UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

☒ **Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the quarterly period ended June 30, 2005

or

☐ **Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
One Golden Shore Drive, Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934). Yes ☒ No ☐

The number of shares of the issuer's Common Stock, par value $0.001 per share, outstanding as of July 29, 2005, was 27,747,343.

MOLINA HEALTHCARE, INC.

Index

		Page
	Part I – Financial Information	
Item 1.	**Financial Statements**	3
	Condensed Consolidated Balance Sheets as of June 30, 2005 (unaudited) and December 31, 2004	3
	Condensed Consolidated Statements of Operations for the three and six month periods ended June 30, 2005 and 2004 (unaudited)	4
	Condensed Consolidated Statements of Cash Flows for the six month periods ended June 30, 2005 and 2004 (unaudited)	5
	Notes to Condensed Consolidated Financial Statements (unaudited)	6
Item 2.	**Management's Discussion and Analysis of Financial Condition and Results of Operations**	12
Item 3.	**Quantitative and Qualitative Disclosures About Market Risk**	21
Item 4.	**Controls and Procedures**	21
	Part II - Other Information	
Item 1.	**Legal Proceedings**	22
Item 6.	**Exhibits**	22
Signatures		23

PART I - FINANCIAL INFORMATION

Item 1: Financial Statements.

MOLINA HEALTHCARE, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except per share data)

	June 30, 2005 (Unaudited)	December 31, 2004
ASSETS		
Current assets:		
Cash and cash equivalents	$ 202,463	$ 228,071
Investments	85,615	88,530
Receivables	68,974	65,430
Income tax receivable	11,931	—
Deferred income taxes	3,576	3,981
Prepaid and other current assets	8,593	8,306
Total current assets	381,152	394,318
Property and equipment, net	29,248	25,826
Goodwill and intangible assets, net	125,290	98,727
Restricted investments	10,936	10,847
Other assets	9,013	4,141
Total assets	$ 555,639	$ 533,859
LIABILITIES AND STOCKHOLDERS’ EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 179,337	$ 160,210
Accounts payable and accrued liabilities	17,066	22,966
Net liability for termination of commercial operations	939	1,676
Income taxes payable	—	7,110
Current maturities of long-term debt	177	171
Total current liabilities	197,519	192,133
Long-term debt, less current maturities	4,735	1,723
Deferred income taxes	4,899	5,315
Other long-term liabilities	4,361	4,066
Total liabilities	211,514	203,237
Stockholders’ equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 27,739,843 shares at June 30, 2005 and 27,602,443 shares at December 31, 2004	28	28
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	161,239	157,666
Accumulated other comprehensive income (loss)	(357)	(234)
Retained earnings	203,605	193,552
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders’ equity	344,125	330,622
Total liabilities and stockholders’ equity	$ 555,639	$ 533,859

See accompanying notes.

Table of Contents

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(amounts in thousands, except per share data)
(Unaudited)

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
Revenue:				
Premium revenue	$400,756	$247,455	$791,680	$465,323
Other operating revenue	1,159	691	2,422	1,986
Total premium and other operating revenue	401,915	248,146	794,102	467,309
Investment income	2,359	912	4,124	1,775
Total revenue	404,274	249,058	798,226	469,084
Expenses:				
Medical care costs:				
Medical services	67,604	51,511	131,271	102,279
Hospital and specialty services	259,016	132,964	485,548	242,753
Pharmacy	42,870	24,573	85,785	48,233
Total medical care costs	369,490	209,048	702,604	393,265
Salary, general and administrative expenses	37,060	18,842	70,606	36,300
Loss contract charge	939	—	939	—
Depreciation and amortization	3,558	1,734	6,756	3,333
Total expenses	411,047	229,624	780,905	432,898
Operating income (loss)	(6,773)	19,434	17,321	36,186
Other income (expense):				
Interest expense	(418)	(258)	(707)	(513)
Other, net	(400)	(19)	(400)	1,143
Total other (expense) income	(818)	(277)	(1,107)	630
Income (loss) before income taxes	(7,591)	19,157	16,214	36,816
Income tax expense (benefit)	(2,885)	7,207	6,161	13,768
Net income (loss)	$ (4,706)	$ 11,950	$ 10,053	$ 23,048
Net income (loss) per share:				
Basic	$ (0.17)	$ 0.44	$ 0.36	$ 0.87
Diluted	$ (0.17)	$ 0.43	$ 0.36	$ 0.86
Weighted average shares outstanding:				
Basic	27,707	27,353	27,662	26,427
Diluted	27,707	27,738	27,981	26,829

See accompanying notes.

Table of Contents

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)
(Unaudited)

	Six months ended June 30,	
	2005	**2004**
Operating activities		
Net income	$ 10,053	$ 23,048
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	6,756	3,333
Amortization of credit facility fees	338	314
Deferred income taxes	68	516
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	1,758	2029
Stock-based compensation	341	—
Changes in operating assets and liabilities:		
Receivables	(3,544)	(2,800)
Prepaid and other current assets	(287)	(573)
Medical claims and benefits payable	19,127	(4,018)
Accounts payable and accrued liabilities	(6,637)	1,906
Income taxes payable (receivable)	(17,784)	218
Net cash provided by operating activities	10,189	23,973
Investing activities		
Purchases of equipment	(6,798)	(2,172)
Purchases of investments	(19,645)	(401,644)
Sales and maturities of investments	22,358	382,546
Increase in restricted cash	(89)	—
Net cash paid in purchase transactions	(31,200)	(18,000)
Other long-term liabilities	295	(5)
Other assets	(5,210)	2,953
Net cash used in investing activities	(40,289)	(36,322)
Financing activities		
Issuance of common stock	—	47,360
Proceeds from exercise of stock options	1,474	1,478
Borrowings under credit facility	3,100	—
Principal payments on capital lease obligation and mortgage note	(82)	—
Net cash provided by financing activities	4,492	48,838
Net increase (decrease) in cash and cash equivalents	(25,608)	36,489
Cash and cash equivalents at beginning of period	228,071	141,850
Cash and cash equivalents at end of period	$202,463	178,339
Supplemental cash flow information		
Cash paid during the period for:		
Income taxes	$ 22,122	11,008
Interest	$ 281	197
Schedule of non-cash investing and financing activities:		
Change in unrealized gain on investments	$ (202)	$ (733)
Deferred taxes	79	275
Change in net unrealized gain on investments	$ (123)	(458)

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(dollars in thousands, except share and per share data)
(Unaudited)
June 30, 2005

1. The Reporting Entity

Molina Healthcare, Inc. (the Company) is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. We were founded in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, we began operating as a health maintenance organization (HMO). We operate our HMO business through subsidiaries in California (California HMO), Indiana (Indiana HMO), Michigan (Michigan HMO), New Mexico (New Mexico HMO), Utah (Utah HMO), and Washington (Washington HMO).

2. Basis of Presentation

The unaudited condensed consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the latest fiscal year ended December 31, 2004. Accordingly, certain note disclosures that would substantially duplicate the disclosures contained in the December 31, 2004 audited financial statements have been omitted. These unaudited condensed consolidated interim financial statements should be read in conjunction with our December 31, 2004 audited financial statements.

The condensed consolidated financial statements include the accounts of the Company and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented, which consist solely of normal recurring adjustments, have been included. All significant inter-company balances and transactions have been eliminated in consolidation. The condensed consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2005.

Stock-Based Compensation

At June 30, 2005, we had two stock-based employee compensation plans: the 2000 Omnibus Stock and Incentive Plan, and the 2002 Equity Incentive Plan. The 2000 Omnibus Stock and Incentive Plan is frozen. We account for stock-based compensation under the recognition and measurement principles (the intrinsic-value method) prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations. Compensation cost for stock options is reflected in net income (loss) and is measured as the excess of the market price of the Company's stock at the date of grant over the amount an employee must pay to acquire the stock. We have adopted the disclosure provisions required by SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure*.

Common shares issued pursuant to the exercise of stock options for the six months ended June 30, 2005 and 2004 were 118,871 and 231,140, respectively.

Table of Contents

The following table illustrates the effect on net income (loss) and earnings (loss) per share as if we had applied the fair value recognition provisions to stock-based employee compensation permitted by SFAS No. 148.

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
Net income (loss), as reported	$(4,706)	$11,950	$10,053	$23,048
Reconciling items (net of related tax effects):				
Add: Stock-based employee compensation expense determined under the intrinsic-value based method for stock option and employee stock purchase plan awards	—	—	—	—
Deduct: Stock-based employee compensation expense determined under the fair-value based method for stock option and employee stock purchase plan awards	(200)	(209)	(436)	(430)
Net adjustment	(200)	(209)	(436)	(430)
Net income (loss), as adjusted	$(4,906)	$11,741	$ 9,617	$22,618
Earnings (loss) per share:				
Basic—as reported	$ (0.17)	$ 0.44	$ 0.36	$ 0.87
Basic—as adjusted	$ (0.18)	$ 0.43	$ 0.35	$ 0.86
Diluted—as reported	$ (.017)	$ 0.43	$ 0.36	$ 0.86
Diluted—as adjusted	$ (0.18)	$ 0.42	$ 0.34	$ 0.84

The following table illustrates the components of our stock-based compensation expense (net of tax) for the three months and six months ended June 30, 2005 and 2004 as reported in the Condensed Consolidated Statements of Operations:

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
Stock grants	$ 102	$ —	$ 211	$ —
Total stock-based compensation expense	$ 102	$ —	$ 211	$ —

The recognition and measurement of stock grants is the same under APB Opinion No. 25 and SFAS No. 123, *Accounting for Stock Based Compensation*. The related expenses for the fair value of stock grants were charged to salary, general and administrative expenses and are included in the net income (loss), as reported amounts in the pro forma net income (loss) table above.

In December 2004, the FASB issued SFAS No. 123R, *Share-Based Payment*. SFAS No. 123R is a revision of SFAS No. 123, and supersedes APB 25. Among other items, SFAS 123R eliminates the use of APB 25 and the intrinsic value method of accounting, and requires companies to recognize in the financial statements the cost of employee services received in exchange for awards of equity instruments, based on the grant date fair value of those awards. The effective date of SFAS 123R is the beginning of our next fiscal year, which means we do not need to adopt it until the first quarter of 2006, although early adoption is allowed. SFAS 123R permits companies to adopt its requirements using either a “modified prospective” method or a “modified retrospective” method. Under the “modified prospective” method, compensation cost is recognized in the financial statements beginning with the effective date, based on the requirements of SFAS 123R for all share-based payments granted after that date, and based on the requirements of SFAS 123 for all unvested awards granted prior to the effective date of SFAS 123R. Under the “modified retrospective” method, the requirements are the same as under the “modified prospective” method, but entities are also permitted to restate financial statements of previous periods based on pro forma disclosures made in accordance with SFAS 123.

Earnings Per Share

The denominators for the computation of basic and diluted earnings (loss) per share are calculated as follows:

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
Shares outstanding at the beginning of the period	27,668,000	27,346,000	27,602,000	25,374,000
Weighted average number of shares issued in public offering	—	—	—	930,000
Weighted average number of shares issued for stock options and employee stock purchases	39,000	7,000	60,000	123,000
Denominator for basic earnings (loss) per share	27,707,000	27,353,000	27,662,000	26,427,000
Dilutive effect of employee stock options	—	385,000	319,000	402,000
Denominator for diluted earnings (loss) per share	27,707,000	27,738,000	27,981,000	26,829,000

3. Loss Contract Charge

In connection with the sale by our New Mexico HMO of certain commercial employer group contracts to another health plan on August 1, 2004, our New Mexico HMO entered into a transition services agreement (the TSA). The TSA requires the New Mexico HMO to provide certain administrative services in support of the commercial membership through the date of each member group's renewal. In exchange for those services, the New Mexico HMO is compensated by the buyer at a specific amount per member per month. The New Mexico HMO entered into the TSA as an inducement to the buyer to purchase the commercial membership, and anticipated that the TSA would be unprofitable. Effective with the implementation of the TSA (August 1, 2004), the New Mexico HMO recorded a liability for the costs of the run out of the commercial business of $2,640, the bulk of which consisted of anticipated losses under the TSA. During the second quarter of 2005, that reserve was exhausted. We anticipate that we will continue to provide services under the TSA through year-end at a net cost of $939 and have recorded a loss contract charge for that amount as of June 30, 2005. A summary of activity for the net liability for termination of commercial operations for the period July 1, 2004 through June 30, 2005 follows:

Net liability for termination of commercial operations at July 1, 2004	$ 2,640
Revenue earned on transition services agreement	1,710
Expenses incurred in providing transition services	(4,350)
Loss contract charge recognized	939
Net liability for termination of commercial operations at June 30, 2005	$ 939

4. Other Income and Expenses

Other expense recorded for the quarter and six months ended June 30, 2005 of $400 consists of a charge for the write off of costs associated with a registration statement filed during the second quarter of 2005. Other income for the six months ended June 30, 2004 consists of $1,162 in income arising from the termination of a split dollar life insurance arrangement with a related party.

5. Receivables

Receivables consist primarily of amounts due from the various states in which we operate. Accounts receivable by operating subsidiary are comprised of the following:

	June 30, 2005	December 31, 2004
California HMO	$31,977	$ 23,304
Utah HMO	23,625	29,292
Washington HMO	8,304	6,669
Other	5,068	6,165
Total receivables	$68,974	$ 65,430

In July 2005, $25,300 in receivables due our California HMO was collected.

Our agreement with the state of Utah calls for the reimbursement of our Utah HMO of medical costs incurred in serving our members plus an administrative fee of 9% of medical costs and all or a portion of any cost savings realized, as defined in the agreement. Our Utah HMO bills the state of Utah monthly for actual paid health care claims plus administrative fees. Our receivable balance from the state of Utah includes: 1) amounts billed to the state for actual paid health care claims plus administrative fees; 2) amounts estimated to be due under the savings sharing provision of the agreement; and 3) amounts estimated for incurred but not reported claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid.

6. Other Assets

Other assets at June 30, 2005 include an equity investment of approximately $1,600 in a medical service provider that provides medical services to the Company’s members.

7. Long-Term Debt

On March 9, 2005, we entered into an amended and restated five-year secured credit agreement for a $180,000 revolving credit facility with a syndicate of lenders. The credit facility will be used for working capital purposes. This credit facility replaced the facility that we entered into on March 19, 2003.

The credit facility has a term of five years and all amounts outstanding under the credit facility will be due and payable on March 8, 2010. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the credit facility to up to $200,000.

Borrowings under the credit facility are based, at our election, on the London interbank deposit, or LIBOR, rate or the base rate plus an applicable margin. The base rate will equal the higher of Bank of America’s prime rate or 0.5% above the federal funds rate. We also will pay a commitment fee on the total unused commitments of the lenders under the credit facility. Until the delivery of a compliance certificate with respect to the our financial statements for the quarter ending June 30, 2005, the applicable margin is fixed at 1.25% for LIBOR loans and 0.25% for base rate loans and the commitment fee is fixed at 0.30%. Thereafter, the applicable margins and commitment fee will be based on our ratio of consolidated funded debt to consolidated EBITDA. The applicable margins will range between 1.00% and 1.75% for LIBOR loans and between 0% and 0.75% for base rate loans. The commitment fee will range between 0.25% and 0.375%. Effective upon delivery to the administrative agent of a compliance certificate for the quarter ended June 30, 2005, we expect the applicable margins to increase to 1.75% for LIBOR loans and 0.75% for base rate loans, and the commitment fee to increase to 0.375%. In addition, we will pay a fee for each letter of credit issued under the credit facility equal to the applicable margin for LIBOR loans and a customary fronting fee.

As with our prior credit facility, our obligations under the amended and restated credit facility are secured by a lien on substantially all of our assets and by our previous pledge of the capital stock of our Michigan, New Mexico, Utah, and Washington HMO subsidiaries.

The credit agreement includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The credit agreement also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.00 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of 2.00 to 1.00 (which increases to 3.00 to 1.00 as of December 31, 2006).

At June 30, 2005, we were not in compliance with certain financial ratio covenants, constituting an event of default under the credit agreement. As a result of this event of default, the administrative agent may, at the request of or with the consent of the syndicate of lenders, demand repayment of any amounts outstanding under the credit agreement, terminate the obligations of all lenders under the credit agreement, and exercise remedies as a secured lender. At June 30, 2005, and through August 8, 2005, we had borrowings of $3,100 outstanding under the credit facility. At June 30, 2005, we had approximately $49,000 of cash available. We are currently working with the administrative agent in an effort either to waive this default or to amend the credit agreement in a manner that causes us to be in compliance with the financial covenants.

8. Provider Settlements

Hospital and specialty services expense for the second quarter of 2005 includes a $1,750 charge related to the anticipated settlement of certain claims made against us by various hospitals. These claims seek additional or first-time reimbursement for services ostensibly provided to our members that purportedly were not paid or were underpaid by us. The claims made by these hospitals involve issues of contract compliance, interpretation, payment methodology and intent. These claims extend to services provided over a number of years. (Refer to Note 9 for further discussion).

9. Commitments and Contingencies

Legal

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

Arbitration with Tenet Hospital. In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital, or Tenet, seeking damages of approximately $4,500 involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospital claimants and to increase its damage claim to approximately $8,000. To date, no significant discovery has taken place. We believe that the California HMO has meritorious defenses to Tenet's claims and we intend to vigorously defend this matter. We do not believe that the ultimate resolution of this matter will materially affect our consolidated financial position, results of operations, or cash flows.

Starko. Our New Mexico health plan subsidiary, Molina Healthcare of New Mexico, Inc., is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named health maintenance organizations (HMOs) participating in the New Mexico Medicaid program as defendants, including the predecessor of Molina Healthcare of New Mexico. Plaintiff asserts that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. Discovery has recently commenced. At this time, it is too early to assess the amount or range of potential loss or probability of a favorable or unfavorable outcome. Under the terms of the stock purchase agreement pursuant to which Molina Healthcare, Inc. acquired Health Care Horizons, Inc., the parent company to Molina Healthcare of New Mexico, Inc. (formerly known as Cimarron Health Plan, Inc.), an indemnification escrow account was established and funded with $6,000 in order indemnify Molina Healthcare of New Mexico against the costs of such litigation and any eventual liability or settlement costs. Currently, $4,812 remains in the indemnification escrow fund.

Stockholder Securities Lawsuits. Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired our common stock between November 3, 2004 and July 20, 2005 (collectively, the "Actions"). The Actions purport to allege claims against Molina Healthcare, Inc., J. Mario Molina, and John C. Molina for alleged violations of the Securities Exchange Act of 1934 arising out of the Company's announcement of its guidance for the 2005 second quarter and fiscal year. The Actions, and any subsequently filed related actions, will be consolidated into a single consolidated action. The Actions are in the early stages, and no prediction can be made as to the outcome. We believe the Actions are without merit and intend to defend against them vigorously.

We are involved in other legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Los Angeles County Department of Health. The Los Angeles County Department of Health (Department of Health) has contacted our California HMO seeking additional or first-time reimbursement of claims for services ostensibly provided

by Los Angeles County Hospitals to members of our California HMO that purportedly were not paid or were underpaid by us. The total amount claimed by the Department of Health in additional and first-time reimbursement is approximately $2,900. We are evaluating the Department of Health claims in consultation with Department of Health staff, but are unable at this time to fully determine either the validity of those claims or the degree, if any, of our liability in regards to this matter. Nevertheless, we do not believe that the ultimate resolution of this matter will materially affect our consolidated financial position, results of operations, or cash flows.

Other providers have also contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Subscriber Group Claims

The United State Office of Personnel Management (OPM) has contacted our New Mexico HMO seeking repayment of approximately $3,800 in premiums paid by OPM on behalf of Federal employees for the years 1999, 2000 and 2002. OPM is also seeking recovery of approximately $500 in interest in connection with this matter. OPM is asserting that it did not receive rate discounts equivalent to the largest discount given by the New Mexico HMO for Similar Sized Subscriber Groups, as required by the New Mexico HMO's agreement with OPM, during the years in question. We are evaluating the OPM claim and are unable at this time to determine either the validity of the claim or the degree, if any, of our liability in regards to this matter.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our six HMO subsidiaries operating in California, Indiana, Michigan, New Mexico, Utah, and Washington. Our HMOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations), which may not be transferable to us in the form of loans, advances, or cash dividends, was $132,500 at June 30, 2005, and $130,000 at December 31, 2004. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Washington, Indiana, Michigan and Utah have adopted these rules (which may vary from state to state). While New Mexico has not formally adopted the RBC rules, that state holds our New Mexico HMO to those rules. California has not yet adopted NAIC risk-based capital requirements for HMOs and has not given notice of any intention to do so. Such requirements, if adopted by California, may increase the minimum capital required by that state.

As of June 30, 2005, our HMOs had aggregate statutory capital and surplus of approximately $138,300 compared with the required minimum aggregate statutory capital and surplus of approximately $86,600. All of our HMOs were in compliance with the minimum capital requirements. We have the ability and commitment to provide additional working capital to each of our HMOs when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

10. Acquisitions

San Diego Transactions

On June 1, 2005, we transitioned approximately 85,000 Medi-Cal and Healthy Families members living in San Diego County, California into our California HMO from Sharp Health Plan (Sharp) and Universal Care, Inc., a California corporation (Universal).

We paid total consideration of $25,000 in the Sharp transaction. Our agreement with Sharp allows for adjustment of the amount to be paid based upon a reconciliation of membership transferred at June 1, 2005. In addition to any adjustment

resulting from the reconciliation of membership, further consideration may be paid to Sharp through May 31, 2008. Such further consideration may not exceed $3,500.

We paid total consideration of $6,200 in the Universal transaction. Our agreement with Universal allows for adjustment of the amount to be paid based upon a reconciliation of membership transferred at June 1, 2005.

Based upon preliminary analysis of these transactions, the entire consideration paid is reflected in goodwill and intangible assets, net, in the Condensed Consolidated Balance Sheets.

Pro Forma Financial Information

On July 1, 2004, we acquired the capital stock of Health Care Horizons, Inc., or HCH, which is the parent company of New Mexico-based Cimarron Health Plan, Inc. Our condensed consolidated results of operations include HCH from July 1, 2004. The pro forma results listed below are unaudited and reflect the condensed consolidated results of operations, for the sixth months ended June 30, 2004, of the Company and HCH as if HCH had been acquired, and the commercial membership had been transferred to Lovelace Sandia Health Systems, Inc., as of January 1, 2004. The pro forma adjustments include amortization of intangibles, reduction of investment income for proceeds used to pay the purchase price consideration, elimination of incremental commercial activities (premiums, medical care costs, administrative expenses), and related income tax effects.

	Six months ended June 30, 2004
Total operating revenue	$ 594,976
Income before income taxes	$ 37,283
Net income	$ 23,302
Basic income per share	$ 0.88
Diluted earnings per share	$ 0.87

The pro forma results are not necessarily indicative of what actually would have occurred if the acquisition had been in effect for the entire period presented. In addition, they are not intended to be a projection of future results and do not reflect any synergies that might be achieved from the combined operations.

11. Public Offerings of Common Stock

In March 2004, we completed a public offering of our common stock. We sold 1,800,000 shares, generating net proceeds of approximately $47,282 after deducting approximately $600 in fees, costs, and expenses and $2,520 in underwriters' discount.

12. California Contract Appeal

On May 10, 2005, the California Department of Health Services ("DHS") notified our California HMO that our proposal to serve Medi-Cal members in San Bernardino and Riverside Counties had been disqualified and that DHS intended to award the contracts to Blue Cross of California. On May 17, 2005, we filed a formal appeal with DHS challenging that decision. On July 11, 2005, MHC, DHS and Blue Cross of California each filed separate opening briefs concerning this matter. The parties may file reply briefs by August 10, 2005.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward Looking Statements

The information made available below and elsewhere in this quarterly report on Form 10-Q contains forward-looking statements that involve risks and uncertainties. These forward-looking statements are often accompanied by words such as "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "goal," "may," "will" and similar expressions. These statements include, without limitation, statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions and investments and the adequacy of our available cash resources. Investors are cautioned that matters subject to forward-looking statements involve risks and uncertainties that may affect our business, including economic, regulatory, competitive and other factors that may be described in our Annual Report on Form 10-K and/or other filings with the Securities and Exchange Commission. These statements are not guarantees of future performance and are subject to risks, uncertainties, and assumptions.

Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements as a result of, but not limited to, the following factors:

- Uncertainty regarding our ability to control our medical costs and other operating expenses.
- Uncertainty regarding our ability to accurately estimate incurred but not reported medical care costs.
- Our dependence upon a relatively small number of government contracts and subcontracts for our revenue.
- Government efforts to limit Medicaid expenditures.
- Uncertainty regarding high dollar claims.
- Changes to government laws and regulations or in the interpretation and enforcement of those laws and regulations.
- Difficulties we encounter in managing, integrating, and securing our information systems.
- Difficulties we encounter in executing our acquisition strategy, including business integration difficulties.
- Ineffective management of our growth.
- The superior financial resources of our competitors.
- Restrictions and covenants in our credit facility that may impede our ability to make acquisitions and declare dividends.
- Our dependence upon certain key employees.
- Our increased exposure to malpractice and other litigation risks as a result of the operation of our primary care clinics in California.
- The existence of state regulations that may impair our ability to upstream cash from our subsidiaries.
- Demographic changes.
- Inherent uncertainties involving pending legal or administrative proceedings.

Investors should also refer to our Annual Report on Form 10-K for the year ended December 31, 2004 for a discussion of certain risk factors. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and therefore caution investors not to place undue reliance on these statements.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Report on Form 10-K for the year ended December 31, 2004.

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. Our objective is to become the leading managed care organization in the United States focused primarily on serving people who receive health care benefits through state-sponsored programs for low-income populations.

We generate revenues primarily from premiums we receive from the states in which we operate. Premium revenue is fixed in advance of the periods covered and is not subject to significant accounting estimates. In the six months ended June 30, 2005, we received approximately 87.6% of our premium revenue as a fixed amount per member per month pursuant to

our contracts with state Medicaid agencies and other managed care organizations with which we operate as a subcontractor. These premium revenues are recognized in the month members are entitled to receive health care services. Approximately 6.4% of our premium revenue in the six months ended June 30, 2005 was realized under a cost plus reimbursement agreement that our Utah HMO has with that state. We also received approximately 5.9% of our premium revenue for the six months ended June 30, 2005 in the form of birth payments (one-time payments for the delivery of children) from the Medicaid programs in Michigan, New Mexico and Washington. Such payments are recognized as revenue in the month the birth occurs. The state Medicaid programs periodically adjust premium rates.

Membership growth has been the primary reason for our increasing revenues. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members by state as of the dates indicated.

Market	As of June 30, 2005	As of June 30, 2004
California	339,000	245,000
Indiana	8,000	—
Michigan	152,000	90,000
New Mexico	60,000	—
Utah	54,000	48,000
Washington	285,000	269,000
Total	898,000	652,000

The following table details member months (defined as the aggregation of each month's membership for the period) by state for the three and six-months ended June 30, 2005 and 2004:

	Three months ended June 30,			Six months ended June 30,		
	2005	2004	% of Increase (Decrease)	2005	2004	% of Increase (Decrease)
California	839,000	742,000	13.1%	1,592,000	1,503,000	5.9%
Indiana	20,000	—	—	20,000	—	—
Michigan	463,000	268,000	72.8%	934,000	524,000	78.2%
New Mexico	183,000	—	—	370,000	—	—
Utah	169,000	138,000	22.5%	328,000	270,000	21.5%
Washington	842,000	679,000	24.0%	1,665,000	1,269,000	31.2%
Total	2,516,000	1,827,000	37.7%	4,909,000	3,566,000	37.7%

Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California; savings sharing revenues in California and Utah, where we receive additional incentive payments from those states if medical costs are less than prescribed amounts; and certain ancillary revenues in New Mexico.

Our operating expenses include expenses related to the provision of medical care services and salary, general and administrative, or SG&A, costs. Our results of operations depend on our ability to effectively manage expenses related to health benefits and accurately predict costs incurred.

Expenses related to medical care services include two components: direct medical expenses and medically related administrative costs. Direct medical expenses include payments to physicians, hospitals and providers of ancillary medical services, such as pharmacy, laboratory and radiology services. Medically-related administrative costs include expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, member services and compliance. In general, primary care physicians are paid on a capitation basis (a fixed amount per member per month regardless of actual utilization of medical services), while specialists and hospitals are paid on a fee-for-service basis. For the six months ended June 30, 2005, approximately 86.2% of our direct medical expenses were related to fees paid to providers on a fee-for-service basis, with the balance paid on a capitation basis. Physician providers not paid on a capitated basis are paid on a fee schedule set by the state or by our contracts with these providers. We pay hospitals in a variety of ways, including fee-for-service, per diems, diagnostic-related groups and case rates.

Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. Fee-for-service payments are

expensed in the period services are provided to our members. Medical care costs include actual historical claims experience and estimates of medical expenses incurred but not reported, or IBNR. We estimate our IBNR monthly based on a number of factors, including prior claims experience, inpatient hospital utilization data and prior authorization of medical services. As part of this review, we also consider estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership and medical cost trends. These estimates are adjusted monthly as more information becomes available. We employ our own actuary and engage the service of independent actuaries as needed. We believe that our process for estimating IBNR is adequate, but all estimates are subject to uncertainties and our actual medical care costs have in the past exceeded, and may in the future exceed, such estimates.

SG&A costs are largely comprised of wage and benefit costs related to our employee base and other administrative expenses. Some SG&A services are provided locally, while others are delivered to our health plans from a centralized location. The major centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally-provided functions include marketing (to the extent permitted by law and regulation), plan administration and provider relations. Included in SG&A expenses are premium taxes for our Michigan and Washington HMOs and, beginning with its acquisition on July 1, 2004, our New Mexico HMO.

Results of Operations

The following table sets forth selected operating ratios. All ratios with the exception of the medical care ratio are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium and other operating revenue because there is a direct relationship between the premium and other operating revenue earned and the cost of health care.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2005	2004	2005	2004
Premium revenue	99.1%	99.3%	99.2%	99.2%
Other operating revenue	0.3%	0.3%	0.3%	0.4%
Investment income	0.6%	0.4%	0.5%	0.4%
Total operating revenue	100.0%	100.0%	100.0%	100.0%
Medical care ratio	91.9%	84.2%	88.5%	84.2%
Salary, general and administrative expenses	9.2%	7.6%	8.8%	7.7%
Operating income (loss)	(1.7%)	7.8%	2.2%	7.7%
Net income (loss)	(1.2%)	4.8%	1.3%	4.9%

Three Months Ended June 30, 2005 Compared to Three Months Ended June 30, 2004

Net Income or Loss

Net loss for the second quarter ended June 30, 2005, was $4.7 million, or $0.17 per diluted share, compared with net income of $12.0 million, or $0.43 per diluted share, for the quarter ended June 30, 2004.

Premium Revenue

Premium revenue for the second quarter of 2005 was $400.8 million, representing an increase of $153.3 million, or 61.9%, over premium revenue of $247.5 million for the same period of 2004.

Membership growth contributed $109.6 million to the increase in premium revenue. Acquisitions in Washington (June 1, 2004), New Mexico (July 1, 2004), Michigan (October 1, 2004), and California (June 1, 2005), were the primary reason for the year-over-year increase in membership.

Higher premium rates contributed the remaining $43.7 million to the increase premium revenue. Blended premium increases were most pronounced at our Michigan and Washington HMOs. Additionally, premium rates at our New Mexico HMO are considerably higher than the average for our company as a whole.

Sequentially, enrollment grew by 11.8%, or 95,000 members, over the three month period ended June 30, 2005. Premium revenue grew sequentially by $9.9 million, or 2.5%, for the second quarter of 2005 when compared with the first quarter of 2005. Most of the increase in membership and revenue between the first and second quarter of 2005 was the result

of the Company's two acquisitions in San Diego, California. Including the Company's Indiana HMO, organic membership grew by approximately 1.2% in the second quarter of 2005.

Other Operating Revenue

Other operating revenue was $1.2 million for the quarter ended June 30, 2005 compared to $0.7 million for the same period ended June 30, 2004. Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California; savings sharing revenues in Utah and California, where we receive additional incentive payments from those states if medical costs are less than prescribed amounts; and certain ancillary revenues in New Mexico.

Investment Income

Investment income for the quarter ended June 30, 2005 increased to $2.4 million from $0.9 million for the quarter ended June 30, 2004, an increase of 158.7%, principally as a result of larger invested balances as well as higher rates of return.

Medical Care Costs

Medical care costs as a percentage of premium and other operating revenue (the medical care ratio) increased to 91.9% in the second quarter of 2005 from 84.2% in the second quarter of 2004. Hospital and specialty services expense for the second quarter of 2005 includes a $1.75 million charge related to the anticipated settlement of certain claims made against us by various hospitals. These claims seek additional or first-time reimbursement for services ostensibly provided to our members that purportedly were not paid or were underpaid by us. The claims made by these hospitals involve issues of contract compliance, interpretation, payment methodology and intent. These claims extend to services provided over a number of years. Our medical care ratio before giving effect to this charge was 91.5%. Medical care costs increased in absolute terms to $369.5 million in the second quarter of 2005 from $209.0 million in the second quarter of 2004.

Our medical care ratio increased for the quarter ended June 30, 2005 compared to the quarter ended June 30, 2004 for the following main reasons:

- *Increased hospital costs*. We experienced a shift in utilization to higher cost hospitals.
- *Increased costs from catastrophic cases*. We experienced increases in both the incidence and the acuity of catastrophic cases. The financial impact of such cases outpaced membership growth.
- *Increased maternity costs in Michigan and Washington*. We experienced increased costs and increased utilization of maternity services, particularly in Western and Northeastern Michigan and in Washington. The cost of providing these services grew faster than the revenue we received for providing the services.
- *Increased outpatient utilization caused in part by a high incidence of flu-like illness in Washington and a late arriving flu season in Michigan*. Flu season in Washington appears to have been particularly severe in 2005. Additionally, the unexpectedly delayed arrival of flu season in Michigan led us to underestimate the impact of the flu season on our medical care ratio during the first quarter of 2005.

Salary, General and Administrative Expenses

SG&A expenses were $37.1 million for the second quarter of 2005, representing 9.2% of total revenue, as compared with $18.8 million, or 7.6% of total revenue, for the second quarter of 2004. SG&A expenses excluding premium taxes (Core SG&A) were 6.7% of total revenue in the second quarter of 2005, as compared with 5.9% in the second quarter of 2004.

Core SG&A as a percentage of revenue increased in the second quarter of 2005 when compared to the second quarter of 2004 as a result of:

- Pre-operating costs associated with our Indiana, Ohio, and Texas start-up activities.
- Costs associated with our Medicare Advantage application.
- Additional insurance assessment costs, primarily as a result of our New Mexico acquisition.

Loss contract charge

In connection with the sale by our New Mexico HMO of certain commercial employer group contracts to another health plan in August 1, 2004, our New Mexico HMO entered into a transition services agreement (the TSA). The TSA requires that the New Mexico HMO provide certain administrative services in support of the commercial membership through the date of each member group's renewal. In exchange for those services, the New Mexico HMO is compensated by the buyer at a specific amount per member per month. We anticipate that the New Mexico HMO will continue to provide services under the TSA through year-end at a net cost of $0.9 million and have recorded a loss contract charge for that amount as of June 30, 2005.

Other expense

Other expense recorded for the quarter and six months ended June 30, 2005 of $0.4 million consists of a charge for the write off of costs associated with a registration statement filed during the second quarter of 2005.

Interest expense

Interest expense increased to $0.4 million for the three month period ended June 30, 2005 from $0.3 million for the same period in 2004 due to increases in debt balances.

Depreciation and Amortization

Depreciation and amortization expense for the quarter ended June 30, 2005 increased to $3.6 million from $1.7 million for the same period of the prior year. The increase was primarily due to the amortization of identifiable intangible assets acquired in the California, Washington (Premera) and New Mexico acquisitions, as well as increased capital expenditures.

Income Taxes

Income tax benefit was approximately $2.9 million in the second quarter of 2005 as compared to an expense of $7.2 million in the second quarter of 2004. The effective tax rate for the second quarter of 2005 was 38.0% as compared with an effective tax rate of 37.6% for the second quarter of 2004. The reduction in tax expense is attributable to the operating loss sustained during the quarter ended June 30, 2005.

Six months ended June 30, 2005 Compared to Six months ended June 30, 2004

Net Income

Net income for the six months ended June 30, 2005, was $10.1 million, or $0.36 per diluted share, compared with $23.0 million, or $0.86 per diluted share, for the quarter ended June 30, 2004.

Premium Revenue

Premium revenue for the six months ended June 30, 2005 was $791.7 million, representing an increase of $326.4 million, or 70.1%, over premium revenue of $465.3 million for the same period of 2004. Membership growth contributed $216.4 million to the increase in premium revenue. Higher premium rates contributed $110.0 million to the increase in premium revenue.

Other Operating Revenue

Other operating revenue was $2.4 million for the six months ended June 30, 2005 and $2.0 million for the six months ended June 30, 2004. Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California; savings sharing revenues in Utah and California, where we receive additional incentive payments from those states if medical costs are less than prescribed amounts; and certain ancillary revenues in New Mexico.

Investment Income

Investment income for the six months ended June 30, 2005 increased to $4.1 million from $1.8 million for the same period of 2004, an increase of 132.3%, principally as a result of larger invested balances as well as higher rates of return.

Medical Care Costs

The medical care ratio increased to 88.5% in the first half of 2005 from 84.2% in the same six-month period of 2004. Medical care costs increased in absolute terms to $702.6 million in the six months ended June 30, 2005 from $393.3 million in the same period of 2004.

The increase in our medical care ratio for the six months ended June 30, 2005 compared to the six months ended June 30, 2004 was due to the same factors as identified above regarding the increase in our medical care ratio for the second quarter.

Salary, General and Administrative Expenses

SG&A expenses were $70.6 million for the first half of 2005, representing 8.8% of total revenue, as compared with $36.3 million, or 7.7% of total revenue, for the first half of 2004. Core SG&A expenses were consistent at 6.2% of total revenue in the first half of 2005, as compared with the first half of 2004.

Interest Expense

Interest expense increased to $0.7 million for the six months ended June 30, 2005 from $0.5 million for the first half of 2004 due to increases in debt balances.

Depreciation and Amortization

Depreciation and amortization expense for the six months ended June 30, 2005 increased to $6.8 million from $3.3 million for the same period of the prior year. The increase was primarily due to the amortization of identifiable intangible

assets acquired in the California (Sharp & Universal), Washington (Premera) and New Mexico acquisitions, as well as increased capital expenditures.

Income Taxes

Income tax expense decreased to $6.2 million in the six months ended June 30, 2005 from $13.8 million in the prior year period. The decrease in income tax expense is due to the decline in operating profit. Our effective tax rate was 38.0% for the six months ended June 30, 2005, as compared to 37.4% for the six months ended June 30, 2004. The increase in effective tax rate is principally attributable to the decline in operating profit which has reduced the Company's ability to absorb the impact of non-deductible operating expenses.

Liquidity and Capital Resources

We generate cash from premium revenue, services provided on a fee-for-service basis at our clinics and investment income. Our primary uses of cash include the payment of expenses related to medical care services and SG&A expenses. We generally receive premium revenue in advance of payment of claims for related health care services.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets. As of June 30, 2005, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. At June 30, 2005, our investments (all of which are classified as current assets) consisted solely of investment grade debt securities with a maximum maturity of eight years and an average duration of three years. Two professional portfolio managers operating under documented investment guidelines manage our investments. The average annualized portfolio yield for the six months ended June 30, 2005 and 2004 was approximately 2.5% and 1.3%, respectively.

The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. Our restricted investments are invested principally in certificates of deposit and treasury securities.

Net cash provided by operating activities was $10.2 million for the six months ended June 30, 2005 and $24.0 million for the six months ended June 30, 2004. The decrease in net cash provided by operations for the six months ended June 30, 2005 when compared to the six months ended June 30, 2004 was due to the following factors:

- decrease in net income ($13.0 million lower in 2005);
- increases in accounts receivable balances (a use of $3.5 million in the six months ended June 30, 2005 compared to a use of $2.8 million in the six months ended June 30, 2004);
- increases in taxes receivable of $17.8 million due to revised estimates of taxes owed for the first half of 2005 compared to increases in tax amounts payable of $0.2 million for the first half of 2004; and
- changes in other miscellaneous working capital accounts (a use of $4.4 million in the six months ended June 30, 2005 compared to a source of $4.2 million in the six months ended June 30, 2004).

These factors were offset in part by the following factors:

- increase in depreciation and amortization expense ($3.4 million higher in 2005); and
- changes in medical claims liabilities, a source of $19.1 million in the six months ended June 30, 2005 compared to a use of $4.0 million in the six months ended June 30, 2004.

At June 30, 2005, we had working capital of $183.6 million as compared to $202.2 million at December 31, 2004. At June 30, 2005 and December 31, 2004, cash, cash equivalents and investments (all classified as current assets) were $288.1 million and $316.6 million, respectively.

Our subsidiaries are required to maintain minimum capital prescribed by various jurisdictions in which we operate. As of June 30, 2005, all of our subsidiaries were in compliance with the minimum capital requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements at least through 2005. We also believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements and capital expenditures for at least the next 12 months.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our six HMO subsidiaries operating in California, Indiana, Michigan, New Mexico, Utah, and Washington. The HMOs are subject to state laws that, among other things, may require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment and amount of dividends and other distributions that may be paid to their stockholders.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which may vary from state to state, have been adopted in Indiana, Michigan, Utah and Washington. While New Mexico has not formally adopted the RBC rules, that state holds our New Mexico HMO to those rules. California has not adopted RBC rules and has not given notice of any intention to do so. The RBC rules, if adopted by California, may increase the minimum capital required by that state.

As of June 30, 2005, our HMOs had aggregate statutory capital and surplus of approximately $138.3 million, compared with the required minimum aggregate statutory capital and surplus of approximately $86.6 million. All of our HMOs were in compliance with the minimum capital requirements. We have the ability and commitment to provide additional working capital to each of our HMOs when necessary to ensure that capital and surplus continue to meet regulatory requirements.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2004, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report other than the addition of approximately $3.1 million in long term debt under our amended and restated credit facility.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations and requires the application of significant judgment by our management and, as a result, is subject to an inherent degree of uncertainty.

Our medical care costs include actual historical claims experience and estimates for medical care costs incurred but not reported to us (IBNR). We, together with our in-house actuaries, estimate medical claims liabilities using actuarial methods based upon historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services and other relevant factors. The estimation methods and the resulting reserves are frequently reviewed and updated, and adjustments, if necessary, are reflected in the period known. We also record reserves for estimated referral claims related to medical groups under contract with us that are financially troubled or insolvent and that may not be able to honor their obligations for the payment of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses are not expected to be significant. In applying this policy, we use judgment to determine the appropriate assumptions for determining the required estimates. While we believe our current estimates are adequate, we have in the past been required to make a significant adjustment to these estimates and it is possible that future events could require us to make significant adjustments or revisions to these estimates. In assessing the adequacy of accruals for medical claims liabilities, we consider our historical experience, the terms of existing contracts, our knowledge of trends in the industry, information provided by our providers and information available from other sources as appropriate. The most significant estimates involved in determining our claims liability concern the determination of claims payment completion factors and trended per member per month cost estimates.

Table of Contents

For the five months of service prior to the reporting date and earlier, we estimate our outstanding claims liability based upon actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date based on historical payment patterns. The following table reflects the change in our estimate of claims liability as of June 30, 2005 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding June 30, 2005 by the percentages indicated. A reduction in the completion factor results in an increase in medical liabilities. Our Utah HMO is excluded from these calculations, as the majority of its business is conducted under a cost reimbursement contract. Dollar amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ 16,218
(2)%	10,812
(1)%	5,406
1%	(5,406)
2%	(10,812)
3%	(16,218)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim. For these months of service, we estimate our claims liability based upon trended per member per month (PMPM) cost estimates. These estimates reflect recent trends in payments and expense, utilization patterns, authorized services and other relevant factors. The following table reflects the change in our estimate of claims liability as of June 30, 2005 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical liabilities. Our Utah HMO is excluded from these calculations, as the majority of its business is conducted under a cost reimbursement contract. Dollar amounts are in thousands.

Increase (Decrease) in Trended Per Member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ (7,212)
(2)%	(4,808)
(1)%	(2,404)
1%	2,404
2%	4,808
3%	7,212

Assuming a hypothetical 1% change in both completion factors and PMPM cost estimates from those used in our calculation of IBNR at June 30, 2005 net income for the six months ended June 30, 2005 would increase or decrease by approximately $1.9 million, or $0.07 per diluted share, net of tax.

The following table shows the components of the change in medical claims and benefits payable for the six months ended June 30, 2005 and 2004. Dollar amounts are in thousands.

	Six months ended June 30,	
	2005	2004
Balances at beginning of period	$160,210	$105,540
Components of medical care costs related to:		
Current year	702,454	398,970
Prior years	150	(5,705)
Total medical care costs	702,604	393,265
Payments for medical care costs related to:		
Current year	538,999	310,162
Prior years	144,478	86,921
Total paid	683,477	397,083
Balances at end of period	$179,337	$101,722

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. Quantitative and Qualitative Disclosures About Market Risk.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables and restricted investments. We invest a substantial portion of our cash in the CADRE Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. Two professional portfolio managers operating under documented investment guidelines manage our investments. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

As of June 30, 2005, we had cash and cash equivalents of $202.5 million, investments of $85.6 million and restricted investments of $10.9 million. Cash equivalents consist of highly liquid securities with original maturities of up to three months. Our investments (all of which are classified as current assets) consist solely of investment grade debt securities with a maximum maturity of eight years and an average duration of three years. The restricted investments consist of interest-bearing deposits required by the respective states in which we operate. These investments are subject to interest rate risk and will decrease in value if market rates increase. All non-restricted investments are maintained at fair market value on the balance sheet. We have the ability to hold these investments until maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13(a)-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the three months ended June 30, 2005 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II – OTHER INFORMATION

Item 1. Legal Proceedings

Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired our common stock between November 3, 2004 and July 20, 2005 (collectively, the “Actions”). The Actions purport to allege claims against Molina Healthcare, Inc., J. Mario Molina, and John C. Molina for alleged violations of the Securities Exchange Act of 1934 arising out of the Company’s announcement of its guidance for the 2005 second quarter and fiscal year. The Actions, and any subsequently filed related actions, will be consolidated into a single consolidated action. The Actions are in the early stages, and no prediction can be made as to the outcome. We believe the Actions are without merit and intend to defend against them vigorously.

Item 6. Exhibits

Exhibit No.	Title
10.1	Medicaid Managed Care Services Agreement between Molina Healthcare of New Mexico, Inc. and the State of New Mexico Human Services Department.
10.2	Agreement between the California Department of Health Services and Molina Healthcare of California regarding the Geographic Managed Care Program in San Diego County as transferred and assigned by Sharp Health Plan and Universal Care, Inc.
10.3	Form of Restricted Stock Award Agreement (Executive Officer)
10.4	Form of Restricted Stock Award Agreement (Outside Director)
10.5	Form of Restricted Stock Award Agreement (Employee)
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

	MOLINA HEALTHCARE, INC. (Registrant)
Dated: August 9, 2005	/s/ JOSEPH M. MOLINA, M.D.
	Joseph M. Molina, M.D. Chairman of the Board, Chief Executive Officer and President (Principal Executive Officer)
Dated: August 9, 2005	/s/ JOHN C. MOLINA, J.D.
	John C. Molina, J.D. Executive Vice President, Financial Affairs, Chief Financial Officer and Treasurer (Principal Financial Officer)

Exhibit 10.1

PSC _____-_______

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAID MANAGED CARE SERVICES AGREEMENT

This agreement ("Agreement") between the New Mexico Human Services Department ("HSD") and Molina Health Plan of Albuquerque, New Mexico ("CONTRACTOR") specifies the terms and conditions under which the CONTRACTOR shall provide Medicaid managed care services for the HSD's Medical Assistance Division ("MAD").

The term of this Agreement shall be from July 1, 2005 and shall expire June 30, 2009, unless amended or terminated pursuant to its terms. In no circumstance shall the Agreement exceed a total of four (4) years in duration. This Agreement shall not become effective until approved in writing by the Department of Finance and Administration and the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS").

The term day(s) refers to calendar days, unless otherwise specified. The first day is excluded and the last day is included. Timelines or due dates falling on a weekend or state or federal holiday shall be extended to the first business day after the weekend or holiday.

The terms "contract" and "agreement" are used interchangeably throughout this document.

ARTICLE 1 - RECITALS

1.1 All services provided pursuant to this Agreement are subject to the Procurement Code and 1.4.1 NMAC unless specifically provided otherwise herein.

1.2 All services purchased under this Agreement shall be subject to the following provisions for administration of the Medicaid program, which are incorporated herein by reference:

(1) The HSD/MAD program eligibility and provider policy manuals, including all updates, revisions, substitutions and replacements;

(2) Title XIX and Title XXI of the Social Security Act and Code of Federal Regulations Title 42 Parts 430 to end, as revised from time to time;

(3) The RFP, all RFP Amendments, CONTRACTOR'S Questions and HSD/MAD's Answers, and HSD/MAD written Clarifications;

(4) The CONTRACTOR'S Best and Final Offer;

(5) The CONTRACTOR'S Proposal (including any and all written materials presented in the orals portion of the procurement) where not inconsistent with this Agreement and subsequent amendments to this Agreement;

(6) All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico ("State"), and HSD/MAD, concerning Medicaid services, managed care organizations (MCOs), health maintenance organizations, fiscal and fiduciary responsibilities applicable under the Insurance Code of New Mexico, NMSA 1978 §§ 59A-1-1 et. seq., and any other applicable laws.

(7) The HSD/MAD Policy Manual, including all updates and revisions thereto, or substitutions and replacements thereof, duly adopted in accordance with applicable law. All defined terms used within the Agreement shall have the meanings given them in the Policy Manual; and

(8) All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico, and HSD/MAD concerning the State Children's Health Insurance Program ("SCHIP").

1.3 HSD/MAD is responsible for administering New Mexico's Medicaid program. HSD/MAD shall require that most Medicaid recipients enroll with MCOs. HSD/MAD plans to execute agreements with MCOs that meet the requirements specified under the terms of this Agreement and the RFP.

1.4 HSD/MAD shall award risk-based contracts to the CONTRACTORS with statutory authority to enter into capitated agreements, assume risk and meet applicable requirements and/or standards delineated under state and federal law.

1.5 The CONTRACTOR possesses the required authorization and expertise to meet the terms of this Agreement.

1.6 The CONTRACTOR shall be National Committee for Quality Assurance ("NCQA") accredited, or in active pursuit of accreditation by July 1, 2005. "Active pursuit" is defined as having applied for accreditation.

1.7 The parties to this contract acknowledge the need to work cooperatively to address and resolve problems that may arise in the administration and performance of this contract. The parties agree to document agreements in writing prior to implementation any new contract requirements.

1.8 HSD/MAD may, in the administration of this contract, seek input on health care related issues from any advisory group or steering committee. HSD/MAD may seek the input of the CONTRACTOR on issues raised by advisory groups or steering committees that may affect the CONTRACTOR.

1.9 The CONTRACTOR shall make reasonable efforts to notify HSD/MAD of the CONTRACTOR'S or its subcontractors' potential public relations issues that could affect HSD/MAD or the Agreement.

NOW, THEREFORE, in consideration of the mutual promises contained herein, HSD/MAD and the CONTRACTOR agree as follows:

ARTICLE 2 - SCOPE OF WORK

The CONTRACTOR shall perform professional services, including, but not necessarily limited to, the following:

2.1 PROGRAM ADMINISTRATION

(1) Member Services

HSD/MAD shall implement procedures governing the following activities by the CONTRACTOR or entities acting on behalf of the CONTRACTOR: Development of information and educational media; provision of materials explaining the enrollment options and process to potential members; and provision of informational presentations to eligible members, members, member advocates and other interested parties.

The CONTRACTOR shall have a member services function that coordinates communication with members and acts as a member advocate. There should be sufficient staff to allow members to resolve problems or inquiries.

A. Policies and Procedures:

The CONTRACTOR shall have and comply with written policies and procedures regarding the treatment of minors; adults who are in the custody of the State; children and adolescents who are under the jurisdiction of the Children, Youth, and Families Department (CYFD); and any individual who is unable to exercise rational judgment or give

informed consent, under applicable federal and state laws and New Mexico Medicaid Regulations. The CONTRACTOR shall:

i. have and comply with written policies and procedures that describe a process to detect, measure, and eliminate operational bias or discrimination against enrolled Medicaid members by the CONTRACTOR or its providers;

ii. maintain and comply with written policies and procedures to ensure that its providers and their facilities are in compliance with the Americans with Disabilities Act ("ADA");

iii. maintain and comply with written policies and procedures regarding members' and/or legal guardians' right to select a primary care provider;

iv. perform an initial assessment of member's health care needs within ninety (90) days of the date of a member's enrollment. A member is considered to be enrolled for the purpose of this subsection at the time the member is considered locked into the CONTRACTOR'S MCO. The initial assessment shall, at a minimum, include the distribution of an appropriate form to members and the clinical review of any form returned by members. The form, if mailed to a member, shall include a pre-addressed return postage-paid envelope;

v. provide potential members upon request and enrolled members with a directory to include MCO addresses and telephone numbers. The CONTRACTOR shall also provide upon request a listing of primary care and specialty providers with the identity, location, phone number and qualifications that include area of specialty, board certification and any area of special expertise that would be helpful to individuals deciding to enroll with the CONTRACTOR. This material must be available in an easily understood manner and format. At the option of the CONTRACTOR, the directory may be limited to primary care and self-refer providers;

vi. provide potential members upon request and enrolled members with a list of all items and services that are available to members covered either directly or through a method of referral and/or prior authorization. These materials must be available in a manner and format that can be easily understood; and

vii. have written policies and procedures that shall be made available upon request to members and their representatives for review during normal business hours.

B. Member Education

Medicaid members shall be educated about their rights, responsibilities, service availability, and administrative roles under the managed care system. Member education is initiated when members become eligible for Medicaid and is augmented by information provided by HSD/MAD and the CONTRACTOR.

C. Initial Information

The education of the member is initiated when the member becomes eligible for Medicaid. HSD/MAD distributes information about Medicaid managed care and the enrollment process.

D. MCO Enrollment Information

Once a member is determined to be an MCO mandatory member, HSD/MAD provides specific information about services included in the benefit packages, MCOs from which the member can choose, and enrollment of the member(s). The CONTRACTOR shall have written policies and procedures regarding the utilization of information on race, ethnicity, and primary language spoken, as provided by HSD/MAD to the CONTRACTOR at the time of enrollment in the MCO of each Medicaid member.

E. Member Handbook

i. The CONTRACTOR shall maintain written policies and procedures governing the development and distribution of marketing materials for members.

ii. The CONTRACTOR is responsible for providing members with a member handbook and provider directory within thirty (30) days of the CONTRACTOR being notified by HSD/MAD of the member’s enrollment. The CONTRACTOR must notify all

members at least once per year of their right to request and obtain this information. The member handbook shall include information contained in 42 CFR, Section 438.10.F.2.

iii. The CONTRACTOR shall send a provider directory and member handbook to members or potential members who request a copy and when HSD/MAD requests them. The CONTRACTOR may direct a person requesting a member handbook or a provider directory to an Internet site. However, the CONTRACTOR shall meet a specific request for a printed document. The CONTRACTOR shall provide a one-page, two-sided summary of its benefits, which may be distributed by HSD/MAD at its discretion. The CONTRACTOR must notify all members at least once per year of their right to request and obtain this information.

iv. Member handbooks shall be available in formats other than English and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency, if, in the CONTRACTOR'S or HSD/MAD's determination there is a prevalent population i.e., five percent (5%) or more of the CONTRACTOR'S Salud! members who are conversant only in those other languages or require alternate formats. In addition, oral interpretation must be made available free of charge to potential members or members. Oral interpretations must be available in all non-English languages, not just those languages the CONTRACTOR and HSD/MAD determine to be prevalent. The CONTRACTOR must notify potential members that oral interpretation is available in any language, that written information is available in prevalent languages and about how to access this information. The handbook shall:

(a) use easily understood language and format;

(b) be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency; and

(c) explain that potential members upon request and enrolled members may access these formats.

v. The handbook shall include the following:

(a) benefits and services, including preventive services, included in, and excluded from, coverage;

(b) any special benefit provisions that may apply to services obtained outside the CONTRACTOR'S system;

(c) any restrictions on benefits that apply to services obtained outside the CONTRACTOR'S service area;

(d) the CONTRACTOR demographic information including the organization's toll-free member phone number;

(e) notice to members on both the CONTRACTOR'S internal grievance and appeal processes and HSD/MAD's fair hearing process;

(f) information on how to obtain services, such as after hours and emergency service, including the 911-telephone system or its local equivalent;

(g) the member's rights, protections, and responsibilities;

(h) information on accessing specialty services, including, but not limited to: EPSDT and family planning services; information regarding the member's rights to self-refer to in-plan and out-of-plan family planning providers; and a female member's right to self-refer to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. The female member's right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist;

(i) information on the member's rights to terminate enrollment and the process for voluntarily disenrolling from the plan;

(j) other information determined by HSD/MAD to be essential during the member’s initial contact with the CONTRACTOR;

(k) information regarding advanced directives;

(l) the means for obtaining primary care services, specialty care, and hospital services;

(m) the means for obtaining care after normal office hours;

(n) the means for obtaining emergency care, including the CONTRACTOR’S policy on when to directly access emergency care or use 911 services;

(o) the means for obtaining care and coverage when out of the CONTRACTOR’S service area;

(p) the means by which the CONTRACTOR shall notify members affected by the termination or change in any benefit, service or service delivery office/site;

(q) information on cost sharing if any;

(r) additional information upon request, including information on how to obtain the CONTRACTOR’S structure and operation and physician incentive plans;

(s) its policy on freedom of provider choice;

(t) changing assigned providers, if applicable;

(u) accessing the toll-free phone lines; and

(v) all other policies and procedures regarding member rights and responsibilities.

vi. The Provider Directory shall include:

(a) a list of providers, by provider type and specialty, including names, locations, telephone numbers and

non-English languages spoken, available through the CONTRACTOR and how to access them. Such list, at the option of the CONTRACTOR, may be limited to primary care providers and those providers to whom members may self-refer, including, but not limited to, family planning providers, urgent and emergency care providers, IHS and other Native American providers, and Pharmacies; and

(b) upon request, the CONTRACTOR shall provide information on the participation status of any provider; and the means for obtaining more information about providers who participate in the MCO.

F. <u>Benefit Information</u>

i. The CONTRACTOR shall provide each member and/or legal guardian with written information in English and Spanish about benefits including:

(a) all Medicaid benefits and services, as well as preventive services, included in, and excluded from, coverage;

(b) services for which prior authorization or a referral is required, and the method for obtaining both;

(c) any restrictions on the member's freedom of choice among network providers;

(d) the CONTRACTOR'S policy on referrals for specialty care and other benefits not furnished by the member's primary care provider; and

(e) information regarding the member's rights of access to and coverage of emergency services which shall include:

1. the fact that the member has a right to use any hospital or other setting for emergency care; and

2. what constitutes emergency medical condition, emergency services, and post-stabilization services.

ii. The CONTRACTOR shall provide affected members and/or legal guardians with written updated information within thirty (30) days of the intended effective date of any material change. In addition, the CONTRACTOR must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

G. Second Opinions

i. The CONTRACTOR shall provide members with the option of receiving a second opinion from another provider participating with the CONTRACTOR when members need additional information regarding recommended treatment or when requested care has been denied by the provider.

ii. The CONTRACTOR may select the provider giving the second opinion in accordance with a method established by the CONTRACTOR to equitably distribute these duties, provided that the provider selected practices in an area that provides expertise appropriate to the member's specific treatment or condition.

iii. The CONTRACTOR shall provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network if there is not another qualified provider in the network, at no cost to the member.

H. Maintenance of Toll-Free Line

The CONTRACTOR shall maintain one or more toll-free telephone line(s) accessible twenty-four (24) hours a day, seven (7) days a week, to facilitate member access to qualified clinical staff. MCO members may also leave a voice mail message to obtain the CONTRACTOR'S policy information and /or to register grievances with the CONTRACTOR. The phone call shall be returned the next business day by an appropriate CONTRACTOR staff person.

I. Member Notification

i. The CONTRACTOR shall adopt written policies and procedures to ensure prompt notification of the member regarding abnormal results of diagnostic laboratory, diagnostic imaging, and other testing and, if clinically indicated, informing the member of a scheduled follow-up visit. Confirmation of this shall be documented in the member's record.

ii. At the request of a member, the CONTRACTOR shall provide information to the member on options for private health insurance when the member's enrollment is terminated due to loss of Medicaid eligibility. The provision of these options shall be documented in the member's records the CONTRACTOR maintains.

J. Member Identification Card

The CONTRACTOR shall issue to each member a member identification card within thirty (30) days of enrollment. The card shall be substantially the same as the card issued to commercial enrollees.

K. Advance Directives

The CONTRACTOR shall implement written policies and procedures with respect to advance directives. The CONTRACTOR shall provide adult members with written information on advance directive policies that includes a description of applicable State law. The information must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

The CONTRACTOR shall:

i. provide written information to adult members concerning their rights to accept or refuse medical or surgical treatment and to formulate advance directives, and include the CONTRACTOR'S policies and procedures with respect to the implementation of such rights;

ii. document in the member's medical record whether or not the member has executed an advanced directive;

iii. prohibit discrimination against a member in the provision of care or in any other manner discriminating against a member based on whether the member has executed an advanced directive;

iv. ensure compliance with the provision of Federal and State laws; and

v. provide education for staff and the community on issues concerning advance directives.

(2) Quality Assurance

A. Member Bill of Rights and Responsibilities

The CONTRACTOR shall be required to comply with the MAD regulation 8.305.8.15. Member Bill of Rights. The CONTRACTOR shall provide each member with the written information, in English or the prevalent language, as appropriate, found in the MAD Member Bill of Rights pursuant to MAD 8.305.8.15. The CONTRACTOR’S written information on member rights and responsibilities shall include the following:

i. members and/or legal guardians have a right to obtain equitable treatment, respecting and recognizing of the member’s dignity and need for privacy;

ii. members have a right to receive health care services in a non-discriminatory fashion;

iii. members and, as appropriate, their families and/or legal guardians have a right to participate with practitioners in decision making regarding all aspects of their health care, including development of the course of treatment. The CONTRACTOR’S policy shall contain procedures for obtaining informed consent;

iv. legally determined surrogate decision makers have a right to be involved, as appropriate, to facilitate care decisions;

v. members and/or legal guardians have a right and the means to voice complaints or file grievances and appeals about the care provided by the CONTRACTOR;

vi. members and/or legal guardians have a right and the means to be able to choose from among the available providers within the limits of the plan network and its referral and prior authorization requirements;

vii. members have a right to formulate advance directives consistent with Federal and State laws and regulations;

viii. members have a right to have access to their medical records in accordance with the applicable Federal and State laws and regulations;

ix. members and/or legal guardians, to the extent possible, have a responsibility to provide information that the CONTRACTOR, its practitioners, and providers need in order to care for them;

x. members and/or legal guardians, to the degree possible, have a responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals;

xi. members and/or legal guardians have a responsibility to follow the plans and instructions for care that they have agreed upon with their practitioners;

xii. members and/or legal guardians have a responsibility to keep, reschedule, or cancel a scheduled appointment rather than to simply fail to keep it; and

xiii. members have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

B. Consumer Advisory Board

i. The CONTRACTOR shall establish a Consumer Advisory Board representing physical health members. The board shall include regional representation, including members, advocates and providers.

ii. The Consumer Advisory Board shall serve to advise the CONTRACTOR on issues concerning service delivery and quality, member rights and responsibilities, the process for resolving member grievances, and the needs of the groups they represent as they pertain to Medicaid managed care. The Board shall meet on at least a quarterly basis. The CONTRACTOR shall conduct outreach activities in the State's regions to ensure member input. The CONTRACTOR is responsible for keeping a written record of the board meetings.

iii. The CONTRACTOR'S Consumer Advisory Board shall maintain documentation of all attempts to invite and include its members in its meetings. The Board roster and minutes shall be made available to HSD/MAD upon request.

iv. The Consumer Advisory Board shall advise HSD/MAD in writing ten (10) days in advance of all meetings to be held. HSD/MAD reserves the right to attend and observe the meetings of the Board at its discretion.

v. The Consumer Advisory Board shall consist of a fair representation of the CONTRACTOR'S members in terms of race, gender and New Mexico geographic areas.

vi. The CONTRACTOR shall send the CONTRACTOR'S representatives to attend at least two statewide consumer meetings to help ensure that member issues are being heard and addressed.

C. <u>Standards for Utilization Management (UM)</u>

The CONTRACTOR shall:

i. ensure that its Utilization Management (UM) Program properly manages the use of limited resources, maximizes the effectiveness of care by evaluating clinical appropriateness, and authorizes the type and volume of services through fair, consistent and culturally competent decision making to ensure equitable access to care and a successful link between care and outcomes;

ii. define, in writing, the UM program structure and accountability mechanisms;

iii. ensure that its senior management and the Medical Director or Internal Quality Management and Improvement ("QI") program annually evaluates and approves or revises the UM program;

iv. define and submit proposed utilization review clinical criteria to be used for all services which require prior authorization. HSD/MAD reserves the right to review and approve all UR clinical criteria used for approving prior authorizations;

v. develop and implement written policies and procedures for review of utilization decisions to ensure their basis in sound clinical evidence and that they conform to medical necessity criteria;

vi. ensure the involvement of appropriate, practicing practitioners in the development of UM procedures;

vii. comply with NCQA standards for UM and follow NCQA timeliness standards for urgent and emergent situations. NCQA standards shall be superseded by the Balanced Budget Amendment requirements. A possible extension of up to 14 additional calendar days may apply if:

(a) the member, or provider, requests extension; or

(b) the CONTRACTOR justifies to HSD/MAD a need for additional information and documents how the extension is in the member's interest.

viii. approve or deny services for routine/non-urgent, urgent care requests within the timeframes stated in regulation. These required timeframes are not to be affected by a "pend" decision. The decision-making timeframes must accommodate the clinical urgency of the situation and not delay the provision of services to members for lengthy periods of time;

ix. evaluate member and provider satisfaction with the utilization process;

x. ensure that UM functions are appropriately implemented, monitored and managed by clinical professionals;

xi. provide ad hoc reports about service utilization upon request by HSD/MAD;

xii. develop and implement policies and procedures to promote inter-rater reliability among the UM staff. Monitoring activities must be included in the UR/UM program design;

xiii. develop and implement policies and procedures for providers to have access to UM criteria;

xiv. develop and implement policies and procedures by which UM decisions may be appealed by members in a timely manner, which must include all necessary requirements and timeframes for submission;

xv. define how UM decisions will be communicated to the member and the member's provider requesting the authorization;

xvi. provide education, assistance and monitoring to providers regarding appropriate referrals for behavioral health consultation and treatment; and

xvii. ensure that the Pharmacy and Therapeutics Committee membership includes behavioral health expertise to aid in the proper development of pharmacy and practice guidelines for PCPs prescribing psychotropic and antidepressant medications.

D. Authorization and Notice of Services

i. Coverage of Services

The CONTRACTOR shall:

(a) identify, define, and specify the amount, duration, and scope of each service that the CONTRACTOR is required to offer;

(b) require that the services be furnished in an amount,

duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid as set forth in 42 CFR, Section 440.230;

(c) ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished;

(d) not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(e) place appropriate limits on a service:

1. on the basis of criteria dictated by HSD such as medical necessity; or

2. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

(f) specify what constitutes “medically necessary services” in a manner that:

1. is no more restrictive than that used by HSD/MAD as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

2. addresses the extent to which the CONTRACTOR is responsible for covering services related to the prevention, diagnosis, and treatment of health impairments and the ability to attain, maintain or regain functional capacity.

ii. Authorization of Services

For the processing of requests for initial and continuing authorization of services, the CONTRACTOR shall:

(a) require that its subcontractors have in place, and follow, written policies and procedures;

(b) have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

(c) consult with the requesting provider when appropriate; and

(d) require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease, such as the CONTRACTOR'S Medical Director.

iii. Notice of Adverse Action.

The CONTRACTOR must notify the requesting provider, and give the member written notice, of any decision by the CONTRACTOR to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR Section 438.404.

iv. Compensation for UM Activities.

Each contract must provide that, consistent with 42 CFR, Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

E. Denials

The CONTRACTOR shall:

i. clearly document in English or Spanish, as appropriate, on a form agreed to by HSD/MAD, and communicate in writing the reasons for each denial to the requesting provider and the member. A "denial" is defined as a refusal by the CONTRACTOR to authorize a service requested or recommended by the member's health care provider;

ii. provide in writing the reason for a denial of service coverage to the requesting practitioner and the affected member. There shall be an established and well-publicized internal and accessible grievance and appeals mechanism for both providers and members; the notification of a denial shall include a description of how to file a grievance and an appeal in the CONTRACTOR'S system and how to obtain an HSD/MAD Fair Hearing;

iii. recognize that a UR decision resulting from a Fair Hearing conducted by the designated HSD/MAD official is final and shall be honored by the CONTRACTOR.; However, the CONTRACTOR shall have the right to dispute the financial responsibility for the decision through the dispute resolution process in Article 15;

iv. evaluate member and provider satisfaction with the UM process as a part of its member satisfaction survey while maintaining the Federal and State confidentiality requirements of surveyed participants; and

v. forward survey results to HSD/MAD. HSD/MAD shall have access to the CONTRACTOR'S UM review documentation.

F. Standards for Internal Quality Management and Quality Improvement (QM/QI)

The CONTRACTOR shall:

i. have QI programs based on a model of continuous quality improvement. The QI programs shall encompass physical health. The ultimate responsibility for QI is with the CONTRACTOR and shall not be delegated to subcontractors. The QI structures and procedures shall be clearly defined with responsibilities appropriately assigned;

ii. submit to HSD/MAD and the CONTRACTOR'S members, upon request, an annually evaluated and updated program description. The QI program description shall contain a work plan, or schedule of activities to be reviewed quarterly which includes:

(a) objectives, scope, and planned projects or activities for the year;

(b) planned monitoring of previously identified issues, including tracking of issues over time; and

(c) planned evaluation of the QI program.

iii. designate a physician with primary responsibility for the implementation of the QI program;

iv. establish a committee to oversee and implement the following QI requirements:

(a) QI program and policy;

(b) QI committee and policy;

(c) annual QI work plan and evaluation;

(d) confidentiality policy and procedures;

(e) medical records documentation policy and procedures;

(f) policy and procedures for working with high need members;

(g) member satisfaction surveys;

(h) disease management protocols and procedures; and

(i) policy and procedures for continuity and coordination of care.

v. The CONTRACTOR shall, every two years, appropriately update and disseminate applicable evidence-based practice guidelines for providing services for acute and/or chronic conditions, relevant to its enrolled membership. The QI program shall be approved by HSD/MAD prior to implementation.

G. Quality Management/Quality Improvement Program (QM/QI)

The CONTRACTOR shall:

i. have a QM/QI program, including goals, objectives, structure, policies, and authorities that shall result in continuous quality improvement for physical health care;

ii. have a QI work plan that includes immediate objectives for each contract period and long-term objectives for the entire contract period. This work plan shall contain the scope of the objectives, activities planned, timeframe and other relevant information;

iii. evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members;

iv. have a process for exchanging information throughout the CONTRACTOR'S organization;

v. have written policies and procedures for medical records documentation;

vi. have disease management protocols and procedures;

vii. have policies and procedures for working with high need members;

viii. have written policies and procedures for conducting member surveys;

ix. have written policies and procedures for continuity and coordination of care as they relate to the delivery of physical health services as well as for coordinating with the Single Statewide Entity (SE) that will be delivering Medicaid behavioral health services;

x. have written policies and procedures on confidentiality, including a provision that all materials concerning the care and treatment of members shall be made available to HSD/MAD; and

xi. provide a QI work plan that includes mechanisms for monitoring, addressing and correcting any evidence of cost-shifting practices by the physical health provider network such as pharmaceutical cost-shifting of behavioral health medications currently and effectively being prescribed by primary care providers.

H. QI Projects and Reviews

The CONTRACTOR shall:

i. be required to have access to, and the ability to collect and manage, data necessary to support the measurement aspects of QI activities;

ii. be required to have the ability to design sound quality studies, apply statistical analysis to data, and derive meaning from the statistical analysis;

iii. demonstrate to HSD/MAD that the results of QI projects and reviews are used to improve the quality of service coverage and delivery with appropriate individual practitioners and institutional providers. When the CONTRACTOR determines that there are provider performance problems, the CONTRACTOR is responsible to take and to document appropriate action; and

iv. ensure that the QI program is applied to the entire range of health services provided through the CONTRACTOR by assuring that all major population groups, care settings, and service types are included in the scope of the review. A major population group is one that represents at least five percent (5%) of a CONTRACTOR'S enrollment.

I. Continuous Quality Improvement (CQI)

The CONTRACTOR shall ensure that management is based on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM) including: the recognition that opportunities for improvement are unlimited; that the QI process shall be data driven, requiring continual measurement of clinical and non-clinical effectiveness and programmatic improvements of clinical and non-clinical processes driven by such measurements; requiring re-measurement of effectiveness and continuing

development and implementation of improvements as appropriate; and shall rely on customer input.

J. QI Program Effectiveness Evaluation

The CONTRACTOR shall annually evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members. The CONTRACTOR shall submit its written evaluation of the QI program to HSD/MAD. This evaluation shall include at least the following:

i. a description of completed and ongoing QI activities;

ii. trending of measures to assess performance in quality of clinical care and quality of service;

iii. an analysis of whether there have been demonstrated improvements in the quality of clinical care and quality of service; and

iv. an evaluation of the overall effectiveness of the QI program.

K. Delegation

HSD/MAD reserves the right to approve and disapprove any delegated subcontract templates. The CONTRACTOR shall:

i. have a written document (Agreement), signed by both parties, that describes the responsibilities of the CONTRACTOR and the delegate; the delegated activities; the frequency of reporting (if applicable) to the CONTRACTOR; the process by which the CONTRACTOR evaluates the delegate; and the remedies, including revocation of the delegation, available to the CONTRACTOR if the delegate does not fulfill its obligation;

ii. have written policies and procedures to ensure that the delegated agency meets all standards of performance mandated by HSD/MAD;

iii. have written policies and procedures for the oversight of the delegated agency’s performance of the delegated functions;

iv. have written policies and procedures to ensure consistent statewide application of all UM criteria when UM is delegated;

v. include in its agreement with the delegate whether the CONTRACTOR or the delegate shall oversee the performance of the sub delegate to ensure that there is a mutually agreed document in place for any sub delegated functions;

vi. be ultimately accountable for all delegated activities and may not under any circumstances abrogate any responsibility for decisions made by a delegate regarding delegated functions;

vii. provide to HSD/MAD notice of any proposed new agreement for delegation or of any material changes to existing agreements at least thirty (30) calendar days prior to the proposed beginning date of the Agreement or the proposed effective date of material amendments to existing agreements;

viii. ensure the delegate takes corrective action of the CONTRACTOR identified deficiencies; and

ix. revoke delegation or impose other sanctions if the delegate's performance is inadequate, in accordance with CONTRACTOR'S policy and procedures.

L. Clinical Performance

The CONTRACTOR shall identify and monitor on an on-going basis indicators of clinical performance and, shall implement activities designed to improve the process of providing a clinical service.

M. Member Satisfaction Survey

As part of its QI Program, the CONTRACTOR shall conduct at least one annual survey of member satisfaction which shall be designed by the CONTRACTOR with input from the Consumer Advisory Board and which shall assess member satisfaction with the quality, availability, and accessibility of care. The survey shall provide a statistically valid sample of all CONTRACTOR members, including members who have requested to change their primary care providers (PCPs) and all members who have

voluntarily disenrolled from the CONTRACTOR. The member survey shall address member receipt of educational materials and the member's use and usability of the provided education materials. The CONTRACTOR'S survey shall address the satisfaction of Individuals with Special Health Care Needs. The CONTRACTOR shall follow all Federal and State confidentiality requirements in conducting this survey with members.

The CONTRACTOR shall:

i. use the CAHPS 2.0H Adult and Child Survey Instruments (most current version) to assess member satisfaction as part of the HEDIS requirements and report the results of the CAHPS survey to HSD/MAD. The CONTRACTOR shall utilize the annual CAHPS results in the CONTRACTOR'S internal QI program by using areas of decreased satisfaction as areas for targeted improvement;

ii. disseminate results of the member satisfaction survey to practitioners, providers, HSD/MAD and members;

iii. participate in the design of a separate annual member satisfaction survey to be conducted by an independent entity determined by HSD/MAD. The survey itself shall not be the financial responsibility of the CONTRACTOR; and

iv. follow NCQA guidelines for the conduct of provider satisfaction surveys; cooperate with HSD/MAD in conducting a provider satisfaction survey, including making available a current, unduplicated provider file(s) available to HSD/MAD or its External Quality Review Organization (EQRO) upon request.

N. External Quality Review

i. HSD/MAD shall retain the services of an EQRO in accordance with the Social Security Act, Section 1902 (a) (30) [C], and the CONTRACTOR shall cooperate fully with that organization and prove to that organization the CONTRACTOR'S adherence to HSD/MAD's quality standards as set forth in MAD Policy Section 8.305.8.

ii. HSD/MAD shall also contract with an EQRO to audit a statistically valid sample of the CONTRACTOR'S physical health UM decisions, including authorizations, reductions, terminations and denials. This audit is intended to determine if authorized service levels are appropriate with respect to accepted standards of clinical care. The CONTRACTOR shall cooperate fully with that organization.

iii. The CONTRACTOR shall participate in various other tasks identified by HSD/MAD that shall enable HSD/MAD to gauge performance in a variety of areas, including care coordination and treatment of special populations.

vi. The CONTRACTOR shall utilize technical assistance and guidelines offered by the EQRO, unless otherwise agreed upon by HSD/MAD and the CONTRACTOR.

v. The EQRO retained by HSD/MAD shall not be a competitor of the CONTRACTOR.

O. Publication

At its discretion, HSD/MAD shall release all aggregate results of the QI/audit functions to the public and to the Federal Government.

P. Disease Management

Disease management (DM) is a strategy of delivering health services using interdisciplinary clinical teams, continuous analysis of relevant data, and cost-effective technology to improve the health outcomes of individuals with specific diseases. HSD/MAD seeks to improve the health status of all individuals in the population with specific diseases. Disease Management programs and Performance Measures are two of the tools that HSD/MAD has chosen to use to measure the CONTRACTOR'S ability to impact health outcomes. Examples of chronic illnesses/diseases to be included but are not limited to: Diabetes, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Obesity and Asthma. HSD/MAD expects that each CONTRACTOR shall improve its ability to manage chronic illness to meet the goals set by HSD/MAD for Disease Management.

The CONTRACTOR shall:

i. participate in disease management programs/performance measures projects annually. HSD/MAD will coordinate with CONTRACTOR to select programs that meet NCQA requirements;

ii. adhere to timely and accurate collection of baseline project indicator data (physical health, administrative), which shall show the CONTRACTOR'S performance rate for those indicators identified for improvement by HSD/MAD;

iii. identify specific interventions that the CONTRACTOR intends to use to improve performance in a given area;

iv. demonstrate improvement in each quality indicator within each calendar year of the contract; and

v. perform subsequent measurement and written assessment on the ongoing effectiveness of named interventions.

Q. Critical Indicators Report

The CONTRACTOR shall:

i. track, analyze, and report to HSD/MAD quarterly, those indicators identified specific to physical health that shall enable HSD/MAD to determine potential problems areas within quality of care, access, or service delivery;

ii. collect the requested data monthly, perform analysis on the data for the purpose of determining completeness and validity, and report results to HSD/MAD no less often than quarterly;

iii. analyze the data, including the identification of any significant trends; and

iv. address all negative trends in the analysis and develop appropriate CQI initiatives. Examples of negative trends may include involuntary hospitalizations, decrease in Early Periodic Screening Diagnostic Treatment (EPSDT) screens, high infant mortality or an increase in suicides or suicide attempts.

R. Managed Care Performance Measures for 2005 Salud! Managed Care Program

i. Managed Care Performance Measures:

The CONTRACTOR will be provided with a copy of the HSD/MAD's performance measures and relative portions of the HSD/MAD Strategic Plan.

For capitation payments made on or after June 30 of the applicable contract year, the CONTRACTOR shall withhold one-half of one percent (0.5%), net of premium taxes of HSD/MAD's capitation payments and hold such funds on HSD/MAD's behalf. The withheld funds shall be released to the CONTRACTOR no sooner than July 1st and no later than October 31st after the applicable contract year only if, in the judgment of HSD/MAD, performance targets in the contract are achieved.

HEDIS will be the methodology used for all performance measures, unless HSD/MAD determines to use a non-HEDIS methodology or a HEDIS measure does not exist.

For those performance measures utilizing a HEDIS methodology, HSD/MAD agrees that the measures will be evaluated using the HEDIS collection specifications in effect on July 1 of the applicable contract year, except for the HEDIS timeframes.

For those measures that HSD/MAD determines to use a non-HEDIS measure, or for which a HEDIS measure does not exist, HSD/MAD will provide the CONTRACTOR the methodology to be used to measure the CONTRACTORS performance before July 1, 2005.

Withheld funds shall be released to the CONTRACTOR based on the following scoring system for each of the performance measures listed below:

(a) PM#1 - EPSDT Preventative Dental Care shall be worth 20 points;

(b) PM#2 - Cervical Cancer Screening shall be worth 15 points;

(c) PM#3 - Diabetes Disease Management Performance shall be worth 15 points;

(d) PM#4 - Provider Payment Timeliness shall be worth 15 points;

(e) PM#5 - Encounter Data Reporting shall be worth 15 points; and

(f) PM#6 - Timely submission, accuracy, and analysis of HSD/MAD required reports shall be worth 20 points.

The percentage of the CONTRACTOR'S withheld funds to be released shall be calculated by summing all earned points, dividing the sum by 100, and converting to a percentage (Withheld Percentage). No partial number of points will be assigned if the CONTRACTOR fails to completely meet performance measures described in (a) through (f) above, except with respect to performance measure (f) (i.e., PM#6 – Timely submission, accuracy and analysis of HSD/MAD required reports), for which the parties will meet to establish a mutually agreeable method of allocating points for this measure taking into account the frequency of such reports and the materiality of any inaccuracies. Points assigned for the other performance measures will be all or none (i.e. fifteen (15) points or zero (0) points).

To the extent that the following performance measures are not based on HEDIS measures, the parties agree that the measure shall be evaluated based on the standard reports for such measures already submitted to HSD/MAD by the CONTRACTOR, provided that HSD/MAD shall have the right to audit and validate the information or results as reported by CONTRACTOR.

ii. Performance Measures Requirements:

The performance measures shall be evaluated using the following criteria:

(a) PM#1 - EPSDT Preventable Dental

The CONTRACTOR will follow EPSDT preventative health guidelines to deliver preventative dental services for the EPSDT population 24 months – 20 years of age. The CONTRACTOR'S members between the ages of 24 months to twenty years who were enrolled with the CONTRACTOR during the reporting period will have at least one preventative dental visit during the first year of the contract. Data for this performance measure will be obtained from the existing MCO Comparison Report from Encounter Data (Children's Health Services #13). The percent of total eligibles for this age group will be tracked quarterly and the expectation of an overall year end total of at least fifty percent (50%) of this age group receiving at least one preventative dental visit.

(b) PM#2 - Cervical Cancer Screening

Female members aged twenty-one (21) through sixty-four (64) years old who were continuously enrolled with the CONTRACTOR during the measurement year will receive one or more Pap tests during the measurement year or the two years prior to the measurement year as evidenced by HEDIS reported data. The percent of total eligibles for this age group will be tracked quarterly and the expectation of an overall year-end total of at least seventy percent (70%) of this age group having a screening.

(c) PM#3 - Diabetes Disease Management Performance

The CONTRACTOR'S members who were enrolled with the CONTRACTOR during the first reporting year will demonstrate a one percent (1%) decrease in acute hospitalizations for the diagnosis of diabetic-related complications, to be defined by HSD/MAD. Initially, the

CONTRACTOR shall use the 2005 HEDIS requirements documented in the HEDIS 2005 Technical Specifications to measure the efficacy of Diabetes DM interventions to decrease reliance on acute hospitalizations. The requirements may be adjusted as per HEDIS in the coming contract years. HSD/MAD shall assist the CONTRACTOR with establishing a baseline measure.

Additional improvement for year two will be specified in accordance with HSD performance measures and NCQA/HEDIS guidelines.

Data for this performance measure will be obtained from a newly defined element from the MCO Comparison Report from Encounter Data. HSD/MAD will establish the specifications required for the MCO Comparison Report.

(d) PM#4 - Provider Payment Timeliness

The CONTRACTOR shall pay ninety percent (90%) of all clean claims within thirty (30) days and ninety-nine percent (99%) of all clean claims within ninety (90) days. The CONTRACTOR may reference Balanced Budget Act of 1997 for specifications.

(e) PM#5 - Encounter Data Reporting

The CONTRACTOR shall submit 100 percent (100%) of all required encounter data on a timely basis for submissions and necessary re-submissions as set forth in the contract. The submissions and required re-submissions shall have an error rate of three percent (3%) or less for at least ninety percent (90%) of the files.

(f) PM#6 - Timely Submission, Accuracy, and Analysis of HSD/MAD Required Reports

The CONTRACTOR shall achieve and maintain compliance with all format and content changes required by HSD/MAD reports. HSD/MAD will finalize the descriptions of the required reports by July 15, 2005. By

August 30, 2005 the reports submitted to HSD/MAD shall be quality checked for validity, accuracy and contract timeliness. The CONTRACTOR shall submit a systems analysis of the data interpretation (i.e., tracking and trending). “Timely submission” shall mean that the report was submitted on or before the date it was due. “Accuracy shall mean the report was substantially prepared according to the specific written guidance, including reporting template, provided by HSD/MAD to the CONTRACTOR.

iii. Retention and Release of Withheld Funds

(a) The retention of funds withheld shall be accomplished as follows:

The CONTRACTOR shall place all funds described in section R.i. (Managed Care Performance Measures) in a separate account and shall provide to HSD/MAD a monthly statement of the account in order to verify that the withheld funds are being maintained during the period of time specified in this contract.

(b) The release of the funds withheld shall be made as follows:

The funds in the withheld funds account shall be released for use by the CONTRACTOR only after HSD/MAD has submitted in writing that, in HSD/MAD’s judgment, the performance targets in the contract have been achieved for the period of time specified in the contract. HSD/MAD shall provide written confirmation no sooner than July 1 and no later than October 31, of the appropriate contract year, or within thirty (30) days of verification, whichever comes first.

(c) The release of funds withheld shall be calculated by taking the amount of capitation payments withheld by the CONTRACTOR pursuant to section R.i. as of June 30th of the applicable contract year and multiplying by the Withheld Percentage for the applicable contract year.

iv. Challenge Pool Funding

If the CONTRACTOR fails to earn any portion of its withheld funds, these funds will immediately be placed in a challenge pool. The challenge pool funds will be paid based upon the performance across HEDIS average Use of Services Measurements as defined in v. (a). and (b).

v. Challenge Pool Measurement.

For purposes of the challenge pool funds, the percentage of the CONTRACTOR'S qualifying members meeting each target measurement will be weighted together pursuant to the following:

(a) Use of Appropriate Medications for People with Asthma.

During year one (1) of the measurement period, the CONTRACTOR will demonstrate a five percent (5%) increase from FY04 data evidenced by the prescribing of appropriate medications acceptable as primary therapy for long-term control of asthma.

For calculation of the numerator for this measure, the following four classes of long-term control asthma medications, consistent with HEDIS requirements and may include the following:

1. inhaled corticosteroids (preferred therapy)
2. cromolyn sodium and nedocromil (alternative therapy for mild, persistent asthma)
3. leukotriene modifiers (alternative therapy for mild, persistent asthma)
4. methylxanthines (alternative but not preferred therapy for mild, persistent asthma)

The eligible populations should be reported using HEDIS requirements, in the following age stratifications:

1. 5-9 year olds
2. 10-17 year olds
3. 18-56 year olds
4. combined rate

(b) Child EPSDT Screens

Members who were three (3), four (4), five (5) or six (6) years old during the measurement year and who received one or more well-child visit(s) with a primary care practitioner during the measurement year.

For the purpose of weighting together the Use of Service measurements, the CONTRACTOR that does not submit data to HSD/MAD for either of the two target measurements above shall receive a zero score for any unreported HEDIS target.

vi. Challenge Pool Payments

(a) A CONTRACTOR that earns all withhold funds described in section R.i. shall not be eligible for any Challenge Pool payment.

(b) The CONTRACTOR with the highest overall average of two HEDIS 2005 measurements during the measurement year will have released an amount that does not exceed one hundred percent of the funds withheld from the CONTRACTOR.

(c) All other CONTRACTORS will have returned a percentage of their withhold funds not already returned calculated as: the CONTRACTOR'S average performance divided by the highest CONTRACTOR average performance, times the amount of the CONTRACTOR'S withhold fund that were not earned under section R.i.

vii. Tracking Measures that are not subject to the Managed Care Withhold or Challenge Pool

The following measures are not subject to the Managed Care Withhold or challenge pool and shall be reported to HSD/MAD:

(a) TM#1 - Breast Cancer Screening

Female members aged fifty (50) through sixty-nine years (69) old who were continuously enrolled with the CONTRACTOR during the measurement year will receive one mammogram during the measurement year or the year prior to the measurement year as evidenced by HEDIS reported data.

(b) TM#2 - Adolescent EPSDT Screens

The CONTRACTOR'S members between the ages of fifteen through eighteen years who were enrolled with the CONTRACTOR during the reporting period will have at least one EPSDT screen. Data for this performance measure will be obtained from the existing MCO Comparison Report from Encounter Data (Children's Health Services #6).

(c) TM #3 - Teen Maternity Care

The CONTRACTOR shall:

1. report utilization information on maternity-related care for enrolled females ages fifteen (15) through eighteen (18) years old who had live births during the measurement year. The information is reported for total deliveries, vaginal deliveries Cesarean section (C-section) deliveries;
2. report percentage of low birth weight babies as well as number of stillborn and infant deaths within the first three days of birth of the total number of pregnancies within this population;

3. gather, during year one (1) and year two (2), baseline data and submit reports quarterly to HSD/MAD. During the third (3) and fourth (4) year of this contract, HSD/MAD may use these two baselines years to establish a targeted performance measures.

(d) TM#4 - Obesity

The CONTRACTOR shall:

1. report the percentage of members eighteen (18) years and older enrolled during the measurement year who were seen by an MCO practitioner during the measurement year and who received advice to lose weight and/or whose practitioner recommended or discussed weight loss methods, strategies or medications; and

2. gather, during year one (1) and year two (2), baseline data and submit reports quarterly to HSD/MAD.

3. HSD/MAD shall provide a reporting format to the CONTRACTOR before the CONTRACTOR shall begin tracking and reporting this measure. The CONTRACTOR shall report to HSD/MAD using this format.

(e) TM#5 - Customer Support Services

1. Ninety-five percent (95%) of the CONTRACTOR'S member services calls shall be answered within thirty (30) seconds or less. reported quarterly but the measure will be based on an annual average.

2. This will be determined by: total number of calls answered within thirty (30) seconds or less divided by total number of calls received minus all calls abandoned prior to thirty (30) seconds.

S. Standards for Access

i. The CONTRACTOR shall ensure the Salud! member caseload of any PCP does not exceed fifteen hundred (1,500) enrollees of the CONTRACTOR. Exceptions to this limit may be made with the consent of HSD/MAD. Reasons for exceeding the limit may include continuing established care, assigning of a family unit or the availability of mid-level clinicians in the practice, which expands the capacity of the PCP.

ii. The CONTRACTOR shall provide to members and providers clear instructions on how to access services, including those that require prior approval or referral.

iii. The CONTRACTOR shall meet time and distance standards for PCPs and pharmacies as determined by HSD/MAD or as described in MAD Policy 8.305.8.18. The CONTRACTOR shall have systems to track and report this data, and such data shall be available to HSD/MAD upon request.

iv. The CONTRACTOR shall meet provider appointment and pharmacy in-person prescription fill time standards as described in MAD Policy 8.305.8.18 and shall approve or deny requests for DME within seven (7) working days of the initial request. Members shall be able to obtain prescribed medical supplies and non-specialized DME within twenty-four (24) hours, when needed on an urgent basis. All new, customized, made-to-measure equipment shall be delivered within one hundred and fifty (150) days of the request date. All repairs or modifications shall be delivered within sixty (60) days of the request date.

v. Routine and non-specialized supplies

The CONTRACTOR shall:

(a) ensure supplies are delivered consistent with clinical need;

(b) have an emergency response plan for medical equipment or supplies needed on an emergent basis;

(c) ensure that members and/or their family receive adequate instruction on use of the supplies or equipment;

(d) be able to deliver the transportation benefit statewide;

(e) have a sufficient transportation network available to meet the transportation needs of members. This includes requiring an appropriate number of handivans for members who are wheelchair or ventilator-dependent or have other equipment needs;

(f) require that all transportation vehicles be equipped with a communication device for use in case of an emergency; and

(g) have CPR-certified drivers to transport members whose clinical needs dictate.

vi. Emergency Conditions

The CONTRACTOR shall:

(a) provide services for emergency and urgent conditions, including emergency transportation anywhere within the United States;

(b) ensure that there is no clinically significant delay caused by the CONTRACTOR’S utilization control measures; and

(c) ensure that members have access to the nearest appropriately designated Trauma Center according to established Emergency Medical Services triage and transportation protocols.

vii. Non-Emergency Access Standards

The CONTRACTOR shall comply with the following non-emergency access standards for outpatient appointments:

(a) for routine, asymptomatic, recipient-initiated, outpatient appointments for primary preventive medical care, the request-to-appointment time shall be no greater than thirty (30) days, unless the member requests a later time;

(b) for routine, symptomatic, recipient-initiated, outpatient appointments for non-urgent primary medical care, the request-to-appointment time shall be no greater than fourteen (14) days, unless the member requests a later time;

(c) primary medical, including dental care outpatient appointments for urgent conditions, shall be available within twenty-four (24) hours;

(d) for specialty outpatient referral and/or consultation appointments, the request-to-appointment time shall be consistent with the clinical urgency but no greater than twenty-one (21) days, unless the member requests a later time;

(e) for outpatient scheduled appointments the time the member is seen shall not be more than thirty (30) minutes after the scheduled time unless the member is late;

(f) for routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency but no greater than fourteen (14) days unless the member requests a later time;

(g) for urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing, appointments availability shall be consistent with the clinical urgency but no greater than forty-eight (48) hours; and

(h) the timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

viii. The CONTRACTOR shall ensure that PCP and pharmacy availability meet specified geographic access standards based on the county of residence: ninety percent (90%) of members residing in urban counties shall travel no longer than thirty (30) miles to receive pharmacy and PCP availability; ninety percent (90%) of members residing in rural counties shall travel no longer than

forty-five (45) miles to receive pharmacy and PCP availability; and ninety percent (90%) of members residing in frontier counties shall travel no longer than sixty (60) miles to receive pharmacy and PCP availability. The CONTRACTOR shall ensure that members have access to pharmacy availability within twenty-four (24) hours of discharge from a hospital, urgent care facility or emergency room.

ix. The CONTRACTOR shall meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services; establish to ensure compliance by providers; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply.

T. Referral and Coordination

The CONTRACTOR shall have and comply with written policies and procedures for the coordination of care. The CONTRACTOR'S policies and procedures shall ensure that referrals to other specialists, out-of-network providers, and all publicly supported providers for medically necessary services are available to members. The CONTRACTOR'S referral process shall be effective and efficient and not present an impediment to timely receipt of services.

U. General Care Coordination Requirements

i. The CONTRACTOR shall:

(a) provide statewide care coordination by licensed or otherwise qualified professionals, either directly or through subcontractors, for members with multiple and complex special physical health care needs;

(b) provide or assure delivery of the five targeted case management programs included in the Medicaid benefit package, on a statewide basis, and be held accountable for delivering these services according to HSD/MAD policy;

(c) develop and implement written policies and procedures, approved by HSD/MAD, which govern how members with multiple and complex special physical health care needs shall be identified;

(d) develop and implement written policies and procedures governing how care coordination shall be provided for members with special health care needs, as required by federal regulation. These policies shall address the development of a member's individual plan of care, based on a comprehensive assessment of the goals, capacities and medical condition of the member and the needs and goals of the family. Also included shall be the criteria for evaluating a member's response to care and revising the plan when indicated. A member and family shall be involved in the development of the plan of care, as appropriate. A member or family shall have a right to refuse care coordination or case management;

(e) develop and implement policies and procedures which define care coordination, including the targeted case management programs, according to HSD/MAD policy on each. Direct, face-to-face meetings may be required as indicated for the targeted case management programs;

(f) measure and evaluate outcomes and monitor progress of members to ensure that services are received and assist in resolution of identified problems and prevent duplication of services;

(g) specify how care coordination shall be supported by an internal information system;

(h) develop and implement policy and procedures to establish working relationships between care coordinators and providers; and

(i) continue to work with the School Based Health Services providers to identify and coordinate with the child's primary care provider (PCP).

ii. Specific Coordination Requirements

(a) <u>Initial Written Referral Report</u>. A written report of the

outcome of any referral, containing sufficient information to coordinate the member's care, shall be forwarded to the PCP by the specialty care health provider within seven (7) calendar days after the screening and evaluation visit unless the member does not agree to release this information.

(b) Ongoing Reporting. The PCP, with the member's consent, shall keep the specialty care health provider informed of drug therapy, laboratory and radiology results, medical consultations, and sentinel events such as hospitalization and emergencies.

(c) Physical Health Consultation and Treatment. The CONTRACTOR shall have and comply with written policies and procedures governing referrals from behavior health providers for physical health consultation and treatment.

(d) Coordination With Waiver Programs. The CONTRACTOR shall provide all covered benefits to members who are waiver participants. There are four Home and Community-Based Waiver programs: the Developmentally Disabled Waiver, the Disabled and Elderly Waiver, the Medically Fragile Waiver and the AIDS Waiver. An integral part of each waiver is the provision of case management. The CONTRACTOR shall coordinate closely with the waiver case manager to ensure that case information is shared, that necessary services are provided and that they are not duplicative. HSD/MAD shall monitor utilization to ensure that the CONTRACTOR provides to members who are waiver participants all benefits included in the CONTRACTOR benefit package.

(e) Coordination of Services with Children, Youth and Families Department (CYFD). The CONTRACTOR shall have written policies and procedures requiring coordination with the CYFD Protective Services and Juvenile Justice Divisions to ensure that members receive medically necessary services regardless of the member's custody status. These policies and procedures shall specifically address compliance with the current New Mexico

Children's Code. If Child Protective Services (CPS), Juvenile Justice or Adult Protective Services (APS) has an open case on a member, the CYFD social worker or Juvenile Probation Officer assigned to the case shall be involved in the assessment and planning for the course of treatment, including decisions regarding the provision of services for the member. The CONTRACTOR shall designate a single contact point for these cases. The CONTRACTOR has the right to demand a release of information from CYFD that is consistent with information sharing through the JPA between HSD/MAD and CYFD.

(f) Coordination of Services with Schools. The CONTRACTOR shall have and implement written policies and procedures regarding coordination with the schools for those members receiving services excluded from managed care as specified in the Individualized Education Program (IEP) or Individualized Family Service Program (IFSP). The CONTRACTOR shall provide the names of the members' PCPs to schools participating in the Medicaid in the Schools (MITS) program.

(g) Coordination with the SE for Transportation. The CONTRACTOR shall coordinate and manage the delivery of the transportation benefit to members receiving behavioral health services. The CONTRACTOR shall coordinate with the SE as necessary to perform this function. Such coordination will include receiving information from and providing information to the SE regarding members, providers, and services; meeting with the SE to resolve provider and member issues to improve services, communication, and coordination; contacting the SE as necessary to provide quality transportation services; and maintaining and distributing statistical information and data as may be required.

(h) Coordination with the SE for Pharmacy.
The CONTRACTOR shall coordinate as necessary with the SE, the agency that will be administering behavioral health services. This will ensure that member and provider questions are appropriately directed. The CONTRACTOR

shall edit claims to assure any authorizations given and any claims paid are within the scope of the responsibility of the pharmacy contractor. The pharmacy contractor will appropriately inform members and providers when the claim falls within the scope of the responsibility of the SE for behavioral health services. Such determinations will be made primarily on the basis of the prescriber and other criteria as may be provided by HSD/MAD.

V. Selection or Assignment to a Primary Care Provider (PCP)

The CONTRACTOR shall maintain and comply with written policies and procedures governing the process of member selection of a PCP and requests for change.

i. Initial Enrollment. At the time of enrollment, the CONTRACTOR shall ensure that each member has the freedom to choose a PCP within a reasonable distance from the member's place of residence. The process whereby a CONTRACTOR assigns members to PCPs shall include at least the following features:

(a) the CONTRACTOR shall provide the member with the means for selecting a PCP within five (5) business days of enrollment;

(b) the CONTRACTOR shall offer freedom of choice to members in making a PCP selection;

(c) if a member does not select a PCP within a reasonable period of enrollment, the CONTRACTOR shall make the assignment and notify the member in writing of his/her PCP's name, location, and office telephone number, while providing the member with an opportunity to select a different PCP if he/she is dissatisfied with the assignment; and

(d) the CONTRACTOR shall assign a PCP based on factors such as member age, residence, and if known, current provider relationships.

ii. Subsequent Change in PCP Initiated by Member. Members may initiate a PCP change at any time, for any reason. The request can be made in writing or by telephone. If a request is made by the 20th of a month it becomes effective as of the first of the following month. If a request is made after the 20th of the month the change becomes effective the first of the month after the following month.

iii. Subsequent Change in PCP Initiated by the CONTRACTOR. The CONTRACTOR may initiate a PCP change for a member under the following circumstances:

(a) the member and the CONTRACTOR agree that assignment to a different PCP in the CONTRACTOR'S provider network is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to participate in the CONTRACTOR'S network;

(c) a member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made all reasonable efforts to accommodate the member; or

(d) a member has initiated legal actions against the PCP.

iv. In instances where a PCP has been terminated, the CONTRACTOR shall allow affected members to select another PCP or make an assignment within fifteen (15) days of the termination effective date.

v. PCP Lock In. HSD/MAD shall allow the CONTRACTOR to require that a member see a certain PCP when identification of utilization of unnecessary services indicates a need to provide case continuity. Prior to placing the member on PCP lock in, the CONTRACTOR shall inform the member of the intent to lock in, including the reasons for imposing the PCP lock in. The CONTRACTOR'S grievance procedure shall be made available to any member being designated for PCP lock in. The CONTRACTOR shall document review of the PCP. The PCP lock in shall be reviewed and documented by the CONTRACTOR and

reported to HSD/MAD at least every six months. The member shall be removed from PCP lock in when the CONTRACTOR has determined that the utilization problems have been solved and that recurrence of the problems are judged to be improbable. HSD/MAD shall be notified of all lock in removals.

2.2 ENROLLMENT

(1) Maximum Medicaid Enrollment

HSD/MAD and the CONTRACTOR may mutually agree in writing to establish a maximum Medicaid enrollment level for Medicaid beneficiaries, which may vary throughout the terms of the Agreement. The maximum Medicaid enrollment also may be established by HSD/MAD on a statewide or county-by- county basis based on the capacity of the CONTRACTOR'S provider network, or to ensure that the CONTRACTOR has the capacity to provide statewide Medicaid services to its enrollment. Subsequent to the establishment of this limit, if the CONTRACTOR wishes to change its maximum enrollment level, the CONTRACTOR shall notify HSD/MAD in writing ninety (90) days prior to the desired effective date of the change. HSD/MAD shall approve all requests for changing maximum enrollment levels before implementation. Should a maximum enrollment level be reduced to below the actual enrollment level, HSD/MAD may disenroll members to establish compliance with the new limit.

(2) Enrollment Requirements

As required by 42 C.F.R. 434.25, the CONTRACTOR shall accept eligible individuals, in the order in which they apply:

A. without restriction, unless authorized by the CMS Regional Administrator;

B. up to the limits established pursuant to the Agreement;

C. all enrollments shall be voluntary, and the CONTRACTOR shall not discriminate against eligible individuals on the basis of health status or need for health services; and

D. the CONTRACTOR shall assume responsibility for all covered medical conditions of each member inclusive of pre-existing conditions as of the effective date of enrollment.

(3) Eligibility

A. HSD/MAD shall determine eligibility for enrollment in the managed care program. All Medicaid eligible members are required to participate in the Medicaid managed care program except for the following:

i. institutionalized members e.g. those residing for greater than thirty (30) days in nursing facilities;

ii. members residing in intermediate care facilities for the mentally retarded;

iii. members participating in the Health Insurance Premium (HIPP) Program or the Breast and Cervical Cancer (BCC) Medicaid program;

iv. children and adolescents in out-of-state foster care or adoption placement; and

v. Native Americans who have the option to voluntarily enroll with the CONTRACTOR.

(4) HSD/MAD Exemptions

HSD/MAD shall grant exemptions to mandatory enrollment based upon criteria established by HSD/MAD. A member or his or her representative, parent, or legal guardian shall submit such requests in writing to HSD/MAD, including a description of the special circumstances justifying an exemption. Requests are evaluated by HSD/MAD clinical staff and forwarded to the HSD/MAD Medical Director or his/her designee for final determination.

(5) Special Situations

A. Newborn Enrollment

Newborns are automatically eligible for a period of six months and are immediately enrolled with the mother's MCO. If the child's mother is not a member at the time of the birth, in a hospital or at home, then the child is enrolled during the next applicable enrollment cycle. The CONTRACTOR is not responsible for care of a child hospitalized during enrollment, until discharge except for newborns born to enrolled mothers.

B. Hospitalized Members

A member who is hospitalized in a general acute-care or rehabilitation hospital at the time he/she first enrolls with the CONTRACTOR may enroll with the CONTRACTOR. However, the CONTRACTOR shall not be responsible for the costs of such hospitalization, except newborns born to a member mother, until the member is discharged from the hospital or there is a change in the level of care. Instead, HSD/MAD shall pay the appropriate provider(s) on a fee-for-service basis for all provider-submitted claims related to a member who is hospitalized in a general acute care or rehabilitation hospital at the time such member enrolls with the CONTRACTOR, until such time as the member is discharged from the hospital.

C. Native Americans

The CONTRACTOR shall:

i. make documented efforts to contract with the appropriate urban Indian clinics, tribally owned health centers, and IHS facilities for the provision of medically necessary services;

ii. ensure that translation services are reasonably available when needed, both in providers' offices and in contacts with the CONTRACTOR;

iii. ensure appropriate medical transportation for Native American members residing in rural and remote areas; and

iv. ensure that culturally appropriate materials are available to Native Americans.

D. Members Placed in Nursing Facilities.

If a member is placed in a nursing facility for what is expected to be a long- term or permanent placement, the CONTRACTOR remains responsible for the member until the member is disenrolled by HSD/MAD.

E. Members Receiving Hospice Services.

Members who have elected and are receiving hospice services at the time of enrollment shall be exempt from enrolling in an MCO unless they revoke their hospice election.

(6) Enrollment Process for Members

Current members may request a change in CONTRACTORS during the first ninety (90) days of a twelve (12)-month enrollment period.

A. Minimum Selection Period

A new member shall have at least fourteen (14) calendar days from the date of eligibility to select a CONTRACTOR from the provided information. The new member can select anytime during this selection period. If a selection is not made during this selection period, HSD/MAD shall assign the new member to a CONTRACTOR.

B. Begin Date of Enrollment

Enrollment generally shall begin the first day of the first full month following selection of assignment.

C. Member Switch and Loss of Medicaid Eligibility

A current CONTRACTOR member has the opportunity to change CONTRACTORS during the first ninety (90) days of a twelve (12)-month period. HSD/MAD shall notify the CONTRACTOR'S members of their opportunity to select a new CONTRACTOR provider. A member is limited to one ninety-day switch period per CONTRACTOR. After exercising the switching rights, and returning to a previously selected CONTRACTOR, the member shall remain with the CONTRACTOR until his/her twelve (12)-month lock-in period expires before being permitted to switch CONTRACTORS.

If a member loses Medicaid eligibility for a period of two months or less, he/she will be automatically reenrolled with the former CONTRACTOR. If the member misses the annual disenrollment opportunity during this two-month time, he/she may request to be assigned to another CONTRACTOR.

D. Mass Transfer Process

The mass transfer process is initiated when HSD/MAD determines that the transfer of CONTRACTOR members from one CONTRACTOR to another is appropriate.

i. Triggering Mass Transfer Process. The mass transfer process may be triggered by two situations: maintenance change, i.e., changes in CONTRACTOR identification number or CONTRACTOR name; and significant change in the CONTRACTOR contracting status including, but not limited to, loss of licensure, substandard care, fiscal insolvency or significant loss in network providers.

ii. Effective Date of Mass Transfer. The change in enrollment initiated by the mass transfer begins with the first day of the month following the identification of the need to transfer the CONTRACTOR members.

iii. Member Selection Period. Following a mass transfer, the CONTRACTOR members are given an opportunity to select a different CONTRACTOR.

E. Transition of Care

The CONTRACTOR shall:

i. develop a detailed plan that addresses the clinical transition issues and transfer of potentially large numbers of members into or out of its organization. This plan shall include how the CONTRACTOR proposes to identify members currently receiving services;

ii. develop a detailed plan for the transition of an individual member, which includes member and provider education about the CONTRACTOR, and the CONTRACTOR process to assure any existing courses of treatment are revised as necessary;

iii. be able to identify members and provide necessary data and information to the future CONTRACTOR for members switching plans, either individually or in large numbers to avoid unnecessary delays in treatment that could be detrimental to the member;

iv. honor all prior approvals granted by HSD/MAD for the first thirty (30) days of enrollment or until the CONTRACTOR has made other arrangements for the transition of services. Providers associated with these services shall be reimbursed by the CONTRACTOR;

v. reimburse the providers and facilities approved by HSD/MAD, if a donor organ becomes available during the first thirty days of enrollment and transplant services have been prior approved by HSD/MAD;

vi. fill prescriptions for drug refills for the first thirty (30) days or until the CONTRACTOR has made other arrangements, for newly enrolled managed care members;

vii. pay for DME costing two thousand dollars ($2,000) or more, approved by the CONTRACTOR but delivered after disenrollment;

viii. be responsible for covered medical services provided to the member for any month they receive a capitation payment, even if the member has lost Medicaid eligibility;

ix. be responsible for payment of all inpatient services provided by a general acute-care or rehabilitation hospital until discharge from the hospital or transfer to a different level of care, if the member is hospitalized in such a facility at the time the member becomes exempt or switches enrollment;

x. ensure the transition of care requirements outlined above can be met with both individual and mass enrollment into and out of its organization; and

xi. cooperate with the SE in the transition of services and the provision of records as necessary for behavioral health services.

(7) <u>Member Disenrollment</u>

A. <u>CONTRACTOR Requests for Disenrollment</u>

i. Member disenrollment shall only be considered in rare circumstances. The CONTRACTOR may request that a particular member be disenrolled. Disenrollment requests shall be submitted in writing to HSD/MAD. The request and supporting documentation shall meet requirements specified by HSD/MAD. If the disenrollment request is granted, the CONTRACTOR retains responsibility for the member's care until such time as the member is enrolled with a new CONTRACTOR. If a request for disenrollment is approved, the member shall not be re-enrolled with the CONTRACTOR for a period of time to be determined by HSD/MAD. Conditions that may permit lockout or disenrollment are:

(a) the CONTRACTOR demonstrates that it has made a good faith effort to accommodate the member, but such efforts have been unsuccessful;

(b) the conduct of the member is such that it is not feasible, safe or prudent to provide medical care subject to the terms of the contract;

(c) the CONTRACTOR has offered to the member in writing the opportunity to utilize the grievance procedures;

(d) the CONTRACTOR shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the CONTRACTOR seriously impairs the CONTRACTOR'S ability to furnish services to either this particular member or other members). The CONTRACTOR shall provide adequate documentation that the CONTRACTOR'S request for termination is proper; and

(e) the CONTRACTOR has received threats or attempts of intimidation from the member to the CONTRACTOR, providers or its own staff.

B. Member Initiated Disenrollment

i. A member who is required to participate in managed care may request to be disenrolled from the CONTRACTOR “for cause” at any time, even during a lock-in period. The following are causes for disenrollment:

(a) the member moves out of the CONTRACTOR’S service area;

(b) the CONTRACTOR does not, because of moral or religious objections, cover the service the member seeks;

(c) the member needs related services (for example, a caesarian section and a tubal ligation) to be performed at the same time, there is no network provider able to do this and another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(d) other reasons, including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member’s health care needs.

ii. This request shall be submitted in writing to HSD/MAD for review. HSD/MAD shall complete the review and furnish a written decision to the member and the CONTRACTOR. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member files the request. If HSD/MAD fails to make the determination within this timeframe, the disenrollment is considered approved. A member who is denied disenrollment shall have access to the State fair hearing process.

C. HSD/MAD-Initiated Disenrollment

i. HSD/MAD may initiate disenrollment in three circumstances:

(a) if a member loses Medicaid eligibility;

(b) if the member is re-categorized into a Medicaid coverage category not included in the managed care initiative; or

(c) the CONTRACTOR'S enrollment maximum is reduced to below contract levels. After HSD/MAD becomes aware of, or is alerted to, the existence of one of the reasons listed above, HSD/MAD shall immediately notify the member or family and the CONTRACTOR and shall update the enrollment roster.

D. Retroactive Reenrollment

A member who is no longer enrolled with the CONTRACTOR, whether in error or otherwise, shall be retroactively reenrolled by the CONTRACTOR only if HSD/MAD submits its request for re-enrollment to the CONTRACTOR within the first month in which the CONTRACTOR did not receive enrollment data/member capitation from HSD/MAD for this member. Reenrollment and retro capitation will be initiated if the notification is given to the CONTRACTOR by the last day of the enrollment month and the CONTRACTOR shall be financially responsible for all medically necessary covered services provided to the member for that month. If notification is done after the last day of the enrollment month, the CONTRACTOR may choose to accept or deny the reenrollment and retro capitation. Nothing in this section shall restrict the appropriate enrollment of newborns in accordance with the provision of 2.2 (5)A.

2.3 PROVIDERS

The CONTRACTOR shall establish and maintain a comprehensive network of providers capable of serving all members who enroll in the MCO. Pursuant to Section 1932(b)(7) of the Social Security Act, the CONTRACTOR shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. In addition, the CONTRACTOR shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification. If the CONTRACTOR declines to include individual or groups of providers in its network, it must give the affected providers

written notice of the reason for its decision. The CONTRACTOR shall not be required to contract with providers beyond the number necessary to meet the needs of its members. The CONTRACTOR shall be allowed to use different reimbursement amounts for different specialties or for different practitioners in the same specialty. The CONTRACTOR shall be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to members.

(1) Required Policies and Procedures

The CONTRACTOR shall:

A. maintain written policies and procedures on provider recruitment and termination of provider participation with the CONTRACTOR. HSD/MAD shall have the right to review these policies and procedures upon demand. The recruitment policies and procedures shall describe how a CONTRACTOR responds to a change in the network that affects access and its ability to deliver services in a timely manner;

B. require that each physician providing services to Medicaid members has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act;

C. annually develop and implement a training plan to educate providers and their staff on selected managed care or the CONTRACTOR'S processes and procedures. The plan shall be submitted to HSD/MAD for review and approval on or before July 1st of each year;

D. consider, in establishing and maintaining the network of appropriate providers, its:

i. anticipated enrollment;

ii. expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the CONTRACTOR'S population;

iii. numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;

iv. numbers of network providers who are not accepting new Medicaid patients; and

v. geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid member; and whether the location provides physical access for Medicaid members with disabilities.

E. ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

(2) General Information Submitted to HSD/MAD

The CONTRACTOR shall maintain an accurate list of all active PCPs, specialists, hospitals, and other providers participating or affiliated with the CONTRACTOR. The CONTRACTOR shall submit the list to HSD/MAD on a monthly basis and include a clear delineation of all additions and terminations that have occurred the prior month. The CONTRACTOR'S contracts with providers must include language stating that the MCO providers will report any changes in their capacity to take new Medicaid clients or serve current clients.

(3) The Primary Care Provider (PCP)

The PCP shall be a medical provider participating with the CONTRACTOR who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of the member's care. The CONTRACTOR shall distribute information to the network providers that explains the Medicaid-specific policies and procedures relating to PCP responsibilities. The CONTRACTOR is prohibited from excluding providers as primary care providers based on the proportion of high-risk patients in their caseloads.

(4) Primary Care Responsibilities

A. The CONTRACTOR shall ensure that the following primary care responsibilities are met by the PCP, or in another manner:

i. the PCP shall provide twenty-four (24)-hour, seven (7)-day-a-week access;

ii. the PCP shall ensure coordination and continuity of care with providers who participate with the CONTRACTOR network and with providers outside the CONTRACTOR network according to the CONTRACTOR policy; and

iii. the PCP shall ensure that the member receives appropriate prevention services for the member's age group.

The CONTRACTOR shall have a formal process for provider education regarding Medicaid, the conditions of participation in the network and the provider's responsibilities to the CONTRACTOR and its members. HSD/MAD shall be provided documentation upon request that such provider education is being conducted.

(5) CONTRACTOR Responsibility for PCP Services

A. The CONTRACTOR shall retain responsibility for monitoring PCP activities to ensure compliance with the CONTRACTOR and HSD/MAD policies. The CONTRACTOR shall educate PCPs about special populations and their service needs. The CONTRACTOR shall ensure that PCPs successfully identify and refer patients to specialty providers as medically necessary.

B. The CONTRACTOR shall have an internal provider appeals process.

(6) Specialty Providers

The CONTRACTOR shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of CONTRACTOR members shall be met within the CONTRACTOR network of providers. The CONTRACTOR shall also have a system to refer members to providers who are not affiliated with the MCO network if providers with the necessary qualifications or certifications do not participate in the network.

(7) Federally Qualified Health Centers ("FQHCs")

A. Federally Qualified Health Centers (FQHCs) are federally funded Community Health Centers, Migrant Health Centers and Health Care for the Homeless Projects that receive grants under Sections 329, 330 and 340 of the US Public Health Services Act. The current federal statute, Section 1902(a)(13)(E) of the Social Security Act, specifies that states shall

guarantee access to FQHCs and Rural Health Centers (RHCs) under Medicaid managed care programs; therefore, the CONTRACTOR shall provide access to FQHCs and RHCs to the extent that access is required under federal law.

B. The CONTRACTOR shall contract with as many FQHCs and RHCs as necessary to permit beneficiaries access to participating FQHCs and RHCs without having to travel a significant distance. At least one FQHC shall specialize in provider health care for the homeless in Bernalillo County. At least one FQHC shall be with one urban Indian FQHC in Bernalillo County.

C. The CONTRACTOR shall contract with FQHCs and RHCs in accordance with the 30-minute travel time standards for routinely used delivery sites. A CONTRACTOR with an FQHC or RHC on its panel that has no capacity to accept new patients shall not satisfy these requirements unless there exist no other FQHCs or RHCs in the area.

D. The CONTRACTOR shall offer FQHCs and RHCs terms and conditions, including reimbursement, that are at least equal to those offered to other providers of comparable services.

E. If the CONTRACTOR cannot satisfy the standard for FQHC and RHC access at any time while the CONTRACTOR holds a Medicaid contract, the CONTRACTOR shall allow its members to seek care from non-contracting FQHCs and RHCs and shall reimburse these providers at the Medicaid fee schedule.

(8) Local Department of Health Offices

A. The CONTRACTOR shall contract with public health providers for services as described in Section MAD 8.305.6.15 and those defined as public health services under State law, NMSA 1978, §§ 24-1-1 et. seq.

B. The CONTRACTOR shall contract with local and district public health offices for family planning services.

C. The CONTRACTOR may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal care or prenatal case management.

(9) Children's Medical Services (CMS)

The CONTRACTOR shall contract with CMS to administer outreach clinics at sites throughout the State. The clinics offer pediatric sub-specialty services in local communities, which include cleft palate, neurology, endocrine, asthma and pulmonary.

(10) Shared Responsibility between the CONTRACTOR and Public Health Offices

A. The CONTRACTOR shall coordinate with the public health offices regarding the following services:

i. sexually transmitted disease services, including screening, diagnosis, treatment, follow-up and contact investigations;

ii. HIV prevention counseling, testing, and early intervention;

iii. Tuberculosis screening, diagnosis, and treatment;

iv. disease outbreak prevention and management, including reporting according to state law requirements, responding to epidemiology requests for information, and coordination with epidemiology investigations and studies;

v. referral and coordination to ensure maximum participation in the Supplemental Food Program for Women, Infants, and Children (WIC);

vi. health education services for individuals and families with a particular focus on injury prevention including car seat use, domestic violence, and lifestyle issues, including tobacco use, exercise, nutrition, and substance use;

vii. development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education; and

viii. participation and support for local health councils to create healthier and safer communities with a focus on coordination of efforts, such as DWI councils, maternal and child health councils, tobacco coalitions, safety counsel, safe kids and others.

(11) School-Based Providers

The CONTRACTOR shall contract with the School Based Health Centers programs to provide primary care services.

(12) Indian Health Services (IHS) & Tribal Health Centers

A. The CONTRACTOR shall allow members who are Native American to seek care from any IHS or Tribal Provider defined in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), whether or not the provider participates in the CONTRACTOR provider network.

B. The CONTRACTOR shall not prevent members who are IHS beneficiaries from seeking care from IHS, Tribal and Urban Indian Providers, or from network providers due to their status as Native Americans.

C. The CONTRACTOR shall track IHS utilization and expenditures by members for those Native Americans who voluntarily enroll in the MCO. The CONTRACTOR shall reimburse these providers.

D. The CONTRACTOR shall track reimbursement to these providers by member.

(13) Family Planning Services and Providers

A. Federal law prohibits restricting access to family planning services for Medicaid recipients. The CONTRACTOR shall implement written policies and procedures defining how members are educated about their right to family planning services, freedom of choice, and methods of accessing such services.

B. The CONTRACTOR shall give each member, including adolescents, the opportunity to use his or her own primary care provider or go to any family planning center for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive health care services. This right to self-refer is in addition to the member’s designated source of primary care if that source is not a women’s health specialist. Clinics and providers,

including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CONTRACTOR for all family planning services, regardless of whether they are participating or non-participating providers. Unless otherwise negotiated, the CONTRACTOR shall reimburse providers of family planning services at the Medicaid rate.

C. Non-participating providers are responsible for keeping family planning information confidential in favor of the individual patient even if the patient is a minor. The CONTRACTOR is not responsible for the confidentiality of medical records maintained by non-participating providers.

D. Family planning services are defined as the following:

i. health education and counseling necessary to make informed choices and understand contraceptive methods;

ii. limited history and physical examination;

iii. laboratory tests if medically indicated as part of the decision making process for choice of contraceptive methods;

iv. diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated;

v. screening, testing and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment;

vi. follow-up care for complications associated with contraceptive methods issued by the family planning provider;

vii. provision of, but not payment for, contraceptive pills;

viii. provision of devices/supplies;

ix. tubal ligations;

x. vasectomies; and

xi. pregnancy testing and counseling

E. If a non-participating provider of family planning services detects a problem outside of the scope of services listed above, the provider should refer the member back to the CONTRACTOR. The CONTRACTOR is not under any HSD/MAD-initiated obligation to reimburse non-participating family planning providers for non-emergent services outside the scope of these defined services.

(14) Standards For Provider Credentialing and Recredentialing

A. Individual Providers

i. The CONTRACTOR shall have written policies and procedures for the credentialing process, which include the CONTRACTOR'S initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or re-appointment of practitioners.

ii. The CONTRACTOR shall designate a credentialing committee or other peer review body to make recommendations regarding credentialing decisions.

iii. The CONTRACTOR shall identify those practitioners who fall under the scope of credentialing authority and action. This shall include, at a minimum, all physicians, dentists, and other licensed independent practitioners. This will provide an indication of those practitioners whose service to members is contracted or anticipated.

iv. At the time of credentialing, the CONTRACTOR shall comply with all NCQA standards for credentialing and re-credentialing and requirements in the HSD/MAD Policy Manual, which include the requirement to verify from primary sources that at a minimum the provider has:

(a) a current valid license to practice;

(b) clinical privileges in good standing at the institution designated by the practitioner as the primary admitting facility, if applicable;

(c) a valid Drug Enforcement Administration (DEA) registration or a Controlled Substance Registration (CSR) certificate, if applicable;

(d) graduated from an accredited professional school/program and/or highest training program applicable to the academic or professional degree, discipline, and licensure of the practitioner;

(e) board certification if the practitioner states that he/she is board certified in a specialty on the application;

(f) current, adequate malpractice insurance, in accordance with the CONTRACTOR'S requirements;

(g) the absence of a prohibitive history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner; and

(h) not been barred from participation based on existing Medicare or Medicaid sanctions.

(15) Organizational Providers

The CONTRACTOR shall:

A. have written policies and procedures for the initial and ongoing assessment of all organizational providers with which it intends to contract or with which it is contracted. Providers include, but are not limited to hospitals, home health agencies, nursing facilities, and free-standing surgical centers;

B. confirm that the provider is in good standing with State and Federal regulatory bodies, including HSD/MAD; and

C. confirm that the provider has been reviewed and approved by an accrediting body; or

D. develop and implement standards of participation that demonstrate the provider is in compliance with provider participation requirements under federal laws and regulations, if the provider has not been approved by an accrediting body.

(16) Re-credentialing

The CONTRACTOR shall formally re-credential its network providers at least every three years.

(17) Primary Source Verification

A. HSD/MAD shall have the right to name a single primary source verification entity to be used by the CONTRACTOR and its subcontractors in its provider credentialing process. All CONTRACTORS shall use one standardized credentialing form. HSD/MAD shall have the right to mandate a standard credentialing application to be used by the CONTRACTOR and its subcontractors in its provider credentialing process. The form shall meet NCQA standards.

B. The CONTRACTOR shall provide to HSD/MAD copies of all Medicaid provider specific forms used in its health system operations and credentialing/recredentialing process for prior approval. The forms shall be user friendly. The CONTRACTOR shall participate in a workshop to consolidate and standardize forms across all plans and for its credentialing/recredentialing processes/applications.

2.4 BENEFITS/SERVICES

The CONTRACTOR shall be required to provide a comprehensive coordinated and fully integrated system of health care services. The CONTRACTOR does not have the option of deleting benefits from the Medicaid defined benefit package.

Behavioral health services provided by the CONTRACTOR'S network providers will be covered by the CONTRACTOR even when the primary diagnosis is a behavioral health diagnosis. Facility costs, including emergency room costs, will be covered by the CONTRACTOR unless there is a specific psychiatric revenue code on the facility claim form. Any professional services provided by a behavioral health provider in an emergency room or in an inpatient or outpatient hospital setting will be covered by the SE. Any services provided by a physical health provider in an emergency room or in an inpatient setting will be covered by the CONTRACTOR. The SE will cover outpatient hospital services that require the use of a psychiatrist or psychological revenue code for billing the services. Pharmacy claims prescribed by a physical health provider will be covered by the CONTRACTOR.

The following services are included in the covered benefit package of this Agreement:

(1) Inpatient Hospital Services

The benefit package includes hospital inpatient acute care, procedures, and services as set forth in MAD Program Manual section 8.311.2 NMAC, HOSPITAL SERVICES. The CONTRACTOR shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act of 1996. Coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than 96 hours for both mother and newborn child.

(2) Transplant Services

The benefit package includes transplantation services. The following transplants are covered in the benefit package: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allegoric bone marrow transplants and corneal transplants, as detailed in MAD Program Manual Section 8.325.5 NMAC, TRANSPLANT SERVICES, and Section 8.325.6 NMAC, EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES, TECHNOLOGIES, OR NON-DRUG THERAPIES.

(3) Hospital Outpatient Service

The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative, or palliative medical services as set forth in MAD Program Manual Section 8.311.2 NMAC, OUTPATIENT COVERED SERVICES.

(4) Case Management Services

The benefit package includes case management services as set forth in the MAD Program Manual Sections, including Case Management Services for Adults With Developmental Disabilities, as set forth in the MAD Program Manual Section 8.326.2 NMAC; Case Management Services for Pregnant Women and Their Infants as set forth in MAD Program Manual Section 8.326.3 NMAC; Case Management Services for Traumatically Brain Injured Adults set forth in the MAD Program Manual Section 8.326.5 NMAC; Case Management Services for children up to the age of three (3) as set forth in MAD Program Manual Section 8.326.6 NMAC; and Case Management Services for The Medically at Risk as set

forth in MAD Program Manual Section 8.320.5 NMAC. The benefit package does not include Case Management provided to DD children age 0 -3 who are receiving early intervention services, or case management provided by the Children, Youth and Families Department, defined as child protective services management.

(5) Emergency Services

A. The benefit package includes emergency and post-stabilization care services. Emergency services are covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and which are needed to evaluate or stabilize an emergency condition. An emergency condition shall meet the definition of emergency as per 8.305.1.7.V NMAC. Emergency services shall be provided in accordance with 8.305.7.11F NMAC. Post-stabilization care services are covered services related to an emergency condition that are provided after a patient is stabilized in order to maintain the stabilized condition or to improve or resolve the patient's condition, such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during discharge of the patient or transfer of the patient to another facility.

B. Reimbursement for Emergency Services

i. The CONTRACTOR shall ensure that acute general hospitals are reimbursed for emergency services, which they are required to provide because of federal mandates such as the "anti-dumping" law in the Omnibus Budget Reconciliation Act of 1989. P.L. 101-239 and 42 U.S.C. Section 1395 dd (Section 1867 of the Social Security Act).

ii. The CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the patient, if the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists.

iii. The CONTRACTOR is required to pay for all emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

iv. If the screening examination leads to a clinical determination by

the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR shall review the presenting symptoms of the member and shall pay for all services involved in the screening examination where the present symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard. If the member believes that a claim for emergency services has been inappropriately denied by the CONTRACTOR, the member may seek recourse through the CONTRACTOR or an HSD/MAD appeal.

v. When the member's primary care physician or other CONTRACTOR representative instructs the member to seek emergency care in-network or out-of-network, the CONTRACTOR is responsible for payment, at the in network rate, for the medical screening examination and for other medically necessary emergency services intended to stabilize the patient without regard to whether the member meets the prudent layperson standard.

vi. The CONTRACTOR must be in compliance with Medicare Part C regulations for coordinating post-stabilization care.

(6) Physical Health Services

The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner performed within the scope of practice as defined by State Law and set forth in MAD Program Manual Section 8.310.2 NMAC, MEDICAL SERVICES PROVIDERS; Section 8.310.9 NMAC, MIDWIFE SERVICES; Section 8.310.9 NMAC, PODIATRY SERVICES; Section 8.310.3 NMAC, RURAL HEALTH CLINIC SERVICES; and Section 8.310.4 NMAC, FEDERALLY QUALIFIED HEALTH CENTER SERVICES.

(7) Laboratory Services

The benefit package includes all laboratory services provided according to the applicable provisions of CLIA as set forth in MAD Program Manual Section 8.324.2 NMAC, LABORATORY SERVICES.

(8) Diagnostic Imaging and Therapeutic Radiology Services

The benefit package includes medically necessary diagnostic imaging and radiology services as set forth in MAD Program Manual Section 8.324.3 NMAC, DIAGNOSTIC IMAGING AND THERAPEUTIC RADIOLOGY SERVICES.

(9) Anesthesia Services

The benefit package includes anesthesia and monitoring services necessary for performance of surgical or diagnostic procedures as set forth in MAD Program Manual Section 8.310.5 NMAC, ANESTHESIA SERVICES.

(10) Vision Services

The benefit package includes vision services as set forth in MAD Program Manual Section 8.310.6 NMAC, VISION CARE SERVICES.

(11) Audiology Services

The benefit package includes audiology services as set forth in MAD Program Manual Section 8.324.6 NMAC, HEARING AIDS AND RELATED EVALUATION.

(12) Dental Services

The benefit package includes dental services as set forth in MAD Program Manual Section 8.310.7 NMAC, DENTAL SERVICES.

(13) Dialysis Services

The benefit package includes medically necessary dialysis services as set forth in MAD Program Manual Section 8.325.2 NMAC, DIALYSIS SERVICES. Dialysis providers shall assist members in applying for and pursuing final Medicare eligibility determination.

(14) Pharmacy Services

A. The benefit package includes all pharmacy and related services, as set forth in 8.324.4 NMAC, PHARMACY SERVICES. The CONTRACTOR’S Preferred Drug List (PDL) shall use the following guidelines:

i. there is at least one representative drug for each of the categories in the First Data Bank Blue Book;

ii. generic substitution shall be based on AB Rating and/or clinical need;

iii. for a multiple-source, brand-name product within a therapeutic class, the CONTRACTOR may select a representative drug;

iv. the PDL shall follow the CMS special guidelines relating to drugs used to treat HIV infection;

v. the PDL shall include coverage of certain over the counter (OTC) drugs when prescribed by a licensed practitioner; and

vi the CONTRACTOR shall implement an appeals process for practitioners who think that an exception to the PDL shall be made for an individual member.

B. The CONTRACTOR shall use a PDL developed with consideration of the clinical efficacy, safety and cost effectiveness of drug items and shall provide medically appropriate drug therapies for members. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Atypical antipsychotic medications must be available in the same manner as conventional antipsychotic medications for the treatment of severe mental illness, including schizophrenia, clinical depression, bipolar disorder, anxiety-panic disorder and obsessive-compulsive disorder. In compliance with state legislation, HSD will be creating a single Medicaid Preferred Drug List (PDL), to be used by all Medicaid contractors for all Medicaid programs. HSD/MAD will require that the CONTRACTOR deliver a pharmacy benefit using a single Medicaid PDL.

C. The CONTRACTOR shall coordinate as necessary with the SE when administering pharmacy services, to ensure that member and provider questions are appropriately directed. The CONTRACTOR shall edit pharmacy claims to ensure that any authorizations given and claims paid are within the scope of the responsibility of the CONTRACTOR or the CONTRACTOR'S pharmacy contractor, and appropriately inform members or providers when the claims fall within the scope of the responsibility of the SE or behavioral health services. Such

determinations will be made primarily on the basis of the prescriber and other criteria as may be provided by HSD/MAD.

D. The CONTRACTOR shall maintain written policies and procedures governing its drug utilization review (DUR) program, in compliance with any applicable Federal Medicaid law.

E. HSD/MAD acknowledges and agrees that CONTRACTOR has entered into this Agreement, in part, on the understanding that it will be entitled to use its own PDL. In the event that HSD/MAD, or other changes in law, rule or regulation requires or results in a change in the ability of the CONTRACTOR to implement its PDL as originally designed HSD/MAD shall reopen the contract pursuant to Section 5.2. In addition, the parties agree that the CONTRACTOR shall not be responsible for pharmacy claims prescribed by their network providers functioning within their role under the SE.

(15) Durable Medical Equipment and Medical Supplies

The benefit package includes the purchase, delivery, maintenance and repair of equipment, oxygen and oxygen administration equipment, nutritional products, disposable diapers, and disposable supplies essential for the use of the equipment as set forth in MAD Program Manual Section 8.324.5 NMAC, DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.

(16) EPSDT Services

The benefit package includes the delivery of the Federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services as set in forth MAD Program Manual Section 8.320.2 NMAC, EPSDT SERVICES.

A. EPSDT Private Duty Nursing

The benefit package includes private duty nursing for the EPSDT population as set forth in MAD Program Manual Section 8.323.4 NMAC, EPSDT PRIVATE DUTY NURSING SERVICE. The services shall either be delivered in the member’s home or the school setting.

B. EPSDT Personal Care

The CONTRACTOR shall pay for medically necessary personal care services furnished to eligible members under twenty-one (21) years of age as part of EPSDT, set forth in MAD Program Manual Section 8.323.2 NMAC.

C. Tot-to-Teen Health Checks

The CONTRACTOR shall adhere to the periodicity schedule to ensure that eligible members receive EPSDT screens (Tot-to-Teen Health Checks), including:

i. education of and outreach to members regarding the importance of the health checks;

ii. development of a proactive approach to ensure that the services are received by the members;

iii. facilitation of appropriate coordination with school-based providers;

iv. development of a systematic communication process with CONTRACTOR'S participating providers regarding screens and treatment coordination for members;

v. processes to document, measure, and ensure compliance with the periodicity schedule; and

vi. development of a proactive process to ensure the appropriate follow-up evaluation, referral, and/or treatment, especially early intervention for mental health conditions, vision and hearing screening and current immunizations.

(17) Nutritional Services

The benefit package includes nutritional services furnished to pregnant women and children as set forth in MAD Program Manual Section 8.324.9 NMAC, NUTRITIONAL SERVICES.

(18) Home Health Services

The benefit package includes home health services as set forth in MAD Program Manual Section 8.325.9 NMAC, HOME HEALTH SERVICES. The CONTRACTOR shall coordinate Home Health and the Home and Community-Based Waiver programs if a member is eligible for both Home Health and Waiver Services.

(19) Hospice Services

The benefit package includes hospice services as set forth in MAD Program Manual Section 8.325.4 NMAC, HOSPICE CARE SERVICES.

(20) Ambulatory Surgical Services

The benefit package includes surgical services rendered in an ambulatory surgical center setting as set forth in MAD Program Manual Section 8.324.10 NMAC, AMBULATORY SURGICAL CENTER SERVICES.

(21) Rehabilitation Services

The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational, and speech therapy services as set forth in MAD Program Manual Section 8.325.8 NMAC, REHABILITATION SERVICES and licensed speech and language pathology services furnished under the EPSDT program as set forth in MAD Program Manual Section 8.323.5 NMAC, LICENSED SPEECH AND LANGUAGE PATHOLOGISTS. The CONTRACTOR shall coordinate rehabilitation services and Home and Community-Based Waiver programs if a member is eligible for both rehabilitation services and Waiver Services.

(22) Reproductive Health Services

The benefit package includes reproductive health services as set forth in MAD Program Policy Section 8.325.3 NMAC, REPRODUCTIVE HEALTH SERVICES. The CONTRACTOR shall provide Medicaid members with sufficient information to allow them to make informed choices, including: the types of family planning services available; the member's right to access these services in a timely and confidential manner; and the freedom to choose a qualified family planning provider who participates in the CONTRACTOR network or from a provider who does not participate in the CONTRACTOR network. A female member shall have the right to self-refer to a women's health

specialist within the network for covered care necessary to provide women's routine and preventive health care services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

(23) Pregnancy Termination Procedures

The benefit package includes services for the termination of pregnancy and/or pre- or post-decision counseling or psychological services as set forth in MAD Program Manual Section 8.325.7 NMAC, PREGNANCY TERMINATION PROCEDURES.

(24) Transportation Services

A. The benefit package includes transportation services such as ground ambulance, air ambulance, taxicab and/or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services set forth in MAD Program Manual Section 8.324.7 NMAC, TRANSPORTATION SERVICES. Pursuant to NMSA 1978, Section 65-2-97.F and applicable rules and interpretations of this law by the State Public Regulation Commission, rates paid by the CONTRACTOR to transportation providers are not subject to and are exempt from New Mexico State Public Regulation Commission approved tariffs.

B. The CONTRACTOR shall coordinate, manage and be financially responsible for the delivery of the transportation benefit to members receiving behavioral health services. The CONTRACTOR shall coordinate with the SE as necessary to perform this function. Such coordination shall include:

i. receiving information from and providing information to the SE regarding members, providers and services;

ii. meeting with the SE to resolve provider and member issues to improve services, communication and coordination;

iii. contacting the SE as necessary to provide quality transportation services; and

iv. maintaining and distributing statistical information and data as may be required.

(25) Prosthetics and Orthotics

The benefit package includes prosthetic and orthotic services as set forth in the MAD Program Manual Section 8.324.8 NMAC, PROSTHETICS AND ORTHOTICS.

(26) School-Based Services

The benefit package includes evaluation and physical, speech and occupational therapy furnished in a school-based setting, but not when specified in the Individualized Education Plan (IEP) or the Individualized Family Service Plan (IFSP), as detailed in the Medical Assistance Program Manual 8.320.6 NMAC, SCHOOL-BASED SERVICES FOR RECIPIENTS UNDER 21 YEARS OF AGE.

(27) Health Education and Preventive Care

A. The CONTRACTOR shall provide a continuous program of health education without cost to members. Such a program may include publications (e.g., brochures, newsletters), media (e.g., films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction.

B. The CONTRACTOR shall provide programs of wellness education. Additional programs may be provided which address the social and physical consequences of high-risk behaviors.

C. The CONTRACTOR shall make preventive services available to members. The CONTRACTOR shall periodically remind and encourage their members to use benefits, including physical examinations, which are available and designed to prevent illness (e.g., HIV counseling and testing for pregnant women).

(28) Experimental Technology

The CONTRACTOR shall not deem a technology or its application experimental, investigational or unproven and deny coverage unless that technology or its application fulfills the definition of “experimental, investigational or unproven” contained in the MAD Program Policy Manual, 8.325.6 NMAC,

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES TECHNOLOGIES OR NON-DRUG THERAPIES.

(29) Standards for Preventive Health Services

A. Unless a member refuses offered services, and such refusal is documented, the CONTRACTOR shall provide, to the extent possible, the services described in this section. Member refusal is defined to include both failure to consent and refusal to access care.

B. Preventive health services shall include:

i. Immunizations: The CONTRACTOR shall ensure that, within six months of enrollment, members are immunized and current according to the type and schedule provided by the most current version of the Recommendations of the Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more that four months overdue.

ii. Screens: The CONTRACTOR shall ensure that, to the extent possible, within six months of enrollment or within six months of a charge in the standard, asymptomatic members receive and are current for at least the following preventative screening services. "Current" is defined as no more than four months overdue. The CONTRACTOR shall require its providers to perform the appropriate interventions based on the results of the screening.

(a) Screening for Breast Cancer. Females fifty (50) through sixty-nine (69) years old who are not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. Females at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) Screening for Cervical Cancer. Female members with a cervix shall receive Papanicolaou (Pap) testing starting at the onset of sexual activity, but at least by eighteen (18)

years of age, and every three years thereafter until reaching sixty-five (65) years of age if prior testing has been consistently normal and the member has been confirmed to be not at high risk. If the member is at high risk, the testing frequency shall be at least annual.

(c) Screening for Colorectal Cancer. Members aged fifty (50) years and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the CONTRACTOR.

(d) Blood Pressure Measurement. Members of all ages shall receive a blood pressure measurement as medically indicated.

(e) Serum Cholesterol Measurement. Enrolled men aged thirty-five (35) to sixty-five (65) years old and all enrolled women aged forty-five (45) to sixty-five (65) years old who are at normal risk for coronary heart disease shall receive serum cholesterol measurement every five years. Those members with multiple risk factors shall also receive HDL-C measurement.

(f) Screening for Obesity. All members shall receive annual body weight and height measurements to be used in conjunction with a calculation of the Body Mass Index or reference to a table of recommended weights.

(g) Screening for Elevated Lead Levels. Members aged nine (9) to fifteen (15) months old (ideally 12 months old) shall receive a blood lead measurement at least once.

(h) Screening for Diabetes. Members shall receive a fasting or two-hour post-prandial serum glucose measurement at least once.

(i) Screening for Tuberculosis. Members shall receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) Screening for Rubella. Enrolled women of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology at their first clinical encounter in an office setting.

(k) Screening for Visual Impairment. Members three (3) to four (4) years old shall be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) Screening for Hearing Impairment. Members fifty (50) years and older shall be routinely screened for hearing impairment by questioning them about their hearing.

(m) Screening for Problem Drinking and Substance Abuse. Adolescent and adult members shall be screened at least once by a careful history of alcohol use and/or the use of a standardized screening questionnaire such as the Alcohol Use Disorders Identification Test (AUDIT) or the four- question CAGE instrument and the Substance Abuse Screening and Severity Inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications.

(n) Prenatal Screening. Pregnant members shall be screened for preeclampsia, D (Rh) Incompatibility, Down syndrome, neural tube defects, and hemoglobinopathies, vaginal and rectal Group B Streptococcal infection, and counseled and offered testing for HIV.

(o) Newborn Screening. At a minimum, newborn members shall be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with the Department of Health regulation 7 NMAC 30.6.

(p) During an encounter with a primary care provider, a behavioral health screen shall occur.

(q) The CONTRACTOR shall ensure that clinically appropriate follow-up and/or intervention is performed

when indicated by the screening results and that this is done using the guidance provided in the Guide to Clinical Preventive Services, Report of the U.S. Preventive Services Task Force, Second Edition, Shalliams and Wilkins, 1996.

iii. Tot-to-Teen Health checks: The CONTRACTOR shall operate a Tot-to-Teen Health check Program for members up to twenty-one (21) years of age to ensure the delivery of the Federally mandated EPSDT services. Within six months of enrollment the CONTRACTOR shall endeavor to ensure that eligible members (up to age 21) are current according to screening schedule in EPSDT services 8.320.3 NMAC.

iv. The CONTRACTOR shall provide to applicable asymptomatic members counseling on the following unless recipient refusal is documented: to prevent tobacco use, to promote physical activity, to promote a healthy diet, to prevent osteoporosis and heart disease in menopausal women, citing the advantages and disadvantages of calcium and hormonal supplementation, to prevent motor vehicle injuries, to prevent household and recreational injuries, to prevent dental and periodontal disease, to prevent HIV infection and other sexually transmitted diseases, and to prevent unintended pregnancies.

v. The CONTRACTOR shall provide a toll-free health advisor telephone hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various Medicaid populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the member’s symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment health care decision assistance based on symptoms.

vi. The CONTRACTOR shall have a written family planning policy. This policy shall ensure that members of the appropriate age of both sexes who seek Family Planning services shall be provided

with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; HIV and other sexually transmitted diseases and risk reduction practices; options for pregnant members who do not wish to keep a child; and options for pregnant members who may wish to terminate the pregnancy.

vii. The CONTRACTOR shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. The program shall include at least the following:

(a) educational outreach to all members of child-bearing ages;

(b) prompt and easy access to obstetrical care, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of all pregnant members to identify high risk cases for special management;

(d) counseling which strongly advises voluntary testing for HIV;

(e) case management services to address the special needs of members who have a high risk pregnancy, especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(f) screening for determination of need for a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

2.5 CULTURALLY COMPETENT SERVICES

(1) The CONTRACTOR shall develop and implement a Cultural Competency/Sensitivity Plan, through which the CONTRACTOR shall ensure that it provides, both directly and through its health care providers and subcontractors, culturally competent services to its members. The CONTRACTOR shall participate with HSD/MAD's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural ethnic backgrounds.

The CONTRACTOR shall:

A. develop a Cultural Competency Plan that describes how the CONTRACTOR shall ensure that services provided are culturally competent and shall submit the plan to HSD/MAD annually for approval;

B. develop written policies and procedures that implement the Cultural Competency Plan and ensure that culturally competent services are provided by the CONTRACTOR both directly and through its health care providers and subcontractors;

C. target cultural competency training to primary care providers, care coordinators/case managers, home health care staff and ensure that staff at all levels receive on-going education and training in culturally and linguistically appropriate service delivery;

D. develop and implement a plan for interpretive services and written materials to meet the needs of consumers and their decision-makers whose primary language is not English, using qualified medical interpreters, if available and make available easily understood member-oriented materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area;

E. identify community advocates and agencies that could assist non-English and limited-English-speaking individuals and/or that provide other culturally appropriate and competent services, which include methods for outreach and referral;

F. incorporate cultural competence into utilization management, quality improvement and planning for the course of treatment;

G. identify resources and interventions for high-risk health conditions found in certain cultural groups;

H. develop and incorporate contract language specific to cultural competency requirements for inclusion in contracts between the CONTRACTOR and providers and subcontractors;

I. recruit and retain a diverse staff and leadership that are representative of the demographic characteristics of the CONTRACTOR'S service area; and

J. ensure that new member assessment forms contain questions related to primary language preference and cultural expectations and that information received is maintained in the member file.

(2) The CONTRACTOR shall conduct initial and annual organizational self-assessments of culturally and linguistically competent-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, member satisfaction assessments, and outcomes-based evaluations.

2.6. INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN)

(1) General Requirements

Individuals with special health care needs have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the CONTRACTOR can facilitate access to appropriate services. The definition also allows for a flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

The CONTRACTOR shall:

A. produce a special handbook or create an insert to include in its member services handbook a description of providers and programs available to ISHCN;

B. identify from among its members individuals with special health care needs, using the criteria for identification and information provided by HSD/MAD to the MCO;

C. work with HSD/MAD to develop and implement written policies and procedures, which govern how members with multiple and complex physical health care needs shall be identified;

D. have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to ISHCN; and

E. have written policies and procedures to facilitate a smooth transition of a member to another CONTRACTOR, when a member chooses and is approved to switch to another CONTRACTOR.

(2) Information and Education for Individuals with Special Health Care Needs

The CONTRACTOR shall:

A. develop and distribute, as appropriate, information and materials specific to the needs of ISHCN, and, in the case of children with special health care needs, their caregiver(s). This includes, but is not limited to, information such as:

i. a list of items and services that are in the Salud! benefit package and those that are carved out;

ii. how to plan for and arrange transportation;

iii. how to present for care in an emergency room unfamiliar with the ISHCN; and

iv. the availability of a care coordinator;

B. make available health education programs to assist ISHCN, and, in the case of children with special health care needs, the caregiver(s), in understanding how to cope with the day-to-day stress of living with the limitation or providing care;

C. provide a list of key CONTRACTOR resource people and their phone numbers; and

D. designate a single entity that can be called for information during the enrollment process and after becoming a member.

(3) Choice of Specialist as Primary Care Provider (PCP) for Individuals with Special Health Care Needs

The CONTRACTOR shall develop and implement written policies and procedures governing the process for member selection of a PCP, including the right to choose a specialist as a PCP, if warranted and agreed upon by the specialist provider.

(4) Specialty Providers for Individuals with Special Health Care Needs

The CONTRACTOR shall have policies and procedures in place to allow direct access to necessary specialty care, consistent with SALUD! access appointment standards for clinical urgency.

(5) Transportation for Individuals with Special Health Care Needs for both Physical and Behavioral Health Services

The CONTRACTOR shall:

A. have written policies and procedures in place to ensure that the appropriate level of transportation is arranged for physical and behavioral health services based on the individual's clinical condition;

B. have past physical and behavioral health member and service data available at the time services are requested to expedite appropriate arrangements;

C. ensure that CPR-certified drivers transport ISHCN whose clinical need dictates;

D. have written policies and procedures to ensure that transportation mode is clinically appropriate, including access to non-emergency ground ambulance carriers;

E. develop and implement written policies and procedures to ensure that individuals can access and receive authorization for needed transportation services under certain unusual circumstances without the usual advance notification;

F. develop and implement a written policy regarding the transportation of minors if a parent or legal guardian shall not be in attendance to ensure the minor’s safety; and

G. distribute clear and detailed written information to ISHCN and, if needed, their caregiver(s) on how to obtain transportation services and also make this information available to network providers.

(6) Care Coordination for Individuals with Special Needs

The CONTRACTOR shall:

A. have an internal operational process, in accordance with policy and procedure, to target Medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The CONTRACTOR will provide HSD/MAD with the applicable policy and procedure describing the targeting and stratification process;

B. have written policies and procedures for accessing the need for care coordination;

C. have written policies and procedures for educating ISHCN and, in the case of children with special health care needs, parent(s), legal guardians, that care coordination is available and when it may be appropriate to their needs;

D. have written policies and procedures for educating providers about the availability of care coordination, its value as a resource in caring for ISHCN, and how to access it; and

E. have policies and procedures for the development, implementation and periodic evaluation of a member’s plan of treatment. These policies must address the involvement of parent(s), legal guardians, and/or caregivers as well as the member, in decisions about the member’s care and development and implementation of the plan of treatment. Caregivers of ISHCN and the members themselves, where indicated, must be empowered to be full participants in setting and achieving their own goals related to the member’s health.

(7) Emergency, Inpatient and Outpatient Ambulatory Surgery Hospital Requirements for Individuals with Special Health Care Needs

The CONTRACTOR shall:

A. develop and implement written policies and procedures for educating ISHCN with complicated clinical histories, and their caregivers, on how to utilize emergency room (ER) care, including what clinical history to present when emergency care or inpatient admission are needed;

B. develop and implement written policies and procedures governing how coordination with the PCP and hospitalists shall occur when an ISHCN is hospitalized;

C. develop and implement written policies and procedures to ensure that the ER physician has access to the individual's medical history; and

D. develop and implement written policies and procedures for obtaining any necessary referrals from PCPs for hospitals that require in-house staff to examine or treat individuals having outpatient or ambulatory surgical procedures performed.

(8) Rehabilitation Therapy Services (Physical, Occupational, Speech Therapy) for Individuals with Special Health Care Needs

The CONTRACTOR shall:

A. develop and implement therapy clinical practice guidelines specific to the chronic or long-term conditions of their ISHCN population, based on Medicaid managed care policy on medical necessity;

B. be informed about and coordinate with other therapy services being delivered by: Special Rehabilitation Services, the Home and Community Based Waiver programs or by the schools to avoid unnecessary duplication;

C. involve families of members, physicians and therapy providers to identify issues that should be addressed in developing the new criteria; and

D. develop and implement utilization prior approval and continued stay criteria, including timeframes, that are appropriate to the chronicity of the member’s status and anticipated development process.

(9) Durable Medical Equipment (DME) and Supplies for Individuals with Special Health Care Needs

The CONTRACTOR shall:

A. develop and implement a process to permit members utilizing supplies on an ongoing basis to submit a list of supplies monthly, subject to any requirements to procure a physician’s order to provide supplies to members. The CONTRACTOR shall contact the member or the member’s legal guardian when requested supplies cannot be delivered (require back-ordering, etc.) and make other arrangements, consistent with clinical need;

B. develop and implement a system for monitoring compliance with standards for DME and medical supplies, and for instituting corrective action, if the provider is out of compliance; and

C. have an emergency response plan for DME and medical supplies needed on an emergent basis.

(10) Clinical Practice Guidelines for Provision of Care to Individuals with Special Health Care Needs

The CONTRACTOR shall develop clinical practice guidelines, practice parameters and/or other specific criteria that consider the needs of ISHCN and provide guidance in the provision of acute and chronic medical health care services to this population. The guidelines should be professionally accepted standards of practice and national guidelines.

(11) Utilization Management (UM) for Services to Individuals with Special Health Care Needs

The CONTRACTOR shall develop written policies and procedures to exclude from prior authorization any item or service in the course of treatment, and/or extend the authorization periodicity, for services provided for a chronic condition. There should be a process for review and periodic update of the course of treatment, as indicated.

(12) Consumer Surveys Specific to Individuals with Special Health Care Needs

The CONTRACTOR shall add questions about ISHCN to the most current HEDIS CAHPS survey.

(13) Individuals with Special Health Care Needs Performance Improvement Project

The CONTRACTOR shall perform a performance improvement project specific to ISHCN.

2.7 SERVICES EXCLUDED FROM THE BENEFIT PACKAGE

(1) The following services are not included in the benefit package. Reimbursement for these services shall be made by HSD/MAD on a fee-for-service basis:

A. Services provided in nursing facilities or hospital swing beds to members residing over thirty (30) continuous days or at the time of disenrollment from a CONTRACTOR due to the member's residing in the nursing facility, or on a permanent basis as set forth in MAD Program Manual Section 8.312.2 NMAC, NURSING FACILITIES, and 8.311.5 NMAC, SWING BED HOSPITAL SERVICES;

B. Services provided in intermediate care facilities for the mentally retarded as set forth in MAD Program Manual Section 8.313.2 NMAC, INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED;

C. Services provided pursuant to the Home and Community-Based Services Waiver programs as set forth in MAD Program Manual Sections MAD-733 NMAC, HOME AND COMMUNITY-BASED SERVICES WAIVERS;

D. Emergency services to undocumented aliens as set forth in MAD Program Manual Section 8.325.10 NMAC, EMERGENCY SERVICES FOR UNDOCUMENTED ALIENS;

E. Experimental or investigational procedures, technologies or non-drug therapies as set forth in MAD Program Manual Section 8.325.6 NMAC, EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES, TECHNOLOGIES OR NON-DRUG THERAPIES;

F. Special Rehabilitation Services at set forth in MAD Program Manual Section 8.320.4 NMAC, SPECIAL REHABILITATION SERVICES;

G. Case management provided by the Children Youth and Families Department defined as child protective services case management and as detailed in MAD Program Manual Section 8.320.5 NMAC, EPSDT CASE MANAGEMENT;

H. Case management provided by the Children, Youth and Families Department as detailed in the Medical Assistance Manual Section 8.326.7 NMAC, ADULT PROTECTIVE SERVICES CASE MANAGEMENT;

I. Case management provided by Children, Youth and Families Department as detailed in the Medical Assistance Manual Section 8.326.8 NMAC, CASE MANAGEMENT SERVICES FOR CHILDREN PROVIDED BY JUVENILE PROBATION AND PAROLE OFFICERS; and

J. Services provided in the schools and specified in the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), as detailed in the MAD Program Manual Section 8.320.6 NMAC, SCHOOL- BASED SERVICES FOR RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE.

2.8 **ENHANCED BENEFITS/SERVICES**

The CONTRACTOR shall provide a schedule for implementing enhanced services pursuant to the CONTRACTOR’S proposal. The schedule shall include identification of enhanced services that are not already part of the benefit package. All enhancements shall be identifiable and measurable through the use of unique payment and/or processing codes, which shall be part of the encounter data submitted to HSD/MAD, unless the enhanced benefits offered by the CONTRACTOR do not generate claim or encounter data.

2.9 **GRIEVANCE**

The CONTRACTOR shall have a grievance system in place for members that includes a grievance process related to dissatisfaction, and an appeals process related to a CONTRACTOR action, including the opportunity to request an HSD/MAD fair hearing.

A grievance is a member's expression of dissatisfaction about any matter or aspect of the CONTRACTOR or its operation other than a CONTRACTOR action.

An appeal is a request for review by the CONTRACTOR of a CONTRACTOR action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

The member, legal guardian of the member for minors or incapacitated adults, or a representative of the member as designated in writing to the CONTRACTOR, has the right to file a grievance or an appeal of a CONTRACTOR action on behalf of the member. A provider acting on behalf of the member and with the member's written consent may file a grievance and/or an appeal of a CONTRACTOR action.

In addition to the CONTRACTOR grievance process described above, a member, legal guardian of the member or an incapacitated adult, or the representative of the member, as designated to the contractor in writing, has the right to request a fair hearing on behalf of the member with HSD/MAD directly as described in MAD Program Manual Section 8.352.2 NMAC, Fair Hearings, if the MCO member believes the CONTRACTOR has taken an action erroneously. A fair hearing may be requested prior to, concurrent with, subsequent to or in lieu of a grievance to a CONTRACTOR.

(1) General Requirements for Grievance & Appeals

The CONTRACTOR shall:

A. implement written policies and procedures describing how the member may register a grievance or an appeal with the CONTRACTOR and how the CONTRACTOR resolves the grievance or appeal and meet all requirements in MAD Program Manual Section 8.305.12 NMAC;

B. provide a copy of its policies and procedures for resolution of a grievance and/or an appeal to all service providers in the CONTRACTOR'S network;

C. have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

D. name a specific individual(s) designated as the CONTRACTOR'S Medicaid member grievance coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action;

E. ensure that the individuals who make decisions on grievances and/or appeals are not involved in any previous level of review or decision-making. The CONTRACTOR shall also ensure that health care professionals with appropriate clinical expertise will make decisions for the following:

i. an appeal of a CONTRACTOR denial that is based on lack of medical necessity;

ii. a CONTRACTOR denial that is upheld in an expedited resolution; and

iii. a grievance or appeal that involves clinical issues;

F. provide members, within thirty (30) calendar days of enrollment and at no cost, with a member information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD/MAD Hearings Bureau, upon notification of a CONTRACTOR action, or concurrent with or following an appeal of the CONTRACTOR action. The information shall meet the standards for communication specified in MAD Program Manual Section 8.305.8.15.(13); and

G. ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or against a provider that supports a member's grievance and/or appeal.

(2) Grievance

A grievance is a member's expression of dissatisfaction about any matter or aspect of the CONTRACTOR or its operation other than a CONTRACTOR action.

A. A member may file a grievance either orally or in writing with the CONTRACTOR within ninety (90) calendar days of the date the dissatisfaction occurred. The legal guardian of the member for minors or incapacitated adults, a representative of the member as designated in writing to the CONTRACTOR, or a provider acting on behalf of the member and with the member's written consent, has the right to file a grievance on behalf of the member.

B. Within five (5) working days of receipt of the grievance, the CONTRACTOR shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final CONTRACTOR resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the CONTRACTOR and shall include a resolution letter to the grievant.

D. The CONTRACTOR may request an extension from HSD/MAD of up to fourteen (14) calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD/MAD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member the CONTRACTOR shall give the member written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the CONTRACTOR shall mail a resolution letter to the member. The resolution letter must include, but not be limited to, the following:

i. all information considered in investigating the grievance;

ii. findings and conclusions based on the investigation; and

iii. the disposition of the grievance.

(3) <u>Appeal</u>

An appeal is a request for review by the CONTRACTOR of a CONTRACTOR action.

A. An “action” is defined as:

i. the denial or limited authorization of a requested service, including the type or level of service;

ii. the reduction, suspension, or termination of a previously authorized service;

iii. the denial, in whole or in part, of payment for a service;

iv. the failure of the CONTRACTOR to provide services in a timely manner, as defined by HSD/MAD; or

v. the failure of the CONTRACTOR to complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

B. Notice of CONTRACTOR Action

The CONTRACTOR shall mail a notice of action to the member or provider and all those parties affected by the decision within ten (10) days of the date of an action except for denial of claims which may result in client financial liability which requires immediate notification. The notice must contain, but not be limited to, the following:

i. the action the CONTRACTOR has taken or intends to take;

ii. the reasons for the action;

iii. the member’s or the provider’s right to file an appeal of the CONTRACTOR action through the CONTRACTOR;

iv. the member’s right to request an HSD/MAD fair hearing and what the process would be;

v. the procedures for exercising the rights specified;

vi. the circumstances under which expedited resolution of an appeal is available and how to request it; and

vii. the member’s right to have benefits continue pending resolution of an appeal, how to request the benefits be continued, and the

circumstances under which the member may be required to pay the costs of these services.

C. A member may file an appeal of a CONTRACTOR action within ninety (90) calendar days of receiving the CONTRACTOR'S notice of action. The legal guardian of the member for minors or incapacitated adults, a representative of the member as designated in writing to the CONTRACTOR, or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member.

D. The CONTRACTOR has thirty (30) calendar days from the date the oral or written appeal is received by the CONTRACTOR to resolve the appeal.

E. The CONTRACTOR shall have a process in place that assures that an oral inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal that is signed by the member.

F. Within five (5) working days of receipt of the appeal, the CONTRACTOR shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The CONTRACTOR shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

G. The CONTRACTOR may extend the thirty (30)-day timeframe by fourteen (14) calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD/MAD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the CONTRACTOR must give the member written notice of the extension and the reason for the extension within two (2) working days of the decision to extend the timeframe.

H. The CONTRACTOR shall provide the member and/or the representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

I. The CONTRACTOR shall provide the member and/or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents

and records considered during the appeals process. The CONTRACTOR shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

J. For all appeals, the CONTRACTOR shall provide written notice within the thirty (30)-calendar-day timeframe of the appeal resolution to the member and the provider, if the provider filed the appeal.

i. The written notice of the appeal resolution must include, but not be limited to, the following information:

(a) the result(s) of the appeal resolution; and

(b) the date it was completed.

ii. The written notice of the appeal resolution for appeals not resolved wholly in favor of the member must include, but not be limited to, the following information:

(a) the right to request an HSD/MAD fair hearing and how to file for a fair hearing;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of those benefits if the hearing decision upholds the CONTRACTOR'S action.

iii. The CONTRACTOR may continue benefits while the appeal and/or the HSD/MAD fair hearing process is pending. The CONTRACTOR shall continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the CONTRACTOR action (within ten (10) days of the date the CONTRACTOR mails the notice of action);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

iv. The CONTRACTOR shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) ten (10) days have passed since the date the CONTRACTOR mailed the resolution letter, providing the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD/MAD issues a hearing decision adverse to the member; or

(d) the time period or service limits of a previously authorized service has expired.

v. If the final resolution of the appeal is adverse to the member, that is, the CONTRACTOR'S action is upheld, the CONTRACTOR may recover the cost of the services furnished to the member while the appeal was pending to the extent that services were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR Section 431.230(b).

vi. If the CONTRACTOR or HSD/MAD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the CONTRACTOR must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

vii. If the CONTRACTOR or HSD/MAD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the CONTRACTOR must pay for these services.

(4) Expedited Resolution of Appeals

An expedited resolution of an appeal is an expedited review by the CONTRACTOR of a CONTRACTOR action.

A. The CONTRACTOR shall establish and maintain an expedited review process for appeals when the CONTRACTOR determines that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

   i. a request from the member;

   ii. a provider's support of the member's request;

   iii. a provider's request on behalf of the member; or

   iv. the CONTRACTOR'S independent determination.

B. The CONTRACTOR shall ensure that the expedited review process is convenient and efficient for the member.

C. The CONTRACTOR shall resolve the appeal within three (3) working days of receipt of the request for an expedited appeal, if the request meets the definition of an expedited appeal.

D. The CONTRACTOR may extend the timeframe by up to fourteen (14) calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD/MAD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the CONTRACTOR shall make reasonable efforts to give the member prompt verbal notification and follow-up with a written notice within two (2) working days.

E. The CONTRACTOR shall ensure that punitive action is not taken against a member or a provider who requests an expedited resolution or supports a member's expedited appeal.

F. The CONTRACTOR shall provide expedited resolution of an appeal in response to an oral or written request from the member or provider on behalf of the member.

G. The CONTRACTOR shall inform the member of the limited time available to present evidence and allegations in fact or law.

H. If the CONTRACTOR denies a request for an expedited resolution of an appeal, it shall:

i. transfer the appeal to the thirty (30)-day timeframe for standard resolution, in which the thirty (30)-day period begins on the date the CONTRACTOR received the request;

ii. make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and

iii. inform the member in the written notice of the right to file an appeal if the member is dissatisfied with the CONTRACTOR'S decision to deny an expedited resolution.

I. The CONTRACTOR shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

(5) Special Rule for Certain Expedited Service Authorization Decisions

In the case of certain expedited service authorization decisions that deny or limit services, the CONTRACTOR shall, within seventy-two (72) hours of receipt of the request for service, automatically file an appeal on behalf of the member, make a best effort to give the member oral notice of the decision of the automatic appeal, and make a best effort to resolve the appeal.

(6) Other Related Contractor Process

A. Information About Grievance System to Providers and Subcontractors The CONTRACTOR must provide information specified in 42 CFR Section, 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

B. Grievance and/or Appeal Files

i. All grievance and/or appeal files shall be maintained in a secure, designated area and be accessible to HSD/MAD upon request, for

review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the CONTRACTOR, HSD/MAD, judicial appeal, or closure of a file, whichever occurs later.

ii. The CONTRACTOR will have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the member of receipt of the grievance and/or appeal, all correspondence between the CONTRACTOR and the member, the date the grievance and/or appeal is resolved, the resolution, and notices of final decision to the member and all other pertinent information.

iii. Documentation regarding the grievance shall be made available to the member, if requested.

(7) Reporting

A. The CONTRACTOR shall provide information requested or required by the Centers for Medicare and Medicaid Services.

B. The CONTRACTOR shall provide a quarterly report to HSD/MAD of all grievances received from or about Medicaid members, by the CONTRACTOR or its subcontractors in compliance with the timelines and procedures set forth in Section 2.12(2).

(8) MCO Provider Grievance Process

The CONTRACTOR shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance or an appeal with the CONTRACTOR regarding utilization management decisions and/or provider payment issues. Grievances shall be resolved within thirty (30) calendar days. A provider may not file a grievance on behalf of a member without written designation by the member as the member’s representative. See MAD Program Manual Section 8.305.12.13 NMAC for special rules for certain expedited service authorizations.

2.10 FIDUCIARY RESPONSIBILITIES

(1) Solvency Requirements and Risk Protections

A CONTRACTOR that contracts with HSD/MAD for the provision of services shall comply with and is subject to all applicable State and Federal laws and regulations including those regarding solvency and risk standards. In addition to requirements imposed by State or Federal law, the CONTRACTOR shall be required to meet specific Medicaid financial requirements and to present to HSD/MAD or its agent any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HSD/MAD, at no cost to HSD/MAD, in a reasonable time from the date of request or as specified herein.

(2) Reinsurance

The CONTRACTOR shall have and maintain a minimum of one million dollars ($1,000,000.00) in reinsurance protection against financial loss due to outlier (catastrophic) cases. The CONTRACTOR shall submit to HSD/MAD such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance. Information provided to HSD/MAD on the CONTRACTOR’S reinsurance must be computed on an actuarially sound basis.

(3) Third-Party Liability

The CONTRACTOR is responsible for identification of third-party coverage of members and coordination of benefits with applicable third parties. The CONTRACTOR shall inform HSD/MAD of any member who has other health care coverage. The CONTRACTOR shall provide documentation to HSD/MAD enabling HSD/MAD to pursue its rights under State and Federal law. Documentation includes payment information on enrolled members as requested by HSD/MAD, Third Party Liability Unit of the MAD, to be delivered within 20 business days from receipt of the request. Other documentation to be provided by the CONTRACTOR, upon request by HSD/MAD, includes a quarterly listing of potential accident and personal injury cases that are known to the CONTRACTOR. The CONTRACTOR has the sole right of subrogation, for twelve (12) months, to initiate recovery or to attempt to recover any third-party resources available to Medicaid members.

The CONTRACTOR and HSD/MAD shall jointly develop and agree upon a reporting format to carry out the requirement of this subsection. However, if an agreed upon format cannot be developed, HSD/MAD retains the right to make a final determination of the reporting format.

(4) Fidelity Bond Requirement

The CONTRACTOR shall maintain in force a fidelity bond in the amount specified under the Insurance Code, NMSA 1978, §§ 59A-1-1 et. seq.

(5) Net Worth Requirement

The CONTRACTOR shall at all times be in compliance with the net worth requirements in the Insurance Code.

(6) Solvency Cash Reserve Requirement

A. The CONTRACTOR shall have sufficient reserve funds available to ensure that the provisions of services to Medicaid members are not at risk in the event of the CONTRACTOR insolvency. The CONTRACTOR shall comply with all State and Federal laws and regulations regarding solvency, risk, and audit and accounting standards.

B. Per Member Cash Reserve

The CONTRACTOR shall maintain three percent (3 %) of the monthly capitated payments per member with an independent trustee during each month of the first year of the Agreement; provided, however, that if this Agreement replaces or extends a previous agreement with HSD/MAD to provide Medicaid managed care, then continued maintenance of the per member cash reserve established and maintained by CONTRACTOR pursuant to such previous agreement shall be deemed to satisfy this requirement. The CONTRACTOR shall maintain this cash reserve for the duration of the Agreement. HSD/MAD shall adjust this cash reserve requirement annually, or as needed, based on the number of the CONTRACTOR'S members. Each CONTRACTOR shall maintain its own cash reserve account. This account may be accessed solely for payment for services to that CONTRACTOR'S members in the event that the CONTRACTOR becomes insolvent. Money in the reserve account remains the property of the CONTRACTOR, and any interest earned (even if retained in the account) shall be the property of the CONTRACTOR. The CONTRACTOR shall be permitted to invest its cash reserve account, with HSD/MAD approval and consistent with Department of Insurance (DOI) regulations and guidelines.

(7) Inspection and Audit for Solvency Requirements

The CONTRACTOR shall meet all requirements for licensure within the State with respect to inspection and auditing of financial records. The CONTRACTOR shall also cooperate with HSD/MAD or its designee, and provide all financial records required by HSD/MAD or its designee so that they may inspect and audit the CONTRACTOR'S financial records at least annually or at HSD/MAD's discretion.

(8) Timely Payments

A. The CONTRACTOR shall make timely payments to both its contracted and non-contracted providers.

i. The CONTRACTOR shall promptly pay for all covered emergency services, including medically necessary testing to determine if a medical emergency exists, that are furnished by providers that do not have arrangements with the CONTRACTOR. This includes all covered emergency services provided by a nonparticipating provider, including those when the time required to reach the CONTRACTOR'S facilities or the facilities of a provider with which the CONTRACTOR has contracted, would mean risk of permanent damage to the member's health.

ii. The CONTRACTOR shall pay ninety percent (90%) of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities within thirty (30) days of date of receipt, and shall pay ninety-nine percent (99%) of all such clean claims within ninety (90) days of receipt. A "clean claim" means a manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan's system.

iii. Consistent with the requirements of MAD Program Manual Section 8.305.11.9.B(1) NMAC, which applies to clean claims submitted electronically, and NMSA Section 59A-2-9.2, the CONTRACTOR shall pay interest at the rate of one and one-half percent (1 ½%) a month on:

(a) the amount of a clean claim electronically submitted by a contracted provider and not paid within thirty (30) days of the date of receipt;

(b) the amount of a clean claim manually submitted by a contracted provider and not paid within forty-five (45) days of the date of receipt; and

(c) interest payments shall accrue and begin on the 31st day for electronic submissions and the 46th day for hard copy.

(9) Insurance

A. The CONTRACTOR, its successors and assignees shall procure and maintain such insurance as is required by currently applicable Federal and State law and regulation. Such insurance shall include, but not be limited to, the following:

i. Liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the CONTRACTOR, its agents and employees;

ii. Workers compensation;

iii. Unemployment insurance;

iv. Reinsurance; and

v. Automobile insurance to the extent applicable to CONTRACTOR'S operations.

B. The CONTRACTOR shall provide HSD/MAD with documentation that the above specified insurance has been obtained; and the CONTRACTOR'S subcontractors shall provide the same documentation to the CONTRACTOR.

(10) The CONTRACTOR shall have and maintain adequate protections against financial loss due to outlier (catastrophic) cases and member utilization that is greater than expected. The CONTRACTOR shall submit to HSD/MAD such written documentation as is necessary to show the existence of this protection, which may include policies and procedures of reinsurance.

(11) Special contract provisions as required by 42 CFR Section 438.6 (c)(5): Pursuant to 42 CFR Section 438.6(c)(5), contract provisions for reinsurance, stop-loss limits or other risk-sharing methodologies must be computed on an actuarially sound basis.

2.11 PROGRAM INTEGRITY

The CONTRACTOR shall:

(1) have written policies and procedures to address prevention, detection, preliminary investigation, reporting of potential and actual Medicaid fraud and abuse;

(2) have a comprehensive internal program to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions;

(3) have specific controls for prevention, such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the plan's contracts with its providers and subcontractors;

(4) cooperate with the Medicaid Fraud Control Unit (MFCU) and other investigatory agencies as mutually agreed to by the parties in writing;

(5) have systems that can monitor service utilization and encounters for fraud and abuse;

(6) immediately report to HSD/MAD any activity giving rise to a reasonable suspicion of fraud and abuse, including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to HSD/MAD as defined by the CONTRACTOR in consultation with HSD/MAD and MFCU. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the CONTRACTOR as mutually agreed to in writing between the parties during the investigation will be required;

(7) not use its organization's determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from HSD/MAD;

(8) report all suspected fraud and abuse to HSD/MAD promptly, including the results of all internal investigations of suspected fraud and abuse; and

(9) send to HSD/MAD as required, the names of all providers identified with aberrant utilization according to provider profiles regardless of the cause of the aberrancy; and not use its organization's determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from HSD/MAD.

2.12 REPORTING

The CONTRACTOR shall provide to HSD/MAD managerial, financial, utilization and quality reports. The content, format, and schedule for submission shall be determined by HSD/MAD in advance for the financial reporting period and shall conform to reasonable industry and/or to CMS standards. HSD/MAD may also require the CONTRACTOR to submit non-routine ad hoc reports, provided that HSD/MAD shall pay the CONTRACTOR to produce any non-routine ad hoc reports that require a significant amount of time, resources or effort on the part of the CONTRACTOR.

(1) Reporting Standards

Reports submitted by the CONTRACTOR to HSD/MAD shall meet the following standards:

A. reports or other required data shall be received on or before scheduled due dates;

B. reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or HSD/MAD defined standards;

C. all required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omission;

D. the submission of late, inaccurate, or otherwise incomplete reports constitutes failure to report. In such cases, a penalty may be assessed by HSD/MAD; and

E. HSD/MAD requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of the managed care contract. The CONTRACTOR shall comply with all

changes specified in writing by HSD/MAD, after HSD/MAD has discussed such changes with the CONTRACTOR.

(2) Monitoring of Grievance Resolution

The CONTRACTOR shall submit a Quarterly Grievance Report to HSD/MAD using the Quarterly Grievance Report format no later than forty-five (45) days from the end of the quarter.

(3) Financial Reporting

A. The CONTRACTOR shall submit annual audited financial statements including, but not limited to, its Income Statement, Statement of Changes in Financial Condition or cash flow, and Balance Sheet, and the CONTRACTOR shall include an audited schedule of Salud! revenues and expenses according to generally accepted accounting principles. The result of the CONTRACTOR'S annual audit and related management letters shall be submitted no later than one hundred and fifty (150) days following the close of the CONTRACTOR'S fiscal year. The audit shall be performed by an independent Certified Public Accountant. The CONTRACTOR shall submit for examination any other financial reports requested by HSD/MAD and related to the CONTRACTOR'S solvency or performance of this Agreement.

B. The CONTRACTOR and its subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between the CONTRACTOR and its subcontractors, and the CONTRACTOR and HSD/MAD. These transactions shall include, but are not limited to, claim payments, refunds, and adjustments of payments.

C. The CONTRACTOR and its subcontractors shall make available to HSD/MAD and any other authorized State or Federal agency, any and all financial records required to examine the compliance by the CONTRACTOR insofar as those records are related to CONTRACTOR'S performance under this Agreement. For the purpose of examination, review, and inspection of its records, the CONTRACTOR and its subcontractors shall provide HSD/MAD access to its facilities.

D. The CONTRACTOR and its subcontractors shall retain all records and reports relating to agreements with HSD/MAD for a minimum of ten (10) years from the date of final payment. In cases involving incomplete audits and/or unresolved audit findings, administrative sanctions, or litigation, the minimum ten (10)-year retention period shall begin when such actions are resolved.

E. The CONTRACTOR is mandated to notify HSD/MAD immediately when any change in ownership can legally be disclosed. The CONTRACTOR shall submit a detailed work plan during the transition period or no later than the date of the approval of sale by the DOI that identifies areas of the contract that will be impacted by the change in ownership, including management and staff.

F. The CONTRACTOR shall submit records involving any business restructuring when changes in ownership interest of five percent (5%) or more have occurred. These records shall include, but are not limited to, an updated list of names and addresses of all persons or entities having ownership interest of five percent (5%) or more. These records shall be provided no later than sixty (60) days following the change of ownership.

G. The following table gives an overview of the reporting requirements the HSD/MAD has established to monitor and examine the CONTRACTOR for solvency and compliance with Federal requirements for financial stability. These requirements shall enable HSD/MAD or its designee to determine if changes have occurred which affect a CONTRACTOR and/or its subcontractors' financial condition. The CONTRACTOR'S required level of reinsurance, fidelity bond, or insurance and solvency cash reserves may change with changes to the CONTRACTOR'S net worth or other financial condition.

H. Financial Reporting Requirement

Reporting requirements include, but are not limited to, the following:

Definition	Frequency	Objective	Due Date
Calendar-Year Independently Audited Financial Statements	Annual	Examine for Solvency and CMS Compliance	June 1
Calendar-Year Medicaid-Specific Audited Schedule of Revenue and Expenses	Annual	Examine for Solvency and CMS Compliance	June 1
MCO Quarterly Department of Insurance Unaudited Statements	Quarterly	DOI Quarterly Statements	45 days from end of Qtr
Department of Insurance Annual Statement including all supporting schedules (Medicaid specific included)	Annual	DOI Annual Statement	March 1
Department of Insurance Reports	Quarterly	Examine for Solvency and CMS Compliance	45 days from end of Quarter, March 1 for Annual Statement
Claims Aging	Quarterly	Examine for Solvency and CMS Compliance	30 days from end of Qtr
Expenditures by Category of Services for hospital, pharmacy, physician, dental, transportation and other	Quarterly	Determine Cost Efficiency	30 days from end of Qtr
Expenditures of services to FQHC’s	Quarterly	Enable HSD/ MAD to make wraparound payments to FQHC’s	30 days from end of Qtr
Expenditures of services to RHC’s	Quarterly	Enable HSD/ MAD to make wraparound payments to RHC’s	30 days from end of Qtr

Expenditures specifically made to IHS and tribal 638 facilities	Quarterly	Enable HSD/MAD to reconcile the payments made by the CONTRACTOR to IHS and tribal 638 facilities, against the supplemental capitation payments made by HSD/MAD to the CONTRACTOR	30 days from end of Qtr
Analysis of Benefit Coordination savings	Quarterly	Rate payment and Cost Efficiency	30 days from end of Qtr
Identify the Fidelity Bond or Insurance Protection by Amount of Coverage in relation to Annual Payments. Identify MCO Directors, Officers Employees or Partners.	Annual	Examine for Solvency and CMS Compliance	Initially and upon renewal
Analysis of Stop-loss protection with Detail of Panel Composition	Quarterly and Annually	Examine for Solvency, Rate Payment.	30 days from end of Qtr
Reinsurance Policy	Annual	Assess Solvency and CMS Compliance	Initially and upon renewal
Cash Reserve Statement	Quarterly	Examine for Solvency and CMS Compliance	30 days from end of Qtr

(4) Automated Reporting

A. The CONTRACTOR is required to submit data to HSD/MAD. Subject to the provisions of Section 4.2 of this Agreement. HSD/MAD shall define the format and data elements after having consulted with the CONTRACTOR on the definition of these elements.

B. The CONTRACTOR is responsible for identifying and reporting to HSD/MAD immediately upon discovery any inconsistencies in its automated reporting. The CONTRACTOR shall make necessary adjustments to its reports at its own expense.

C. HSD/MAD, in conjunction with its fiscal agent, intends to implement electronic data interchange standards for transactions related to managed health care. Subject to the provisions of Section 4.2 of this Agreement, the CONTRACTOR shall work with HSD/MAD to develop the technical components of such an interface.

(5) Encounters

CMS requires that encounter data be used for rate-setting purposes. Encounter data will also be used to determine compliance with performance measures and other contractual requirements as appropriate. Therefore, submission of accurate and complete encounter data is a mandatory requirement.

HSD/MAD maintains oversight responsibility for evaluating and monitoring the volume, timeliness, and quality of encounter data submitted by the CONTRACTOR. If the CONTRACTOR elects to contract with a third party contractor to process and submit encounter data, the CONTRACTOR remains responsible for the quality, accuracy, and timeliness of the encounter data submitted to HSD/MAD. HSD/MAD shall communicate directly with the CONTRACTOR any requirements and/or deficiencies regarding quality, accuracy and timeliness of encounter data, and not with the third party contractor. The CONTRACTOR shall submit encounter data to HSD/MAD in accordance with the following:

A. Encounter Submission Media

The CONTRACTOR shall provide encounter data to HSD/MAD by electronic media, such as magnetic tape or direct file transmission. Paper submission is not permitted.

B. Encounter Submission Time Frames

The CONTRACTOR shall submit encounters to HSD/MAD within one hundred and twenty (120) days of the date of service or discharge, regardless of whether the encounter is from a subcontractor or subcapitated arrangement. Exceptions may be allowed for encounters from out-of-state, non-contracted providers. Encounters for claims involving other insurance or liable third parties must be submitted within three hundred and sixty-five (365) days from the date of service. Encounters that do not clear edit checks shall be returned to the CONTRACTOR for

correction and re-submission. The CONTRACTOR shall correct and resubmit the encounter data to HSD/MAD.

C. Encounter Data Elements

Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats, which comprise a minimum core data set for states and managed care organizations, and those required by CMS or HSD/MAD for use in managed care. . Subject to the provisions of Section 4.2 of this Agreement, HSD/MAD may increase or reduce or make mandatory or optional, data elements, as it deems necessary. The CONTRACTOR will be held harmless in conversion to HIPAA coded encounter data when delays are the result of HIPAA implementation issues at HSD/MAD. The transition to HIPAA codes and requirements does not relieve the CONTRACTOR of timely submission of encounter data. HSD/MAD will approve necessary default values for paper claim encounters that must pass HSD/MAD required HIPAA format edits.

D. Encounter Data Formats

The CONTRACTOR shall submit encounter data to HSD/MAD using the 837 and NCPDP formats.

(6) Disease Reporting

The CONTRACTOR shall ensure that its providers comply with the disease reporting required by the A New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980.

(7) HEDIS

The CONTRACTOR shall participate in the most current HEDIS reporting system, submit a copy of the HEDIS data in accordance with the NCQA requirement, and submit a final audit report to HSD/MAD along with the HEDIS data submission tool. The HEDIS compliance audit will be at the expense of the CONTRACTOR.

(8) Provider Network Reports

The CONTRACTOR shall notify HSD/MAD within five (5) working days of any unexpected changes to the composition of its provider network that negatively

affect member access or the CONTRACTOR’S ability to deliver all services included in the benefit package in a timely manner. Any anticipated material changes in the CONTRACTOR’S provider network shall be reported to HSD/MAD in writing when the CONTRACTOR knows of the anticipated change or within thirty (30) calendar days, whichever comes first. The notice submitted to HSD/MAD shall include the following information: nature of the change; information about how the change affects the delivery of covered services or access to the services; and the CONTRACTOR’S plan for maintaining the access and quality of member care.

2.13 **SYSTEM REQUIREMENTS**

(1) The CONTRACTOR’S Management Information System (MIS) shall be capable of accepting, processing, maintaining and reporting specific information necessary to the administration of the managed care program by June 1, 2005.

(2) System Hardware, Software and Information Systems Requirements: The CONTRACTOR is required to maintain system hardware, software, and information systems (IS) resources sufficient to provide the capability to:

A. accept, transmit, maintain, and store electronic data and enrollment roster files;

B. accept, process, maintain, and report specific information necessary to the administration of managed care and other contracted service arrangements;

C. conduct automated claims processing in current HIPAA compliant formats;

D. accept and maintain at least a ten digit member identification number to be used for identification, eligibility verification, and claims adjudication by the CONTRACTOR and all subcontractor;

E. estimate the number of records to be received from providers and subcontractors; monitor and transmit electronic encounter data to HSD/MAD according to encounter data submission standards, in order to monitor the completeness of the data being received and to detect providers or subcontractors who are transmitting partial or no records;

F. disseminate enrollment information to providers within twenty-four (24) hours of receipt of the information;

G. maintain a website for dispersing information to providers and members, and be able to receive comments electronically and respond when appropriate;

H. receive data elements associated with identifying members who are receiving ongoing services under fee-for-service Medicaid or from another CONTRACTOR and using, where possible, the formats that HSD/MAD uses to transmit similar information to an MCO;

I. transmit to HSD/MAD or another CONTRACTOR data elements associated with its members who have been receiving ongoing services within its organization or under another contractual arrangement;

J. have an automatic access system for providers to obtain member enrollment information. Address the cross-reference capability of the system to the member's ten-digit identification number designated by HSD/MAD to the member's social security number, and the member's most current category of eligibility; and

K. maintain a system backup and recovery plan.

(3) Provider Network Information Requirements: The CONTRACTOR'S provider network capabilities shall include, but not be limited to:

A. maintaining complete provider information for all providers contracted with the CONTRACTOR and its subcontractors and any other non-contracted providers who have provided services to date;

B. transmitting a Provider Network File to HSD/MAD on a monthly basis, no later than the 28th day of each month, which must be sent along with encounter files, to include all contracted providers, non-contracted providers who have provided service to date, and providers who have been terminated. The file is a general replacement file each month with no deletions from the file until three (3) years past the date of the provider's termination or denied status. Once a provider is shown on the file, the provider should continue to be reported regardless of whether any encounters are reported;

C. providing a complete and accurate designation of each provider according to the data elements and definitions included in the Medicaid Systems

Manual, including assignment of unique provider numbers to each type of certification the provider organization has, according to HSD/MAD classification of provider type; and

D. providing automated access to members and providers of a member’s PCP assignment.

(4) Claims Processing Requirements: The CONTRACTOR and any of its subcontractors or providers paying their own claims are required to maintain claims processing capabilities to include, but not be limited to:

A. accepting HIPAA-compliant formats for electronic claims submission;

B. assigning unique identifiers for all claims received from providers;

C. standardizing protocols for the transfer of claims information between the CONTRACTOR and its subcontractors/providers, audit trail activities, and the communication of data transfer totals and dates;

D. meeting both State and Federal standards for processing claims;

E. generating remittance advice to providers;

F. participating on a committee with HSD/MAD to discuss and coordinate systems-related issues;

G. accepting from providers and subcontractors only national HIPAA- compliant standard codes;

H. editing claims to ensure that services being billed are provided by providers licensed to render these services, that services are appropriate in scope and amount, that enrollees are eligible to receive the service, and that services are billed in a manner consistent with national coding criteria (e.g., discharge type of bill includes discharge date, rendering provider is always identified for facility and group practices, services provided in any inpatient/residential setting are coded with an inpatient type of bill, etc.); and

I. developing and maintaining a HIPAA-compliant electronic billing system for all providers submitting bills directly to the CONTRACTOR and requiring all subcontractor benefit managers to meet the same standards.

(5) Member Information Requirements: The CONTRACTOR'S member information requirements shall include, but not be limited to:

A. accepting, maintaining and transmitting all required member information;

B. monitoring newborns whose mothers are enrolled in managed care at the time of the newborn's birth to ensure minimal lapse in the time between the infant's birth and the determination of Medicaid eligibility. Retroactive capitations will only be issued for the first two months of life, during which time the mother's CONTRACTOR must cover the services of the newborn. After the time, if that newborn has not appeared on a roster for the CONTRACTOR, the CONTRACTOR will not be responsible for the continuing health care for the child. However, the parent or guardian may choose a different CONTRACTOR for the newborn as early as the second month of life. In such a case, the CONTRACTOR of the mother is only entitled to the capitation for the birth month;

C. generating member information to providers within twenty-four (24) hours of receipt of the enrollment roster from HSD/MAD;

D. accepting at least a ten-digit recipient identification number designated by HSD/MAD to be used for identification, eligibility verification and claims adjudication. This ten-digit number will be connected to the recipient's social security number and any internal number used in the offeror's system to identify that recipient;

E. maintaining a special medical status identifier on its system's database consistent with HSD/MAD's for this field. This requirement also applies to any subcontractor who maintains a copy of the member rosters for the purpose of distributing eligibility or roster information to providers of verifying member eligibility;

F. meeting Federal CMS and HIPAA standards for release of member information (applies to subcontractors as well). Standards are specified in the Medicaid Systems Manual and at 42 CFR Section 431.306(b);

G. tracking changes in the members' category of eligibility to ensure appropriate services are covered and appropriate application of co-pays;

H. maintaining accurate member eligibility and demographic data; and

I. providing automated access to providers regarding member eligibility. Automated Voice response Systems, Electronic Verification Systems, and the use of swipe card or smart cards would all be considered automated access. It is expected that the information would always be current, or if the information is out of date, that the information still be honored because the error would originate with the CONTRACTOR.

(6) Encounter and Provider Network Reporting Requirements: CMS requires that encounter data be used for rate-setting purposes. Encounter data will also be used to determine compliance with performance measures and other contractual requirements as appropriate. Therefore, submission of accurate and complete encounter data is a mandatory requirement. The following Encounter and Provider Network File Submission and Reporting capabilities shall include, but not be limited to, the CONTRACTOR:

A. submitting to HSD/MAD sixty percent (60%) of the CONTRACTOR'S encounters within sixty (60) days of the date of service, at least eighty percent (80%) of its encounters within ninety days (90) and a total of one hundred percent (100%) submitted within one hundred and twenty (120) days of the date of service, according to the specifications included in the Medicaid Systems Manual regardless of whether the encounter is from a subcontractor or subcapitated arrangement;

B. submitting encounter files with no more than three percent (3%) error rate;

C. submitting corrections to encounters denied by HSD/MAD within thirty (30) days of the notice of denial;

D. submitting adjustments/voids to encounters that have previously been accepted by HSD/MAD within thirty (30) days of the adjustment or void of claim by the CONTRACTOR;

E. having a written contractual requirement of its subcontractors or providers that pay their own claims to submit encounters to the CONTRACTOR on a timely basis, which ensures that the CONTRACTOR can meet its timeline requirements for encounter submissions;

F. editing encounters prior to submission to prevent or decrease submission of duplicate encounters, encounters from providers not on the CONTRACTOR'S provider network file, and other types of encounter errors;

G. having a formal monitoring and reporting system to reconcile submissions and resubmission of encounter data between the CONTRACTOR and HSD/MAD to assure timeliness of submissions, resubmissions and corrections and completeness of data. The CONTRACTOR shall be required to report the status of its encounter data submissions overall on a form developed by HSD/MAD;

H. complying with the most current federal standards for encryption of any data that is transmitted via the internet (also applies to subcontractors). A summary of the current CMS and HIPAA guidelines is included in the Medicaid Systems Manual;

I. complying with CMS standards for electronic transmission, security, and privacy, as may be required by HIPAA (also applies to subcontractors); and

J. reporting all data noted as "required" in the HIPAA Implementation Guide and HSD/MAD's Encounter Companion Guide.

2.14 CARE COORDINATION

(1) General Requirements

Care coordination is defined as an office-based administrative service to assist members with multiple and complex, special health care needs, on an as-needed basis. It is member-centered and consumer-directed, family focused when appropriate, culturally competent and strength based. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the member and family if appropriate. Care coordination operates independently within the CONTRACTOR'S organization and has a separately defined function with a dedicated care coordination staff but is structurally linked to the CONTRACTOR'S other systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal considerations. If both physical and behavioral aspects of care exist, the care coordination responsibility lies with the condition that is most acute.

Care coordination provides services statewide, both internally for services, which are covered under Medicaid and externally to the CONTRACTOR for non-covered services. Examples of services external to the MCO with which the CONTRACTOR shall coordinate include: behavioral health services with the SE, the Home and Community–based Waiver programs; special rehabilitation; Children’s Medical Services (CMS); CYFD Protective Services; Juvenile Justice Divisions; and the Medicaid School-Based Services program. The CONTRACTOR will also provide care coordination activities with the New Mexico’s safety net providers, and the primary care clinics.

(2) Primary Elements of Care Coordination

The CONTRACTOR shall use the following primary elements for care coordination by:

A. developing and implementing policies and procedures, approved by HSD/MAD, which govern how members with multiple and complex health care needs will be identified;

B. developing policies and procedures to ensure access to care coordination for all Medicaid eligible individuals with special health care needs;

C. identifying proactively the eligible populations;

D. identifying proactively the needs of the eligible population;

E. designating an individual who has primary responsibility for coordinating health services and serves as the single point of contact for the member;

F. informing the member regarding the care coordinator’s name and how to contact him/her;

G. ensuring access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan or plan of care as per applicable provider regulation and based on a comprehensive assessment of goals, capacities and the medical condition of the member and the needs and goals of the family if applicable. The provider must also address criteria for evaluating a member’s response to care, revising the plan, as indicated, and measuring and evaluating outcomes. A member and family shall be involved in the plan of care, as appropriate;

H. ensuring the provision of necessary services and actively assisting members and providers in obtaining such services;

I. providing statewide care coordination by qualified d professionals either directly or through subcontractors, for Salud! members with multiple and complex health care needs;

J. providing the five targeted case management programs included in the Medicaid benefit package, and be held accountable for delivering these services according to HSD/MAD policy;

K. coordinating with the SE responsible for the delivery and coordination of behavioral health services;

L. monitoring the progress of members to ensure that services are received and assisting in resolving identified problems;

M. being responsible for linking individuals to case management as needed if the local case manager/designated provider is not available;

N. educating and assisting PCPs to make appropriate referrals for behavioral health consultation and treatment;

O. working with the Medicaid School-based Services (MSBS) program providers to identify and coordinate care with the child's Salud! PCP;

P. developing and implementing policies and procedures to establish working relationships between care coordinators and providers;

Q. specifying how care coordination will be supported by an internal information system; and

R. developing policies and procedures to ensure that the PCP provides for twenty-four (24)-hour, seven (7)-day-a-week access to care, provides coordination and continuity of care and maintains a current medical record for members, including documentation of all primary and specialty services and/or referrals provided to the member.

ARTICLE 3 - LIMITATION OF COST

In no event shall capitation fees or other payments provided for in the Agreement exceed the payment limits set forth in 42 C.F.R. Sections 447.361 and 447.362. In no event shall HSD/MAD pay twice for the provision of services.

ARTICLE 4 - HSD/MAD RESPONSIBILITY

4.1 HSD/MAD shall:

(1) establish and maintain Medicaid eligibility information and transfer eligibility information to ensure appropriate enrollment in and assignment to the CONTRACTOR. On the CONTRACTOR'S request, this information shall be transferred electronically. The CONTRACTOR shall have the right to rely on eligibility and enrollment information transmitted to the CONTRACTOR by HSD/MAD;

(2) support implementation deadlines by providing technical information at the required level of specificity in a timely fashion;

(3) provide the CONTRACTOR with enrollment information concerning each Medicaid member enrolled with the CONTRACTOR, including the member's name and social security number, the member's address, the member's date of birth and gender, the availability of third-party coverage, and the member's rate category;

(4) compensate the CONTRACTOR as specified in Article 5 – Compensation and Payment Reimbursement for Managed Care;

(5) provide a mechanism for fair/administrative hearings to review denials and Utilization Management decisions made by the CONTRACTOR;

(6) monitor the effectiveness of the CONTRACTOR'S Quality Assurance Program;

(7) review the CONTRACTOR'S grievance files as necessary;

(8) establish requirements for review and make decisions concerning the CONTRACTOR'S requests for disenrollment;

(9) determine the period of time within which a member cannot be reenrolled with a CONTRACTOR that successfully has requested his/her disenrollment;

(10) provide mandatory Medicaid enrollees with specific information about services, benefits, and MCOs from which to choose and member enrollment;

(11) have the right to receive solvency and reinsurance information from the CONTRACTOR, and to inspect the CONTRACTOR'S financial records as frequently as necessary, but at least annually;

(12) have the right to receive all information regarding third party liability from the CONTRACTOR so that it may pursue its rights under State and Federal law;

(13) review the CONTRACTOR'S policies and procedures concerning Medicaid fraud and abuse until they are deemed acceptable;

(14) provide the content, format and schedule for the CONTRACTOR'S report submission;

(15) inspect, examine, and review the CONTRACTOR'S financial records as necessary to ensure compliance with all applicable State and Federal laws and regulations;

(16) monitor encounter data submitted by the CONTRACTOR and provide data elements for reporting;

(17) provide the CONTRACTOR with specifications related to data reporting requirements;

(18) amend its fee-for-service and other provider agreements, or take such other action as may be necessary to encourage health care providers paid by HSD/MAD to enter into contracts with the CONTRACTOR at the applicable Medicaid reimbursement rate for the provider, absent other negotiated arrangements, and encourage any Medicaid participating provider who is not contracted with the CONTRACTOR to accept the applicable Medicaid reimbursement as payment in full for covered services provided to a member who is enrolled with the CONTRACTOR. The applicable Medicaid reimbursement rate is defined to exclude disproportionate share and medical education payments;

(19) establish maximum enrollment levels to ensure that all MCOs maintain statewide enrollment capacity;

(20) ensure that no requirement or specification established or provided by HSD/MAD

under this section conflicts with requirements or specifications established pursuant to the Federal Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated there under. All requirements and specifications established or provided by HSD/MAD under this section shall comply with the requirements of Section 4.2 of this Agreement; and

(21) cooperate with the CONTRACTOR in the CONTRACTOR'S efforts to achieve compliance with HIPAA requirements. The CONTRACTOR shall be held harmless for implementation delays when the CONTRACTOR is not responsible for the cause of the delay.

4.2. HSD/MAD and/or its fiscal agent shall implement electronic data standards for transactions related to managed health care.

In the event that HSD/MAD and/or its fiscal agent requests that the CONTRACTOR or its subcontractors deviate from or provide information in addition to the information called for in required and optional fields included in the standard transaction code sets established under HIPAA, such request shall be made by amendment to this Agreement in accordance with the provisions of Article 36.

4.3 Performance by the CONTRACTOR shall not be contingent upon time availability of HSD/MAD personnel or resources with the exception of specific responsibilities stated in the RFP and the normal cooperation that can be expected in such a contractual Agreement. The CONTRACTOR'S access to HSD/MAD personnel shall be granted as freely as possible. However, the competency/sufficiency of HSD/MAD staff shall not be a reason for relieving the CONTRACTOR of any responsibility for failing to meet required deadlines or producing unacceptable deliverables. To the extent the CONTRACTOR is unable to perform any obligation or meet any deadline under this Agreement because of the failure of HSD/MAD to perform its specific responsibilities under the Agreement, the CONTRACTOR'S performance shall be excused or delayed, as appropriate. The CONTRACTOR shall provide HSD/MAD written notice as soon as possible, but in no event later than the expiration of any deadline or date for performance, that identifies the specific responsibility that HSD/MAD has failed to meet, as well as the reason HSD/MAD's failure impacts the CONTRACTOR'S ability to meet its performance obligations under the Agreement.

4.4 Promptly upon becoming aware of any claim or information that may have an impact on the CONTRACTOR or the services to be performed by the CONTRACTOR under this Agreement, HSD/MAD will provide the CONTRACTOR with written notice of such claim or information.

ARTICLE 5 - COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE

5.1 HSD/MAD shall make payments under capitated risk contracts, which are actuarially sound. Rates shall be developed in accordance with generally accepted actuarial principles and practices. Rates must be appropriate for the populations to be covered, the services to be furnished under the contract and be certified as meeting the foregoing requirements by actuaries. The actuaries must meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. To the extent, if any, it is determined by the appropriate taxing authority that the performance of this Agreement by the CONTRACTOR is subject to taxation, the amounts paid by HSD/MAD to the CONTRACTOR under this Agreement shall include such tax(es). The CONTRACTOR is responsible for reporting and remitting all applicable taxes to the appropriate taxing agency.

5.2 The PARTIES to this contract understand and agree that the compensation and payment reimbursement for managed care is dependent upon Federal and State funding and regulatory approvals. The Parties further understand that program changes effecting the rate of compensation for managed care are likely to occur during the term of this contract and further agree to the following if such program changes are implemented by HSD/MAD during the term of this contract:

In the event that HSD/MAD initiates a programmatic change effecting compensation and payment reimbursement for managed care during the term of this contract, HSD/MAD shall, prior to initiating any such change, provide the CONTRACTOR with as much notice as is possible, given the circumstance, of the contemplated change and the effect it will have on compensation and payment reimbursement for managed care.

Upon notice of a proposed program change, benefit modification, or a final judicial decision affecting reimbursement rates, the CONTRACTOR may initiate negotiations for a modification of the contract concerning changes in compensation and payment reimbursement for managed care and program changes, as provided in the notice from HSD/MAD. Such programmatic changes and any resulting negotiations and modifications shall be limited to the change in compensation and payment reimbursement for managed care and program changes, and shall not subject the entire contract to being reopened as provided for in Article 12 or 36.

If the CONTRACTOR does not request negotiations for a modification of the contract concerning the change in compensation and payment reimbursement for managed care and program changes, within fifteen (15) working days of the notice from HSD/MAD,

then the change shall be implemented and become effective under Article 36 of this contract.

5.3 Payment for Services

(1) HSD/MAD shall pay a capitated amount to the CONTRACTOR for the provision of the managed care benefit package at the rates specified below. The monthly rate for each member is based on actuarially sound capitation rate cells. Medicaid members shall be held harmless against any liability for debts of a CONTRACTOR that were incurred within the Agreement in providing covered services to the Medicaid member.

(2) If a member loses eligibility for any reason and is reinstated as eligible by HSD/MAD before the end of the month, the CONTRACTOR must accept a retro capitation payment for that month of eligibility and assume financial responsibility for all services supplied to the member. HSD/MAD must notify the CONTRACTOR of this retro capitation by the last day of the month. If this notification is not made by the last day of the month, the CONTRACTOR may choose to refuse the retro capitation.

(3) HSD/MAD shall pay each CONTRACTOR an additional payment for each enrolled Native American identified in HSD/MAD's system. This additional payment is to be used to cover medical costs of Native Americans provided at Indian Health Service (IHS) and tribal 638 facilities. The Native American payment (supplemental payment) amount is established by HSD/MAD. The supplemental payment amounts are subject to revision based upon an actuarial review. These payments are cost neutral to the CONTRACTOR. Any payment made to an IHS facility or tribal 638 facility beyond the amount of the supplemental capitation shall be reimbursed by HSD/MAD. Any payment made by HSD/MAD that is not expended to the above identified facilities shall be recouped from the CONTRACTOR.

(4) Medicaid and SCHIP members shall be held harmless against any liability for debts of the CONTRACTOR which were incurred within the Agreement in providing health care to the Medicaid or SCHIP member, excluding any member's liability for co-payments or member's liability for an overpayment resulting from benefits paid pending the results of a fair hearing. The CONTRACTOR has no obligation to continue to see members for treatment if the member fails to meet co-payment obligations.

(5) 42 CFR Section 438.6(c), which regulates participation in the Medicaid program, requires that all payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound and approved as such by the Centers for Medicare and Medicaid Services (CMS) prior to implementation. To meet the requirement for actuarial soundness, all capitation rates must be certified by an actuary meeting the qualification standards of the American Academy of Actuaries following generally accepted actuarial principles, as set forth in the standards of practice established by the Actuarial Standards Board. Accordingly, HSD/MAD's offer of all capitation rates referred to in the attached Schedule of this contract is contingent on both certification by HSD/MAD's actuary and final approval by CMS, prior to becoming effective for payment purposes. In the event such certification or approval is not obtained for any or all capitation rates subject to this regulation, HSD/MAD reserves the right to renegotiate these rates. HSD/MAD's decision to renegotiate the rates under the circumstances described above is binding on the CONTRACTOR.

5.4 Payment on Risk Basis

The CONTRACTOR is at risk of incurring losses if its expenses for providing the managed care benefit package exceed its capitation payment. HSD/MAD shall not provide a retroactive payment adjustment to the CONTRACTOR to reflect the cost of services actually furnished by the CONTRACTOR. The CONTRACTOR may retain its profits.

5.5 Changes in the Capitation Rates

(1) The capitation rates awarded with this RFP shall be effective for the time period shown on the attached rate sheet. The term of the contract signed as a result of this RFP is for a four (4)-year period. HSD/MAD reserves the option of amending the initial contract. In no case shall the contracts exceed a total of four (4) years in duration. HSD/MAD reserves the right to renegotiate the rate for years two (2), three (3) and four (4) of these contracts if necessary. Upon mutual agreement of the CONTRACTOR and HSD/MAD, the capitation rates may be adjusted based on factors such as changes in the scope of work, CMS requiring a modification of the HSD/MAD's waiver if new or amended Federal or State laws or regulations are implemented, inflation, significant changes in the demographic characteristics of the member population, or the disproportionate enrollment selection of the CONTRACTOR by members in certain rate cohorts. Any changes to the rates shall be actuarially sound and negotiated and implemented pursuant to Articles 12 (Contract Modification) and 36 (Amendments) of this Agreement.

(2) HSD/MAD shall compensate the CONTRACTOR for work performed under this Agreement at the following rates shown on Attachments A.

(3) The CONTRACTOR shall obtain reinsurance for coverage of members as required by this Agreement. However, the CONTRACTOR remains ultimately liable to HSD/MAD for the services rendered under the terms of this Agreement. The CONTRACTOR shall provide a copy of its proposed reinsurance agreement with its response to the RFP.

5.6 Procedures

(1) HSD/MAD shall distribute an aggregate amount to the CONTRACTOR for all members enrolled with the CONTRACTOR on or before the second Friday of each month.

(2) Until a newborn receives a separate member identifier from HSD/MAD, the CONTRACTOR shall submit a payment request to HSD/MAD for the newborn member. HSD/MAD shall pay the CONTRACTOR the monthly rate for the newborn after receipt and verification of the claim by HSD/MAD.

(3) HSD/MAD shall make a full monthly payment to the CONTRACTOR for the month in which the member’s enrollment is terminated. The CONTRACTOR shall be responsible for covered medical services provided to the member in any month for which HSD/MAD paid the CONTRACTOR for the member’s care under the terms of this Agreement.

(4) HSD/MAD shall have the discretion to recoup payments made by HSD/MAD pursuant to the time periods governed by this Agreement for members who are incorrectly enrolled with more than one CONTRACTOR, including members categorized as newborns or X5; payments made for members who die prior to the enrollment month for which payment was made; and/or payments for members whom HSD/MAD later determines were not eligible for Medicaid during the enrollment month for which payment was made. HSD/MAD periodically will recoup capitations from the CONTRACTOR for individuals who should not have been enrolled with the CONTRACTOR. If the CONTRACTOR has incurred provider expense during any of the months to be recouped by HSD/MAD, reconciliation will be done comparing the CONTRACTOR’S medical expense to the recoupment for that member. Any funds remaining after incurred expense will be recouped. If no expense has been incurred, the entire capitation will be recouped by HSD/MAD. To allow for claim submission lags, HSD/MAD will not request a payment recoupment until one hundred and twenty (120) days have

elapsed from the date on which the enrollment/claims payment error was made. In the event of an error, which causes payment(s) to the CONTRACTOR to be issued by HSD/MAD, the CONTRACTOR shall reimburse HSD/MAD within thirty (30) days of written notice of such error for the full amount of the payment, subject to the provision of Section 5.6(4) of the agreement. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the thirtieth (30th) day following the notice. Any process that automates the recoupment procedures will be mutually agreed upon in advance by HSD/MAD and the CONTRACTOR and documented in writing, prior to implementation of a new automated recoupment process. The CONTRACTOR has the right to dispute any recoupment requests in accordance with Article 15 (DISPUTES).

(5) With the exception of newborns born while the mother is an enrolled member, HSD/MAD is responsible for payment of all inpatient facility and professional services provided from the date of admission until the date of discharge, if a member is hospitalized at the time of enrollment.

(6) If the member is hospitalized at the time of disenrollment, the CONTRACTOR shall be responsible for payment of all covered acute inpatient facility and professional services from the date of admission to the date of discharge. The CONTRACTOR shall be responsible for coverage of such services until the member is discharged from the hospital. The CONTRACTOR shall be responsible for ensuring proper transition of care if the reason for disenrollment is the member's selection of a different CONTRACTOR.

(7) If a member is in a nursing home at the time of disenrollment (not including loss of Medicaid eligibility), the CONTRACTOR shall be responsible for payment of all covered services until the date of discharge or the time the nature of the member's care ceases to be sub acute or skilled nursing care, whichever first occurs. The CONTRACTOR shall be responsible for ensuring proper transition of care if the reason for disenrollment is the member's selection of a different CONTRACTOR.

(8) On a periodic basis, HSD/MAD shall provide the CONTRACTOR with coordination of benefits information for enrolled members. The CONTRACTOR shall:

A. not refuse or reduce services provided under this Agreement solely due to the existence of similar benefits provided under other health care contracts;

B. have the sole right of subrogation, for twelve (12) months, to initiate recovery or to attempt to recover any third-party resources available to Medicaid members and shall make records pertaining to Third Party Collections (TPL) for members available to HSD/MAD for audit and review;

C. notify HSD/MAD as set forth below when the CONTRACTOR learns (not identified in enrollment roster) that a member has TPL for medical care:

i. within fifteen (15) working days when a member is verified as having dual coverage under its managed care organization; and

ii. within sixty (60) calendar days when a member is verified as having coverage with any other managed care organization or health carrier.

D. communicate and ensure compliance with the requirements of this section by subcontractors that provide services under the terms of this Agreement;

E. not charge members for services covered under the terms of this Agreement, except as provided in the MAD Provider Policy Manual Section MAD-701.7, ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS; and

F. deny payments provided for under this Agreement for new members when, and for so long as, payment for those members is denied under 42 CFR Section 438 Subpart I.

(9) Except as provided in Section 5.6 (4), in those instances where a duplicate payment is identified either by the CONTRACTOR or HSD/MAD, HSD/MAD retains the ability to recoup these payments within time periods allowed by law.

5.7 Special Payment Requirements

This section lists special payment requirements by provider type:

(1) Reimbursement of Federally Qualified Health Centers (FQHCs)

FQHCs are reimbursed at one hundred percent (100 %) of reasonable cost under a Medicaid fee-for-service or managed care program. The FQHC can waive its right to reasonable cost and elect to receive the rate negotiated with the CONTRACTOR. During the course of the contract negotiations with the CONTRACTOR, the FQHC shall state explicitly that it elects to receive one hundred percent (100%) of reasonable costs or waive this requirement.

(2) Reimbursement for Providers Furnishing Care to Native Americans

If an Indian Health Service (IHS), or tribal 638 provider delivers services to the CONTRACTOR'S member who is a Native American, the CONTRACTOR shall reimburse the provider at the rate currently established for the IHS facilities or federally leased facilities by the Office of Management and Budget (OMB), or by Medicaid, or at a fee negotiated between the provider and the CONTRACTOR.

(3) Reimbursement for Family Planning Services

The CONTRACTOR shall reimburse out-of-network family planning providers for provision of services to CONTRACTOR members at a rate, which at a minimum equals the applicable Medicaid fee-for-service rate appropriate to the provider type.

(4) Reimbursement for Women in the Third Trimester of Pregnancy

If a pregnant woman in the third trimester of pregnancy has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not participating with the CONTRACTOR, the CONTRACTOR shall reimburse the nonparticipating provider at the applicable Medicaid fee-for-service rate appropriate to the provider type.

(5) Reimbursement for Newborns

The CONTRACTOR is responsible for providing services for the first two months of life to a newborn who is born to an enrolled mother. The CONTRACTOR shall make best efforts to assist the mother with the enrollment of the newborn in the Medicaid system. The CONTRACTOR has six months to inform HSD/MAD that they have provided services to a newborn that has not been included on their roster. HSD/MAD shall be responsible to reimburse the CONTRACTOR for the first two months of life regardless of whether or not the member enrolls the newborn in the Medicaid system.

5.8 Reimbursement for Emergency Services

(1) The CONTRACTOR shall ensure that acute general hospitals are reimbursed for emergency services, which they provide because of federal mandates such as the "anti-dumping" law in the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 and 42 U.S.C. Section 1395 dd (Section 1867 of the Social Security Act).

(2) If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the patient.

(3) The CONTRACTOR is required to pay for all emergency and post stabilization care services that are medically necessary until the emergency medical condition is stabilized and maintained such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during discharge of the patient or transfer of the patient to another facility.

(4) If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR shall review the presenting symptoms of the member and shall pay for all services involved in the screening examination where the present symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard. If the member believes that a claim for emergency services has been inappropriately denied by the CONTRACTOR, the member may seek recourse through the CONTRACTOR or HSD/MAD appeal process.

(5) When the member's primary care physician or other CONTRACTOR representative instructs the member to seek emergency care in network or out of network, the CONTRACTOR is responsible for payment at least at the in network rate, for the medical screening examination and for other medically necessary emergency services, intended to medically stabilize the patient without regard to whether the member meets the prudent layperson standard.

5.9 The CONTRACTOR shall accept the capitation rate paid each month by the HSD/MAD as payment in full for all services to be provided pursuant to this Agreement, including all administrative costs associated therewith. A minimum of eighty-five percent (85%) of all the CONTRACTOR'S income generated under this Agreement, including but not

limited to Third Party Recoupments and Interest, shall be expended on the medical health services required under this Agreement to be provided to the CONTRACTOR’S Medicaid members. If the CONTRACTOR does not expend a minimum of eighty-five percent (85%) on medical health services of the Agreement, HSD/MAD will withhold an amount so that the CONTRACTOR’S ratio for service expenditures are eighty-five percent (85%). HSD/MAD will calculate the CONTRACTOR’S income at the end of the State Fiscal Year to determine if eighty-five percent (85%) was expended on the medical health services required under the contract utilizing reported information and the Department of Insurance Reports. Administrative costs, to be no higher that fifteen percent (15%), including administrative expenses for all CONTRACTOR-delegated entities and other financial information will be monitored on a regular basis by HSD/MAD. Upon mutual agreement of the parties, this requirement may be renegotiated pursuant to Article 12 due to revision of governmental or regulatory costs, taxes or fees. The following are HSD/MAD’s designated administrative expense functions:

(1) network development and contracting;

(2) direct provider contracting;

(3) credentialing/re-credentialing;

(4) information systems;

(5) encounter data collection and submission;

(6) claims processing for select contractors;

(7) Consumer Advisory Board;

(8) Member Services;

(9) training and education for providers and consumers;

(10) financial reporting;

(11) licenses;

(12) taxes;

(13) plant expenses;

(14) staff travel;

(15) legal and risk management;

(16) recruiting and staff training;

(17) salaries and benefits;

(18) supplies, non-medical;

(19) purchased service, non-medical;

(20) depreciation and amortization;

(21) audits;

(22) grievances and appeals;

(23) capital outlay;

(24) reporting and data requirements;

(25) compliance;

(26) profit;

(27) care coordination;

(28) surveys;

(29) quality Assurance;

(30) quality improvement/quality management; and

(31) marketing.

Members shall be entitled to receive all covered services for the entire period for which payment has been made by HSD/MAD. Any and all costs incurred by the CONTRACTOR in excess of the capitation payment will be borne in full by the CONTRACTOR. Interest generated through investment of funds paid to the

CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR.

ARTICLE 6 - CONTRACT ADMINISTRATOR

The Contract Administrator is, and his/her successor shall be, designated by the Secretary of HSD/MAD. HSD/MAD shall notify the CONTRACTOR of any changes in the identity of the Contract Administrator. The Contract Administrator is empowered and authorized as the agent of HSD/MAD to represent HSD/MAD in all matters related to this Agreement except those reserved to other HSD/MAD personnel by the Agreement. Notwithstanding the above, the Contract Administrator does not have the authority to amend the terms and conditions of this Agreement. All events, problems, concerns or requests affecting this Agreement shall be reported by the CONTRACTOR to the Contract Administrator

ARTICLE 7 - - CONTRACTOR PERSONNEL

7.1 The CONTRACTOR warrants and represents that it shall assign sufficient employees to the performance of this Agreement to meet all aspects of its performance as represented by the CONTRACTOR to HSD/MAD in its proposal.

7.2 Replacement of any CONTRACTOR personnel shall be with personnel of equal ability, experience, and qualifications.

7.3 HSD/MAD reserves the right to require the CONTRACTOR to make changes in its staff assignments if the assigned staff is/are not, in the opinion of HSD/MAD, meeting the needs of Medicaid members or the needs of HSD/MAD in implementing and enforcing the terms of this Agreement, provided that such CONTRACTOR staff changes shall comport with the CONTRACTOR'S personnel policies.

7.4 The CONTRACTOR may not have an employment, consulting or other agreement with a person who has been convicted of crimes specified in Section 1128 of the Social Security Act for the provision of items and services that are significant and material to the entity's obligations under the Agreement.

ARTICLE 8 - ENFORCEMENT

8.1 HSD/MAD Sanctions

(1) Unless otherwise required by law, the level or extent of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to (or incurred by) members or to the integrity of the Medicaid program.

(2) If the Secretary of HSD/MAD or his/her designee determines, after notice and opportunity by the CONTRACTOR to be heard in accordance with Article 15, that the CONTRACTOR or any agent or employee of the CONTRACTOR, or any persons with an ownership interest in the CONTRACTOR, or related party of the CONTRACTOR, has or have failed to comply with any applicable law, regulation, term of this Agreement, policy, standard, rule, or for other good cause, the Secretary of HSD/MAD may impose any or all of the following in accordance with applicable law.

A. <u>Plans of Correction:</u> The CONTRACTOR shall be required to provide to HSD/MAD, within fourteen (14) days, a plan of correction to remedy any defect in its performance.

B. <u>Directed Plans of Correction:</u> The CONTRACTOR shall be required to provide to HSD/MAD, within fourteen (14) days, a response to the directed plan of correction as directed by HSD/MAD.

C. <u>Civil or Administrative Monetary Penalties:</u> HSD/MAD may impose upon the CONTRACTOR civil or administrative monetary penalties to the extent authorized by Federal or State law.

i. HSD/MAD retains the right to apply progressively strict sanctions against the CONTRACTOR, including an assessment of a monetary penalty against the CONTRACTOR, for failure to perform in any contract areas.

ii. Unless otherwise required by law, the level of extent of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to or incurred by members or to the integrity of the Medicaid program. HSD/MAD shall impose liquidated damages consistent with letter J of this Article.

iii. The limit on, or specific amount of, civil monetary penalties that HSD/MAD may impose upon the CONTRACTOR varies, depending upon the nature and severity of the CONTRACTOR'S action or failure to act, as specified below:

(a) a maximum of twenty-five thousand dollars ($25,000) for each of the following determinations: failure to provide medically necessary services; misrepresentation or false

statements to members, potential members, or health care provider(s); or failure to comply with physician incentive plan requirements and marketing violations;

(b) a maximum of one hundred thousand dollars ($100,000) for each of the following determinations: for discrimination or for misrepresentation or false statements to HSD/MAD or CMS;

(c) a maximum of fifteen thousand dollars ($15,000) for each member HSD/MAD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice. This is subject to an overall limit of one hundred thousand dollars ($100,000) under (b) above; and

(d) a maximum of twenty-five thousand dollars ($25,000) or double the amount of excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the Medicaid program. HSD/MAD will deduct from the penalty the amount of overcharge and return it to the affected member(s).

iv. Any withholding of capitation payments in the form of a penalty assessment does not constitute just cause for the CONTRACTOR to interrupt services provided to members.

v. Any withholding of monthly capitation payments in the form of a penalty assessment may not exceed five percent (5%) of the entire monthly capitation payment made to the CONTRACTOR.

vi. All other administrative, contractual or legal remedies available to HSD/MAD shall be employed in the event that the CONTRACTOR violates or breaches the terms of the Agreement.

D. Adjustment of Automated Assignment Formula: HSD/MAD may selectively assign members who have not selected a CONTRACTOR to an alternative CONTRACTOR in response to the CONTRACTOR'S failure to fulfill its duties.

E. Suspension of New Enrollment: HSD/MAD may suspend new enrollment to the CONTRACTOR.

F. Appointment of a State Monitor: Should HSD/MAD be required to appoint a State monitor to assure the CONTRACTOR'S performance, the CONTRACTOR shall bear the reasonable cost of the State intervention.

G. Payment Denials: HSD/MAD may deny payment for all members or deny payment for new members.

H. Rescission: HSD/MAD may rescind marketing consent.

I. Actual Damages: HSD/MAD may assess to the CONTRACTOR actual damages to HSD/MAD or its members resulting from the CONTRACTOR'S non-performance of its obligations.

J. Liquidated Damages: HSD/MAD may pursue liquidated damages in an amount equal to the costs of obtaining alternative health benefits to the member in the event of the CONTRACTOR'S non-performance. The damages shall include the difference in the capitated rates that would have been paid to the CONTRACTOR and the rates paid to the replacement health plan. HSD/MAD may withhold payment to the CONTRACTOR for liquidated damages until such damages are paid in full.

K. Removal: HSD/MAD may remove members with third-party coverage from enrollment with the CONTRACTOR.

L. Temporary Management:

i. Optional imposition of sanction. HSD/MAD may impose temporary management to oversee the operations of the CONTRACTOR upon a finding by the Secretary of HSD/MAD that there is continued egregious behavior by the CONTRACTOR, including but not limited to, behavior that is described in 42 CFR Section 438.700, or that is contrary to any requirements of 42 USC, Sections 42 USC 1396b (m) or 1396u-2; there is substantial risk to member's health; or the sanction is necessary to ensure the health of the CONTRACTOR'S members while improvement is made to remedy violations under 42 CFR Section 438.700; or until there is an orderly termination or reorganization of the CONTRACTOR.

ii. The CONTRACTOR does not have the right to a predetermination hearing prior to the appointment of temporary management if the conditions above are not met.

iii. Required imposition of sanction. HSD/MAD shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in 42 USC Sections 1396b (m) or 1396u-2 or 42 CFR 438, Subpart I (Sanctions).

iv. Hearing. HSD/MAD shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

v. Duration of Sanction. HSD/MAD shall not terminate temporary management until it determines that the CONTRACTOR can ensure that the sanctioned behavior will not recur.

M. Terminate Enrollment: HSD/MAD shall grant members the right to terminate enrollment without cause as described in 42 CFR Section 438.702 (a) (3), and shall notify the affected members of their right to terminate enrollment.

N. Impose Penalty: HSD/MAD may impose an administrative penalty of not more than five thousand dollars ($5,000) each for engaging in any practice described in Section B of the Medicare Provider Act.

O. Intermediate Sanctions: HSD/MAD may issue an intermediate sanction in the form of administrative order requiring the CONTRACTOR to cease or modify any specified conduct or practice engaged in by it or its employees, subcontractors or agents to fulfill its contractual obligations in the manner specified in the order; to provide any services that have been denied or take steps to provide or arrange for the provision of any services that it has agreed to or is otherwise obligated to make available.

i. Basis for imposition of Sanctions: HSD/MAD will impose the foregoing sanctions if HSD/MAD determines that the CONTRACTOR acts or fails to act as follows:

(a) fails substantially to provide medically necessary services and items that the CONTRACTOR is required to provide, under law or under its contract with HSD/MAD, to a member covered under the contract;

(b) imposes on members' premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(c) acts to discriminate among members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a member, except as permitted by the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by members whose medical condition or history indicate probable need for substantial future medical services;

(d) intentionally misrepresents or falsifies information that it furnishes to HSD/MAD or CMS;

(e) intentionally misrepresents or falsifies information that it furnishes to a member, potential member, or health care provider;

(f) fails to comply with Federal requirements for physician incentive plans, including disclosures;

(g) has distributed directly, or becomes aware of material distributed indirectly through any agent or independent subcontractor, marketing materials that have not been approved by HSD/MAD or that contain false or materially misleading information; or

h) fails to perform in any other contract areas.

ii. HSD/MAD's determination of any of the above may be based on findings from onsite reviews; surveys or audits; member or other complaints; financial status; or any other source.

iii. HSD/MAD retains authority to impose additional sanctions under state statutes or state regulations that address areas of noncompliance specified in 42 CFR Section 438.700, as well as additional areas of noncompliance.

iv. Intermediate Sanctions: The Secretary of HSD/MAD or designee shall impose upon the CONTRACTOR any of the following intermediate sanctions:

(a) civil monetary penalties in the amounts specified in the 42 CFR Section 438.704;

(b) appointing temporary management for the CONTRACTOR or a State Monitor as provided in 42 CFR Section 438.706;

(c) granting members the right to terminate enrollment without cause (affected members will be notified by HSD/MAD of their right to disenroll);

(d) suspending all new enrollment, including default enrollment after the effective date of sanction; and

(e) suspending of payment for members enrolled after the effective date of the sanction until HSD/MAD or CMS is satisfied that the reason for imposing the sanction no longer exists and is not likely to recur.

P. Suspension: HSD/MAD may suspend the Agreement.

Q. Termination: The Secretary of HSD/MAD or the designee has the authority to terminate the contract and enroll the CONTRACTOR'S members in another MCO or other MCOs, or provide their Medicaid benefits through other options included in the State plan, if HSD/MAD determines that the CONTRACTOR has failed to do either of the following:

i. carry out the substantive terms of its contract; or

ii. meet applicable requirements in Sections 1932, 1903 (m), and 1905 of the Social Security Act.

R. Notice of Sanction: Except as provided in this Article regarding Temporary Management, before imposing any of the intermediate sanctions specified, HSD/MAD must give the CONTRACTOR timely written notice that explains the basis and nature of the sanction and any other due process protections that HSD/MAD elects to provide.

i. Pre-termination hearing: Before terminating the contract, HSD/MAD must provide the CONTRACTOR a pre-termination hearing, which consist of the following procedures:

(a) HSD/MAD shall give the CONTRACTOR written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing;

(b) after the hearing, HSD/MAD shall give the CONTRACTOR written notice of the decision affirming or reversing the proposed-termination of the contract and, for an affirming decision, the effective date of termination;

(c) for an affirming decision, give members of the CONTRACTOR notice of the termination and information, consistent with their options for receiving Medicaid services following the effective date of termination; and

(d) the pre-termination hearing procedures shall proceed according to Section 15.3 (Dispute Procedures) of the Agreement.

ii. HSD/MAD will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in Section 8.1.(2).O. of this Article. The notice will be given no later than thirty (30) days after HSD/MAD imposes or lifts a sanction; and must specify the affected CONTRACTOR, the kind of sanction, and the reason for HSD/MAD's decision to impose or lift the sanction.

8.2 Federal Sanctions

(1) Section 1903 (m)(5)(A) and (B) of the Social Security Act vests the Secretary of HHS with the authority to deny Medicaid payments to a health plan for members who enroll after the date on which the health plan has been found to have committed one of the violations set forth in the Agreement. State payments for the CONTRACTOR'S members are automatically denied whenever, and for so long as, Federal payment for such members has been denied as a result of the

commission of such violations. The following violations can trigger denial of payment pursuant to section 1903(m)(5) of the Social Security Act:

A. substantial failure to provide required medically necessary items or services when the failure has adversely affected or has substantial likelihood of adversely affecting a member;

B. imposition of premiums on Medicaid members in excess of permitted premiums;

C. discrimination among Medicaid beneficiaries with respect to enrollment, re-enrollment, or disenrollment on the basis of Medicaid beneficiaries' health status or requirements for health care services;

D. misrepresentation or falsification of certain information; or

E. failure to cover emergency services under Section 1932(b)(2) of the Social Security Act when the failure affects or has a substantial likelihood of adversely affecting a member.

(2) HSD/MAD may also deny payment if HSD/MAD learns that a CONTRACTOR subcontracts with an individual provider, an entity, or an entity with an individual who is an officer, director, agent or manager or person with more than five percent (5%) of beneficial ownership of an entity's equity, that has been convicted of crimes specified in the Section 1128 of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

(3) HSD/MAD shall notify the Secretary of Health and Human Services of noncompliance with subparagraph A. above. HSD/MAD may allow continuance of the Agreement unless the Secretary directs otherwise but may not renew or otherwise extend the duration of the existing Agreement with the CONTRACTOR unless the Secretary provides to HSD/MAD and Congress a written statement describing the compelling reasons that exist for renewing and extending the Agreement.

(4) This section is subject to the "Non-exclusivity of Remedy" language below.

8.3 Notice and Cure

HSD/MAD shall provide reasonable written notice of its decision to impose sanctions on the CONTRACTOR and, as HSD/MAD may deem necessary and proper, subsequently to members and others who may be directly interested. Such written notice shall set forth the effective date and the reason(s) for the sanctions. Prior to imposing sanctions, HSD/MAD shall afford the CONTRACTOR a reasonable opportunity to cure, unless such opportunity would result in immediate harm to members, or the improper diversion of Medicaid program funds.

8.4 Non-exclusivity of Remedy

The provisions of this Article supplement, rather than replace, any other sanctions or remedies available to the HSD/MAD under the provisions of this Agreement or of applicable law or regulations.

8.5 CONTRACTOR'S Incentive Requirements

HSD/MAD may provide incentives to the CONTRACTOR that receives exceptional grading during the procurement process and for ongoing performance under the Agreement for quality assurance standards, performance indicators, enrollment processing, fiscal solvency, access standards, encounter data submission, reporting requirements, Third Party Liability collections and marketing plan requirements as determined by HSD/MAD by automatically assigning a greater number of members to the CONTRACTOR determined by HSD/MAD to warrant greater assignments of such Medicaid recipients.

ARTICLE 9 - TERMINATION

9.1 All terminations shall be effective at the end of a month, unless otherwise specified in this Article. This Agreement may be terminated under the following circumstances:

(1) by mutual written agreement of HSD/MAD and the CONTRACTOR upon such terms and conditions as they may agree;

(2) by HSD/MAD for convenience, upon not less than one hundred and eighty (180) days written notice to the CONTRACTOR;

(3) this Agreement shall terminate on the Agreement termination date. The CONTRACTOR shall be paid solely for services provided prior to the termination date. The CONTRACTOR is obligated to pay all claims for all dates of service

prior to the termination date. In the event of the Agreement termination date or if the CONTRACTOR terminates this Agreement prior to the Agreement termination date, and, if a member is hospitalized at the time of termination, the CONTRACTOR shall be responsible for payment of all covered inpatient facility and professional services from the date of admission to the date of discharge. Similarly, in the event of the Agreement termination date or if the CONTRACTOR terminates this Agreement prior to the Agreement termination date and a member is in a nursing home at the time of termination, the CONTRACTOR shall be responsible for payment of all covered services from the date of admission until the date of discharge or the time the nature of the member's care ceases to be sub acute or skilled nursing care, whichever occurs first. In the event that HSD/MAD terminates this Agreement prior to the agreement termination date and a member is hospitalized at the time of termination, the CONTRACTOR shall be responsible for payment of all covered inpatient facility and professional services from the date of admission to sixty (60) days after the effective date of termination. Similarly, in the event that HSD/MAD terminates this Agreement prior to the Agreement termination date, and a member is in a nursing home at the time of the effective date of termination the CONTRACTOR shall be responsible for payment of all covered services until sixty (60) days after the effective date of termination or the time the nature of the member's care ceases to be sub acute or skilled nursing care, whichever occurs first;

(4) by HSD/MAD for cause upon failure of the CONTRACTOR to materially comply with the terms and conditions of this Agreement. HSD/MAD shall give the CONTRACTOR written notice specifying the CONTRACTOR'S failure to comply. The CONTRACTOR shall correct the failure within thirty (30) days or begin in good faith to correct the failure and thereafter proceed diligently to complete or cure the failure. If within thirty (30) days the CONTRACTOR has not initiated or completed corrective action, HSD/MAD may serve written notice stating the date of termination and work stoppage arrangements;

(5) by HSD/MAD, if required by modification, change, or interpretation in State or Federal law or CMS waiver terms, because of court order, or because of insufficient funding from the Federal or State government(s), if Federal or State appropriations for Medicaid managed care are not obtained, or are withdrawn, reduced, or limited, or if Medicaid managed care expenditures are greater than anticipated such that funds are insufficient to allow for the purchase of services as required by this Agreement. HSD/MAD's decision as to whether sufficient funds are available shall be accepted by the CONTRACTOR and shall be final;

(6) by HSD/MAD, in the event of default by the CONTRACTOR, which is defined as the inability of the CONTRACTOR to provide services described in this Agreement or the CONTRACTOR'S insolvency. With the exception of termination due to insolvency, the CONTRACTOR shall be given thirty (30) days to cure any such default, unless such opportunity would result in immediate harm to members or the improper diversion of Medicaid program funds;

(7) by HSD/MAD, in the event of notification by the Public Regulation Commission or other applicable regulatory body that the certificate of authority under which the CONTRACTOR operates has been revoked, or that it has expired and shall not be renewed;

(8) by HSD/MAD, in the event of notification that the owners or managers of the CONTRACTOR, or other entities with substantial contractual relationship with the CONTRACTOR, have been convicted of Medicare or Medicaid fraud or abuse or received certain sanctions as specified in section 1128 of the Social Security Act;

(9) by HSD/MAD, in the event it determines that the health or welfare of Medicaid members is in jeopardy should the Agreement continue. For purposes of this paragraph, termination of the Agreement requires a finding by HSD/MAD that a substantial number of members face the threat of immediate and serious harm;

(10) by HSD/MAD, in the event of the CONTRACTOR'S failure to comply with the composition of enrollment requirement contained in 42 C.F.R. Section 434.26 and the Scope of Work. The CONTRACTOR shall be given fourteen (14) days to cure any such enrollment composition requirement, unless such opportunity would violate any federal law or regulation;

(11) by HSD/MAD in the event a petition for bankruptcy is filed by or against the CONTRACTOR;

(12) by HSD/MAD if the CONTRACTOR fails substantially to provide medically necessary items and services that are required under this Agreement;

(13) by HSD/MAD, if the CONTRACTOR discriminates among members on the basis of their health status or requirements for health services, including expulsion or refusal to reenroll a member, except as permitted by this Agreement and Federal law, or for engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the CONTRACTOR by the

eligible member or by members whose medical condition or history indicates a need for substantial future medical services;

(14) by HSD/MAD, if the CONTRACTOR intentionally misrepresents or falsifies information that is furnished to the Secretary of Health and Human Services, HSD/MAD or Medicaid members, potential members or health care providers under the Social Security Act or pursuant to this Agreement;

(15) by HSD/MAD, if the CONTRACTOR fails to comply with applicable physician incentive prohibitions of Section 1903(m)(2)(A)(x) of the Social Security Act;

(16) by the CONTRACTOR, on at least sixty (60) days prior written notice, in the event HSD/MAD fails to pay any amount due the CONTRACTOR hereunder within thirty (30) days of the date such payments are due;

(17) by the CONTRACTOR, on at least sixty (60) days prior written notice, in the event that HSD/MAD is unable to make future payments of undisputed capitation payments due to a lack of a state budget or legislative appropriation; and

(18) by either party, upon ninety (90) days written notice, in the event of a material change in the Medicaid managed care program, regardless of the cause of or reason for such change, if the parties after negotiating in good faith are unable to agree on the terms of an amendment to incorporate such change.

9.2 If HSD/MAD terminates this Agreement pursuant to this Article and unless otherwise specified in this Article, HSD/MAD shall provide the CONTRACTOR written notice of such termination at least sixty (60) days prior to the effective date of the termination, unless HSD/MAD itself receives less than sixty (60) days notice, in which case HSD/MAD shall provide the CONTRACTOR with as much notice as possible, but in no event less than sixty (60) days notice. If HSD/MAD determines a reduction in the scope of work is necessary, it shall notify the CONTRACTOR and proceed to amend this Agreement pursuant to its provisions.

9.3 By termination pursuant to this Article, neither party may nullify obligations already incurred for performance of services prior to the date of notice or, unless specifically stated in the notice, required to be performed through the effective date of termination. Any agreement or notice of termination shall incorporate necessary transition arrangements.

ARTICLE 10 - TERMINATION AGREEMENT

10.1 When HSD/MAD has reduced to writing and delivered to the CONTRACTOR a notice of termination, the effective date, and reasons therefore, if any, HSD/MAD, in addition to other rights provided in this Agreement, may require the CONTRACTOR to transfer, deliver, and/or make readily available to HSD/MAD, property in which HSD/MAD has a financial interest. Prior to invoking the provisions of this paragraph, HSD/MAD shall identify that property in which it has a financial interest, provided that, subject to HSD/MAD's recoupment rights herein, property acquired with capitation or other payments made for members properly enrolled shall not be considered property in which HSD/MAD has a financial interest.

10.2 In the event this Agreement is terminated by HSD/MAD, immediately as of the notice date, the CONTRACTOR shall:

(1) incur no further financial obligations for materials, services, or facilities under this Agreement, without prior written approval of HSD/MAD;

(2) terminate all purchase orders or procurements and subcontracts and stop all work to the extent specified in the notice of termination, except as HSD/MAD may direct for orderly completion and transition;

(3) agree that HSD/MAD is not liable for any costs of the CONTRACTOR arising out of termination unless the CONTRACTOR establishes that the Agreement was terminated due to HSD/MAD's negligence, wrongful act, or breach of the Agreement;

(4) take such action as HSD/MAD may reasonably direct, for protection and preservation of all property and all records related to and required by this Agreement;

(5) cooperate fully in the closeout or transition of any activities so as to permit continuity in the administration of HSD/MAD programs; and

(6) allow HSD/MAD, its agents and representatives full access to the CONTRACTOR'S facilities and records to arrange the orderly transfer of the contracted activities. These records include the information necessary for the reimbursement of any outstanding Medicaid claims.

10.3 Dispute Procedure Involving Contract Termination Proceedings. In the event HSD/MAD seeks to terminate this Agreement with the CONTRACTOR, the CONTRACTOR may

appeal the termination directly to the HSD/MAD Secretary within ten (10) days of receiving HSD/MAD's termination notice and proceed as follows:

(1) the HSD/MAD Secretary shall acknowledge receipt of the CONTRACTOR'S appeal request within three (3) calendar days of the date the appeal request is received;

(2) the HSD/MAD Secretary will conduct a formal hearing on the contract termination issues raised by the CONTRACTOR;

(3) the CONTRACTOR and HSD/MAD, or its successor, shall be allowed to present evidence in the form of documents and testimony;

(4) the parties to the hearing are the CONTRACTOR and HSD/MAD, or its successor;

(5) the hearing shall be recorded by a court reporter paid for equally by HSD/MAD and the CONTRACTOR. Copies of transcripts of the hearing shall be paid by the party requesting the copies;

(6) the court reporter shall swear witnesses under oath;

(7) the HSD/MAD Secretary shall determine which party presents its issues first and shall allow both sides to question each other's witnesses in the order determined by the Secretary;

(8) the HSD/MAD Secretary may, but is not required, to allow opening statements from the parties before taking evidence;

(9) the HSD/MAD Secretary may, but is not required to, request written findings of fact, conclusions of law and closing arguments or any combination thereof. The Secretary may, but is not required to, allow oral closing argument only;

(10) the HSD/MAD Secretary shall render a written decision and mail the decision to the CONTRACTOR within sixty (60) days of the date the request for a hearing is received;

(11) HSD/MAD, or its successor, and the CONTRACTOR may be represented by counsel or another representative of choice at the hearing. The legal or other representatives shall submit a written request for an appearance with the Secretary within fifteen (15) days of the date of the hearing request;

(12) the civil rules of procedure and rules of evidence shall not apply, but the Secretary may limit evidence that is redundant or not relevant to the contract termination issues presented for review; and

(13) the Secretary's written decision shall be mailed by certified mail, postage prepaid, to the CONTRACTOR. Another copy of the decision shall be sent to the HSD/MAD director.

ARTICLE 11 - RIGHTS UPON TERMINATION OR EXPIRATION

11.1 Upon termination or expiration of this Agreement, the CONTRACTOR shall, upon request of HSD/MAD, make available to HSD/MAD, or to a person authorized by HSD/MAD, all records and equipment that are the property of HSD/MAD.

11.2 Upon termination or expiration, HSD/MAD shall pay the CONTRACTOR all amounts due for service through the effective date of such termination. HSD/MAD may deduct from amounts otherwise payable to the CONTRACTOR monies determined to be due HSD/MAD from the CONTRACTOR. Any amounts in dispute at the time of termination shall be placed by HSD/MAD in an interest-bearing escrow account with an escrow agent mutually agreed to by HSD/MAD and the CONTRACTOR.

11.3 In the event that HSD/MAD terminates the Agreement for cause in full or in part, HSD/MAD may procure services similar to those terminated and the CONTRACTOR shall be liable to HSD/MAD for any excess costs for such similar services for any calendar month for which the CONTRACTOR has been paid for providing services to Medicaid members. In addition, the CONTRACTOR shall be liable to HSD/MAD for administrative costs incurred by HSD/MAD in procuring such similar services. The rights and remedies of HSD/MAD provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

11.4 The CONTRACTOR is responsible for any claims from subcontractors or other providers, including emergency service providers, for services provided prior to the termination date. The CONTRACTOR shall promptly notify HSD/MAD of any outstanding claims which HSD/MAD may owe, or be liable for fee-for-service payment, which are known to the CONTRACTOR at the time of termination or when such new claims incurred prior to termination are received.

11.5 Any payments advanced to the CONTRACTOR for coverage of members for periods after the date of termination shall be promptly returned to HSD/MAD. For termination of an Agreement, which occurs mid-month, the capitation payments for that month shall

be apportioned on a daily basis. The CONTRACTOR shall be entitled to capitation payments for the period of time prior to the date of termination, and HSD/MAD shall be entitled to a refund for the balance of the month. All terminations shall include a final accounting of capitation payment received and number of members during the month in which termination is effective.

11.6 The CONTRACTOR shall ensure the orderly and reasonable transfer of member's care in progress, whether or not those members are hospitalized or in long-term treatment.

11.7 The CONTRACTOR shall be responsible to HSD/MAD for liquidated damages arising out of CONTRACTOR'S breach of this Agreement.

11.8 In the event HSD/MAD proves that the CONTRACTOR'S course of performance has resulted in reductions in HSD/MAD's receipt of Federal program funds, as a Federal sanction, the CONTRACTOR shall remit to HSD/MAD, as liquidated damages, such funds as are necessary to make HSD/MAD whole, but only to the extent such damages are caused by the actions of the CONTRACTOR. This provision is subject to Article 15, Disputes.

ARTICLE 12 - CONTRACT MODIFICATION

12.1 In the event that changes in Federal or State statute, regulation, rules, policy, or changes in Federal or State appropriation(s) or other circumstances require a change in the way HSD/MAD manages its Medicaid program, this Agreement shall be subject to substantial modification by amendment. Such election shall be effected by HSD/MAD sending written notice to the CONTRACTOR. HSD/MAD's decision as to the requirement for change in the scope of the program shall be final and binding.

12.2 The amendment(s) shall be implemented by Agreement renegotiation in accordance with Article 36, Amendment. In addition, in the event that approval of HSD/MAD's 1915(b) waiver is contingent upon amendment of this Agreement, the CONTRACTOR agrees to make any necessary amendments to obtain such waiver approval. Notwithstanding the foregoing, any material change in the cost to the CONTRACTOR of providing the services herein that is caused by CMS in granting the waiver shall be negotiated and mutually agreed to between HSD/MAD and the CONTRACTOR. The results of the negotiations shall be placed in writing in compliance with Article 36, (Amendment) of this Agreement.

ARTICLE 13 - INTELLECTUAL PROPERTY

13.1 In the event the CONTRACTOR shall elect to use or incorporate in the materials to be produced any components of a system already existing, the CONTRACTOR shall first notify HSD/MAD, who after investigation may direct the CONTRACTOR not to incorporate such components. If HSD/MAD shall not object, and after the CONTRACTOR obtains written consent of the party owning the same, and furnishing a copy to HSD/MAD, the CONTRACTOR may incorporate such components.

13.2 The CONTRACTOR warrants that all materials produced hereunder shall not infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the CONTRACTOR shall indemnify and hold HSD/MAD harmless from and against any loss, cost, liability, or expense arising out of breach or claimed breach of this warranty.

ARTICLE 14 - APPROPRIATIONS

14.1 The terms of this Agreement are contingent upon sufficient appropriations or authorizations being made by either the Legislature of New Mexico, the U.S. Department of Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS), or the U.S. Congress for the performance of this Agreement. If sufficient appropriations and authorizations are not made by either the Legislature, HHS/CMS or the Congress, this Agreement shall be subject to termination or amendment. Subject to the provisions of Article 27 of this Agreement, HSD/MAD's decision as to whether sufficient appropriations or authorizations exist shall be accepted by the CONTRACTOR and shall be final and binding. Any changes to the Scope of Work and compensation to CONTRACTOR affected pursuant to this Section 14.1 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 36 (Amendments) of this Agreement and any other applicable State or Federal statutes, rules or regulations.

14.2 To the extent CMS, legislation or congressional action impacts the amount of appropriation available for performance under this contract, HSD/MAD has the right to amend the Scope of Work, in its discretion, which shall be effected by HSD/MAD sending written notice to the CONTRACTOR. Any changes to the Scope of Work and compensation to CONTRACTOR affected pursuant to this Section 14.2 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 36 (Amendments) of this Agreement and any other applicable State or Federal statutes, rules or regulations.

ARTICLE 15 - DISPUTES

15.1 The entire agreement shall consist of: (1) this Agreement, including the Scope of Work, items incorporated by reference in paragraph 1.2.7, and any amendments; (2) the Request for Proposal, HSD/MAD written clarifications to the Request for Proposal and CONTRACTOR responses to RFP questions where not inconsistent with the terms of this Agreement or its amendments; (3) The CONTRACTOR'S Best and Final Offer, and (4) the CONTRACTOR'S additional responses to the Request for Proposal where not inconsistent with the terms of this Agreement or its amendments, all of which are incorporated herein or by reference.

15.2 In the event of a dispute under this Agreement, the various documents shall be referred to for the purpose of clarification or for additional detail in the order of priority and significance, specified below:

(1) amendments to the Agreement in reverse chronological order followed by;

(2) the Agreement, including items incorporated by reference in Paragraph 1.2, followed by;

(3) the CONTRACTOR'S Best and Final Offer followed by;

(4) the Request for Proposal, including attachments thereto and HSD/MAD's written responses to written questions and HSD/MAD's written clarifications, and the CONTRACTOR'S response to the Request for Proposal, including both technical and cost portions of the response (but only those portions of the CONTRACTOR'S response including both technical and cost portions of the response that do not conflict with the terms of this Agreement and its amendments).

15.3 Dispute Procedures for Other than Contract Termination Proceedings

(1) Except for contract termination (specified in Section 8.1(2) (Q)), any dispute concerning sanctions imposed under this Agreement shall be reported in writing to the HSD/MAD Director within fifteen (15) days of the date the reporting party receives notice of the sanction. The decision of the Director regarding the dispute shall be delivered to the parties in writing within thirty (30) days of the date the Director receives the written dispute. The decision shall be final and conclusive unless, within fifteen (15) days from the date of the decision, either party files with the HSD/MAD Secretary a written appeal of the decision of the Director.

(2) Any other dispute concerning performance of the Agreement shall be reported in writing to the MAD Director within thirty (30) days of the date the reporting party knew of the activity or incident giving rise to the dispute. The decision of the Director shall be delivered to the parties in writing within thirty (30) days and shall be final and conclusive unless, within fifteen (15) days from the date of the decision, either party files with the HSD/MAD Secretary a written appeal of the decision of the Director.

(3) Failure to file a timely appeal shall be deemed acceptance of the Director's decision and waiver of any further claim.

(4) In any appeal under this Article, the CONTRACTOR and HSD/MAD shall be afforded an opportunity to be heard and to offer evidence and argument in support of their position to the Secretary or his designee. The appeal is an informal hearing which shall not be recorded or transcribed, and is not subject to formal rules of evidence or procedure.

(5) The Secretary or a designee shall review the issues and evidence presented and issue a determination in writing which shall conclude the administrative process available to the parties. The Secretary shall notify the parties of the decision within thirty (30) days of the notice of the appeal, unless otherwise agreed to by the parties in writing or extended by the Secretary for good cause.

(6) Pending decision by the Secretary, both parties shall proceed diligently with performance of the Agreement, in accordance with the Agreement.

(7) Failure to initiate or participate in any part of this process shall be deemed waiver of any claim.

ARTICLE 16 - APPLICABLE LAW

16.1 This Agreement shall be governed by the laws of the State of New Mexico. All legal proceedings arising from unresolved disputes under this Agreement shall be brought before the First Judicial District Court in Santa Fe, New Mexico.

16.2 Each party agrees that it shall perform its obligations hereunder in accordance with all applicable Federal and State laws, rules and regulations now or hereafter in effect.

16.3 If any provision of this Agreement is determined to be invalid, unenforceable, illegal or void, the remaining provisions of this Agreement shall not be affected, providing the remainder of the Agreement is capable of performance, the remaining provisions shall be

binding upon the parties hereto, and shall be enforceable, as though said invalid, unenforceable, illegal, or void provision were not contained herein.

ARTICLE 17 - STATUS OF CONTRACTOR

17.1 The CONTRACTOR is an independent CONTRACTOR performing professional services for HSD/MAD and is not an employee of the State of New Mexico. The CONTRACTOR shall not accrue leave, retirement, insurance, bonding, use of State vehicles, or any other benefits afforded to employees of the State of New Mexico as a result of this Agreement.

17.2 The CONTRACTOR shall be solely responsible for all applicable taxes, insurance, licensing and other costs of doing business. Should the CONTRACTOR default in these or other responsibilities, jeopardizing the CONTRACTOR'S ability to perform services, this Agreement may be terminated immediately upon written notice.

17.3 The CONTRACTOR shall not purport to bind HSD/MAD, its officers or employees nor the State of New Mexico to any obligation not expressly authorized herein unless HSD/MAD has expressly given the CONTRACTOR the authority to so do in writing.

ARTICLE 18 - ASSIGNMENT

18.1 With the exception of provider subcontracts or other subcontracts expressly permitted under this Agreement, the CONTRACTOR shall not assign, transfer or delegate any rights, obligations, duties or other interest in this Agreement or assign any claim for money due or to become due under this Agreement.

ARTICLE 19 - SUBCONTRACTS

19.1 The CONTRACTOR is solely responsible for fulfillment of the Agreement with HSD/MAD. HSD/MAD shall make Agreement payments only to the CONTRACTOR.

19.2 The CONTRACTOR shall remain solely responsible for performance by any subcontractor under such subcontract(s).

19.3 HSD/MAD may undertake or award other agreements for work related to the tasks described in this document or any portion therein if the CONTRACTOR'S available time and/or priorities do not allow for such work to be provided by the CONTRACTOR. The CONTRACTOR shall fully cooperate with such other CONTRACTORS and HSD/MAD in all such cases.

19.4 Subcontracting Requirements

(1) Except as otherwise provided in this agreement, the CONTRACTOR may subcontract to a qualified individual or organization for the provision of any service defined in the benefit package or other required CONTRACTOR function. The CONTRACTOR remains legally responsible to HSD/MAD for all work performed by any subcontractor. The CONTRACTOR shall submit to HSD/MAD boilerplate contract language and/or sample contracts for various types of subcontracts during the procurement process. Changes to contract templates that may materially affect Medicaid members shall be approved by HSD/MAD prior to execution by any subcontractor.

(2) HSD/MAD reserves the right to review and disapprove all subcontracts and/or any significant modifications to previously approved subcontracts to ensure compliance with requirements set forth in 42 CFR 434.6 or this Agreement. The CONTRACTOR is required to give HSD/MAD prior notice with regard to its intent to subcontract certain significant contract requirements as specified herein or in writing by HSD/MAD, including, but not limited to, credentialing, utilization review, and claims processing. HSD/MAD reserves the right to disallow a proposed subcontracting arrangement if the proposed subcontractor has been formally restricted from participating in a Federal entitlement program (i.e., Medicare, Medicaid) for other good cause.

(3) The CONTRACTOR shall not contract with an individual provider, an entity, or an entity with an individual who is an officer, director, agent or manager or person with more than five percent (5%) of beneficial ownership of an entity's equity, that has been convicted of crimes specified in the Section 1128 of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

(4) Pursuant to 42 CFR Section 417.479(a), no specific payment may be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member. The CONTRACTOR shall disclose to HSD/MAD the information on provider incentive plans set forth in 42 CFR Sections 471.479(h)(1)(ii)-(iv) at the times required by 42 CFR Section 434.70(a)(3) to allow HSD/MAD to determine whether the incentive plans meet the requirements of 42 CFR Section 417.479(d) through (g). The CONTRACTOR shall provide capitation data required by 42 CFR Section 479(h)(1)(iv) for the previous calendar year to HSD/MAD by application/CONTRACTOR renewal of each year. The

CONTRACTOR shall provide the information on its physician incentive plans allowed by 42 CFR Section 417.479(h)(3) to any Medicaid recipient upon request.

(5) In its subcontracts, the CONTRACTOR shall ensure that subcontractors agree to hold harmless both HSD/MAD and the CONTRACTOR'S members in the event that the CONTRACTOR cannot or shall not pay for services performed by the subcontractor pursuant to the subcontract. The hold harmless provision shall survive the effective termination of the CONTRACTOR/subcontractor contract for authorized services rendered prior to the termination of the contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the members.

(6) The CONTRACTOR shall have a written document (agreement), signed by both parties, that describes the responsibilities of the CONTRACTOR and the delegate; the delegated activities; the frequency of reporting (if applicable) to the CONTRACTOR; the process by which the CONTRACTOR evaluates the delegate; and the remedies, including the revocation of the delegation, available to the CONTRACTOR if the delegate does not fulfill its obligations.

(7) The CONTRACTOR shall have policies and procedures to ensure that the delegated agency meets all standards of performance mandated by HSD/MAD for the Medicaid program. These include, but are not limited to, use of appropriately qualified staff, application of clinical practice guidelines and utilization management, reporting capability, and ensuring members' access to care.

(8) The CONTRACTOR shall have policies and procedures for the oversight of the delegated agency's performance of the delegated functions.

(9) The CONTRACTOR shall have policies and procedures to ensure consistent statewide application of all UM criteria when UM is delegated.

A. Credentialing Requirements: The CONTRACTOR shall maintain policies and procedures for verifying that the credentials of all its providers and subcontractors meet applicable standards as stated in the Article 2, Scope of Work.

B. Review Requirements: The CONTRACTOR shall maintain fully executed originals of all subcontracts, which are accessible to HSD/MAD upon request.

C. Minimum Requirements: Subcontracts shall contain at least the following provisions:

i. subcontracts shall be executed in accordance with all applicable Federal and State laws, regulations, policies, procedures and rules;

ii. subcontracts shall identify the parties of the subcontract and their legal basis of operation in the State of New Mexico;

iii. subcontracts shall include the procedures and specific criteria for terminating the subcontract;

iv. subcontracts shall identify the services to be performed by the subcontractor and those services performed under any other subcontract(s). Subcontracts shall include provision(s) describing how services provided under the terms of the subcontract are accessed by members;

v. subcontracts shall include the reimbursement rates and risk assumption, if applicable;

vi. subcontractors shall maintain all records relating to services provided to members for a ten (10)-year period and shall make all enrollee medical records available for the purpose of quality review conducted by HSD/MAD or its designated agents both during and after the contract period;

vii. subcontracts shall require that member information be kept confidential, as defined by Federal and State law;

viii. subcontracts shall include a provision that authorized representatives of HSD/MAD have reasonable access to facilities and records for financial and medical audit purposes both during and after the contract period;

ix. subcontracts shall include a provision for the subcontractor to release to the CONTRACTOR any information necessary to perform any of its obligations;

x. subcontracts shall state that the subcontractor shall accept payment from the CONTRACTOR as payment for any services included in

the benefit package, and cannot request payment from HSD/MAD for services performed under the subcontract;

xi. subcontracts shall state that if the subcontract includes primary care, provisions for compliance with PCP requirements delineated in the primary MCO contract apply;

xii. subcontracts shall require the subcontractor shall comply with all applicable State and Federal statutes, laws, rules, and regulations;

xiii. subcontracts shall include provisions for termination for any violation of applicable HSD/MAD, State or Federal requirements;

xiv. subcontracts may not prohibit a provider or other subcontractor (with the exception of third-party administrators) from entering into a contractual relationship with another CONTRACTOR;

xv. subcontracts may not include any incentive or disincentive that encourages a provider or other subcontractor not to enter into a contractual relationship with another CONTRACTOR;

xvi. subcontracts cannot contain any gag order provisions that prohibit or otherwise restrict covered health professionals from advising patients about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act or in contravention of NMSA 1978, § 59A-57-1 to 57-11, the Patient Protection Act; and

xvii. subcontracts for pharmacy providers shall include a payment provision consistent with 1978 NMSA § 27-2-16B unless there is a change in law or regulation.

ARTICLE 20 - RELEASE

20.1 Upon final payment of the amounts due under this Agreement, the CONTRACTOR shall release HSD/MAD, its officers and employees and the State of New Mexico from all liabilities and obligations whatsoever under, or arising from, this Agreement. The CONTRACTOR agrees not to purport to bind the State of New Mexico.

20.2 Payment to the CONTRACTOR by HSD/MAD shall not constitute final release of the CONTRACTOR. Should audit or inspection of the CONTRACTOR'S records or the

CONTRACTOR'S member complaints subsequently reveal outstanding CONTRACTOR liabilities or obligations, the CONTRACTOR shall remain liable to HSD/MAD for such obligations. Any payments by HSD/MAD to the CONTRACTOR shall be subject to any appropriate recoupment by HSD/MAD.

20.3 Notice of any post-termination audit or investigation of complaint by HSD/MAD shall be provided to the CONTRACTOR, and such audit or investigation shall be initiated in accordance with CMS requirements. HSD/MAD shall notify the CONTRACTOR of any claim or demand within thirty (30) days after completion of the audit or investigation or as otherwise authorized by CMS. Any payments by HSD/MAD to the CONTRACTOR shall be subject to any appropriate recoupment by HSD/MAD in accordance with the provisions of Article 5 of this Agreement.

ARTICLE 21 - RECORDS AND AUDIT

21.1 Compensation Records

After final payment under the contract or ten (10) years after a pending audit is completed and resolved, whichever is later, HSD/MAD or its designee shall have the right to audit billings both before and after payment. The CONTRACTOR shall maintain all necessary records to substantiate the services it rendered under this Agreement. These records shall be subject to inspection by HSD/MAD, the Department of Finance and Administration, the State Auditor and/or any authorized State or Federal entity and shall be retained for ten (10) years. Payment under this Agreement shall not foreclose the right of HSD/MAD to recover excessive or illegal payments as well as interest, attorney fees and costs incurred in such recovery.

21.2 Other Records

In addition, the CONTRACTOR shall retain all member medical records, collected data, and other information subject to HSD/MAD, State, and Federal reporting or monitoring requirements for ten (10) years after the contract is terminated under any provisions of Article 11 of this Agreement or ten (10) years after any pending audit is completed and resolved, whichever is later. These records shall be subject to inspection by HSD/MAD, the Department of Finance and Administration and/or any authorized State or Federal entity. Payment under this Agreement shall not foreclose the right of HSD/MAD to recover excessive or illegal payments as well as interest, attorney fees and costs incurred in such recovery.

21.3 Standards for Medical Records

(1) The CONTRACTOR shall require medical records to be maintained on paper and/or in electronic format in a manner that is timely, legible, current, set forth, and organized, and that permits effective and confidential patient care and quality review.

(2) The CONTRACTOR shall have written medical record confidentiality policies and procedures that implement the requirements of State and Federal law and policy and of this Agreement.

(3) The CONTRACTOR shall establish, and shall require its practitioners to have, an organized medical record-keeping system and standards for the availability of medical records appropriate to the practice site.

(4) The CONTRACTOR shall include provisions in its contracts with providers requiring appropriate access to the medical records of the MCO members for purposes of quality reviews to be conducted by HSD/MAD or agents thereof, and that the medical records be available to health care practitioners for each clinical encounter.

21.4 The CONTRACTOR shall comply with HSD/MAD's reasonable requests for records and documents as necessary to verify that the CONTRACTOR is meeting its obligations under this Agreement, or for data reporting legally required of HSD/MAD. However, nothing in this Agreement shall require the CONTRACTOR to provide HSD/MAD with information, records, and/or documents which are protected from disclosure by any law, including, but not limited to, laws protecting proprietary information as a trade secret, confidentiality laws, and any applicable legal privileges (including but not limited to, attorney/client, physician/patient, quality assurance and peer review), except as may otherwise be required by law or pursuant to a legally adequate release from the affected member(s).

21.5 The CONTRACTOR shall provide the State of New Mexico, HSD/MAD, and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the CONTRACTOR'S premises or other places where work under this contract is performed to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this contract. The CONTRACTOR shall provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties (e.g. assistance from the CONTRACTOR staff to retrieve and/or copy materials). HSD/MAD and its authorized agents shall schedule access with the CONTRACTOR in advance within a reasonable

period of time except in case of suspected fraud and abuse. All inspection, monitoring and evaluation shall be performed in such a manner as not to unduly interfere with the work being performed under this contract.

21.6 In the event right of access is requested under this section, the CONTRACTOR or subcontractor shall upon request provide and make available staff to assist in the audit or inspection effort, and shall provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort.

21.7 All inspections or audits shall be conducted in a manner as shall not unduly interfere with the performance of the CONTRACTOR'S or any subcontractor's activities. The CONTRACTOR shall be given ten (10) working days to respond to any findings of an audit before HSD/MAD shall finalize its findings. All information so obtained shall be accorded confidential treatment as provided in applicable law.

ARTICLE 22 - INDEMNIFICATION

22.1 The CONTRACTOR agrees to indemnify, defend, and hold harmless the State of New Mexico, its officers, agents and employees from any and all claims and losses accruing or resulting from any and all CONTRACTOR employees, agents, or subcontractors, in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, association, partnership, entity, or corporation who may be injured or damaged by the CONTRACTOR in the performance or failure in performance of this Agreement. The provisions of this Section 22.1 shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, HSD/MAD, or any of its officers, employees, or agents.

22.2 The CONTRACTOR shall at all times during the term of this Agreement, indemnify and hold harmless HSD/MAD against any and all liability, loss, damage, costs or expenses which HSD/MAD may sustain, incur or be required to pay (1) by reason of any member suffering personal injury, death or property loss or damage of any kind as a result of the erroneous or negligent acts or omissions of the CONTRACTOR either while participating with or receiving care or services from the CONTRACTOR under this Agreement, or (2) while on premises owned, leased, or operated by the CONTRACTOR or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the CONTRACTOR or any officer, agent, subcontractor or employee thereof. The provisions of this Section 22.2 shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or

omissions of the State of New Mexico, HSD/MAD, or any of its officers, employees, or agents.

22.3 The CONTRACTOR shall agree to indemnify and hold harmless HSD/MAD, its agents and employees from any and all claims, causes of action, suits, judgments, losses, or damages, including court costs and attorney fees, or causes of action, caused by reason of CONTRACTOR'S erroneous or negligent acts or omissions, including the following:

(1) any claims or losses attributable to any persons or firm injured or damaged by erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid regulations or statutes by the CONTRACTOR, its officers, employees, or subcontractors in the performance of the Agreement, regardless of whether HSD/MAD knew or should have known of such erroneous or negligent acts; unless the State of New Mexico, or any of its officers, employees or agents directed or affirmatively consented in writing to the performance of such acts; and

(2) any claims or losses attributable to any person or firm injured or damaged by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement or by Federal or State regulations or statutes, regardless of whether HSD/MAD knew or should have known of such publication, translation, reproduction, delivery, performance, use, or disposition unless the State of New Mexico, or any of its officers, employees or agents directed or affirmatively consented in writing to such publication, translation, reproduction, delivery, performance, use or disposition.

(3) the provisions of this Article 22.3 shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, HSD/MAD, or any of its officers, employees, or agents.

22.4 The CONTRACTOR, including its subcontractors, agrees that in no event, including but not limited to nonpayment by the CONTRACTOR, insolvency of the CONTRACTOR or breach of this Agreement, shall the CONTRACTOR or its subcontractor bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against an enrollee or persons (other than the CONTRACTOR) acting on their behalf for services provided pursuant to this Agreement except for any Medicaid population required to make co-payments under Medical Assistance Division policy. In no case, shall the State, HSD/MAD and/or Medicaid beneficiaries be liable for any debts of the CONTRACTOR.

22.5 The CONTRACTOR agrees that the above indemnification provisions shall survive the termination of this Agreement, regardless of the cause giving rise to termination. This provision is not intended to apply to services provided after this Agreement has been terminated.

22.6 HSD/MAD shall notify the CONTRACTOR of any claim, loss, damage, suit or action at such time as HSD/MAD reasonably believes that such claim, loss, damage, suit or action may give rise to a right to indemnification under this Article. The failure of HSD/MAD, however, to deliver such notice shall not relieve CONTRACTOR of its obligation to indemnify HSD/MAD under this Article. Prior to entering into any settlement for which it may seek indemnification under this Article, HSD/MAD shall consult with the CONTRACTOR, but the CONTRACTOR need not approve the settlement. Nothing in this provision shall be interpreted as a waiver of HSD/MAD's right to indemnification.

ARTICLE 23 - LIABILITY

23.1 The CONTRACTOR shall be wholly at risk for all covered services. No additional payment shall be made by HSD/MAD, nor shall any payment be collected from an enrollee, except for co-payments authorized by HSD/MAD or State laws or regulation.

23.2 The CONTRACTOR is solely responsible for ensuring that it issues no payments for services for which it is not liable under this Agreement. HSD/MAD shall accept no responsibility for refunding to the CONTRACTOR any such excess payments unless the State of New Mexico, or any of its officers, employees or agents directed such services to be rendered or payment made.

23.3 The CONTRACTOR, its successors and assignees shall procure and maintain such insurance and other forms of financial protections as are identified in this Agreement.

ARTICLE 24 - EQUAL OPPORTUNITY COMPLIANCE

The CONTRACTOR agrees to abide by all Federal and State laws, rules, regulations and executive orders of the Governor of the State of New Mexico and the President of the United States pertaining to equal opportunity. In accordance with all such laws, rules, and regulations, and executive orders, the CONTRACTOR agrees to ensure that no person in the United States shall, on the grounds of race, color, national origin, sex, sexual preference, age, handicap or religion be excluded from employment with, participation in, be denied the benefit of, or otherwise be subjected to discrimination under any program or activity performed under this Agreement. If HSD/MAD finds that the CONTRACTOR is not in compliance with this requirement at any time during the term of this Agreement, HSD/MAD reserves the right to

terminate this Agreement pursuant to Article 9 or take such other steps it deems appropriate to correct said deficiency.

ARTICLE 25 - RIGHTS TO PROPERTY

All equipment and other property provided or reimbursed to the CONTRACTOR by HSD/MAD is the property of HSD/MAD and shall be turned over to HSD/MAD at the time of termination or expiration of this Agreement, unless otherwise agreed in writing.

ARTICLE 26 - ERRONEOUS ISSUANCE OF PAYMENT OR BENEFITS

In the event of an error, which causes payment(s) to the CONTRACTOR to be issued by HSD/MAD, the CONTRACTOR shall reimburse the State within thirty (30) days of written notice of such error for the full amount of the payment, subject to the provisions of Section 5.6(4) of this Agreement. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the thirtieth (30th) day following the notice.

ARTICLE 27 - EXCUSABLE DELAYS

The CONTRACTOR shall be excused from performance hereunder for any period that it is prevented from performing any services hereunder in whole or in part as a result of an act of nature, war, civil disturbance, epidemic, court order, or other cause beyond its reasonable control, and such nonperformance shall not be a default hereunder or ground for termination of the Agreement.

In addition, the CONTRACTOR shall be excused from performance hereunder during any period for which the State of New Mexico has failed to enact a budget or appropriate monies to fund the managed care program, provided that the CONTRACTOR notifies HSD/MAD, in writing, of its intent to suspend performance and HSD/MAD is unable to resolve the budget or appropriation deficiencies within forty-five (45) days.

In addition, the CONTRACTOR shall be excused from performance hereunder for insufficient payment by HSD/MAD, provided that the CONTRACTOR notifies HSD/MAD in writing of its intent to suspend performance and HSD/MAD is unable to remedy the monetary shortfall within forty-five (45) days.

ARTICLE 28 - MARKETING

28.1 The CONTRACTOR shall maintain written policies and procedures governing the development and distribution of marketing materials for members.

28.2 HSD/MAD shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at members before use.

(1) The CONTRACTOR shall distribute its marketing materials to its entire service area.

(2) The CONTRACTOR shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance, not including public/private partnerships.

(3) The CONTRACTOR shall specify the methods by which the entity assures HSD/MAD that marketing materials are accurate and do not mislead, confuse, or defraud the members or HSD/MAD. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

A. the member must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits; or

B. the CONTRACTOR is endorsed by CMS, the Federal or State Government, or similar entity.

28.3 Minimum Marketing and Outreach Requirements: The marketing and outreach material shall meet the following minimum requirements:

(1) marketing and/or outreach materials shall meet requirements for all communication with Medicaid members, as set forth in Section 8.305.5.16 NMAC, MEDICAID MANAGED CARE MARKETING GUIDELINES; and

(2) all marketing and/or outreach materials produced by the CONTRACTOR under the Agreement shall state that such services are funded pursuant to an Agreement with the State of New Mexico.

28.4 Marketing and outreach activities not permitted under the Medicaid Managed Care Agreement

(1) The following marketing and outreach activities are prohibited, regardless of the method of communication (oral, written) or whether the activity is performed by the CONTRACTOR directly, its participating providers, its subcontractors, or any other party affiliated with the CONTRACTOR:

A. asserting or implying that a member shall lose Medicaid benefits if he/she does not enroll with the CONTRACTOR or inaccurately depicting the consequences of choosing a different CONTRACTOR;

B. designing a marketing or outreach plan which discourages or encourages CONTRACTOR selection based on health status or risk;

C. initiating an enrollment request on behalf of a Medicaid recipient;

D. making inaccurate, false, materially misleading or exaggerated statements;

E. asserting or implying that the CONTRACTOR offers unique covered services when another CONTRACTOR provides the same or similar service;

F. the use of gifts such as diapers, toasters, infant formula, or other incentives to entice people to join a specific health plan;

G. directly or indirectly conducting door-to-door, telephonic or other "Cold Call" marketing. "Cold Call" marketing is defined as any unsolicited personal contact by the CONTRACTOR with a potential member for the purpose of marketing. Marketing means any communication from a CONTRACTOR to a Medicaid member who is not enrolled in that entity that can reasonably be interpreted as intended to influence the member to enroll in that particular CONTRACTOR'S Medicaid product not to enroll in or to disenroll from, another CONTRACTOR'S Medicaid product. The CONTRACTOR may send informational material regarding its benefit package to potential members; and

H. conducting any other marketing activity prohibited by HSD/MAD during the course of this Agreement.

28.5 The CONTRACTOR shall take reasonable steps to prevent subcontractors and participating providers from committing the acts described herein; the CONTRACTOR shall be held liable only if it knew or should have known that its subcontractors or participating providers were committing the act described herein and did not take timely corrective actions. HSD/MAD reserves the right to prohibit additional marketing activities at its discretion.

28.6 Marketing Time Frames

The CONTRACTOR may initiate marketing and outreach activities at any time.

28.7 The Medicaid Managed Care Marketing Guidelines are incorporated into this Agreement by reference. This Agreement shall incorporate all revisions to the Guidelines produced during the course of the Agreement.

28.8 Health Education and Outreach Materials may be distributed to the CONTRACTOR'S members by mail or in connection with exhibits or other organized events, including but not limited to, health fair booths at community events and health plan hosted health improvement events. Health Education means programs, services or promotions that are designed or intended to inform the CONTRACTOR'S actual or potential members upon request about the issues related to health lifestyles, situations that affect or influence health status or methods or modes of medical treatment. Outreach is the means of educating or informing the CONTRACTOR'S actual or potential members about health issues. Health Education and Outreach materials include, but are not limited to, general distribution brochures, member newsletters, posters, and member handbooks. HSD/MAD shall not approve health education materials.

ARTICLE 29 - PROHIBITION OF BRIBES, GRATUITIES & KICKBACKS

29.1 Pursuant to Sections NMSA 1978, § 13-1-191, 30-24-1 et seq., 30-41-1, and 30-41-3, the receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited.

29.2 No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Agreement. No individual employed by the State of New Mexico shall be admitted to any share or part of the Agreement or to any benefit that may arise therefrom.

29.3 HSD/MAD may, by written notice to the CONTRACTOR, immediately terminate the right of the CONTRACTOR to proceed under the Agreement if it is found, after notice and hearing by the Secretary or his duly authorized representative, that gratuities in the form of entertainment, gifts or otherwise were offered or given by the CONTRACTOR or any agent or representative of the CONTRACTOR to any officer or employee of the State of New Mexico with a view toward securing the Agreement or securing favorable treatment with respect to the award or amending or making of any determinations with respect to the performing of such Agreement. In the event the Agreement is terminated as provided in this section, the State of New Mexico shall be entitled to pursue the same remedies against the CONTRACTOR as it would pursue in the event of a breach of

contract by the CONTRACTOR and as a penalty in addition to any other damages to which it may be entitled by law.

ARTICLE 30 - LOBBYING

30.1 The CONTRACTOR certifies, to the best of its knowledge and belief, that:

(1) No Federally appropriated funds have been paid or shall be paid, by or on behalf of the CONTRACTOR, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or shall be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the CONTRACTOR shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

30.2 The CONTRACTOR shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

30.3 This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 USC Section 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than ten thousand dollars ($10,000) and not more than one hundred thousand dollars ($100,000) for such failure.

ARTICLE 31 - CONFLICT OF INTEREST

31.1 The CONTRACTOR warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under this Agreement, and further warrants that signing

of this Agreement shall not be creating a violation of the Governmental Conduct Act, NMSA 1978, § 10-16-1 et seq.

31.2 If during the term of this Agreement and any extension thereof, the CONTRACTOR becomes aware of an actual or potential relationship, which may be considered a conflict of interest, the CONTRACTOR shall immediately notify the Contract Administrator in writing. Such notification includes when the CONTRACTOR employs or contracts with a person, on a matter related to this Agreement, and that person: (1) is a former HSD/MAD employee who has an obligation to comply with NMSA 1978, § 10-16-1 et. seq., or (2) is a former employee of the Department of Health or the Children, Youth and Families Department who was substantially and directly involved in the development or enforcement of this Agreement.

ARTICLE 32 - COOPERATION WITH THE MEDICAID FRAUD CONTROL UNIT

32.1 The CONTRACTOR shall make an initial report to HSD/MAD within five working days when, in the CONTRACTOR'S professional judgment, suspicious activities may have occurred. The CONTRACTOR shall then take steps to establish whether or not, in its professional judgment, potential fraud has occurred. The CONTRACTOR will then make a report to HSD/MAD and submit any applicable evidence in support of its findings. If HSD/MAD decides to refer the matter to the New Mexico State Medicaid Fraud Control Unit of the Attorney General's Office (MFCU), HSD/MAD will notify the CONTRACTOR within five working days of making the referral. The CONTRACTOR shall cooperate fully with any and all requests from MFCU for additional documentation or other types of collaboration in accordance with applicable law.

32.2 The CONTRACTOR shall cooperate fully in any investigation by the MFCU or subsequent legal action that may result from such investigation. The CONTRACTOR and its subcontractors and participating network providers shall, upon request, make available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which HSD/MAD monies are expended, unless otherwise provided by law. In addition, the MFCU shall be allowed to have access during normal business hours to the place of business and all records of the CONTRACTOR and its subcontractors and participating network providers, except under special circumstances when after hours access shall be allowed. Special circumstances shall be determined by the MFCU.

32.3 The CONTRACTOR shall disclose to HSD/MAD, the MFCU, and any other State or Federal agency charged with overseeing the Medicaid program, full and complete information regarding ownership, significant financial transactions or financial transactions relating to or affecting the Medicaid program and persons related to the

CONTRACTOR convicted of criminal activity related to Medicaid, Medicare, or the federal Title XX programs.

32.4 Any actual or potential conflict of interest within the CONTRACTOR'S program shall be referred by the CONTRACTOR to the MFCU. The CONTRACTOR also shall refer to the MFCU any instance where a financial or material benefit is given by any representative, agent or employee of the CONTRACTOR to HSD/MAD or any other party with direct responsibility for this Agreement. In addition, the CONTRACTOR shall notify the MFCU if it hires or enters into any business relationship with any person who, within two years previous to that hiring or contract, was employed by HSD/MAD in a capacity relating to the Medicaid program or any other party with direct responsibility for this Agreement.

32.5 Any recoupment received from the CONTRACTOR by HSD/MAD pursuant to the provisions of Article 8 (Enforcement) of this Agreement herein shall not preclude the MFCU from exercising its right to criminal prosecution, civil prosecution, or any applicable civil penalties, administrative fines or other remedies.

32.6 Upon request to the CONTRACTOR, the MFCU shall be provided with copies of all grievances and resolutions affecting Medicaid recipients.

32.7 Should the CONTRACTOR know about or become aware of any investigation being conducted by the MFCU or HSD/MAD, the CONTRACTOR, and its representatives, agents and employees, shall maintain the confidentiality of this information.

32.8 The CONTRACTOR shall have in place and enforce policies and procedures to educate Medicaid recipients of the existence of, and role of, the MFCU.

32.9 The CONTRACTOR shall have in place and enforce policies and procedures for the detection and deterrence of fraud. These policies and procedures shall include specific requirements governing who within the CONTRACTOR'S organization is responsible for these activities, how these activities shall be conducted, and how the CONTRACTOR shall address cases of suspected fraud and abuse.

32.10 All documents submitted by the CONTRACTOR to HSD/MAD, if developed or generated by the CONTRACTOR, or its agents, shall be deemed to be certified by the CONTRACTOR as submitted under penalty of perjury.

ARTICLE 33 - WAIVERS

33.1 No term or provision of this Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing by the party claimed to have waived or consented.

33.2 A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or Agreement herein contained.

ARTICLE 34 - PROVIDER AVAILABILITY

All providers owned (wholly or partially) or controlled by the CONTRACTOR, or any of the CONTRACTOR'S related or affiliated entities, and any and all providers that own (wholly or partially) or control the CONTRACTOR, to the extent of its legal authority, shall be willing to become a network provider for any CONTRACTOR that contracts with HSD/MAD for Medicaid care services, to be reimbursed by such CONTRACTOR at the then-current and applicable Medicaid reimbursement rate for that provider type. The applicable Medicaid reimbursement rate is defined to exclude disproportionate share and medical education payments.

ARTICLE 35 - NOTICE

35.1 A notice shall be deemed duly given upon delivery, if delivered by hand, or three (3) days after posting if sent by first-class mail, with proper postage affixed. Notice may also be tendered by facsimile transmission, with original to follow by first class mail.

35.2 All notices required to be given to HSD/MAD under this Agreement shall be sent to the HSD/MAD Contract Administrator or his/her designee:

Alana E. Reeves, Bureau Chief
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348

35.3 All notices required to be given to the CONTRACTOR under this Agreement shall be sent to:

Sharon Jones, Director
Government Programs and Compliance
Molina Healthcare of New Mexico
8801 Horizon Boulevard, N.E.
Albuquerque, NM 87113

ARTICLE 36 - AMENDMENTS

This Agreement shall not be altered, changed or amended other than by an instrument in writing executed by the parties to this Agreement. Amendments shall become effective and binding when signed by the parties, approved by the Department of Finance and Administration, and written approvals have been obtained from any necessary State and Federal agencies. All necessary approvals shall be attached as exhibits to the Agreement.

ARTICLE 37 - SUSPENSION, DEBARMENT AND OTHER RESPONSIBILITY MATTERS

37.1 Pursuant to 45 C.F.R. Part 76 and other applicable federal regulations, the CONTRACTOR certifies by signing this Agreement, that it and its principals, to the best of its knowledge and belief: (1) are not debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal department or agency; (2) have not, within a three-year period preceding the effective date of this Agreement, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) contract or subcontract; violation of Federal or State antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; (3) have not been indicted for, or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with, commission of any of the offenses enumerated above in this Article 37.1; (4) have not, within a three-year period preceding the effective date of this Agreement, had one or more public agreements or transactions (Federal, State or local) terminated for cause or default; and (5) have not been excluded from participation from Medicare, Medicaid, Federal health care programs or Federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7 and other applicable federal statutes.

37.2 The CONTRACTOR’S certification in Article 37.1 is a material representation of fact upon which HSD/MAD relied when this Agreement was entered into by the parties. The

CONTRACTOR shall provide immediate written notice to HSD/MAD's Contract Administrator if, at any time during the term of this Agreement, the CONTRACTOR learns that its certification in Article 37.1 was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances. If it is later determined that the CONTRACTOR'S certification in Article 37.1 was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances, in addition to other remedies available to HSD/MAD, HSD/MAD may terminate the Agreement.

37.3 As required by 45 C.F.R. Part 76 or other applicable federal regulations, the CONTRACTOR shall require each proposed first-tier subcontractor whose subcontract will equal or exceed twenty-five thousand dollars ($25,000), to disclose to the CONTRACTOR, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by any Federal department or agency. The CONTRACTOR shall make such disclosures available to the HSD/MAD when it requests subcontractor approval from the HSD/MAD pursuant to Article 19.4. If the subcontractor, or its principals, is debarred, suspended, or proposed for debarment by any Federal department or agency, HSD/MAD may refuse to approve the use of the subcontractor.

ARTICLE 38 - ENTIRE AGREEMENT

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, agreements and understandings have been merged into this written Agreement. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

ARTICLE 39 - AUTHORIZATION FOR CARE

The CONTRACTOR shall, to the extent possible, ensure that administrative burdens placed on providers are minimized. In furtherance of this objective, the CONTRACTOR shall provide to HSD/MAD, on a quarterly basis, a report of all benefits and procedures for which the CONTRACTOR or any of its subcontractors require a prior authorization. This report shall identify, for each such benefit and procedures, the number of such authorization requests that were made by providers, and the percentage that were approved and denied.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of execution by the State Contracts Officer, below.

CONTRACTOR

By: ______________________________ Date: ____________________
Title:

STATE OF NEW MEXICO

By: ______________________________ Date: ____________________
Pamela S. Hyde, J.D. Secretary
Human Services Department

Approved as to Form and Legal sufficiency:

By: ______________________________ Date: ____________________
Paul R. Ritzma, General Counsel
Human Services Department

DEPARTMENT OF FINANCE AND ADMINISTRATION

By: ______________________________ Date: ____________________
State Contracts Officer

The records of the Taxation and Revenue Department reflect that the CONTRACTOR is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross Receipts and compensating taxes.

TAXATION AND REVENUE DEPARTMENT

ID Number:

By: ______________________________________ Date: ______________________

Exhibit 10.2

STATE OF CALIFORNIA

STANDARD AGREEMENT
STD. 2_(__V. 5-91)

____ APPROVED BY THE ATTORNEY GENERAL

CONTRACT NUMBER 00-91035

AM. NO.

TAXPAYER'S FEDERAL EMPLOYER IDENTIFICATION NUMBER 33-0519730

THIS AGREEMENT, made and entered into this 1st day of August, 2000, in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE OF OFFICER ACTING FOR STATE	AGENCY	
Chief, Program Support Branch	Department of Health Services	, hereafter called the State, and

CONTRACTORS NAME
Sharp Health Plan

WITNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter expressed, does hereby agree to furnish to the State services and materials as follows: *(Set forth service to be rendered by Contractor, amount to be paid Contractor, time for performance of completion, and attach plans and specifications, if any.)*

This Contract is entered into under the provisions of Section 14089 and 14089.05, Welfare and Institutions Code.

WHEREAS, it is in the best interest of all parties to enter into this Contract,

NOW THEREFORE, the Contract is entered as follows:

CONTINUED ON 152 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement.

.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Services	CONTRACTOR *(If Other than an individual, state whether a corporation, partnership, etc.)* Sharp Health Plan
BY (AUTHORIZED SIGNATURE) /s/ Nadine Fujita Roh	BY (AUTHORIZED SIGNATURE) /s/ B. Kathlyn Mead
PRINTED NAME OF PERSON SIGNING Edward E. Stahlberg — Nadine Fujita Roh, Chief CMU Production	PRINTED NAME AND TITLE OF PERSON SIGNING B. Kathlyn Mead, President and CEO
TITLE Chief, Program Support Branch	ADDRESS 9325 Sky Park Court, Suite 300, San Diego, CA 92123

AMOUNT ENCUMBERED BY THIS DOCUMENT $	PROGRAM/CATEGORY (CODE AND TITLE) Loc. Asst. Sect. 14157 W&I Code	FUND TITLE Health Care Deposit	***Department of General Services Use Only***
PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT $ -0-	(OPTIONAL USE) Fed. Cat. No. 93778		EXEMPT FROM PCC PER W&I CODE SECTION 14089(j)
TOTAL AMOUNT ENCUMBERED TO DATE $	ITEM 4260-601-912 — CHAPTER 52	STATUTE 2000 — FISCAL YEAR 00/01	
	OBJECT OF EXPENDITURE (CODE AND TITLE) 9912-705-95915		

__ hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.

T.B.A. NO. B.R. NO.

SIGNATURE OF ACCOUNTING OFFICER /s/ Illegible

DATE 7/31/00

☐ CONTRACTOR ☐ STATE AGENCY ☐ ___________ ☐ CONTROLLER ☐ ___________

TABLE OF CONTENTS

ARTICLE 1.0 - PREAMBLE		1-1
ARTICLE 2.0 - DEFINITIONS		2-1
ARTICLE 3.0 - GENERAL PROVISIONS		3-1
3.1	Governing Law	3-1
3.2	Compliance with Applicable Laws	3-1
3.3	Authorized Representative/Delegation of Authority	3-2
3.4	Authority of the State	3-3
3.5	Fulfillment of Obligations	3-3
3.6	Assignment of Contract	3-4
3.7	Amendment of Contract	3-4
3.8	Interpretation of Contract/Captions/Word Usage	3-5
3.9	Submissions to DHS/Notices	3-5
3.10	Disputes and Appeals	3-6
3.11	Inspection Rights	3-10
3.12	Confidentiality of Information	3-11
3.13	Discrimination Prohibition	3-11
3.14	Discrimination Complaints	3-12
3.15	Equal Opportunity Employer	3-12
3.16	Nondiscrimination Clause Compliance	3-13
3.17	Contractor’s National Labor Relations Board (NLRB) Declaration	3-13
3.18	Ownership/Interest Certification	3-14
3.19	Financial Interest Disclosure	3-14
3.20	Conflict of Interest - Current and Former State Employees	3-15
3.21	Disabled Veteran Business Enterprises	3-15
3.22	Drug Free Workplace Act of 1990	3-15
3.23	Americans with Disabilities Act of 1990 and Rehabilitation Act of 1973 Requirements	3-16
3.24	Child Support Compliance Act Acknowledgment	3-16
3.25	Consequential Damages	3-16

ARTICLE 4.0 - TERM AND TERMINATION 4-1
4.1 Contract Term 4-1
4.2 Termination of Covered Service Obligations 4-1
4.3 Termination 4-2
4.4 Notice to Members of Transfer of Care 4-4
4.5 Sanctions 4-4

ARTICLE 5.0 - POLICIES, PROTOCOLS AND STANDARDS 5-1
5.1 Operational Policies 5-1
5.2 Amendments to Operational Policies 5-2
5.3 Compliance with Operational Policies 5-2
5.4 Operational Protocols/Obtaining State Approval 5-2
5.5 Compliance with Protocols 5-3
5.6 License and Certification Standards 5-4
5.7 Preventive Care Standards 5-5

ARTICLE 6.0 - ENROLLMENT AND DISENROLLMENT 6-1
6.1 Enrollment 6-1
6.2 Enrollment Capacity 6-1
6.3 Enrollment Limitation 6-1
6.4 Coverage 6-2
6.5 Participation in Enrollment Program 6-2
6.6 Disenrollment 6-2
6.7 Circumstances Under Which Member Is Disenrolled For Service Exclusion 6-7
6.8 Marketing Activities 6-9
6.9 Liability 6-11

ARTICLE 7.0 - SERVICE DELIVERY REQUIREMENTS 7-1
7.1 Scope of Service/Contractor Risk in Providing Services 7-1
7.2 Network Capacity/Composition 7-2
7.3 Specified Services 7-6
7.4 Preventive Services 7-8
7.5 Availability and Accessibility 7-11

7.6 Coordination of Care and Referral Requirements 7-13
7.7 Services With Special Payment Arrangement/Or Payments for Out-Of-Plan Providers 7-22
7.8 Member Health Education Services 7-30
7.9 Religious or Ethical Objections to Perform Services 7-33
7.10 Subcontract With Local Health Department (LHD) 7-34
7.11 Subcontract or Memorandum of Agreement (MOA) with Other Entities 7-35

ARTICLE 8.0 - ADMINISTRATIVE & OPERATIONAL REQUIREMENTS 8-1
8.1 Organizational Legal Authority 8-1
8.2 Organization and Administrative Capabilities 8-1
8.3 Financial Systems 8-3
8.4 Books and Records 8-12
8.5 Management Information System (MIS) 8-14
8.6 Quality Improvement Plan (QIP) 8-17
8.7 Credentialing and Recredentialing 8-26
8.8 Facility Review 8-28
8.9 Medical Records 8-29
8.10 Utilization Management (UM) Program 8-31
8.11 Infection Control Plan 8-32
8.12 Member Services 8-33
8.13 Cultural and Linguistic Services 8-39
8.14 Provider Services 8-41
8.15 Reporting Fraud and Abuse 8-42

ARTICLE 9.0 - SUBCONTRACT 9-1
9.1 Knox-Keene Regulations 9-1
9.2 Subcontract Requirements 9-1
9.3 Subcontract Non-federally Qualified HMOs - DHS Approval 9-3
9.4 Subcontract Federally Qualified HMOs - DHS Approval 9-3
9.5 Subcontract Compensation 9-3
9.6 Payments to Subcontractors . 9-4
9.7 Public Records 9-4
9.8 Disclosures 9-4

9.9 Linguistic Service Provisions 9-5
9.10 Physician Incentive Plan Requirements 9-5

ARTICLE 10.0 - PAYMENT PROVISIONS 10-1
10.1 Contractor Risk in Providing Provisions 10-1
10.2 Amounts Payable 10-1
10.3 Capitation Rates 10-1
10.4 Capitation Rates Constitute Payment In Full 10-2
10.5 Negotiation of Rates 10-3
10.6 Redetermination of Rates - Obligation Changes 10-4
10.7 Reinsurance 10-5
10.8 Catastrophic Coverage Limitation 10-5
10.9 Recovery of Capitation Payments 10-5
10.10 Limitation to Federal Financial Participation 10-6

ARTICLE 11.0 - DUTIES OF THE STATE 11-1
11.1 Payment for Services 11-1
11.2 Medical Reviews 11-1
11.3 Facility Inspections 11-2
11.4 Enrollment Processing 11-2
11.5 Disenrollment Processing 11-2
11.6 Certification of Marketing Representatives 11-3
11.7 Approval Process 11-3
11.8 Program Information 11-3
11.9 Beneficiary Notification of Health Plan Contract Termination 11-3
11.10 Pilot Projects 11-4
11.11 Confidentiality of Information 11-4

ATTACHMENT I EXCLUDED DRUGS FOR THE TREATMENT OF HIV AND AIDS

ATTACHMENT II EXCLUDED PSYCHOTHERAPUETIC DRUGS

ARTICLE 2.0 - DEFINITIONS

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

2.1 **Administrative Costs** means only those costs which arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services which would ordinarily be incurred in the provision of these services whether or not through a plan.

2.2 **Affiliate** means an organization or person that directly, or indirectly through one or more intermediaries controls or is controlled by, or is under common control with Contractor and that provides services to or receives services from Contractor.

2.3 **Ambulatory Care** means the type of health services that are provided on an outpatient basis, at locations such as a clinic, health center, or physician's office.

2.4 **California Children Services (CCS) Program** means a public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41800.

2.5 **Catastrophic Coverage Limitation** means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster including but not limited to, an act of war, declared or undeclared, and which occurs subsequent to Enrollment.

2.6 **Child Health and Disability Prevention (CHDP) Program Service** means those preventive health care services for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et seq., and Title 17, CCR, Sections 6840 through 6850.

2.7 **CMAC** means the California Medical Assistance Commission.

2.8 **Collaborative Initiative** means collaboration of all Medi-Cal Managed Care Plans and Department of Health Services (DHS) to develop a standard methodology in order to study a common topic and produce comparable results.

2.9 **Confidential Information** means specific facts or documents identified as "confidential" by either law, regulations or Contract language.

2.10 **Contract** means this written agreement between the State and Contractor.

2.11 **Contracting Officer** means the single administrator of this Contract appointed by the Director of DHS. On behalf of DHS, the Contracting Officer will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations.

2.12 **Contracting Providers** means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with a health plan to provide medical services to Members.

2.13 **Contractor** means the Knox-Keene licensed plan, Sharp Health Plan.

2.14 **Contractor's Representative** means the single administrator who is designated by the Contractor to make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract and federal and State laws and regulations.

2.15 **Coordinate Benefits** means the process of utilizing third party liability resources to ensure that the Medi-Cal program is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of Medicare or private health coverage is known at the time the claim is processed, or the method of post- payment recovery of the cost of services, if the coverage is identified retroactively.

2.16 **Corrective Actions** means specific identifiable activities or undertakings of Contractor which address program deficiencies or problems identified by formal audits or monitoring activities by the State or its designated representatives.

2.17 **Covered Services** means Medical Case Management and those services set forth in Title 22, CCR, Division 3, Subdivision I, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, except the following excluded services:

a) Services for major organ transplant meaning heart, liver, heart-lung, lung, combined liver and small bowel, combined liver and kidney transplant, and bone marrow transplant or any new transplant that is approved by DHS as a Medi-Cal benefit;

b) Long term care services rendered to Members who require Skilled Nursing Facility Services as described in Title 22, CCR, Section 51335; Intermediate Care Facility Services as described in Title 22, CCR, Sections 51334, 51343.1, 51343.2; or Sub-Acute Care Services as described in Title 22, CCR, Section 51335.5; and who have been institutionalized for more than the month of admission plus one month;

c) Home and community based services as defined in 22, CCR, Section 51176. Home and community based services do not include any service that is available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, including EPSDT supplemental services, as described in Title 22, CCR, Sections 51184,51340 and 51340.1. Early and Periodic Screening, Diagnosis and Treatment services are Covered Services under this Contract;

d) California Children Services;

e) Specialty Mental Health Services;

f) Alcohol and drug treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR, Section 51341.1, and outpatient heroin detoxification as provided for in Title 22, CCR Section 51328;

g) Fabrication of optical lenses;

h) Directly Observed Therapy (DOT) for tuberculosis;

i) Services in any federal or State governmental hospital;

j) In-home medical care services as defined in Title 22, CCR, Section 51344;

k) Personal Care Services as defined in Title 22, CCR, Section 51183 and 51350;

l) Dental services as specified in Title 22, CCR, Section 51307, and Early Periodic Screening, Diagnosis and Treatment supplemental dental services as described in Title 22, CCR, Section 51340.1(a). However, Contractor is responsible for all medical Covered Services necessary to support dental services provided to Members as specified in Article 7, Subsection 7.6.4;

m) Any Local Education Agency services as specified in Title 22, CCR, Sections 51360 and 51190.4 provided pursuant to an Individualized Education Plan as set forth in Education Code, Section 56340 et seq., or an Individualized Family Service Plan as set forth in Government Code Section 95020, or Local Education Agency services provided under an Individualized Health and Support Plan, as described in Title 22, CCR, Section 51535.5(f)(2)(C);

n) Laboratory services provided under the State serum alphafetoprotein testing program administered by the Genetic Disease Branch of DHS;

o) Adult Day Health Care;

p) Targeted case management services as defined in Title 22, CCR, Section 51185 and specified in Title 22, CCR, Section 51351;

q) Childhood lead poisoning case management services provided by San Diego County Local Health Department;

r) Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency (AIDS) drugs listed in Attachment I (consisting of one page), and HIV and AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, approved by the federal Food and Drug Administration (FDA) after July 1, 1997 and psychotherapeutic drugs listed in Attachment II (consisting of two pages).

2.18 **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, and professional licensure.

2.19 **DDS** means the Department of Developmental Services.

2.20 **Derivative Aid Code** means an aid code which is a subset of Eligible Beneficiaries derived from an original Covered Aid Code.

2.21 **DHS** means the Department of Health Services, the single Department responsible for administration of the Medi-Cal Program, Children's Medical Services Program, California Children Services, Genetically Handicapped Persons Program, Child Health and Disability Prevention Program, and other health related programs.

2.22 **DHHS** means the Department of Health and Human Services, the federal agency responsible for management of the Medicaid program.

2.23 **Director** means the Director of the State of California Department of Health Services.

2.24 **Disproportionate Share Hospital** means a health facility licensed pursuant to Chapter 2, Division *2*, Health and Safety Code, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare & Institution (W&I) Code, Section 14105.98.

2.25 **Eligible Beneficiary** means a Medi-Cal beneficiary who is residing in Contractor's Service Area with either a mandatory aid code or a non-mandatory aid code. Those with non-mandatory aid codes are not required to enroll in a managed care plan but may do so voluntarily.

Mandatory Aid Codes:

Public Assistance, Family (CalWORKS formerly AFDC):
Aid Codes: 30, 32, 33, 35, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U

Public Assistance - Family:
Aid Codes: 38, 39, 54, 59, 5X, 7X

Medically Needy, Family (CalWORKS formerly AFDC), No Share of Costs:
Aid Codes: 3A, 3C, 3N, 34

Special Program/Percent/Children:
Aid Codes: 47, 72, 7A, 8P, 8R

Medically Indigent Child:
Aid Code: 82

Refugee/Entrant:
Aid Codes: 01, 02, 08, 0A

Non-Mandatory Aid Codes:

Public Assistance, Aged:
Aid Codes: 10, 18

Public Assistance, Blind/Disabled:
Aid Codes: 20, 28, 60, 68

Medically Needy, Aged, No Share of Costs:
Aid Codes: 14, 16

Medically Needy, Blind/Disabled, No Share of Costs:
Aid Codes: 6A, 6C, 6G, 6N, 24, 26, 36, 64, 66

Foster Care:
Aid Codes: 4C, 40, 42, 4F, 4G, 4K, 5K

Pregnant/Medically Indigent Adult:
Aid Code: 86

Disabled/Medically Needy/Children:
Aid Code: 6P, 6R

Foster Care/Medically Indigent Children:
Aid Code: 45

Adoption Assist/Medically Indigent - Child:
Aid Codes: 03, 04, 4A

Individuals with the following status regardless of aid code are not Eligible Beneficiaries for the purposes of enrollment:

a) Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for bone marrow, heart, heart-lung, liver, lung, combined liver and kidney, or combined liver and small bowel transplants.

b) Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, and the Model Waiver Program.

c) Individuals determined by the Medi-Cal Field Office to be in need of long term care and residing in a skilled nursing facility for 30 days past the month of admission.

d) Individuals who have commercial or Medicare HMO coverage.

2.26 **Emergency Medical Condition** means a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

i) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

ii) serious impairment to bodily functions, or

iii) serious dysfunction of any bodily organ or part.

2.27 Emergency Services means health services needed to evaluate or stabilize an Emergency Medical Condition.

2.28 Encounter means a single "face-to-face" visit or medically related service rendered by (a) provider(s) in an Ambulatory Care setting to an Eligible Beneficiary enrolled in the health plan during the date of service. It includes, but is not limited to, all services for which Contractor incurred any financial liability.

2.29 Enrollment means the process by which an Eligible Beneficiary becomes a Member of Contractor's plan.

2.30 Facility means any premise that is owned, leased, used or operated directly or indirectly by or for Contractor or its Affiliates for purposes related to this Contract or maintained by a provider to provide services on behalf of Contractor.

2.31 Federal Financial Participation means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

2.32 Federally Qualified Health Center (FQHC) means an entity as defined in Title 22, CCR, Section 53810(r).

2.33 Fee-For-Service (FFS) means a method of charging based upon billing for a specific number of units of services rendered to an Eligible Beneficiary.

2.34 Fee-For-Service Medi-Cal Mental Health (FFS/MC) means the mental health services covered through Fee-For-Service Medi-Cal which include outpatient services and acute care inpatient services. These services are provided through Primary Care Physicians as well as psychiatrists and psychologists.

2.35 Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHS, in an amount determined by DHS, which shall not be less than one full month's capitation.

2.36 **Financial Statements** means reports including balance sheets, income statements, statements of cash flows, statements of equity and accompanying footnotes prepared in accordance with generally accepted accounting principles.

2.37 **Fiscal Year (FY)** means any 12-month period for which annual accounts are kept. The State fiscal year is July 1 through June 30; the federal fiscal year is October 1 through September 30.

2.38 **Geographic Managed Care (GMC) Program** means the GMC Program authorized by Section 14089 et seq., of the W&I Code.

2.39 **Grievance** means a complaint filed by either a Member or a provider.

2.40 **Health Plan Employer Data and Information Set (HEDIS)** means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

2.41 **HEDIS Compliance Audit** means an audit process that uses specific standards and guidelines for assessing the collecting, storing, analyzing and reporting of HEDIS measures. This audit process is designed to ensure accurate HEDIS reporting.

2.42 **Internal Quality Improvement Projects (IQIPs)** means studies selected by each Medi-Cal Managed Care Plan to be used for their own internal quality improvement purposes. The studies include an initial report, 4 phases and a final report:

Initial Report: Includes information about the purpose and feasibility of the proposed project.

Phase 1: Development of the research design, methodology and project timeline.

Phase 2: Collection of baseline data.

Phase 3: Baseline data analyzed and interventions have been proposed.

Phase 4: Interventions have been implemented and remeasurement shows Significant Improvement.

Final Report: Remeasurement indicates Sustained Improvement has been achieved.

2.43 Knox-Keene Health Care Service Plan Act means the law which regulates health maintenance organizations and is administered by the Department of Managed Health Care commencing with Section 1340, Health & Safety Code.

2.44 Local Health Department (LHD) means the County of San Diego Health and Human Services Agency.

2.45 Marketing means any activity conducted on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.

2.46 Marketing Representative means a person who is engaged in Marketing activities on behalf of Contractor either through direct employment by Contractor or through a Marketing organization.

2.47 Medical Case Management means services provided by a Primary Care provider to ensure the coordination of Medically Necessary health care services, assuring the provision of preventive services in accordance with established standards and periodicity schedules and ensuring continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual’s health care needs.

2.48 Medical Records means written documentary evidence of treatments rendered to plan Members.

2.49 Medically Necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

2.50 Member means any Eligible Beneficiary who has enrolled in Contractor's plan and receives Covered Services under this Contract.

2.51 Minimum Performance Level refers to a minimum requirement of performance of the Contractor on each of the HEDIS measures selected by DHS.

2.52 Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access related to:

a) Sexual assault, including rape;

b) Drug or alcohol abuse for children 12 years of age or older;

c) Pregnancy and abortion services;

d) Family planning;

e) Sexually transmitted diseases, designated by the Director, in children 12 years of age or older;

f) Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

g) State law provides minors the right to obtain an abortion without parental consent.

2.53 National Committee for Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

2.54 NCQA Licensed HEDIS Compliance Organization is an entity licensed by NCQA to provide auditors certified by NCQA to conduct HEDIS Compliance Audits.

2.55 Newborn Child means a child born to a Medi-Cal beneficiary during the period of time she is receiving Medi-Cal benefits or in the month prior to initial receipt of Medi-Cal benefits.

2.56 Non-Medical Transportation Services means transportation required to access medical appointments and to obtain other Medically Necessary Covered Services by Members who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.

2.57 Non Physician Medical Practitioners means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide primary care under physician supervision.

2.58 Not-Report means:

a) Contractor did not calculate the measure and a population existed for which the measure could have been calculated.

b) Contractor calculated the measure but result was in error:

i) for measures reported as a rate (e.g. effectiveness of care measures) any error that causes a (+/-) 5 percentage point difference in the reported rate.

ii) for non-rate measures (e.g. Use of Services measures) any error that causes a (+/-) 10 percent change in the reported event.

2.59 Other Health Coverage (OHC) means coverage for health related services or entitlements for which an Eligible Beneficiary is eligible under any private health plan, any indemnification insurance program, any other State or federal medical care program, or under other contractual or legal entitlement.

2.60 Operations Period means that period of time during which Contractor is responsible for the delivery of Covered Services to Members, commencing August 1, 2000 through and including the last day of the Contract term.

2.61 **Physician Incentive Plan** means any compensation arrangement between Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

2.62 **Policy Letter** means a document which has been dated, numbered and issued by the Medi-Cal Managed Care Division and clarifies regulatory or contractual requirements, but does not add new obligations to the Contract.

2.63 **Preventive Care** means health care designed to prevent disease and /or its consequences. There are three levels of Preventive Care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.

2.64 **Primary Care** means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and Non-Physician Medical Practitioners. This type of care emphasizes caring for the Member’s general health needs as opposed to specialists focusing on specific needs.

2.65 **Primary Care Physician (PCP)** means a person duly licensed by the Medical Board of California who is responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals and for maintaining the continuity of care for the Member. A Primary Care Physician has focused the delivery of medicine to general practice or is a board certified or board eligible internist, obstetrician/gynecologist, pediatrician or family practitioner. A resident or intern shall not be a Primary Care Physician.

2.66 **Prior Authorization** means the process by which Contractor approves, usually in advance of the rendering, requested medical services. This is part of the utilization management system.

2.67 **Prior Authorization Request** means a method by which practitioners seek approval from Contractor to render medical services. Contractor’s utilization review coordinator is responsible for granting approval of providing specific, non-emergency Covered Services in advance of rendering such services.

2.68 **Quality Assurance (QA)** means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and Corrective Actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both health services and administrative and support services.

2.69 **Quality Improvement (QI)** means the result of an effective QA program which objectively and systematically monitors and evaluates the quality and appropriateness of care and services to Members through quality of care studies and other health related activities.

2.70 **Quality Improvement Plan (QIP)** means systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Contract language. The QIP consists of processes which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis towards an identified, targeted outcome measurement.

2.71 **Quality of Care** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

2.72 **Quality Indicators** means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

2.73 **Rural Health Clinic (RHC)** means an entity as defined in Title 22, CCR, Section 51115.5.

2.74 **Safety-net Provider** means a provider of comprehensive Primary Care and/or a hospital providing acute inpatient services to both the medically indigent and Eligible Beneficiaries. Safety-net Providers are:

a) Governmental - operated health systems,

b) Community health centers, rural and Indian/Alaskan Native Health Clinics,

c) Disproportionate Share Hospitals, public and university hospitals, and rural and children's hospitals, and

d) Federally Qualified Health Centers and qualified look-a-likes.

2.75 Sensitive Services means those services related to:

a) Family planning;

b) Sexually Transmitted Disease (STD);

c) Abortion; and

d) Human Immunodeficiency Virus testing.

2.76 Service Area means the geographic area comprised of those areas designated by the United States Postal Service ZIP codes in San Diego County that have been proposed by Contractor and approved in writing by DHS.

2.77 Service Location means any location at which a Member obtains any health care service provided by Contractor under the terms of this Contract.

2.78 Service Site means the location designated by Contractor at which Members receive Primary Care services.

2.79 Short-Doyle Medi-Cal Mental Health Services (SD/MC) means those services as defined in Title 22, California Code of Regulations, Section 51341. Short-Doyle Medi-Cal Mental Health Services include: crisis intervention, crisis stabilization, inpatient hospital services, crisis residential treatment case management, adult residential treatment, day treatment intensive, rehabilitation, outpatient therapy, medication, and support services.

2.80 Significant Improvement means a reduction of the performance gap, which is further defined, by the reduction of at least ten percent in the number of Members that do not achieve the desired outcome. This can also be defined as demonstrating that an improvement measured is statistically significant with a P value of less than or equal to 0.10.

2.81 **Specialty Mental Health Provider** means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, and registered nurses authorized to provide Specialty Mental Health Services.

2.82 **Specialty Mental Health Services** means:

1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
2. Psychiatric inpatient hospital services;
3. Targeted Case Management;
4. Psychiatrist services;
5. Psychologist services; and
6. EPSDT supplemental specialty mental health services.

2.83 **State** means the State of California.

2.84 **Subcontract** means a written agreement entered into by Contractor with any of the following:

a) A provider of health care services which agrees to furnish Covered Services to Members;

b) A Marketing organization; and

c) Any other organization or person(s) which agree(s) to perform any administrative function or service for Contractor specifically related to fulfilling Contractor's obligations to the State under the terms of this Contract.

2.85 Sub-Subcontractor means a party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

2.86 Sustained Improvement means the organization sustains the improvements in performance for at least one year after the improvement in performance is first achieved. Sustained Improvement is documented through the continued measurement of Quality Indicators for at least one year after the performance improvement project is completed.

2.87 Third Party Liability means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of all or part of the medical costs incurred because of illness, trauma, disease, or disability sustained by a Member. This liability may result from a health insurance policy, or other contractual agreement, or legal obligation, excluding tort liability.

2.88 Third Party Tort Liability means the responsibility of persons other than Contractor or the Member for payment of claims for injuries or trauma sustained by Members. This responsibility may be contractual, a legal obligation or as a result of or the fault or negligence of third parties (e.g., auto accidents or other personal injury casualty claims or workers compensation appeals).

2.89 Traditional Provider means physicians, Non-physician Medical Practitioners, pharmacies, optometrists and podiatrists who have and continue to deliver health care services to Eligible Beneficiaries. Traditional Providers can be profit or non-profit entities, publically or privately run and operated.

2.90 Turnover and Phaseout Period means the six month time period commencing on the date the Operations Period of the Contract or Contract extension ends.

2.91 **Urgent Care** means the services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

2.92 **Utilization** means the rate patterns of service usage or types of service occurring within a specified time. Inpatient Utilization is generally expressed in rates per unit of population-at-risk for a given period; e.g., the number of hospital admissions per 1,000 persons enrolled in a health maintenance organization per year.

2.93 **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

ARTICLE 3.0 - GENERAL PROVISIONS

3.1 GOVERNING LAW

This Contract will be construed in accordance with the applicable laws of the State of California. Such applicable laws may be used as aids in interpreting this Contract. However, the parties agree that such applicable laws will not create additional contractual obligations upon DHS, unless such applicable laws are expressly incorporated into this Contract in some other Section other than Section 3.1.

3.1.1 Severance and Acquiescence

In the event any provision of this Contract shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof.

3.2 COMPLIANCE WITH APPLICABLE LAWS

Contractor shall comply with all federal and State statutes and regulations.

Contractor’s failure to comply with any applicable State or federal statute or regulation will be grounds for the imposition of sanctions in accordance with Article 4, Section 4.5.

The parties agree that any remedies for DHS’ non-compliance with laws not expressly incorporated into this Contract, or any covenants implied to be part of the Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance.

3.2.1 Change in Statutes or Regulations

The parties recognize that during the life of this Contract, the Medi-Cal Managed Care Program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of these changes will vary widely over the life of the Contract.

The parties agree that the development of a system that has the capability to implement such changes in an orderly and timely manner is of considerable importance.

Any provision of this Contract which is in conflict with current or future applicable State or federal statutes or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Failure or refusal by Contractor to comply with such an amendment shall constitute grounds for termination of this Contract in accordance with the provisions of Article 4, Subsection 4.3.1, Termination - DHS, and Article 4, Subsection 4.3.2, Termination - Contractor. The parties shall be bound by the terms of the amendment until the effective date of the termination.

3.3 AUTHORIZED REPRESENTATIVES/DELEGATION OF AUTHORITY

The Director of the Department of Health Services shall appoint a single administrator for the Contract, hereafter called the “Contracting Officer”. The Contracting Officer, on behalf of the Director, shall make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through prior written notice to Contractor.

Contractor’s Chief Executive Officer shall be Contractor’s Project Director who shall designate a single administrator, hereafter called the “Contractor’s Representative,” who shall be located at Contractor’s facility in the State of California. The Project Director may act as Contractor’s Representative. Contractor’s Representative, on behalf of Contractor, shall make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and State laws and regulations. Contractor’s Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. Contractor’s Representative shall be empowered to legally bind Contractor to all agreements reached with the State.

Contractor’s Representative shall be designated in writing by Contractor. Such designation shall be submitted to the Contracting Officer.

3.4 AUTHORITY OF THE STATE

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of Covered Services under the Geographic Managed Care Program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or providers to participate in the Geographic Managed Care Program resides with the State.

Sole authority to establish or interpret policy and its application related to the above areas resides with the State.

Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

3.5 FULFILLMENT OF OBLIGATIONS

No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract shall be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party shall have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

3.6 ASSIGNMENT OF CONTRACT

This Contract shall not be assigned, in whole or in part, without the express written consent of DHS and amendment of the Contract by CMAC.

3.7 AMENDMENT OF CONTRACT

Should either party during the life of this Contract desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within 10 calendar days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth a detailed explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for changes mutually agreed to by the parties on the condition that the amendment is approved by DHHS, if necessary. Contractor-proposed changes shall be submitted to DHS and CMAC.

3.7.1 Informal Amendment Ineffective

It is the expressed intention of both DHS and Contractor that the terms of this totally integrated writing consisting of the Contract, standard agreement form, documents incorporated by reference and any amendments shall comprise the entire Contract which is not subject to rescission, modification, or waiver except as defined in a subsequent written instrument executed in the same manner and with the same authority. In furtherance of this agreement, the State and Contractor mutually covenant and request of any reviewing tribunal that any claim of rescission, modification, or waiver predicated upon any evidence other than a subsequent written instrument executed in the same manner and with the same authority as this writing be regarded as void.

The informal toleration by either party of defective performance of any independent covenant in this Contract shall not constitute a waiver of either the right to performance or the express conditions which have been created in this Contract.

3.8 INTERPRETATION OF CONTRACT/CAPTIONS/WORD USAGE

This Contract is the product of mutual negotiations, and if ambiguities arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

The captions, index, or headings in this Contract are for convenience only and in no way define, limit or describe the scope or intent of any provisions, articles, sections or clauses of this Contract.

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and other neuter genders shall each be deemed to include the others; (c) “shall”, “will”, or “agrees” are mandatory, and “may” is permissive; (d) “or” is not exclusive; and (e) “includes and including” are not limiting.

3.9 SUBMISSIONS TO DHS/NOTICES

All deliverables, correspondence, notices, reports and records required under this Contract shall be in writing and shall be deemed to have been provided when mailed. All submissions to the State shall be sent to DHS, except requests to re-negotiate the Contract shall be submitted to CMAC. Required notices, records and reports shall be sent to the following addresses as appropriate:

State Department of Health Services
Medi-Cal Managed Care Division
Healthy San Diego, Geographic Managed Care Project
714 P Street, Room 1400
P.O. Box 942732
Sacramento, CA 94234-7320
Attn: Contracting Officer

Sharp Health Plan
9325 Sky Park Court, Suite 300
San Diego, CA 92123
Attention: Andrew Shogren
Government Contract Manager

California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, California 95814

3.10 DISPUTES AND APPEALS

This Dispute and Appeals Section shall be used by Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute shall not preclude the State from recouping the value of the amount in dispute from Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds 25 percent of the capitation payment, amounts of up to 25 percent shall be withheld from successive capitation payments until the amount in dispute is fully recouped. If a recoupment or offset is later found to be inappropriate, the State shall repay Contractor the full amount of recoupment or offset, plus interest at the pooled money investment rate pursuant to Government Code, Section 16480 et seq.

3.10.1 Disputes/Resolution by Negotiation

DHS and Contractor agree to attempt to resolve all Contract issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

Before issuance of a Contracting Officer’s decision, informal discussions between the parties by individuals who have not participated substantially in the matter in dispute shall be considered by the parties in efforts to reach mutual agreement.

3.10.2 Notification of Dispute

Within 15 calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to Contractor, Contractor shall notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

Contractor's Notification of Dispute shall state, on the basis of the most accurate information then available to Contractor, the following:

a) That it has a dispute;

b) The date, nature, and circumstances of the conduct which is the subject of the dispute, including specification of applicable Contract provisions at issue;

c) The names, business address, phone numbers, function, and activity of each Contractor, subcontractor employee, State official or State employee involved in or who has knowledge of the conduct;

d) The identification of any documents and the substances of any oral and written communications involved in the conduct. Copies of all identified documents shall be attached;

e) The reason why Contractor is disputing the conduct;

f) The cost impact to Contractor directly attributable to the alleged conduct, if any; and

g) Contractor's desired remedy.

The required documentation, including cost impact data, shall be carefully prepared and submitted with substantiating documentation by Contractor. This documentation shall serve as the basis for any subsequent appeal under Section 3.10.6.

Notwithstanding submission of the required notification, with supporting documentation, and the pendency of a dispute and appeal, Contractor shall diligently continue performance of this Contract, including matters identified in this Section, and shall not be excused therefrom.

3.10.3 Contracting Officer's or Alternative Dispute Officer's Decision

Any disputes concerning performance of this Contract shall be decided by the Contracting Officer in a written decision stating the factual basis for the decision. Alternatively pursuant to a request by Contractor, the Contracting Officer shall provide for a dispute to be decided

by an Alternative Dispute Officer designated by the State, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program.

Within 30 calendar days of receipt of a Notification of Dispute, the decision maker, who is the Contracting Officer or the Alternative Dispute Officer, shall either render a decision or shall request additional substantiating documentation from Contractor, which in the opinion of the decision maker is sufficient to allow the rendering of a decision.

Within 30 calendar days of receipt of additional substantiating documentation requested, a decision shall be rendered by the decision maker. A copy of the decision shall be served on Contractor. The decision shall be final and conclusive unless within 30 calendar days from the date of service of that decision Contractor files a written appeal addressed to the Director, Department of Health Services, State of California. The decision shall:

a) Find in favor of Contractor, in which case the decision maker may:

   i) countermand the earlier conduct which caused Contractor to file a dispute; or

   ii) reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the provisions contained in Article 10, Payment Provisions, direct DHS to comply with those requirements.

b) Deny Contractor’s dispute and, where necessary, direct the manner of future conduct or performance; or

c) Request additional substantiating documentation in the event the information in Contractor’s notification is inadequate to permit a decision to be made under a) or b) directly above, and advise Contractor as to what additional information is required, and how that information is to be furnished. Contractor shall have 30 calendar days to respond to the decision maker’s request for further information. Upon receipt of this additional requested information, the decision maker shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the decision maker within the time period specified above shall constitute waiver by Contractor of all claims, actions and proceedings in accordance with Subsection 3.10.5.

3.10.4 Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or Alternate Dispute Officer's (decision maker's) decision.

If pursuant to an appeal under Section 3.10.6 (Appeal of Contracting Officer's or Alternate Dispute Officer's Decision), the Contracting Officer or Alternate Dispute Officer's decision is reversed, the effect of the decision pursuant to Section 3.10.6 shall be retroactive to the date of the Contractor Officer's or Alternate Dispute Officer's decision, and Contractor shall promptly receive any benefits of such decision. DHS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or Alternate Dispute Officer's decision or any appeal of such decision.

3.10.5 Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, or any additionally required information in the manner and within the time specified in the Disputes and Appeals sections, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct.

3.10.6 Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director and make a request for a hearing to the Director. All appeals and requests for hearing shall be governed by Health and Safety Code, Section 100171, and Government Code Sections 1140 et seq., and 1150 et seq., except for those provisions of Government Code Section 100171(d)(1), relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals and requests for hearing shall be in writing and shall be filed with and addressed to DHS Office of Administrative Hearings and Appeals, 1029 J Street, Room 200, Sacramento, CA. 95814 with a copy served on and addressed to the Contracting Officer.

An appeal and a request for hearing shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal and request for hearing shall

specifically set forth each issue in dispute, include Contractor's contentions as to those issues, and the estimated amount each issue involves. However, Contractor's appeal shall be limited to those issues raised in its Notice of Dispute filed pursuant to Section 3.10.2, (Notification of Dispute). Failure to timely appeal the decision and request a hearing shall constitute a waiver by Contractor of all claims, actions, and proceedings arising out of that conduct, in accordance with Section 3.10.5, (Waiver of Claims).

3.10.7 Exhaustion of Disputes and Appeals Procedures

Contractor shall exhaust all procedures provided for under Section 3.10. (Disputes and Appeals) prior to initiating or maintaining any other action to enforce this Contract.

3.11 INSPECTION RIGHTS

Contractor shall allow the State, including the Department of Health Services, the Department of Justice (DOJ) Bureau of Medi-Cal Fraud and the Department of Managed Health Care (DMHC), the federal government, including the Department of Health and Human Services and the Comptroller General of the United States; any other government entity which is statutorily authorized to have oversight responsibilities over the GMC program and contracts; and the successors and duly authorized representatives of the above noted entities, including DHS external quality review organization contractor, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract and applicable federal and State laws and regulations, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Contractor or subcontractor and any and all Subcontracts pertaining to these services at any time during normal business hours with or without notice and copy records as needed.

Books and records shall include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers, reports, financial records, and books of account, Medical Records, medical charts, prescription files, laboratory results, Subcontracts, management information systems and procedures and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in this Contract,

Contractor shall furnish any record, or copy of it, to the entities specified in this Section, or their duly authorized representatives.

Staff designated by the State shall have access to all security areas and Contractor shall provide, and shall require any and all of its subcontractors to provide reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access shall be undertaken in such a manner as to not unduly delay the work of Contractor and/or the subcontractor(s).

3.12 CONFIDENTIALITY OF INFORMATION

Notwithstanding any other provision of this Contract, names of persons receiving public social services are Confidential Information and are to be protected from unauthorized disclosure in accordance with Title 42, Code of Federal Regulations (CFR), Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to individual Members shall be protected by Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information.

3.13 DISCRIMINATION PROHIBITION

Contractor shall not discriminate against Eligible Beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations.

For purposes of this Contract, discrimination on the basis of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include but are not limited to the following: denying any Eligible Beneficiary any

Covered Service or availability of a Facility; providing to an Eligible Beneficiary any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated; subjecting an Eligible Beneficiary to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting an Eligible Beneficiary in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating an Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to race, color, creed, religion, sex, national origin, ancestry, age, marital status, sexual orientation, or physical or mental handicap, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person’s offspring, but which causes no adverse effects on the carrier. Such genes shall include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.14 DISCRIMINATION COMPLAINTS

Contractor agrees that copies of all Grievances alleging discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap shall be forwarded to the State for review.

3.15 EQUAL OPPORTUNITY EMPLOYER

Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of Contractor, state that Contractor is an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement

or other contract or understanding, a notice to be provided by the State, advising the labor union or workers' representative of Contractor's commitments as an equal opportunity employer. Contractor shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.16 NONDISCRIMINATION CLAUSE COMPLIANCE

During the performance of this Contract, Contractor and its subcontractors shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and use of family medical care leave and pregnancy disability leave. Contractor and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. Contractor and subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Contractor and its subcontractors shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

Contractor shall include the nondiscrimination and compliance provisions of this Section in all Subcontracts under this Contract.

3.17 CONTRACTOR'S NATIONAL LABOR RELATIONS BOARD (NLRB) DECLARATION

Contractor, by signing this agreement, does swear under penalty of perjury that no more than one final unappealable finding of contempt of court by a federal court has been issued against

Contractor within the immediately preceding two-year period because of Contractor failure to comply with an order of a federal court which orders Contractor to comply with an order of the NLRB.

3.18 OWNERSHIP/INTEREST CERTIFICATION

Contractor shall under penalty of perjury, certify that no person who has an ownership or controlling interest in Contractor’s firm, or is an agent or managing employee of Contractor, has been convicted of a criminal offense related to involvement in any program under Medi-Cal, Medicare, or Medicaid since the inception of these programs.

3.19 FINANCIAL INTEREST DISCLOSURE

Contractor shall file an annual statement with DHS disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have an ownership or control interest as defined in Title 42, CFR, Section 455.01.

a) Any person also having an ownership or control interest in Contractor,

b) Any director, officer, partner, trustee, or employee of Contractor; or

c) Any spouse or child of any person designated in (a) or (b) above.

3.19.1 Compliance

Contractor shall comply with federal regulations Title 42, CFR, Section 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), Title 42, CFR, Section 455.105 (Disclosure by providers: Information related to business transactions), and Title 42, CFR, Section 455.106.

3.19.2 Disclosure Form Submittal

The disclosures required pursuant to Section 3.19 and 3.19.1 will be submitted by Contractor at the time the Contract is executed, annually with Contractor's Certified Public Accountant (CPA) audit and Financial Statements, and within 35 calendar days of a written request from the State or 35 calendar days of any change in previously submitted information. The Fair Political Practices Commission Form 700, Statement of Economic Interest (hereinafter Form 700) based upon the Department of Health Services' Conflict of Interest Code, may be utilized to provide the required disclosures. To the extent that the Form 700 does not provide the required disclosure information, such information must be provided separately.

3.20 CONFLICT OF INTEREST - CURRENT AND FORMER STATE EMPLOYEES

Contractor shall not utilize in the performance of this Contract any current State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. Employee in the State civil service is defined to be any person legally holding a permanent or intermittent position in the State civil service.

Contractor shall not utilize in the performance of this Contract any former State officer or employee or other appointed official in violation of the provisions of Government Code Section 87406.

3.21 DISABLED VETERAN BUSINESS ENTERPRISES

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises commencing at Section 10115 of the Public Contract Code.

3.22 DRUG FREE WORKPLACE ACT OF 1990

Contractor shall comply with applicable requirements of the Drug Free Workplace Act of 1990, Government Code Section 8355.

3.23 AMERICANSWITH DISABILITIES ACT OF 1990 AND REHABILITATION ACT OF 1973 REQUIREMENTS

Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12100 et seq.), Title 45, CFR, Part 84 and Title 28, CFR, Part 36.

3.24 CHILD SUPPORT COMPLIANCE ACT ACKNOWLEDGMENT

By signing this Contract that exceeds $ the Contractor acknowledges that:

a) Contractor recognizes the importance of child and family support obligations and shall fully comply with all applicable State and federal law relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code; and

b) Contractor, to the best of its knowledge is fully complying with the earnings assignment orders of all employees and is providing names of all new employees to the New Hire Registry maintained by the California Employment Development Department.

c) Questions about the New Employee Registry and reporting requirements are to be directed to the California Employment Development Department.

3.25 CONSEQUENTIAL DAMAGES

In no event shall the State be liable for any incidental, indirect, special or consequential damages, including without limitation any lost profits, lost goodwill, or lost business regardless of the form of action and even if the State has been advised of the possibility of such damages.

ARTICLE 4.0 - TERM AND TERMINATION

4.1 CONTRACT TERM

This Contract shall become effective on August 1, 2000 and shall continue in full force and effect through July 31, 2002, subject to the provisions of Article 10, Section 10.2 and Article 4, Subsections 4.3.3, and 4.1.1 because the State has not yet appropriated funds available for encumbrance to cover costs of the program.

4.1.1 Contract Extension

DHS will have the exclusive option to extend the term of the Contract during the last twelve (12) months of the Contract, as determined by the original termination date or by a new termination date if an extension has been exercised. DHS may invoke up to three (3) separate extensions of two (2) years each. Contractor will be given at least nine (9) months of prior written notice of DHS' decision on whether or not it will exercise this option to extend the Contract.

The Contractor will notify DHS of its intent to accept or reject the extension within ten (10) State working days of the receipt of the notice from DHS.

4.2 TERMINATION OF COVERED SERVICE OBLIGATIONS

All obligations to provide Covered Services under this Contract shall automatically terminate on the effective date of any termination of this Contract pursuant to this Article or upon expiration of the term of this Contract. Contractor shall be responsible for providing Covered Services to Members until the termination or expiration of the Contract and shall remain liable for the processing and payment of invoices and statements for Covered Services provided to Members prior to that expiration or termination, during Turnover and Phaseout Period.

4.2.1 Turnover Requirements

Upon request by the Member, Contractor shall assist the Member in the orderly transfer of Member's medical care. In doing this, Contractor shall make available to the provider of the Member copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient Medical Case Management of Members. In no circumstances shall a Member be billed for this service.

4.2.2 Phaseout Requirements

Phaseout for this Contract shall consist of the processing, payment, monetary and reporting reconciliation(s) necessary regarding claims for payment for Covered Services. Contractor shall remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination of the Contract. Contractor shall submit to the State all reports required in Article 7, for the period from the last submitted report through the expiration or termination date.

All data and information provided by Contractor during Phaseout Period shall be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

4.2.3 Turnover and Phaseout Period

Turnover and Phaseout related activities are non-payable activities.

4.3 TERMINATION

4.3.1 Termination - DHS

DHS may terminate the Contract under the following circumstances:

a) For good cause shown at any time, by giving written notice to Contractor at least 30 calendar days prior to the effective date of termination. Good cause includes failure to comply with applicable federal or State statues, regulations or any of the terms of this Contract.

b) At the time DHS notifies Contractor of the intent to terminate the Contract under paragraph a), DHS shall notify Members enrolled with Contractor of the pending termination and give them an opportunity to disenroll immediately without cause.

c) Pursuant to Welfare and Institutions Code Section 14304 and Title 22, CCR, Section 53352, if Contractor requests a hearing within five days after receipt of the notice of intention to terminate, a public hearing shall be held 30 days after receipt of the notice by Contractor. The proceedings to terminate the Contract shall be governed by the provisions of the Health and Safety Code, Section 100171. DHS shall assign an administrative law judge who shall provide a written recommendation to DHS on the termination of the Contract within 30 days after the conclusion of the hearing.

4.3.2 Termination - Contractor

Contractor may terminate the Contract for good cause shown at any time by giving written notice to DHS to that effect, stating the reasons for the termination. The termination shall become effective on the last day of the second calendar month following the month in which notice of termination was given.

4.3.3 Mandatory Termination

DHS shall terminate this Contract in the event that:

a) The Secretary, DHHS, makes a final determination following any administrative appeals that Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act;

b) The Department of Managed Health Care makes a final determination, following any administrative appeals, that Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act; or

c) Congress does not appropriate sufficient funds for the program.

Under these circumstances, termination of the Contract shall be effective on the last day of the month when these events occur. Termination under this Section does not relieve Contractor of its obligations under Section 4.2.1 Turnover Requirements and Section 4.2.2 Phaseout Requirements.

4.3.4 Termination - Without Cause

DHS or Contractor may terminate this Contract without cause with 90 calendar days written notice to the other party.

4.4 NOTICE TO MEMBERS OF TRANSFER OF CARE

DHS or its designated representative shall notify Members about their medical benefits and available options no later than 60 calendar days prior to the termination or expiration of the Contract.

4.5 SANCTIONS

In the event DHS finds Contractor non-compliant with the standards and requirements prescribed in this Contract, governing statutes or regulations, or for other good cause shown, DHS may impose sanctions provided in Welfare and Institutions Code, Section 14304 and Title 22, California Code of Regulations, Section 53350. DHS may require Contractor to ensure that providers or subcontractors cease activities which include, but are not limited to, referrals, assignment of Eligible Beneficiaries, and reporting, until new activities are approved by DHS and DHS determines that Contractor is again in compliance.

ARTICLE 5.0 - POLICIES, PROTOCOLS AND STANDARDS

5.1 OPERATIONAL POLICIES

The parties acknowledge that Contractor has participated in the Healthy San Diego GMC Program pursuant to operational policies previously submitted to and/or approved by the State. During the term of this Contract either Contractor or State may request review or amendment of existing operational policies to reflect changes in statutes or regulations and methods and manner of delivery of managed care. The State will make its best efforts to review and accept or reject operational policies in writing within 60 days of receipt. The State may request additional information if needed. If such additional information is received, then the State will attempt to complete its review within 60 days of receipt of the additional information. If such materials are rejected, the State will specify the reasons therefore and the specific changes required for State approval. If Contractor does not have formal, written approval from the State for operational policies, Contractor implements or uses such policies at its own risk. These operational policies consist of a written document, consistent with the requirements of the Contract, describing in detail satisfactory to the State the following:

a) The manner and method by which Contractor will provide Primary Care and physician specialty services, inpatient and emergency room services, drugs, out-of-county care, health education services, all other services covered by this Contract, and the manner in which continuity of care will be assured, and identification of the additions to services currently provided to Eligible Beneficiaries in FFS Medi-Cal;

b) All requirements, and/or limitations, on provider participation in the GMC pilot project;

c) All limitations on the Eligible Beneficiary’s freedom to choose, or change, a health care provider;

d) The manner and method of provider reimbursement, including the use of risk pools, FFS, negotiated Contract rates, sharing of savings;

e) Member rights and the Grievance procedure;

f) The manner and method of Contractor's Quality Improvement Plan;

g) The plan to administer the program, including a general description of the requirements of the claims processing/management information system; and

h) The system for providing culturally competent services.

5.2 AMENDMENTS TO OPERATIONAL POLICIES

Contractor, at any time, may propose an amendment to its operational policies. The State will make its best efforts to review and accept or reject in writing any proposed amendments within 60 calendar days of receipt. The State may request additional information if needed. If such additional information is received, then the State will attempt to complete its review within 60 days of receipt of the additional information. If Contractor does not have formal, written approval from the State, Contractor implements or uses such operational policies at its own risk.

5.3 COMPLIANCE WITH OPERATIONAL POLICIES

Contractor shall operate the county-wide organized health delivery system pursuant to the operational policies, and any subsequent amendments, approved by the State, and all Subcontracts and operational protocols submitted to the State shall be consistent with those policies.

5.4 OPERATIONAL PROTOCOLS/OBTAINING STATE APPROVAL

All operational protocols required by this Contract shall be submitted to the State for prior written approval. The State will make its best efforts to review and accept or reject materials submitted within 60 calendar days of receipt. The State may request additional information if needed. If such additional information is received, then the State will attempt to complete

its review within 60 days of the receipt of additional information. If Contractor does not have formal, written approval from the State, Contractor implements or uses such operational protocols at its own risk.

Operational protocols refers to any document, plan, or report, other than the operational policies, which is required by this Contract, including but not limited to information concerning:

a) Provider network for Covered Services, except for providers of seldom used or unusual services as determined by the State;

b) Facilities;

c) Marketing activities;

d) Marketing materials, promotional materials, and public information releases relating to performance under this Contract; Member service guides; Member newsletters; and provider claim forms unique to the Contract;

e) Member Grievance procedure;

f) Member disenrollment procedure; and

g) Grievance forms.

Revisions to these items must be submitted to the State for prior written approval.

5.5 COMPLIANCE WITH PROTOCOLS

Contractor shall develop and provide the State with the policies, protocols, procedures and standards specific to and necessary to ensure Contractor's compliance with the provisions and requirements of this Contract. Contractor shall implement and comply with these policies, protocols, procedures and standards within 30 calendar days of written State approval. All subsequent revisions thereof shall be approved in writing by the State and

implemented by Contractor within 30 calendar days of such approval. Contractor shall not implement protocols, procedures or revisions thereof prior to written approval by the State.

5.6 LICENSE AND CERTIFICATION STANDARDS

The following standards for licensure and certification of providers and facilities are the minimum acceptable standards under this Contract.

5.6.1 Providers

Each provider who delivers Covered Services to Members shall be eligible for participation in the Medi-Cal program and shall meet applicable requirements established under Titles VIII and XIX of the Social Services Act unless exempted from these provisions. All providers of Covered Services shall be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. Providers treating Members with Hansen’s disease and/or active tuberculocis shall be approved by the LHD.

5.6.2 Facilities

Facilities used by Contractor for providing Covered Services shall comply with the provisions of Title 22, CCR, Section 53230.

5.6.3 Laboratories

Contractor shall ensure that each laboratory used by Contractor or Contractor’s subcontractor(s) to provide services under this Contract comply with federal and State laws.

Contractor shall ensure that each location used for testing or examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, treatment or assessment of any disease, impairment, or health of a human have in effect:

a) Current, unrevoked or unsuspended certificate for provider-performed microscopy procedures, certificate of accreditation, certificate of registration or certificate of waiver issued under the requirements of Title 42, USC, Section 263a and the regulations adopted thereunder and found at Title 42, CFR, Subpart A, Section 493.1 et seq.; and either

i) A current, unrevoked or unsuspended license or registration issued under the requirements of Chapter 3 (commencing with Section 1200) of Division 2 of the California Business and Professions Code and the regulations adopted thereunder; or

ii) Be operated in conformity with Chapter 7 (commencing with Section 1000) of Division 1 of the Health and Safety Code and the regulations adopted thereunder.

b) Any laboratory that does not comply with the appropriate federal and State law is not eligible for participation in, or reimbursement from, the Medicare or Medi-Cal programs.

5.7 PREVENTIVE CARE STANDARDS

The following standards and guidelines for Preventive Care are the minimum acceptable standards for provision of Covered Services to Members under this Contract. These standards serve as a baseline for assessment against which care actually delivered will be compared.

5.7.1 Pediatrics

For pediatric care, minimum acceptable standards for periodic health screen schedules are based on the most recent recommendations of the American Academy of Pediatrics (AAP). Immunization schedules based on recommendations of either the Advisory Committee on Immunization Practices or the AAP shall be acceptable.

5.7.2 Obstetrics

For obstetric care, minimum standards are based on recommendations of the American College of Obstetrics and Gynecology (ACOG). Contractors axe further required to provide risk assessment and interventions consistent with Comprehensive Perinatal Services Program (CPSP) requirements as specified in Title 22, CCR, Sections 51348 and 51348.1.

5.7.3 Adult Preventive Care

For adult Preventive Care, minimum acceptable standards are the guidelines established in the Report of the United States Preventive Services Task Force.

5.7.4 Tuberculosis

For care and treatment of Members with tuberculosis (TB), the guidelines recommended by the American Thoracic Society and Center for Disease Control are the minimum acceptable standards.

ARTICLE 6.0 - ENROLLMENT AND DISENROLLMENT

6.1 ENROLLMENT

Eligible Beneficiaries residing within San Diego County may be enrolled at any time during the term of the Contract. All Eligible Beneficiaries shall be accepted by Contractor up to the limits of Contractor's Enrollment capacity approved by DHS pursuant to Section 6.2. Contractor shall accept Eligible Beneficiaries without regard to physical or mental condition, age, sex, race, religion, creed, color, national origin, marital status, sexual orientation or ancestry.

6.1.1 Assignment of Eligible Beneficiaries

If an Eligible Beneficiary fails to timely choose a health plan, the DHS' Enrollment contractor shall notify the Eligible Beneficiary in writing of the plan in which the Eligible Beneficiary will be enrolled. If, at any time, an Eligible Beneficiary notifies DHS or DHS' Enrollment contractor of a health plan choice, such choice shall override the Eligible Beneficiary assignment to a health plan except if disenrollment of the Eligible Beneficiary is restricted under Section 6.6.1.

6.2 ENROLLMENT CAPACITY

Contractor's maximum Enrollment capacity under this Contract shall not exceed 100,000.

6.3 ENROLLMENT LIMITATION

Enrollment may proceed to the plan's Enrollment capacity unless limited by DHS. Such limitations will be defined in writing and Contractor notified at least 10 calendar days prior to the start of the period of limitation. Release of limitations will be in writing and transmitted to Contractor at least 10 calendar days prior to the date of the release.

6.4 COVERAGE

Member coverage will begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approval list of beneficiaries furnished by the State to Contractor. The term of membership will continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in this Article.

6.4.1 Newborn Child Coverage

Contractor shall provide Covered Services to a Newborn Child of a Member for the calendar month of birth and the calendar month following the month of birth. For a child born in the month immediately preceding the mother's membership, Contractor shall provide Covered Services to the child during the mother's first month of Enrollment. No additional capitation payment shall be made to Contractor by DHS.

6.5 PARTICIPATION IN ENROLLMENT PROGRAM

Contractor shall cooperate and participate in the State program by providing DHS' Enrollment contractor Marketing materials, evidence of coverage and disclosure forms, Member services guide, list of network providers, linguistic and cultural capabilities of Contractor and other information deemed necessary by the State to assist Eligible Beneficiaries in making an informed choice of health plan.

6.6 DISENROLLMENT

The Health Care Options (HCO) Enrollment contractor will process a Member disenrollment subject to approval by DHS, in accordance with the provisions of Title 22, CCR, Section 53925.5.

6.6.1 Restricted Disenrollment

To the extent allowed under State and federal law, if DHS directs the Enrollment contractor and notifies Contractor in writing, newly enrolled Members shall be restricted from disenrolling from Contractor during the nine month period beginning 90 days after the Member is notified of Enrollment and continuing through the twelfth month of initial Enrollment. Members may disenroll for cause at any time. Members shall be allowed to disenroll without cause during the first 90 days after the Member is notified of Enrollment and during an unrestricted disenrollment period at least once every 12 months after initial Enrollment pursuant to Subsection 6.6.2(a).

6.6.2 Mandatory Disenrollment

Disenrollment of a Member is mandatory when:

a) The Member requests disenrollment, and the request is not during any restricted disenrollment period for the Member;

b) The Member's eligibility for Enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Eligible Beneficiary;

c) Enrollment was in violation of Title 22, CCR, Sections 53400, 53921, 53921.5, 53922, or 53402, or requirements of this Contract regarding Marketing, and the State or Member requests disenrollment;

d) Disenrollment is requested in accordance with W&I Code Section 14303.1 or 14303.2;

e) There is a change of a Member's place of residence to outside Contractor's Service Area;

f) It is determined that the Member is enrolled as a commercial or Medicare beneficiary of an HMO; or

g) Disenrollment is based on the circumstances described in Section 6.7.

6.6.3 Effective Date of Disenrollment

Disenrollment will become effective on the first day of the second month following receipt by DHS of all documentation necessary, as determined by DHS, to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date, except for disenrollment pursuant to Subsection 6.7.1, for which disenrollment will be effective the beginning of the month in which a transplant is approved.

Except as provided in Section 6.4, Enrollment shall cease no later than midnight on the last day of the second calendar month in which the Member's disenrollment request and all required supporting documentation are received by DHS. On the first day after membership ceases, Contractor is relieved of all obligations to provide Covered Services to the Eligible Beneficiary under the terms of this Contract. Contractor agrees in turn to return to the State any capitation payment forwarded to Contractor for persons no longer enrolled under this Contract.

6.6.4 Contractor Initiated Disenrollment

Contractor may recommend to the State the disenrollment of any Member in the event of a breakdown in the "doctor-patient relationship" which makes it impossible for Contractor's Contracting Providers to render services adequately to a Member. Except in cases of violent behavior or fraud, Contractor shall make a significant effort to resolve the problem with the Member through avenues such as reassignment of PCP, education, or referral to services (such as mental health or substance abuse programs), before requesting a Contractor-initiated disenrollment. In cases of Contractor-initiated disenrollment, Contractor must submit to the State a written request for disenrollment with supporting documentation based on the breakdown of Contractor Member relationship. Contractor-initiated disenrollments must be prior approved by DHS and will be considered only under the following circumstances:

.1 Verbal Abuse

Member is repeatedly verbally abusive to the Contracting Providers, ancillary or administrative staff, subcontractor staff or to other plan Members;

.2 Physical Abuse

Member physically assaults a Contracting Provider or staff person, subcontractor staff person, or other Member, or threatens another individual with a weapon on Contractor's premises. In this instance, Contractor or subcontractor will file a police report and file charges against the Member;

.3 Disruptive Behavior

Member is disruptive to Contractor operations, in general;

.4 Habitual Use of Non-Network Providers

Member habitually uses providers not affiliated with Contractor for non-emergency services without required authorizations (causing Contractor to be subjected to repeated provider demands for payment for those services or other demonstrable degradation in Contractor's relations with community providers);

.5 Fraudulent Use of Medi-Cal Coverage

Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan membership card to receive services from Contractor; or

.6 Noncompliance with Prescribed Treatment

A Member's failure to follow prescribed treatment (including failure to keep established medical appointment) will not, in and of itself, be good cause for the approval by DHS of a Contractor-initiated disenrollment request unless Contractor can demonstrate to DHS that, as a result of the failure, Contractor is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Contract and rate negotiations.

6.6.5 Procedure for Contractor Initiated Disenrollment

A formal procedure for Contractor-initiated disenrollments shall be established by Contractor and approved by DHS. As a part of the procedure, Contractor must document problem resolution efforts described in Section 6.6.4. Also, the Member will be notified in writing by Contractor of the intent to disenroll the Member for cause and allowed a period of no less than 20 calendar days to respond to the proposed action.

.1 Contractor Written Request for Disenrollment

Contractor must submit a written request for disenrollment and the documentation supporting the request to DHS for approval. The supporting documentation must establish the pattern of behavior and Contractor's efforts to resolve the problem.

.2 DHS Review of Request

DHS will review the request and render a decision in writing within 10 working days of receipt of a Contractor request and necessary documentation.

a) If Contractor-initiated request for disenrollment is approved, DHS will submit the disenrollment request to the Enrollment contractor for processing. Contractor shall be notified by DHS of the decision, and if the request is granted, will be notified by the Enrollment contractor of the effective date of the disenrollment.

.3 Contractor Notice to Member

Contractor shall notify the Member of the disenrollment for cause if DHS grants Contractor-initiated request for disenrollment.

.4 Continuation of Coverage Until Disenrollment

Contractor shall continue to provide Covered Services to the Member until the effective date of the disenrollment.

6.6.6 Procedure For Member Initiated Disenrollment

Contractor shall implement and maintain procedures to ensure that Contractor's Member Services' telephone number is readily available at all Service Sites and that Members requesting disenrollment or information regarding the disenrollment process are immediately referred to the Enrollment contractor.

6.7 CIRCUMSTANCES UNDER WHICH MEMBER IS DISENROLLED FOR SERVICE EXCLUSION

6.7.1 Major Organ Transplants

Major organ transplant procedures are not Covered Services under the Contract. If the transplant center physician considers the Member to be a suitable candidate, Contractor shall initiate disenrollment of a Member who requires a bone marrow transplant, heart transplant, liver transplant, heart-lung transplant, lung transplant, combined liver and kidney transplant or combined small bowel and liver transplant or any new transplant approved by DHS as a Medi-Cal benefit when all of the following has occurred:

a) Contractor's referral of the Member to a Medi-Cal approved organ transplant center;

b) Submission of a Prior Authorization Request by the Contractor to either the Medi- Cal Field Office (for adults) or the California Children Services (CCS) Program (for children) for approval;

c) Concurrence by transplant center, supported by clinical evaluation, that the Member is a candidate for an organ transplant; and

d) Transplant authorization by either DHS' Medi-Cal Field Office (for adults) or the CCS Program (for children).

.1 Effective Date of Disenrollment

Upon disenrollment, Contractor shall ensure continuity of care by transferring all of the Member's medical documentation to the transplant physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the transplant is approved. All services provided during this month will be billed FFS.

.2 Continued Member Enrollment

If the Member is evaluated and determined not to be a candidate for a major organ transplant or the State denies authorization for a transplant, the Member will not be disenrolled. The cost of the evaluation and responsibility for the continuing treatment of the Member will remain with Contractor.

6.7.2 Waiver Programs

Contractor shall initiate disenrollment for the Member if the Member elects to join any of the following waiver programs identified in Section 2.21 b), In-Home Medi-Cal Waiver Program, Skilled Nursing Facility Waiver Program; the Model Waiver Program; the agency administering the waiver program concurs with Contractor's assessment of the Member; and there is available placement in the waiver program. Contractor shall follow this procedure:

a) Identify and refer Members to the appropriate waiver program;

b) Seek concurrence from the waiver program; and

c) Upon the Member's acceptance into waiver program provide documentation to ensure the Member's orderly transfer to the Medi-Cal FFS program.

If the Member does not meet the criteria for the waiver program, or if the placement is not available, the Member will not be disenrolled and Contractor shall continue Medical Case Management and provide all Medically Necessary Covered Services to the Member.

6.7.3 Long Term Care

Contractor shall assess Members' projected lengths of stay upon admission to skilled nursing facilities, subacute facilities, pediatric subacute facilities, or intermediate care. If the Member will require long term care, care in the Facility for longer than the month of admission plus one month, Contractor shall submit a disenrollment request for the Member to the State for approval according to the following procedures:

a) Contractor shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective.

b) An approved disenrollment request will become effective the first day of the second month following the month of the Member's admission to the facility, provided Contractor submitted the disenrollment request at least 30 calendar days prior to that date. If Contractor submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request.

c) Upon disenrollment, Contractor shall ensure the Member's orderly transfer from Contractor to the Medi-Cal FFS program.

6.7.4 Members Requiring Hospice Services Not Disenrolled

Election of hospice services as described in Title 22, CCR, Section 51349, does not affect the Member's eligibility for Enrollment under the Contract. Hospice services are Covered Services under the Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing facility.

6.8 MARKETING ACTIVITIES

Contractor shall not conduct Marketing activities without prior written approval of its Marketing plan from DHS. Contractor shall comply with the most recent version of the DHS Managed Care Health Plan Marketing Manual in conducting Marketing activities.

6.8.1 Marketing Plan

Contractor will implement and maintain a Marketing plan approved by DHS prior to its implementation. Conducting door-to-door, telephone or other cold call Marketing is strictly prohibited. Contractor shall not offer cash or other incentives to Medi-Cal Eligible Beneficiaries to induce them to enroll.

6.8.2 Certification of Marketing Representatives

Contractor shall ensure that any office staff of a provider whose primary duties are Marketing, are certified as Marketing Representatives.

.1 Marketing Representatives

Contractor shall comply with the requirements of Title 22, CCR, Sections 53920 and 53920.5 and ensure that:

a) Marketing Representatives comply with all State and federal laws and regulations regarding Marketing;

b) All Marketing Representatives including supervisors, have satisfactorily completed Contractor's Marketing orientation, training program and the State Marketing Representative Certification Examination prior to engaging in Marketing activities on behalf of Contractor;

c) Marketing Representative shall not provide Marketing services on behalf of more than one Contractor; and

d) Marketing Representatives shall not engage in Marketing practices that discriminate against an Eligible Beneficiary because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap, or health status.

6.9 LIABILITY

The Marketing Representative is responsible for all Marketing activity conducted on behalf of Contractor. Contractor shall be held liable for any and all violations by Marketing Representatives.

ARTICLE 7.0 - SERVICE DELIVERY REQUIREMENTS

7.1 SCOPE OF SERVICE/CONTRACTOR RISK IN PROVIDING SERVICES

Contractor shall provide or arrange and pay for all Medically Necessary Covered Services including Medical Case Management services under the Contract. Covered Services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract. Contractor shall ensure that the medical necessity of Covered Services is determined through Utilization control procedures established in accordance with Sections 8.10.2, Pre-Authorization/Review Procedures, and 8.10.3, Exceptions to Prior Authorization Requirement, unless specific Utilization control requirements are included as terms of the Contract under sections applicable to specific services. However, no Utilization control procedure, or any other policy or procedure used by Contractor, shall limit services Contractor is required to provide under this Contract.

7.1.1 Continuity of Care and Case Management

In providing or arranging for the provision of Covered Services, Contractor shall:

.1 Health Assessment

Develop, implement, and maintain procedures for the performance of an initial health assessment for each Member within 120 calendar days of Enrollment.

.2 Referrals and Follow-Up Care

Develop, implement, and maintain an adequate system for tracking all referrals and follow-up care.

.3 Coordination of Care

Maintain procedures for monitoring and measuring the coordination of care provided to the Members in all settings, including, but not limited to, coordination of discharge planning from inpatient Facilities and coordination of all Medically Necessary services both within and outside Contractor's provider network.

.4 Missed/Broken Appointments

Implement and maintain policies and procedures to follow-up on missed/broken appointments.

.5 Continuity of Care

Ensure continuity of care from the Ambulatory Care setting to the inpatient care setting and all other care settings as needed.

.6 Standing Referrals to a Specialist or Specialty Care Center

Implement and maintain policies and procedures to comply with the requirements of Section 1374.16 of the Health and Safety Code.

.7 Continuation of Care with Terminated Providers

Implement and maintain policies and procedures to assure continuation of care for enrollees with terminated providers in a manner consistent with the requirements of Section 1373.96 of the Health and Safety Code.

7.2 NETWORK CAPACITY/COMPOSITION

Contractor shall maintain an adequate number of inpatient Facilities; Service Locations; Service Sites; and professional, allied, specialist and supportive paramedical personnel within its network to provide Covered Services to Members in San Diego County.

Contractor shall increase the capacity of the network as necessary to accommodate Enrollment growth beyond the State-approved Enrollment capacity.

Contractor shall ensure that the composition of the provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

7.2.1 Adequate Facilities and Personnel

Contractor shall demonstrate the continuous availability and accessibility of adequate numbers of institutional Facilities; Service Locations; Service Sites; and professional, allied, and supportive paramedical personnel to provide Covered Services including the provision of all medical care necessary under emergency circumstances on a 24-hours-a-day, seven-days-a-week basis. Contractor shall ensure that a plan physician is available 24-hours-a-day for timely authorization of Medically Necessary care and to coordinate transfer of stabilized Members in the emergency department, if necessary. Contractor shall have as a minimum a designated Emergency Services Facility, providing care on a 24-hours-a-day, seven-days-a-week basis. This designated Emergency Services Facility will have one or more physicians and one nurse on duty in the Facility at all times.

7.2.2 Primary Care Physician (PCP)

Contractor shall maintain a network of PCPs which are located within 30 minutes or 10 miles of a Member's residence unless Contractor has a State approved alternative time and distance standard to ensure that each new Member has an appropriate and available PCP. Contractor shall ensure that each Member has a PCP or, if selected by the Member, a Non Physician Medical Practitioner who is available and physically present at the service site for sufficient time to ensure access for the assigned Member upon request by the Member or when medically required and to personally case manage the Member on an on-going basis.

.1 Primary Care Physician Selection

Contractor shall provide each new Member an opportunity to select a PCP within the first 30 calendar days of Enrollment. If Contractor's provider network includes Non Physician Medical Practitioners, the Member may select such a provider within 30 calendar days of Enrollment to provide Primary Care services. Contractor shall

ensure that the Member who selects a Non Physician Medical Practitioner is also assigned to a Primary Care Physician who is responsible for the medical coordination of the Member's care and serves in a consultative, collaborative or supervisory relationship to the Non Physician Medical Practitioner consistent with federal and State statutes and regulations. Contractor shall ensure that Members are allowed to change a PCP or Non Physician Medical Practitioner, upon request, by selecting a different PCP or from Non Physician Medical Practitioner from Contractor's network of providers. Contractor shall provide the Eligible Beneficiary sufficient information (verbal and written) in the appropriate language and reading level about the selection process and the available providers in the network to ensure the ability to make an informed decision.

a) Disclosures

Contractor will disclose to affected Members any reasons for which their selection or change in PCPs cannot be made.

.2 Primary Care Physician Assignment

If the Eligible Beneficiary does not select a physician or Non Physician Medical Practitioner to provide Primary Care within 30 calendar days of the effective date of Enrollment, Contractor shall assign that Eligible Beneficiary to a PCP and notify the Eligible Beneficiary and the assigned PCP no later than 40 calendar days after the Eligible Beneficiary's Enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Eligible Beneficiaries to Contracting Providers.

a) Continuity of Care

Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.

7.2.3 Specialists

Contractor shall maintain adequate numbers and types of specialists within the network through staffing, subcontracting or referral to accommodate Members' need for specialty care. Contractor shall provide a recording/tracking mechanism for each authorized, denied, or modified referral. In addition, Contractor shall offer second opinions by specialists to any Member upon request.

7.2.4 Provider - To - Member Ratios

Contractor shall ensure compliance with Title 10, CCR, Section 1300.67.2, Accessibility of Services.

.1 Contractor shall ensure that networks continuously satisfy the following full time equivalent provider to Member ratios:

a)	Primary Care Physicians	1:2,000
b)	Total Physicians	1:1,200

.2 If Non Physician Medical Practitioners are included in Contractor's provider network, each individual Non Physician Medical Practitioner will not exceed a full-time equivalent Non Physician Medical Practitioner provider/patient caseload of one provider per 1,000 patients; 1:1,000:

a) Contractor shall ensure compliance with Title 22, CCR, Sections 51240 and 51241 in utilizing Non Physician Medical Practitioners.

.3 An alternative mechanism may be provided by Contractor to demonstrate an adequate ratio of physicians to Members. DHS must approve any alternative mechanism prior to plan implementation.

7.2.5 Safety-net and Traditional Providers Participation

Contractor shall ensure the participation and broad representation of Traditional and Safety-net Providers within San Diego County.

7.2.6 Report of Changes in Network

Contractor shall submit to the State on a quarterly basis, 30 calendar days following the end of the reporting quarter, in a format specified by the State, a report summarizing changes in the provider network. The report will identify provider deletions and additions and the resulting impact to:

a) Geographic access for the Members;

b) Cultural and linguistic services;

c) The percentage of Safety-net Providers and Traditional Providers;

d) The ethnic composition of providers; and

e) The number of Members assigned to PCPs and the percentage of Members assigned to Safety-net and Traditional Providers.

7.3 SPECIFIED SERVICES

7.3.1 Pharmaceutical Services and Prescribed Drugs

Contractor shall provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including, but not limited to, Title 22, CCR, Section 53912. At a minimum, such pharmaceutical services and drugs shall be available to Members during Service Site hours. A sufficient quantity of drugs shall be provided to a Member to last until the Member can reasonably be expected to

have a prescription filled when drugs are provided to a Member under emergency circumstances.

7.3.2 Vision Care Services

Contractor shall ensure a vision care services system, consistent with good professional practice, which provides that a Member may be seen initially by either of the following:

a) An optometrist or an ophthalmologist; or

b) A PCP before referral to an optometrist or an ophthalmologist.

Contractor shall provide ophthalmic lenses in accordance with Subsection 7.6.5.

7.3.3 Inpatient Care

Contractor shall provide acute inpatient services to Members in accordance with Title 10, CCR, Section 1300.67(b).

Contractor shall implement and maintain procedures to monitor Quality of Care provided to Members in inpatient Facilities. If Contractor delegates the Quality Improvement functions to hospitals, Contractor shall maintain procedures to monitor the delegated function, including review of services provided by its physicians within the hospital.

7.3.4 Long Term Care

Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing facility services are placed in facilities providing the appropriate level of care commensurate with the Member's medical needs. These facilities include skilled nursing facilities, subacute facilities, pediatric subacute facilities, or intermediate care. Contractor shall base decisions on the appropriate level of care in accordance with the definitions set forth in Title 22, CCR, Sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in Title 22, CCR, Sections 51335, 51335.5, 51335.6 and 51334 and related Sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22, CCR, Section 51003 (e).

7.4 PREVENTIVE SERVICES

In providing and arranging for Covered Services for Members, Contractor shall include, as a minimum, the following clinical preventive services.

7.4.1 Initial Health Assessment

Contractor shall schedule and provide an initial health assessment (complete history and physical examination) to Members age 21 years of age and older within 120 calendar days of the date of Enrollment, unless the Member's Primary Care provider determines that the Member's Medical Record contains complete and current information to allow for assessment of the Member's health status and health risk in accordance with the assessment requirements below. For Members 21 years and older, the initial health assessment shall follow the guidelines required by Section 7.4.4 and include a discussion of appropriate preventive measures and arrangement for follow-up appointments. For Members under the age of 21 years, the initial health assessment shall follow the requirements of Health and Safety Code (H&S), Sections 124025, et seq., and Title 17, CCR, Sections 6840 through 6850, except that Contractor shall follow the most recent periodicity schedule recommended by the American Academy of Pediatrics (AAP). If the Member fails to keep the scheduled appointment, Contractor shall recontact the Member in accordance with the procedures for follow-up on missed appointments.

7.4.2 Child Health And Disability Prevention Program Services (CHDP)

Contractor shall maintain and operate a system which ensures the provision of CHDP services to Members under the age of 21 years in accordance with the applicable provisions of the H&S Code, Section 124025 et seq. and Title 17, CCR, Section 6840 through 6850, except that Contractor shall follow the most recent periodicity schedule recommended by the American Academy of Pediatrics (AAP). The system shall include the following components:

.1 Initial health assessments;

.2 Notification, in writing, of the availability of health assessment services, the times and places where these services are available, and the method by which appointments

for CHDP services may be made. Notification will be provided upon Enrollment and annually thereafter. Notification may be given to the parent(s) or guardian of the Member under 21 years of age, or to the Member directly if the Member is an emancipated minor;

.3 Where a request is made for CHDP services by the Member the Member's parent(s) or guardian, or through a referral from the local CHDP program, an appointment will be made for the Member to be examined within four weeks of the request;

.4 Members under the age of 21 years will be scheduled for periodic health assessments in accordance with periodicity schedule recommended by the American Academy of Pediatrics and the immunizations will be provided following the recommendations of either the Advisory Committee on Immunization Practices or the American Academy of Pediatrics;

.5 At each non-emergency Primary Care Encounter with Members under the age of 21 years, the Member (if an emancipated minor) or the parent(s) or guardian of the Member will be advised of the CHDP services available from Contractor, if the Member has not received CHDP services in accordance with the AAP periodicity schedule. Documentation will be entered in the Member's Medical Record which will indicate the receipt of CHDP services in accordance with the AAP periodicity schedule or proof of voluntary refusal of these services in the form of a signed statement by the Member (if an emancipated minor) or the parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal will be noted in the Member's Medical Record;

.6 Written notification and explanation of the results of CHDP health assessments will be supplied to the Member (if an emancipated minor) or the parent(s) or guardian of the Member in a timely manner. Upon request by the Member or the parent(s) or the guardian, Contractor shall provide for additional discussion or consultation regarding the results of the assessment if appropriate;

.7 Diagnosis and treatment of any medical conditions identified through any CHDP assessment will normally be initiated within 60 calendar days of the CHDP assessment appointment, consistent with the terms of the Contract for the identified

services or conditions. Justification for delays beyond 60 calendar days will be maintained in the Medical Record;

.8 The Confidential Screening/Billing Report form, PM 160-PHP, will be used to report all CHDP Encounters. Contractor shall submit completed forms to the State and to the local CHDP program within 30 calendar days of the end of each month for all Encounters during that month; and

.9 Contractor shall coordinate its CHDP system with the local CHDP program.

7.4.3 Pregnant Members

Contractor shall provide services to pregnant Members in accordance with the most recent Standards of American College of Obstetrics and Gynecologists (ACOG - currently the Seventh Edition) at a minimum. Contractor shall develop and implement standardized risk assessment tools which are consistent with Comprehensive Perinatal Services Program (CPSP) requirements set forth in Title 22, CCR, Sections 51348 and 51348.1. Contractor shall submit assessment tools and protocols to DHS for approval prior to implementation.

.1 Contractor shall ensure that an obstetrical record and a comprehensive initial risk assessment tool is completed on all pregnant Members at the initiation of pregnancy-related services. The risk assessment will include medical/obstetrical risk assessment; nutritional assessment; psycho-social assessment; and health education assessment. Evaluation of the patient’s risk status shall be performed at each trimester and at the postpartum visit. All identified risk conditions will be followed up by interventions designed to ameliorate or remedy the condition or problem in a prioritized manner.

.2 Contractor shall implement and maintain policies and procedures for appropriate referrals of Members with high risk pregnancies to specialists and have procedures for genetic screening and referral, and for admission to the appropriate hospitals for delivery.

7.4.4 Adult Preventive Services

Contractor shall provide a core set of preventive services for adult screening of asymptomatic, healthy Members over the age of 21 consistent with The Guide to Clinical Preventive Services, a report of the U.S. Preventive Service Task Force (USPSTF). Contractor shall ensure that Contracting Providers provide information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in Business and Professions Code Section 2248.

7.5 AVAILABILITY AND ACCESSIBILITY

Contractor shall implement and maintain procedures for Members to ensure access to its delivery system for routine care, Urgent Care, emergency care, inpatient care, prenatal care, CHDP periodic health screens, adult initial health assessments, and specialist care.

7.5.1 Emergency Care

Contractor shall ensure that a Member with an Emergency Condition will be seen immediately and Emergency Services shall be available and accessible within the Service Area 24-hours-a-day. Contractor shall ensure adequate follow-up care for those Members who require non-emergency care and who are denied services in the emergency department (ED).

.1 Contractor shall implement and distribute to all emergency departments in the County of San Diego protocols which include at a minimum:

a) Description of telephone access, triage and advice systems used, by Contractor;

b) A plan contact person responsible for coordinating services that can be accessed 24 hours a day;

c) Process for rapid interfacing with emergency care systems;

d) Referral procedures (including after-hours instruction) which ED personnel can provide to Members who present at the ED for non-emergency services; and

e) Procedures for EDs to report system and/or protocol failures and process for ensuring corrective action.

7.5.2 Urgent Care

Contractor shall ensure that a Member needing Urgent Care shall be seen within 48 hours upon request.

7.5.3 OB/GYN Services

Contractor shall permit Members access to network OB/GYN providers without prior referral or Prior Authorization from a Primary Care Physician.

Contractor shall ensure that the first prenatal visit for a pregnant Member shall be available within a week upon request.

7.5.4 Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times for obtaining various types of appointments, response times for the answer and return of telephone calls, and waiting times in providers' offices for scheduled appointments.

7.5.5 Telephone Procedures

Contractor shall maintain a procedure for triage of the Member's telephone calls and provision of telephone medical advice.

7.5.6 After Hours Calls

At a minimum, Contractor shall ensure that a physician or a nurse under his/her supervision shall be available at all times for after-hours calls.

7.5.7 Sensitive Services

Contractor shall implement and maintain procedures to ensure confidentiality and ready access to Sensitive Services for all Members including minors. Members shall be able to access Sensitive Services in a timely manner and without barriers such as Prior Authorization requirements.

Contractor shall develop, implement and maintain policies and procedures for treatment of HIV infection and AIDS. These policies and procedures shall be submitted to DHS no later that three months after the effective date of the Contract. Contractor shall submit any changes in the policies and procedures to DHS at least 30 calendar days prior to their implementation.

7.5.8 Access for Disabled Members

Contractor’s Facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

7.5.9 Seldom Used Specialty Services

Contractor shall arrange for the provision of seldom used specialty services from specialists outside the network when determined Medically Necessary.

7.6 COORDINATION OF CARE AND REFERRAL REQUIREMENTS

When Members are in need of services which are not Covered Services Contractor has an obligation to coordinate or refer the Member for care.

7.6.1 California Children Services (CCS)

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS Program. The policies and procedures shall include, but not be limited to:

a) Policies and operational controls that assure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member child has a CCS-covered medical condition;

b) Procedures for assuring that Contracting Providers are informed about CCS-paneled providers and CCS-approved hospitals within Contractor's network; and

c) Procedures for initial referrals of Member children with CCS-eligible conditions to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS Program.

d) Procedures that provide for continuity of care between the Contractor's providers and CCS providers for Member children determined eligible for the CCS Program.

.1 Contractor shall consult and coordinate CCS referral activities with the local CCS Program in accordance with the agreement reached under a Memorandum of Agreement (MOA) between Contractor and LHD for coordination of CCS services.

.2 Contractor shall continue to provide all Medically Necessary Covered Services and case management services for Member children referred to CCS until eligibility for the CCS Program is established. Eligibility for the CCS Program includes confirmation by the local CCS Program of a Member child's CCS-eligible condition and agreement by the local CCS Program to assume case management responsibilities for the Member child.

.3 Once eligibility for the CCS Program is established for a Member child:

a) Contractor shall continue to provide Primary Care and other Medically Necessary Covered Services unrelated to the CCS-eligible condition and will ensure the coordination of services between its Primary Care providers, the CCS speciality providers, and the local CCS Program.

b) The CCS Program shall authorize Medi-Cal payments to Contractor network physicians who currently are members of the CCS panel and to other providers who provided CCS-covered services to the Member child during the CCS-eligibility determination period and are deemed to meet the CCS standards in accordance with Subsection 7.6.1.4. Authorization for payment shall be retroactive to the date Contractor's initial referral was received by the CCS Program. Authorization shall be issued upon confirmation of panel status or completion of the process described in Subsection 7.6.1.4. Payment shall be dependent on the submittal of appropriately completed and timely claims to the Medi-Cal Fee-For-Service program fiscal intermediary.

c) For purposes of b) above, initial referral means either referral by Contractor or referral by a Contractor network physician.

.4 Upon submission to the CCS Program by Contractor of the completed provider Credentialing application form used by Contractor and a signed and dated CCS Program Agreement for a qualified physician contracting with Contractor who has successfully met Contractor's Credentialing standards and meets the CCS certification standards in accordance with Title 22, CCR, Sections 42320,42321, and 42336, the physician shall be determined to meet the CCS standards for participation as a CCS provider and shall be added to the CCS panel. The addition of such a physician to the CCS panel will be retroactive to the extent necessary to enable the physician to receive payment for services on or after the initial referral date as provided in Subsection 7.6.1.3.

7.6.2 Mental Health

Contractor shall provide outpatient mental health services within the Primary Care Provider's scope of practice. Contractor shall provide assistance to Members needing Specialty Mental Health Services by referring such Members, whose mental health diagnosis is covered by the local Medi-Cal mental health plan (MHP) or whose diagnosis is uncertain, to the local Medi-Cal mental health plan, if operational. If the Medi-Cal mental health plan is not operational or if the Member's diagnosis is not covered by the local Medi-Cal mental health plan, Contractor shall refer such Members to an appropriate Fee-For-Service Medi-Cal Mental Health Provider accepting Medi-Cal patients, if known to Contractor, or shall refer to the County Mental Health Department or other community resources that may be able to assist the Member to locate mental health services, including, but not limited to local CHDP program, regional centers for the developmentally disabled, and provider referral services.

.1 Contractor shall provide Medical Case Management and cover and pay for all Medically Necessary Covered Services for the Member including services listed below, and coordinate services with the Specialty Mental Health Provider:

a) Emergency room professional services described in Title 22, CCR, Section ,53855, except psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other Specialty Mental Health Providers;

b) Facility charges for emergency room visits which do not result in a psychiatric admission;

c) All laboratory, radiological and radioisotope services when these services are necessary for the diagnosis, monitoring or treatment of a Member's mental health condition;

d) Emergency medical transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, in accordance with Title 22, CCR, Section 51323;

e) All non-emergency medical transportation services in accordance with Title 22, CCR, Section 51323, required by Members to access Medi-Cal covered mental health services, subject to a written prescription by a Medi-Cal Specialty Mental Health Provider, except when the transportation is required to transfer the Member from one facility to another, with the purpose of reducing the local Medi-Cal mental health plan's cost of providing services;

f) Medically Necessary Covered Services for Members admitted to a psychiatric inpatient hospital, including the initial health history and physical assessment required upon admission and any consultations related to Medically Necessary Covered Services. Notwithstanding this requirement, Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital stays by Members; and

g) All Medically Necessary, Medi-Cal covered psychotherapeutic drugs for Members not otherwise excluded under this Contract. This includes reimbursement for psychotherapeutic drugs prescribed by out-of-plan psychiatrists. Reimbursement to pharmacies for those psychotherapeutic drugs listed in Attachment II (consisting of two pages) and psychotherapeutic drugs classified as anti-psychotics and approved by the Federal Drug Administration after July 1, 1997 shall be made by DHS through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

h) Paragraphs c), e), f) and g) shall not be construed to preclude Contractor from requiring that these services be provided through Contractor's provider network or that Contractor may apply Utilization controls for these services including prior authorization.

.2 Disputes between Contractor and the local Medi-Cal mental health plan regarding this Section shall be resolved pursuant to Title 9, CCR, Section 1850.505. Any decision rendered by DHS and the California Department of Mental Health regarding a dispute between Contractor and the local Medi-Cal mental health plan concerning

provision of mental health services or Covered Services required under this Contract shall not be subject to the Disputes and Appeals procedures specified in Article 3, Section 3.10.

.3 Contractor shall negotiate in good faith and execute a Memorandum of Understanding (MOU) with the local mental health plan. The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:

a) Protocols and procedures for referrals between Contractor and the MHP;

b) Protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;

c) Protocols for the delivery of mental health services within the Primary Care Physician's scope of practice;

d) Protocols and procedures for the exchange of Medical Records information, including procedures for maintaining the confidentiality of Medical Records;

e) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

i) Pharmaceutical services and prescription drugs;

ii) Laboratory, radiological and radioisotope services;

iii) Emergency room facility charges and professional services;

iv) Emergency and non-emergency medical transportation;

v) Home health services; and

vi) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals and psychiatric nursing facilities.

f) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition; and

g) Procedures to resolve disputes between Contractor and the MHP.

.4 To the extent Contractor does not execute an MOU within four months after implementation of the Medi-Cal Specialty Mental Health Services Consolidation program in the area being served by this Contract, Contractor shall submit documentation substantiating its good faith efforts to enter into an MOU. Until such time as an MOU is executed, Contractor shall submit monthly reports to DHS documenting its continuing good faith efforts to execute an MOU and the justifications why such an MOU has not been executed.

7.6.3 Alcohol and Drug Treatment Services

Contractor shall arrange and coordinate Medically Necessary services, including referral of Members requiring alcohol and drug treatment to Drug Medi-Cal substance abuse services including outpatient heroin detoxification providers. Contractor shall assist Members in locating available treatment locations. To the extent that treatment slots are not available within Contractor's geographical service area, Contractor is encouraged to pursue placement outside the area.

7.6.4 Dental

Contractor shall perform dental screening for all Members as part of the initial health assessment and ensure referral of Members to Medi-Cal dental providers. Dental screenings for Members under 21 years of age shall be performed as part of the initial health assessment in accordance with the most recent recommendations of the American Academy of Pediatrics.

Services related to dental services that are medical Covered Services and are not provided by dentists or dental anesthetists, are the responsibility of Contractor. Covered medical services include: prescription drugs, laboratory services, pre-admission physical examinations required for admission to a Facility, anesthesia services, medical transportation services, out-patient surgical center services, and in-patient hospitalization services required for a dental procedure. Contractor may require Prior Authorization for medical services required in support of dental procedures.

Contractor shall develop referral and Prior Authorization policies and procedures to implement the above requirements. Contractor shall submit these policies and procedures to DHS for review and approval.

7.6.5 Vision Care - Lenses

Contractor shall order the fabrication of optical lenses for Members from Prison Industry Authority (PIA) optical laboratories. The State will reimburse PIA for these lenses in accordance with the Contract between the State and PIA. Contractor shall provide all other Covered Services described in Title 22, CCR, Section 51317, including contact lenses and eyeglass frames.

7.6.6 Directly Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

Contractor shall assess the risk of noncompliance for each Member who needs to be placed on anti-TB drugs. Members who are determined to be at risk will be referred to the Local Health Department TB Control Officer for DOT. Contractor shall follow up and coordinate care with the LHD TB Control Officer.

Contractor shall refer the following groups of Members with active TB for DOT: patients with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin), patients whose treatment has failed or who have relapsed after completing a prior regimen, children and adolescents, and individuals who have demonstrated noncompliance (those who failed to keep office appointments).

Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.

7.6.7 Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services (HCBS) Waiver

Contractor shall maintain systems for identifying Members who qualify or are at risk for institutional placement and refer these Members to the HCBS Waiver program administered by DDS. If DDS concurs with Contractor's assessment of the Member and there is available placement in the Waiver program, the Member will receive HCBS Waiver services while remaining enrolled in the plan. Contractor shall continue to provide all Primary Care and other Medically Necessary Covered Services to a plan Member who is receiving HCBS Waiver services. Contractor shall coordinate the case management of the Member with DDS while the Member remains under the Waiver program. If the Member does not meet the criteria for the Waiver program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary, Covered Services to the Member.

7.6.8 Targeted Case Management Services

If a Member is receiving targeted case management services as defined in Title 22, CCR, Section 51185 and Section 51351, Contractor shall be responsible to coordinate the Member's health care with the targeted case management provider and to determine the medical necessity of diagnostic and treatment services recommended by the targeted case management provider that are Covered Services under the Contract.

7.6.9 Excluded Drugs for the Treatment of HIV and AIDS

Reimbursement to pharmacies for those excluded drugs for the treatment of HIV/AIDS listed in Attachment I (consisting of one page) and HIV/AIDS drugs classified as Nucleoside Analogues or Nucleoside Reverse Transcriptase Inhibitors, Non-Nucleoside Reverse Transcriptase Inhibitors and Protease Inhibitors approved by the FDA after July 1, 1997, shall be made by DHS through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To

qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

7.6.10 Miscellaneous Services Carve-Outs

Contractor, upon request, may refer Members to adult day health care service and childhood lead poisoning case management services which are not Covered Services under this Contract.

Local Education Agency (LEA) assessment services provided to any student and any LEA services provided pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) or Individualized Health and Support Plan (IHSP) are not covered under the Contract.

7.7 SERVICES WITH SPECIAL PAYMENT ARRANGEMENT/OR PAYMENTS FOR OUT-OF-PLAN PROVIDERS

The following Covered Services have special payment arrangements with network providers or out-of-plan providers.

7.7.1 Emergency Service Providers

Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Contractor shall make payments to non-contract providers for the treatment of an Emergency Medical Condition including Medically Necessary services rendered to a Member until the Member’s condition has stabilized sufficiently to permit discharge, or referral and transfer in accordance with instructions from Contractor. Emergency Services will not be subject to Prior Authorization by Contractor.

.1 Contractor shall pay for those services provided by a non-contracting emergency department that are required to determine whether treatment of the Member’s condition qualifies as Emergency Services. At a minimum, Contractor must reimburse the non-contracting ED and, if applicable, its affiliated providers, for physician services at the lowest level of evaluation and management in the

physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology,

.2 Payment by Contractor or by a subcontractor which is at risk for out-of-plan Emergency Services for properly documented claims for services rendered by a non-contracting provider pursuant to this Section will not exceed the lower of the following rates applicable at the time the services were rendered by the provider:

a) The usual charges made to the general public by the provider;

b) The maximum FFS rates for similar services under the Medi-Cal program; or

c) The rate agreed to by Contractor and the provider.

.3 For inpatient services, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, to an out-of-plan Emergency Services provider will be the lower of the following rates:

a) The inpatient rate negotiated by Contractor or subcontractor with the provider; or

b) The Medi-Cal FFS rate consistent with Title 22, CCR, 53912.5.

.4 Disputed claims may be submitted to the State for resolution under the provisions of Section 14454, W&I Code and Title 22, CCR, Section 53620 et seq. Contractor agrees to abide by the findings of the State in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to the State within 30 calendar days will result in liability offsets in accordance with Title 22, CCR, Section 53702.

7.7.2 School Linked CHDP Services: Coordination of Care

Contractor shall maintain and ensure the overall coordination of care and case management of Members who obtain CHDP services through the local school districts or school sites.

.1 School Linked CHDP Services: Cooperative Arrangements

Contractor shall enter into one or a combination of the following arrangements with the local school district or school sites:

a) Cooperative arrangements (e.g. Subcontracts) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements will also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services;

b) Cooperative arrangements whereby Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services;

c) Referral protocols/guidelines between Contractor and the school sites to assure that Members who are identified at school sites as being in need of CHDP services receive those services from Contractor within the required State and federal time frames. This will include strategies for Contractor to follow-up and document that services are provided to the Member; and

d) Any innovative approach that Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

.2 School Linked CHDP Services: Subcontracts

Contractor shall ensure that the Subcontracts with the local school districts or school sites provide for the coordination of care, identify the arrangement with the local school district or site, address the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination and educational responsibilities, Utilization Review requirements, referral procedures, medical information flows, patient information confidentiality, Quality Assurance interface, data reporting requirements, and Grievances and complaint procedures.

7.7.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services

For Members under the age of 21 years, Contractor shall provide or arrange and pay for EPSDT supplemental services as defined in Title 22, CCR, Section 51184, except when EPSDT supplemental services are provided as CCS services pursuant to Subsection 7.6.1. or as EPSDT supplemental dental services pursuant to Subsection 7.6.4. or EPSDT supplemental Speciality Mental Health Services. Contractor shall determine the medical necessity of EPSDT supplemental services using the criteria established in Title 22, CCR, Sections 51340 and 51340.1.

For Members under the age of 21 years, who meet the medical necessity criteria for EPSDT case management, pursuant to Title 22, CCR, Section 51340(f), Contractor shall refer the Member to a targeted case management (TCM) provider under contract with a local government agency pursuant to W&I Code, Section 14132.44, or to entities and organizations, including regional centers, that provide TCM services pursuant to W&I Code Section 14132.48. If EPSDT case management services are rendered by these referral providers, Contractor is not required to pay for the EPSDT case management services. If EPSDT case management services are not available from these referral providers, Contractor shall provide or arrange and pay for the EPSDT case management services.

7.7.4 Family Planning

Contractor shall provide the full array of family planning Covered Services without Prior Authorization. Contractor shall inform its Member in writing of their right to access any qualified family planning provider without Prior Authorization.

.1 Family Planning: Informed Consent

Contractor shall ensure that Members are informed of the full array of covered contraceptive methods and that informed consent is obtained from Members for sterilization, consistent with requirements of Title 22, CCR, Sections 51305.1 and 51305.3.

.2 Family Planning: Out-of-Network Reimbursement

Contractor shall reimburse out-of-network family planning providers at the appropriate Medi-Cal FFS rate, unless otherwise negotiated with the out-of-plan family planning provider for the following services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

a) Health education and counseling necessary to make informed choices and understand contraceptive methods;

b) Limited history and physical examination;

c) Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods. Contractor shall not be required to reimburse out-of-plan providers for pap smears if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines;

d) Diagnosis and treatment of the disease episode, as defined by the State for each sexually transmitted disease, if medically indicated;

e) Screening testing and counseling of at risk individuals for HIV and referral for treatment;

f) Follow-up care for complications associated with contraceptive methods issued by the family planning provider;

g) Provision of contraceptive pills, devices, supplies;

h) Tubal Ligation;

i) Vasectomies; and

j) Pregnancy testing and counseling.

7.7.5 Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without prior authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through Local Health Department clinics, family planning clinics, or through other community STD service providers. Contractor shall reimburse STD providers at the Medi-Cal FFS rate, unless another rate is negotiated between Contractor and provider for the diagnosis and treatment of STDs for the disease episode, as defined by DHS, if medically indicated. Contractor shall provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member’s refusal to release medical records to Contractor along with billing information.

For community providers other than LHD and family planning providers, the reimbursement of out-of-plan STD services is limited to one office visit per disease episode for the purposes of:

a) Diagnosis and treatment of vaginal discharge and urethra discharge;

b) Those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale; and

c) Evaluation and treatment of Pelvic Inflammatory Disease (PID).

Contractor shall provide follow-up care.

7.7.6 Early Intervention Services

Contractor shall refer to the local Early Start program those children in need of early intervention services, e.g., those with an established condition leading to developmental delay, those in whom a significant development delay is suspected, or those whose early health history places them at risk for delay. Contractor shall also collaborate with the regional center or local Early Start program to provide all Medically Necessary diagnostic, preventive and treatment services.

7.7.7 Services for Persons with Developmental Disabilities

Contractor shall provide all screening, preventive, and Medically Necessary and therapeutic Covered Services to Members with developmental disabilities. Contractor shall coordinate all medical services rendered to the Members, including the determination of medical necessity. Contractor shall refer enrollees with developmental disabilities to the regional centers for those non-medical services such as respite, out-of-home placement and supportive living for persons with substantial disabilities if such services are needed.

7.7.8 Confidential HIV Testing and Counseling

Members may access confidential HIV counseling and testing services through Contractor's provider network and through the out-of-network Local Health Department and family planning providers. Contractor shall reimburse these providers at the Medi-Cal FFS rate, unless otherwise negotiated, for HIV testing and counseling provided that out-of-network Local Health Department and family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Contractor.

7.7.9 Immunizations

Contractor shall fully immunize Members in accordance with State requirements. Contractor shall, upon request, provide updated information on the status of Members' immunizations and ensure reimbursement to LHD for the administration fee of immunizations given to Members. However, Contractor shall not reimburse the LHD for an immunization provided to a Member who was already up-to-date according to State requirements. The LHD will provide immunization records when immunization services are billed to Contractor.

Providers other than LHD will not be reimbursed by Contractor unless they enter into an agreement with Contractor.

7.7.10 Women, Infants, and Children (WIC) Supplemental Food Program

Contractor, as part of its initial assessment of Members, and as part of the initial evaluation of newly pregnant women, will provide and document the referral of pregnant, breast-feeding, or postpartum women or a parent/guardian of a child under the age of five, as indicated, to the WIC program as mandated by Title 42, CFR, Section 431.635(c).

.1 Contractor shall conduct the hemoglobin or hematocrit test and use the CHDP program Form PM160-PHP to document the laboratory values for eligible children and/or a prescription pad written by a physician to document laboratory values for eligible women for referral to the WIC program. Contractor shall document such referrals in the Members' Medical Records.

7.7.11 Nurse Midwife and Nurse Practitioners Services

Contractor shall meet federal requirements for access and reimbursement for certified nurse midwife (CNM) services as defined in Title 22, CCR, Section 51345 and certified nurse practitioner (CNP) services as defined in Title 22, CCR, Section 51345.1. If Members do not have access to CNM or CNP services within Contractor's provider network, Contractor shall inform Members that they have a right to obtain out-of-plan CNM or CNP services, and Contractor shall reimburse CNMs or CNPs for services provided out-of-plan to Members at the applicable Medi-Cal Fee-For-Service rates, subject to the following conditions.

a) If CNM or CNP services are not available in Contractor's provider network, but Eligible Beneficiaries may select and enroll in another plan in the county that offers these services within DHS time and distance standards for access to Primary Care for Contractor's Members, Contractor is not obligated to reimburse out-of-plan CNMs or CNPs for services provided to Members, unless the services are authorized by Contractor.

b) If CNM services are not available in Contractor's provider network and Eligible Beneficiaries who are required to enroll in a Medi-Cal managed care plan in the

county are unable to select and enroll in another plan that offers CNM services within the time and distance standards for access to Primary Care, Contractor shall reimburse out-of-plan CNMs for services provided to its Members within the CNM's scope of practice.

c) If CNP services are not available in Contractor's provider network and Eligible Beneficiaries who are required to enroll in a Medi-Cal managed care plan in the county are unable to select and enroll in another plan that offers CNP services within the time and distance standards for access to Primary Care, Contractor shall reimburse out-of-plan CNPs for services provided to its Members within the CNP's scope of practice.

7.7.12 Federally Qualified Health Center (FQHC) Services

Contractor shall meet federal requirements for access and reimbursement for FQHC services, including those in Title 42, United States Code, Section 1396 b(m) and Medicaid Regional Memorandum 93-13 and be reimbursed in accordance with the provisions of Article 9, Subsection 9.5.1.

7.7.13 Indian Health Services Facilities

Contractor shall reimburse out-of-plan Indian Health Services facilities for services provided to Members who are qualified to receive services from an Indian Health Services facility. Contractor shall reimburse the out-of-plan Indian Health Services facility at the approved Medi-Cal rate for that facility.

The requirements of Article 9, Section 9.5.1 apply to any Indian Health Services Facility that is also an FQHC.

7.8 MEMBER HEALTH EDUCATION SERVICES

Contractor shall implement and maintain a system for providing Member health education services, clinical preventive services, health education and promotion, and patient education and counseling. The system will utilize one-to-one and group interventions, written and

audio-visual materials. Contractor shall ensure that all plan health education materials used to communicate Covered Services are written at an appropriate reading level, as determined by Contractor and approved by the State. Contractor shall ensure that the services are provided directly by Contractor or through Subcontracts or formal agreements with other providers specializing in health education services. Contractor shall maintain a health education system which includes, at a minimum, the following services.

7.8.1 Member Education:

a) Use of clinical preventive services;

b) Promotion of appropriate use of managed care plan services; and

c) Availability of local social and health care programs.

7.8.2 Clinical Preventive Services, Education and Counseling:

a) Nutrition;

b) Tobacco Prevention and Cessation;

c) HIV/STD Prevention;

d) Family Planning;

e) Exercise;

f) Dental;

g) Perinatal;

h) Age Specific Anticipatory Guidance - EPSDT;

i) Injury Prevention; and

j) Immunizations.

7.8.3 Patient Education and Clinical Counseling:

a) Diabetes;

b) Asthma;

c) Hypertension;

d) Substance Abuse;

e) Tuberculosis;

f) Inpatient - Condition Specific; and

g) Other Outpatient.

7.8.4 Health Education Standards, Policies and Procedures

Contractor shall develop and maintain Member health education services standards, policies and procedures, monitor provider performance to ensure the standards for health education services are maintained and include methods for formally communicating findings with providers. These standards, policies and procedures shall be integrated into the QIP and ensure the provision of:

a) Member orientation, education regarding health promotion, personal health behavior, and patient education and counseling;

b) Provider education on health education services; and

c) Individual health education behavioral assessment, referral, and follow-up.

7.8.5 Health Educator

Contractor's qualified full time health educator shall maintain administrative oversight of health education services. The health education system will be coordinated and integrated into the QIP.

7.8.6 Individual Health Education Behavioral Assessments

For purposes of this Contract, individual health education behavioral assessments are defined as health practices, values, behaviors, knowledge, attitudes, cultural practices, beliefs, literacy levels, and health education needs.

Contractor shall ensure that individual health education behavioral assessments are conducted on all Members within 120 calendar days of Enrollment. Contractor shall ensure that the assessment tool has been submitted to the State and approved by the State prior to use.

7.8.7 Group Needs Assessment

Contractor shall conduct a group needs assessment of Members to determine health education needs, including literacy level and cultural and linguistic needs of the Members who speak a primary language other than English. A report summarizing the methodology, findings, proposed services, key activities, timeline for implementation and the responsible individuals shall be available to DHS upon request.

This subsection shall be inoperative for the period from August 1, 2000 to July 31, 2002. In the event that this Contract is extended or renewed, Contractor must comply with the requirements of this provision by July 31, 2003.

7.9 RELIGIOUS OR ETHICAL OBJECTIONS TO PERFORM SERVICES

Contractor shall arrange for the timely referral and coordination of those Covered Services to which Contractor or subcontractor has religious or ethical objections to perform or

otherwise support and will demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to the State.

7.10 SUBCONTRACT WITH LOCAL HEALTH DEPARTMENT (LHD)

Contractor shall enter into a Subcontract and/or Memorandum of Agreement with the LHD for the coordination referral and/or reimbursement for the provision of the public health services:

a) Confidential HIV counseling and testing services;

b) CCS;

c) CHDP;

d) Hansen’s Disease Control Program;

e) Immunizations;

f) Perinatal Care;

g) Sexually Transmitted Diseases (STD); services, for the disease episode, as defined by DHS for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancriod trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale;

h) Services associated with DOT services for the treatment of tuberculosis; and

i) Children’s Emergency Shelter Care.

7.10.1 Scope of Subcontract

The Subcontract shall specify the scope and responsibilities of both parties, reporting responsibilities, Medical Record management to ensure coordinated health care and for services specified in Subsection 7.10 a, d, e, and g, billing and reimbursement provisions. This Subcontract shall become effective no later than six (6) months following the effective date of this Contract.

7.10.2 Reimbursement for Services

Any reimbursement arrangement between the Contractor and the County of San Diego, for the provision of any of the public health services specified below, in effect on the date this Contract is implemented shall remain in effect until such time as the new Subcontract required by Subsection 7.10.1 becomes effective.

If Contractor has not met the requirements of Subsection 7.10.1 within six months of the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into such Subcontract.

Until, such time as the Subcontract required by Subsection 7.10.1 becomes operative, Contractor shall pay appropriate Medi-Cal Fee-For-Service rates to County of San Diego public health facilities for the provision of the services specified below, when rendered to Contractor’s members who present at these facilities.

a. Services associated with treatment of sexually transmitted disease.

b. Family Planning services.

7.11 SUBCONTRACT OR MEMORANDUM OF AGREEMENT (MOA) WITH OTHER ENTITIES

Contractor shall negotiate in good faith a Subcontract or MOA for the coordination and referral, with non-profit organizations or other agencies, for the provisions of WIC (as Mandated by Title 42, CFR. Section 431.635) and family planning Covered Services. The Subcontract or MOA shall specify the scope and responsibilities of both parties, reporting responsibility, and medical records management to ensure coordinated health care.

ARTICLE 8.0 - ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS

8.1 ORGANIZATIONAL LEGAL AUTHORITY

Contractor shall maintain the legal authority to contract with DHS and shall maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 Health and Safety Code Section 1340 et seq., and Title 10, CCR, Section 1300 et seq.

8.2 ORGANIZATION AND ADMINISTRATIVE CAPABILITIES

Contractor shall maintain the organizational and administrative capabilities, including staffing, to carry out the duties and responsibilities set forth under this Contract and comply with federal and State Medicaid laws, regulations and policies. These shall include, but not be limited to, the following:

.1 Contractor's organization has an accountable governing body;

.2 Contractor shall provide any and all necessary resources to ensure Contractor's full performance of the terms, conditions and provisions of this Contract;

.3 The parent organization, if Contractor is a subsidiary, shall attest to the compliance and successful fulfillment of the terms, conditions, provisions and responsibilities set forth in this Contract. The parent organization shall also attest to providing any and all necessary resources to assure full performance of the Contract.

.4 Contractor shall maintain a full time physician as Medical Director who shall oversee and be responsible for the proper provision of Medi-Cal Covered Services including case management to Members. Contractor shall report to the Department, in writing, any changes in the status of the Medical Director within ten calendar days. The Medical Director shall:

a) Ensure that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management;

b) Ensure that medical care provided meets the standards for acceptable medical care;

c) Ensure that medical protocols and rules of conduct for plan medical personnel are followed;

d) Develop and implement medical policy;

e) Resolve medically related Grievances;

f) Have a significant role in monitoring, investigating and hearing Grievances;

g) Have a significant role in Contractor's Quality Improvement Program.

.5 Contractor shall designate persons, qualified by training or experience, to be responsible for the Medical Record service;

.6 Contractor shall establish and maintain a Member and Enrollment reporting systems, including a Primary Care Physician (PCP) Selection System;

.7 Contractor shall operate a Member Grievance procedure consistent with Subsection 8.12.6 and a mechanism to ensure Medi-Cal Member participation in development of Contractor's Medi-Cal programs;

.8 Contractor shall maintain data reporting capabilities sufficient to provide necessary and timely reports to the State;

.9 Contractor shall employ a full time financial officer to maintain financial records and books of account on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received;

.10 Contractor shall ensure separation of management of delivery of health services from fiscal and administrative management activities sufficient to assure the State that medical decisions shall not be unduly influenced by fiscal and administrative management decisions;

.11 Contractor shall implement and maintain a system for providing Members health education services, clinical preventive services and patient education and counseling consistent with Article 7, Section 7.8;

.12 Contractor shall operate a provider Grievance procedure; and

.13 Contractor shall implement and maintain a Quality Improvement System consistent with Section 8.6.

8.3 FINANCIAL SYSTEMS

Contractor shall maintain and implement financial policies which relate to Contractor's systems for budgeting and operations forecasting. The policies shall include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed and variance analysis, and follow-up procedures.

8.3.1 Submittal of Financial Information

Contractor shall prepare financial information requested in accordance with Generally Accepted Accounting Principles (GAAP) and where Financial Statements and/or projections are requested these statements and/or projections should be prepared on the 1989 Health Maintenance Organization Financial Report of Affairs and Conditions Format (commonly known as the "Orange Blank"). Information submitted shall be based on current operations.

8.3.2 Compliance with Audit Requirements

Contractor shall cooperate with the State’s own independent audits annually or as necessary for good cause, at the discretion of the State. Such audits may be waived upon submission of the financial audit for the same period conducted by DMHC pursuant to Health and Safety Code, Section 1382.

8.3.3 Submittal of Financial Audit/Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code, Section 14459. Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared.

Contractor shall have separate certified Financial Statements prepared if an independent accountant decides that preparation of combined statements is inappropriate. The independent accountant shall state in writing reasons for not preparing combined Financial Statements. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable the State to analyze the overall financial status of the entire health care delivery system.

.1 In addition to annual certified Financial Statements, Contractor shall complete the entire 1989 “Orange Blank”, and the supplemental information required by Title 10, CCR, Section 1300.84.06(b). The CPA audited Financial Statements, the “Orange Blank” report and required supplemental information shall be submitted to DHS no later than 120 calendar days after the close of Contractor’s Fiscal Year.

.2 On a quarterly basis, Contractor shall submit to DHS, 45 calendar days after the end of each quarter under this Contract, financial reports consistent with Title 22, CCR, Section 53862(b)(2) and hereby made applicable to this Contract. The required

quarterly financial reports shall be prepared on the “Orange Blank” format and shall include, at a minimum, the following reports/schedules:

a) Jurat;

b) Report 1A and 1B: Balance Sheet;

c) Report 2: Statement of Revenue, Expenses, and Net Worth;

d) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance);

e) Report 4: Enrollment and Utilization Table;

f) Schedule F: Unpaid Claims Analysis; and

g) Appropriate footnote disclosures in accordance with GAAP.

.3 Contractor may be required to file monthly Financial Statements at the State’s request. If Contractor is required to file monthly Financial Statements with DHMC, Contractor shall file a copy of the monthly Financial Statements with the California Department of Health Services within 30 calendar days of the end of each month under this Contract or until the monthly filing requirement is discontinued by DHMC. The monthly Financial Statements shall be in the format required by Title 10, CCR, Section 1300.84.3(d).

.4 Contractor shall authorize the independent accountant to allow representatives of the State, upon written request, to inspect any and all working papers related to the preparation of the audit report.

.5 Contractor shall submit to DHS all financial reports relevant to Affiliates as specified in Title 22, CCR, Section 53330.

.6 Contractor shall submit to DHS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 53324(d).

.7 Contractor shall report inpatient days to DHS in accordance with W&I Code, Section 14105.985(b)(2). Contractor shall submit additional reports as requested by DHS for the administration of the Disproportionate Share Hospital program.

.8 The Contractor shall submit to the State the annual Certified Public Accountant's report on Children's Hospital of San Diego and the San Diego Hospital Association within 120 calendar days after the close of their respective fiscal years.

8.3.4 Financial Viability/Standards Compliance

Contractor shall demonstrate financial viability/standards compliance to the State's satisfaction for each of the following elements:

.1 Tangible Net Equity (TNE)

Contractor at all times shall be in compliance with the TNE requirements in accordance with Title 10, CCR, Section 1300.76.

.2 Administrative Costs

Contractor's Administrative Costs shall not exceed the guidelines as established under Title 10, CCR, Section 1300.78.

.3 Standards of Organization and Financial Soundness

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 10, CCR, Sections 1300.67.3, 1300.75.1, 1300.76, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and 1300.78, Title 22, CCR, Section 53251, and H&S Code, Section 1375.1.

.4 Working Capital

a) Contractor shall maintain a working capital ratio of at least 1:1; or

b) Contractor shall demonstrate to the State that Contractor is currently meeting financial obligations on a timely basis and has been doing so for at least the preceding two calendar years; or

c) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of] :1, if the noncurrent assets are considered current.

8.3.5 Financial Performance Guarantee

If capitation is prepaid, Contractor shall provide satisfactory evidence of and maintain Financial Performance Guarantee in an amount equal to at least one month's capitation payment, in a manner specified by DHS. At Contractor's request and with DHS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. The Financial Performance Guarantee will remain in effect for at least 90 calendar days following termination or expiration of this Contract or until, in the judgment of DHS the obligations set forth in this Contract are fulfilled. If Contractor elects to receive capitation on a postpaid basis, the requirement for the Financial Performance Guarantee will be considered satisfied by the DHS.

8.3.6 Cost Avoidance and Recovery of Other Health Coverage

Contractor shall cost avoid or make a post-payment recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHC covers the same services, either fully or partially. "Cost avoid" means Contractor requires a provider to bill the liable third party and receive payment or proof of denial prior to Contractor paying for the services rendered. Post-payment recovery means Contractor pays for the services rendered and then attempts to recover the cost of the services from the liable third party. However, in no event shall Contractor cost avoid or seek post-payment recovery for the reasonable value of services from a Third Party Tort Liability action nor from estates of deceased beneficiaries. All monies recovered are retained by Contractor.

Contractor shall coordinate benefits with other coverage programs or entitlements which provide or pay for services to the Member, recognizing the OHC as primary and Medi-Cal as the payer of last resort.

.1 Cost Avoidance

a) If Contractor reimburses the provider on a Fee-For-Service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by an Other Health Coverage code, without proof that the provider has first exhausted all benefits of the other liable party(ies).

b) Contractor shall submit the written procedures for the process described in Subsection 8.3.6.1a) above to DHS for review and approval within 60 days of Contract effective date.

c) Proof of third party billing, by the provider, is not required before payment for services provided to Members with OHC codes A, M, X, Y, or Z (see Subsection 8.3.6.2).

.2 Post-payment Recovery

a) Contractor shall have written procedures describing the circumstances under which:

i) Contractor shall pay the provider's claim on a FFS basis and then seek to recover the cost of the claim by billing the liable third party for services provided to Members with OHC codes A, M, X, Y or Z, child support enforcement cases, or services defined by DHS as prenatal or preventive pediatric services.

ii) In instances where Contractor does not reimburse the provider on a Fee-For-Service basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage,

designated by an OHC code or Medicare coverage, and then shall bill the liable third party for the cost of the actual services rendered.

b) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHS as having OHC.

c) Contractor shall submit written procedures for the process described in .2 a) above to DHS for review and approval within 60 days of Contract effective date.

.3 Contractor shall refer all Members whose eligibility record indicates OHC codes K, C, P or F to DHS' Enrollment contractor for disenrollment from Contractor's plan. Until Member is disenrolled, Contractor shall cost avoid or seek post-payment recovery as specified in Subsection .1 and .2 above.

.4 Reporting Requirements

a) Contractor shall submit monthly reports to DHS, in a format prescribed by DHS, displaying claims counts and dollar amounts cost avoided and the amount of post-payment recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A and Part B. Reports shall be sent to the Department of Health Services, Third Party Liability Branch, Cost Avoidance Unit, P.O. Box 2471, Sacramento, CA 95812-2471.

b) When Contractor identifies OHC unknown to DHS, Contractor shall report this information to DHS within ten calendar days of discovery in an automated format as prescribed by DHS. This information will be sent to the Department of Health Services, Third Party Liability Branch, Health Identification Unit, P.O. Box 2471, Sacramento, CA 95812-2471. Contractor shall not suggest nor recommend to a Member that he/she should drop their OHC.

c) Contractor shall demonstrate to DHS, using a cost benefit analysis, that where Contractor does not cost avoid or perform post-payment recovery, that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

8.3.7 Third Party Tort Liability/Estate Recovery

Contractor shall make no claim for recovery of the value of Covered Services rendered to a Members when such recovery would result from an action involving the tort liability of a third party or recovery from the estates of deceased Members or casualty liability insurance, including Workers' Compensation awards and uninsured motorists coverage. Contractor shall identify and notify the DHS Third Party Liability Branch of cases in which an action by the Member involving the tort or Workers' Compensation liability of a third party or estate recovery could result in recovery by the Member of funds to which DHS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Such cases shall be reported to DHS Third Party Liability Branch within 10 calendar days of discovery. To assist DHS in exercising its authority for such recoveries, Contractor shall meet the following requirements:

.1 Service Information Requests

If DHS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall provide the requested information within 30 calendar days of the request. Service information includes subcontractor and out-of-plan provider date. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.

.2 Information to be delivered shall contain the following data items:

a) Member name;

b) Full 14 digit Medi-Cal number;

c) Social Security Number;

d) Dale of birth;

e) Contractor name;

f) Provider name (if different from Contractor);

g) Dates of service;

h) Diagnosis code and/or description of illness/injury;

i) Procedure code and/or description of services rendered;

j) Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable);

k) Amount paid by other health insurance to Contractor or subcontractor, (if applicable);

1) Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable);

m) Date of denial and reasons for denial of claims (if applicable);

n) Date of death (if applicable).

.3 Contractor shall notify DHS' Third Party Liability Branch, in writing, of the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

.4 If Contractor receives any requests from attorneys, insurers, or Members for copies of bills, Contractor shall provide DHS's Third Party Liability Branch with a copy of any document released as a result of such request, and shall provide the name, address, and telephone number of the requesting party.

.5 Information submitted to DHS under this Section shall be sent to the Department of Health Services, Third Party Liability Branch, Recovery Section, P.O. Box 2471, Sacramento, CA 95812-2471.

8.4 BOOKS AND RECORDS

Contractor shall maintain such books and records necessary to disclose how Contractor discharged its obligations under this Contract. These books and records shall disclose the quantity and quality of Covered Services provided under this Contract, the manner and amount of payment made for those Covered Services, persons eligible to receive Covered Services, the manner in which Contractor managed its daily business and the cost hereof.

These books and records shall include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to the State; financial records and books of account; all Medical Records, medical charts and prescription files; Subcontracts; and any other documentation pertaining to medical and non-medical services rendered to Members.

8.4.1 Records Retention

These books and records shall be maintained for a minimum of five years from the end of the Fiscal Year in which the Contract expires or is terminated, or, in the event Contractor has been duly notified that DHS, DHHS, DOJ, or the Comptroller General of the United States, or their duly authorized representative, have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

8.4.2 Contractor Certifications

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, Contractor’s Representative or his/her designee shall certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements

to the best of the individual's knowledge and belief, unless the requirement for such certification is expressly waived by the State in writing.

8.4.3 Records Related to Recovery for Litigation

Upon request by DHS, Contractor shall timely gather, preserve, and provide to DHS, in the form and manner specified by DHS, any information specified by DHS, subject to any lawful privileges, in Contractor's or its subcontractors' possession relating to threatened or pending litigation by or against DHS.

If Contractor asserts that any requested documents are covered by a privilege, Contractor shall:

a) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

b) state the privilege being claimed that supports withholding production of the document.

Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHS. Contractor acknowledges that time may be of the essence in responding to such requests. Contractor shall use all reasonable efforts to immediately notify DHS of any subpoenas, document production requests, or requests for records, received by Contractor related to this Contract or Subcontracts entered into pursuant to this Contract.

.1 In addition to the payments provided for in Article 10, DHS agrees to pay Contractor for complying with Section 8.4.3. Records Related to Recovery for Litigation, above, as follows:

a) DHS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with Section 8.4.3. Any third party assisting Contractor with compliance with Section 8.4.3 shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with Section 8.4.3 shall not

exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHS.

b) If Contractor uses existing personnel and resources to comply with Section 8.4.3, DHS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHS.

   i) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Section 8.4.3.

   ii) Costs for copies of all documentation submitted to DHS pursuant to Section 8.4.3 subject to a maximum reimbursement of ten cents per copied page.

c) Contractor shall submit to DHS all information needed by DHS to determine reimbursement to Contractor under this Section, including, but not limited to, copies of invoices from third parties and payroll records.

8.5 MANAGEMENT INFORMATION SYSTEM (MIS)

Contractor shall implement and maintain an MIS system that can process and provide all Medi-Cal eligibility, membership enrolled in Contractor's plan, provider claims payment and status, Encounter-level health care services delivery, provider network, financial, and any other data necessary to carry out all processes and procedures needed by Contractor, to perform and administer all of the functions required under this Contract.

8.5.1 Encounter Data Submittal

Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of Encounter level data for all services which Contractor incurred any financial liability whether directly or through Subcontracts or other arrangements.

Contractor shall submit Encounter-level data to DHS and to LHD on a monthly basis, no later than 90 calendar days following the end of the reporting month in which the Encounter occurred in the form and manner specified in the DHS' most recent Managed Care Data Element Dictionary, hereby incorporated by reference. Encounter-level data shall include data elements as specified in DHS' most recent Managed Care Data Manual Element Dictionary.

.1 MIS/Data Correspondence

Upon written notice by DHS of any problems related to the submittal of data to DHS as required under this Contract, or upon written notice by DHS of concerns regarding any other changes or clarifications made by Contractor to its MIS system, Contractor shall submit Corrective Actions with measurable benchmarks within five working days from the date of DHS' facsimile notice to Contractor. Within 30 days of DHS' receipt of Contractor's Corrective Action plan, DHS shall approve the Corrective Action plan or request revisions. Within 15 days after receipt of a request for revisions to the Corrective Action plan, Contractor shall submit a revised Corrective Action plan for DHS approval.

.2 Timely, Complete and Accurate Data Submission

Contractor shall ensure that the Encounter-level data submitted to DHS are timely, complete and accurate and in compliance with the requirements of DHS' most recent Managed Care Data Element Dictionary.

Upon written notice by DHS that Encounter data is insufficient or inaccurate, Contractor shall ensure that corrected data is submitted within 15 calendar days.

8.5.2 Claims Processing/Payment

Contractor shall ensure the accuracy and timeliness of provider claims processing and payment to Contracting Providers and non-contracting providers as required in 42 USC, Section 1396a(a)(37), and Section 1371, Article 5, Chapter 2.2, Division 2, Health and Safety Code.

a) Contractor shall ensure that 90% of claims for payment submitted by Contracting Providers and non-contracting providers for which no further written documentation or substantiation is required are processed and paid or denied within 30 calendar days of receipt by Contractor. Notice must be provided to providers in the case of contested claims within 30 calendar days after receipt. Failure to timely provide notification to any provider of a contested claim means that the claim is not being contested and is subject to the requirements for paying uncontested claims.

b) Contractor shall ensure that 100% of claims for payment submitted by Contracting Providers and non-contracting providers for which no further written documentation or substantiation is required are processed and paid or denied within 45 working days after receipt.

c) Contractor shall maintain procedures for prepayment and post-payment claims review, including review of data related to provider, Member, and Covered Services for which payment is claimed.

d) Contractor shall maintain sufficient claims processing/tracking/payment systems capability to demonstrate compliance with applicable State and federal law, regulations and this Contract, and to determine the status of received claims and calculate provisions for incurred but not reported claims.

8.5.3 Electronic Billing Capability

Contractor shall submit to DHS within six months of the effective date of this Contract a written report of Contractor's actual or planned capacity to accept provider claims electronically. The report shall describe Contractor's electronic capability for accepting the following types of claims:

a) Pharmacy;

b) Hospital;

c) Physician, including emergency room physician; and

d) Allied health providers.

The written description will include a timetable for implementation of the necessary electronic capability for each type of claim that Contractor plans to install. For each type of claim that Contractor has no plans to accept electronically, the written description will include a supporting statement, which will include a cost-benefit analysis, any infrastructure limitations, and any other circumstances that could preclude acceptance of those claims electronically. Contractor will respond to any questions from DHS within 60 days.

8.6 QUALITY IMPROVEMENT PLAN (QIP)

Contractor shall implement policies and protocols to systematically assess, monitor, evaluate, and take effective action to address any needed Quality Improvements in its operations; or in the quality of health services delivery; and in the quality and appropriateness of clinical care to Members. Contractor shall be accountable for the quality of preventive, primary, specialty, emergency, or ancillary health care services in all settings. The QIP shall include an identified process methodology and outcome measurements for QI compliance and accountability of all Contracting Providers delivering Covered Services on its behalf in all Service Locations, including accountability for QIP related functions to subcontractors.

Contractor will ensure that studies conducted pursuant to the QIP reflect the population served in terms of age groups, disease categories and special risk status. The QIP will continuously monitor care against practice guidelines or clinical standards and will use appropriate Quality Indicators as measurable variables. The Contractor will ensure that the appropriate health professionals will analyze data collected, and multi-disciplinary teams will address system problems. Contractor will undertake Corrective Actions whenever problems are identified, within the time frames determined by DHS. The Contractor will maintain a system for tracking the problems over time to ensure that actions for improvement are effective.

8.6.1 Quality Improvement Plan Components

Contractor shall implement and maintain a written description of its QIP which shall include the following:

a) Organizational commitment to deliver quality health care services, goals, and objectives, including accreditation of its QIP, which are evaluated and updated annually and include a time table for implementation and accomplishment;

b) Organizational chart showing the key persons, committees and groups responsible for Quality Improvement, reporting relationships of QIP committees within Contractor's organization, and provisions for support staff including reporting relationships;

c) Qualifications of staff responsible for Quality Improvement studies and activities including appropriate education, experience and training;

d) The QIP scope of review, which must include:

   i) quality of clinical care services including, but not limited to, preventive services, prenatal care, and family planning services;

   ii) quality of non-clinical services including, but not limited to, availability, accessibility, coordination and continuity of care, Grievance process, and, marketing and information standards; and

   iii) representation of the entire range of care provided by Contractor including all demographic groups, care settings (e.g. Emergency Services, inpatient, ambulatory, and home health care) and types of services (e.g. preventive, primary, specialty and ancillary).

e) A description of specific Quality of Care studies and other activities to be undertaken over a prescribed period of time, the responsible individuals, organizational resources utilized to accomplish them, methodologies to be used, including but not limited to process measurements and health outcome and mechanisms for tracking issues over time;

f) A description of a system for provider review of the QIP which at a minimum demonstrates physicians' and other professionals' involvement and provisions for

feedback to staff and Contracting Providers regarding performance and outcomes; and

g) A description of the annual QIP report shall include a summary of all QIP studies and other activities completed; trending of clinical and service indicators and other performance data; areas of deficiency and Corrective Actions undertaken; an evaluation of the overall effectiveness of the QIP and evidence that activities have contributed to significant improvements in care delivered to Members.

8.6.2 Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of Contractor's organization, the designation of a Quality Improvement Committee with oversight and performance responsibility, the supervision of activities by the Medical Director, the inclusion of Contracting Providers in the process of QIP development and performance review.

8.6.3 Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

a) Approves the overall QIP and the annual QIP report;

b) Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIP;

c) Routinely receives written progress reports from the Quality Improvement Committee describing actions taken, progress in meeting QIP objectives, and improvements made;

d) Formally reviews, (at least annually), a written report on the QIP which includes studies undertaken, results, subsequent actions, and aggregate data on Utilization and quality of services rendered; and assess the QIP's continuity, effectiveness, and current acceptability; and

e) Directs the operational QIP to be modified on an ongoing basis, and tracks all review findings for follow-up.

8.6.4 Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to, the governing body. The role, structure, function of this committee shall be delineated. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. On a scheduled basis, the activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing. Contractor shall ensure that, minutes of committee meetings are submitted to the State quarterly for review. Subcontractors, who are representative of the composition of the Contracting Provider network, shall actively participate in the Quality Improvement Committee. Contractor shall maintain a process to ensure confidentiality of QIP discussions as well as avoidance of conflict of interest on the part of the reviewer.

8.6.5 Medical Director

Contractor shall ensure that the Medical Director shall be directly involved in the implementation of Quality Improvement activities.

8.6.6 Provider Participation

Contractor shall ensure that physicians and other health care providers shall be involved as an integral part of the QIP. Contractor shall maintain and implement appropriate procedures to keep providers informed of the written QIP, its activities and outcomes. Contractor shall maintain employment agreements and provider Contracts which include a requirement securing cooperation with the QIP.

Contractor shall ensure that subcontracting hospitals and other subcontractors shall allow Contractor access to the Medical Records of its Members.

8.6.7 Delegation of QIP Activities

Contractor is accountable for Quality Improvement even when it delegates Quality Improvement activities to its subcontractors. Contractor shall maintain a system to ensure accountability of delegated QIP activities including:

a) Maintaining policies and procedures which describe delegated activities, QIP authority, function, and responsibility, how each subcontractor shall be informed of its scope of QIP responsibilities, and the subcontractor's accountability for delegated activities;

b) Establishing reporting standards to include findings and actions taken by the subcontractor as a result of the QIP activities with the reporting frequency to be at least quarterly;

c) Maintaining written procedures and documentation of continuous monitoring and evaluation of the delegated functions, evidence that the actual Quality of Care being provided meets professionally recognized standards;

d) Obtaining assurance and documentation that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;

e) Approving the delegate's QIP, including its policies and procedures which shall meet standards set forth by Contractor; and

f) Ensuring that the actual Quality of Care being provided is being continuously monitored and evaluated.

8.6.8 Coordination With Other Management Activities

Contractor shall implement its Quality Improvement Plan to include all other management performance monitoring functions which must have identified process measurements to support attainment of identified outcomes. These include, but are not limited to, Utilization management, infection control, Credentialing, Encounter data collection, monitoring and resolution of Member and provider Grievances and complaints, Medical Record review, and

availability and accessibility of care. Contractor's QIP shall also maintain and demonstrate identifiable linkages and coordination activities with other management functions including, but not limited to, provider network changes, practice feedback to physicians, Member health education, and Member services.

8.6.9 Participation in LHD Sponsored QI

Contractor shall participate in an LHD sponsored Quality Improvement Committee review of quality issues, including but not limited to, Grievance trends and patterns in the Healthy San Diego GMC pilot project.

8.6.10 Quality Performance Measures Reporting Studies

Contractor will report audited results for a minimum of seven (7) Health Plan Employer Data Information Set (HEDIS) measures each calendar year. These measures will be selected by DHS after taking into consideration the recommendations of the Quality Improvement (QI) workgroup. These measures will be reported in accordance with the National Committee Quality Assurance (NCQA) specifications and timelines unless other timelines are specified by DHS. The results of the HEDIS measures will be audited by a NCQA Licensed HEDIS Compliance Organization. Contractor has the option of utilizing a NCQA Licensed HEDIS Compliance Organization, designated by DHS, at no cost to the Contractor or may use another NCQA Licensed HEDIS Compliance Organization of its choice, at its own cost. Contractor must notify DHS in writing of its intent to utilize the NCQA Licensed HEDIS Compliance Organization designated by DHS, or submit the name of the NCQA Licensed HEDIS Compliance Organization it will use to DHS in a time frame specified by DHS.

If the Contractor uses a non-DHS designated NCQA Licensed HEDIS Compliance Organization, the Contractor must ensure that the organization submits a copy of the HEDIS Compliance Audit to DHS in accordance with the NCQA timelines unless other timelines are specified by DHS.

The minimum performance levels of HEDIS measures are determined by DHS after taking into consideration the recommendations of the QI workgroup. The Contractor will achieve

or exceed DHS established minimum performance levels for each HEDIS measure. If the Contractor fails to achieve the minimum performance level for any of the measures or receives a Not-Report for any of the measures, the Contractor will be required to develop and implement Corrective Actions. Contractor will submit the Corrective Actions to DHS in accordance with the timelines specified by DHS. The Corrective Actions must achieve or exceed DHS established minimum performance levels in accordance with timelines approved by DHS.

8.6.11 Collaborative Initiative

Contractor will undertake a joint Quality Improvement Collaborative Initiative addressing a common topic among all DHS Medi-Cal Managed Care Contractors. The initiative will consist of a standardized methodology that is to be used by all participating Medi-Cal Managed Care Contractors. The Collaborative Initiative will be completed and reported to DHS in accordance with a timeline specified by DHS after taking into consideration recommendations from the QI workgroup.

8.6.12 Internal Quality Improvement Projects (IQIPs)

Contractor will initiate four (4) IQIPs, (two clinical and two non-clinical) and complete at least three phases of the IQIPs unless DHS approves the completion of fewer phases during the term of the Contract. Should this Contract be renewed, it is the intent of the parties that the IQIPs will be completed in the term of the renewed contract. Contractor must secure written approval from DHS prior to initiating and terminating any IQIP.

The clinical topics will pertain to the care of, as well as, the primary, secondary, and/or tertiary prevention of both acute and chronic conditions. The non-clinical topics will pertain to quality of health services delivery (e.g. availability and accessibility, cultural competency, interpersonal aspects of care, quality of provider/patient Encounter, appeals, Grievances and other complaints, or focus on Consumer Assessment of Health Plans Study Version 2.0H (CAHPS) results when available. DHS reserves the right to require the Contractor to focus on a specific subject (clinical or non-clinical) for an IQIP.

8.6.13 Standards and Guidelines

For IQIPs in the health services delivery areas, Contractor will use the Standards and Guidelines set forth in Article 5, Section 5.7

8.6.14 Reporting Timelines

.1 HEDIS Measures

Contractor will report certified audited HEDIS measures to DHS on an annual basis following timelines specified by DHS.

.2 Collaborative Initiative

Contractor will report results of the Collaborative Initiative to DHS following the timelines specified by DHS.

.3 Internal Quality Improvement Projects

For each of the four Internal Quality Improvement Projects, Contractor will provide reports for DHS or a delegate's evaluation, upon completion of each phase of an IQIP or an annual progress report if the phase is not completed within 12 months, whichever is appropriate. If an IQIP is completed during the term of the Contract, Contractor will submit a final report to DHS.

8.6.15 QIP Contract Requirements When Termination of Contract Occurs

a) If this Contract is terminated prior to the completion of a Contract year the following requirements shall apply:

Subsection 8.6.10 Collaborative Initiative — Contractor must submit a final status report that covers the time period from the last report to the point of termination of the Contract.

Subsection 8.6.11 Internal Quality Improvement Projects — Contractor must submit a final status report that covers the time period from the last report to the point of termination of the Contract.

b) If this Contract is terminated at the completion of a full Contract year but prior to the expiration of the Contract, the following requirements shall apply:

Subsection 8.6.9 Quality Performance Measure Reporting — Contractor must report the HEDIS measures in accordance with the specifications and timelines as determined by DHS.

Subsection 8.6.10 Collaborative Initiative — Contractor must submit a final status report that covers the time period from the last report to the point of Contract termination.

Subsection 8.6.11 Internal Quality Improvement Projects — Contractor must submit a final status report that covers the time period from the last report to the point of Contract termination.

8.6.16 Contract Extension

If this Contract is extended, the Contractor shall comply with all the reporting requirements specified in this Contract.

8.6.17 Contract Provisions Not Specifically Governed by Regulations

The requirements of Subsection 8.6.9 through 8.6.15 are all Contract provisions which are not specifically governed by Chapter 4.0 (commencing with Section 53000) of Division 3 of Title 22, CCR. Therefore, consistent with Article 4, Section 4.5, sanctions for violations of these provisions shall be governed by Title 22, CCR, Section 53350(b)(5).

8.7 CREDENTIALING AND RECREDENTIALING

Contractor shall ensure the qualifications of all network practitioners, approve new providers and sites, and terminate or suspend individual providers. Contractor shall develop, and maintain written policies and procedures which include initial Credentialing, recredentialing, recertification, and reappointment of providers. Contractor shall ensure that policies and procedures are reviewed and approved by the governing body, or its designee. Contractor shall ensure that the responsibility for recommendations regarding Credentialing decisions shall rest with a Credentialing committee or other peer review body.

8.7.1 Credentialing

Contractor shall ensure that the initial Credentialing process obtains and verifies the following information:

a) A current valid license, registration or certificate to practice, a valid Drug Enforcement Agency registration number as applicable;

b) Graduation from a medical school, completion of a residency, board certification, if any, or other professional education as required;

c) Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting Facility (this requirement may be waived for practices which do not have or do not need access to hospitals), includes review of past history of curtailment or suspension of medical staff privileges;

d) Work history;

e) Professional liability claims history;

f) Requested information from: National Practitioner Data Bank and the Medical Board of California (MBC);

g) Any sanctions imposed by Medi-Cal or Medicare; and

h) A signed statement by the practitioner at time of application regarding any physical, mental health, chemical dependency/substance abuse problems, loss of license and/or felony convictions, loss or limitation of privileges or disciplinary actions.

8.7.2 Recredentialing

Contractor shall maintain and implement policies and procedures delineating the process for periodic reverification of clinical credentials which shall occur at least every two years. Contractor shall ensure that the process includes a review of all areas reviewed for Credentialing, excluding previously researched past history, a performance review which includes data from Member complaints, results of quality reviews, Utilization management, Member satisfaction surveys. A site visit to Primary Care providers' Service Sites shall also be included in the recredentialing process.

8.7.3 Delegated Credentialing

Contractor may delegate Credentialing and recredentialing activities but shall monitor the completion and effectiveness of the delegated process. If Contractor delegates Credentialing and recredentialing activities, Contractor shall implement and maintain policies and procedures which delineate the delegated activities and responsibility for these activities.

8.7.4 Disciplinary Actions

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies which result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process. Contractor shall ensure that any providers impacted by adverse determinations are provided due process through Contractor's provider appeal process.

8.8 FACILITY REVIEW

Contractor shall conduct Facility reviews on all Primary Care provider Service Sites as part of the Credentialing procedures using the May 24, 2000 DHS approved document entitled “Healthy San Diego Facility Evaluation Policy and Procedure Resource Manual”, as may be amended or superceded, which is hereby incorporated by reference.

8.8.1 After Operations Begin

Contractor, shall complete Facility reviews on all (100 percent) Primary Care sites within six months after plan operation and shall conduct ongoing Facility reviews as part of the recredentialing process.

8.8.2 State Inspections

Contractor shall provide any necessary assistance to the State in its conduct of Facility inspections and medical reviews of the Quality of Care being provided to Members. Contractor shall ensure correction of deficiencies as identified by those inspections and reviews according to the time frames delineated in the resulting reports.

8.8.3 Corrective Actions

Contractor shall take Corrective Actions if a Contractor review or State inspection finds a Primary Care Service Site to be in substantial non-compliance with requirements May 24, 2000 DHS approved document entitled “Healthy San Diego Facility Evaluation Policy and Procedure Resource Manual”, as may be amended or superceded. Contractor shall ensure that Primary Care Service Sites with major or repeated uncorrected deficiencies are not allowed to provide services to Members unless the State and Contractor agree to a plan of Corrective Action to be implemented by the Service Site, and such plan is being implemented to the satisfaction of the State.

8.8.4 Continuing Oversight

Contractor shall remain responsible for the oversight and monitoring of delegated Facility review activities.

8.9 MEDICAL RECORDS

Contractor shall ensure that an appropriate Medical Record for each Member is available to health providers consistent with Title 10, CCR, Section 1300.67.1 (c), 1300.80(b)(4), and Title 22, CCR, Section 53915.5(a)(4), by ensuring that each Service Location maintains and implements:

a) Procedures for storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval identification, and distribution;

b) A written policy to ensure that Medical Records are protected and confidential;

c) Written procedures for release of information and obtaining consent for treatment;

d) Policies and procedures to ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or hard copy); and

e) A designated individual at each Service Site responsible for services and maintaining Medical Records.

8.9.1 Member Medical Record

Contractor shall ensure that a complete Medical Record is maintained for each Member and the record reflects all aspects of patient care, including ancillary services, and at a minimum includes:

a) Member identification on each page; personal/biographical data in the record;

b) All entries dated and author identified; the entries will include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment;

c) A problem list, a complete record of immunizations and health maintenance or preventive services rendered;

d) Allergies and adverse reactions prominently noted in the record;

e) All informed consent documentation, including the human sterilization consent procedures required by Title 22, CCR, Sections 51305.1 through 51305.6, if applicable;

f) All emergency care provided (directly by the Contracting Provider or through an emergency department) and the hospital discharge summaries for all hospital admissions while the patient is enrolled;

g) All consultations, referrals, and specialists' reports, and all pathology and laboratory reports. Any abnormal results will have an explicit notation in the record;

h) Documentation for Medical Records of adults regarding whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care;

i) Request for/or refusal of language/interpretation services; and

j) Health education behavioral assessment and referrals to health education services for patients 12 years of age or older, must include a notation concerning use of cigarettes, alcohol, and substance abuse, health education or counseling and anticipatory guidance.

8.9.2 Medical Records Review

Contractor shall implement and maintain a system to review records for compliance with Medical Records policies and procedures implemented by Contractor, and institute corrective action when necessary. Contractor shall ensure that Medical Records are reviewed for:

a) Uniformity of forms;

b) Legibility (the record is legible to a person other than the writer);

c) Completeness;

d) Quality and appropriateness of services provided;

e) Immunizations; and

f) Preventive health screening.

8.10 UTILIZATION MANAGEMENT (UM) PROGRAM

Contractor shall implement and maintain a Utilization Management (UM) program which includes list of services that require Prior Authorization, persons responsible for UM and their qualifications, procedures to evaluate medical necessity, criteria used for approval, referral and denial of services, information sources, and the process used to review and approve the provision of medical services.

8.10.1 Under-Utilization and Over-Utilization

Contractor shall ensure that the UM program has mechanisms to detect both under and over-utilization of services.

8.10.2 Prior Authorization/Review Procedures

Contractor shall ensure that its Prior Authorization and concurrent review procedures shall meet the following minimum requirements:

a) Review decisions are supervised by qualified medical professionals and all denials shall be reviewed by a qualified physician;

b) There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is updated regularly, and is consistently applied;

c) Reasons for decisions are clearly documented;

d) There is a well-publicized appeals procedure for both providers and Members; and

e) Decisions and appeals are made in a timely manner.

8.10.3 Exceptionsto Prior Authorization Requirement

Contractor shall ensure that Prior Authorization requirements are not applied to Emergency Services or family planning services for network or out-of-plan providers. In addition, Prior Authorization shall not be required to access Sensitive Services and basic prenatal care through network providers.

8.10.4 DelegatingUM Activities

Contractor shall ensure that delegated UM activities to subcontractors are approved and regularly evaluated. Contractor shall ensure that this process is documented.

8.11 INFECTION CONTROL PLAN

Contractor shall implement and maintain policies and procedures for surveillance, prevention and control of infection transmission in patients and personnel which shall be reviewed every two years and include the following components:

a) Identification of person responsible for oversight and maintenance of the infection control plan;

b) Monitoring activities;

c) Application of universal precaution procedures;

d) The availability of adequate infection control devices and supplies in the patient areas;

e) Infectious or biohazardous waste disposal procedures complying with applicable State and federal regulations;

f) Isolation precautions and procedures;

g) Cleaning and sterilization methods, agents, and schedules, including maintenance of autoclave, spore testing, storage of sterile packs, etc.;

h) Training and continuing education of all personnel; and

i) Review of patient infections that present the potential for prevention or intervention to reduce the risk of future occurrence.

j) Procedures for reporting infectious diseases to public health authorities are required by State law.

8.11.1 Contractorshall ensure that its infection control plan policies are communicated to subcontractors and shall monitor subcontractors for compliance.

8.12 MEMBER SERVICES

Contractor shall maintain the capability to provide Member services to Members through sufficient assigned, trained staff consistent with Contractor's policies, and procedures regarding Member's rights and responsibilities and Member's scope of benefits.

8.12.1 Evidenceof Coverage

Contractor shall provide to all Members the Evidence of Coverage and Disclosure Form materials which constitute a fair disclosure of the provisions of the Covered Services.

8.12.2 MembershipIdentification Card

Within seven calendar days of Enrollment Contractor shall provide an identification card to each Member which identifies the Member as a plan Member and authorizes the provision of Covered Services to the Member. The card will specify that Emergency Services rendered to the Member by non-contracting providers are reimbursable by Contractor without Prior Authorization.

8.12.3 Membership Services Guide

Contractor shall develop and distribute a Membership Services Guide to each Member no later than seven calendar days following Enrollment, which includes the following information:

a) The name, address and telephone number of the Contractor;

b) A description of the full scope of Medi-Cal Covered Services including health education, interpretive services, and “carve out” services, and an explanation of any service limitations and exclusions from coverage, charges for services, when applicable, and copayments for services, if authorized by DHS;

c) Procedures for obtaining Covered Services including the address and telephone number of each Service Site (hospitals, Primary Care Physicians, optometrists, pharmacies, skilled nursing facilities, Urgent Care facilities);

d) In the case of a medical foundation or independent practice association, the address and telephone number of each physician provider;

e) The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours;

f) Procedures for selecting or requesting a change in PCPs, including requirements for a change in PCPs; reasons for which a request may be denied; and reasons why a provider may request a change;

g) The purpose and value of scheduling an initial health assessment appointment;

h) The appropriate use of health care services in a managed care system;

i) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers;

j) Procedure for obtaining emergency health care both within and outside Contractor's Service Area;

k) Process for referral to specialists;

l) Procedures for obtaining any Non-Medical Transportation Services offered by Contractor and through local EPSDT and CHDP programs, and how to obtain such services;

m) The causes for which a Member will lose entitlement to receive Covered Services under this Contract;

n) Procedures for filing a complaint/Grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization, (include the title, address, and telephone number of the person responsible for processing and resolving complaints/Grievances);

o) Procedures for disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period;

p) Information concerning the Member's right to the Medi-Cal fair hearing process regardless of whether or not a complaint/Grievance has been submitted or if the complaint/Grievance has been resolved, when a health care service requested by the Member or provider has not been provided. (The State Department of Social Services' Public Inquiry and Response Unit toll free telephone number (1-800-952-5253);

q) Information concerning the availability of, and procedures for obtaining, FQHCs and Indian Health Clinic services, and certified nurse midwife and certified nurse practitioner services, pursuant to Section 7.7.11;

r) Information concerning the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, and a description of those services, such as the following statement:

"Family planning services are provided to Members of child bearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member you pick a doctor who is located near you and will give you the services you need. Our PCPs and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] will pay that doctor or clinic for the family planning services you get";

s) DHS's Office of Family Planning's toll free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics;

t) Any other information determined by DHS to be essential for the proper receipt of Covered Services;

u) Information on how to access State resources for investigation and resolution of Member complaints including the DHS Medi-Cal Managed Care Ombudsman's toll free telephone number (1-888-452-8609), and the DMHC HMO Consumer Service toll free telephone number (1-800-400-0815);

v) When such information is furnished to Contractor by DHS, information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Welfare and Institutions Code Section 14005.84(b);

w) Information concerning the provision and availability of services covered under the CCS Program from providers outside Contractor's provider network and how to access these services;

x) An explanation of the expedited disenrollment process for children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to. Major organ transplants, for which disenrollment is required under this Contract; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan and inadvertently enrolled in Contractor's plan, for which disenrollment is required under this Contract;

y) Information on how to obtain Minor Consent Services through Contractor's plan, and an explanation of those services;

z) An explanation on how to use the Fee-For-Services system when Medi-Cal Covered Services are excluded or limited under this Contract; and

aa) An explanation of an American Indian Member's right not to be restricted in their access to Indian Health Services facilities by Contractor and their right to disenroll from Contractor's plan at any time, without cause.

bb) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code, Section 7158.2, this notice must be provided upon Enrollment and annually thereafter, in the evidence of coverage, Contractor's newsletter or any other direct communications with Members.

cc) A statement as to whether the Contractor uses provider financial bonuses or other incentives with its Contracting Providers of health care services and that the Member may request additional information about these bonuses or incentives from the Contractor, the Member's provider or the provider's medical group, or Independent Practice Association pursuant to California Health and Safety Code, Section 1367.10

dd) A notice as to whether the Contractor uses a drug formulary. Pursuant to California Health and Safety Code, Section 1363.01 the notice shall 1) be in language that is easily understood and in a format that is easy to understand; 2) include an explanation of what a formulary is, how the plan decides which presciption drugs are included in or excluded from the formulary, and how often the formulary is updated; 3) indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information; and 4) indicate that the presence of a drug on the Contractor's formulary does not guarantee that a member will be prescribed that drug by his or her prescribing provider for a particular medical condition.

ee) Subsections bb) through dd) above shall be included in the Contractor's Membership Services Guide upon the next reprinting of the Contractor's Membership Services Guide.

8.12.4 Enrollment Information

Contractor shall provide to the Member or Member’s family unit either in the form of a cover letter or insert in the Membership Services Guide each Member’s effective date of Enrollment and term of Enrollment and the name, telephone number, and Service Site address of the PCP chosen by or assigned to the Member.

8.12.5 Changes in Availability or Location of Covered Services

Contractor shall ensure Members are notified in writing of any changes in the availability or location of covered services at least 30 calendar days prior to the effective date of such changes, or within 14 calendar days prior to the change in cases of unforeseeable circumstances. The notification must be approved by DHS prior to the release.

8.12.6 Member Complaint/Grievance System

Contractor shall implement and maintain a Member complaint/Grievance system in accordance with Title 10, CCR, Section 1300.68, except Subsection 1300.68(g), and Title 22, CCR, Sections 53914 to address health delivery, medical and administrative issues, including an expedited review of emergency care complaint/Grievances as required by the Health and Safety Code Section 1368.01.

.1 Contractor shall acknowledge receipt of a complaint within five calendar days. The written acknowledgment will also notify the complainant of a person at the plan who may be contacted regarding the complaint. Contractor shall resolve the complaint within 30 calendar days or document reasonable efforts to resolve the complaint within 30 calendar days.

a) Expedited review of emergency care complaints shall result in resolution of the complaints/Grievances within 2 - 5 calendar days of receipt.

.2 Contractor shall systematically aggregate and analyze the Grievance data for use in Quality Improvement.

a) On a quarterly basis, 45 calendar days after the end of each quarter under this Contract Contractor shall submit a report of aggregated Grievance data to DHS and LHD.

8.12.7 Denial, Deferral, or Modification of Prior Authorization Requests

Contractor shall notify Members in writing of denial, deferral, or modification of requests for Prior Authorization, in accordance with the requirements and time frames of Title 22, CCR, Sections 51014.1, 51014.2, and 53261.

Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form approved by the State, informing the Member of all the following:

a) The Member's right to, and method of obtaining, a fair hearing to contest the denial, deferral or modification action;

b) The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson; and

c) The name and address of Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.

The notice to the Member may inform the Member that the Member may file a complaint/Grievance concerning Contractor's action using Contractor's complaint/Grievance process prior to or concurrent with the initiation of the fair hearing process.

8.13 CULTURAL AND LINGUISTIC SERVICES

8.13.1 Linguistic Services

Contractor shall provide linguistic services to a population group of mandatory Medi-Cal Eligible Beneficiaries residing in the proposed Service Area who indicate their primary language as other than English and who meet a numeric threshold of 3,000, or a population group of mandatory Medi-Cal Eligible Beneficiaries residing in the proposed Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

Contractor shall provide the following services to those Member groups at these key points of contact.

Key Points of Contact:

a) Medical: advice and Urgent Care telephone, face-to-face Encounters with providers; and

b) Non-medical: membership services, orientations, and appointments.

Types of Services:

a) Interpreters;

b) Translated signage;

c) Translated written materials, including the Member Services Guide, enrollee information, welcome packets, and marketing information; and

d) Referrals to culturally and linguistically appropriate community services programs.

.1 Provide 24-hour access to interpreter services for all Members at all Service Sites within Contractor's network either through telephone language services or interpreters.

8.13.2 Standards and Performance Requirements

Contractor shall develop and implement standards and performance requirements for the provision of linguistic services, and shall monitor the performance of the individuals who provide linguistic services. These standards shall include but are not limited to:

.1 A system for coordinating interpreters and implementation of standards for appointment scheduling to ensure continuity in the assignment of interpreters to Members when follow-up care is required.

.2 Assessment, identification and reporting the linguistic capability of interpreters or bilingual employed and contracted clinical and non-clinical staff.

8.13.3 Community Advisory Committee (CAC)

Contractor shall implement and maintain community linkages through the formation of a CAC with demonstrated participation of consumers, community advocates, Traditional

Providers and Safety-net Providers. Contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who speak a primary' language other than English and cultural competency of Contracting Providers.

8.14 PROVIDER SERVICES

8.14.1 Provider Grievance System

Contractor shall implement and maintain procedures to monitor the providers' Grievance system which includes:

a) Procedure to ensure timely resolution and feedback to Contracting Providers and non-contracting providers. Contractor shall acknowledge receipt of the complaint within five calendar days and resolve the complaint within 30 calendar days or document reasonable efforts to resolve the complaint;

b) Procedure for systematic aggregation and analysis of the Grievance data and use for Quality Improvement; and

c) Procedure to ensure that the Grievance submitted is reported to an appropriate level, i.e., payment or administrative issues versus medical or health care delivery issues.

8.14.2 Provider Training

Contractor shall ensure that ail Contracting Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and State regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all providers within 10 calendar days after Contractor places a newly Contracting Provider on active status. Contractor shall ensure that ongoing training is conducted when deemed necessary by either Contractor or the State.

8.14.3 Users Manual and Bulletins

Contractor shall issue a Users Manual and Bulletins (updates) to the providers of Medi-Cal services. The manual and bulletins shall serve as a source of information to health care

providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements.

8.15 REPORTING FRAUD AND ABUSE

Contractor shall report all cases of alleged fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, by subcontractors. Members, providers, or employees within 10 business days of the date when Contractor is on notice of the activity. Contractor shall establish and submit to DHS for approval, written policies and procedures for identifying, investigating and taking appropriate Corrective Action against fraud and/or abuse in the provision of health care services under the Medi-Cal program. The policies and procedures will include, at a minimum, notification of DHS and consultation with DHS prior to conducting any investigations; and reporting investigations results within 10 business days of conclusion of any fraud and/or abuse investigation.

ARTICLE 9.0 - SUBCONTRACTS

9.1 KNOX-KEENE REGULATIONS

The Contractor may elect to enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. In doing so, the Contractor shall meet the subcontracting requirements stated in Title 22, CCR, Section 53250, as well as those specified in this Contract.

All Subcontracts shall be in writing, and shall be entered into in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975 Health and Safety Code, Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W&I Code, Section 14200 et seq.; Title 22, CCR, Section 53250; Title 22, CCR, Section 53900 et seq.; and applicable federal and State laws and regulations, as well as the requirements of this Contract.

9.2 SUBCONTRACT REQUIREMENTS

Each Subcontract shall contain:

a) The subcontractor’s agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the Subcontract, available for inspection, examination and copying:

   i) by entities specified in Section 3.11,

   ii) at all reasonable times at the subcontractor’s place of business or at such other mutually agreeable location in California,

   iii) in a form maintained in accordance with the general standards applicable to such book or record keeping,

   iv) for a term of at least five years from the close of the State’s Fiscal Year in which the Subcontract expired or was terminated, and

v) including all Encounter data for a period of at least five years from the date of expiration or termination of Subcontracts.

b) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

c) Subcontractor's agreement to maintain and make available to the State, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-subcontractor:

i) make all applicable books and records available at all reasonable times for inspection, examination, or copying by the entities specified in Section 3.11, and

ii) retain such books and records for a term of at least five years from the close of the State's Fiscal Year in which the sub-subcontract expired or was terminated.

d) Subcontractor's agreement to assist the Contractor in the transfer of care pursuant to Article 4, Subsection 4.2.1 in the event of Contract termination.

e) Subcontractor's agreement to notify the State in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed to the Contracting Officer and deposited in the United States Postal Service as first-class registered mail, postage attached.

f) Subcontractor's agreement that assignment or delegation of the Subcontract shall be void unless prior written approval is obtained from the State.

g) Subcontractor's agreement to hold harmless both the State and plan Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.

9.3 SUBCONTRACT NON-FEDERALLY QUALIFIED HMOs - DHS APPROVAL

Except as provided in Subsection 9.4, a provider or management Subcontract entered into by a Contractor which is not a federally qualified HMO shall become effective upon approval by DHS in writing, or by operation of law where DHS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within 60 calendar days of receipt.

Subcontract amendments shall be submitted to DHS for prior written approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved or disapproved by DHS, shall become effective by operation of law 30 calendar days after DHS has acknowledged receipt or upon the date specified in the Subcontract amendment, whichever is later.

9.4 SUBCONTRACT FEDERALLY QUALIFIED HMOs - STATE APPROVAL

Except as provided in Subsection 9.5.1, Subcontracts entered into by a plan which is a federally qualified HMO shall be exempt from prior approval by DHS and submitted to DHS upon request.

9.5 SUBCONTRACT COMPENSATION

The Contractor shall not enter into any Subcontract if the compensation or other consideration which the subcontractor shall receive under the terms of the Subcontract is determined by a percentage of the Contractor’s payment from the State. This Subsection shall not be construed to prohibit Subcontracts in which compensation or other consideration is determined on a capitation basis.

9.5.1 FQHCs and Rural Health Clinic - Compensation

Contractor shall submit to DHS, within 30 days of a request and in the form and manner specified by DHS, for each of Contractor’s FQHC and RHC Subcontracts the services to be provided and the reimbursement level and amount. Further, Contractor shall certify to DHS that pursuant to Welfare and Institutions Code Section 14087.325(b) and (d), as amended by

Chapter 894/Statutes of 1998, that FQHC and RHC Subcontract terms and conditions are the same as offered to other Subcontractors providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. Contractor shall be required to pay its FQHC and RHC Subcontractors reimbursement that is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. DHS reserves the right to review and audit Contractor's FQHC and RHC reimbursement at its discretion to ensure compliance with State and federal law and shall approve all FQHC and RHC Subcontracts consistent with the provisions of Welfare and Institutions Code Section 14087.325(h).

In Subcontracts where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

9.6 PAYMENTS TO SUBCONTRACTORS

The Contractor shall pay all subcontractors for provision of Covered Service in accordance with 42 USC, Section 1396a(a)(37) and Article 8, Subsection 8.5.2 unless the subcontractor and Contractor have agreed to an alternate payment schedule.

9.7 PUBLIC RECORDS

Subcontracts entered into by the Contractor and all information received in accordance with this Subsection shall be public records on file with the State, except as specifically exempted in statute. The names of the officers and owners of the subcontractor, stockholders owning more than 10 percent of the stock issued by the subcontractor and major creditors holding more than five percent of the debt of the subcontractor shall be attached to the Subcontract at the time the Subcontract is presented to the State.

9.8 DISCLOSURES

Each Subcontract shall contain at least the elements required by Subsection 9.2, and the following:

a) Specification of the services to be provided;

b) Specification that the Subcontract shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the Contractor;

c) Specification that the Subcontract or Subcontract amendments shall be consistent with Section 9.3 or Subsection 9.5.1;

d) Specification of the term of the Subcontract including the beginning and ending dates as well as methods of extension, re-negotiation and termination; and

e) Subcontractor's agreement to submit reports as required by the Contractor.

9.9 LINGUISTIC SERVICE PROVISIONS

The Contractor shall document in Subcontracts with Traditional and Safety-net Providers the linguistic services to be provided and the individuals who will provide the linguistic services to Eligible Beneficiaries within the proposed Service Area.

9.10 PHYSICIAN INCENTIVE PLAN REQUIREMENTS

The Contractor may implement and maintain a Physician Incentive Plan only if:

a) No specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to a Member, and

b) The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR, Section 417.479 are met by the Contractor.

ARTICLE 10.0 PAYMENT PROVISIONS

10.1 CONTRACTOR RISK IN PROVIDING SERVICES

Contractor shall assume the total risk of operating a health care delivery system on the basis of a periodic capitation payment for each Member, except as otherwise allowed in the Contract. Any money not expended by Contractor after having fulfilled all obligations under this Contract shall be retained or spent by Contractor at its discretion.

10.2 AMOUNTS PAYABLE

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of this Contract. The maximum amount payable under this Contract in the 2000-2001 FY ending June 30,2001 will not exceed $. If funds become available for purposes of this Contract from future appropriations by the Legislature, and the maximum amount payable under this Contract in the 2001-2002 FY ending June 30, 2002 will not exceed $ and the maximum amount payable under this Contract in 2002-2003 FY ending June 30, 2003 will not exceed $. The maximum amount payable under this Contract shall not exceed $

10.3 CAPITATION RATES

The State shall remit to Contractor a post-paid capitation payment for each Member, for each month following the month in which that Member appears on the approved list of Eligible Beneficiaries supplied to Contractor by the State. The payment period for health care services shall commence on the first day of operations, as determined by the State. Capitation payments shall be made in accordance with the following schedule of capitation payment rates for the Operations Period.

Aid Group	Aid Codes	Rate
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 5X, 7X, 4F, 4G	$
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6G, 6N, 6P, 6R	$
Aged	10, 14, 16, 18	$
Child	03, 04, 4C, 4K, 5K, 45, 82, 4A	$
Adult	86	$
Percent of Poverty	47, 72, 7A, 8P, 8R	$

10.3.1 Derivative Aid Code

If DHS activates an aid code which is a Derivative Aid Code of an existing aid code included in the Contract, Contractor agrees to enroll Eligible Beneficiaries with the Derivative Aid Codes as Members and to provide Covered Services at the rate specified for the original aid code from which the Derivative Aid Code originated.

10.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

The capitation payment constitutes payment in full subject to any stop loss reinsurance by the State on behalf of a Member for all Covered Services required by the Member and for all Administrative Costs incurred by Contractor in providing or arranging for those services. It does not include payment for the recoupment of current or previous losses incurred by Contractor.

The capitation rates contained in this Contract result from negotiations and agreement between the Contractor and CMAC. CMAC negotiates rates from a Fee-For-Service equivalent upper payment limit determined by actuaries employed by the Department of Health Services.

The rate development process for this Contract consists of two separate calculations. First, a Fee-For-Service equivalent is determined for the entire group of Medi-Cal eligibles. Second, an experienced based methodology is employed to calculate rates for each Contract plan by beneficiary aid code using historical Medi-Cal managed care data. Both Fee-For-Service equivalent and experienced based methodologies use factors which directly influence the cost of providing health care to Medi-Cal beneficiaries. These factors are age, sex, geographic area with price indices, Medi-Cal aid code and eligibility for Medicare. The rate methodologies also employ adjustments for changes likely to occur during the term of the Contract. These adjustments include fee, benefit, or policy changes to reflect changes to the Medi-Cal program that are mandated each year by the State Legislature and the use of a tend factor to project costs to the term of the Contract.

10.5 NEGOTIATION OF RATES

CMAC and Contractor may annually review and renegotiate the capitation rates to determine whether such rates shall be increased, decreased, or remain the same for the following year. If it is determined by CMAC and Contractor that the capitation rates shall be increased or decreased, such increase or decrease may be effectuated through an amendment to this Contract in accordance with the provisions of Article 3, Section 3.7, subject to Subsection 10.5.1 and 10.5.2.

10.5.1 Effective Date of Rate Change

Any amendment resulting from the renegotiations of rates will be effective on August 1, 2001. If the Contract is extended pursuant to Article 4, Subsection 4.1.1, renegotiated rates will be effective on August 1 of each subsequent year in which a rate adjustment is negotiated and agreed upon.

10.5.2 Delay in Determination of Rates

In the event there is any delay in a determination to increase or decrease capitation rates, so that an amendment may not be processed in time to permit payment of new rates commencing on August 1, the payment to Contractor will continue at the rates then in effect. Those continued payments will constitute interim payments only. Upon final approval of the amendment providing for the rate change, the State will make adjustments for those months for which interim payments were made.

a) Any underpayment by the State shall be paid to Contractor within 30 calendar days after final approval of the new rates; and

b) Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from the capitation check exceeds 25 percent of the capitation payment for the month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the State.

10.6 REDETERMINATION OF RATES - OBLIGATION CHANGES

The capitation rates may be adjusted during the rate year to provide for a change in obligations which results in an increase or decrease in costs to Contractor, in accordance with the provisions of Welfare and Institutions Code Section 14301(c), and regulations adopted thereunder, of more than one percent of cost to Contractor. Any adjustments will be effectuated through an amendment to this Contract in accordance with the provisions of Article 3, Section 3.7 subject to Subsections 10.6.1 and 10.6.2.

10.6.1 Effective Date

The amendment will be effective as of the first day of the month in which such change in obligations is effective, as determined by CMAC.

10.6.2 Interim Payments

In the event the State is unable to process the amendment in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment will constitute interim payment only. Upon final approval of the amendment providing for the change in obligations, the State will make adjustments for those months for which interim payments were made.

10.7 REINSURANCE

Contractor may obtain reinsurance (stop loss coverage) through the State or other insurers or may self-insure upon approval by the State to ensure maintenance of adequate capital by Contractor, for the cost of providing Covered Services under this Contract. Reinsurance will not limit Contractor's liability below $ per Member for any 12-month period as specified by the State. Contractor may obtain reinsurance for the total cost of services provided to Members by non-contractor Emergency Service providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor FY.

10.8 CATASTROPHIC COVERAGE LIMITATION

The State may limit Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from, or is greatly aggravated by, a catastrophic occurrence or disaster.

Contractor shall return a prorated amount of the capitation payment following the Director's invocation of the Catastrophic Coverage Limitation. The amount returned will be determined by dividing the total capitation payment by the number of days in the month. The amount will be returned to the State for each day in the month after the Director has invoked the Catastrophic Coverage Limitation clause.

10.9 RECOVERY OF CAPITATION PAYMENTS

The State will have the right to recover amounts paid to Contractor in the circumstances as specified in the following Subsections.

10.9.1 Improper Member Enrollment/DisenroIIment

The State determines that a Member has either been improperly enrolled, or should have been disenrolled with an effective date in a prior month. The State may recover the capitation payments made to Contractor for the beneficiary and absolve Contractor from all financial and other risk for the provision of services to the beneficiary under the terms of the Contract for the month(s) in question.

Upon request by Contractor, the State may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Article 6, Section 6.6, or under other circumstances as approved by the State. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member until the Member is disenrolled on a non-retroactive basis pursuant to Article 6, Section 6.6.

10.9.2 Disallowance of Federal Financial Participation (FFP)

As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the Department of Health and Human Services disallows Federal Financial Participation (FFP) for payments made by the State to Contractor. The State may recover the amounts disallowed by DHHS by an offset to the capitation payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, the State at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months.

10.9.3 Other Improper Payment

If the State determines that any other erroneous or improper payment not mentioned above has been made to Contractor, the State may recover the amount determined by an offset to the capitation payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, the State, at its discretion, may grant a Contractor's request to repay the recoverable amount in monthly installments over a period of consecutive months not to exceed six months. At least 30 calendar days prior to seeking any such recovery, the State will notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

10.10 LIMITATION TO FEDERAL FINANCIAL PARTICIPATION

It is mutually understood between the parties that this Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties in order to avoid program and fiscal delays which would occur if the Contract were executed after that determination was made.

This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States government for each Fiscal Year for the purpose of this program. In addition, this Contract is subject to any additional restriction, limitation or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Contract in any manner.

It is mutually agreed that if Congress does not appropriate sufficient funds for the program, this Contract will be amended to reflect any reduction in funds.

DHS has the option to terminate the Contract under the termination clause pursuant to Article 4, Subsection 4.3.3 or to amend the Contract to reflect any reduction in funds.

ARTICLE 11.0 - DUTIES OF THE STATE

11.1 PAYMENT FOR SERVICES

The State shall pay the appropriate capitation payments set forth in Article 10, Payment Provisions, to Contractor for each Eligible Beneficiary under this Contract, and ensure that such payments are reasonable and do not exceed the amount set forth in Title 42, CFR, Section 447.361. Payments will be made monthly commencing with the Operations Period and continuing for the duration of this Contract. Any adjustments for Federally Qualified Health Centers will be made in accordance with Section 14087.325, Welfare & Institution Code.

11.1.1 Turnover and Phaseout Withhold

The State shall withhold an amount equal to 10 percent or one million dollars ($1,000,000), whichever is greater, unless provided otherwise by the Financial Guarantee Performance agreement, from the capitation payment of the last month of the Operations Period until all activities required during the Turnover and Phaseout Period are completed.

If all Turnover and Phaseout activities are completed by the end of the Turnover and Phaseout Period, the State shall pay Contractor the amount withheld. If Contractor fails to meet one or more requirement(s) by the end of the Turnover and Phaseout Period, the State shall deduct the costs of the remaining activities proportionately from the withhold amount and continue to withhold payment until all activities are completed.

11.2 MEDICAL REVIEWS

The State shall conduct medical reviews at least once every 12 months in accordance with the provisions of Section 14456, W&I Code, and issue medical review reports to Contractor detailing findings, recommendations, and Corrective Actions, as appropriate.

11.3 FACILITY INSPECTIONS

The State shall conduct unannounced validation reviews on a number of Contractor's Primary Care sites, selected at the State's discretion, to verify compliance of these sites with the State's requirements.

11.4 ENROLLMENT PROCESSING

The State, or designated representative, shall review applications for Enrollment and check the eligibility of applicants for services under this Contract. For those applications for Enrollment received prior to the specified deadlines, the State will provide to Contractor a list of Eligible Beneficiaries on a monthly basis, effective the first of the following month, as set forth in the annual health care plan cut-off schedule, published by Data Systems Branch, Department of Health Services.

Those applications for Enrollment received after the specified submission deadlines will become effective the first day of the second month following the receipt of the late application.

Contractor understands that Eligible Beneficiaries have a choice of competing health plans in the San" Diego Geographic Managed Care program. Contractor agrees that the State has made no representations or guarantees relating to the number of Eligible Beneficiaries who may choose or be enrolled in Contractor. Contractor specifically agrees that the State shall not be liable for any lack of Eligible Beneficiary Enrollment in Contractor's plan.

11.5 DISENROLLMENT PROCESSING

The State, or designated representative, shall review and process requests for disenrollment and notify Contractor and Member of its decision.

11.6 CERTIFICATION OF MARKETING REPRESENTATIVES

The State will test all of Contractor's Marketing Representatives for knowledge of the program prior to their engaging in marketing or Medi-Cal Managed Care information activities on behalf of Contractor. The State will certify, as qualified Marketing Representatives, those persons demonstrating adequate knowledge of the program, provided they are of good moral character. Contractor may be permitted, subject to approval and oversight by the State, to perform such testing on behalf of the State, provided that Contractor is free of marketing violations or abuses. With respect to evidence of good moral character, Contractor will be permitted to rely on the representative's written statements. The State reserves the right to rescind approval for Contractor testing at any time.

11.7 APPROVAL PROCESS

The State will acknowledge in writing, within five working days of receipt, the receipt of any material sent to the State by Contractor under the provisions of Article 5, Section 5.4, Obtaining State Approval. Within 60 calendar days of receipt, approve in writing the use of such material or provide Contractor with a written explanation why its use is not approved.

11.8 PROGRAM INFORMATION

The State will provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within 30 calendar days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, the State will notify Contractor within 30 calendar days, in writing, of the reason for the delay and when Contractor may expect the requested information.

11.9 BENEFICIARY NOTIFICATION OF HEALTH PLAN CONTRACT TERMINATION

The State will notify Medi-Cal beneficiaries affected by this Contract of their health care benefits and options available upon termination or expiration of this Contract.

11.10 PILOT PROJECTS

The State, pursuant to W&I Code Section 14094.3(c)(2), may establish pilot projects to test alternative managed care models tailored to the special health care needs of children under the California Children Services Program. These pilot projects may affect Contractor's obligations under the Contract in the areas of Covered Services, Eligible Beneficiaries and administrative systems. These pilot projects shall be implemented through Contract amendment. The State shall not require Contractor to cover CCS services under the capitation rate as part of a pilot project unless Contractor is a voluntary participant in the project.

11.11 CONFIDENTIALITY OF INFORMATION

The State shall comply with the confidentiality of information provisions detailed in Section 3.12.

ATTACHMENT I

EXCLUDED DRUGS FOR THE TREATMENT OF HIV AND AIDS

Abacavir Sulfate (Ziagen)
Ampernavir (Agenerase)
Delavirdine Mesylate (Rescriptor)
Efavirenz (Sustiva)
Indinavir Sulfate (Crixivan)
Lamivudine (Epivir)
Nelfinavir Mesylate (Viracept)
Nevirapine (Viramune)
Ritonavir (Norvir)
Saquinavir (Fortovase)
Saquinavir Mesylate (Invirase)
Stavudine (Zerit)
Zidovudine/Lamivudine (Combivir)

ATTACHMENT II

EXCLUDED PSYCHOTHERAPEUTIC DRUGS

Generic Name

Amantadine HCL
Benztropine Mesylate
Biperiden HCL
Biperiden Lactate
Chlorpromazine HCL
Chlorprothixene
Clozapine
Fluphenazine Decanoate
Fluphenazine Enanthate
Fluphenazine HCL
Haloperidol
Haloperidol Decanoate
Haloperidol Lacate
Isocarboxazid
Lithium Carbonate (Lithotabs, Eskalith, Lithobib CR)
Lithium Citrate
Loxapine HCL
Loxapine Succinate

Mesoridazine Besylate
Molindone HCL
Olanzapine
Perphenazine
Phenelzine Sulfate
Pimozide
Procyclidine HCL
Promazine HCL
Quetiapine
Risperidone
Thioridazine HCL
Thiothixene
Thiothixene HCL
Tranylcypromine Sulfate
Trifluopromazine
Trifluopromazin HCL
Trihexphenidyl HCL
Trifluoperazine HCL

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213 A (DHS Rev 7/04)

	AGREEMENT NUMBER	AMENDMENT NUMBER
☒ CHECK HERE IF ADDITIONAL PAGES ARE ADDED **3** PAGES	**00-91035**	**A-07**
	REGISTRATION NUMBER:	

1. This Agreement is entered into between the State Agency and Contractor named below:

   STATE AGENCY'S NAME (Also referred to as CDHS, DHS, or the State
   California Department of Health Services

   CONTRACTOR'S NAME (Also referred to as Contractor
   Sharp Health Plan (Effective June 1, 2005, Molina Healthcare of California)

2. The term of this Agreement is August 1, 2000 through December 31, 2005

3. The maximum amount of this Agreement is: $343,269,000
   Three Hundred Forty-three Million, Two Hundred Sixty-nine Thousand Dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

   1) Amendment effective date: June 1, 2005
   2) Purpose of amendment: All parties expressly consent to a novation by discharging contractor Sharp Health Plan and substituting the new contractor, Molina Healthcare of California; to revise the definition of Contractor to include Molina Healthcare of California; and to revise the notice provision to include Molina Healthcare of California.
   3) By executing this Amendment, Sharp Health Plan assigns and transfers to Molina Healthcare of California all of Sharp Health Plan's rights and interests in this Contract, and Sharp Health Plan is hereby expressly released by the Department of Health Services from all obligations and liabilities that accrue under this Contract on and after June 1, 2005. By executing this Amendment, Molina Healthcare of California assumes all rights, duties, obligations, responsibilities, and liabilities of any type that accrue under this Contract on and after June 1, 2005, and agrees to abide by the terms and conditions of the Contract. Molina Healthcare of California shall not be liable under this Contract to indemnify the State of California for any acts, omissions, cause or reason occurring prior to June 1, 2005.

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CALIFORNIA
Department of General Services
Use Only

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
Sharp Health Plan (Effective June 1, 2005, Molina Healthcare of California)

BY *(Authorized Signature)*	DATE SIGNED	BY *(Authorized Signature)*	DATE SIGNED
/s/ B. Kathlyn Mead	4/__/05	/s/ Joann Zarza-Garrido	4/__/05

PRINTED NAME AND TITLE OF PERSON SIGNING	PRINTED NAME AND TITLE OF PERSON SIGNING
B. Kathlyn Mead, President/CEO	Joann Zarza-Garrido, President/CEO
ADDRESS	ADDRESS
4305 University Avenue, Suite 200 San Diego, CA 92105	One Golden Shore Drive Long Beach, CA 90802

STATE OF CALIFORNIA

AGENCY NAME
California Department of Health Services

BY *(Authorized Signature)*	DATE SIGNED *(Do not type)*
/s/ Stan Rosenstein	5/31/05

PRINTED NAME AND TITLE OF PERSON SIGNING
Stan Rosenstein, Deputy Director, Medical Care Services

ADDRESS
1501 Capitol Avenue, 6th Floor, MS 4000, PO Box 997413
Sacramento, CA 95899-7413

Exempt per:
☐ Welfare and Institutions Code section 14087.55(c)
☒ Welfare and Institutions Code section 14089.8(b)

4) ARTICLE 2.0, DEFINITIONS, Section 2.13 Contractor, is amended to read:

2.13 Contractor means the Knox-Keene licensed plan: Sharp Health Plan for the period August 1, 2000 through May 31, 2005; and effective June 1, 2005, Contractor means the Knox-Keene licensed plan, Molina Healthcare of California.

5) ARTICLE 3.0, GENERAL PROVISIONS, Section 3.3 Authorized Representatives/Delegation of Authority, is amended to add the following:

The Contract representatives of this Contract from August 1, 2000 through May 31, 2005 will be:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Chief, Plan Management Branch
Telephone: (916) 449-5100, (916) 449-5101
Fax: (916) 449-5090, (916) 449-5091

Contractor
Sharp Health Plan
B. Kathlyn Mead, President/CEO
Telephone: (619) 228-2440

Direct all inquiries to:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Contracting Officer
1501 Capitol Avenue, Suite 71.4001
PO Box 942732, Mail Stop 4407
Sacramento, CA 94234-7320

Telephone: (916) 449-5100
Fax: (916) 449-5090, (916) 449-5091

Contractor
Sharp Health Plan
B. Kathlyn Mead, President/CEO
9325 Sky Park Court, Suite 300
San Diego, CA 92123

Telephone: (619) 228-2440

The Contract representatives of this Contract from June 1, 2005 will be:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Chief, Plan Management Branch

Telephone: (916) 449-5100, (916) 449-5101
Fax: (916) 449-5090, (916) 449-5091

Contractor
Molina Healthcare of California
Joann Zarza-Garrido,
President/CEO
Telephone: (562) 435-3666, ext. 7019

Direct all inquiries to:

Department of Health Services	**Contractor**
Medi-Cal Managed Care Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 PO Box 942732, Mail Stop 4407 Sacramento, CA 94234-7320	Molina Healthcare of California Joann Zarza-Garrido, President/CEO One Golden Shore Drive Long Beach, CA 90802
Telephone: (916) 449-5100 Fax: (916) 449-5090, (916) 449-5091	Telephone: (562) 435-3666, ext. 7019

Either party may make changes to the contact information in this Section 3.3 by giving updated written information to the other party. These changes shall not require an amendment to this Contract.

6) ARTICLE 3.0, GENERAL PROVISIONS, Section 3.9 Submissions to DHS/Notices, is amended to read:

3.9 Submissions to DHS/Notices

All deliverables, correspondence, notices, reports and records required under this Contract shall be in writing and shall be deemed to have been provided when mailed. All submissions to the State shall be sent to DHS, except requests to re-negotiate the Contract, which shall be submitted to CMAC. Required notices, records and reports shall be sent to the following addresses as appropriate:

State Department of Health Services
Medi-Cal Managed Care Division
Healthy San Diego, Geographic Managed Care Plan Management Unit
Attn: GMC - Healthy San Diego
1501 Capitol Avenue, Suite 71.4001
MS: 4408, P.O. Box 997413
Sacramento, CA 95899-7413

For matters prior to June 1, 2005:

Sharp Health Plan
9325 Sky Park Court, Suite 300
San Diego, CA 92123
Attn: Government Compliance/Contract Manager

For matters on or after June 1, 2005:

Molina Healthcare of California
Attention: Contract Manager
One Golden Shore Drive
Long Beach, CA 90802

California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

7) All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213 A (DHS Rev 7/04)

	AGREEMENT NUMBER	AMENDMENT NUMBER
☒ CHECK HERE IF ADDITIONAL PAGES ARE ADDED **3** PAGES	**00-91036**	**A-07**
	REGISTRATION NUMBER:	

1. This Agreement is entered into between the State Agency and Contractor named below:

   STATE AGENCY'S NAME (Also referred to as CDHS, DHS, or the State)
   California Department of Health Services

   CONTRACTOR'S NAME (Also referred to as Contractor)
   Universal Care (Effective June 1, 2005, Molina Healthcare of California)

2. The term of this Agreement is August 1, 2000 through December 31, 2005

3. The maximum amount of this Agreement is: $ 86,884,000
   Eighty-six Million, Eight Hundred Eighty-four Thousand Dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

   1) Amendment effective date: June 1, 2005

   2) Purpose of amendment: All parties expressly consent to a novation by discharging contractor Universal Care and substituting the new contractor, Molina Healthcare of California; to revise the definition of Contractor to include Molina Healthcare of California; and to revise the notice provision to include Molina Healthcare of California.

   3) By executing this Amendment, Universal Care assigns and transfers to Molina Healthcare of California all of Universal Care's rights and interests in this Contract, and Universal Care is hereby expressly released by the Department of Health Services from all obligations and liabilities that accrue under this Contract on and after June 1, 2005. By executing this Amendment, Molina Healthcare of California assumes all rights, duties, obligations, responsibilities, and liabilities of any type that accrue under this Contract on and after June 1, 2005, and agrees to abide by the terms and conditions of the Contract. Molina Healthcare of California shall not be liable under this Contract to indemnify the State of California for any acts, omissions, cause or reason occurring prior to June 1, 2005.

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CALIFORNIA
Department of General Services
Use Only

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
Universal Care (Effective June 1, 2005, Molina Healthcare of California)

BY *(Authorized Signature)*	DATE SIGNED	BY *(Authorized Signature)*	DATE SIGNED
/s/ Jeffrey V. Davis	4/9/05	/s/ Joann Zarza-Garrido	4/18/05

PRINTED NAME AND TITLE OF PERSON SIGNING
Jeffrey V. Davis, Exec. VP and COO

ADDRESS
1600 East Hill Street
Signal Hill, CA 90806

PRINTED NAME AND TITLE OF PERSON SIGNING
Joann Zarza-Garrido, President/CEO

ADDRESS
One Golden Shore Drive
Long Beach, CA 90802

STATE OF CALIFORNIA

AGENCY NAME
California Department of Health Services

BY *(Authorized Signature)*	DATE SIGNED *(Do not type)*
/s/ Stan Rosenstein	5/31/05

PRINTED NAME AND TITLE OF PERSON SIGNING
Stan Rosenstein, Deputy Director, Medical Care Services

ADDRESS
1501 Capitol Avenue, 6th Floor, MS 4000, PO Box 997413
Sacramento, CA 95899-7413

Exempt per:
☐ Welfare and Institutions Code section 14087.55(c)
☒ Welfare and Institutions Code section 14089.8(b)

4) ARTICLE 2.0, DEFINITIONS, Section 2.13 Contractor, is amended to read:

2.13 Contractor means the Knox-Keene licensed plan: Universal Care for the period August 1, 2000 through May 31, 2005; and effective June 1, 2005, Contractor means the Knox-Keene licensed plan, Molina Healthcare of California.

5) ARTICLE 3.0, GENERAL PROVISIONS, Section 3.3 Authorized Representatives/Delegation of Authority, is amended to add the following:

The Contract representatives of this Contract from August 1, 2000 through May 31, 2005 will be:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Chief, Plan Management Branch
Telephone: (916) 449-5100, (916) 449-5101
Fax: (916) 449-5090, (916) 449-5091

Contractor
Universal Care
Jeffrey V. Davis, Executive Vice President and COO
Telephone: (562) 981-4004
Fax: (562) 427-4634

Direct all inquiries to:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Contracting Officer
1501 Capitol Avenue, Suite 71.4001
PO Box 942732, Mail Stop 4407
Sacramento, CA 94234-7320

Telephone: (916)449-5100
Fax: (916) 449-5090, (916) 449-5091

Contractor
Universal Care
Jeffrey V. Davis, Executive Vice President and COO
1600 East Hill Street
Signal Hill, CA 90806

Telephone: (562)981-4004
Fax: (562) 427-4634

The Contract representatives of this Contract from June 1, 2005 will be:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Chief, Plan Management Branch
Telephone: (916) 449-5100, (916) 449-5101
Fax: (916) 449-5090, (916) 449-5091

Contractor
Molina Healthcare of California
Joann Zarza-Garrido,
President/CEO
Telephone: (562) 435-3666, ext. 7019

Direct all inquiries to:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Contracting Officer

1501 Capitol Avenue, Suite 71.4001
PO Box 942732, Mail Stop 4407
Sacramento, CA 94234-7320

Telephone: (916) 449-5100
Fax: (916) 449-5090, (916) 449-5091

Contractor
Molina Healthcare of California
Joann Zarza-Garrido,
President/CEO
One Golden Shore Drive
Long Beach, CA 90802

Telephone: (562) 435-3666, ext. 7019

Either party may make changes to the contact information in this Section 3.3 by giving updated written information to the other party. These changes shall not require an amendment to this Contract.

6) ARTICLE 3.0, GENERAL PROVISIONS, Section 3.9 Submissions to DHS/Notices, is amended to read:

3.9 Submissions to DHS/Notices

All deliverables, correspondence, notices, reports and records required under this Contract shall be in writing and shall be deemed to have been provided when mailed. All submissions to the State shall be sent to DHS, except requests to re-negotiate the Contract, which shall be submitted to CMAC. Required notices, records and reports shall be sent to the following addresses as appropriate:

State Department of Health Services
Medi-Cal Managed Care Division
Healthy San Diego, Geographic Managed Care Plan Management Unit
Attn: GMC - Healthy San Diego
1501 Capitol Avenue, Suite 71.4001
MS: 4408, P.O. Box 997413
Sacramento, CA 95899-7413

For matters prior to June 1, 2005:

Universal Care
1600 East Hill Street
Signal Hill, CA 90806
Attn: Executive Vice President and COO

For matters on or after June 1, 2005:

Molina Healthcare of California
Attention: Contract Manager
One Golden Shore Drive
Long Beach, CA 90802

California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

7) All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213 A (DHS Rev 7/04)

	AGREEMENT NUMBER	AMENDMENT NUMBER
☒ CHECK HERE IF ADDITIONAL PAGES ARE ADDED **6** PAGES	**00-91035**	**A-08**
	REGISTRATION NUMBER:	

1. This Agreement is entered into between the State Agency and Contractor named below:

   STATE AGENCY'S NAME (Also referred to as CDHS, DHS, or the State)
   California Department of Health Services

   CONTRACTOR'S NAME (Also referred to as Contractor)
   Molina Healthcare of California

2. The term of this Agreement is August 1, 2000 through December 31, 2005

3. The maximum amount of this Agreement is: $351,849,000
   Three Hundred Fifty-one Million, Eight Hundred Forty-nine Thousand Dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

   1) Amendment effective date: June 1, 2005
   2) Purpose of amendment: To revise the enrollment capacity; to adjust rates; and to adjust the encumbrances/amounts payable accordingly.
   3) The Members covered under Contractor's Medi-Cal San Diego Geographic Managed Care Contract No. 00-91036 Universal Care, with the Department of Health Services, will be enrolled in this Contract No. 00-91035 Molina Healthcare of California effective June 1, 2005.

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CALIFORNIA
Department of General Services
Use Only

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
Molina Healthcare of California

BY *(Authorized Signature)* DATE SIGNED *(Do not type)*

/s/ Joann Zarza-Garrido 5/18/05

PRINTED NAME AND TITLE OF PERSON SIGNING
Joann Zarza-Garrido, President/CEO

ADDRESS
One Golden Shore Drive
Long Beach, CA 90802

STATE OF CALIFORNIA

AGENCY NAME
California Department of Health Services

BY *(Authorized Signature)* DATE SIGNED *(Do not type)*

/s/ Stan Rosenstein 6/16/05

PRINTED NAME AND TITLE OF PERSON SIGNING
Stan Rosenstein, Deputy Director, Medical Care Services

ADDRESS
1501 Capitol Avenue, 6th Floor, MS 4000, PO Box 997413
Sacramento, CA 95899-7413

Exempt per:
☐ Welfare and Institutions Code section 14087.55(c)
☒ Welfare and Institutions Code section 14089.8(b)

4) ARTICLE 6.0, ENROLLMENT AND DISENROLLMENT, Section 6.2 Enrollment Capacity, is amended to read:

6.2 Enrollment Capacity

Contractor’s maximum Enrollment capacity under this Contract shall not exceed 200,000.

5) ARTICLE 10.0, PAYMENT PROVISIONS, Section 10.2 Amounts Payable, is amended to read:

10.2 Amounts Payable

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of this Contract. The maximum amount payable under this Contract in the 2000-2001 FY ending June 30, 2001 will not exceed the maximum amount payable under this Contract in the 2001-2002 FY ending June 30, 2002 will not exceed ; the maximum amount payable under this Contract in 2002-2003 FY ending June 30, 2003 will not exceed and the maximum amount payable under this Contract in 2003-2004 FY ending June 30, 2004 will not exceed and the maximum amount payable under this Contract in the 2004-2005 FY ending June 30, 2005 will not exceed If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable under this Contract in the 2005-2006 FY ending June 30, 2006 will not exceed The maximum amount payable under this Contract shall not exceed

6) ARTICLE 10.0, PAYMENT PROVISIONS, Section 10.3 Capitation Rates, is amended to read:

10.3 Capitation Rates

The State shall remit to Contractor a postpaid capitation payment for each Member, for each month in which that Member appears on the approved list of Eligible Beneficiaries supplied to Contractor by the State. The payment period for health care services shall commence on the first day of operations, as determined by the State. Capitation payments shall be made in accordance with the following schedule of capitation payment rates for the Operations Period.

A. From August 1, 2001 through June 30, 2002:

Aid Group	Aid Codes	Rate
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4C*, 4F, 4G, 4M, 5X, 7X	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6G, 6H, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1H	
Child	03, 04, 45, 82, 4A, 4K, 5K, 7J**	
Adult	86	
Percent of Poverty	47, 72, 7A, 8P, 8R	
Breast and Cervical Cancer Treatment Program (BCCTP)***	0M, 0N, 0P, 0R, 0T, 0U	

* The effective date of the movement of 4C to the Family Aid Grouping from the Child Aid Grouping is September 1, 2001.

** The effective date of the addition of Aid Code 7J is October 1, 2001.

*** The effective date of the addition of the BCCTP Aid Group is February 1, 2002.

B. From July 1, 2002 through June 30, 2003:

Aid Group	Aid Codes	Rate
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4C, 4F, 4G, 4M, 5X, 7X	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 2E*, 6A, 6C, 6E*, 6G, 6H, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1E*, 1H	
Child	03, 04, 45, 82, 4A, 4K, 5K, 7J	
Adult	86	
Percent of Poverty	47, 72, 7A, 8P, 8R	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U	

* The effective date of the addition of Aid Codes 1E, 2E, 6E is May 1, 2003.

C. From July 1, 2003 through July 31, 2003:

Aid Group	Aid Codes	Rate
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4C, 4F, 4G, 4M, 5X, 7X	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6P, 2E, 6A, 6C, 6E, 6G, 6H, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4K, 5K, 7J	
Adult	86	
Percent of Poverty	47, 72, 7A, 8P, 8R	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U	

D. From August 1, 2003 through December 31, 2003:

Aid Group	AidCodes	Rate
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4C, 4F, 4G, 4M, 5X, 7X	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 2E, 6A, 6C, 6E, 6G, 6H, 6J*, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4K, 5K, 7J	
Adult	86	
Percent of Poverty	47, 72, 7A, 8P, 8R	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N ,0P, OR, 0T, 0U	

* The effective date of the addition of Aid Code 6J is October 1, 2003.

E. From January 1, 2004 through June 30, 2004:

Aid Group	Aid Codes	Rate
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4C, 4F, 4G, 4M, 5X, 7X	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 2E, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4K, 5K, 7J	
Adult	86	
Percent of Poverty	47, 72, 7A, 8P, 8R	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U	

F. From July 1, 2004 through July 31, 2004:

Aid Group	Aid Codes	Rate
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4C, 4F, 4G, 4M, 5X, 7X	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 2E, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4K, 5K, 7J ,	
Adult	86	
Percent of Poverty	47, 72, 7A, 8P, 8R	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U	

G. From August 1, 2004 through May 31, 2005:

Aid Group	Aid Codes	Rate
Family	01, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 45, 47, 54, 59, 72, 82, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 2E, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1E, 1H	
Adult	86	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U	

H. Commencing June 1, 2005:

Aid Group	Aid Codes	Rate
Family	01, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 40, 42, 45, 47, 54, 59, 72, 82, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 2E, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V	
Aged	10, 14, 16, 18, 1E, 1H	
Adult	86	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U	

7) All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213 A (DHS Rev 7/04)

	AGREEMENT NUMBER	AMENDMENT NUMBER
☒ CHECK HERE IF ADDITIONAL PAGES ARE ADDED **4** PAGES	**00-91035**	**A-09**
	REGISTRATION NUMBER:	

1. This Agreement is entered into between the State Agency and Contractor named below:

   STATE AGENCY'S NAME (Also referred to as CDHS, DHS, or the State)
   California Department of Health Services

   CONTRACTOR'S NAME (Also referred to as Contractor)
   Molina Healthcare of California (Effective July 1, 2005, Molina Healthcare of California Partner Plan, Inc.)

2. The term of this Agreement is August 1, 2000 through December 31, 2005

3. The maximum amount of this Agreement is: $351,849,000
   Three Hundred Fifty-one Million, Eight Hundred Forty-nine Thousand Dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

   1) Amendment effective date: June 1, 2005
   2) Purpose of amendment: All parties expressly consent to a novation by discharging contractor Molina Healthcare of California and substituting the new contractor, Molina Healthcare of California Partner Plan, Inc. to revise the definition of Contractor to include Molina Healthcare of California Partner Plan, Inc.; and to revise the notice provision to include Molina Healthcare of California Partner Plan, Inc.
   3) By executing this Amendment, Molina Healthcare of California assigns and transfers to Molina Healthcare of California Partner Plan, Inc. all of Molina Healthcare of California's rights and interests in this Contract, and Molina Healthcare of California is hereby expressly released by the Department of Health Services from all obligations and liabilities that accrue under this Contract on and after June 1, 2005. By executing this Amendment, Molina Healthcare of California Partner Plan, Inc. assumes all rights, duties, obligations, responsibilities, and liabilities of any type that accrue under this Contract on and after June 1, 2005, and agrees to abide by the terms and conditions of the Contract. Molina Healthcare of California Partner Plan, Inc. shall not be liable under this Contract to indemnify the State of California for any acts, omissions, cause or reason occurring prior to June 1, 2005.

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CALIFORNIA
Department of General Services
Use Only

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
Molina Healthcare of California (Effective July 1, 2005, Molina Healthcare of California Partner Plan, Inc.)

BY *(Authorized Signature)*	DATE SIGNED	BY *(Authorized Signature)*	DATE SIGNED
/s/ Joann Zarza-Garrido	6/28/05	/s/ Joann Zarza-Garrido	6/28/05
PRINTED NAME AND TITLE OF PERSON SIGNING		PRINTED NAME AND TITLE OF PERSON SIGNING	
Joann Zarza-Garrido, President/CEO		Joann Zarza-Garrido, President/CEO	
ADDRESS		ADDRESS	
One Golden Shore Drive Long Beach, CA 90802		One Golden Shore Drive Long Beach, CA 90802	

STATE OF CALIFORNIA

AGENCY NAME
California Department of Health Services

BY *(Authorized Signature)* DATE SIGNED *(Do not type)*

/s/ Stan Rosenstein 7/11/05

PRINTED NAME AND TITLE OF PERSON SIGNING
Stan Rosenstein, Deputy Director, Medical Care Services

ADDRESS
1501 Capitol Avenue, 6th Floor, MS 4000, PO Box 997413
Sacramento, CA 95899-7413

Exempt per:
☐ Welfare and Institutions Code section 14087.55(c)
☒ Welfare and Institutions Code section 14089.8(b)

4) ARTICLE 2.0, DEFINITIONS, Section 2.13 Contractor, is amended to read:

2.13 Contractor means the Knox-Keene licensed plan: Sharp Health Plan for the period August 1, 2000 through May 31, 2005; Molina Healthcare of California for the period of June 1, 2005 through June 30, 2005; and effective July 1, 2005, Molina Healthcare of California Partner Plan, Inc.

5) ARTICLE 3.0, GENERAL PROVISIONS, Section 3.3 Authorized Representatives/Delegation of Authority, is amended to read:

The Contract representatives of this Contract from August 1, 2000 to May 31, 2005 will be:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Chief, Plan Management Branch
Telephone: (916) 449-5100, (916) 449-5101
Fax: (916) 449-5090, (916) 449-5091

Contractor
Sharp Health Plan
B. Kathlyn Mead, President/CEO
Telephone: (619) 228-2440

Direct all inquiries to:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Contracting Officer
1501 Capitol Avenue, Suite 71.4001
PO Box 997413, Mail Stop 4407
Sacramento, CA 95899-7413

Telephone: (916) 449-5000
Fax: (916) 449-5005

Contractor
Sharp Health Plan
B. Kathlyn Mead, President/CEO
9325 Sky Park Court, Suite 300
San Diego, CA 92123

Telephone: (619) 228-2440

The Contract representatives of this Contract from June 1, 2005 to June 30, 2005 will be:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Chief, Plan Management Branch
Telephone: (916) 449-5100, (916) 449-5101
Fax: (916) 449-5090, (916) 449-5091

Contractor
Molina Healthcare of California
Joann Zarza-Garrido, President/CEO
Telephone: (562) 435-3666, ext. 7019

Direct all inquiries to:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Contracting Officer
1501 Capitol Avenue, Suite 71.4001
PO Box 997413, Mail Stop 4407
Sacramento, CA 95899-7413

Telephone: (916) 449-5000
Fax: (916) 449-5005

Contractor
Molina Healthcare of California
Joann Zarza-Garrido, President/CEO
One Golden Shore Drive
Long Beach, CA 90802

Telephone: (562) 435-3666, ext. 7019

The Contract representatives of this Contract commencing July 1, 2005 will be:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Chief, Plan Management Branch

Telephone: (916) 449-5100, (916) 449-5101
Fax: (916) 449-5090, (916) 449-5091

Contractor
Molina Healthcare of California Partner Plan, Inc.
Joann Zarza-Garrido, President/CEO

Telephone: (562) 435-3666, ext. 127019

Direct all inquiries to:

Department of Health Services
Medi-Cal Managed Care Division
Attention: Contracting Officer
1501 Capitol Avenue, Suite 71.4001
PO Box 997413, Mail Stop 4407
Sacramento, CA 95899-7413

Telephone: (916) 449-5000
Fax: (916) 449-5005

Contractor
Molina Healthcare of California
Partner Plan, Inc.
Joann Zarza-Garrido, President/CEO
One Golden Shore Drive
Long Beach, CA 90802

Telephone: (562) 435-3666, ext. 127019

Either party may make changes to the contact information in this Section 3.3 by giving updated written information to the other party. These changes shall not require an amendment to this Contract.

6) ARTICLE 3.0, GENERAL PROVISIONS, Section 3.9 Submissions to DHS/Notices, is amended to read:

3.9 Submissions to DHS/Notices

All deliverables, correspondence, notices, reports and records required under this Contract shall be in writing and shall be deemed to have been provided when mailed. All submissions to the State shall be sent to DHS, except requests to re-negotiate the Contract, which shall be submitted to CMAC. Required notices, records and reports shall be sent to the following addresses as appropriate:

State Department of Health Services
Medi-Cal Managed Care Division
Healthy San Diego, Geographic Managed Care Plan Management Unit
Attn: GMC - Healthy San Diego
1501 Capitol Avenue, Suite 71.4001
MS: 4408, P.O. Box 997413
Sacramento, CA 95899-7413

For matters prior to June 1, 2005:

Sharp Health Plan
9325 Sky Park Court, Suite 300
San Diego, CA 92123
Attn: Government Compliance/Contract Manager

For matters from June 1, 2005 through June 30, 2005:

Molina Healthcare of California
Attention: Contract Manager
One Golden Shore Drive
Long Beach, CA 90802

For matters on or after July 1, 2005:

Molina Healthcare of California Partner Plan, Inc.
Attn: Joann Zarza-Garrido, President/CEO
One Golden Shore Drive
Long Beach, CA 90802

California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

7) All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

Exhibit 10.3

Molina Healthcare, Inc. 2002 Equity Incentive Plan

Restricted Stock Award Agreement

This RESTRICTED STOCK AWARD AGREEMENT (the "Agreement") effective as of [Grant Date] is between Molina Healthcare, Inc., a Delaware corporation (the "Company"), and [Executive Officer], an employee of the Company or one of its Affiliates (the "Grantee"), pursuant to and subject to the terms and conditions of the Molina Healthcare, Inc. 2002 Equity Incentive Plan (the "Plan").

The Company desires to award to the Grantee a number of shares of the Company's common stock, par value $.001 per share (the "Common Stock"), subject to certain restrictions as provided in this Agreement, in order to carry out the purpose of the Plan. The purpose of this Agreement is to evidence the terms and conditions of an award of restricted stock granted to the Grantee under the Plan.

Accordingly, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Company and the Grantee hereby agree as follows:

Section 1. Award of Restricted Stock.

Effective as of the [Grant Date] (the "Effective Date"), the Company granted to the Grantee a restricted stock award of __________________ shares of Common Stock (the "Shares"), subject to the terms and conditions set forth in this Agreement and in accordance with the terms of the Plan (the "Restricted Stock Award").

Section 2. Rights with Respect to the Shares.

(a) *Stockholder Rights*. With respect to the Shares, the Grantee shall be entitled at all times on and after the date of issuance of the Shares to exercise the rights of a stockholder of Common Stock of the Company, including the right to vote the Shares and the right to receive dividends on the Shares as provided in Section 2(b) hereof, unless and until the Shares are forfeited pursuant to Section 3 hereof. However, the Shares shall be nontransferable and subject to a risk of forfeiture to the Company at all times prior to the dates on which such Shares become vested, and the restrictions with respect to the Shares lapse, in accordance with Section 3 of this Agreement.

(b) *Dividends*. As a condition to receiving the Shares under the Plan, the Grantee hereby agrees to defer the receipt of dividends paid on the Shares. Cash dividends or other cash distributions paid with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate, shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary, and shall be forfeited in the event that the Shares with respect to which the dividends were paid are forfeited.

(c) *Issuance of Shares*. The Company shall cause the Shares to be issued in the Grantee's name or in a nominee name on the Grantee's behalf, either by book-entry registration or issuance of a stock certificate or certificates evidencing the Shares, which certificate or certificates shall be held by the Secretary of the Company or the stock transfer agent or brokerage service selected by the Secretary of the Company to provide such services for the Plan. The Shares shall be restricted from transfer and shall be subject to an appropriate stop-transfer order. If any certificate is issued, the certificate shall bear an appropriate legend referring to the restrictions applicable to the Shares. The Grantee hereby agrees to the retention by the Company of the Shares and, if a stock certificate is issued, the Grantee agrees to execute and deliver to the Company a blank stock power with respect to the Shares as a condition to the receipt of this Restricted Stock Award. After any Shares vest pursuant to Section 3 hereof, and following payment of the applicable withholding taxes pursuant to Section 7 of this Agreement, the Company shall promptly cause to be issued a certificate or certificates, registered in the Grantee's name, evidencing such vested whole Shares (less any Shares withheld to pay withholding taxes) and shall cause such certificate or certificates to be delivered to the

Grantee free of the legend and the stop-transfer order referenced above. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share at the time certificates evidencing the Shares are delivered to the Grantee.

Section 3. Vesting; Forfeiture.

(a) *Vesting*. Subject to the terms and conditions of this Agreement, twenty percent (20%) of the Shares shall vest, and the restrictions with respect to the Shares shall lapse, on each of the first, second, third, fourth, and fifth anniversaries of the Effective Date if the Grantee remains continuously employed by the Company or an Affiliate of the Company until such respective vesting dates.

(b) *Forfeiture.* If the Grantee ceases to be employed by the Company and all Affiliates of the Company for any reason prior to the vesting of the Shares pursuant to Section 3(a) hereof, Grantee's rights to all of the unvested Shares shall be immediately and irrevocably forfeited, including the right to vote such Shares and the right to receive dividends on such Shares.

Section 4. Acceleration of Vesting.

(a) *Termination without Cause or for Good Reason*. In the event the Grantee's Service Relationship is terminated by the Company without Cause or is terminated by the Grantee for Good Reason, then one hundred percent (100%) of the Shares, to the extent not vested, shall no longer be Restricted Shares and shall become Vested Shares.

(b) *Termination for Cause or without Good Reason*. Any portion of the Shares that are not vested on the date of termination of the Service Relationship by the Company for Cause or by the Grantee without Good Reason shall immediately be subject to forfeiture as provided in Section 3 hereof.

(c) *Corporate Transactions*. Upon and subject to the effectiveness of a Transaction in which the Company's assets or stock are acquired or exchanged for consideration that does not consist solely of stock or the dissolution or liquidation of the Company, then one hundred percent (100%) of the Shares, to the extent not vested, shall no longer be Restricted Shares and shall become Vested Shares. Further, upon and subject to the occurrence of a Transaction in which the Company's assets or stock are acquired or exchanged solely for stock consideration or part cash and part stock consideration, the provisions of this Agreement shall remain applicable to the shares of stock consideration received by the Grantee and any Permitted Transferee in exchange for the Restricted Shares. For purposes of this Section 4(c), the term "stock" shall include all equity securities.

Section 5. Restrictions on Transfer of Shares.

None of the Shares now owned or hereafter acquired by the Grantee or any Permitted Transferee shall be sold, assigned, transferred, pledged, hypothecated, given away, or in any other manner disposed of or encumbered, whether voluntarily or by operation of law, unless such transfer is in compliance with all applicable securities laws (including, without limitation, the Securities Act of 1933 (the "Act")) and such disposition is in accordance with the terms and conditions of this Section 5. In connection with any transfer of Shares, the Company may require the transferor to provide, at the transferor's own expense, an opinion of counsel, satisfactory to the Company, that such transfer is in compliance with all applicable foreign, federal, and state securities laws (including, without limitation, the Act). Any attempted disposition of Shares not in accordance with the terms and conditions of this Section 5 shall be null and void and the Company shall not reflect on its records any change in record ownership of any Shares as a result of any such transfer, shall otherwise refuse to recognize any such transfer and shall not in any way give effect to any such transfer of any Shares. Subject to the foregoing general provisions, Shares may be transferred pursuant to the following specific terms and conditions:

(a) *Transfers to Permitted Transferees*. The Grantee may sell, assign, transfer, or give away any or all of the Shares to Permitted Transferees; provided that, such Permitted Transferee(s) shall, as a condition to any such transfer, agree to be subject to the provisions of this Agreement and shall have delivered a written acknowledgment to that effect to the Company.

(b) *Transfers Upon Death or Disability*. Upon the death or Disability of the Grantee, Vested Shares may be transferred by will or by the laws of descent and distribution; provided that, any Shares which are Restricted Shares at the time of such death or Disability shall be subject to forfeiture under the terms of Section 3 hereof.

Section 6. Distributions and Adjustments.

(a) If any Shares vest subsequent to any change in the number or character of the Common Stock of the Company through any stock dividend or other distribution, recapitalization, stock split, reverse stock split, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase or exchange of shares or other securities of the Company, issuance of warrants or other rights to purchase shares of Common Stock or other securities of the Company or other similar corporate transaction or event such that an adjustment is determined by the Committee to be appropriate in order to prevent dilution or enlargement of the benefits or potential benefits intended to be made available under this Agreement, then the Committee shall, in such manner as it may deem equitable, in its sole discretion, adjust any or all of the number and type of such Shares.

(b) Any additional shares of Common Stock of the Company, any other securities of the Company and any other property distributed with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate and shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary.

Section 7. Taxes.

(a) The Grantee acknowledges that the Grantee will consult with the Grantee's personal tax adviser regarding the income tax consequences of the grant of the Shares, payment of dividends on the Shares, the vesting of the Shares and any other matters related to this Agreement. In order to comply with all applicable federal, state, local or foreign income tax laws or regulations, the Company may take such action as it deems appropriate to ensure that all applicable federal, state, local or foreign payroll, withholding, income or other taxes, which are the Grantee's sole and absolute responsibility, are withheld or collected from the Grantee.

(b) In accordance with the terms of the Plan, and such rules as may be adopted by the Committee administering the Plan, the Grantee may elect to satisfy tax withholding obligations arising from the receipt of, or the lapse of restrictions relating to, the Shares by (i) delivering cash, check, bank draft, money order or wire transfer payable to the order of the Company, (ii) having the Company withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes, or (iii) delivering to the Company shares of Common Stock having a Fair Market Value equal to the amount of such taxes. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share. The Grantee's election must be made on or before the date that the amount of tax to be withheld is determined. If the Grantee does not make an election, the Company will withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes.

Section 8. Definitions.

For purposes of this Agreement, the following terms shall have the following respective meanings. All capitalized terms used in this Agreement and not otherwise defined shall have the respective meanings set forth in the Plan.

"*Cause*" shall mean, unless otherwise defined in Grantee's employment agreement: (i) any material breach by the Grantee of any agreement to which the Grantee and the Company are parties, including, but not limited to, any agreement containing covenants not to compete and covenants relating to the protection of confidential information and proprietary rights of the Company, which breach is not cured pursuant to the terms of such agreements, (ii) any act (other than retirement) or omission to act by the Grantee which would reasonably be likely to have the effect of injuring the reputation, business, or business relationships of the Company or on the Grantee's ability to perform services for the Company, (iii) the Grantee's conviction (including any pleas of guilty or nolo contendre) of any crime (other than ordinary traffic violations) which impairs the Grantee's ability to perform her duties, (iv) any material misconduct or willful and deliberate non-performance of duties by the Grantee in connection with the business or affairs of the Company, (v) the Grantee's theft, dishonesty, misrepresentation, or falsification of the Company's documents or records, (vi) the Grantee's improper use or disclosure of the Company's confidential or proprietary information, or (vii) the Grantee's use of the facilities or premises of the Company to conduct unlawful or unauthorized activities or transactions. For purposes of this paragraph, the term "Company" shall include any Subsidiary of the Company.

"Disability" has the meaning specified in Section 22(e)(3) of the Internal Revenue Code of 1986, as amended, and related rules, regulations, and interpretations.

"*Good Reason*" shall mean, unless otherwise defined in Grantee's employment agreement, the occurrence of any of the following events without the Grantee's consent: (i) a substantial adverse change in the Grantee's responsibilities, authorities, powers, functions, or duties as in effect on the date of a Transaction; (ii) a reduction in the Grantee's annual base salary as in effect on the date of a Transaction except for across-the-board salary reductions similarly affecting all, or substantially all, employees; or (iii) the relocation of the offices at which the Grantee is principally employed as of the date of a Transaction to a location more than fifty (50) miles from such offices.

"Permitted Transferee" shall mean any of the following to whom the Grantee may transfer Shares hereunder: members of the Grantee's immediate family, trusts for the benefit of such family members and/or for the Grantee, partnerships in which such family members are the only partners, or limited liability companies in which such family members are the only members.

"Vested Shares" shall mean all Shares which are not Restricted Shares.

Section 9. Governing Law.

The internal law, and not the law of conflicts, of the State of Delaware will govern all questions concerning the validity, construction and effect of this Agreement.

Section 10. Plan Provisions.

This Agreement is made under and subject to the provisions of the Plan, and all of the provisions of the Plan are also provisions of this Agreement. If there is a difference or conflict between the provisions of this Agreement and the provisions of the Plan, the provisions of the Plan will govern. By accepting this Restricted Stock Award, the Grantee confirms that the Grantee has received a copy of the Plan and represents that the Grantee is familiar with the terms and provisions thereof, and hereby accepts this Restricted Stock Award subject to all the terms and provisions of the Plan.

Section 11. No Rights to Continue Service or Employment.

Nothing herein shall be construed as giving the Grantee the right to continue in the employ or to provide services to the Company or any Affiliate, whether as an employee or as a consultant or otherwise, or interfere with or restrict in any way the right of the Company or any Affiliate to discharge the Grantee,

whether as an employee or consultant or otherwise, at any time, with or without cause. In addition, the Company or any Affiliate may discharge the Grantee free from any liability or claim under this Agreement.

Section 12. Entire Agreement.

This Agreement together with the Plan supersede any and all other prior understandings and agreements, either oral or in writing, between the parties with respect to the subject matter hereof and constitute the sole and only agreements between the parties with respect to said subject matter. All prior negotiations and agreements between the parties with respect to the subject matter hereof are merged into this Agreement. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party or by anyone acting on behalf of any party, which are not embodied in this Agreement or the Plan and that any agreement, statement or promise that is not contained in this Agreement or the Plan shall not be valid or binding or of any force or effect.

Section 13. Modification.

No change or modification of this Agreement shall be valid or binding upon the parties unless the change or modification is in writing and signed by the parties. Notwithstanding the preceding sentence, the Plan, this Agreement and the Restricted Stock Award may be amended, altered, suspended, discontinued or terminated to the extent permitted by the Plan.

Section 14. Shares Subject to Agreement.

The Shares shall be subject to the terms and conditions of this Agreement. Except as otherwise provided in Section 6, no adjustment shall be made for dividends or other rights for which the record date is prior to the issuance of the Shares. The Company shall not be required to deliver any Shares until the requirements of any federal or state securities or other laws, rules or regulations (including the rules of any securities exchange) as may be determined by the Committee to be applicable are satisfied.

Section 15. Lockup Provision.

The Grantee and each Permitted Transferee agrees that, if the Company proposes to offer for sale any shares of Stock pursuant to a public offering under the Act and if requested by the Company and any underwriter engaged by the Company for a reasonable period of time specified by the Company or such underwriter following the effective date of the registration statement filed with respect to such offering, the Grantee will not, directly or indirectly, offer, sell, pledge, contract to sell (including any short sale), grant any option to purchase, or otherwise dispose of any securities of the Company held by her (except for any securities sold pursuant to such registration statement) or enter into any Hedging Transaction relating to any securities of the Company held by her (including, without limitation, pursuant to Rule 144 under the Act or any successor or similar exemptive rule hereinafter in effect). Notwithstanding the foregoing, such period of time shall not exceed ninety (90) days in the case of any public offering.

Section 16. Severability.

In the event that any provision that is contained in the Plan or this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or would disqualify the Plan or this Agreement for any reason and under any law as deemed applicable by the Committee, the invalid, illegal or unenforceable provision shall be construed or deemed amended to conform to applicable laws, or if it cannot be so construed or deemed amended without, in the determination of the Committee, materially altering the purpose or intent of the Plan or this Agreement, such provision shall be stricken as to such jurisdiction or Shares, and the remainder of the Plan or this Agreement shall remain in full force and effect.

Section 17. Headings.

Headings are given to the sections and subsections of this Agreement solely as a convenience to facilitate reference. Such headings shall not be deemed in any way material or relevant to the construction or interpretation of this Agreement or any provision hereof.

Section 18. Grantee's Acknowledgments.

The Grantee hereby agrees to accept as binding, conclusive and final all decisions or interpretations of the Committee or the Board of Directors of the Company, as appropriate, upon any questions arising under the Plan or this Agreement. Any determination in this connection by the Company, including the Board of Directors of the Company or the Committee, shall be final, binding and conclusive. The obligations of the Company and the rights of the Grantee are subject to all applicable laws, rules and regulations.

Section 19. Parties Bound.

The terms, provisions and agreements that are contained in this Agreement shall apply to, be binding upon, and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives and permitted successors and assigns, subject to the limitation on assignment expressly set forth herein. This Agreement shall have no force or effect unless it is duly executed and delivered by the Company.

The Company has caused this Agreement to be signed and delivered as of the date set forth above.

MOLINA HEALTHCARE, INC.

By:

Name:

Title:

Exhibit 10.4

Molina Healthcare, Inc. 2002 Equity Incentive Plan

Restricted Stock Award Agreement

This RESTRICTED STOCK AWARD AGREEMENT (the "Agreement") effective as of [Grant Date] is between Molina Healthcare, Inc., a Delaware corporation (the "Company"), and [Outside Director], a non-employee Director of the Company (the "Grantee"), pursuant to and subject to the terms and conditions of the Molina Healthcare, Inc. 2002 Equity Incentive Plan (the "Plan").

The Company desires to award to the Grantee a number of shares of the Company's common stock, par value $.001 per share (the "Common Stock"), subject to certain restrictions as provided in this Agreement, in order to carry out the purpose of the Plan. The purpose of this Agreement is to evidence the terms and conditions of an award of restricted stock granted to the Grantee under the Plan.

Accordingly, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Company and the Grantee hereby agree as follows:

Section 1. Award of Restricted Stock.

Effective as of the [Grant Date] (the "Effective Date"), the Company granted to the Grantee a restricted stock award of __________________ shares of Common Stock (the "Shares"), subject to the terms and conditions set forth in this Agreement and in accordance with the terms of the Plan (the "Restricted Stock Award").

Section 2. Rights with Respect to the Shares.

(a) *Stockholder Rights*. With respect to the Shares, the Grantee shall be entitled at all times on and after the date of issuance of the Shares to exercise the rights of a stockholder of Common Stock of the Company, including the right to vote the Shares and the right to receive dividends on the Shares as provided in Section 2(b) hereof, unless and until the Shares are forfeited pursuant to Section 3 hereof. However, the Shares shall be nontransferable and subject to a risk of forfeiture to the Company at all times prior to the dates on which such Shares become vested, and the restrictions with respect to the Shares lapse, in accordance with Section 3 of this Agreement.

(b) *Dividends*. As a condition to receiving the Shares under the Plan, the Grantee hereby agrees to defer the receipt of dividends paid on the Shares. Cash dividends or other cash distributions paid with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate, shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary, and shall be forfeited in the event that the Shares with respect to which the dividends were paid are forfeited.

(c) *Issuance of Shares*. The Company shall cause the Shares to be issued in the Grantee's name or in a nominee name on the Grantee's behalf, either by book-entry registration or issuance of a stock certificate or certificates evidencing the Shares, which certificate or certificates shall be held by the Secretary of the Company or the stock transfer agent or brokerage service selected by the Secretary of the Company to provide such services for the Plan. The Shares shall be restricted from transfer and shall be subject to an appropriate stop-transfer order. If any certificate is issued, the certificate shall bear an appropriate legend referring to the restrictions applicable to the Shares. The Grantee hereby agrees to the retention by the Company of the Shares and, if a stock certificate is issued, the Grantee agrees to execute and deliver to the Company a blank stock power with respect to the Shares as a condition to the receipt of this Restricted Stock Award. After any Shares vest pursuant to Section 3 hereof, and following payment of the applicable withholding taxes pursuant to Section 6 of this Agreement, the Company shall promptly cause to be issued a certificate or certificates, registered in the Grantee's name, evidencing such vested whole Shares (less any Shares withheld to pay withholding taxes) and shall cause such certificate or certificates to be delivered to the

Grantee free of the legend and the stop-transfer order referenced above. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share at the time certificates evidencing the Shares are delivered to the Grantee.

Section 3. Vesting; Forfeiture.

(a) *Vesting*. Subject to the terms and conditions of this Agreement, and except as otherwise provided in Section 3(c) hereof, twenty five percent (25%) of the Shares shall vest, and the restrictions with respect to the Shares shall lapse, on the last day of each fiscal quarter after the Effective Date if the Grantee serves continuously on the Board of Directors of the Company until such respective vesting dates.

(b) *Forfeiture.* Except as otherwise provided in Section 3(c) hereof, if the Grantee ceases to serve on the Board of Directors of the Company for any reason prior to the vesting of the Shares pursuant to Section 3(a) hereof, Grantee's rights to all of the unvested Shares shall be immediately and irrevocably forfeited, including the right to vote such Shares and the right to receive dividends on such Shares.

(c) *Corporate Transactions*. Notwithstanding the vesting and forfeiture provisions contained in Sections 3(a) and 3(b) hereof, but subject to the other terms and conditions set forth in this Agreement, upon and subject to the effectiveness of a Transaction in which the Company's assets or stock are acquired or exchanged for consideration that does not consist solely of stock or the dissolution or liquidation of the Company, then one hundred percent (100%) of the Shares, to the extent not vested, shall no longer be Restricted Shares and shall become Vested Shares. Further, upon and subject to the occurrence of a Transaction in which the Company's assets or stock are acquired or exchanged solely for stock consideration or part cash and part stock consideration, the provisions of this Agreement shall remain applicable to the shares of stock consideration received by the Grantee and any Permitted Transferee in exchange for the Restricted Shares. For purposes of this Section 4(c), the term "stock" shall include all equity securities. In the event that the provisions of this Section 3(c) result in "payments" that are finally and conclusively determined by a court or Internal Revenue Service proceeding to be subject to the excise tax imposed by Section 4999 of the Code, the Company shall pay to the Grantee an additional amount such that the net amount retained by the Grantee following realization of all compensation under the Plan that resulted in such "payments," after allowing for the amount of such excise tax and any additional federal, state and local income and employment taxes paid on the additional amount, shall be equal to the net amount that would otherwise have been retained by the Grantee if there were no excise tax imposed by Section 4999 of the Code.

(d) *Early Vesting*. Except as provided in Section 3(c) hereof or unless otherwise determined by the Committee in its sole discretion, in no event will any of the Shares vest prior to their respective vesting dates set forth in Section 3(a) hereof.

Section 4. Restrictions on Transfer of Shares.

None of the Shares now owned or hereafter acquired by the Grantee or any Permitted Transferee shall be sold, assigned, transferred, pledged, hypothecated, given away, or in any other manner disposed of or encumbered, whether voluntarily or by operation of law, unless such transfer is in compliance with all applicable securities laws (including, without limitation, the Securities Act of 1933 (the "Act")) and such disposition is in accordance with the terms and conditions of this Section 5. In connection with any transfer of Shares, the Company may require the transferor to provide, at the transferor's own expense, an opinion of counsel, satisfactory to the Company, that such transfer is in compliance with all applicable foreign, federal, and state securities laws (including, without limitation, the Act). Any attempted disposition of Shares not in accordance with the terms and conditions of this Section 5 shall be null and void and the Company shall not reflect on its records any change in record ownership of any Shares as a result of any such transfer, shall otherwise refuse to recognize any such transfer and shall not in any way give effect to any such transfer of any Shares. Subject to the foregoing general provisions, Shares may be transferred pursuant to the following specific terms and conditions:

(a) *Transfers to Permitted Transferees*. The Grantee may sell, assign, transfer, or give away any or all of the Shares to Permitted Transferees; provided that, such Permitted Transferee(s) shall, as a condition to any such transfer, agree to be subject to the provisions of this Agreement and shall have delivered a written acknowledgment to that effect to the Company.

(b) *Transfers Upon Death or Disability*. Upon the death or Disability of the Grantee, Vested Shares may be transferred by will or by the laws of descent and distribution; provided that, any Shares which are Restricted Shares at the time of such death or Disability shall be subject to forfeiture under the terms of Section 3 hereof.

For the purposes of this Agreement, "Permitted Transferees" shall include members of the Grantee's immediate family, trusts for the benefit of such family members and/or for the Grantee, partnerships in which such family members are the only partners, or limited liability companies in which such family members are the only members.

Section 5. Distributions and Adjustments.

(a) If any Shares vest subsequent to any change in the number or character of the Common Stock of the Company through any stock dividend or other distribution, recapitalization, stock split, reverse stock split, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase or exchange of shares or other securities of the Company, issuance of warrants or other rights to purchase shares of Common Stock or other securities of the Company or other similar corporate transaction or event such that an adjustment is determined by the Committee to be appropriate in order to prevent dilution or enlargement of the benefits or potential benefits intended to be made available under this Agreement, then the Committee shall, in such manner as it may deem equitable, in its sole discretion, adjust any or all of the number and type of such Shares.

(b) Any additional shares of Common Stock of the Company, any other securities of the Company and any other property distributed with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate and shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary.

Section 6. Taxes.

(a) The Grantee acknowledges that the Grantee will consult with the Grantee's personal tax adviser regarding the income tax consequences of the grant of the Shares, payment of dividends on the Shares, the vesting of the Shares and any other matters related to this Agreement. In order to comply with all applicable federal, state, local or foreign income tax laws or regulations, the Company may take such action as it deems appropriate to ensure that all applicable federal, state, local or foreign payroll, withholding, income or other taxes, which are the Grantee's sole and absolute responsibility, are withheld or collected from the Grantee.

(b) In accordance with the terms of the Plan, and such rules as may be adopted by the Committee administering the Plan, the Grantee may elect to satisfy tax withholding obligations, if any, arising from the receipt of, or the lapse of restrictions relating to, the Shares by (i) delivering cash, check, bank draft, money order or wire transfer payable to the order of the Company, (ii) having the Company withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes, or (iii) delivering to the Company shares of Common Stock having a Fair Market Value equal to the amount of such taxes. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share. The Grantee's election must be made on or before the date that the amount of tax to be withheld is determined. If the Grantee does not make an election, the Company will withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes.

Section 7. Definitions.

Terms not defined in this Agreement shall have the meanings given to them in the Plan, and the following terms shall have the following meanings when used in this Agreement:

Section 8. Governing Law.

The internal law, and not the law of conflicts, of the State of Delaware will govern all questions concerning the validity, construction and effect of this Agreement.

Section 9. Plan Provisions.

This Agreement is made under and subject to the provisions of the Plan, and all of the provisions of the Plan are also provisions of this Agreement. If there is a difference or conflict between the provisions of this Agreement and the provisions of the Plan, the provisions of the Plan will govern. By signing this Agreement, the Grantee confirms that the Grantee has received a copy of the Plan and represents that the Grantee is familiar with the terms and provisions thereof, and hereby accepts this Restricted Stock Award subject to all the terms and provisions of the Plan.

Section 10. No Rights to Continue Board Service.

Nothing herein shall be construed as giving the Grantee the right to continue to serve on the Board of Directors of the Company.

Section 11. Entire Agreement.

This Agreement together with the Plan supersede any and all other prior understandings and agreements, either oral or in writing, between the parties with respect to the subject matter hereof and constitute the sole and only agreements between the parties with respect to said subject matter. All prior negotiations and agreements between the parties with respect to the subject matter hereof are merged into this Agreement. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party or by anyone acting on behalf of any party, which are not embodied in this Agreement or the Plan and that any agreement, statement or promise that is not contained in this Agreement or the Plan shall not be valid or binding or of any force or effect.

Section 12. Modification.

No change or modification of this Agreement shall be valid or binding upon the parties unless the change or modification is in writing and signed by the parties. Notwithstanding the preceding sentence, the Plan, this Agreement and the Restricted Stock Award may be amended, altered, suspended, discontinued or terminated to the extent permitted by the Plan.

Section 13. Shares Subject to Agreement.

The Shares shall be subject to the terms and conditions of this Agreement. Except as otherwise provided in Section 5, no adjustment shall be made for dividends or other rights for which the record date is prior to the issuance of the Shares. The Company shall not be required to deliver any Shares until the requirements of any federal or state securities or other laws, rules or regulations (including the rules of any securities exchange) as may be determined by the Committee to be applicable are satisfied.

Section 14. Severability.

In the event that any provision that is contained in the Plan or this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or would disqualify the Plan or this Agreement for any reason and under any law as deemed applicable by the Committee, the invalid, illegal or

unenforceable provision shall be construed or deemed amended to conform to applicable laws, or if it cannot be so construed or deemed amended without, in the determination of the Committee, materially altering the purpose or intent of the Plan or this Agreement, such provision shall be stricken as to such jurisdiction or Shares, and the remainder of the Plan or this Agreement shall remain in full force and effect.

Section 15. Headings.

Headings are given to the sections and subsections of this Agreement solely as a convenience to facilitate reference. Such headings shall not be deemed in any way material or relevant to the construction or interpretation of this Agreement or any provision hereof.

Section 16. Grantee’s Acknowledgments.

The Grantee hereby agrees to accept as binding, conclusive and final all decisions or interpretations of the Committee or the Board of Directors of the Company, as appropriate, upon any questions arising under the Plan or this Agreement. Any determination in this connection by the Company, including the Board of Directors of the Company or the Committee, shall be final, binding and conclusive. The obligations of the Company and the rights of the Grantee are subject to all applicable laws, rules and regulations.

Section 17. Parties Bound.

The terms, provisions and agreements that are contained in this Agreement shall apply to, be binding upon, and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives and permitted successors and assigns, subject to the limitation on assignment expressly set forth herein. This Agreement shall have no force or effect unless it is duly executed and delivered by the Company.

Section 18. Lockup Provision.

The Grantee and each Permitted Transferee agrees that, if the Company proposes to offer for sale any shares of Stock pursuant to a public offering under the Act and if requested by the Company and any underwriter engaged by the Company for a reasonable period of time specified by the Company or such underwriter following the effective date of the registration statement filed with respect to such offering, the Grantee will not, directly or indirectly, offer, sell, pledge, contract to sell (including any short sale), grant any option to purchase, or otherwise dispose of any securities of the Company held by her (except for any securities sold pursuant to such registration statement) or enter into any Hedging Transaction relating to any securities of the Company held by her (including, without limitation, pursuant to Rule 144 under the Act or any successor or similar exemptive rule hereinafter in effect). Notwithstanding the foregoing, such period of time shall not exceed ninety (90) days in the case of any public offering.

The Company has caused this Agreement to be signed and delivered as of the date set forth above.

MOLINA HEALTHCARE, INC.

By:

Name:

Title:

Exhibit 10.5

Molina Healthcare, Inc. 2002 Equity Incentive Plan

Restricted Stock Award Agreement

This RESTRICTED STOCK AWARD AGREEMENT (the "Agreement") effective as of [Grant Date] is between Molina Healthcare, Inc., a Delaware corporation (the "Company"), and [Employee], an employee of the Company or one of its Affiliates (the "Grantee"), pursuant to and subject to the terms and conditions of the Molina Healthcare, Inc. 2002 Equity Incentive Plan (the "Plan").

The Company desires to award to the Grantee a number of shares of the Company's common stock, par value $.001 per share (the "Common Stock"), subject to certain restrictions as provided in this Agreement, in order to carry out the purpose of the Plan. The purpose of this Agreement is to evidence the terms and conditions of an award of restricted stock granted to the Grantee under the Plan.

Accordingly, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Company and the Grantee hereby agree as follows:

Section 1. Award of Restricted Stock.

Effective as of [Grant Date] (the "Effective Date"), the Company granted to the Grantee a restricted stock award of _________________ shares of Common Stock (the "Shares"), subject to the terms and conditions set forth in this Agreement and in accordance with the terms of the Plan (the "Restricted Stock Award").

Section 2. Rights with Respect to the Shares.

(a) *Stockholder Rights*. With respect to the Shares, the Grantee shall be entitled at all times on and after the date of issuance of the Shares to exercise the rights of a stockholder of Common Stock of the Company, including the right to vote the Shares and the right to receive dividends on the Shares as provided in Section 2(b) hereof, unless and until the Shares are forfeited pursuant to Section 3 hereof. However, the Shares shall be nontransferable and subject to a risk of forfeiture to the Company at all times prior to the dates on which such Shares become vested, and the restrictions with respect to the Shares lapse, in accordance with Section 3 of this Agreement.

(b) *Dividends*. As a condition to receiving the Shares under the Plan, the Grantee hereby agrees to defer the receipt of dividends paid on the Shares. Cash dividends or other cash distributions paid with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate, shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary, and shall be forfeited in the event that the Shares with respect to which the dividends were paid are forfeited.

(c) *Issuance of Shares*. The Company shall cause the Shares to be issued in the Grantee's name or in a nominee name on the Grantee's behalf, either by book-entry registration or issuance of a stock certificate or certificates evidencing the Shares, which certificate or certificates shall be held by the Secretary of the Company or the stock transfer agent or brokerage service selected by the Secretary of the Company to provide such services for the Plan. The Shares shall be restricted from transfer and shall be subject to an appropriate stop-transfer order. If any certificate is issued, the certificate shall bear an appropriate legend referring to the restrictions applicable to the Shares. The Grantee hereby agrees to the retention by the Company of the Shares and, if a stock certificate is issued, the Grantee agrees to execute and deliver to the Company a blank stock power with respect to the Shares as a condition to the receipt of this Restricted Stock Award. After any Shares vest pursuant to Section 3 hereof, and following payment of the applicable withholding taxes pursuant to Section 6 of this Agreement, the Company shall promptly cause to be issued a certificate or certificates, registered in the Grantee's name, evidencing such vested whole Shares (less any Shares withheld to pay withholding taxes) and shall cause such certificate or certificates to be delivered to the

Grantee free of the legend and the stop-transfer order referenced above. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share at the time certificates evidencing the Shares are delivered to the Grantee.

Section 3. Vesting; Forfeiture.

(a) *Vesting*. Subject to the terms and conditions of this Agreement, twenty percent (20%) of the Shares shall vest, and the restrictions with respect to the Shares shall lapse, on each of the first, second, third, fourth, and fifth anniversaries of the Effective Date if the Grantee remains continuously employed by the Company or an Affiliate of the Company until such respective vesting dates.

(b) *Forfeiture.* If the Grantee ceases to be employed by the Company and all Affiliates of the Company for any reason prior to the vesting of the Shares pursuant to Section 3(a) hereof, Grantee's rights to all of the unvested Shares shall be immediately and irrevocably forfeited, including the right to vote such Shares and the right to receive dividends on such Shares.

(c) *No Early Vesting*. Unless otherwise determined by the Committee in its sole discretion, in no event will any of the Shares vest prior to their respective vesting dates set forth in Section 3(a) hereof.

Section 4. Restrictions on Transfer.

Until the Shares vest pursuant to Section 3 hereof, neither the Shares, nor any right with respect to the Shares under this Agreement, may be sold, assigned, transferred, pledged, hypothecated (by operation of law or otherwise) or otherwise conveyed or encumbered and shall not be subject to execution, attachment or similar process. Any attempted sale, assignment, transfer, pledge, hypothecation or other conveyance or encumbrance shall be void and unenforceable against the Company or any Affiliate of the Company.

Section 5. Distributions and Adjustments.

(a) If any Shares vest subsequent to any change in the number or character of the Common Stock of the Company through any stock dividend or other distribution, recapitalization, stock split, reverse stock split, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase or exchange of shares or other securities of the Company, issuance of warrants or other rights to purchase shares of Common Stock or other securities of the Company or other similar corporate transaction or event such that an adjustment is determined by the Committee to be appropriate in order to prevent dilution or enlargement of the benefits or potential benefits intended to be made available under this Agreement, then the Committee shall, in such manner as it may deem equitable, in its sole discretion, adjust any or all of the number and type of such Shares.

(b) Any additional shares of Common Stock of the Company, any other securities of the Company and any other property distributed with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate and shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary.

Section 6. Taxes.

(a) The Grantee acknowledges that the Grantee will consult with the Grantee's personal tax adviser regarding the income tax consequences of the grant of the Shares, payment of dividends on the Shares, the vesting of the Shares and any other matters related to this Agreement. In order to comply with all applicable federal, state, local or foreign income tax laws or regulations, the Company may take such action as it deems appropriate to ensure that all applicable federal, state, local or foreign payroll, withholding, income or other taxes, which are the Grantee's sole and absolute responsibility, are withheld or collected from the Grantee.

(b) In accordance with the terms of the Plan, and such rules as may be adopted by the Committee administering the Plan, the Grantee may elect to satisfy tax withholding obligations arising from the receipt of, or the lapse of restrictions relating to, the Shares by (i) delivering cash, check, bank draft, money order or wire transfer payable to the order of the Company, (ii) having the Company withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes, or (iii) delivering to the Company shares of Common Stock having a Fair Market Value equal to the amount of such taxes. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share. The Grantee's election must be made on or before the date that the amount of tax to be withheld is determined. If the Grantee does not make an election, the Company will withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes.

Section 7. Definitions.

Terms not defined in this Agreement shall have the meanings given to them in the Plan.

Section 8. Governing Law.

The internal law, and not the law of conflicts, of the State of Delaware will govern all questions concerning the validity, construction and effect of this Agreement.

Section 9. Plan Provisions.

This Agreement is made under and subject to the provisions of the Plan, and all of the provisions of the Plan are also provisions of this Agreement. If there is a difference or conflict between the provisions of this Agreement and the provisions of the Plan, the provisions of the Plan will govern. By accepting this Restricted Stock Award, the Grantee confirms that the Grantee has received a copy of the Plan and represents that the Grantee is familiar with the terms and provisions thereof, and hereby accepts this Restricted Stock Award subject to all the terms and provisions of the Plan.

Section 10. No Rights to Continue Service or Employment.

Nothing herein shall be construed as giving the Grantee the right to continue in the employ or to provide services to the Company or any Affiliate, whether as an employee or as a consultant or otherwise, or interfere with or restrict in any way the right of the Company or any Affiliate to discharge the Grantee, whether as an employee or consultant or otherwise, at any time, with or without cause. In addition, the Company or any Affiliate may discharge the Grantee free from any liability or claim under this Agreement.

Section 11. Entire Agreement.

This Agreement together with the Plan supersede any and all other prior understandings and agreements, either oral or in writing, between the parties with respect to the subject matter hereof and constitute the sole and only agreements between the parties with respect to said subject matter. All prior negotiations and agreements between the parties with respect to the subject matter hereof are merged into this Agreement. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party or by anyone acting on behalf of any party, which are not embodied in this Agreement or the Plan and that any agreement, statement or promise that is not contained in this Agreement or the Plan shall not be valid or binding or of any force or effect.

Section 12. Modification.

No change or modification of this Agreement shall be valid or binding upon the parties unless the change or modification is in writing and signed by the parties. Notwithstanding the preceding sentence, the Plan, this Agreement and the Restricted Stock Award may be amended, altered, suspended, discontinued or terminated to the extent permitted by the Plan.

Section 13. Shares Subject to Agreement.

The Shares shall be subject to the terms and conditions of this Agreement. Except as otherwise provided in Section 5, no adjustment shall be made for dividends or other rights for which the record date is prior to the issuance of the Shares. The Company shall not be required to deliver any Shares until the requirements of any federal or state securities or other laws, rules or regulations (including the rules of any securities exchange) as may be determined by the Committee to be applicable are satisfied.

Section 14. Severability.

In the event that any provision that is contained in the Plan or this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or would disqualify the Plan or this Agreement for any reason and under any law as deemed applicable by the Committee, the invalid, illegal or unenforceable provision shall be construed or deemed amended to conform to applicable laws, or if it cannot be so construed or deemed amended without, in the determination of the Committee, materially altering the purpose or intent of the Plan or this Agreement, such provision shall be stricken as to such jurisdiction or Shares, and the remainder of the Plan or this Agreement shall remain in full force and effect.

Section 15. Headings.

Headings are given to the sections and subsections of this Agreement solely as a convenience to facilitate reference. Such headings shall not be deemed in any way material or relevant to the construction or interpretation of this Agreement or any provision hereof.

Section 16. Grantee’s Acknowledgments.

The Grantee hereby agrees to accept as binding, conclusive and final all decisions or interpretations of the Committee or the Board of Directors of the Company, as appropriate, upon any questions arising under the Plan or this Agreement. Any determination in this connection by the Company, including the Board of Directors of the Company or the Committee, shall be final, binding and conclusive. The obligations of the Company and the rights of the Grantee are subject to all applicable laws, rules and regulations.

Section 17. Parties Bound.

The terms, provisions and agreements that are contained in this Agreement shall apply to, be binding upon, and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives and permitted successors and assigns, subject to the limitation on assignment expressly set forth herein. This Agreement shall have no force or effect unless it is duly executed and delivered by the Company.

The Company has caused this Agreement to be signed and delivered as of the date set forth above.

MOLINA HEALTHCARE, INC.

By:

Name:

Title:

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended June 30, 2005 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 9, 2005

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended June 30, 2005, of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 9, 2005

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Executive Vice President,
Financial Affairs,
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the “Company”) on Form 10-Q for the period ended June 30, 2005 (the “Report”), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 9, 2005

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2005 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 9, 2005

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Executive Vice President, Financial Affairs
Chief Financial Officer and Treasurer