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AMENDMENT

It is hereby agreed by and between the Parties, **State of Vermont, Department of Vermont Health Access** (hereinafter called "State") and **Gainwell Technologies LLC** (the "Contractor") that Contract #35485B originally dated as of January 1, 2017, as amended to date, is hereby amended effective retroactive to August 1, 2021 as follows:

I. **Attachment A, Scope of Services.** The Scope of Services is amended as set forth in Appendix I to this Amendment #7.

II. **Attachment B, Payment Provisions.** The Payment Provisions are amended as set forth in Appendix II to this Amendment #7.

This document consists of 28 pages. Except as modified by this Amendment No. 7, all provisions of the Contract remain in full force and effect.

STATE OF VERMONT

DEPARTMENT OF VERMONT HEALTH ACCESS

DocuSigned by:
Sandi Hoffman 9/30/2021
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CONTRACTOR

GAINWELL TECHNOLOGY SERVICES LLC

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Appendix I

1. Section III (Additional One-time, Ongoing, and Future MMIS Modernization Projects), as previously amended, is hereby deleted in its entirety, and replaced as set forth below:

III. Additional One-time, Ongoing, and Future MMIS Modernization Projects

This section provides a summary of MMIS projects that are planned, in progress, and previously completed. The Change Management process will be followed for State authorization of the Contractor's project work outlined in this section. This work is not included in the base scope detailed within Section I and II of this Attachment A or included in the base price detailed within Attachment B. The State, at its sole discretion and upon availability of funding, may choose to initiate, continue, or stop work under any of these projects independently or otherwise. The parties will agree to the timing and schedule of each of these projects.

The Contractor will produce a monthly bill for the actual hours worked each month or for the deliverables approved by the State as described in the sections below. Any work performed in excess of the maximum hours set forth in the tables in the subsections below will require approval by the State prior to the Contractor performing the additional hours. The bill will include the hours used for each activity listed. The Contractor will be reimbursed at the customer service request (CSR) hourly rate described in Attachment B, unless the parties have agreed the project will be performed for a fixed price.

The Contractor must employ accessibility standards, processes, and commercially reasonable practices and apply these to all end-user applications. As independent external IT delivery methodologies and standards (such as those listed in Section II.D) are modified, commercially reasonable practices shall be enhanced and applied to any projects affected.

A. Medical Assistance Provider Incentive Repository (MAPIR) Core Development

The VT MAPIR Project is supported by an existing, approved Implementation Advance Planning Document (IAPD).

The State participates in the development of the Core MAPIR application in coordination with multiple states. The scope of Core MAPIR is for software enhancements due to CMS requirement changes, and for deployment of the Core MAPIR application updates and patches. Core MAPIR development payments will be invoiced on a quarterly basis at amounts indicated within Attachment B. Pricing may be adjusted if the number of members in the MAPIR Collaborative increases or decreases.

B. Vermont Specific MAPIR Integration/Customization

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

The Installation and Customization of Core MAPIR releases consist of the following activities. The project budget for the duration of the contract, is based on the annual estimates below:

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MAPIR Customization Activity	Annual Hour Maximum Years 1-3	Annual Hour Maximum Years 4-5	Contract Hour Maximum
Environmental Changes (DB2, Websphere/Stored procedures)	120	20	400
MAPIR Installation	120	80	520
State Configuration	80	100	440
Additional Customization	300	200	1300
Project Management	300	200	1300
Testing	120	100	560
Subtotal	**1,040**	**700**	**4,520**
Technical Support of VT production environment	500	300	2100
Annual Customization Hours	**1,540**	**1,000**	**6,620**

C. Payment and Delivery System (PADS) Reform

MMIS enhancements are required in support of the State's efforts to continue the expansion and the success of the reform efforts in alignment with the Vermont All Payer Model Agreement. The overarching goals of the work covered by payment reform enhancements include moving away from fee-for-service reimbursement models, increasing provider flexibility to deliver care, and ensuring high-quality data is available to evaluate program performance. MMIS enhancement areas for various programs to help meet these objectives have been identified in the table below. The total number of hours estimated for PADS work through December 31, 2021 is 9,196 hours.

MMIS System Work Description
Modify batch process and MMIS screens for third party liability claims, to support third party billing for Accountable Care Organization (ACO) claims that were not paid as fee-for-service
Assign Health Service Area, new Prior Authorization indicator values, and new attributing provider information when loading the ACO Provider Roster file, to support ACO financial reporting and reconciliation requirements. Display new information on MMIS screens.
Enhance MMIS and Business Objects data warehouse reporting capabilities, to support ACO financial reconciliation activities.
Allow claims service limit exceptions to prior authorization requirements for ACO members - codes, limits, associated flags, and reports
Reform Initiatives - MMIS enhancements

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Support additional billing modifiers for reporting, billing, limits, flags, and payments for adult and child mental health claims (such as the T2025 case rates)
Capture federal poverty level (FPL) between the Vermont Department of Mental Health (DMH) and access for Community Rehabilitation and Treatment (CRT) populations
Applied Behavior Analysis (ABA) - MMIS analysis, design, development, and implementation for support of alternative payment models
Children's and Adult Mental Health - MMIS analysis, design, development, and implementation for support of detailed encounter data capture and payment models
Substance Use Disorder (SUD) waiver - modify MMIS claims and financial processing to support change to substance abuse program
Developmental Disability Services (DS) - MMIS analysis, design, development, and implementation for support of detailed encounter data capture and payment models
Pediatric Palliative Care - MMIS analysis, design, development, and implementation for support of alternative payment models
Children's Integrated Services (CIS)– modify MMIS claims and financial processing to support changes to payment models and encounter data capture
Support enhancements to analytics, data warehouse, data extracts and reporting to enable improved oversight and insights into reform initiatives - ACO, DMH, ABA, DS, CIS, other
Other MMIS enhancements as specified by the State in support of Reform Initiatives that are funded by Reform Initiative budgets.

D. TMSIS Reporting Enhancement Project

The State is seeking to improve data quality and provide additional TMSIS data elements. Effort is planned for enhancements to derive and obtain additional data to include in TMSIS reporting.

The defined Project work identified in the tables below is ongoing in response to continued data quality work with CMS and its TMSIS contractors. A budget is established for monthly quality analysis, design, and implementation of further improvements to TMSIS data quality. This Quality Analysis and Improvements budget will enable ongoing assessment with CMS and its vendors for future enhancements beyond those identified to-date.

Summary

Data Quality Analysis and Improvements	**Hours**
2018 Data Monthly Quality Analysis and Improvements	720
2019 Monthly Quality Analysis and Improvements	720
2020 Monthly Quality Analysis and Improvements	5,704
2021 Monthly Quality Analysis and Improvements	5,704
GAP Compliance - complete	645

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Addendum B Table 3 - (through December 2019, absorbed into data quality for 2020 and future)	2,070
Common Solution Integration – (through December 2019, absorbed into data quality for 2020 and future)	940
Total Project Hours	**16,503**

E. Technology Updates

Due to the age of current technologies and known business drivers, the following areas of MMIS technology have been identified as needing to be addressed under this Contract. These projects will require additional definition and funding through a contract amendment, change order, or other work authorization mechanism.

i. Enhance report generation and analytic capabilities:

The Contractor will update the commercial software technology and configuration of the tools used for ad-hoc queries and reporting of MMIS Claims and Provider data, as performed by the State and the Contractor's employees. Change Request hours from the annual hours budget included in the fixed price amount may be authorized by the State for performance of this work.

ii. Migrate MMIS report and document archival to a standardized Content Management (CM) platform: The current IBM OnDemand (third party) software and server platform used for Content Management of paper claims images, batch reports, and other documents, is at end-of-life for Contractor support and does not meet State needs for access to MMIS information. The Contractor shall retire the current software and systems and integrate MMIS with a State approved CM as a Service solution.

The project scope will include effort associated with the migration of existing MMIS Contractor OnDemand system to a State provided Content Management Platform. The Contractor will provide the following within the scope of the project:

- Develop and test an interface between the MMIS AIM system and the CM service to send MMIS files to the CM service daily
- Support the evaluation of existing MMIS batch reports and other file types with the State to confirm which archived content will be migrated to the new CM service.
- Migrate existing archived content from the existing solution as agreed upon with the State via the approved CM interface.

A budget of up to $125,000 for technical development and up to $90,000 for testing and migration support is included in Appendix B. Actual hours will be invoiced monthly, and a one-time charge of $15,000 for Impressions third party software modifications will also be invoiced against the budget. This work will be performed as directed and agreed to by the State.

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F. Enhanced EDI Services Migration Project

i. Project Summary

The State anticipates submitting an IAPD to CMS for support of a project to migrate to an enhanced Electronic Data Interchange (EDI) service.

In support of ongoing processing of claims and other Accredited Standards Committee (ASC) X12 EDI standard health insurance transactions, and in compliance with ACA 1104 required CAQH CORE Operating Rules, the Contractor shall prepare for updated EDI transaction standards and requirements. A technical need exists to migrate State transaction processing from the current SAP Sybase (third-party) software platform, and associated Contractor "EDI Shared Translator" services. The Sybase ECRTP translator software is no longer being offered as a commercial product by the vendor SAP. This lack of support poses risks to current operations and the ability to meet future federal requirements. The Contractor shall migrate the State's MMIS to interface with a new EDI Software as a Service (SaaS) solution as an initial project phase. A second phase will follow to implement new transaction standards (once finalized).

The Enhanced EDI SaaS solution is based on IBM Commercial Off-The-Shelf (COTS) software and is currently utilized by multiple other state Medicaid programs. Compliance checking will comply with the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) WEDI/SNIP types at currently supported State SNIP types for EDI transactions identified below.

ii. Transaction Scope

EDI compliance and translation support is currently provided for the following inbound batch transactions for trading partner file exchange with the Vermont MMIS (AIM) System and will continue to be provided with the enhanced EDI solution:

- 270 Health Care Eligibility Benefit Inquiry
- 276 Health Care Claim Status Request
- 837D Health Care Claim - Dental
- 837I Health Care Claim - Institutional
- 837P Health Care Claim – Professional
- Payer Initiated Eligibility/Benefit (PIE) Transaction (X279A1)

EDI compliance and translation support is currently provided for the following outbound batch transactions for trading partner file exchange with the Vermont MMIS (AIM) System and will continue to be provided with the enhanced EDI solution:

- 271 Health Care Eligibility Benefit Response
- 277 Health Care Claim Status Response
- U277 Unsolicited Claims Status Response
- 820 Health Insurance Exchange Related Payments
- 835 Health Care Claim Payment Advice
- 999 Implementation Acknowledgement

EDI compliance and translation support is currently provided for the following real-time transactions for trading partner file exchange with the Vermont MMIS (AIM) System and will continue to be provided with the enhanced EDI solution:

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- 270 Health Care Eligibility Benefit Inquiry
- 271 Health Care Eligibility Benefit Response
- 276 Health Care Claim Status Request
- 277 Health Care Claim Status Response
- 999 Implementation Acknowledgement

The following non-standard file formats will be provided in conjunction with the enhanced EDI SaaS solution:

- Proprietary format of remittance advice files, equivalent to those currently provided in addition to the 835 RA files.
- Proprietary HTML file format for batch acknowledgements, to contain same information as in the 999 acknowledgements in a browser (i.e. human) readable format.

System-to-System File Exchange is currently provided in compliance with CAQH 'Safe Harbor' Phase I, II, and III CORE operating rules. The enhanced EDI Service will remain compliant with current and future required CAQH CORE operating rules and Phases, as federally required. The enhanced EDI Service will provide equivalent web-based, compliant file exchange services on a new platform.

iii. Implementation Scope

The following areas of technical work will be performed by the Contractor, to migrate from the current EDI shared service to the enhanced EDI SaaS service. A combination of leveraged EDI services team and account-based technical and operations staff, will perform this work:

- Installation and Configuration of Model Office, User Acceptance, and Production environments for enhanced EDI services, including all required IT infrastructure and software.

- Analysis and testing of VT electronic claims transaction files to identify any compliance gaps between the current and new EDI compliance rules.

- Design, Construction, and Testing of interfaces between the enhanced EDI solution and Vermont MMIS AIM systems, for batch and real-time EDI transaction processing.

- Modification of existing MMIS AIM system programs, to accept and produce standard XML file formats for exchange of transaction files and trading partner authentication data with the enhanced EDI service. This work will allow utilization of reusable, common EDI translation maps, thereby reducing current and future customization efforts. Local customization required will be done outside of the common maps.

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- Systems integration testing will occur in the MMIS Model Office environment, to execute planned functional testing for in-scope transactions and interfaces. Production EDI files will be used for high-volume testing, to maximize test coverage for the myriad of possible transaction data combinations.

- A two-month window for trading partner testing will occur in the User Acceptance Test EDI and MMIS test environment. Trading partner testing will be enabled via MMIS systems such as the Provider Portal website and supported by the Contractor EDI coordinator and Contractor technical staff. Trading partners will be encouraged through Provider communication and outreach, to submit test transactions to ensure readiness.

iv. Timeline

The detailed work plan will define a schedule for implementation activities, to be followed by a trading partner testing window. Upon the go-live implementation date, State trading partners will begin use of the production version of enhanced EDI services. The start of the project will begin on a date agreed to by the Contractor and the State, and as supported by an approved CMS Implementation APD plan.

v. Deliverables

The following deliverables shall be produced by the Contractor for the EDI migration project:

- A compliance analysis and design document will be produced to identify impact(s) to the EDI Companion Guides where a change in technology may introduce new compliance rules.

- A detailed Project Work Plan (i.e. Project Schedule), in Microsoft Project format, by day 60 of the implementation project.

- EDI Interface Design documents, for integration between the enhanced EDI Service and existing MMIS systems, by day 60 of the implementation project or as defined in the project schedule.

- Transaction crosswalk design documents, for identifying X12 field level requirements, by day 90 of the implementation project or as defined in the project schedule.

- A Systems Test Plan and related test artifacts, to document the systems integration, interface, and trading partner testing scope and detailed test cases. A final version of this deliverable will include pass/fail test results, to be provided to the State for review no later than end of month six (6) of the implementation timeline or as defined in the project schedule.

- Updated EDI-related business documentation where necessary, for Provider-facing information and instructions on use of EDI services, to be provided to the State for

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review no later than end of month six (6) of the implementation timeline or as defined in the project schedule.

- Provider communications activities and deliverables will be jointly agreed upon with the State and identified in the detailed Project Work Plan deliverable.

vi. Implementation Budget

The project budget for implementation of the enhanced EDI service is planned as fixed price, one-time costs to be invoiced based on State acceptance of the following schedule of deliverables.

Enhanced EDI Service Implementation Deliverable	Fixed Price Charge
Claim Compliance Analysis testing and design	$93,750
Acceptance of Project Work Plan, EDI Interface Design, and transaction crosswalk deliverables; EDI Service Model Office and UAT test environments are installed	$100,000
Implementation Project Complete, Trading Partners migrated to enhanced EDI Service, all Project deliverables accepted	$250,000
Total One-Time Costs	**$443,750**

G. Electronic Visit Verification Project

The purpose of the project is to ensure the State is compliant with Section 12006 of the 21st Century CURES Act, which was passed by the U.S Congress in December 2016 and mandates States to implement Electronic Visit Verification (EVV) solutions for defined personal care services. Non-compliance of the requirements can lead to a reduction in the Federal Medical Assistance Percentage (FMAP) for the associated personal care services.

The Contractor will deliver the EVV solution as SaaS which will be utilized by personal care providers, the State, and its agents. The following software modules will be made available via the Internet:

- Santrax Electronic Visit Verification
- Santrax Provider EVV Portal
- Santrax Consumer Directed Care Fiscal Portal
- Santrax Jurisdictional View Portal

The Contractor shall provide an electronic visit verification system that meets the following requirements:

- The Electronic Visit Verification system will be available for personal care services effective June 1, 2020 or as agreed to by the State and CMS.

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- The Electronic Visit Verification system will be available for receiving data from home health service systems effective January 1, 2020.
- The Electronic Visit Verification system must be compliant with Section 12006 of the 21st Century Cures Act.

Data exchange between the EVV solution and existing State and Contractor systems will occur as specified in Attachment A, Exhibit 4 Electronic Visit Verification Project Statement of Work to enable the EVV solution and to provide EVV data to MMIS systems to enhance operational program oversight of personal care services.

Limited training for use of EVV software is included in the implementation scope. Ongoing support of EVV modules includes regular software updates and user help desk support.

The project budget for the implementation phase of the EVV solution is planned as fixed price costs to be invoiced based on State acceptance of the implementation deliverables. Ongoing service charges shall be billed at the rates and frequencies specified in Table A below. EVV Certification and customization requests shall be billed in accordance with State approved Specification Orders not to exceed the budgeted amounts listed below.

Table A: EVV Implementation / Operations Budget

Phase	**Deliverables Included**	**Payment**	**Billing Frequency**	**Total Budget per Line Item**
Implementation	Implementation deliverables to be paid as specified in Attachment A, Exhibit 4 Electronic Visit Verification Solution Statement of Work	$784,400	Per Exhibit 4	$784,400
EVV Support	Ongoing support, as specified in Attachment B, Section 5 A. MMIS Operations of this document.	$7,273.33	Monthly, beginning 3/1/2020	$174,560
EVV Operations	Minimum transactional service charges, as specified in Attachment B, Section 5 A. MMIS Operations of this document.	$5,437.46	Monthly, to begin upon use of portals for consumer directed care training	$130,499.10
Operations – Visits per member per month (PMPM) over minimum transactions, Billed as Utilized	Excess EVV Transactions Estimates as specified in Section B i.v. Volume and Accounting section of this document. EVV Recurring Visit Fee represented here is estimated only for budget purposes.	$0.225 per transaction over the minimum transaction ceiling	Monthly	$130,498.66

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Operations – Aggregator PMPM Billed As Utilized	Aggregator fee PMPM as specified in Section B i.v. Volume and Accounting section of this document. Fee represented here is estimated only for budget purposes.	$1.375 per Member per month	Monthly	$82,474.22
Certification Services – Billed as Utilized	Outcome-based certification scope will be authorized against this budget via Specification Orders.	$35,306	Per Completed and State Approved Specification Order(s)	$35,306
Customization Requests – Billed As Utilized	Additional customization work for EVV modules or MMIS to support State business requirements, will be authorized against this budget via Specification Orders.	$100,000	Per Completed and State Approved Specification Order(s)	$100,000
Training Revised Scope	For CDS webinars as identified in Attachment A Exhibit 4	$7,872	Per Exhibit 4	$7,872
Additional PM support	For Contractor Project Manager for January 2020 through December 2020 to support extended CDS implementation window	$28,533.33	Monthly	$342,399.96

H. Payer-Initiated Eligibility Information Exchange (PIE) Transaction

The scope of this project is for the Vermont MMIS system to support the CMS standard for transmission of Payer-Initiated Eligibility Information Exchange (PIE) Transaction data to be received from carriers such as Blue Cross Blue Shield of Vermont, Cigna, and MVP. Existing data matching reports will be leveraged with these new sources of member eligibility data for Coordination of Benefits purposes. Additional enhancements will be made in support of improved member matching and automation of COB information into the State's ACCESS system. MMIS technical work activities will include analysis, design, construction, testing, and project management. Testing effort will include integration testing between MMIS and ACCESS systems, as well as support of testing with additional carriers.

PIE Data Match Activity	Hour Estimates
Analysis and Design	100
Construction and Testing	325
Project Management	75
Subtotal Hours Estimate	**500 hours**

I. 5% Cost Sharing (Co-Pay) Enhancement Project

Per 42 CFR § 447.56(f), the aggregate cost sharing of premiums and copays for a Medicaid beneficiary cannot exceed 5% of the beneficiary's family income. Vermont's plan is to

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enhance cost sharing logic in MMIS and the PBM systems, to proactively discontinue member co-pay charges on claims based on the beneficiary's income threshold. Analysis and design activities will begin in 2021. The Contractor will deliver a Work Plan that identifies staff allocation for detailed analysis and design phase activities and will deliver monthly status reporting for those activities performed by the Contractor. Based upon State written authorization of the Work Plan, the Contractor shall invoice the State monthly for actual hours worked not to exceed $150,000.00.

J. Dr. Dynasaur Expansion Project

To support Vermont Act 48 (H.430), MMIS changes will be needed relating to eligibility for Dr. Dynasaur-like coverage for all income-eligible children and pregnant individuals regardless of immigration status. Analysis and design activities will begin in 2021 with development, testing, and implementation activities planned to complete by July 2022. Only 2021 costs of up to $80,000 are budgeted for in Appendix B Table B.5. Invoicing will occur monthly for actual hours worked.

K. Provider Services Enhancement Project: Complete

The Provider Management Module (PMM) was a project under the MMIS Program and is part of the overall MMIS Road Map as presented to CMS. The project milestones were completed upon CMS certification of the PMM modules in February 2020. The PMM project was a high priority legislative initiative aimed to reduce the timeframe to enroll Medicaid Providers. The bill that has been introduced is S.282, https://legislature.vermont.gov/bill/status/2018/S.282. The bill requires the State to complete screening and enrollment for an applicant to be a participating Provider in the Medicaid program within 60 calendar days after receiving the application, direct the State to identify and report on the main concerns of the participating Providers, and to make recommendations for any necessary changes to the Medicaid fraud and abuse statutes. Further specifications are defined in Exhibit 3 to Attachment A.

The Contractor delivered the enhanced Provider Services SaaS, which is being utilized by Providers, the State, and the Contractor in continued performance of the Contractor's Provider Services fiscal agent (FA) responsibilities as described in Exhibit 3, Provider Services Enhancement Project Scope of Work.

The project budget for implementation of the Provider Services SaaS was planned as fixed price costs to be invoiced based on State acceptance of the following schedule of deliverables:

DDI Phase	Deliverables Included	Payment
Planning and Installation	Install Test Environments Project Management Plan Quality Management Plan Data Conversion Specifications Testing Artifacts – initial version	$450,000

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	Training Plan	
Integration Testing and User Acceptance Testing	Business Configuration Specifications Documentation Testing Artifacts – Final Versions Requirements Traceability Matrix (RTM) Training Rosters	$722,826
Implementation	Operational Checklist and Results Solution Documentation for Software Modules Interface and Deployment Specifications	$1,150,000
Certification	Certification Management Plan CMS Certification Checklists deliverables Certification Acceptance	$700,000
Total		**$3,022,826**

L. New Medicare Card Project: Complete

Medicare Card Project work concluded in May 2018. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project. The State received an approved IAPD from CMS for support of the Medicare Card project, including work to be done in the MMIS system.

Congress passed Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015 (PL 114-10) on April 16, 2015. Section 501 of MACRA requires CMS to remove the Social Security Numbers (SSNs) from Medicare cards and replace with a Medicare Beneficiary Identifier (MBI).

Policies and systems were examined, the appropriate changes identified, and modifications tested prior to CMS distributing new Medicare cards. MMIS required modification to integrate with other State systems in order to accommodate the load, storage, display, and reporting of a new MBI identifier for members. The project timeline for MMIS project changes aligned with the schedule proposed in the IAPD. Construction and functional systems testing of MMIS occurred in September 2017 through March 2018, with integration testing and implementation activities for MMIS changes occurring from January through May of 2018.

Summary

Medicaid Card Project – VT MMIS System Changes
REQUIREMENTS DEFINITION AND ANALYSIS **CONSTRUCTION AND TESTING BATCH**
Produces the rekr650v report - Medicare Suspect Recipient. Ran Monthly and contains the HICN.
Processes the daily medi.dat file that contains the HICN.
Processes the daily eligibility file containing the HICN.
Creates the PDP 820 Premium file that contains the HICN.

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Creates the PDP Premium Remittance Report that contains the HICN. Mailed to PDPs.	
Creates the Medicaid Remittance Advice. Claims that are denied for Medicare on the RA have the members Medicare ID printed on the RA.	
Creates the GCR recipient extract that contains the HICN.	
Uses the presence of a HICN to set a recipient Medicare indicator to a 1 in the t_recipient_info table in EVAH.	
TMSIS file creation, includes the HICN.	
TMSIS file creation, includes the HICN from crossover claims that have it.	
TMSIS Inpatient file creation, includes the HICN from crossover claims that have it.	
TMSIS Nursing Home file creation, includes the HICN from crossover claims that have it.	
TMSIS Other file creation, includes the HICN from crossover claims that have it.	
TMSIS Pharmacy file creation, includes the HICN from crossover claims that have it.	
Creates the COBA file sent to Medicare monthly that contains the members HICN.	
Creates the COBB file sent to Medicare monthly that contains the members HICN.	
Screens	
Recipient LIS Information - Displays the HIC #	
Recipient Header - Displays and allows query by the HIC #	
Recipient Base - Displays and allows query by the HIC #	
Other Insurance - Displays the HIC #	
Tables	
t_re_medcr_id table	
Total Hours	**275.25**
Total Cost	**$33,555.28**

M. Presumptive Eligibility (PE) Project: Complete

Presumptive Eligibility Project work concluded in March 2018. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project.

Vermont hospitals may determine presumptive eligibility as allowed under 42 CFR 435.1110. The State provides Medicaid coverage for individuals under this provision, consistent with Vermont DCF Health Benefits Eligibility and Enrollment rule 66.04. Enhancements to the MMIS system were needed to align with ACCESS eligibility system enhancements, where MMIS receives, for purposes of claims processing, an eligibility record with one of multiple new aid categories to identify members who have received presumptive eligibility. MMIS eligibility inquiry features and financial reporting were updated by the Contractor, to provide presumptive eligibility information.

Summary	Developer	Analyst/PM
REQUIREMENTS DEFINITION AND ANALYSIS	40	20
CONSTRUCTION AND TESTING		
UPDATE MMIS COPAY LOGIC TO EXCLUDE PRESUMPTIVE ELIGIBILITY AID CATEGORY	3	3

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ADD 2 FINANCIAL REPORTING NEW SUB BUCKETS UNDER GLOBAL COMMITMENTS FOR PE	25	15
ADD NEW AID CATERGORIES FOR PRESUMPTIVE ELIGIBILITY PROGRAM	50	20
MODIFY THE DAILY ELIGIBILITY FEED TO ACCEPT FOUR NEW AID CATEGORY CODES	10	5
MODIFY ELIGIBILITY VERFICATION SYSTEMS TO ACCOMMODATE NEW PRESUMPTIVE ELIGIBILITY PROGRAM	25	10
IMPLEMENTATION SUPPORT	40	
Subtotal Change Effort Hours	193	73
Total Hours		**266**

N. Medicare Grant Project: Complete

Medicare Grant Project work concluded in July 2017. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project.

MMIS processes the Medicare Blueprint and Community Health Team (CHT) payments on behalf of the State through a Medicare Grant effective 1/1/2017. Funding originates from CMS for Medicare beneficiaries and the State pays the Providers on behalf of Medicare.

The following enhancements to MMIS were completed via State only funding. A one-time amount of $13,200 was invoiced upon completion and promotion to MMIS production of these changes:

- The MMIS uses Medicare Blueprint rates each month to generate lump sum Medicare Blueprint payments. The Medicare CHT payments are processed quarterly.
- A special program payment type and financial reason codes will identify the payments.
- The MMIS screen Provider Special Program (PRSP) is used to enter and maintain the providers who are eligible for the Medicare Blueprint and CHT payments and the Reference Special Program Rates (RFSP) screen is used to enter and maintain the rates.
- Two new special program payment types (BM – Blueprint Medicare, CM – CHT Medicare) and two financial reason codes were assigned to the payments. (Financial Reason Code 361- Medicare Blueprint Payment and 362 – Medicare CHT Payment)
- The FBR (Financial Balancing Report) was updated to report the Medicare Blueprint and CHT payments in the "Federal" bucket, sub-bucket of None.

O. Provider 6028 Project: Complete

The VT Provider 6028 Project concluded in April 2017 and was supported by an Implementation Advance Planning Document (IAPD) with CMS. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project.

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ACA Rule 6028 introduced guidelines to State Medicaid Agencies regarding Provider Credentialing and Certification for Providers who are participating and being reimbursed by the Medicaid program. This project identified and performed several enhancements to the MMIS system and identified process changes to meet these compliance guidelines.

The Provider project scope included detailed process analysis, systems design, construction, testing, and project management of required enhancements in the following areas:

Item #	Item	Billing	Provider 6028 Project Description
1	**MMIS LexisNexis File Exchange**	$0.00	MMIS System and Integration Testing Phase of the LexisNexis File Exchange process and LexisNexis Base Package Files. MMIS Construction, System and Integration Testing of the Advanced Package Files. Ref. 42 CFR § 455.412(a)(b), § 455.436, § 455.452
2	**Collection of Provider Enrollment Fees**	$0.00	Create a Manual Process for Collecting of Provider Enrollment Fees and MMIS modification to create a new screen to capture if they have paid the fee to Medicare, to another Medicaid program, or to Vermont Medicaid. Create new financial transactions to capture the enrollment fee under the refund functionality in the MMIS. Assumption: Estimate assumes a manual process for updating the new Enrollment Fee information in the MMIS. Ref. 42 CFR § 455.46
3	**LexisNexis – MMIS Automated Processes**	$2,360.94	The **Provider Updates 2014** Project introduced the LexisNexis Advanced Package of data files to the MMIS. This item is to build upon the data available in these files. The Contractor will work with the State to review data in the post-production data feeds and recommend processes to automate data updates in the MMIS. Possible items that could be built under this item include: Updating Provider License Expiration Dates, Updating Provider DEA, and DEAX Expiration Dates, Adding/Updating/Deleting Provider Service Address Information, Modification to Provider Risk Assessment Level, etc. Ref. 42 CFR § 455.412(a)(b), § 455.436
4	**Automated Welcome Letters and Revalidation Acknowledgement Letters**	$434.20	Welcome Letters are manually generated when new Providers are enrolled in the Vermont Medicaid Program. There are four different types of letters generated. A new requirement to the MMIS is to generate an acknowledgement when a provider revalidates their credentials and renews their enrollment in the Vermont Medicaid Program. This item is to automate the generation of both the Welcome

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Item #	Item	Billing	Provider 6028 Project Description
			Letters and the Revalidation Acknowledgement Letters.
5	**Fingerprint Background Screenings for Providers and Disclosing Entities**	$0.00	This item includes time to incorporate Fingerprinting into the MMIS Provider Credentialing Process. There is not currently enough information at this time to provide a detail analysis of impacts to the MMIS. Estimate includes efforts to create a Screen to capture those providers who have been Fingerprinted, when that occurred, and simple Provider Reports to list the new Fingerprinting data. Assumption: Estimate assumes a manual process for updating the Fingerprinting data in the MMIS. (DAIL's Fingerprinting Efforts is separate from the MMIS Fingerprinting efforts/process.) Estimate does not include any cost associated with Third Party Vendors which may be necessary to perform Fingerprinting and the background checks. Ref. 42 CFR § 455.434 (a) and (b)(1)(2) and § 455.450
Total Project Cost			**$2,795.14**

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Appendix II

Attachment B, Payment Provisions beginning on page 60 of 106 of the base agreement, and as previously amended, is hereby deleted and replaced with the following Attachment B:

ATTACHMENT B
PAYMENT PROVISIONS

The maximum dollar amount payable under this contract is not intended as any form of a guaranteed amount. The Contractor will be paid for products or services actually delivered or performed, as specified in Attachment A, up to the maximum allowable amount specified on page 1 of this contract.

1. Prior to commencement of work and release of any payments, Contractor shall submit to the State:
    a. a certificate of insurance consistent with the requirements set forth in Attachment C, Section 8 (Insurance), and with any additional requirements for insurance as may be set forth elsewhere in this contract; and
    b. a current IRS Form W-9 (signed within the last six months).
2. Payment terms are **Net 30** days from the date the State receives an error-free invoice with all necessary and complete supporting documentation.
3. Contractor shall submit detailed invoices itemizing all work performed during the invoice period, including the dates of service, rates of pay, hours of work performed, and any other information and/or documentation appropriate and sufficient to substantiate the amount invoiced for payment by the State. All invoices must include the Contract # for this contract.
4. Contractor shall submit invoices to the State in accordance with the schedule set forth in this Attachment B. Contractor invoices shall be submitted no more frequently than monthly, but no later than quarterly. For services set forth in Sections I and II of Attachment A, the Contractor shall submit monthly invoices not to exceed $1/12^{th}$ of the annual amount listed in the Fixed Price subtotal of Table B.1 this Attachment B. Invoices for services set forth in Section III of Attachment A shall include the number of hours worked by employee during the specified billing period and the total amount billed, and reference the specific project being billed. Invoices shall reference this contract number, include date of submission, invoice number, amount billed for each scope of work, total amount billed, and be signed by the authorized representative of the Contractor.
5. No benefits or insurance will be reimbursed by the State.
6. Invoices and any required reports shall reference this contract number and be submitted electronically to: AHS.DVHAInvoices@vermont.gov
7. The total maximum amount payable under this contract shall not exceed $85,405,203.40
8. **MMIS Operations**
    A. The following Operational Invoice Payment Schedules depict the maximum amounts payable to the Contractor for MMIS services as set forth in Attachment A, Sections I and II,

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to this Contract based on claims processing volume parameters, known as "base services". The Contractor shall invoice the State monthly for 1/12th of the annual fixed price amounts listed in the fixed price subtotal of the table below. The Contractor shall invoice the state monthly for bill as utilized services. This table does not include project costs shown in Table B.5 for which the Contractor shall invoice separately.

Table B.1 – Operational Payments

FIXED PRICE	**1/1/17 –12/31/17**	**1/1/18-12/31/18**	**1/1/19-12/31/19**	**1/1/2020 - 12/31/2020**	**1/1/2021 - 12/31/2021**	**Maximum 5 Year Operations Cost**
Provider Enrollment	$1,546,698.54	$1,569,899.01	$3,097,852.29	$2,672,813.99	$2,687,309.09	**$11,574,572.92**
Financial Management	$1,036,424.46	$1,051,970.82	$1,117,852.07	$1,114,011.59	$1,122,719.46	**$5,442,978.40**
Operations Management	$3,264,964.42	$3,313,938.88	$3,521,479.27	$3,509,380.92	$3,536,812.60	**$17,146,576.09**
Drug Payment Transactions	$583,300.72	$592,050.24	$629,128.27	$626,966.84	$631,867.64	**$3,063,313.71**
Plan Management	$1,195,339.85	$1,213,269.94	$1,289,252.79	$1,284,823.45	$1,294,866.50	**$6,277,552.53**
Provider Management	$697,809.25	$708,276.39	$752,633.26	$750,047.52	$755,910.39	**$3,664,676.81**
MES IT Support	$2,216,483.24	$2,249,730.49	$2,390,623.24	$1,882,410.04	$1,901,032.56	**$10,640,279.57**
MES System	$2,829,273.57	$2,871,712.67	$3,051,557.99	$3,041,074.09	$3,064,845.17	**$14,858,463.49**
EVV Support Service	$0.00	$0.00	$0.00	$87,280.00	$87,280.00	**$174,560.00**
EVV Monthly Min Visit Fees	$0.00	$0.00	$0.00	$65,249.55	$65,249.55	**$130,499.10**
Fixed Price Subtotals	**$13,370,294.05**	**$13,570,848.44**	**$15,850,379.18**	**$15,034,057.99**	**$15,147,892.96**	**$72,973,472.62**
Billed as Utilized						
EVV Recurring Visit Fee Over Min	$0.00	$0.00	$0.00	$65,249.33	$65,249.33	**$130,498.66**
EVV Recurring Aggregator PMPM	$0.00	$0.00	$0.00	$41,237.11	$41,237.11	**$82,474.22**
CSR Hours	$0.00	$0.00	$0.00	$500,000.00	$500,000.00	**$1,000,000.00**
Postage	$108,000.00	$108,000.00	$108,000.00	$108,000.00	$108,000.00	**$540,000.00**
Additional Space	$0.00	$0.00	$0.00	$54,000.00	$54,000.00	**$108,000.00**
Maximum Annual Spend	**$13,478,294.05**	**$13,678,848.44**	**$15,958,379.18**	**$15,802,544.43**	**$15,916,379.40**	**$74,834,445.50**

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B. Volume Accounting and Reconciliation

Table B.2 - Volume Parameters

VOLUME PARAMETERS	Claims Processing	EDI Transactions
High Estimate	9,000,000	35,000,000
Median Estimate	6,000,000	25,000,000
Low Estimate	4,500,000	15,000,000

i. Claim volume accounting and reconciliation of changes in Contractor reimbursement

The following definitions of a claim delineate between claim types, and shall apply to administrative claims processing adjudication counts tracked and reported by the Contractor:

a. For all institutional based services (Hospice (H), Inpatient/Outpatient (I/O), Home Health (Q), Institutional Crossovers (W,X), Nursing Home (N), a claim is a paper document and EMC (X12N) record of services rendered during a statement period or date range for which there are one or more service, accommodation, HCPCS and/or ancillary codes.

b. For all professional based services (Dental (L), Physician (M), Vision (P), Professional Crossovers (Y), a claim is a line item on paper document or an EMC (X12N) record of services rendered for a service date(s) for which there is a service code.

Financial Adjustment

c. Claim Transactions: The total amount payable each year shall remain fixed unless the claims volume falls outside the estimated parameters for that year. Should the actual claims volume, for a given year, fall outside the estimated parameters, a year-end financial adjustment to the amount payable for operations for that year may be made using the following process:

d. A unit value will be calculated by dividing the Operations Management price for the applicable year by the midpoint claims estimate for that year.

e. If the actual claims volume falls below the low estimate claim parameter, the Contractor shall reimburse the State a portion of the fixed price per the following calculation:

Low Claims Volume Estimate minus **Actual Claims Volume** x 40% of the calculated unit value for the same contract year.

f. If the actual claims volume exceeds the high claims parameter for the contract year, the State will make an additional payment to the Contractor per the following calculation:

Actual Claims Volume minus **High Claims Volume Estimate** x 40% of the calculated unit value for the same contract year.

An adjustment in the fixed price payment to the Contractor for operations shall depend on verification and certification that actual claims volume counts are accurate and consistent with the definition of a claim as set forth in this section B.i.

Financial Adjustment

ii. EDI Transaction volume accounting and reconciliation of changes in Contractor reimbursement

The following definition of an EDI transaction shall apply to counts tracked and reported by the Contractor:

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Table B.3 – Transaction Measurement Rules

Transaction	Guideline
837 transactions	Counts are based on the number of CLM segments.
835 transactions	Counts are based on the number of CLP segments.
834 transactions	Counts are based on the number of INS segments.
820 transactions	Counts are based on the number of 2100B: ENT for members. For organizations the count is based on 2100A: ENT
270 Batch transactions	Counts are based on the number of 2100C:NM1 name segments.
271 Batch transactions	Counts are based on the number of 2100C:NM1 name segments.
270 Interactive transactions	Counts are by transaction, as each 270-interactive transaction contains only 1 member.
271 Interactive transactions	Counts are by transaction, as each 270-interactive transaction contains only 1 member.
276 Batch transactions	Counts are based on the number of 2200D: TRN claim status tracking number segments.
277 Batch transactions	Counts are based on the number of 2200D: TRN claim status tracking number segments.
276 Interactive transactions	Counts are by transaction, as each 276-interactive transaction in contains only 1 claim status request.
277 Interactive transactions	Counts are by transaction, as each 276-interactive transaction in contains only 1 claim status response.
278 transactions	Counts are based on the number of ST segments.
999 transactions	Counts are based on the number of 999 response files.
TA1 transactions	Counts are based on the number of TA1 response files.
277CA transactions	Counts are based on the number of 2200D: TRN claim status tracking number segments
277U transactions	Counts are based on the number of 2100D NM1 name segments. If the count is less than 1, then the count is based on the number of 2200D TRN segments in the transaction set.
HTML report (Readable acknowledgement)	Counts are based on the number of 999 response files (source for HTML file).
824 transactions	Counts are based on the number of 2000: QTY01 Quantity segments.
Payer Initiated Eligibility/Benefit (PIE) Transaction (X279A1)	Counts are based on the number of members records in batch file

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Financial Adjustment

a. EDI Transactions: The total amount payable each year shall remain fixed unless the EDI transactions volume falls outside the estimated high and low parameters for that year. Should the actual EDI transaction volume, for a given year, fall outside the high and low estimated parameters, a year-end financial adjustment to the amount payable for operations for that year may be made using the following process:

b. The unit value will be set at 0.004 per transaction.

c. If the actual EDI transactions volume falls below the low estimate EDI transactions parameter, the Contractor shall reimburse the State a portion of the fixed price per the following calculation:

Low EDI Transactions Volume Estimate minus **Actual EDI Transactions Volume** x the unit value.

d. If the actual EDI transactions volume exceeds the high estimate EDI transactions parameter for the contract year, the State will make an additional payment to the Contractor per the following calculation:

Actual EDI Transactions minus **High EDI Transactions Volume Estimate** x unit value.

An adjustment in the fixed price payment to the Contractor for operations shall depend on verification and certification that actual EDI transaction counts are accurate and consistent with the definition of a claim as set forth this Section B.iii

iv. EVV Visit Transaction volume accounting and reconciliation of changes in Contractor Reimbursement.

The total amount payable each month shall remain fixed unless the EVV transactions volume exceeds the minimum estimated volume of 24,167 transactions. Any transaction over the minimum will be billed as utilized at the rate of $0.225 per transaction on a monthly basis.

The minimum monthly visit fee is calculated based on State provided data assuming 2,418 members, 20 visits per month:

- Total Monthly visits expected: 48,333 (580,000 annual)
- Expected Visits of 48,333 x 50% = 24,167 minimum visits
- 24,167 minimum visits x $0.225 per visit = $5,437

For all EVV transactions exceeding 24,167 per month, the Contractor will charge a per visit fee. A visit is defined as a single service delivery. Visits may be recorded using (a) telephony call into the Sandata system (b) the recording by the Sandata system of any of the following (i) the start of a visit, (ii) the end of a visit, (iii) the duration of a visit, (iv) a service performed during a visit, (v) corrections to any data in the Sandata EVV system or (vi) recording of a visit using the Sandata Mobile Connect Application.

v. EVV Aggregator PMPM transaction volume account and reconciliation of changes in Contractor Reimbursement

For all members whose data is received via third-party EVV systems interfacing with the Aggregator service, a per member per month (PMPM) fee of $1.375 will be assessed. The Contractor will provide

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a monthly count of all members who are associated with a third party EVV vendor from the Aggregator system to support the monthly fee.

9. MAPIR Collaborative Quarterly Payment

Table B.4 – MAPIR Payment Schedule

Time Period	Payment Date	Quarterly Price with 14 Members	Quarterly Price with 13 Members	Quarterly Price with 12 Members	Quarterly Price with 11 Members	Quarterly Price with 10 Members	Quarterly Price with 9 Members	Quarterly Price with 8 Members
Jan 2017 – Mar 2017	March 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Apr 2017 – June 2017	June 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Jul 2017 – Sep 2017	September 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Oct 2017 – Dec 2017	December 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Jan 2018 – Mar 2018	March 2018	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Apr 2018 -Jun 2018	June 2018	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Jul 2018 – Sep 2018	September 2018	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Oct 2018 – Dec 2018	December 2018	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jan 2019 – Mar 2019	March 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Apr 2019 – June 2019	June 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jul 2019 – Sep 2019	September 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Oct 2019 – Dec 2019	December 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jan 2020 – Mar 2020	March 2020	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Apr 2020 – Jun 2020	June 2020	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jul 2020 – Sep 2020	September 2020	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Oct 2020 – Dec 2020	December 2020	$58,051.00	$62,516.00	$67,726.00	$73,883.00	$81,271.00	$90,302.00	$101,589.00
Jan 2021 – Mar 2021	March 2021	$58,051.00	$62,516.00	$67,726.00	$73,883.00	$81,271.00	$90,302.00	$101,589.00
Apr 2021 – June 2021	June 2021	$29,026.00	$31,258.00	$33,863.00	$36,942.00	$40,636.00	$45,151.00	$50,795.00
Jul 2021 – Sep 2021	September 2021	$29,026.00	$31,258.00	$33,863.00	$36,942.00	$40,636.00	$45,151.00	$50,795.00
TOTAL FOR 57 MONTHS PER STATE		$1,055,355.72	$1,136,538.84	$1,231,253.41	$1,343,186.76	$1,477,501.25	$1,641,667.81	$1,117,488.00

10. Project Retainage

The Contractor agrees to a 10% retainage of each project invoice amount, for **One-time, Ongoing, and Future MMIS Modernization Projects** defined in Section III of Attachment A,

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and when the State has defined the initiative to be managed as a project. The State will only authorize the retainage payment for each individual project if all the following occur:

a. Contractor completes all deliverables associated with the project or specific payment in accordance with the acceptance criteria. The acceptance criteria shall be mutually agreed upon by the Parties.
b. State accepts all the milestones/deliverables for the project or specific payment based on the acceptance criteria.
c. Project enhancements are successfully operational for 30 calendar days to be qualified for reimbursement of the retained amount.

After all the above occur, the Contractor may submit a final invoice for payment of the total 10% retainage amount for that specific project. Hardware, software, and license payments are not subject to retainage. For projects that span beyond the State's fiscal year (ending June 30th), the Contractor shall submit an interim invoice and receive payment for the retainage for all deliverables completed and approved as described above by June 30th and December 31th of that year.

11. Customer Service Request Hours (CSRs)

The Contractor shall submit Specification Orders to the State for review and approval for the use of any CSR hours for making requested modifications to MMIS systems.

The Contractor agrees to provide 5,000 customer service hours per year in Years 1-3 to the State for making requested modifications to MMIS systems in each of the following years. This effort is included in the monthly fixed cost for Years 1-3 set forth in Section 5(A) of this Attachment B.

Unused hours for Years 1-3 shall expire each calendar year, except unused hours up to 1,000 hours may be used in the calendar years of 2018 and 2019. All unused hours from calendar year 2019 shall be carried forward into calendar year 2020 and shall be used first by the Contractor. Only after the 2019 carried forward hours are used the Contractor shall bill for State approved Specification Orders as utilized at the rates defined in Section 9 of this Attachment B.

12. Rate per Hour Billing

Effective January 1, 2021 the modification hourly rate will be increased annually from the base rate of $128.00 per hour at the Consumer Price Index (CPI) inflation rate. The Contractor shall bill the State for Task Order hours and Change Order hours utilizing this rate mechanism.

13. Task Order Hours

Task Orders shall be billed in accordance with this Attachment B, the Task Order specifications as agreed upon by both Parties, and this Attachment B. Task Order hours shall be billed at the CSR rate or for such fixed rate as the parties may agree, not to exceed $500,000 over the term of this Agreement.

14. Service Level Credits

The Contractor must adhere to the Technical and Functional Requirements and the Service Level Agreements set forth in Exhibit 1 and Exhibit 2 to Attachment A, and as subsequently amended, unless otherwise directed or authorized by the State in writing. This section describes

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the process by which the State may be entitled to an adjustment to the Service Credits for the Services.

Any remedy provided in this section for Contractor's failure to achieve a Service Level, including Service Level credits ("SLCs"), shall not limit or prevent the State from availing itself of concurrent or subsequent actions as stated within this Contract and permitted under State or federal laws. Based on this evaluation, the State may be entitled to adjustment to the Service Level Credits for the Services.

The following procedures shall govern this section:

a. Notification of Performance Failure: Written notification of each failure to meet a Service Level shall be given to the Contractor prior to assessing SLCs. The Contractor shall have five (5) business days from the date of receipt of written notification of a failure to perform to specifications to cure the failure. However, additional days can be approved by the State's Program Manager if deemed necessary. If the failure is not resolved within this 5-day warning/cure period, SLCs may be imposed from the date of the failure.

b. Determining Applicability of SLCs: After providing notice, and if the failure is not resolved within the warning/cure period, the State may (at its sole discretion) offset SLCs from the next subsequent monthly payment.

SERVICE LEVEL CREDITS (SLCs)

Triggering of SLCs

The Contractor shall apply a Service Level Credit:

A) In the amount provided within the SLA description upon failure to meet that one SLA.
B) Of $1,000 in any month in which the Contractor fails to meet four (4) or more SLAs whose descriptions call for a Cumulative Credit. *
C) Of $1,000 (per SLA) if the Contractor fails to meet any single SLA for three (3) or more months in a six (6) - month period. **

* If B is triggered for the Cumulative Credit, the total credit is $1,000 for the month. *This is not $1,000 per failed SLA.*
** If C is triggered for the repeated failure of a single SLA, the total credit is $1,000 per SLA that meets these criteria.

Invoice & Notice

The credit will be reported via a formal memo from the Contractor according to the notice terms provided in the Contract.
All credits shall be applied to the first invoice submitted by the Contractor following the triggering of the SLC.

The amount of total SLCs in a single calendar month shall not exceed the At-Risk Amount. If the State elects to seek other remedies and is awarded damages under this Contract, any Service Credits paid about or related to such failures or delays shall be deducted from any damages awarded or agreed upon.

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If any of Contractor's reports or documentation to the State contain or state explicit information about failure to meet an SLC Condition per the above Table, then the State is automatically entitled to the applicable SLC and does not need to follow the process in Section c below. The Contractor shall track and report any SLC failure to the State.

c. Reporting SLCs to Contractor: Within 30 calendar days following an SLC being triggered, the State shall inform the Contractor of the SLC by sending written notice to the Contractor and the notice shall contain the following information:
   1. The applicable performance failure and the applicable performance requirement.
   2. Any documentation evidencing Contractor's failure to adhere to performance requirements.
   3. Brief statement of the State's position and the appropriateness of the SLC.
   4. The SLC amount and the appropriateness of the amount of the SLC.

d. Contractor's Response / Dispute Resolution: Contractor's sole response to State's notice of SLC (if elected) shall be Dispute Resolution. The parties agree to be governed by the Dispute Resolution provision stated in Attachment D.

e. General Terms and Conditions of SLCs:
   1. All credits shall be applied to the first invoice submitted by the Contractor following the triggering of an SLC.
   2. If more than one event triggering a Service Level default has occurred within a single month, the sum of the corresponding SLCs (up to the At-Risk Amount) may be claimed by State. If a single event triggers multiple SLA's failure, the State, at its sole discretion, shall choose one SLC condition to apply.
   3. Regardless of the SLC's origin or basis, SLCs may be applied against any invoice from or payment to Contractor that is consistent with this section.
   4. The SLCs may not be applied to any payments or funds due to Contractor outside the scope of this Agreement.
   5. The Contractor shall report the Service Level Credit via a formal memo to the State according to the Notices to Parties term in this Contract. All credits shall be applied to the first invoice submitted by the Contractor following the triggering of an SLC.

f. Parties' Mutual Understanding of SLCs: SLCs credited hereunder shall not be deemed a penalty, but rather a cost adjustment attributable to the lower level of service delivery. Contractor acknowledges and agrees that Services delivered hereunder which meet the SLC Conditions set forth herein have inherently less value for the State and the SLCs represent a fair value for the services actually delivered; provided, however, the State shall retain all of its remedies in law or at equity in the event that the State is entitled to an SLC in any given month, subject to the Contractor's actual limitation on damages as set forth in Attachment D to this Contract.

g. At-Risk Amount: The At-Risk Amount is the maximum amount of SLCs under this Contract that the State may receive in the aggregate for Service Level defaults occurring during a single calendar month unless otherwise specified in this Section. The "At-Risk Amount" shall be 20% percent of any monthly invoice, as determined in accordance with Attachment B, Payment

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Provisions, that are payable by State to Contractor during a calendar month in accordance with the terms and conditions of Attachment B.

h. Excused Performance: Contractor(s) shall only be responsible to the extent a failure to meet the Service Levels was solely and directly caused by acts or omissions of Contractor(s) and/or Contractor's subcontractor. Contractor shall not be responsible to the extent caused by:
   1. any act(s) or omission(s) of third parties (excluding third parties provided by Contractor or other third parties engaged by Contractor in relation to these or any other services provided under an agreement with the State); or
   2. Force Majeure events (as defined in Attachment C, Section 26), except that a Force Majeure Event shall not excuse, delay or suspend Contractor's obligation to invoke and follow its Project Management Plan or any other business continuity or disaster recovery obligations set forth in this Contract in a timely fashion.

i. The Contractor shall:
   1. be liable for, and indemnify State from and against any negligent, unlawful or wrongful acts or omissions all acts or omissions of the Contractor (including their subcontractors, agents, and employees) which arise out of or directly relate to a loss or reduction of FFP (applicable to the services and deliverables under this agreement, and loss or reduction based on the maximum possible FFP eligible as if it were properly carried out), including their subcontractors, agents, and employees, except to the extent that such losses or reductions in FFP result from, in whole or in part, the negligence, unlawful or wrongful acts or omission of the State. This provision, and Contractor's responsibility thereunder, shall survive the term of this agreement to the extent allowed under state and federal law. The obligations in this Section will not exceed the limits on the Contractor's Liability as set forth in Section 8 of Attachment D.
   2. if there is reasonable certainty that FFP will be, or is, lost or reduced per subsection (a), the State may exercise any and all remedies available under this agreement, including but not limited to, the set off provision in Attachment C. Election of remedies under this agreement shall not foreclose, waive, or limit the State's ability to take further actions against Contractor (or its subcontractors, agents, and employees) to the extent allowed by law.

15. Total Budget

TABLE B.5 Total Operational and Project Costs

Total Budget 01/01/2017 – 12/31/2021	
MMIS Operations 5-year cost (includes bill as utilized operations)	$74,834,445.50
Incentive Payments ($160,000 max per year '17-19)	$480,000.00
MAPIR Core Development 1/1/17 thru 9/30/20	$890,362.04
MAPIR Core Development and Support 10/01/20 thru 9/30/21	$174,154.00
MAPIR Integration/Customization	$810,400.00
Payment and Delivery System (PADS) Reform	$1,178,180.00

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Technology Updates – EDI	$443,750.00
Technology Updates – CM Platform	$215,000.00
TMSIS Enhancement	$2,068,107.00
Electronic Visit Verification Project (EVV) Implementation	$1,269,977.98
Provider Initiated Eligibility (PIE) Project	$62,500.00
5% Cost Sharing Project	$150,000.00
Dr. Dynasaur Expansion Project	$80,000.00
Completed Projects	
Presumptive Eligibility: Completed	$32,082.00
Medicare Grant Project: Completed – fixed price	$13,200.00
Provider 6028 Project: Completed	$2,795.14
Medicare Card Project: Completed	$33,555.26
All Payer Model: Completed	$117,142.46
Provider Services Enhancement Project: Completed	$3,022,826.00
Total 'Not to Exceed' Contract Budget	**$85,878,477.38**

15.1 December 21, 2017, project hours were based on an estimated average of $120.61 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B.
15.2 2019 New Project hours were based on an estimated average of $125.00 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B. (Actual 2019 hourly bill rate was $125.48.)
15.3 Monthly costs for additional Contractor space, EVV PMPM charges, CSR hours, and postage charges shall be billed as utilized.
15.4 Amendment 4 new project costs were based on an estimated average of $128.00 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B.
15.5 Amendment 5 & 7 project cost updates were based on an estimated average of $130.00 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B.

16. **Payments Upon Termination.** At the time of termination, whether partial or full, the Contractor shall invoice and State shall issue payment for partially completed services or deliverables satisfactorily delivered to and not yet approved by the State and reasonable shut down expenses for which Contractor can provide sufficient evidence and shall be at a price mutually agreed upon by the Contractor and the State.