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To: Jeb Spaulding, Secretary of Administration
Thru: Doug Racine, Secretary of Human Services
From: Vicki Loner, Director of the Division of Health Services and Managed Care, DVHA
Date: Friday, March 11, 2011
Re: APS Healthcare, Contract #11303, Amendment #3

Since 2007, DVHA has contracted with APS Healthcare for assistance with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with at least one of eleven targeted chronic health conditions. DVHA currently is in the fourth year of its contract with APS Healthcare. The initial contract period was for three (3) years, with the option to extend the contract for up to an additional four (4) years. At the end of the initial three (3) year period, DVHA extended the contract of one (1) additional year, from July 1, 2010 through June 30, 2011. DVHA felt a one (1) year extension was appropriate so vendor support requirements could be assessed and aligned with changes in the way in which we provide support to Medicaid beneficiaries with complex and costly health conditions.

DVHA is transitioning away from traditional disease management and expanding its care coordination services provided by DVHA nurse case managers and social workers. DVHA has found this approach more effective with its highest cost/highest risk beneficiaries. As DVHA expands this approach, it requires a different kind of support than covered in the existing contract with APS. APS presented a cost neutral proposal to provide services to DVHA that are better aligned with DVHA's current needs. Specifically, APS has proposed to provide an enhanced information technology and sophisticated decision-support system to assist DVHA's care coordinators target the most costly and complex beneficiaries, adjusted with new information as frequently as daily. This enhanced system builds upon the case management and tracking system DVHA staff have been using since 2007. In addition, APS will provide support to DVHA's care coordinators working with provider offices as part of the Blueprint Community Health Teams. APS has guaranteed a 2:1 return on investment by implementing these enhancements, which equates to roughly \$5 million dollars and will bear 100% of the investment for system enhancements if the agreed upon savings are not realized (i.e., full risk contract based upon agreed upon savings methodology).

At this time, DVHA wishes to amend the contract effective upon execution of the amendment by both parties, as well as invoke its option to extend the contract for two (2) additional years, ending June 30, 2013.



AMENDMENT

It is hereby agreed by and between the State of Vermont, Department 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 DVHA Chronic Care Management Program, which includes Intervention Services and Assessment Administration, effective June 15, 2007, referred to hereafter as the Agreement and as amended effective October 1, 2008, referred to hereafter as Amendment #1, and amended effective July 1, 2010, referred to hereafter as Amendment #2, are hereby amended to modify the current contracted activities from April 1, 2011 to June 30, 2011 and to extend the Contract for two (2) additional years as allowed by the original contract. This amendment is effective 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 \$17,201,714.

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, 2013.

3. Revise Amendment #2, Item #3, page 1 of 23, by replacing:

"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."

with:

"The Contractor shall collaborate with the State to conduct an Advanced Improvement Program in the management of a Medicaid chronic care initiative. This program includes key components that will provide a statewide support infrastructure that aligns with Vermont's healthcare reform activities that encourage prevention and wellness, improve care coordination for Vermonters with chronic illness, and minimize avoidable costs of care. This infrastructure solution includes innovative technology for care management; technical assistance and training on the use of the technology and information products; development of evidence-based interventions for use by State staff; a pharmacy analysis and prescriber feedback program; and direct-to-provider interventions conducted by APS staff as directed by the State."

APS will also provide technical assistance by APS Clinical Practice Specialists to support DVHA Care Coordinators with interventions for the high cost, high risk population.

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."

4. Revise Amendment #2, Item #4, page 2 of 23, by replacing language in Amendment #2 with:

"The APS CareConnection^{TM1} application will be enhanced to identify on as frequently as a daily basis the highest cost/highest risk (HC/HR) beneficiaries to target for care coordination interventions, using APS Percolator^{TM2} technology. The PercolatorTM is a proprietary and configurable product that integrates indicators (such as HEDIS^{TM3} measures), public domain and proprietary algorithms, and beneficiary-specific scores from the Chronic Illness and Disability Payment System (CDPS) published by the University of California San Diego (USCD). Algorithms used to identify and stratify the Medicaid beneficiary population at the provider and population levels for interventions will include indicators of uncoordinated care, such as:

- Admissions for Ambulatory Care Sensitive Conditions (using the Agency for Health Care Research and Quality Prevention Quality Indicators).
- Visits to multiple physicians indicating lack of engagement in a medical home.
- Polypharmacy; low medication adherence ratios; inappropriate prescribing.
- Emergency Department visits for non-emergent reasons, using the New York University algorithms to identify these services.
- Other visits to Emergency Departments.
- Acute admissions and readmissions.

APS will provide the technical and clinical staffing to maintain CareConnectionTM and the PercolatorTM, provide technical assistance and training to Care Coordinators employed by the Vermont Department of Health Access (DVHA) as well as clinical support to other State Staff as requested by DVHA, and as authorized by the DVHA will conduct interventions with providers delivering services to high cost, high risk beneficiaries."

5. Revise Amendment #2, Item #5, page 2 of 23, by replacing, by replacing language in Amendment #2 with:

¹ CareConnection is a trademark of APS Healthcare (APS).

² Percolator is a trademark of APS Healthcare.

³ HEDIS is a trademark of the National Committee on Quality Assurance (NCQA).

“As part of the Advanced Improvement Program, DVHA Care Coordinators will automatically receive a daily list of high cost, high risk beneficiaries generated by the Percolator™ using data from a variety of sources (e.g., claims, pharmacy, self report, staff interactions, program goals, hospital ED, discharge lists, etc.) and accessible through CareConnection™. This listing will identify potential highest priority cases for that day and suggest evidence-based interventions to direct Care Coordinator workflow. Care Coordinators will use CareConnection™ to manage workflow as well as document beneficiary assessments, interventions, and other aspects of the plan of care for each beneficiary. This information will also be integrated with the Percolator™ to refine the stratification and prioritization of beneficiaries and Care Coordinator workflow. APS clinical staff will train Care Coordinators in the use of Percolator™-generated beneficiary lists as well as in the use of data-driven workflow. The Contractor will assist DVHA Care Coordinators to organize and prioritize their outreach activities on a daily basis to target beneficiaries with the greatest need based on urgency, ability to impact their behaviors, and other variables including those provided by DVHA. APS Clinical Practice Specialists will also assist DVHA Care Coordinators to conduct interventions with the high cost, high risk population and providers delivering services to those beneficiaries as directed by DVHA.”

6. Revise Amendment #2, Item #6, page 3 of 23, by replacing the language added to the contract by that item with:

“The contractor will support DVHA’s efforts to comply with the new ACA 2703 Health Home standards because it will clearly identify and target individuals who meet the minimum criteria for health home eligibility, i.e., having at least two (2) chronic conditions, or one (1) chronic condition and at risk for another, or one (1) serious and persistent mental health condition. The Contractor will support Care Coordinators and other Agency of Human Services (AHS) partners designated by DVHA, and providers to view performance data on their highest risk beneficiaries including key cost drivers.

Health Risk Assessment Administration is removed from the Scope of Work.”

7. Revise Amendment #2, Item #7, page 3 of 23, by replacing language in Amendment #2 with:

“APS Clinical Practice Specialists will assist DVHA Care Coordinators to conduct interventions with the high cost, high risk population as agreed upon with DVHA.”

8. Revise Amendment #2, Item #8, page 4 of 23, by replacing language in Amendment #2 with:

“As part of the Advanced Improvement Program, the Contractor shall provide training and technical assistance to VCCI Care Coordinators, other care management partners and providers as determined by the State, using multiple methodologies, including face-to-face contact, telephone/conference calls, and internet communications (e.g. WebEx). Follow up communications to reinforce training may be provided by email and US Mail.

APS will coordinate with DVHA to provide community-based care management services in location(s) mutually agreed to by DVHA and APS.”

9. Revise Amendment #2, Item #9, page 4 of 23, by replacing language in Amendment #2 with:

“CareConnection™ will be enhanced to generate Patient Health Briefs to monitor pharmaceutical use, provide clinical alerts when there is a change in status requiring intervention, and identify gaps in evidence-based care that drive utilization and clinical outcomes. CareConnection™ will also generate provider-specific Patient Registries for Care Coordinators and providers that assist providers with identifying gaps in care for specific patients. APS Clinical Practice Specialists will work with Care Coordinators and other practice staff as appropriate to integrate Patient Health Brief and Patient Registry information into provider office workflow, address gaps in care, and help improve the delivery of evidence-based care for all beneficiaries, with an emphasis on their highest cost, highest risk patients. Contractor will also offer a website for providers to access information and tools, such as evidence-based care, reports, and other information. The providers will have current and complete information about the member’s treatment and progress via the CareConnection™ Plan of Care. Contractor staff will deliver feedback, technical assistance and training to providers as directed by the State.”

10. Revise Amendment #2, Item #11, page 5 of 23, by replacing language in Amendment #2 with:

“The Contractor shall request and receive approval from the State in advance of distribution of any materials with clinical content. 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.

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
- DVHA’s care coordination services and VCCI leadership
- DVHA’s Provider and Member Relations Unit
- Blueprint for Health Goals and Activities
- AHS
- University of Vermont
- Any other DVHA designee”

11. Revise Amendment #2, Item #12, page 7 of 23, by replacing language in Amendment #2 with:

“The Contractor shall accept data in a mutually acceptable electronic format using secure transfer processes. Data sources include the State, the MMIS contractor, Covisint DocSite, the PBA, and/or any other DVHA designee. The Contractor shall provide required data as

needed to the Program Monitoring Partner performing the 3rd party savings validation. The Contractor will configure CareConnection™ to receive clinical and other information from Covisint DocSite, the registry selected by Vermont for use with the Blueprint for Health and the Vermont Chronic Care Initiative.”

12. Revise Amendment #2, Item #13, page 7 of 23, by replacing language in Amendment #2 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 identified as a beneficiary and who is considered to be “high cost/high risk.”
2. 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.).
3. Data on providers linked with successful engagement of beneficiaries, number of patients enrolled in chronic care management services, and progress of participants.
4. 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.).
5. 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.).
6. Participant progress during intervention services, including Plan of Care, Care Coordinator 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.
7. Information on intervention activities at the case-level for the beneficiary population receiving interventions as entered by Care Coordinators (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.).

8. Data on case duration by diagnoses and case duration by risk level.
9. Monthly and quarterly reports on:
 - a. Utilization and cost indicators.
 - b. Uncoordinated care indicators.
 - c. Care Coordinator performance against key indicators.
 - d. Quality of care indicators.
 - e. Return on Investment (ROI) analyses.

These records or information shall be available to the State or any other DVHA 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 DVHA designee in database format. The Contractor shall consult with the State and any other DVHA designee on the creation of appropriate data collection instruments and coding of responses for assessments, 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 DVHA 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.”

13. Revise Amendment #2, Item #14, page 9 of 23, by replacing, by replacing language in Amendment #2 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 the following information with updates as frequently as possible:

- a. Eligibility files of all Vermont Medicaid program enrollees.
 - b. Claims files on all Vermont program enrollees.
 - c. Pharmacy claims files.
 - d. Data from Utilization Management files that represent authorization determinations for inpatient and other prior authorized care as available and approved by DVHA.
 - e. Up-to-date reference files identifying data on all Vermont claims (e.g., procedure codes, national drug codes, diagnosis codes, etc.).
 - f. Vermont Medicaid enrolled provider lists.
 - g. Beneficiary telephone number files.”
14. Replace in its entirety the material added by Amendment #2, Item #15, pages 11-20 of 23, with the following:

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

Requirement	Standard	Report
<p>1. The Contractor will implement elements of the Advanced Improvement Program according to the timeline defined in the corresponding Standard.</p>	<p>Planning and Training: 6/1/11: In collaboration with DVHA, a comprehensive Provider Education and Training Plan will be developed. With DVHA approval, this plan will include provider trainings in the Advanced Improvement Program tools to enhance provider service to high risk beneficiaries, consistent with the Provider Education and Training Plan. 7/1/11: All DVHA Care Coordinator staff will be trained in the use of the new CareConnection™ application and able to use the system in their work with high risk beneficiaries. 7/1/11: In collaboration with DVHA, meetings with high volume providers will have occurred that include planning sessions to implement use of the CareConnection™ provider tools in the provider settings. “High volume providers” are defined as the providers who serve the largest number of high risk/ high cost members. A minimum of one (1) meeting with each of the high volume providers that together account for 75% of high risk members will occur by 7/1/11.</p> <p>CareConnection™: 6/1/11: The new CareConnection™ application will be online in Vermont for both APS and DVHA staff with eligibility, claims and provider data loaded. Six (6) weeks after DVHA and APS finalize the Percolorator™ system logic and triggers, and all necessary data is loaded into the CareConnection™ system (but no sooner than 6/1/11), the Percolorator™ will be online and operational. Necessary data to enable Percolorator™ operations include, in addition to</p>	<p>Monthly Report</p>

Requirement	Standard	Report
	<p>clinical data from the current CareConnection™ application:</p> <ol style="list-style-type: none"> 1. Eligibility files of all Vermont Medicaid program enrollees. 2. Claims files on all Vermont program enrollees. 3. Pharmacy claims files. 4. Data from Utilization Management files that represent authorization determinations for inpatient and other prior authorized care as available and approved by DVHA. 5. Up-to-date reference files identifying data on all Vermont claims (e.g., procedure codes, national drug codes, diagnosis codes, etc.). 6. Vermont Medicaid enrolled provider lists. 7. Beneficiary telephone number files. <p>7/1/11: Patient Registry and Patient Health Brief will be available for use by DVHA Care Coordinators and APS Clinical Practice Specialists.</p> <p>Patient Registry consists of: Algorithm to associate patients with providers; Condition-specific patient panel for providers; Alerts to provider of gaps in care</p> <p>Patient Health Brief contains: Individualized patient information; Monitor pharmaceutical use/prescribing; multiple prescribers, etc. Provide clinical alerts, advice, support for providers; Notifies physicians when member may exhibit a change in status requiring provider intervention.</p>	

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	<p>Legacy Vermont CareConnection™ clinical information (existing treatment plans/assessments/history) may be ported over to the new CareConnection™ as required by DVHA. DVHA and Contractor will discuss specific content and timing of this activity to ensure optimal functionality of the new CareConnection™ application and usability by DVHA Care Coordinators. By 6/1/11, a transition plan will be developed to port over clinical information on existing cases. The legacy Vermont CareConnection™ system will continue to be operational until October 1, 2011, or as long as needed to ensure there are no gaps in historical clinical data during the transition to the new CareConnection™ application.</p>	
<p>2. The Contractor shall collaborate and integrate provider outreach activities with the DVHA's Care Coordination (CC) staff, the Blueprint for Health, DVHA's Health Services, Managed Care Division and any other DVHA designee.</p>	<p>Contractor Clinical Practice Specialist Outreach will focus on providers of highest priority members as directed by DVHA delivering Patient Health Briefs to identify urgent concerns with care and patient registries to identify patients with chronic disease and gaps in care.</p>	<p>Monthly Patient Health Briefs and Patient Registries</p>
<p>3. Perform population identification and risk stratification to proactively identify the specific intervention populations. Provide results from population identification and stratification.</p>	<p>CareConnection™ will be enhanced to identify <i>on a daily basis</i> the highest cost/highest risk (HC/HR) beneficiaries to target for care coordination interventions, using APS Percolator™ technology.</p>	<p>Daily update to individual beneficiary risk scores. Aggregate risk results and analyses provided quarterly.</p>
<p>4. 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. All tools selected must be approved by the State prior to use.</p>	<p>Written requests for approval of tools</p>

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	Approved exceptions to commercially available tools may include products that are proprietary to APS or that have been customized. These may be available via contract or agreement with APS.	
5. Assist DVHA Care Coordinators with interventions for the high cost, high risk population, including outreach to beneficiaries and providers, as determined in collaboration with DVHA.	Clinical Practice Specialists will provide technical assistance and support to DVHA Care Coordinators.	Monthly Report
6. APS will provide written materials in sufficient quantities for use by State and Contractor staff and conduct occasional targeted mailings to members as agreed to with DVHA.	APS will provide written materials including Action Plans and other clinical and educational information to DVHA Care Coordinators. In collaboration with DVHA, APS will conduct targeted mailings to focused, high risk, high cost members	Monthly Report
7. Report intervention metrics (e.g., 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. 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.	Documentation and reporting will be mutually agreed upon by Contractor and DVHA.	Monthly Report
8. Collaborate and integrate activities with: <ul style="list-style-type: none"> • DVHA's Program Monitoring partners • DVHA's Care Coordination (CC) staff • DVHA's VCCI leadership • The State's initiatives • Vermont's Blueprint for Health goals and activities 	<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. • The Contractor shall participate in chronic care initiative workgroups. • The Contractor shall accommodate reasonable requests of the 	N/A The Contractor shall participate as requested by the State

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Requirement	Standard	Report
<ul style="list-style-type: none"> • DVHA's Medicaid Management Information System (MMIS) and Fiscal Agent vendor • DVHA's Pharmacy Benefits Administrator (PBA) • DVHA's Health Services and Managed Care Division • DVHA'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>State's vendors. The Contractor may not dictate terms of 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. 	
9.	<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 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>	N/A The Contractor shall comply as noted
10.	<p>Accept data from the State or its vendors for names, identification numbers, addresses, and phone numbers on all Vermont Medicaid program enrollees. 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>	Monthly Data Report

	Requirement	Standard	Report
11.	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.	The Contractor shall accept data through suitable, mutually acceptable electronic format and secure transfer processes.	Monthly Data Report
12.	Use APS CareConnection™ to collect self-reported patient level information.	The Contractor and DVHA Care Coordinators will be responsible for this function.	N/A
13.	Provide patient-specific information to appropriate healthcare providers, including the Blueprint's clinical 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 clinical information system.</p>	Monthly Report
14.	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. The APS Reporting Analyst will continue to be available and responsible for report creation and	The Contractor shall provide data through suitable, mutually acceptable electronic format and secure transfer processes.	N/A

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Requirement	Standard	Report
<p>modification.</p> <p>15. Develop best practice quality indicators for high cost, high risk beneficiaries.</p>	<p>The Contractor shall develop and distribute quality indicators for DVHA review for the high cost, high risk population and providers delivering services to those beneficiaries. 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.</p>	<p>Annual Report</p>
<p>16. Identify barriers and propose interventions, outcomes and measurements that support and integrate with the State's Quality Assurance and Performance Improvement (QAPI) goals as a Medicaid Managed Care Entity (MCE).</p>	<p>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.</p>	<p>Annual Report</p>
<p>17. Participate in any DVHA 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>
<p>18. 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>
<p>19. The Contractor shall provide an appropriately qualified and Vermont-licensed Medical Director for the Advanced Improvement Program and 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 Advanced Improvement 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 DVHA care coordination staff state-wide.</p>	<p>N/A</p>
<p>20. Minimum Staffing Levels The Contractor's Program Director, Clinical Specialist Liaison, and Medical Director will be approved by the Commissioner of DVHA or designee in writing, and the Commissioner of</p>	<p>The Contractor shall employ a Program Director, Clinical Manager, Clinical Practice Specialists, Clinical Specialist Liaison, Clinical Informatics Manager, Health Intelligence Analyst, Clinical Pharmacist and Reporting Analyst, and contract with a Medical Director in keeping with its proposal to meet the needs of the Medicaid population.</p>	<p>Monthly Report and Organization and Organization Chart</p>

Requirement	Standard	Report
<p>DVHA will have veto authority over candidates for these positions.</p>	<p>APS clinical and technical staff will be based in Vermont for training and assistance to Care Coordinators and providers, as well as conducting provider interventions as directed by the State. This training and technical assistance will support the use of CareConnection™ by DVHA care coordinators and engage providers to promote care coordination.</p> <p>Clinical Practice Specialists are Registered Nurses, licensed in Vermont. They will assist the DVHA Care Coordinators with limited telephonic care management and health coaching with the high risk, high cost Medicaid members through at least SFY 2012. Case loads will be 50 beneficiaries or less. In their role, they will also complement activities for which the Care Coordinators are responsible. Activities may include, for example, outreach to providers of high acuity members with Patient Health Briefs, Patient Registries, and specific care coordination activities requested by the provider, such as follow up calls to practice office staff. At least two (2) Clinical Practice Specialists will be located primarily in community settings, as agreed upon with the State.</p> <p>Certain technical staff may be based outside of Vermont, as mutually agreed to by both the State and the Contractor.</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 services.</p> <p>The Contractor shall employ a Clinical Specialist Liaison who will work closely with the DVHA VCCI Leadership to ensure effective and close collaboration between the APS and DVHA programs. This position</p>	

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	<p>shall be located on-site at DVHA (in a work space to be provided by DVHA) at least 75% of the time when not working with Care Coordinators in the field.</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>Contractor shall continue to maintain office space in Williston, VT that provides a productive work environment and for the convenience of DVHA to hold meetings and other business activities.</p>	N/A
<p>21. Secure and manage office space in Williston, Vermont with reasonable proximity to DVHA offices to maintain a productive work environment for the Contractor staff persons who will be centrally located and for the convenience of DVHA to allow for DVHA personnel to hold meetings and other business activities.</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 	N/A
<p>22. Transfer capital equipment purchased under this contract to the State at the time of the termination of the contract.</p>	<p>The Contractor shall provide required data as needed to the Program Monitoring Partner performing the 3rd party savings validation.</p>	Required data provided by dates
<p>23. The Contractor recognizes that the State will monitor the implementation, operations, and results</p>		

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Requirement	Standard	Report
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.		determined by the State.

15. Replace in its entirety the material added by Amendment #2, Item #16, pages 21-22 of 23, with the following:

**ATTACHMENT B
PAYMENT PROVISIONS**

The maximum dollar amount payable under this agreement is not intended as any form of a guaranteed amount. The Contractor will be paid for services specified in Attachment A, or services actually performed, up to the maximum allowable amount specified in this agreement. State of Vermont payment terms are Net 30 days from date of invoice, payments against this contract will comply with the State's payment terms. The payment schedule for delivered products, or rates for services performed, and any additional reimbursements, are included in this attachment. The following provisions specifying payments are:

The total maximum amount payable under this contract shall not exceed \$17,201,714. Contractor invoices for services shall be submitted monthly.

Payment for the Advanced Improvement Program and care management support, for the last three months of contract year 4 beginning April 1, 2011, and all of contract years 5 and 6, ending June 30, 2013 shall be based on monthly invoices in the amount of \$220,054. Effective April 1, 2011 there will be no monthly retainage.

Contract Year 4 Retainage and Performance Standards

Obtaining the total retainage (of \$297,073) withheld in the first nine (9) months of contract year 4 is subject to the Contractor demonstrating full compliance with all contract year 4 requirements and standards as described in Amendment #3, including performance standards described below and all Performance Standards found in Attachment A, Appendices I and III. Sixty percent (60%) of the retainage will be at risk for achieving critical healthcare infrastructure Information Technology (IT) implementation target dates below, thirty percent (30%) of the retainage will be at risk for achieving key Planning and Training implementation benchmarks described below, and ten percent (10%) will be at risk for achieving the beneficiary engagement target.

- Sixty percent (60%) (\$178,244) of the retainage will be at risk for achieving the critical healthcare infrastructure Information Technology (IT) implementation dates as follows:
 - 6/1/11: The new CareConnection™ application will be online in Vermont for both APS and DVHA staff with eligibility, claims and provider data loaded.
 - Six (6) weeks after DVHA and APS finalize the Percolator™ system logic and triggers, and all necessary data is loaded into the CareConnection™ system (but no sooner than 6/1/11), the Percolator™ will be online and operational.
 - 7/1/11: Patient Registry and Patient Health Brief tools will be available for use by DVHA Care Coordinators and APS Clinical Practice Specialists. Legacy Vermont CareConnection™ clinical information (existing treatment plans/assessments/history) may be ported over to the new CareConnection™. DVHA and APS will discuss specific content and timing of this activity to ensure optimal functionality of the new CareConnection™ application and usability by DVHA Care Coordinators. A transition plan to port over clinical information on existing cases will be developed by 6/1/11.

- 30% (\$89,122) will be at risk for achieving key Planning and Training implementation benchmarks for the Advanced Improvement Program as follows:
 - By 7/1/11 all DVHA Care Coordinator staff will be trained in the use of the new CareConnection™ application and able to use the system in their work with high risk beneficiaries.
 - By 6/1/11, in collaboration with DVHA, a comprehensive Provider Education and Training Plan will be developed. With DVHA approval, this plan will include provider trainings in the Advanced Improvement Program tools to enhance provider service to high risk beneficiaries.
 - Consistent with the Provider Education and Training Plan and in collaboration with DVHA, by 7/1/11 meetings with high volume providers will have occurred that include planning sessions to implement use of the CareConnection™ provider tools in the provider settings. A minimum of one (1) meeting with each of the six (6) highest volume provider organizations that together serve the largest proportion of high risk members will occur by 7/1/11.
- 10% (\$29,707) is based on engaging 1,349 beneficiaries in contract year 4.

If the Contractor achieves all three (3) of the healthcare infrastructure (IT) implementation target dates, it will receive 60% (\$178,244) of the entire retainage. Contractor will not receive any of the 60% retainage allocated to achieving IT target dates if it does not achieve all 3 of the target dates.

Thirty percent (30%) (\$89,122) of the retainage will be at risk for achieving key Planning and Training implementation benchmarks, as follows: Contractor must achieve all three (3) of the Training and Planning implementation benchmarks by the target date of 7/1/11. The Contractor will not receive any of the 30% retainage allocated to achieving the key Planning and Training implementation benchmarks if it does not achieve all three (3) of the targets.

Ten percent (10%) of the retainage will be at risk for achieving the target for engaging 1,349 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.

Contract Year 5 and Contract Year 6 Cost Savings

The Contractor will have 100% of its annual fees associated with the Advanced Improvement Program at risk to achieve \$5,000,000 in cost savings in Contract Year 5 (ending June 30, 2012). The annual fees associated with the Advanced Improvement Program total \$2,500,000. The Contractor will have 100% of its fees associated with the Advanced Improvement Program, (\$2,500,000) at risk to achieve \$5,000,000 in cost savings in Contract Year 6 (ending June 30, 2013). Each performance period will be evaluated separately and savings will not be counted cumulatively from one year to the next. A third party selected by the State will conduct and/or validate a formal ROI analysis on an annual basis using methodology adapted from the ROI methodology used in the *Blueprint for Health* evaluation as agreed upon with DVHA, which may include but not be limited to:

- Admissions to acute care.
- Emergency Department Utilization.
- Readmissions to Acute Care.
- Selected Pharmacy Costs.

One hundred percent (100%) of the Contractor's annual fees associated with the Advanced Improvement Program (\$2,500,000 each year) are at risk in each of the Contract Years 5 and 6 to achieve \$5,000,000 in

**STATE OF VERMONT
 AMENDMENT TO CONTRACT FOR PERSONAL SERVICES
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cost savings. If the savings are less than \$5,000,000, the Contractor will pay back the difference between \$5,000,000 and the amount saved, up to a maximum payback of \$2,500,000.

Annual Guaranteed Net Savings to Vermont (after contractor cost)	Actual Annual Net Savings Achieved	Contractor Refund to Vermont	Total Annual Savings to Vermont
\$2,500,000	\$2,500,000	\$0	\$2,500,000
\$2,500,000	\$2,000,000	\$500,000	\$2,500,000
\$2,500,000	\$1,500,000	\$1,000,000	\$2,500,000

Contractor will provide a surety bond to the State for \$2,500,000 each year to ensure availability of funds should Contractor fail to achieve the annual savings and fail to refund the difference between the guaranteed and actual savings. Contractor will secure the bond immediately upon execution of this contract amendment and provide documentation to the State. The Contractor must provide the State's Managed Care Director formal notice of issuance of such bond within thirty (30) days of contract amendment execution. Contractor will consult and involve the State's legal and finance personnel, as needed.

Contractor is required to reimburse the State within thirty (30) days of written notification from the State of failure to meet the \$2.5 Million net savings goal.

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 7/1/11.
2. The State will authorize the retainage payment within 30 days of Contractor demonstrating compliance to the State's satisfaction with the following conditions:
 - a) The Advanced Improvement Program IT implementation dates 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 1,349 individuals during Contract Year 4.
 - c) Contractor achieves Advanced Improvement Program Planning and Training implementation benchmarks as described above.
 - 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,

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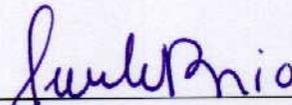
- Unforeseeable catastrophic events experienced by State which has a material effect on the Contractor, or
 - Complying with any directions of the State or its employees regarding changes to Scope of Work.
4. The Contractor will submit a monthly bill/invoice for services rendered under this contract to:
Michael McAdoo, Managed Care Director
Department 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

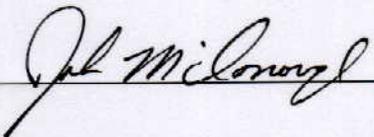
This amendment consists of 20 pages. Except as modified by this amendment, all provisions of this contract (#11303), dated June 15, 2007, and its amendment effective October 1, 2008 and July 1, 2010, shall remain unchanged and in full force and effect.

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

**STATE OF VERMONT
Department of Vermont Health Access**

**CONTRACTOR
APS Healthcare**

By: 
Susan Besio, Commissioner

By: 

Date: 5/4/11

Date: 4/27/11