achieving Plan of Care ▪ Care plan developed in coordination with the primary care provider via written notification <ul style="list-style-type: none"> ○ Written notification sent to primary care provider within 7 days of individual's consent to participate in disease management services. ▪ Contact with individual in accordance with relevant clinical standards and touch levels as mutually agreed upon and approved by OVHA ▪ Health Coach coordination with primary care provider concerning clinical issues as necessary for individuals ▪ Quarterly physician summary reports identifying: <ul style="list-style-type: none"> ○ Member demographics ○ Members by disease ○ Member risk level ○ Clinical outcome metrics by disease (dependent on access to lab values via VITL) ○ Member utilization of hospital/emergency room 	<p style="text-align: center;">Monthly Report</p> <ul style="list-style-type: none"> ▪ Includes number of assessments (general, CCAF and co-morbid) completed/month by risk level ▪ Includes, at minimum, number, mode, and specific type of activities and interventions completed/month in total, by risk level and by disease (disease specific information to be available with agreed upon implementation date for use of new Education Module) ▪ Includes number of attempts to contact that were unsuccessful ▪ Includes number of no contact letters sent/month for care coordination and chronic care management ▪ Includes number who lost Medicaid eligibility
<p>High</p>	<ul style="list-style-type: none"> ▪ Welcome mailing (see above) ▪ Completion of appropriate General Assessment <ul style="list-style-type: none"> ○ General assessment completed or no contact letter sent within 21 days of initial attempt to contact member 	<p style="text-align: center;">Monthly Report</p> <ul style="list-style-type: none"> ▪ Includes number of assessments (general, CCAF and co-morbid) completed/month by risk level

	<ul style="list-style-type: none"> ○ Member brochure sent within 7 days of completion of relevant General Assessment ▪ Completion of Relevant Co-Morbid Assessment(s) ▪ Access to RN Health Coach telephonic education and support ▪ Access to Disease Management Coordinator and/or Social Worker telephonic education and support ▪ Disease specific information mailed, as determined appropriate by program staff ▪ Provide face-to-face interventions if essential to achieving Plan of Care ▪ Care plan developed in coordination with the primary care provider via written notification <ul style="list-style-type: none"> ○ Written notification sent to primary care provider within 7 days of individual's consent to participate in disease management services. ▪ Contact with individual in accordance with relevant clinical standards and touch levels as mutually agreed upon and approved by OVHA ▪ Health Coach coordination with primary care provider concerning clinical issues as necessary for individuals ▪ Quarterly physician summary reports identifying: <ul style="list-style-type: none"> ○ Member demographics ○ Members by disease ○ Member risk level ○ Clinical outcome metrics by disease (dependent on access to lab values via VITL) ○ Member utilization of hospital/emergency room 	<ul style="list-style-type: none"> ▪ Includes, at minimum, number, mode, and specific type of activities and interventions completed/month in total, by risk level and by disease (disease specific information to be available with agreed upon implementation date for use of new Education Module) ▪ Includes number of attempts to contact that were unsuccessful ▪ Includes number of no contact letters sent/month for care coordination and chronic care management ▪ Includes number who lost Medicaid eligibility
<p>Medium</p>	<ul style="list-style-type: none"> ▪ Welcome mailing (see above) ▪ Completion of appropriate General Assessment <ul style="list-style-type: none"> ○ General assessment completed or no contact letter sent within 21 days of initial attempt to contact member ○ Member brochure sent within 7 days of completion of relevant General Assessment ▪ Completion of Relevant Co-Morbid Assessment(s) ▪ Access to RN Health Coach telephonic education and support ▪ Access to Disease Management Coordinator and/or Social Worker telephonic education and support ▪ Disease specific information mailed, as determined appropriate by program staff ▪ Provide face-to-face interventions if essential to achieving Plan of Care 	<p style="text-align: center;">Monthly Report</p> <ul style="list-style-type: none"> ▪ Includes number of assessments (general, CCAF and co-morbid) completed/month by risk level ▪ Includes, at minimum, number, mode, and specific type of activities and interventions completed/month in total, by risk level and by disease (disease specific information to be available with agreed upon implementation date for use of new Education Module) ▪ Includes number of attempts to contact that were unsuccessful ▪ Includes number of no contact letters sent/month for care coordination and chronic

	<ul style="list-style-type: none"> ▪ Care plan developed in coordination with the primary care provider via written notification <ul style="list-style-type: none"> ○ Written notification sent to primary care provider within 7 days of individual's consent to participate in disease management services. ▪ Contact with individual in accordance with relevant clinical standards and touch levels as mutually agreed upon and approved by OVHA ▪ Health Coach coordination with primary care provider concerning clinical issues as necessary for individuals ▪ Quarterly physician summary reports identifying: <ul style="list-style-type: none"> ○ Member demographics ○ Members by disease ○ Member risk level ○ Clinical outcome metrics by disease (dependent on access to lab values via VITL) ○ Member utilization of hospital/emergency room 	<p>care management</p> <ul style="list-style-type: none"> ▪ Includes number who lost Medicaid eligibility
<p>Low Risk</p>	<ul style="list-style-type: none"> ▪ Welcome mailing (see above) ▪ Completion of appropriate General Assessment <ul style="list-style-type: none"> ○ General assessment completed or no contact letter sent within 21 days of initial attempt to contact member ○ Member brochure sent within 7 days of completion of relevant General Assessment ▪ Completion of Relevant Co-Morbid Assessment(s) ▪ Access to RN Health Coach telephonic education and support ▪ Access to Disease Management Coordinator and/or Social Worker telephonic education and support ▪ Disease specific information mailed, as determined appropriate by program staff ▪ Provide face-to-face interventions if essential to achieving Plan of Care ▪ Care plan developed in coordination with the primary care provider via written notification <ul style="list-style-type: none"> ○ Written notification sent to primary care provider within 7 days of individual's consent to participate in disease management services. ▪ Contact with individual in accordance with relevant clinical standards and touch levels as mutually agreed upon and approved by OVHA ▪ Health Coach coordination with primary care provider concerning clinical issues as necessary for individuals 	<p style="text-align: center;">Monthly Report</p> <ul style="list-style-type: none"> ▪ Includes number of assessments (general, CCAF and co-morbid) completed/month by risk level ▪ Includes, at minimum, number, mode, and specific type of activities and interventions completed/month in total, by risk level and by disease (disease specific information to be available with agreed upon implementation date for use of new Education Module) ▪ Includes number of attempts to contact that were unsuccessful ▪ Includes number of no contact letters sent/month for care coordination and chronic care management ▪ Includes number who lost Medicaid eligibility

	<ul style="list-style-type: none"> ▪ Quarterly physician summary reports identifying: <ul style="list-style-type: none"> ○ Member demographics ○ Members by disease ○ Member risk level ○ Clinical outcome metrics by disease (dependent on access to lab values via VITL) ○ Member utilization of hospital/emergency room 	
<p>Chronic Care Management Maintenance</p>	<p>IVR contact once every six months for a period of one year (2 follow-up contacts) to assess maintenance and offer of renewed access to intervention services if necessary.</p>	<p>Monthly Report for the Relevant Months</p> <ul style="list-style-type: none"> ▪ Includes number of calls; response rate; number of warm transfers to program staff

17. Revise in its entirety Attachment B, Payment Provisions, including Appendices I-IV, by replacing it with:

**ATTACHMENT B
PAYMENT PROVISIONS**

The total maximum amount payable under this contract shall not exceed \$9,552,340. Contractor invoices for assessment and intervention services shall be submitted monthly.

Beginning October 1, 2008, the Contractor invoices for intervention services will be paid in nine equal payments of \$218,095 per month for the remainder of Contract Year 2. For contract year 3 beginning July 1, 2009, the equal monthly payments will be \$226,860. A 15% monthly withhold will apply as referenced below.

It is expected that State care coordination and Contractor chronic care management staff will mutually work together toward achieving savings and population served targets. The savings target for Year 2 of the contract is \$7,109,827. The savings target for Year 3 will be mutually agreed upon prior to June 30, 2009.

During Contract Year 2, no bonus will be available if the minimum of \$7,109,827 savings is exceeded. The State and Contractor may discuss incentive payment for Contract Year 3 and beyond.

The methodology used to calculate savings will be mutually agreed upon by the State and Contractor, and the savings calculation will be performed by a 3rd party. The Contractor may propose a methodology. The 15% withhold will not be at risk for meeting the savings target until the savings methodology is determined and therefore will be prorated for Contract Year 2 from the date agreement is reached. The period of time for which the savings target is determined will be similarly prorated. Until the time agreement is reached on savings methodology, payment of the 15% withhold will follow provisions of the original Contract.

The State has selected the third party evaluator for Year 2. The Contractor may provide a list for the State to consider for the savings evaluation in Year 3 and beyond.

The State and Contractor agree the amounts of the 15% withhold at risk will be proportional to the degree to which the savings target described here is achieved. The actual amounts will be mutually agreed upon by December 31, 2008.

The State and Contractor will work together to assure the completion of the work within the overall budget and the completion of the proposed activities as described in Attachment A and its appendices. In the event the State is unable to operate at or near full staffing, the savings target will be adjusted proportionately.

1. The Contractor agrees to a 15% retainage of each monthly invoice amount to demonstrate full compliance with all requirements and standards including the savings target found in #2 here and all Performance Standards found in Attachment A, Appendices I and III.
2. The 15% withhold, or proportion thereof, will not be paid until after the end of the Contract Year, and only if the Medicaid chronic care initiative achieves a minimum savings of \$7,109,827 or proportion thereof.
3. The State will authorize the retainage payment within 30 days of Contractor demonstrating compliance with the following conditions:
 - a) The Medicaid chronic care initiative savings described in #2 here are achieved.

- b) Contractor completes all work requirements according to the standards, both of which are described in Attachment A, Appendices I and III, including services to a minimum of 2,430 individuals. Contractor fees will not be at risk if the target goal of 1,570 individuals served is not met by State staff.
 - c) Contractor provides the State with all required documentation of completion as described in Attachment A, Appendices I and III.
 - d) State accepts all documentation provided by the Contractor.
4. Failure to Meet Performance Standards. The Contractor may be assessed \$1,000.00 per week per Performance Standard for each week the Contractor fails to meet the Performance Standard as stated in Attachment A, Appendices I and III. Such assessment shall not be made to the extent that the failure can be attributed to:
- Unforeseeable catastrophic events experienced at the Contractor local and corporate facilities,
 - Unforeseeable catastrophic events experienced by State which has a material effect on the Contractor, or
 - Complying with any directions of the State or its employees regarding changes to Scope of Work.
5. The Contractor will submit a monthly bill/invoice for services rendered under this contract to:

Ron Clark, Director, Health Program Integration Unit
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-1201

Innovation Resource Group LLC
d/b/a APS Healthcare Midwest
Attn: Frank Miele, MBA
44 South Broadway, Suite 1200
White Plains, NY 10601-4411

This amendment consists of 29 pages. Except as modified by this amendment, all provisions of this contract (#11303), dated June 15, 2007, shall remain unchanged and in full force and effect.

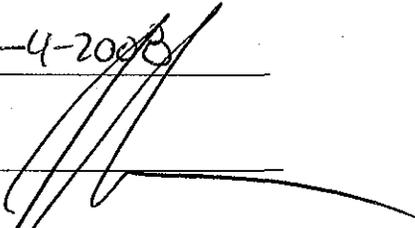
IN WITNESS THEREOF, the parties set forth below agree to execute this Amendment as set forth below:

By the State of Vermont:

By the Contractor:

Date: 12-4-2008

Date: 1/8/09

Signature: 

Signature: 

Name: Joshua Slen
Title: Director
Office of Vermont Health Access

Name: John Tillotson
Title: President, APS Operations
Federal ID #39-2013972