

AMENDMENT

It is hereby agreed by and between the State of Vermont, Agency of Human Services, Department of Vermont Health Access (hereafter referred to as the "State" or the "Department") and HP Enterprise Services, LLC, a Delaware limited liability company (hereafter referred to as the "Contractor") that the Title XIX Medicaid Contract for operation of the Vermont Medicaid Management Information System (MMIS), entered into January 01, 2004 (hereafter referred to as the "Contract"), is hereby amended effective upon execution by the Department's Director, as follows:

1. Replace in Amendment # 13, Item #1, page 1 of 12, with the following:

"5. Maximum amount: The State agrees to pay Contractor pursuant to the payment provisions specified in Attachment B, a sum not to exceed \$ 156,264,431.41

2. By adding Attachment F Part XIII Narrative and Price Proposal dated January 11, 2013, which is an attachment of this amendment on page 2.

This amendment consists of 10 pages. Except as modified by this amendment and any previous Amendments, all provisions of this contract (#8430), dated January 1, 2004, shall remain unchanged and in full force and effect.

STATE OF VERMONT

Department of Vermont Health Access

By: _____
Mark Larson, Commissioner
Department of Vermont Health Access

Date: _____

CONTRACTOR:

HP Enterprise Services, LLC

By: _____
Diane Evenson, Director
US Government, State and Local

Date: _____

Attachment F, Part XIII

HP Narrative and Price Proposal January 11, 2013

Medical Assistance Provider Incentive Repository (MAPIR)

Core MAPIR Ongoing Development and Support:

The State of Vermont participated in the development of the core MAPIR application in coordination with State of Pennsylvania. The ongoing enhancements, support and maintenance of the Core MAPIR application will be reimbursed to HP on a quarterly basis throughout the term of the contract and/or until the State discontinues the use of the application. The annual pricing will be presented to the state through the MAPIR Collaborative no later than October 1st of the preceding year. However, by mutual agreement and in accordance with the approved statement of work, pricing may be adjusted if the number of members in the MAPIR Collaborative increases or decreases. For planning purposes, HP provides the following payment schedule for calendar years 2014 through 2016.

Services Provided	Time Period	Payment Date	Quarterly Price Per State
MAPIR: Enhancements, Ongoing Support and Maintenance	Jan. – March	March	\$61,638.50
MAPIR: Enhancements, Ongoing Support and Maintenance	April – June	June	\$61,638.50
MAPIR: Enhancements, Ongoing Support and Maintenance	July – September	September	\$61,638.50
MAPIR: Enhancements, Ongoing Support and Maintenance	October – December	December	\$61,638.50
TOTAL ANNUAL AMOUNT			\$246,554.00
TOTAL FOR 3 YEARS			\$739,662.00

VT Specific MAPIR Integration/Customization:

The scope of this effort is specific to the integration of the Core MAPIR enhancements into the VT MMIS environment; any associated custom effort required for Vermont specific needs and ongoing production maintenance activities.

Installation and Customization of Core MAPIR release(s) estimates for calendar years 2014 through 2016:

MAPIR Installation and Customization	Hours*	Estimated Cost
Environmental Changes (DB2/WebSphere/Stored procedures)	200	\$22,932
MAPIR Installation	120	\$13,759
State Configuration	80	\$9,173

Interface Development		
Additional Customization	220	\$25,225
Project Management		
Project Management	80	\$9,173
Testing		
Testing of Installation and Customization	120	\$13,759
VT Application Production Support		
Ongoing Technical Support of VT production environment	240	\$27,518
Grand Total Annual Estimates	1060	\$121,539
TOTAL FOR 3 YEARS		\$364,617

**The hours and associated estimated costs provided above are estimates only. HPES will produce a monthly bill for the actual hours used each month. The bill will include the hours used for each activity listed below. HPES will be reimbursed at the modification hourly rate for additional CSR Hours as described in Section 11 as modified by Amendment 5. The estimates provided above are based on the 2013 modification hourly rate of \$114.66.*

ICD-10 Phase 3 Remediation

The scope of this effort is specific to the Phase 3 of the ICD-10 project related to the remediation of all the impacted systems, policies and processes to support both ICD-9 and ICD-10 code sets beginning October 1, 2013. These estimates are based on the approved ICD-10 Phase 2 Deliverable – Work Effort Estimate document V.1 exhibit C for the work to be performed during the period of 01/01/2014 through 12/31/2014.

Staffing Plan

Project Role	Responsibility	FTE	Man - Months
Project Manager	Overall project management	1	12
Customer Service Representative	Post-deployment call center support	2	18
EDI Specialist (Help Desk)	EDI Support	1	9
Total Staffing Effort		4	39

Estimated Costs

Activity	Hours*	Cost
Project Management	1,680	\$189,420
EDI Support	1,260	\$142,065
Post Deployment Call Center	2,520	\$284,130
Total Project Cost	5,460	\$615,615

**The hours and associated costs provided are estimates only for planning purposes. HPES will produce a monthly bill for the actual hours used each month. The bill will include the hours used for each activity listed above. HPES will be reimbursed at the modification hourly rate of \$112.75 per hour as described in Amendment 12, Attachment F, Part XI - ICD-10 remediation project work.*

ACA Section 1104 Compliance

Core Development

Section 1104 of the ACA (H.R.3590) established new requirements for the administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs. All HIPAA covered entities must comply with the CACQ CORE operating rules. The State of Vermont has indicated participation in the HP leveraged approach to assess, design, develop and implement a technical solution in support of the ACA 1104 Operating Rules for HIPAA electronic transactions as evidenced by the attached signed letter of intent (Exhibit A). The leveraged solution will be implemented by each of the HPES MMIS States that utilize HPES's shared HIPAA translator infrastructure.

DVHA agrees to the payment schedule presented below under Cost Per State related to the application design and development and the purchase, installation, maintenance, and ongoing hosting of infrastructure. However, by mutual agreement and in accordance with the approved statement of work, pricing may be adjusted if the number of states participating increases or decreases. The pricing presented below represents the cost per state with 5 states participating.

Core Design and Development

Design and Development Fee Schedule	Payment Date	Cost Per State
Infrastructure Rules Assessment & Design Document	May 2013	\$39,400
Development of Code Release for Infrastructure Connectivity Rules and installation of shared hardware/software platform complete	October 2013	\$197,000
Initial Infrastructure Fee	May 2013	\$25,500
Total		\$261,900

Installation of the leveraged Solution

Installation	Hours *	Cost
Project management	50	\$5,733
Installation	450	\$51,597
Total	500	\$57,330

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Data Content Rules

Installation	Hours *	Cost
Code Development	356	\$40,818
Testing	44	\$5,045
Implementation	30	\$3,440
Total	430	\$49,303

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reimbursed at the modification hourly rate for additional CSR Hours as described in Section 11 as modified by Amendment 5. The estimates provided above are based on the 2013 modification hourly rate of \$114.66.

Ongoing Infrastructure

Installation	Payment Date	Cost
Ongoing Infrastructure and Maintenance Fee	Monthly	\$9,500
Total cost from 7/13-12/16		\$399,000

Enhanced PCP Bump

The Affordable Care Act (ACA) introduced enhanced federal participation match rates for Primary Care Providers (PCP) for dates of service between January 1, 2013 and December 31, 2014 whereby Medicaid agencies will receive 100% matching funds for the difference between the Medicaid rates on file as of July 1, 2009 to the Medicare rate set as of Jan 1, 2013. The estimates below include the effort to implement the MMIS pricing methodology changes and resulting reporting requirements to support this rule.

HP's Provider enrollment responsibilities for this are still in a state of flux, current impact will require additional staff to validate the attestations from the providers. Since this will be a short term need, HP will include cost associated with hiring a temporary employee for two months estimated at \$7500.

PCP Bump Implementation

Activity	Hours *	Cost
Provider Enrollment / Attestation Process	65	\$7,453
MMIS Modifications Rates	304	\$34,856
MMIS Modifications Reporting	87	\$9,975
Total	456	\$52,284

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ACA – CACH Core Phase III 835 RA Transaction

Section 1104 of the ACA (H.R.3590) established new requirements for the administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs. All HIPAA covered entities must comply with the CACQ CORE operating rules. Phase III CORE includes rules around the health care claim payment/advice transaction to allow the industry to leverage its investment in the Phase I and Phase II CORE infrastructure rules and apply them to conducting the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) transaction. HP provides the following high level estimates associated with the MMIS modifications necessary to support this rule.

ACA -835

Activity	Hours *	Cost
Project Management	35	\$4,013
Assessment / Requirements / Design	20	\$2,293
Construction	570	\$65,356
Testing	90	\$10,319
Provider Communication Materials	10	\$1,147
Total	725	\$83,129

**The hours and associated estimated costs provided above are estimates only. HPES will produce a monthly bill for the actual hours used each month. The bill will include the hours used for each activity listed below. HPES will be reimbursed at the modification hourly rate for additional CSR Hours as described in Section 11 as modified by Amendment 5. The estimates provided above are based on the 2013 modification hourly rate of \$114.66.*

ACA - EFT

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The ACH CCD+ and CTX EFT standards will carry all necessary information for an EFT to be correctly processed, recorded, posted and identified by all parties to the EFT. HP provides the following high level estimates associated with the MMIS modifications necessary to support this rule.

EFT

Activity	Hours *	Cost
Project Management	30	\$3,440
Assessment / Requirements / Design	20	\$2,293
Construction	490	\$56,183
Testing	93	\$10,663
Provider Communication Materials	10	\$1,147
Total	643	\$73,726

**The hours and associated estimated costs provided above are estimates only. HPES will produce a monthly bill for the actual hours used each month. The bill will include the hours used for each activity listed below. HPES will be reimbursed at the modification hourly rate for additional CSR Hours as described in Section 11 as modified by Amendment 5. The estimates provided above are based on the 2013 modification hourly rate of \$114.66.*

DUALS Demonstration Grant

The State of Vermont has submitted a proposal to CMS to receive funding through CMS' State Demonstrations to Integrate Care for Dual Eligible Individuals. The goal of this Demonstration is to fully integrate the delivery and financing of Medicare and Medicaid services for Vermont's 22,000 dual eligible individuals.

Vermont will utilize the State's public Managed Care Entity (MCE) to serve the dual eligible population rather than contracting with a private Managed Care Organization (MCO). The MCE will contract with existing qualified providers to serve as Integrated Care Providers (ICP) responsible for providing, coordinating and integrating a wide range of health, mental health, substance abuse, developmental, long term care and support services for these individuals. The same providers could also opt to be Integrated Care Providers PLUS (ICP-PLUS) under which they assume financial risk for some services in exchange for more financial and/or service

flexibility. This new ICP/ICP-PLUS structure will improve beneficiaries’ experience through a person-directed comprehensive individual assessment and one point of contact responsible for ensuring that beneficiary needs are met.

HP provides the following estimates related to the MMIS modifications that will be necessary to support the DUALS demonstration project. Prior to engagement in this project, written approval must be received by the Contractor from the State’s Financial Director and Deputy Commissioner. Approval for this project will be subject to CMS approval of the Grant proposal and available funding.

DUALS Demonstration

Activity	Hours *	Cost
Project Management	808	\$92,645
Assessment / Requirements / Design	3235	\$370,925
Construction	8897	\$1,020,130
Testing	3235	\$370,925
Total	16,175	\$1,854,625

**The hours and associated estimated costs provided above are estimates only. HPES will produce a monthly bill for the actual hours used each month. The bill will include the hours used for each activity listed below. HPES will be reimbursed at the modification hourly rate for additional CSR Hours as described in Section 11 as modified by Amendment 5. The estimates provided above are based on the 2013 modification hourly rate of \$114.66.*

T-MSIS

The most comprehensive and granular Medicaid and CHIP set of data that CMS currently collects from States is the Medicaid Statistical Information System (MSIS) data. Over the last two years, CMS has been working with States to refine this set of data and add additional elements identified as necessary for business purposes by Medicaid and CHIP internal and external partners. This effort is known as the Transformed Medicaid Statistical Information System (T-MSIS) data set. The collection of a single, comprehensive, contemporary set of data for T-MSIS analysis and decision making represents CMS’ vision for reducing the burden on the States of multiple, often redundant, data requests.

The vision for the transformation also contains a fully integrated data environment that will represent the single source of Medicaid and CHIP data and supports advanced levels of internal and external controls, including far greater transparency and stakeholder involvement. The transformed system infrastructure will house more data than CMS previously collected, will meet the business needs of all CMS Centers, and be built within a structure that will enable use by CMS, other federal agencies, and States. It will assure equal access to resources and adaptation in the future for all users. The T-MSIS remediation project will ensure the State of Vermont is compliant with the new CMS reporting requirements. Prior to engagement in this project, written approval must be received by the Contractor from the State’s Financial Director and Deputy Commissioner. Approval for this project will be subject to CMS approval of the Grant proposal and available funding. .

T-MSIS Remediation Estimates

Activity	Hours *	Cost
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Project Management	1130	\$129,566
Assessment / Requirements / Design	500	\$57,330
Construction	2507	\$287,453
Testing	866	\$99,296
Total	5,003	\$573,644

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HP will implement system enhancements and staffing model adjustments in support of the elimination of the following existing contractor requirements.

1. Eliminate the following Contractor Requirements related to the production of Recipient Explanation of Medicaid Benefits (REOMBS) as of 7/1/2013:

- **2.7.4.F.2.c** Generate: Explanation of Medical Benefits (EOMBs) to a State-approved sample and selection of recipients receiving services during the reporting period, with special consideration for confidential services.
- **2.7.4.F.3.a** Outputs: Recipient EOMBs, which include all services provided to a recipient by any participating provider, except for confidential services, and a layperson's description of the services provided, the date(s) of service, and the payment amount
- **2.7.4.F.3.c** Outputs: Summary of EOMB generated.
- **2.7.4.F.6.b** Produce and send to file : Recipient EOMBS
- **2.7.4.F.6.g** Generate EOMBs no less frequently than every 45 calendar days and within two workdays after the most current payment processing cycle.
- **2.7.11.2.c** Generate: Recipient Explanation of Medical Benefits (EOMBs) to a State-approved sample and selection of recipients receiving services during the reporting period, with special consideration for confidential services.
- **2.7.11.3.i** Outputs: Recipient EOMBs, which include all services provided to a recipient by any participating provider, except for confidential services, and a layperson's description of the services provided, the date(s) of service, and the payment amount.

2. Eliminate the following Contractor Requirements related to the FADS / Profiler application which will be disabled as of 7/1/2013 and all related stored data will be purged.

- **2.7.1.11** through **2.7.12.6** – SUR
- **2.8.2.1.a** Completely disable FADS Profiler as referenced in Amendment 1 to this contract.

3. Eliminate the following Contractor Requirements related to the Data Entry Error Rate Reporting as of 7/1/2013:

- **2.6.22.1.b** Maintain a maximum error rate of 3% on all keyed claims, computed weekly
- **2.6.22.1.c** When the error exceeds 3%, the Contractor must provide: Corrective action for reducing the error rate. Results from prior period's corrective action.
- **2.6.22.1.d** Provide standard monthly reports to the State depicting: Overall data entry error rate. Error rate by individual performing data entry.
- **2.7.4.B.6.c** Maintain a maximum data entry error rates below 3%

4. Eliminate the following Contractor Requirements related to the ESI Program, these requirements were added to the contract via Attachment F, Part IV of Amendment 3 to this contract. These requirements will be eliminated as of with the implementation of the State Exchange.

Requirements that will be eliminated as of 01/01/2014:

- Mailing ESI Premium payment checks and remittances weekly
- Encourage use of direct deposit by inserting a bank direct deposit enrollment form with all paper checks or include the direct deposit enrollment instructions on the new check stock.
- Provider help desk support for all 3 programs
- Mail eligibility cards, where necessary
- Business Objects reporting specialist support
- 100 downloads to update swipe boxes
- Maintain the chronic condition indicator on the diagnosis code reference data
- Establish a process to obtain routine file from bank on the status of premium checks. This file will be used to update the MMIS check status field to identify whether or not the check has been cleared.

Requirements that will be eliminated as of 07/01/2014:

- Claims processing of claims for ESI and ESI - VHAP programs
- EFT Rejects, lost checks, void/reissue processing, and resolution of similar related problems
- Undeliverable payments reconciliation process
- Generate mail and follow-up on recipient bills for voided ESI premium payments from retro closed TPL panels
- Premium refund check processing

The net impact of these changes will be a reduction in the monthly base fixed rate of \$9,500 beginning 07/01/2013 resulting in an annual reduction of this line item by \$114,000.

In an effort to support timely MMIS modifications related to additional Federal or State mandates throughout the remainder of this contract, HP and DVHA will add the following language:

Directives/Change Orders

The DVHA may, at any time by a written directive (change order), propose changes to the scope of work. Such changes may include changes to the technical requirements or business services under this Contract. The directive (change order) will specify the scope of the change and the expected completion date. Any directive (change order) shall be subject to the same terms and conditions of the Contract unless otherwise specified in the directive (change order) and agreed upon by the parties. A directive (change order) under this section will not be an amendment to the Contract unless it changes the general terms and conditions or the terms of payment in the base Contract. Except as may be agreed to by the Department, the Contractor shall respond to a change order request within fifteen (15) business days after receipt, advising the Department of any cost or schedule impact. The parties will negotiate in good faith and in a timely manner all aspects of the proposed change order. No directive (change order) will have any force or effect unless signed by authorized representatives of both parties.