AMENDMENT

It is hereby agreed by and between the **State of Vermont, Department of Vermont Health Access** (hereinafter called "State") and **DXC Technology Services LLC**, with a principal place of business in Tysons, VA, (the "Contractor") that the contract between them originally dated as of January 1, 2017, Contract #35485, as amended to date, (the "Contract") is hereby amended effective January 11, 2019 by the State as follows:

I. **Maximum Amount.** The maximum amount payable under the contract, wherever such reference appears in the Contract, shall be changed from $49,777,684.26 to **$50,976,274.91**; representing an increase of $1,198,590.65.

II. **Attachment A, Scope of Services.** The scope of services is amended as follows:

a. **Section I.I. (Location of Services) on page 7 of 106 of the base agreement is hereby deleted in its entirety and replaced as set forth below:**

I. Location of Services
All Key Staff positions must be filled with employees physically located in the State of Vermont. Permanent changes to staffing location requirements shall be presented to the State prior to any candidate selection process and can be modified upon mutual agreement in advance of filling the position. During the course of this agreement, it may be necessary for the Contractor to lease additional space in Vermont in order to fulfill project requirements described within Attachment A. The Contractor shall provide a cost estimate for any additional space required and any approved additional funding for space will be added to this agreement via an Amendment. Amendment 3 includes funding for additional Contractor space to be billed monthly as utilized.

The Contractor will perform the following Services at the Contractor's Vermont facility:

- Claim Receipt and Prescreening
- Checkwrite-related activities
- Business Operations (e.g. manual checks, accounts receivable, cash activity)
- Provider Enrollment
- Provider Call Center
- Print and Distribution
- Suspense Resolution
- Quality Assurance
- Clinical Specialist (PT ("Physical Therapy")/OT ("Occupational Therapy")
- Minimum 5 Application Developers on site in VT
- Minimum 3 Business Analysts
- Minimum 3 Data Analytics Reporting Specialists

The following services may be performed outside of Vermont but within the continental United States:

- Data Center / Operations / Data Processing
- Claims Input (data entry / OCR ("Optical Character Recognition")
- Network Administration

- Application development (to supplement onsite staff)
- Data Analytics Reporting Specialist (to supplement onsite staff)
- Reference File Maintenance

b. 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. 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 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.a) are modified, commercially reasonable practices shall be enhanced and applied to any projects affected.

A. 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.

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

Item #	Item	Billing	Provider 6028 Project Description
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 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

Item #	Item	Billing	Provider 6028 Project Description
			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**

B. 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 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.

C. 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 consists of the following activities. The project budget for the duration of the contract, is based on the annual estimates below:

MAPIR Customization Activity	Annual Hour Maximums	Contract Hour Maximum
Environmental Changes (DB2, Websphere/Stored procedures)	120	360
MAPIR Installation	120	360
State Configuration	80	240
Additional Customization	300	900
Project Management	300	900
Testing	120	360
Subtotal	**1,040**	**3,120**
Technical Support of VT production environment	500	1,500
Annual Customization Hours	**1,540**	**4,620**

D. APM ("All Payer Model") Project (2016-2017): Complete

Vermont is currently adopting Medicaid payment reform, in alignment with the CMS Next Generation ACO ("Accountable Care Organization") Model for Medicare. MMIS claims processing application supported by the Contractor will be modified and configured to support capitated payments to one or more Vermont ACO's. The EVAH ("Enhanced Vermont Ad-Hoc")

reporting tools and reports will be updated to provide the reporting required to support the ACO program as well as continued reporting for Fee for Service claims.

The following table provides the high-level descriptions for scope of the Contractor systems work which was completed in the initial project phase, prior to August 2017.

Systems Area	Description of Changes – 2016-2017 Scope of Work
MMIS Reporting	Update MMIS-generated reporting for state audit reporting, T-MSIS, and others as needed
EVAH (user-generated) Reporting	This scope of work was determined to be not required for scope of the project.
Contractor Project Management	Project management and status reporting.
Provider Outreach and ACO Support	Additional Provider outreach and documentation during transition to ACO payment model; ACO documentation and training
Support for Operational Readiness	Contractor support of operational readiness phase activities with the State
Project Contingency	State management reserve for mitigating risks due to unknown requirements, including changes due to future contract negotiation with ACO.
Billing January through July 2017	**$117,142.46 (971.25 hours)**

E. 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.

MMIS System Work Description	SME Est. Hrs	BA Est. Hrs	Est. Cost
VNMG ACO MMIS enhancements (August 2018 – June 2019)			
Modify batch process and MMIS screens for third party liability claims, to support third party billing for ACO claims that were not paid as fee-for-service	329	215	$68,000

Assign Health Service Area, new PA 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.	248	93	$42,625
Enhance MMIS and Business Objects data warehouse reporting capabilities, to support ACO financial reconciliation activities.	150	100	$31,250
Allow claims service limit exceptions to prior authorization requirements for ACO members - codes, limits, associated flags, and reports	75	50	$15,625
Reform Initiatives - MMIS enhancements (August 2018 – December 2019)			
Support additional billing modifiers for reporting, billing, limits, flags, and payments for adult and child mental health claims (such as the T2025 case rates)	100	100	$25,000
Capture FPL between DMH and Access for CRT populations	40	40	$10,000
Applied Behavior Analysis - MMIS Analysis and Design for support alternative payment models	100	100	$25,000
Children's and Adult Mental Health - MMIS Analysis and Design for support of detailed encounter data capture and payment models	100	100	$25,000
SUD waiver - modify MMIS claims and financial processing to support change to substance abuse program	100	60	$20,000
Development Disability Services - MMIS Analysis and Design for support of detailed encounter data capture and payment models	100	100	$25,000
Pediatric Palliative Care - MMIS Analysis and Design for support of alternative payment models	100	100	$25,000
	1442	**1058**	**$312,500**

F. Medicaid Pathways

MMIS enhancement work for the Medicaid Pathways project requires future definition and funding through a Contract amendment or other work authorization mechanism.

The State's Health Care Innovation Project, also referred to as Medicaid Pathway to and Integrated Health Care System, is funding a workgroup to develop options for an organized delivery system for serving individuals with mental health, substance abuse treatment, and developmental service needs.

MMIS system enhancements will be required for the State to implement the resulting approved delivery system design.

Medicaid Pathways Activity	Hour Estimates
Project Management	100
Analysis and Design	500
Subtotal Hours Estimate	**600**

G. New Medicare Card Project: Completed

The State submitted an IAPD to 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).

In order for the State to be fully compliant, policies and systems must be examined, the appropriate changes identified, and modifications tested prior to CMS distributing new Medicare cards (est. April 2018). MMIS will require 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 will align with the schedule proposed in the IAPD. Construction and functional systems testing of MMIS will occur in September 2017 through March 2018, with integration testing and implementation activities for MMIS changes occurring in 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.
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**

H. TMSIS Reporting Enhancement Project

The State is submitting an updated APD to account for the work across systems, to provide additional TMSIS data elements. Effort is planned for enhancements to derive and obtain additional data to include in TMSIS reporting, and to install planned quarterly releases of the Contractor's Common Solution into the State's systems environment. The Common Solution provides common TMSIS database structures and includes programs to generate the CMS monthly submissions. Using this common code reduces the overall cost to CMS and to the State.

The defined Project work as identified in the tables below is estimated to be completed within 15 months of project start date, pending CMS authorized start date for IAPD funded work. In addition, a budget is established for monthly quality analysis, design, and implementation of further improvements to TMSIS data. This Quality Analysis and Improvements budget will enable ongoing assessment with CMS and its vendors for future enhancements beyond those identified to-date.

Summary

Quality Analysis and Improvements	Duration	Hours
2018 Monthly Quality Analysis and Improvements	12 months	720
2019 Monthly Quality Analysis and Improvements	12 months	720

Project Subtotals of Effort	Duration	Hours
GAP Compliance	4 months	645
Addendum B Table 3	10 months	2070
Common Solution Integration	15 months	940
Total Project hours	**15 months**	**3655**

GAP Compliance Report Items	Duration	Hours
Requirements Analysis	2 weeks	60
Construction and Testing	3 months	525
Implementation	2 weeks	60
Total GAP Hours	**4 months**	**645**

Addendum B Table 3 Items	Duration	Hours
Requirements Analysis	2 weeks	60
Construction and Testing	8 months	1960
Implementation	2 weeks	50
Total Addendum B Hours	**10 months**	**2070**

Common Solution Items	Duration	Hours
Requirements Analysis	2 weeks	60
RELEASE V2.0.00	3 months	200
RELEASE V2.0.01	3 months	200
RELEASE V2.0.02	3 months	200
RELEASE V2.0.03	3 months	200
Implementation	2 weeks	80
Total Common Solution Hours	**15 months**	**940**

I. Presumptive Eligibility (PE) Project: Complete

Work on this project was completed as of March 2018. Vermont hospitals may determine presumptive eligibility as allowed under 42 CFR 435.1110. The State is providing Medicaid coverage for individuals under this provision, consistent with Vermont DCF Health Benefits Eligibility and Enrollment rule 66.04. Enhancements to the MMIS system are needed to align with ACCESS eligibility system enhancements, where MMIS will receive, 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 will also be updated, 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
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**

I. Medicare Grant Project: Complete

Work on this project was completed by July of 2017. MMIS will process the Medicare Blueprint and Community Health Team (CHT) payments on behalf of the State through a Medicare Grant effective 1/1/2017. Funding comes 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.

J. 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 an existing, vendor-hosted 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 vendor 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 CM interface.

The Contractor has budgeted for 1,000 hours of effort for this activity. This work will be performed as directed and agreed to by the State.

K. 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:

- 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.

- 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 seven-month schedule for implementation activities, to be followed by a two-month trading partner testing window. All days referenced are based on calendar days. 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 30 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.
- Transaction crosswalk design documents, for identifying X12 field level requirements, by day 90 of the implementation project.
- 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.
- 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 review no later than end of month six (6) of the implementation timeline.
- 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	Schedule	Fixed Price Charge
Claim Compliance Analysis testing and design	Month 3	$93,750
Acceptance of Project Work Plan, EDI Interface Design, and transaction crosswalk deliverables; EDI Service Model Office and UAT test environments are installed	Month 6	$100,000
Implementation Project Complete, Trading Partners migrated to enhanced EDI Service, all Project deliverables accepted	Month 9	$250,000
Total One-Time Costs		**$443,750**

L. Provider Services Enhancement Project

The Provider Management Module (PMM) is a project under the Medicaid Management Information System (MMIS) Program and is part of the overall MMIS Road Map as presented to CMS. The PMM project is 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 will deliver the enhanced Provider Services SaaS, which will be utilized by Providers, the State, and the Contractor in continued performance of the Contractor's Provider Services fiscal agent (FA) responsibilities as described in Attachment G, Provider Services Enhancement Project Scope of Work.

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

DDI Phase	Deliverables Included	Payment	Timing
Planning and Installation	Install Test Environments Project Management Plan Quality Management Plan Data Conversion Specifications Testing Artifacts – initial version Training Plan	$450,000	Month 3
Integration Testing and User Acceptance Testing	Business Configuration Specifications Documentation Testing Artifacts – Final Versions Requirements Traceability Matrix (RTM) Training Rosters	$722,826	Month 7
Implementation	Operational Checklist and Results Solution Documentation for Software Modules Interface and Deployment Specifications	$1,150,000	Month 10
Certification	Certification Management Plan CMS Certification Checklists deliverables Certification Acceptance	$700,000	Month 16
Total		**$3,022,826**	

M. Electronic Visit Verification Project

The purpose of the project is to ensure the State is compliance 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

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 implementation of the EVV solution is planned as fixed price costs to be invoiced based on State acceptance of the implementation deliverables and for ongoing services charges:

Table A: EVV Implementation / Operations Budget

Phase	Deliverables Included	Payment	Timing
Implementation	Implementation deliverables as specified in Attachment A, Exhibit 4 Electronic Visit Verification Solution Statement of Work	$784,400*	Month 5
EVV Support / Operations	Ongoing support and minimum transactional service charges, as specified in Attachment B, Section 5 A. MMIS Operations of this document.	$12,710	Monthly
Operations – 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. A per transaction charge will be assessed at a rate of 0.225 per transaction billed monthly.	$5,438	Monthly
Operations – 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. A per member per month (PMPM) will be assessed at a rate of $1.375 per member billed monthly.	$3,436	Monthly

*The optional Consumer Direct components represent $37,555 of the overall implementation budget. There are no specific additional ongoing operational charges associated with the Consumer Direct options.

N. 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**

III. By deleting within Exhibit 2 Service Level Requirements, Section F (Data Services Technical Non-Functional) beginning on page 45 of 106 of the base agreement and substituting in lieu thereof the following Exhibit 2, Section F:

F. Data Services Technical Non-Functional

Req. #	Requirements
6.1	Maintain MMIS systems documentation, in adherence to recognized systems development life cycle structured approaches and state-specific documentation standards, including: - Vermont MMIS System Documentation, including documentation of subsystems - Edit and audit listing with detailed criteria (e.g. Reso page specifications) - Pricing rules documentation (e.g. Claims Pricing Manual) - Software Development Documentation - Systems Test Documentation - Operating Procedures for MMIS systems support (automated and manual) - Business Continuity and Disaster Recovery Plan - Database documentation (e.g. MMIS Data Dictionary) - Value tables with code value listing and descriptions (i.e. Codes Reference Manual)
6.2	The Contractor shall transfer data copies of production database tables to AHS via a formal Extraction Transformation and Loading (ETL) process on a mutually agreed upon means and routine periodic basis (e.g. weekly)
6.3	The State has the authority to audit the currency of all system documentation with 10 workdays of notice. If documentation is not current, the Contractor will update it within 30 calendar days or a period of time mutually agreed to by the State and the Contractor.
6.4	Provide for offsite disaster recovery of core MMIS online and batch applications, excluding OnDemand and Business Objects, at a backup data center location, in the event of a disaster impacting the availability of core MMIS at the primary data center location

Req. #	Requirements
6.5	The MMIS must be protected against hardware failure, software malfunction, and human error. The MMIS includes appropriate checkpoint/restart capability and other features to ensure reliability and recovery, including telecommunications reliability. For purposes of this contract, "disaster" means an occurrence(s) of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the MMIS, and/or affects the performance, functionality, efficiency, accessibility, reliability, and security of the system. Disaster events may include natural disasters, human error, computer virus, sabotage, terrorism or a malfunctioning of the hardware or electrical supply.
6.6	Prepare, provide to the State prior to the start of operations, a Business Continuity and Disaster Recovery Plan. At a minimum, the preliminary Business Continuity and Disaster Recovery Plan must include specifics regarding: - Checkpoint/restart capabilities. - Hardware backup for MMIS application servers and storage. - Contractor telecommunications equipment. - Network backup for telecommunications to ensure that committed transactions are backed-up off-site. - Continued processing of transactions (e.g., claims), assuming the loss of the Contractor's primary processing site; this will include interim support for MMIS online functionality. - Back-up procedures and support to accommodate the loss of online communication - Contractor's processing site; these procedures will not only provide for the batch entry of data and provide the Contractor with access to information necessary to adjudicate claims but will also provide the State with access to the MMIS online application necessary to perform its functions. - File and software backup accommodations and procedures, including the off-site storage and retention of crucial transaction and master files; plan and procedures will include a detailed schedule for backing up critical files and their rotation to an off-site storage facility; the off-site storage facility will also provide for comparable security of the data stored there, including fire, sabotage, and environmental considerations. - Maintenance of current system documentation and source program libraries at an off-site location. - Develop back-up procedures to support requirements for State approval, including safe off-site storage and copying of programs and data files of the MMIS.
6.7	Establish and maintain: - Complete daily backups that are adequate and securely stored, for all software and operating programs; data, files, and system, operations, and user documentation (in electronic and hardcopy). - A complete weekly backup that is adequate and securely stored in an approved off-site location, for all software and operating programs; data, files, and system, operations, and user documentation (in electronic and hardcopy). - Complete backups that support the restoration and recovery of lost or corrupted data or software within two calendar days.

Req. #	Requirements
6.8	Maintain or otherwise arrange for an alternative site for use in the event of a catastrophic or other serious disaster event. This site must provide for complete restoration of normal operations, as well as other system and services deemed necessary by the State
6.9	Specify the respective time frames deemed reasonably necessary for complete recovery. The recovery period shall not exceed two calendar days for critical functions: MMIS claims batch functions including claims and financial batch processing for payments to providers; and availability of MMIS online screens for claims, prior authorization, provider management, provider enrollment, reference, and third-party liability maintenance features. The recovery period for all other MMIS functions (including OnDemand, Business Objects, AVR, and non-critical online MMIS screens) shall not exceed 30 calendar days. Implement all steps necessary to fully recover the data and/or system from the effects of a disaster and to reasonably minimize the recovery period.
6.10	Demonstrate disaster recovery capability for production system environment components which are dedicated to Vermont use and with critical (2 day) recovery periods, no less than every calendar year or coincident with significant changes to MMIS core systems. Documentation of failover test results must be provided to the State. The Vermont Disaster Recovery Plan will also address availability and recovery approach for non-critical and shared systems components, which are outside the scope of the Vermont failover test.
6.11	If the MMIS becomes unavailable during the contract period, the State may require the Contractor to convert to the failover site. In this event, the Contractor will not be allowed to return to the original site without State approval. State approval will depend upon the Contractor's ability to demonstrate that the original site is again fully operational and that all systems are available.
6.12	Maintain reporting database claims history retention for 10 years

IV. By adding Exhibit 4 (Electronic Visit Verification Solution Statement of Work):

Exhibit 4
Electronic Visit Verification Project
Scope of Work

1. Electronic Visit Verification (EVV) Project

This Scope of Work (SOW) is made subject to and will be governed by the terms and conditions of the January 1, 2017 Contract between the State of Vermont, Department of Vermont Health Access ("the State") and DXC Technology Services LLC (the "Contractor"). This SOW defines the work to be performed, the responsibilities of the parties, and key assumptions and terms guiding the implementation project (the "Project") for delivery of the EVV Solution (the "Solution"). Contractor will partner with the leading EVV Software Vendor, Sandata Technologies, LLC (the "Supplier") to implement a software-based services solution to support the State's compliance with the CURES Act. The term of this SOW is no later than 4 months from date of signature through end date of Contract #35484.

2. Purpose and Scope

The purpose of the project is to assist the State in complying 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 EVV solutions for defined personal care services by January 1, 2020. Non-compliance of the requirements can lead to a reduction in the Federal Medical Assistance Percentage (FMAP) for the associated personal care services.

Table 1 below summarizes the modules planned for deployment as a result of recent scoping discussions with State leaders. Items listed as optional may be added to the overall scope. At this time, all items are included in the Table A EVV Implementation / Operations budget in Section M - Electronic Visit Verification Project of Amendment 3.

Table 1. State Selected EVV Modules

Module	In Scope	Optional
Supplier Software Services Includes both telephonic and mobile application for IOS and Android. Sandata recommends a "Bring your Own Device and Data Plan" model where the providers are responsible for providing caregivers with devices for use with Mobile Visit Verification. EVV will be used by members receiving care from Provider Agencies and Consumer Direct program	☐	
Supplier Provider and Fiscal Agent Portals Web based provider portal for providers to review and make corrections to visit data and includes a 'provider' portal for the Consumer Direct Program fiscal agent.	☐	
Supplier Jurisdictional View (JV) Portal Read only portal for the State and Contractor to review and report on program information.	☐	
Supplier EVV Aggregator Allows providers to use and pay for their own third party EVV systems, while integrating all third party EVV data for view by the Contractor and the State. Data in the Aggregator is normalized across all EVV vendors to provide an accurate view of visit verification, regardless of source system.	☐	
Supplier MMIS Claims Validation Ensures the appropriate business rules are defined for matching claims and EVV Aggregator Data as well as updates to the MMIS claims edits and adjudication process to include EVV validation.	☐	
Supplier Consumer Directed Care (CDC)—Additional Portals In addition to the standard EVV portal for the Contractor to monitor the Consumer Direct program EVV activity, the State can chose to deploy additional EVV portals for participants and their caregivers to allow them to manage, edit and approve their EVV created timesheets.		Optional
Sandata CDS Data Interface		Optional

If the Supplier Consumer Directed Care Additional Portals is selected, then this additional data exchange from the Contractor will be needed to support management of participant and caregiver portal access.		

3. Solution Requirements

The Contractor will deliver the Solution, which will be utilized by providers, the State, and the Contractor. The Solution is comprised of the following services:

3.1. EVV Software Services

The following Supplier software modules are delivered and maintained as a Software as a Service (SaaS) made available via the Internet. The Supplier provides all hosting, software updates, and software support for the following software components as part of this service:

- Electronic Visit Verification;
- Provider EVV Portal;
- Consumer Directed Care Fiscal Portal;
- Consumer Directed Care Additional Portals (Optional)
- Jurisdictional View Portal;
- EVV Aggregator.

3.1.1. Electronic Visit Verification

The Electronic Visit Verification service captures all of the following data elements required for 21st Century Cures Act compliance:

- Member ID
- Caregiver ID
- Service Type
- Service Date
- Service Start and End Time
- Service Location

In addition, the EVV service captures the following additional data elements:

- Tasks
- Member verification of time of visit and services provided

3.1.2. The following EVV component options support capture of visit verification data:

- Telephone Visit Verification™ ("TVV™") – TVV uses Automatic Number Identification ("ANI") technology to validate telephone calls to record visit data in near real time.
  - Includes two U.S. based toll-free telephone lines for providers to record services provision data twenty-four (24) hours per day, seven (7) days per week, excluding downtime for routine system maintenance.
- Sandata Mobile Connect™ – ADA Section 508 compliant application for mobile devices. Sandata Mobile Connect uses GPS technology, verifying location via GPS enabled devices (mobile phones).
  - Providers shall use their own mobile devices to download supplier's mobile application and their own data plans to transmit visit transactions.
  - Provider devices must conform to supplier's published minimum device specifications and direct care providers must have an appropriate mobile communication plan in place to utilize Sandata Mobile Connect.
  - As a SaaS product, the Supplier routinely releases functionality to meet the needs of our customers. For the Sandata Mobile Connect application, as new releases become

available, they are published to the respective stores (IOS or Android) and users are automatically prompted to download the latest version of the application

3.1.3. Both TVV and Sandata Mobile Connect will be provided in the following languages: English, Spanish, Russian, Somali, Mandarin Chinese, and Egyptian Arabic.

3.1.4. Provider EVV Portal and Consumer Directed Care Fiscal Portal
The Provider EVV Portal and Consumer Directed Care Fiscal Portal, are web-based services for authorized provider and the Contractor log-on and data entry. The Fiscal Agent role of the Contractor for EVV access purposes, is defined as the entity contracted by the State to manage the consumer-directed care program.

3.1.5. The Provider EVV Portal and Consumer Directed Care Fiscal Portal shall support the following functions:

- Provide log-on and access to designated staff and to designated providers and the Contractor. Administrative terminal functionality shall include multi-level access controls to ensure that only authorized individuals can process administrative transactions or access member account information through administrative terminal.
- Provide the ability to maintain data including but not limited to the following records for tracking direct care providers, client/member, and visit information: recipient first name and last name; recipient telephone number; recipient address; recipient Medicaid ID; Direct Care worker ID; Direct Care worker first and last name; service provided; service date; service start and end time; service location; tasks; and visit status (i.e. in process, incomplete, verified, processed, omit).

- A record will be created in the database whenever any of the following actions occur:
  - A check-in is successfully completed by a direct care provider
  - The record shall be amended at the check- out to add the check-out time
  - A record will be created in the database whenever a successful check-out is completed
- The EVV Provider Portal and Sandata Consumer Directed Care Fiscal Portal will record any exceptions that occurred on the visit. The Contractor will work with the State to review and agree on the exceptions based on the configurable exception options which include:
  - Client Signature Exception
  - GPS Distance Exception
  - Missing Service
  - Service Verification Exception
  - Unknown Client
  - Unknown Employee
  - Unmatched Client ID/Phone
  - Visit Verification Exception
  - Visits without in calls
  - Visits without out calls
- Provider entry or edit of visit data: For certain service encounters, Providers will use the EVV Provider Portal or Consumer Directed Care Fiscal Portal to enter data into the system. Data entry and/or edits to service encounter information are allowed only for certain defined and pre-approved circumstances for which documentation of service delivery and reason for manual entry or record edit exists. Optional comments may also be entered for manual edits. The service shall also show to the provider or fiscal agent the equivalent duration for the times entered and required reason codes for changes.
- The Contractor will work with the State to review and agree upon the list of reason codes.

- The EVV Portal and Consumer Directed Care Fiscal Portal include the ability to receive data from import files formatted using Supplier standard specifications for authorizations, clients/members, providers, and member/direct care worker crosswalk for the consumer directed population (if the Consumer Directed Recipient and Caregiver EVV Portals are selected). Authorization data will be used to determine the provider agency that is providing services to the client/member and will allow that member Information to reside in that provider's EVV system.
- If data is not made available via imported files, the Provider EVV Portal or Consumer Directed Care Fiscal Portal allow for manual data entry of this information by the providers or fiscal agents. The Contractor will work with the State to define the policy regarding the usage of these manual data entry features.
- Providers or fiscal agents with appropriate roles-based access will have the ability to enter direct care provider information. Direct care provider information shall include the following:
  - Direct care provider first and last name
  - Direct care provider ID
  - Start Date
  - Termination date
  - Record creation date
  - User creating record
  - Last update date
  - Last updated by
- The system records include an audit trail of manually entered information including:
  - User name
  - Date of entry
- The Provider EVV Portal and Consumer Directed Care Fiscal Portal allow providers and fiscal agents to run standard reports.
- During the implementation, the Contractor will work with the State to configure roles-based access to the EVV applications based on State business rules. The business rules document shall be the deliverable reviewed and accepted by the State for capturing authorization configurations for EVV applications.

Supplier Consumer Directed Care – Additional Portals (Optional)

- In addition to the standard EVV portal or the Fiscal agent to monitor the Consumer Direct program EVV activity, the State can choose to deploy additional EVV portals for participants and their caregivers to allow the State to manage, edit, and approve their EVV created timesheets.
- A decision on this option must be made 4 weeks prior to scheduled kick off meeting in order to be completed in the same implementation cycle. If the State does not implement the additional portals during the initial implementation but decides to implement these portals later, the change order process shall apply.
- Includes portal for viewing, editing, and approving visit data for participants and caregivers.
- Include specific EVV system configuration for the Consumer Direct EVV program.
- Includes the following training activity for the Consumer Direct fiscal agent to support them training and providing Tier 1 support for Consumer Direct EVV users:

3.1.5.1. Five consecutive days of Supplier trainer classroom training for designated CDS staff;

3.1.5.2. Onsite classroom training does not include computer rental and facility charges for each classroom training session and must be provided by the State.

3.1.6. Sandata Jurisdictional View Portal

- The Jurisdictional View service shall support the following functions:
  - Each EVV recipient is set up in the system and assigned to the authorized Provider. Authorized State users can filter and run reports to show all system activity related to recipients.
  - The Jurisdictional View service shall include real-time web interface reporting and online screen display of service delivery encounters. Display of data from the Provider accounts is for viewing parties specified by the State, for monitoring of service delivery.
  - Standard reports shall be available. All reporting shall be available on-demand and reports can be printed or downloaded electronically, in .PDF, Excel, and .CSV formats.

3.2. Data Exchange with EVV Software Services

3.2.1. The State, shall provide the following data files using the Contractor's standard data specifications:
- Member File
- Authorization File
- Provider Agency File

3.2.2. The CDS Fiscal Agent, shall provide the following data files using the Contractor's standard data specifications (Optional):
- Employee File
- Employee/Member Crosswalk File

3.2.3. The CDS Fiscal Agent shall receive the following data files using the Contractor's standard data specifications (Optional):
- Export of Visit Data to Fiscal Agent
- Export of Approved Visits for Payroll

3.2.4. The Contractor will provide the latest versions of the above Contractor's standard data specifications before the analysis and design phase begins. The Contractor will participate in meetings with the State to understand the data exchange requirements contained in the latest versions of the specifications.
- The Contractor will participate in meetings with the State to understand the data contained in the latest version of the data warehouse export specification.
- The Contractor will load the EVV data extract, into the MMIS AIM system database and into the EVAH data warehouse database, for subsequent program monitoring and assurance purposes by the State.

3.3. Sandata Aggregator

3.3.1. The Contractor will support third party provider interfaces that send third party EVV data to the Sandata EVV Aggregator using the Contractor's standard third party interface specification.

3.3.2. The Contractor will work with the Supplier and the State to determine the data elements required in the Aggregator and update the Third Party Interface data documents to reflect those interface requirements.

3.3.3. The following process will be followed to complete all interface work:

- All Providers who select to use a third party interface must first register with Supplier during the implementation process. At that point, the Provider receives their testing credentials
- All Providers must execute certain documents, such as a Business Associate Agreement, Data Use Agreement, and API License Agreement, prior to use of the interface.
- The Provider is responsible for correcting all errors and sending a revised file to retest.
- Once the Provider interface passes the automated testing, the interface is approved for production. At that point, the Provider receives their production credentials.

3.4. MMIS Claims Validation

3.4.1. The Contractor will work with the Supplier and the State to ensure the appropriate business rules and data exchange requirements are identified to support matching claims and the resulting EVV Aggregator Data in the MMIS.

3.4.2. The Contractor will implement new edits to match the EVV visit to the claim submitted for payment based on State defined rules.

3.4.3. The Contractor will use the EVV Aggregator data for claims processing and reporting.

3.5. Environments

3.5.1. The Supplier will create the following environments as part of the implementation process:

- (Supplier access only) Development-level test environment for Supplier testers to deploy target builds and perform integration, data interface testing with Contractor, and regression testing.
- A test environment will be provided for User Acceptance Testing to be performed by Supplier and the State.
- Upon completion of User Acceptance Testing, a training environment will be provided to support all EVV Training.

3.6. Training for EVV Software Services

3.6.1. The Contractor will be responsible for working with the State to define a training plan during the implementation process, to support implementation training and roll out.

3.6.2. The Contractor will provide electronic training materials in English only. The types of documentation materials available include:

- System Users Guides
- E-learning Training Content
- Quick Reference Guides / Cards
- Training Plans
- Training Decks, suitable for onsite instructor led or webinar

3.6.3. The Contractor will provide a separate training environment for provider and fiscal agencies. New users may access the training environment through a secure web portal. The training environment may be used for program launch training, for all major releases, and for training of newly hired provider or State staff after go-live. The training environment will remain available throughout the life of the program for providers and fiscal agencies to continue to train their staff and members. It will always be kept updated to the level of the production environment

3.6.4. The Contractor will deliver EVV training to provider agencies and Jurisdictional View users.

3.6.5. Two days of trainer-led classroom training are included for the 16 providers and 1 fiscal agent identified.

3.6.6. Onsite classroom training does not include computer rental and facility charges for each classroom training session; training facilities will be provided by the State. Facility reservation, coordination, or payment for facilities or training equipment is outside the scope of this contract and is the responsibility of the State.

- One webinar training session is included, that is organized in three (3) two-hour modular webinar sessions.
- Five (5) consecutive days of Train the Trainer for up to 10 Self-Directed Fiscal Agent attendees in the Train the Trainer session.
- Fiscal Agents or designees will be responsible for providing all outreach and training to Members and Caregivers participating in the Self-Directed care program.
- A Learning Management System will be provided that can be accessed for independent training during implementation and post go-live.
- Direct Member or Caregiver training by the Contractor is not in scope. Training materials will be made available to Provider Agencies and Fiscal Agents to share with their caregivers and/or members to support the training activities.
- Additional Contractor-led training may optionally be provided, at an additional cost.

3.6.7. All training materials and delivery are available in English; if additional languages are required for training delivery, additional fees will apply.

3.7. Operations and User Support for EVV Software Services

3.7.1. For the SaaS product, there are releases functionality to meet customer requirements.

3.7.2. There are periodic releases for the services to ensure that the service continues to meet the latest standards and regulations.

3.7.3. Users are notified in advance of all scheduled releases.

3.7.4. For the Sandata Mobile Connect application, as new releases become available, they are published to the respective stores (IOS or Android) and users are automatically prompted to download the latest version of the application.

3.7.5. Contractor's EVV System up time Service Level is 99.9%, not including scheduled downtime. Contractor will report system up time to the State monthly.

3.7.6. The Contractor will provide Tier 1 and Tier 2 Customer Care help desk support to providers and Jurisdictional EVV users.

3.7.7. Customer Care services will be provided in English only.

3.7.8. The Customer Care help desk will have live agents available during normal business hours of 8 am to 5 pm Eastern Time, Monday through Friday, except for the observed holidays as reflected below:

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas

After Hour Support: For system outages, a customer care caller can activate immediate after hours support for outage resolution. For non-urgent needs, callers can leave a message which will be returned the next business day.

3.7.9. When the Self-Directed Recipient and Caregiver EVV Portals are implemented, the Fiscal Agent (s) shall be responsible for providing Tier 1 support to all Members and Caregivers participating in the Self Directed Care Program.

- "Tier 1 Support" means support services provided by the Fiscal agent's help desk personnel: (a) to answer questions regarding the use or operation of the system and (b) to report errors within the system.
- It is assumed and the pricing in this SOW is based on the fact that a minimum of 90% of customer Care calls will be handled by Fiscal Agent Tier 1 by no later than 6 months post system go live. If this percent of Tier 1 calls is not achieved by such date, then Supplier reserves the right to reevaluate the Customer Care plan and fees. Measurement would be based on "Total EVV support calls to Supplier from Fiscal Agent divided by total EVV support calls to Fiscal agent".

4. Implementation Requirements

This section further elaborates on aspects of the Implementation of the EVV Solution, in addition to those implementation activities explained in the Solution Requirements section above. The following approach requirements are the basis for the project work plan, scope, and associated costs models. If any of these items are determined to be incorrect or invalid, then the resulting impact will be assessed and resolved through the State's change control process.

4.1. Implementation Project Assumptions

4.1.1. Recent CMS guidance was issued requiring a streamlined Certification process. At this time there is not enough information available to determine resources, additional fees, deliverables, and support. The effort and cost associated with CMS certification activities will be accounted for in a future new or amended Statement of Work.

4.1.2. The technology meets the CMS certification checklist criteria as described below:

MITA Ref #	System Review Criteria	Solution Meets Criteria
PE.PI1.22	The electronic visit verification (EVV) module captures, tracks, and verifies data with respect to personal care services or home health care services, including: • Type of service performs • Individual receiving the service • Date of service • Location of service delivery • Individual providing the service, and • Time the service begins and ends.	Yes
PE.PI1.23	The EVV module is configurable to support multiple programs or services which have different policies, procedures and business rules, all of which are subject to change during the contract period.	Yes
PE.PI1.24	The EVV module is able to receive information in batch and individual transactions.	Yes
PE.PI1.25	The EVV module verifies visit components within program requirements when the direct care worker initiates the visit verification. Each visit initiated through the EVV should be captured, whether or not the visit is verified.	Yes
PE.PI1.26	The EVV modules requires providers to attest to the presence of hard copy documentation for any manual visit verification.	Yes
PE.PI1.27	Providers are able to submit necessary verification information via alternate methods, should the primary mode of submission be out of	Yes

	service. (For example, if a handheld device is not working properly, the provider is able to phone in the visit information or submit it via a website portal).	

4.1.3. The Contractor assumes a "Bring your Own Device and Data Plan" model where the providers or caregivers are responsible for providing devices and data plans for use with the Sandata Mobile Connect application.

4.1.4. The scope of system configuration activity will consist of setup, configuration, and validation of EVV portal for up to sixteen (16) Provider Agencies and one (1) Consumer Direct Fiscal Agent.

4.1.5. Operations Phase work begins when the Solution goes live through the end of the SOW term.

4.2. Project Timeline

4.2.1. A project start date will be mutually agreed upon and finalized, dependent on the execution of the Amendment 3 between the State and the Contractor. The project start date will be mutually agreed upon within three months after the execution of the Amendment.

4.2.2. Once agreed upon and baselined, changes to the Project Plan schedule will be resolved through the State's change control process. It shall be the joint responsibility of the State and Contractor to monitor the project schedule and take steps deemed reasonable to avoid schedule non-compliance.

4.2.3. Assuming Contract changes are not requested, the Project Plan will indicate completion of implementation of the Deliverables approximately four (4) months from the implementation start date, plus any time required for optional services such as added days for User Acceptance testing.

4.2.4. User Acceptance Testing (UAT) will occur during a pre-defined ten (10) business day period during the implementation project and will be based upon pre-defined testing scripts provided by the Contractor and/or the State. Optionally, the State may select one or more additional weeks of UAT time at additional project cost.

4.2.5. Test scripts provided by the Contractor will be written and customized against the defined business rules document to test the State of Vermont's implementation. The test cases will be tied to the Requirements Traceability Matrix. The test cases will also be provided to the State for review and comment prior to UAT Execution.

4.3. Implementation Deliverables

4.3.1. EVV Software Services configured for use by State and its program providers.

4.3.2. Project Plan. An initial implementation project plan (the "Project Plan") will be agreed and finalized as part of the implementation process and will be updated throughout the implementation process as agreed to by both parties.

4.3.3. A comprehensive outreach strategy and recommended documents to support outreach to ensure all stakeholders are knowledgeable about the new EVV program and Contractor's solutions.

4.3.4. Status Reports. Weekly written status reports will summarize the tasks and activities performed for that time period, activities proposed to be completed in the next time period, and any risks and issues that need to be escalated and tracked.

4.3.5. Requirements Analysis Sessions. As part of the implementation process, the Contractor and Supplier will conduct business review meetings with the State. Attendees of these meetings include Subject Matter Experts on program operations from the Customer and

Contractor staff, State Business Analysis staff, as well as the Supplier Technical Lead and the Implementation Manager. The Supplier Technical Lead and the Implementation Manager lead these guided sessions to review program policies as well as EVV system functionality and configurability. During these sessions the program rules and corresponding system configurations will be documented. Evidence of these sessions will be provided in the form of meeting minutes.

4.3.6. Business Rules Document. A Business Rules document which includes implementation decisions, must be reviewed and accepted by the State prior to configuration of software services.

4.3.7. Data Exchange Specifications Documents. Once the Business Rules Document is completed and approved, a Data Specifications document will be created which describe all of the data exchanges required to support the program. In addition to the Contractor's standard data specifications content, Vermont data-specific decisions will be documented. These specifications documents must be reviewed and accepted by the State prior to configuration of software services.

4.3.8. User Acceptance Test Plan. The State will produce a User Acceptance Test Plan document, with input by the Contractor. The UAT Plan will include roles and define the test strategy for all selected modules as identified in section 2 table 1. UAT testing will be based on predefined test scripts provided by the Contractor and reviewed by the SoV.

4.3.9. Integration Test Plan. An Integration Test Plan will be created by the Contractor for review and acceptance by the State, for data exchange between the modules and other SoV applications (including MMIS). The Integration Test Plan will identify Contractor and State roles and testing strategy for data interfaces, based on the Contractor's standard testing process.

4.3.10. User Acceptance Test Scripts and Results. Test scripts provided by the Contractor will be customized to validate State-specific rules and configuration of the selected modules. Sandata will demonstrate traceability of the test scripts to documented Vermont needs as identified within the implementation deliverables Business Rules and Data Exchange Specifications.. Test scripts will be provided for review by the State prior to UAT execution of the test scripts. The Contractor will provide summarized results of its own test execution.

4.3.11. Training Plan. The Contractor will collaborate with the State in development of a training plan. The training plan will identify agencies and user groups to be trained, will identify the scope of training for State-specific use of modules, and will identify the schedule for training.

4.3.12. Training Manuals. The Contractor will develop all training materials for agreed upon training modalities, as described in the "Training for EVV Services" section above.

4.3.13. Training sessions. Evidence of training performed, as identified in the section above "Training for EVV services", will be provided in the form of training registration artifacts identifying what persons registered or attended training sessions.

4.3.14. Payments will be made based on the completion and State approval of the following key deliverables/milestones:

Implementation Milestones	Payment % of Total Fixed Price
Kick off Meeting and Project Plan Approval of EVV System	25%

Approval of Business Rules for EVV System	25%
Acceptance of User for Acceptance Testing for EVV System	25%
EVV System Deployment	25%

4.3.15. Invoices will be sent only after Customer approval of the applicable milestone as set forth below. Payment for approved services/milestones shall be made in accordance with Section 5 of the Agreement

4.4. Acceptance for Deliverables

4.4.1. All deliverables and work products described within Attachment A of this Contract are subject to review and approval by the Authorized Representative of the State or designee(s) prior to being accepted. Payment shall not be made until a deliverable or work product is formally accepted and approved. Deliverables are considered approved when the State issues a Deliverables Acceptance Document (DAD) signed by the State's authorized representative.

4.4.2. The State's deliverable management process will be followed for review and acceptance of project documentation deliverables. Written deliverables submitted for State review and acceptance shall be responded to by the State within ten (10) business days. The Contractor shall respond within five (5) business days to any written feedback received on each deliverable, and the State shall then have up to an additional five (5) business days to provide written acceptance of the deliverable.

4.4.3. Should a majority of State reviewers determine that a deliverable does not meet expected minimal quality standards and/or content expectations as specified in the Deliverables Expectations Document (DED), the State may reject the deliverable without performing a complete review. In this instance the deliverable submission will be considered as voided, i.e., the State will have ten (10) business days to review the next submitted revision and the project schedule will not consider the original version to have been submitted.

4.4.4. Should the deliverable be deemed acceptable, but issues arise after a DAD is signed by the State, collaborative working sessions will be initiated to determine a solution, and the Contractor shall implement the solution at no additional cost to the State.

4.5. Project Management Responsibilities.

4.5.1. The State will appoint a State Project Manager for the Implementation phase. This may be a leader who is already engaged with other projects for State of Vermont. The State Project Manager will coordinate the activities and tasks to be performed by the State and its other business partners.

4.5.2. The Contractor will appoint, subject to State review, an experienced implementation leader to perform the role of Contractor Project Manager. This may be a leader who is already engaged with other projects for State and who will be fully accountable for overseeing delivery including the work of the subcontract software Vendor.

4.5.3. The Contractor will provide a full-time software project manager to lead the EVV implementation. The software project manager is responsible for participating in project meetings, and for providing meeting agendas, meeting minutes, and creation and maintenance of the implementation project plan.

4.5.4. The Contractor will provide EVV System configuration and testing resources who will configure the system and perform system and integration tests based on the agreed upon System and Integration test plan.

4.5.5. The Contractor will provide resources to support system, integration, and user acceptance testing phases.

V. By deleting Attachment B, Section 5 MMIS Operations beginning on page 60 of 106 of the base agreement and substituting in lieu thereof Section 5:

5. 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, to this Contract based on claims processing and drug transaction volume parameters, known as "base services". The Contractor shall invoice the State monthly for 1/12th of the annual amounts listed in the table below:

FIXED PRICE	1/1/17 –12/31/17	1/1/18-12/31/18	1/1/19-12/31/19	Total Three Year MMIS Cost
Provider Enrollment	$1,546,698.54	$1,569,899.01	$3,097,852.29	$6,214,449.84
Financial Management	$1,036,424.46	$1,051,970.82	$1,117,852.07	$3,206,247.35
Operations Management	$3,264,964.42	$3,313,938.88	$3,521,479.27	$10,100,382.57
Drug Payment Transactions	$583,300.72	$592,050.24	$629,128.27	$1,804,479.23
Plan Management	$1,195,339.85	$1,213,269.94	$1,289,252.79	$3,697,862.58
Provider Management	$697,809.25	$708,276.39	$752,633.26	$2,158,718.89
MES IT Support	$2,216,483.24	$2,249,730.49	$2,390,623.24	$6,856,836.97
MES System	$ 2,829,273.57	$2,871,712.67	$3,051,557.99	$8,752,544.23
EVV Support Service *			$14,546.67	$14,546.67
Fixed Price Subtotal	$ 13,370,294.04	$13,570,848.44	$15,864,925.85	$42,806,068.33
Passthrough				
Postage (estimate only billed as utilized)	$108,000.00	$108,000.00	$108,000.00	$324,000.00
Additional Space **			$40,500.00	$40,500.00
Total Annual Spend	**$13,478,294.04**	**$13,678,848.44**	**$16,013,425.85**	**$43,170,568.33**

*Represents (2) two months of operations in 2019 based on planned implementation by September 30, 2019.
** Represents (9) nine months of charges based on acquiring space by April 1, 2019.

Optional Years 4 and 5:

FIXED PRICE	Option Year 1/1/2020 - 12/31/2020	Option Year 1/1/2021 - 12/31/2021
Provider Enrollment	$2,672,813.99	$2,687,309.09
Financial Management	$1,114,011.59	$1,122,719.46
Operations Management	$3,509,380.92	$3,536,812.60
Drug Payment Transactions	$626,966.84	$631,867.64
Plan Management	$1,284,823.45	$1,294,866.50
Provider Management	$750,047.52	$755,910.39
MES IT Support	$2,382,410.04	$2,401,032.56
MES System	$3,041,074.09	$3,064,845.17
EVV Support Service	$87,280.00	$87,280.00
EVV Monthly Minimum Visit Fees	$65,249.55	$65,249.55
Fixed Price Subtotal	$15,534,057.99	$15,647,892.96
Billed as Utilized		
EVV Recurring Visit Fee Over Minimum (estimate only billed as utilized).	$65,249.33	$65,249.33
EVV Recurring Aggregator PMPM (estimate only billed as utilized	$41,237.11	$41,237.11
Passthrough		
Postage (estimate only billed as utilized)	$108,000.00	$108,000.00
Additional Space	$54,000.00	$54,000.00
Total Annual Spend	**$15,802,544.65**	**15,916,379.62**

B. Volume Accounting and Reconciliation

Volume Parameters

VOLUME PARAMETERS	Claims Processing	Drug Transactions	EDI Transactions
High Estimate	7,500,000	4,500,000	35,000,000
Median Estimate	6,000,000	3,500,000	25,000,000
Low Estimate	4,500,000	2,500,000	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 or 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 60% 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 60% 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.

ii. Drug transaction volume accounting and reconciliation of changes in Contractor reimbursement

The following definition of a drug transaction processing shall apply:

a. The Contractor shall process weekly drug transactions from the State's PBM ("Pharmacy Benefits Manager"). These transactions shall consist of a record of an adjudicated drug claim. Drug transactions are loaded into the MMIS financial cycle and reporting databases so that payments are made to the providers.

Financial Adjustment

b. Drug Transactions: The total amount payable each year shall remain fixed unless the drug transactions volume falls outside the estimated high and low parameters for that year. Should the actual claims 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:

c. A unit value will be calculated by dividing the Drug Transactions price for the applicable year by the median drug transactions estimate for that year.

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

Low Drug Transactions Volume Estimate minus **Actual Drug Transactions Volume** x 60% of the calculated unit value for the same contract year.

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

Actual Drug Transactions minus **High Drug Transactions Volume Estimate** x 60% 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 drug transaction counts are accurate and consistent with the definition of a claim as set forth this Section B.ii.

iii. 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:

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

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

c. By deleting Attachment B, Section 6 MAPIR Collaborative Quarterly Payment beginning on page 63 of 106 of the base agreement and substituting in lieu thereof Section 6:

6. MAPIR Collaborative Quarterly Payment

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
TOTAL FOR 45 MONTHS PER STATE		**$881,201.72**	**$948,990.84**	**$1,028,075.41**	**$1,174,583.25**	**$1,233,687.25**	**$1,370,761.81**	**$812,720.00**

d. By deleting Attachment B, Section 13 (Total Budget) beginning on page 70 of 106 of the base agreement and substituting in lieu thereof the following Section 13:

13. Total Budget

Total Budget 01/01/2017 – 12/31/2019	
MMIS Operations 3-years cost (includes postage and space) ***	$43,170,568.33
Ad Hoc	$500,000.00
Incentive Payments ($160,000 max per year)	$480,000.00
Provider 6028 Project: Completed	$2,795.14
MAPIR Core Development	$707,048.72
MAPIR Integration/Customization: 1,540 hours*	$554,400.00
All Payer Model: Completed, 971.25 hours	$117,142.46
Payment and Delivery System (PADS) Reform	$312,500.00
Medicare Card Project: Completed – 275.25 hours*	$33,555.26
Technology Updates – EDI	$443,750.00
Technology Updates – CM Platform 1,000 hours **	$125,000.00
TMSIS Enhancement – 5,095 hours*	$614,507.00
Presumptive Eligibility: Completed	$32,082.00
Medicare Grant Project: Completed – fixed price	$13,200.00
Provider Services Enhancement Project	$3,022,826.00
Electronic Visit Verification Project (EVV) Implementation	$784,400.00
Provider Initiated Eligibility (PIE) Project **	$62,500.00
Total Budget	**$50,976,274.91**

*As of December 21, 2017, project hours are 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.
** 2019 New Project hours are 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.
***monthly costs for additional Contractor space and postage charges shall be billed as utilized

Taxes Due to the State. Contractor further certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, the Contractor is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due the State of Vermont.

Child Support (Applicable to natural persons only; not applicable to corporations, partnerships or LLCs). Contractor is under no obligation to pay child support or is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date of this amendment.

Certification Regarding Suspension or Debarment. Contractor certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, neither Contractor nor Contractor's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for

debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

Contractor further certifies under pains and penalties of perjury that, as of the date that this contract amendment is signed, Contractor is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing-contracting/debarment.

Sole Source Contractor Certification. This Contract results from a "sole source" procurement under State of Vermont Administrative Bulletin 3.5 process and Contractor hereby certifies that it is and will remain in compliance with the campaign contribution restrictions under 17 V.S.A. § 2950.

This document consists of 38 pages. Except as modified by this Amendment No. 3, all provisions of the Contract remain in full force and effect.

STATE OF VERMONT

DEPARTMENT OF VERMONT HEALTH ACCESS

E-SIGNED by Cory Gustafson on 2019-01-17 15:24:44 UTC January 17, 2019

CORY GUSTAFSON, COMMISSIONER DATE
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
Phone: 802-241-0239
Email: Cory.Gustafson@vermont.gov

CONTRACTOR

DXC TECHNOLOGY SERVICES LLC

E-SIGNED by Andrew Saxe on 2019-01-17 15:12:17 UTC January 17, 2019

ANDREW SAXE, GENERAL MANAGER, DATE
STATE GOVERNMENT, NORTHEAST REGION
Suite 101, 312 Hurricane Lane
Williston, VT 05495
Phone: 617-699-3974
Email: Andrew.f.saxe@dxc.com