

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, and as amended effective October 1, 2008, referred to hereafter as Amendment #1, are hereby amended to extend the Contract for one (1) additional year as allowed by the original contract. This amendment is effective July 1, 2010 upon execution by the parties, as follows:

1. By deleting on page 1 of 45, Section 3 (Maximum Amount) and substituting in lieu thereof the following Section 3:

Maximum Amount. In consideration of the services to be performed by Contractor, the State agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed **\$11,920,418.00**.

2. By deleting on page 1 of 45, Section 4 (Contract Term) and substituting in lieu thereof the following Section 4:

Contract Term. The period of Contractor's performance shall begin on June 15, 2007 and end on June 30, 2011. This contract may be extended up to three additional years subject to the agreement of both parties.

3. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, I. OVERVIEW, page 1 of 29, by replacing:

"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."

with:

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

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, the original Contract #11303 and its Amendment #1 are binding and considered part of this contract."

4. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, B. Risk Stratification, page 2 of 29, by replacing:

“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.”

with:

“Selection of beneficiaries for the chronic care initiative, and assignment of beneficiaries for care coordination, shall be the responsibility of the OVHA, the Contractor, 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 population receiving health coach and/or care coordination services shall be no fewer than 2,960 Medicaid eligible beneficiaries from July 1, 2010, through June 30, 2011. The goal is for eligible beneficiaries to be self-managing or referred to appropriate support services within 12 months.”

5. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, C. Selection and Transfer, page 3 of 29, by replacing:

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.”

with:

“The Contractor and State shall work in collaboration to provide intervention services to no fewer than

2,960 Medicaid eligible beneficiaries between July 1, 2010 and June 30, 2011. 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 and any revisions for transition of beneficiaries 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."

6. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, D. Health Risk Assessments Administration, page 3 of 29, by replacing:

"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."

with:

"The Contractor shall use an Interactive Voice Recognition (IVR) system to attempt to contact people with identified chronic conditions and as otherwise agreed upon by the State and Contractor. People contacted who request immediate assistance shall be provided a warm transfer to appropriate Contractor or State staff to respond to questions and/or complete a general assessment for consideration for intervention services. Upon request, the Contractor will make the IVR system available for OVHA outreach to beneficiaries targeted for care coordination services. However, Contractor is primarily responsible for beneficiary outreach and engagement."

and by deleting:

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

7. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, F. Call Center and Telephonic Nurse Support/Telephonic Interventions, page 4 of 29, 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 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.”

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 6 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 Amendment #1 Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, G. Face to Face Interventions, page 5 of 29, by replacing:

“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.”

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 3.0 FTE Community Health Coaches. Unless specifically requested by the State, the Contractor shall not serve eligible Medicaid beneficiaries of practices/providers participating in the St. Johnsbury Blueprint for Health Integrated Health Services Pilot identified in July 2008. However, the Contractor may continue to serve individuals the Contractor was serving prior to July 2008 if they otherwise fulfill the criteria and guidelines for continued services. Additionally, the Contractor shall not serve individuals residing in Franklin County and individuals residing in Rutland County, or individuals who are patients of practices located in Rutland or Franklin Counties. However, the Contractor may continue to serve individuals the Contractor was serving in these areas prior to July 1, 2010, providing they otherwise fulfill the criteria and guidelines for continued services. Written protocols will be developed and implemented to transition beneficiaries from APS management to appropriate care coordination services. The goal is for eligible beneficiaries to be self-managing or referred to appropriate support services within 12 months.”

9. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, II. GENERAL DELIVERABLES, H. Provider Outreach and Education, page 5 of 29, by replacing:

“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."

with:

"As of July 1, 2010, Contractor will not engage in provider outreach, education, or engagement activities. However, as appropriate and approved by the State, providers may be contacted for assistance locating and/or engaging eligible beneficiaries."

and:

"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.

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 will not provide quarterly summary reports to physicians.

10. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, III. QUALITY ASSURANCE AND QUALITY IMPROVEMENT REQUIREMENTS, page 6 of 29, by deleting:

"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 Amendment #1 Attachment A, Specifications of Work to be Performed, IV. ADMINISTRATIVE PROVISIONS, page 6 of 29, by replacing:

"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."

with:

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 replacing:

"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"

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 Provider and Member Relations Unit
- Blueprint for Health Goals and Activities
- AHS
- University of Vermont
- Any other OVHA designee"

and by deleting:

"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 Amendment #1 Attachment A, Specifications of Work to be Performed, V. ELECTRONIC DATA REQUIREMENTS, page 8 of 29, 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, the Population Selection and Program Monitoring partner, and/or any other OVHA designee."

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, and/or any other OVHA designee. The Contractor shall provide required population data as needed to the Program Monitoring Partner performing the 3rd party savings calculation and shall provide monthly data on beneficiaries in the buprenorphine program as needed for evaluation of the Capitated Program for the Treatment of Opioid Dependency (CPTOD)."

13. Revise Amendment #1 Attachment A, Specifications of Work to be Performed, VIII. CONTRACT MONITORING REQUIREMENTS, page 8 of 29, 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 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.”

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 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 (Customary Contract Provisions, Records Available for Audit) of the Contract:

1. Uniform records of who has been contacted for enrollment.
2. Uniform records of cases enrolled and not enrolled.
3. 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.).
4. Data on providers linked with successful engagement of beneficiaries, number of patients enrolled in chronic care management services, and progress of participants.
5. 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.).
6. Action plans to increase success with beneficiary engagement.
7. Reason for beneficiary 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.).
8. 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.
 9. Information on intervention activities at the case-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.).
 10. Data on case duration by diagnoses and case duration by risk level.

These records or information shall be available to the State 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 other OVHA designee in database format. The Contractor shall consult with the State and 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 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 Amendment #1 Attachment A, Specifications of Work to be Performed, IX. STATE RESPONSIBILITIES, page 10 of 29, by replacing:

“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.”

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 claims data for population selection.
- c. Monthly claims files on all Vermont program enrollees.
- d. Weekly pharmacy claims files
- e. Up-to-date reference files identifying data on all Vermont claims (e.g., procedure codes, national drug codes, diagnosis codes, etc.).
- f. Monthly Vermont Medicaid enrolled provider lists.

g. Monthly beneficiary telephone number files.”

15. Replace in its entirety Amendment #1 Attachment A – Scope of Work, Appendix I, Performance Standards & Operational Metrics: Intervention Services, pages 12 through 20, and Amendment #1 Attachment A – Scope of Work, Appendix III, Performance Standards & Operational Metrics: Chronic Care Management Intervention Standards, pages 21 through 25, with the following:

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

Requirement	Standard	Report
<p>1. The Contractor shall collaborate and integrate provider outreach activities with the OVHA’s Care Coordination (CC) staff, OVHA’s Communications Unit, OVHA’s Managed Care Unit and any other OVHA designee.</p>	<p>Outreach shall include provisions for primary care providers to be notified of the engagement of one of their patients in Contractor-provided intervention services.</p>	<p>Monthly Report</p>
<p>2. Perform population identification and risk stratification to proactively identify the specific intervention populations. Provide results from population identification and stratification. Assignment of beneficiaries based on risk stratification and other variables including but not limited to housing, severe depression, and/or substance abuse to care coordination or disease management will be determined by OVHA and mutually implemented by OVHA and the Contractor. 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. The following eligible and identified Medicaid beneficiaries will not be served by the Contractor unless specifically requested by the State:</p>	<p>The Contractor shall employ its proprietary disease identification methodology, which currently includes the Johns Hopkins’ Adjusted Clinical Groups (ACGs). Additionally, a consistent method of ongoing population stratification will also be used, which utilizes Medicaid claims. A Total Risk Score (TRS) will be assigned for each program eligible Medicaid beneficiary when sufficient information is available to do so. The methodology will be documented in writing, including risk level cut-off scores, as applicable. Population identification will occur on a quarterly basis with data that have been provided by the State or its partners in a mutually acceptable format.</p> <p>Individual patient-level data from disease identification and 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>

- Individuals identified in the St. Johnsbury Blueprint for Health Integrated Health Services Pilot for participating practices/providers identified in July 2008. However, the Contractor may continue to serve individuals the Contractor was serving prior to July 2008 if they otherwise fulfill the criteria and guidelines for continued services.
- Individuals residing in Franklin County and individuals residing in Rutland County, or individuals who are patients of practices located in Rutland or Franklin Counties. However, the Contractor may continue to serve individuals the Contractor was serving in these areas prior to July 1, 2010, if they otherwise meet the criteria guidelines for continued services. Written protocols will be developed and implemented to transition beneficiaries from APS management to appropriate care coordination services. The goal is for eligible beneficiaries to be self-managing or referred to appropriate support services within 12 months.

Contractor will use an Interactive Voice Recognition (IVR) system in addition to other outreach activities to reach out to Medicaid beneficiaries eligible for disease management or care coordination services unless otherwise excluded as outlined above. For people who wish immediate assistance, the IVR will provide a warm transfer to an appropriate Contractor or State staff person, so the beneficiary may respond to questions and/or complete a general assessment and be considered for intervention services. Upon request, the Contractor will make the IVR system available for OVHA outreach to beneficiaries

Beneficiary outreach/case finding efforts by the Contractor shall be intended to engage 2,960 eligible Medicaid beneficiaries for the mutual VCCI program goal, including care coordination services. Contractor is minimally required to engage 1,798 beneficiaries in VCCI. Engagement is defined as eligible members with a plan of care who meet the criteria for being served during SFY 2011.

Beneficiary outreach and engagement data included in Monthly Report

	<p>targeted for care coordination services.</p> <p>The Contractor and State will jointly serve a minimum of 2,960 individuals during Contract Year 4 (SFY 2011). The capacity to transition beneficiaries between State care coordination staff and Contractor IVS staff is built into the system. The Contractor will propose, and OVHA will approve, monthly monitoring reports. Monthly monitoring will 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, other data currently included in monthly monitoring reports and other data mutually agreed upon by the Contractor and State. The Contractor will provide all required 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 Medicaid beneficiaries and providers during business hours (8 AM-6 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. See Chronic Care Management Intervention Standards below.</p>	<p>Monthly Report</p>
<p>4.</p>	<p>Report intervention metrics (e.g., number and type of mailings and telephone calls, number, type, and mode of interventions provided, etc.) with</p>		<p>Monthly Report</p>

<p>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. Care Plans and intervention activities shall be based upon national best practice standards and evidence-based clinical guidelines for each disease and level of patient risk.</p>	
<p>5. 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>6. Provide printed materials (e.g., Action Plans, referral forms, brochures, etc.) in sufficient quantity for use by both APS and State staff.</p> <p>Request approval from the State in advance of distribution of clinical content.</p>	<p>Contractor shall develop to State standards and supply printed copies of all written materials distributed to beneficiaries, providers, and other public entities, as appropriate.</p> <p>Allow a minimum of 14 working days for State to review materials prior to distribution.</p> <p>Exhibit a cooperative and collaborative approach to working with the State and its partners.</p>
<p>7. Collaborate and integrate activities with:</p> <ul style="list-style-type: none"> • OVHA's Program Monitoring partners • OVHA's Care Coordination (CC) staff • OVHA's Communications Unit • The State's initiatives • Vermont's Blueprint for Health goals and activities • OVHA's Medicaid Management Information System (MMIS) and Fiscal Agent vendor • OVHA's Pharmacy Benefits Administrator 	<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. • The Contractor shall participate in chronic care initiative workgroups. • The Contractor shall accommodate reasonable requests of the State's vendors. The Contractor may not dictate terms of <p>Materials supplied as needed.</p> <p>Written requests for approval of Clinical Materials</p> <p>N/A</p> <p>The Contractor shall participate as requested by the State</p>

	<p>(PBA)</p> <ul style="list-style-type: none"> • OVHA's Member Services vendor • University of Vermont • State and local providers to advance understanding of chronic care • Commercial carriers, whenever possible, to promote consistency across payers. 	<p>collaboration.</p> <ul style="list-style-type: none"> • 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.	<p>Comply with the State's IT requirements.</p>	<p>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 to the original Contract and stored on CD.</p>	<p>N/A The Contractor shall comply as noted</p>
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 Program Monitoring partners or other designee as necessary for the operation and continual improvement of the program.</p>	<p>The Contractor shall accept data through suitable, mutually acceptable electronic format and secure transfer processes.</p>	<p>Monthly Report</p>
10.	<p>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, its MMIS vendor and/or PBA vendor for use in the patient-level electronic records and in contract operations.</p>	<p>The Contractor shall accept data through suitable, mutually acceptable electronic format and secure transfer processes.</p>	<p>Monthly Data Report</p>

11.	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
12.	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-specific information to the Blueprint's chronic care information system.</p>	Monthly Report
13.	<p>Provide an easily-accessible database format for individual patient-level results from stratification, 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>The reporting analyst at APS will continue to be available and responsible for report creation and modification.</p>	The Contractor shall provide data through suitable, mutually acceptable electronic format and secure transfer processes.	Monthly Report
14.	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 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
15.	Identify barriers and propose interventions, outcomes and measurements that support and integrate with the State's quality assurance	Upon request of the State, the Contractor shall collaborate in PDSA cycles with the State and its partners. What is learned from the PDSA cycles shall be documented and shared.	Annual Report

CONTRACT FOR PERSONAL SERVICES

	<p>performance improvement (QAPI) goals as a Medicaid Managed Care Organization (MCO).</p>		
16.	<p>Participate in any OVHA advisory committees as requested by the State.</p>	<p>The Contractor shall participate in advisory committee meetings as requested by the State.</p>	<p>N/A Participation as requested by the State</p>
17.	<p>Be on site to meet with State staff, consultants, vendors, providers, and other State or Legislative officials at the State's request.</p>	<p>The Contractor shall exhibit a cooperative and collaborative approach to working with the State and its partners.</p>	<p>N/A</p>
18.	<p>The Contractor shall provide an appropriately qualified and Vermont-licensed Medical Director for the VCCI.</p>	<p>The Contractor shall employ or contract with a physician to perform Medical Director responsibilities as jointly agreed upon by the Contractor and the State for disease management and care coordination services. Duties will include, but not be limited to, clinical research and quality improvement projects, and clinical support and consultation to APS and all OVHA care coordination staff state-wide.</p>	<p>N/A</p>
19.	<p>Minimum Staffing Levels 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, 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.</p> <p>The Contractor shall employ or contract with a physician to perform Medical Director responsibilities as jointly agreed upon by the Contractor and the State for disease management and care coordination services.</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>	<p>Monthly Report and Organization Chart</p>

<p>20.</p>	<p>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.</p>	<p>The Contractor shall exhibit a cooperative and collaborative approach to optimize the interaction of the Contractor and State staff to promote the goals of the State and the VCCI.</p>	<p>N/A</p>
<p>21.</p>	<p>Transfer capital equipment purchased under this contract to the State at the time of the termination of the contract.</p>	<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 • Local printers • Local network equipment 	<p>N/A</p>

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 quarterly 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. ▪ Annual mailing of evidence-based educational materials for diabetes will be sent to all VCCI eligible beneficiaries identified with a diagnosis of diabetes. This shall occur during the first six (6) months of the State Fiscal Year. 	<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 = 2,960/year. ▪ Beneficiaries at very high risk who are identified by their APS-assigned TRS for care coordination are assigned to OVHA staff. ▪ Beneficiaries at high, medium and low risk are assigned to Contractor staff; additionally, beneficiaries at very high risk not assigned to care coordination are also assigned to Contractor. <p>Actual case assignment is determined through the initial general assessment, including PHQ9 and CAGE scores, and follow criteria and operational protocols jointly developed by Contractor and State staff.</p>	<p>Monthly Report</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, and then to medium or low risk individuals. 	<p>Monthly Report</p> <ul style="list-style-type: none"> ▪ Includes activities and interventions by risk level <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) High 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 	<p>Monthly Report</p> <ul style="list-style-type: none"> ▪ Includes number of assessments (general and disease specific) completed/month by risk level <ul style="list-style-type: none"> ▪ Includes, at minimum, number, mode, and specific type of activities and interventions

<p>Low</p>	<p>General Assessment.</p> <ul style="list-style-type: none"> ▪ Completion of Relevant Disease Specific 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. ▪ 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 evidence-based clinical standards as mutually agreed upon and approved by OVHA. ▪ Health Coach coordination with primary care provider concerning clinical issues as necessary for individuals. 	<p>completed/month in total and by disease</p> <ul style="list-style-type: none"> ▪ Includes number of attempts to contact that were successful ▪ Includes number of no contact letters sent/month for care coordination and disease management
<p>Chronic Care Management Maintenance</p>	<p>IVR or written 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</p> <ul style="list-style-type: none"> ▪ Includes number of contacts and IVR response rate; number of warm transfers to program staff

16. Revise in its entirety Amendment #1 Attachment B, Payment Provisions, p. 27 of 29, by replacing it with:

**ATTACHMENT B
PAYMENT PROVISIONS**

The total maximum amount payable under this contract shall not exceed \$11,920,418. Contractor invoices for assessment and intervention services shall be submitted monthly.

For contract year 4 beginning July 1, 2010, monthly invoices will be \$220,054. The Contractor agrees to a 15% retainage of each monthly invoice amount. Quarterly population refreshes will be invoiced for \$2,500 in the months in which they occur and added to the regular monthly invoice, and will not be subject to the 15% retainage. Obtaining the retainage is subject to the Contractor demonstrating full compliance with all requirements and standards, including the savings target and hospital utilization declines described below and all Performance Standards found in Attachment A, Appendices I and III, including engaging 1,798 beneficiaries in the chronic care initiative. Sixty percent (60%) of the retainage will be at risk for achieving the savings target described below, 30% of the retainage will be at risk for achieving declines in hospital utilization described below, and 10% will be at risk for achieving the beneficiary engagement target.

It is expected that State care coordination and Contractor chronic care management staff will mutually work toward achieving targets for savings, beneficiaries engaged, and declines in hospital utilization.

The savings target for Year 4 of the contract is \$3,960,972.

The savings calculation methodology will be mutually agreed to by both parties and will be applicable to contract year 3 and contract year 4, and the savings calculation will be performed by a 3rd party selected by the State.

Sixty percent (60%) of the retainage will be at risk for achieving the savings target of \$3,960,972, 30% will be at risk for achieving declines in hospital utilization, as follows: 10% decline from the base year rate for emergency department utilization and 10% decline from the base year rate for inpatient admissions. Ten percent (10%) of the retainage will be at risk for engaging a minimum of 1,798 beneficiaries in the chronic care initiative. Every attempt will be made to engage 2,960 beneficiaries in health coaching and/or care coordination services.

If the Contractor achieves 100% of the savings target, it will receive 60% of the entire retainage. If the Contractor achieves 90% or more of the target but less than 100%, it will receive 50% of the retainage allocated to achieving the savings target (30% of the entire retainage). Contractor will not receive any of the 60% retainage allocated to achieving the savings target if it achieves less than 90% of the target.

Thirty percent (30%) of the retainage will be at risk for achieving declines in hospital utilization, as follows: Contractor must achieve *both* a 10% decline in hospital emergency department utilization *and* a 10% decline in inpatient hospital admissions. The Contractor will not receive any of the 30% retainage allocated to achieving the hospital utilization targets if it does not achieve both targets.

Ten percent (10%) of the retainage will be at risk for achieving the target for engaging 1,798 beneficiaries in the chronic care initiative. The Contractor must achieve 100% of the target to receive any of the 10% retainage allocated to the beneficiary engagement target.

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.

1. The 15% retainage or proportion thereof as outlined above, will not be paid until after the end of the Contract Year.
2. 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 above are achieved.
 - b) Contractor completes all work requirements according to the standards described in Attachment A, Appendices I and III, including engagement of a minimum of 1,798 individuals.
 - c) Contractor achieves declines in hospital utilization of both 10% for inpatient admissions and 10% for emergency department visits.
 - d) Contractor provides the State with all required documentation of completion as described in Attachment A, Appendices I and III.
 - e) State accepts all documentation provided by the Contractor.
3. 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.
4. The Contractor will submit a monthly bill/invoice for services rendered under this contract to:

Michael McAdoo, Managed Care Director
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-1201
5. The State will remit all payments electronically as specified by the Contractor. The Contractor's point of contact shall be:

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

This amendment consists of 23 pages. Except as modified by this amendment, all provisions of this contract (#11303), dated June 15, 2007, and its amendment effective October 1, 2008, 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: June 30, 2010

Date: June 30, 2010

Signature: Susan Besio

Signature: Jerry Vaccaro

Name: Susan Besio, Ph.D.
Title: Director
Office of Vermont Health Access

Name: Jerry Vaccaro, M.D.
Title: President and Chief Operating Officer
APS Healthcare