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SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2004

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

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)

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

Securities registered pursuant to Section 12(b) of the Act: None

Securities registered pursuant to Section 12(g) of the Act:

Common Stock, par value $0.001 per share
(Title of class)

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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

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 aggregate market value of Common Stock held by non-affiliates of the Registrant as of June 30, 2004, the last business day of our most recently completed second fiscal quarter was approximately $436,696,273 (based upon the closing price for shares of the Registrant's Common Stock as reported by the New York Stock Exchange, Inc. on such date).

As of March 4, 2005, approximately 27,606,108 shares of the Registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Proxy Statement for the 2005 Annual Meeting of Stockholders to be held on April 27, 2005, are incorporated by reference into Part III of this Form 10-K.

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Form 10-K

PART I

Forward-Looking Statements

This annual report contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, which provides a safe harbor for such statements made by or on behalf of the company. We may from time to time make written or oral statements that are "forward-looking" in our periodic reports and other filings with the Securities and Exchange Commission and in reports to our stockholders. Such statements may, for example, express expectations or projections about future actions that we may take. 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 revenues and earnings, our market opportunity, our growth strategy, competition, expected activities, future acquisitions and investments, and the adequacy of our available cash resources. These statements are made on the basis of management's views and assumptions as of the time the statements are made and we undertake no obligation to update these statements. There can be no assurance that our expectations will necessarily come to pass.

Actual results may differ materially from our expectations, projections, or estimates due to a variety of important factors, including the factors described in the section entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations—Risk Factors." Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other operating expenses. A variety of factors, including, but not limited to, competition, changes in health care practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payors, major epidemics, disasters, and numerous other factors affecting the delivery and cost of health care, such as major health care providers' inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs and other operating expenses. Once set, premiums are generally fixed for one year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. The expiration, cancellation, or suspension of our HMO contracts by the federal and state governments would also negatively impact us. Due to these factors and risks, no assurance can be given with respect to our future premium levels or our ability to control our future medical costs.

From time to time, legislative and regulatory proposals have been made at the federal and state government levels related to the health care system, including but not limited to, limitations on managed care organizations and reform or redesign of the Medicaid program. Such legislative and regulatory action could have the effect of reducing the premiums paid to us by governmental programs or increasing our medical costs. We are unable to predict the specific content of any future legislation, action, or regulation that may be enacted or when any such future legislation or regulation will be adopted. Therefore, we cannot predict accurately the effect of such future legislation, action, or regulation on our business.

Item 1: *Business*

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible to receive health care benefits through government-sponsored programs for low-income families and individuals, such as Medicaid and the State Children's Health Insurance Program. We currently have health plans in California, Washington, Michigan, Utah, New Mexico, and Indiana that are administered by our HMO-licensed subsidiaries operating in these states. We also operate 21 company-owned primary care clinics in California that are staffed by physicians, physician assistants, and nurse practitioners. We arrange health care

services for members enrolled in our health plans through contracts with health care providers that include our own clinics, independent physicians and groups, hospitals, and ancillary providers. As of December 31, 2004, approximately 788,000 members were enrolled in our health plans.

C. David Molina, M.D. founded our company in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. We recognized the growing need for more effective management and delivery of health care services to underserved populations, predominantly Medicaid beneficiaries, and became licensed as an HMO. We were incorporated in California in 1999, as the parent company of our health plan subsidiaries, under the name American Family Care, Inc. We changed our name to Molina Healthcare, Inc. in March of 2000 and reincorporated in Delaware on June 26, 2003. We have grown over the past several years by taking advantage of attractive expansion opportunities, often involving either the acquisition or the start-up of health plans. We established our Utah health plan in 1997 as a start-up operation, and later acquired health plans in Michigan, Washington, and New Mexico. We have also recently established a start-up operation in Indiana, where our HMO-licensed subsidiary plans to begin serving members in the second quarter of 2005. In July 2003, we completed our initial public offering of common stock.

Our members have distinct social and medical needs and are characterized by their cultural, ethnic, and linguistic diversity. From our inception, we have designed our company to work with government agencies to serve low-income populations. Our success has resulted from our expertise in working with government agencies, our extensive experience with meeting the needs of our members, our 25 years of owning and operating primary care clinics, our cultural and linguistic expertise, and our focus on operational and administrative efficiency.

Our total annual revenue has increased from $185.7 million in 1999 to $1.175 billion in 2004. Over the same period, our net income grew from $9.4 million to $55.8 million. In California, we remain profitable in an environment characterized by significant competition, heavy regulation, and among the lowest state Medicaid expenditure rates per beneficiary in the U.S. We now have the largest Medicaid HMO in Washington, with approximately 50% market share. In Michigan, we became the state's largest Medicaid HMO in 2004 while increasing our enrollment nearly five-fold between December 31, 2003 and December 31, 2004. Our New Mexico HMO, acquired on July 1, 2004, generated over 18% of our total premium revenue during the second half of 2004. In Utah, we continue to generate substantial savings for the state Medicaid program.

Our principal executive offices are located at One Golden Shore Drive, Long Beach, CA 90802, and our telephone number is (562) 435-3666. Our website is located at www.molinahealthcare.com. Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report.

Our Industry

Medicaid and SCHIP. Medicaid provides health care coverage to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within federal guidelines. The State Children's Health Insurance Program, or SCHIP, is a matching program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. States have the option of administering SCHIP through their Medicaid programs.

The state and federal governments jointly finance Medicaid and SCHIP through a matching program in which the federal government pays a percentage based on the average per capita income in each state. Typically, this percentage match is at least 50%. Federal payments for Medicaid have no set dollar ceiling and are limited only by the amount states are willing to spend. State and local governments pay the share of Medicaid costs not paid by the federal government.

Other Government Programs for Low Income Individuals. In certain instances, states have elected to provide medical benefits to individuals and families who do not qualify for Medicaid. Such programs are often administered in a manner similar to Medicaid and SCHIP, but without Federal matching funds. Our Washington HMO served approximately 21,000 such members under that state's Basic Health Plan at December 31, 2004.

Medicaid Managed Care. The Medicaid members we serve generally represent diverse cultures and ethnicities. Many have had limited educational opportunities and do not speak English as their first language. Lack of adequate transportation is common.

Under traditional Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These individuals typically have minimal access to preventive care such as immunizations, and access to primary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, providers are paid on a fee-for-service basis and lack incentive to monitor utilization and control costs.

In an effort to improve quality and provide more uniform and more cost-effective care, most states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives a predetermined payment per enrollee for the covered health care services. The health plan, in turn, arranges for the provision of such services by contracting with a network of providers who are responsible for providing a comprehensive range of medical and hospital services. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore, and, in many cases, to mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have mandatory Medicaid managed care programs.

Our Approach

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. We believe we are well positioned to capitalize on the growth opportunities in our markets. Our approach to managed care is based on the following key attributes:

Experience. For 25 years we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. In that time we have developed and forged strong relationships with the constituents whom we serve—members, providers, and government agencies. Our ability to deliver quality care and to establish and maintain provider networks, as well as our administrative efficiency, has allowed us to compete successfully for government contracts. We have a strong record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education. As a result, we believe our administrative efficiency is among the best in our industry. In addition, we have designed our administrative and operational infrastructure to be scalable for rapid and cost-effective expansion into new and existing markets.

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations and the transition of members from other health plans. The integration of our New Mexico acquisition, which closed on July 1, 2004, is substantially complete and demonstrates our ability to integrate stand-alone acquisitions. The establishment of our health plans in Utah and Indiana reflects our ability to replicate our business model in new states, while acquisitions in Michigan and Washington have demonstrated our ability to acquire and successfully integrate existing health plan operations into our own business model.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We arrange health care services through contracts with providers that include our own clinics, independent physicians and medical groups, hospitals, and ancillary providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates, and diagnostics related groups. Our provider network strategy is to contract with providers that are best suited, based on expertise, proximity, cultural sensitivity, and experience, to provide services to the membership we serve.

We operate 21 company-owned primary care clinics in California. Our clinics are profitable, requiring low capital expenditures and minimal start-up time. We believe that our clinics serve an important role in providing certain communities with access to primary care and provide us with insights into physician practice patterns, first hand knowledge of the needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. National census data shows that the U.S. population is becoming increasingly diverse. We have a 25-year history of developing targeted health care programs for our culturally diverse membership and believe we are well-positioned to successfully serve these growing populations. We contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. We have established cultural advisory committees in all of our major markets. A full-time cultural anthropologist advises these cultural advisory committees. We educate employees and providers about the differing needs among our members. We develop member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience. In addition, our website is accessible in six languages.

Proven Medical Management. We believe that our experience as a health care provider has helped us to improve medical outcomes for our members while at the same time enhancing the cost effectiveness of care. We carefully monitor day-to-day medical management in order to provide appropriate care to our members, contain costs and ensure an efficient delivery network. We have developed disease management and health education programs that address the particular health care needs of our members. We have established pharmacy management programs and policies that have allowed us to manage our pharmaceutical costs effectively. For example, our staff pharmacists educate our providers on the use of generic drugs rather than branded drugs. As a result, we believe our generic utilization rate is among the highest in our industry.

Our Strategy

Our objective is to be the leading managed care organization serving Medicaid, SCHIP, and other low-income members. To achieve this objective, we intend to:

Focus on serving low-income families and individuals. We believe that the Medicaid population, characterized by low income and significant ethnic diversity, requires unique services to meet its health care needs. Our 25 years of experience in serving this population has provided us significant expertise in meeting the unique needs of our members. We will continue to focus on serving the beneficiaries of Medicaid and other government-sponsored programs, as our experience, infrastructure, and health care programs position us to optimally serve this population.

Increase our membership. We have grown our membership through a combination of acquisitions and internal growth. Increasing our membership provides the opportunity to grow and diversify our revenues, increase profits, enhance economies of scale, and strengthen our relationships with providers and government agencies. We will seek to grow our membership by expanding within existing markets and entering new markets.

- *Expand within existing markets*. We expect to grow in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, maintaining positive provider relationships, and integrating members from other health plans.
- *Enter new markets*. We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion on markets with strong provider dynamics, a fragmented competitive landscape, significant size and, where possible, mandated Medicaid managed care enrollment.

Manage medical costs. We will continue to use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the efficacy of treatment, these programs facilitate the identification of our members with special or high cost needs and help limit the cost of the members' treatment.

Leverage operational efficiencies. Our centralized administrative infrastructure, flexible information systems and dedication to controlling administrative costs provide economies of scale. Our administrative infrastructure has significant expansion capacity, allowing us to integrate new members and expand quickly in new and existing markets.

Our Health Plans

As of December 31, 2004, our operating health plans are located in California, Washington, Michigan, New Mexico, and Utah. We have also recently established a start-up operation in Indiana, where our HMO-licensed subsidiary plans to begin serving members in the second quarter of 2005. An overview of our health plans as of December 31, 2004 is provided in the table below:

State	Total Members	Number of Contracts	Expiration Date
California	253,000	5	Two expire March 31, 2006, one expires June 30, 2005, one expires March 31, 2005[1], and one is evergreen.
Washington	263,000	4	December 31, 2005
Michigan	158,000	1	September 30, 2006
Utah	49,000	3	Two expire June 30, 2005, and one expires June 30, 2006
New Mexico	65,000	1	June 30, 2005

1 Our California HMO has been informed that this contract for the Sacramento Geographic Managed Care (GMC) Program expiring on March 31, 2005 will be extended for four to six months pending the re-drafting of this form of contract for all health plans participating in the GMC Program.

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. We are usually paid a negotiated amount per member per month, with the amount varying from contract to contract. We are also paid an additional amount for each newborn delivery in Washington, Michigan, and New Mexico. Since July 1, 2002, our Utah

health plan has been reimbursed by the state for all medical costs incurred by Utah Medicaid members plus a 9% administrative fee. Our contracts in Washington, New Mexico, and Michigan have higher monthly payments than in California, but require us to cover more services. In California, the state retains responsibility for certain high cost services, such as specified organ transplants and pediatric oncology cases. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. Molina Healthcare of California, our California HMO, has the third largest enrollment of Medicaid beneficiaries among non-governmental health plans in the state, with 253,000 members at December 31, 2004. We arrange health care services for our members either as a direct contractor to the state or through subcontracts with other health plans. Our plan serves counties with three of the largest Medicaid populations in California—Riverside, San Bernardino, and Los Angeles counties—as well as Sacramento and Yolo counties.

Washington. Molina Healthcare of Washington, Inc., our Washington HMO, is now the largest Medicaid managed care health plan in the state, with 263,000 members at December 31, 2004. We serve members in 33 of the state's 39 counties.

Michigan. Molina Healthcare of Michigan, Inc., our Michigan HMO, is now the largest Medicaid managed care health plan in the state, having grown to 158,000 members at December 31, 2004 from 82,000 members at December 31, 2003. Effective October 1, 2004, we assumed responsibility for approximately 73,000 members transferred from the Wellness Plan into our Michigan HMO. Our Michigan HMO serves 39 counties throughout Michigan, including the Detroit metropolitan area.

Utah. Molina Healthcare of Utah, Inc., our Utah HMO, is the largest non-governmental Medicaid managed care health plan in Utah. Under the terms of our Medicaid agreement with the state, we are reimbursed for 100% of our medical costs plus 9% of medical costs as an administrative fee. In addition, if the actual medical costs and administrative fee are less than a predetermined amount, we will receive all or a portion of the difference as additional revenue. Our Utah HMO is compensated for coverage offered to SCHIP members on a per member per month (risk) basis. Our Utah HMO serves 25 of 29 counties in the state, including the Salt Lake City metropolitan area.

New Mexico. On July 1, 2004, we acquired the capital stock of Health Care Horizons, Inc., the parent company of Cimarron Health Plan, Inc. On August 1, 2004, we transferred the commercial membership of Cimarron Health Plan to Lovelace Sandia Health Systems, Inc. On the same date, the name of Cimarron Health Plan, Inc. was changed to Molina Healthcare of New Mexico, Inc., our New Mexico HMO. As of December 31, 2004, our New Mexico HMO served 65,000 members. Our New Mexico HMO serves members in all of New Mexico's 33 counties.

Provider Networks

We arrange health care services for our members through contracts with providers that include our own clinics, independent physicians and groups, hospitals, and ancillary providers. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

The following table shows the total approximate number of primary care physicians, specialists, and hospitals participating in our network as of December 31, 2004:

	California	Washington	Michigan	Utah	New Mexico	Total
Primary care physicians	2,201	2,714	1,249	1,250	1,488	8,902
Specialists	6,366	5,325	1,899	2,097	6,275	21,962
Hospitals	85	81	41	38	69	314

Physicians. We contract with primary care physicians, medical groups, specialists, and independent practice associations. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. Our most frequently utilized specialists are obstetricians/gynecologists, ear nose and throat specialists, and orthopedic surgeons. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Primary Care Clinics. We operate 21 company-owned primary care clinics in California staffed by physicians, physician assistants, and nurse practitioners. In 2004, the clinics provided services to approximately 41,000 of our California enrollees. Additionally, during 2004 our clinic received approximately 53,000 patient visits from non-members. These clinics are located in neighborhoods where our members reside, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, and case rates.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*sm is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*sm is a multidisciplinary disease management program that provides intensive health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*sm is a diabetes disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure. We anticipate that all of these programs will be fully implemented in our California, Washington, Michigan, Utah, and New Mexico HMOs by the end of 2005.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with a copy of *What To Do When Your Child Is Sick*. This book, available in Spanish, Vietnamese, and English, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care. This has resulted in a 99% generic utilization rate when a generic alternative is available in our drug formulary (and an overall generic utilization rate of approximately 75%), while at the same time enhancing our quality of care.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is highly scalable. The software is flexible, easy to use, and readily allows us to accommodate enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating rapid and efficient integration of new plans and acquisitions.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Health Plan Employer Data and Information Set (HEDIS) and accreditation by the National Committee on Quality Assurance, or NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. At December 31, 2004, four of our five HMOs were accredited by the NCQA, with the fifth undergoing review.

Claims Processing. We pay at least 90% of properly billed claims within 30 days. Claims received electronically can be imported directly into our claims system, and many can be adjudicated automatically, thus eliminating the need for manual intervention. Most physician claims that we receive on paper are scanned into electronic format and processed automatically. Our California headquarters is a central processing center for all of our health plan claims.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented and currently subject to significant changes as a result of business consolidations and new strategic alliances entered into by other managed care organizations. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations*—National and regional managed care organizations that have Medicaid members in addition to members in Medicare and private commercial plans.
- *Medicaid HMOs*—National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- *Prepaid Health Plans*—Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- *Primary Care Case Management Programs*—Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states present barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Regulation

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.

In order to operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our health plans are licensed to operate as HMOs in California, Washington, Michigan, Utah, New Mexico, and Indiana. In those states we are regulated by the agency with responsibility for the oversight of HMOs. In most cases that agency is the state department of insurance. In California, that agency is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Each of our health plans is required to report quarterly on its performance to the appropriate state regulatory agencies. They also undergo periodic examinations and reviews by the states. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. Any acquisition of another plan's members must also be approved by the state, and our ability to invest in certain financial securities may be proscribed by statute.

In addition, we are also regulated by each state's department of health services, or the equivalent agency charged with oversight of Medicaid and SCHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the state and federal governments fund it, Medicaid is a state-operated and implemented program. Our contracts with the state Medicaid programs place additional requirements on us. Within broad guidelines established by the federal government, each state:

- establishes its own eligibility standards,
- determines the type, amount, duration, and scope of services,

- sets the rate of payment for services, and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states, such as Washington, award contracts to any applicant demonstrating that it meets the state's requirements. Others, such as California, engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation,
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services,
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, in order to demonstrate our ability to coordinate all of the sources from which our members may receive care,
- We must be able to meet the needs of the disabled and others with special needs,
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf, and
- Our member handbook, newsletters and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against insolvency.

Once awarded, our contracts generally have terms of one to six years, with renewal options at the discretion of the states. Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the contracts' expiration. Our health plans are subject to periodic reporting requirements and comprehensive quality assurance evaluations, and must submit periodic utilization reports and other information to state or county Medicaid authorities. We are not permitted to enroll members directly, and are permitted to market only in accordance with strict guidelines.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- Afford privacy to patient health information, and
- Protect the privacy of patient health information through physical and electronic security measures.

The Federal Centers for Medicare and Medicaid Services are still working to adopt final regulations to fully implement HIPAA. We expect to achieve compliance with HIPAA by the applicable deadlines. However, because of the complexity of HIPAA, the recent adoption of some final regulations, the need to adopt additional final regulations, the possibility that the regulations may change and may be subject to changing, and perhaps conflicting, interpretation, our ability to comply with all HIPAA requirements is uncertain and the cost of compliance difficult to predict.

Fraud and Abuse Laws. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we believe that our compliance efforts are adequate, ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Employees. As of December 31, 2004, we had approximately 1,300 employees, including physicians, nurses, and administrators. Our employee base is multicultural and reflects the diverse member base we serve. We believe we have good relations with our employees. None of our employees are represented by a union.

Web Site Access to Our Reports

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to those reports, are available free of charge on our website, *www.molinahealthcare.com*, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission. Information regarding corporate governance at our company, including our corporate governance guidelines, code of business conduct and ethics, and information regarding our officers, directors, and board committees (including our Audit, Compensation, and Corporate Governance and Nominating committee charters), is available on our website. Such information is also available in print upon the request of any stockholder to our Investor Relations Department at the address of our executive offices set forth above. The information on our website is not incorporated by reference into, or as part of, this report.

Item 2: *Properties*

We lease a total of 36 facilities, including 21 medical clinics in California. We own a 32,000 square-foot office building in Long Beach, California, which serves as our corporate headquarters.

Item 3: *Legal Proceedings*

In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital (“Tenet”) seeking damages of approximately $4.5 million involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospitals as claimants and to increase its damage claim to approximately $8.0 million. To date no significant discovery has taken place. We believe that the California HMO has meritorious defenses to Tenet’s claims and the California HMO intends 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.

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, are not likely, in our opinion, to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 4: ***Submission of Matters to a Vote of Security Holders***

No matter was submitted to a vote of stockholders through the solicitation of proxies or otherwise during the fiscal quarter ended December 31, 2004.

At our 2004 Annual Meeting of Stockholders held on May 12, 2004, our stockholders elected as Class II Directors Charles Z. Fedak, CPA, M.B.A., John C. Molina, J.D., and Sally K. Richardson.

Mr. Fedak received 19,505,330 votes; 741,544 votes were withheld. Mr. Molina received 19,530,140 votes; 716,734 votes were withheld. Ms. Richardson received 20,217,617 votes; 29,257 votes were withheld.

The terms of office of the following other directors continued after the meeting: J. Mario Molina, M.D., George S. Goldstein, Ph.D., Ronald Lossett, CPA, D.B.A., and Ronna Romney.

Mr. Lossett passed away unexpectedly on February 25, 2005. We expect to fill the vacancy caused by Mr. Lossett's passing by Board action prior to our annual meeting on April 27, 2005.

Executive Officers of the Registrant

J. Mario Molina, M.D., age 46, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relation member services, market and quality assurance from 1994 to 1996. Dr. Molina presently serves as a member of the Financial Solvency Standards Board (which is an advisory committee to the California State Department of Managed Health Care), and is a member of the board of the California Association of Health Plans. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., age 40, has served as Executive Vice President, Financial Affairs, since 1995, Treasurer since 2002, and Chief Financial Officer since 2003. He also has served as a director since 1994. Mr. Molina has been employed by us for 25 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

George S. Goldstein, Ph.D., age 63, has served as Executive Vice President, Health Plan Operations since 1999, became the Chief Operating Officer in 1999, and has served as a director since 1998. In January 2005, Dr. Goldstein was named our Executive Director, Public Policy. Prior to his position as Chief Operating Officer, Dr. Goldstein served as the Chief Executive Officer of Molina Healthcare of California. Before joining our company, Dr. Goldstein served as Chief Executive Officer of United Healthcare Corporation of Southern California and Nevada from 1996 to 1998. Dr. Goldstein also served as Senior Vice President of State Programs for Foundation Health Services, Inc. from 1993 to 1996. In Colorado and New Mexico, he held cabinet positions under three governors from 1975 to 1985, and was responsible for the Medicaid, public health, mental health and environmental programs. He earned a Ph.D. in Experimental Psychology from Colorado State University.

Mark L. Andrews, Esq., age 47, has served as Executive Vice President, Legal Affairs and General Counsel since 1998. He also has served as a member of the Executive Committee of our company since 1998. Before joining our company, Mr. Andrews was a partner at Wilke, Fleury, Hoffelt, Gould & Birney of Sacramento, California, where he chaired that firm's health care and employment law departments and represented Molina as outside counsel from 1994 through 1997. Mr. Andrews holds a Juris Doctorate degree from Hastings College of the Law.

M. Martha Bernadett, M.D., age 41, has served as Executive Vice President, Research and Development since 2002. Dr. Bernadett is the principal investigator on a grant from the Robert Wood Johnson Foundation to improve healthcare access for Latinos. She was formerly responsible for the operation of staff model clinics in California. She earned an M.D. from the University of California, Irvine and an M.B.A. from Pepperdine University. Dr. Bernadett is the sister of J. Mario Molina, M.D. and John C. Molina.

Terry P. Bayer, age 54, was named Executive Vice President of Health Plan Operations in January 2005. Ms. Bayer has 25 years of healthcare management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Veterans Health Administration (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communication from Northwestern University.

Sheila K. Shapiro, age 43, was named Executive Vice President of Administrative Services in January 2005. Ms. Shapiro's 15 years of healthcare experience include serving as Senior Vice President of Operations for Premera Blue Cross of Washington, Vice President for PCS Health Systems, and various positions with PacifiCare Health Systems of Arizona and Nevada (formerly FHP, Inc.). She has also served as a volunteer consultant to non-profit healthcare organizations for Executive Service Corps of Washington. Ms. Shapiro holds a Bachelor's degree in Business Administration from Arizona State University and a Master's degree in Management from the University of Phoenix.

PART II

Item 5: ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock became listed on July 2, 2003 on The New York Stock Exchange, Inc. under the symbol "MOH". Prior to that time, there was no established public trading market for any class of our common equity. The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High Sales Price	Low Sales Price
2003		
Third Quarter (beginning July 2, 2003)	$ 27.75	$ 20.15
Fourth Quarter	$ 29.00	$ 21.75
2004		
First Quarter	$ 33.45	$ 23.25
Second Quarter	$ 39.74	$ 29.21
Third Quarter	$ 38.18	$ 29.79
Fourth Quarter	$ 49.45	$ 34.90

As of February 25, 2005, there were approximately 52 holders of record of our common stock.

We did not declare or pay any dividends in 2004 or 2003. We currently anticipate that we will retain any future earnings for the development and operation of our business. Accordingly, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Our ability to pay dividends to stockholders is dependent on cash dividends being paid to us by our subsidiaries. Laws of the states in which we operate or may operate our health plans, as well as requirements of the government sponsored health programs in which we participate, limit the ability of our health plan subsidiaries to pay dividends to us. In addition, the terms of our credit facility limit our ability to pay dividends.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2004)

Plan Category	Number of shares to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of shares remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a) (c)
Equity compensation plans approved by security holders	694,452(1)	$ 14.64	2,140,720(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and Incentive Plan have been frozen.

(2) Includes only shares issuable under the 2002 Equity Incentive Plan and the 2002 Employee Stock Purchase Plan. The number of shares available for issuance under the 2002 Equity Incentive Plan will automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis on January 1st of each year, unless the Board determines not to permit the automatic increase. The number of shares available for issuance under the 2002 Equity Incentive Plan increased by 400,000 on both January 1, 2004 and January 1, 2005.

Use of Proceeds from Initial Public Offering and Secondary Offering

On July 8, 2003, we completed our initial public offering of 7,590,000 shares of common stock, par value $0.001 per share. Managing underwriters for the offering were Banc of America Securities LLC and CIBC World Markets Corp. as joint book-running managers and SG Cowen Securities Corporation as co-manager. The shares of common stock sold in the offering were registered under the Securities Act of 1933, as amended, on a Registration Statement on Form S-1, Registration Number 333-102268, which was declared effective by the Securities and Exchange Commission on July 1, 2003. The initial public offering commenced on July 2, 2003. All of the 7,590,000 shares sold by us were issued at a price of $17.50 per share. We received net proceeds from the offering of approximately $119.6 million, after deducting approximately $3.9 million in fees and expenses and approximately $9.3 million in the underwriters' discount. We used a portion of the proceeds from the offering to repay the then outstanding balance of $8.5 million on our long-term credit facility and to complete a previously contemplated repurchase of an aggregate of 1,120,571 shares of our common stock from two stockholders for $17.50 per share, or an aggregate purchase price of $19.6 million. In such transaction, we purchased 912,806 shares owned by the MRM GRAT 301/2 and 207,765 shares owned by the Mary R. Molina Living Trust. In September 2003, we used $3.75 million of the proceeds to complete the previously contemplated purchase of a Medicaid contract in Michigan. In May 2004, we contributed $20.0 million of the proceeds to our Michigan HMO to increase its capitalization so that it would be allowed to accept additional members in accordance with state regulations. On August 1, 2004, we used the remainder of these proceeds, paying $69.0 million in transaction consideration for the purchase of Health Care Horizons, Inc.

On March 29, 2004, we completed a public offering of 1,800,000 shares of common stock, par value $0.001 per share. Managing underwriters for the offering were Banc of America Securities LLC and CIBC World Markets Corp. as joint book-running managers and SG Cowen Securities Corporation and Legg Mason Wood Walker, Inc. as co-managers. The shares of common stock sold in the offering were registered under the Securities Act of 1933, as amended, on a Registration Statement on Form S-1, Registration Number 333-113221, which was declared effective by the Securities and Exchange Commission on March 24, 2004. All of the 1,800,000 shares sold by us were issued at a price of $28.00 per share. We received net proceeds from the offering of approximately $47.3 million, after deducting approximately $0.6 million in fees and expenses and approximately $2.5 million in the underwriters' discount. On August 1, 2004, we used $5.8 million of these proceeds to extinguish outstanding bank debt of Health Care Horizons, Inc. In December 2004, we contributed $1.2 million of the proceeds to our Michigan HMO to increase its capitalization. We intend to use the remaining net proceeds for general corporate purposes, including acquisitions.

Item 6. ***Selected Financial Data***

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data for the five years ended December 31, 2004 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data.

	Year Ended December 31,				
	2004(1)	2003	2002	2001	2000
Statements of Income Data:					
Revenue:					
Premium revenue	$ 1,166,870	$ 789,536	$ 639,295	$ 499,471	$ 324,300
Other operating revenue	4,168	2,247	2,884	1,402	1,971
Total premium and other operating revenue	1,171,038	791,783	642,179	500,873	326,271
Investment income	4,230	1,761	1,982	2,982	3,161
Total revenue	1,175,268	793,544	644,161	503,855	329,432
Expenses:					
Medical care costs	984,686	657,921	530,018	408,410	264,408
Salary, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	94,150	61,543	61,227	42,822	38,701
Depreciation and amortization	8,869	6,333	4,112	2,407	2,085
Total expenses	1,087,705	725,797	595,357	453,639	305,194
Operating income	87,563	67,747	48,804	50,216	24,238
Total other income (expense), net	122	(1,334)	(405)	(561)	(197)
Income before income taxes	87,685	66,413	48,399	49,655	24,041
Provision for income taxes	31,912	23,896	17,891	19,453	9,156
Income before minority interest	55,773	42,517	30,508	30,202	14,885
Minority interest	—	—	—	(73)	79
Net income	$ 55,773	$ 42,517	$ 30,508	$ 30,129	$ 14,964
Net income per share:					
Basic	$ 2.07	$ 1.91	$ 1.53	$ 1.51	$ 0.75
Diluted	$ 2.04	$ 1.88	$ 1.48	$ 1.46	$ 0.73
Cash dividends declared per Share	—	—	—	—	$ 0.05
Weighted average number of common shares outstanding	26,965,000	22,224,000	20,000,000	20,000,000	20,000,000
Weighted average number of common shares and potential dilutive common shares outstanding	27,342,000	22,629,000	20,609,000	20,572,000	20,376,000
Operating Statistics:					
Medical care ratio (2)	84.1%	83.1%	82.5%	81.5%	81.0%
Salary, general and administrative expense ratio (3)	8.0%	7.8%	9.5%	8.5%	11.7%
Members (4)	788,000	564,000	489,000	405,000	298,000

	As of December 31,				
	2004	2003	2002	2001	2000
Balance Sheet Data:					
Cash and cash equivalents	$ 228,071	$ 141,850	$ 139,300	$ 102,750	$ 45,785
Total assets	533,859	344,585	204,966	149,620	102,012
Long-term debt (including current maturities)	1,894	—	3,350	3,401	3,448
Total liabilities	203,237	123,263	109,699	84,861	67,405
Stockholders' equity	330,622	221,322	95,267	64,759	34,607

(1) The balance sheet and operating results of the New Mexico HMO have been included since July 1, 2004, the date of acquisition.

(2) Medical care ratio represents medical care costs as a percentage of premium and other operating revenue. Other operating revenue includes revenues related to our California clinics and reimbursements under various risks and savings sharing programs. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective healthcare services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See *Management's Discussion and Analysis of Financial Condition and Results of Operations* for further discussion.

(3) Salary, general and administrative expense ratio represents such expenses as a percentage of total operating revenue.

(4) Number of members at end of period.

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operation***

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Consolidated Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report.

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. For the year ended December 31, 2004 we received approximately 85.8% of our premium revenue as a fixed amount per member per month, or PMPM, 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 7.9% of our premium revenue in the year ended December 31, 2004 was realized under a cost plus reimbursement agreement that our Utah subsidiary has with that state. We also received approximately 6.3% of our premium revenue for the year ended December 31, 2004 in the form of birth payments (one-time payments for the delivery of children) from the Medicaid programs in Washington, Michigan and New Mexico. 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 in the periods presented.

	As of December 31,		
State	**2004**	**2003**	**2002**
California	253,000	254,000	253,000
Michigan	158,000	82,000	33,000
Utah	49,000	45,000	42,000
Washington	263,000	183,000	161,000
New Mexico	65,000	—	—
Total	788,000	564,000	489,000

The following table details member months (defined as the aggregation of each month's membership for the period) by state for the years ended December 31, 2004, 2003, and 2002:

State	**2004**	**2003**	**2002**
California	2,989,000	3,063,000	2,953,000
Michigan	1,272,000	585,000	352,000
Utah	576,000	537,000	341,000
Washington	2,851,000	2,142,000	1,802,000
New Mexico	391,000	—	—
Total	8,079,000	6,327,000	5,448,000

Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California and savings sharing revenues in Utah, California, and Michigan, where we receive additional incentive payments from the states if inpatient medical costs are less than prescribed amounts. The savings sharing provisions of our contract with the state of Michigan are no longer in effect, and we recognized our last savings sharing revenue in that state in the second quarter of 2003.

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 year ended December 31, 2004, approximately 82.7% 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. Monthly, we estimate our IBNR 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. We believe that our process for estimating IBNR is adequate, but there can be no assurance that medical care costs will not 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 the Washington HMO, the Michigan HMO (beginning in the second quarter of 2003), and the New Mexico HMO (beginning with its acquisition on July 1, 2004).

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 premiums and other operating revenue earned and the cost of health care.

	Year Ended December 31,		
	2004	2003	2002
Premium revenue	99.3%	99.5%	99.2%
Other operating revenue	0.3%	0.3%	0.5%
Investment income	0.4%	0.2%	0.3%
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	84.1%	83.1%	82.5%
Salary, general and administrative expenses	8.0%	7.8%	9.5%
Operating income	7.5%	8.5%	7.6%
Net income	4.7%	5.4%	4.7%

Year Ended December 31, 2004 Compared to Year Ended December 31, 2003

Premium Revenue

Premium revenue for 2004 was $1.167 billion, up $377.3 million (47.8%) from $789.5 million for 2003.

Membership growth contributed $253.1 million to the increase in revenue. Year-end enrollment increased 39.7% to 788,000 members at December 31, 2004, from 564,000 members at the same date of the prior year. Member months for the year ended December 31, 2004 increased by 27.7% to 8,079,000 from 6,327,000 for the year ended December 31, 2003. Year-end enrollment increased by 43.7% at our Washington HMO and by 92.7% at our Michigan HMO between 2003 and 2004. The transfer of membership from other managed care companies was the primary source of enrollment growth in both states. Our New Mexico acquisition (effective July 1, 2004) added 65,000 members to our total year-end 2004 enrollment

The remaining $124.2 million increase in premium revenue was attributable to increases in premium rates and proportionally greater increases in membership in those states with higher premium rates. Premium revenue on a per member per month basis is substantially higher at our New Mexico HMO than at our other HMOs.

Other Operating Revenue

Other operating revenue increased to $4.2 million for 2004 from $2.2 million for 2003. Other operating revenue for 2004 included $2.1 million of savings sharing income recognized by our Utah HMO. Our Utah HMO recognized no savings sharing income prior to 2004. For 2003, our Michigan HMO recognized approximately $0.7 million in savings sharing income. Our Michigan HMO’s contract with the state no longer contains risk sharing provisions.

Other than the amounts recognized by our Utah and Michigan HMOs for savings sharing, other operating revenue consisted primarily of revenue earned by our California medical clinic operations (approximately $1.2 million for both 2004 and 2003) and approximately $0.3 million of income earned by our New Mexico HMO during 2004 for performing certain administrative services for the state.

Investment Income

Investment income for 2004 increased to $4.2 million from $1.8 million for 2003 due to greater average invested balance and higher investment yields.

Medical Care Costs

Medical care costs for 2004 were $984.7 million, representing 84.1% of premium and other operating revenue for all of 2004, as compared with $657.9 million, representing 83.1% of premium and other operating revenue for all of 2003.

The increase in the medical care ratio is due in large part to increases in enrollment in states and programs that experience higher medical care ratios than our company-wide average. Increased aged, blind and disabled membership in our Michigan HMO and the acquisition of our New Mexico HMO, which has traditionally experienced a higher medical care ratio than our other HMOs, were major contributors to the higher medical care ratio.

Despite the increase in the medical care ratio noted in the preceding paragraph, all of our HMOs remain profitable. The New Mexico HMO, with per member per month revenues over twice the average of the rest of our HMOs, produces the highest medical margin (defined as the difference between total medical care costs and total premium and other operating revenue) per member per month among our HMOs. On a consolidated basis, medical margin per member per month increased to $23.06 for 2004 from $21.16 for 2003.

Salary, General and Administrative Expenses

SG&A expenses for 2004 were $94.2 million as compared with $61.5 million for 2003. The largest component of the increase in SG&A was an increase in premium tax expense of $15.1 million in 2004. SG&A expenses as a percentage of total revenue were 8.0% for 2004 as compared with 7.8% for 2003. Excluding premium taxes, SG&A expenses decreased to 5.9% of total revenue for 2004 from 6.6% of total revenue for 2003.

Depreciation and Amortization

Depreciation and amortization expense for 2004 increased to $8.9 million from $6.3 million for 2003. The increase was primarily due to increased capital spending for computer equipment and leasehold improvements and increased amortization of purchased member contracts.

Interest Expense

Interest expense decreased to $1.0 million for 2004 from $1.5 million for the 2003 due to decreased debt balances.

Other Income

Other income for 2004 includes a pretax gain of $1.2 million recognized upon the termination of certain Collateral Assignment Split-Dollar Insurance Agreements between our company and the Molina Siblings Trust, a related party, during the first quarter of 2004. We had agreed to make premium payments towards the life insurance policies held by the Trust on the life of Mary R. Molina. We were not an insured under the policies, but were entitled to receive repayment of all premium advances from the Trust upon the earlier of Mrs. Molina’s death or cancellation of the policies. Receivables, representing premium payments made by us, were discounted based on Mrs. Molina’s remaining actuarial life. On March 2, 2004, the Collateral Assignment Split-Dollar Insurance Agreements were terminated by the early repayment of the advances to the Trust. The gain of $1.2 million represents the recovery of the discounts previously recorded.

Provision for Income Taxes

Income tax expense totaled $31.9 million in 2004, resulting in an effective tax rate of 36.4%, as compared to $23.9 million in 2003, resulting in an effective tax rate of 36.0%. During both 2004 and 2003, we pursued

various strategies to reduce our federal, state, and local taxes. As a result, we have reduced our state income tax expense due to California Economic Development Tax Credits (Credits). Our tax expense was reduced by approximately $0.9 million and $1.0 million for 2004 and 2003, respectively, by out-of-year Credits. Consulting fees incurred in connection with the Credits, were recorded as salary, general and administrative expenses.

Year Ended December 31, 2003 Compared to Year Ended December 31, 2002

Premium Revenue

Premium revenue for 2003 was $789.5 million, up $150.2 million, or 23.5% from $639.3 million for 2002. Membership growth contributed $109.5 million to the increase in revenue. Year-over-year enrollment increased 15.3% to 564,000 members at December 31, 2003, from 489,000 members at the same date of the prior year. Membership growth was most pronounced at our Michigan HMO, which saw year-over-year enrollment increase to 82,000 from 33,000. The Michigan HMO added 32,000 and 9,400 members in the fourth and third quarters of 2003, respectively, as a result of the acquisition of Medicaid contracts from other health plans. The remainder of the additional revenue, or $40.7 million, was attributable to increases in premium rates and proportionally greater increases in membership in those states with higher premium rates.

Other Operating Revenue

Other operating revenue decreased to $2.2 million for 2003 from $2.9 million for 2002. The decrease was the result of reduced savings sharing revenue at our California and Michigan HMOs.

Investment Income

Investment income for 2003 decreased to $1.8 million from $2.0 million for 2002 due to lower investment yields, which were partially offset by greater invested balances.

Medical Care Costs

Medical care costs for 2003 were $657.9 million, representing 83.1% of premium and other operating revenue, as compared with $530.0 million, representing 82.5% of premium and other operating revenue, for 2002. The increase in the medical care ratio was due to increases in specialty, hospital, and pharmacy expense, partially offset by reduced capitation costs. Additionally, medical margins in 2003 were reduced by changes in the state of Washington's method of compensating us for certain health care costs reimbursed by the Supplemental Security Income program.

Salary, General and Administrative Expenses

SG&A expenses for 2003 were $61.5 million as compared with $53.4 million (after deducting $7.8 million in stock option settlement expenses) for 2002. The increase was primarily due to an increase in premium tax expense of $4.2 million in 2003. SG&A expenses as a percentage of total revenue were 7.8% for 2003 as compared with 8.3% (adjusted for the stock option settlement expense) for 2002.

Depreciation and Amortization

Depreciation and amortization expense for 2003 increased to $6.3 million from $4.1 million for 2002. The increase was primarily due to increased capital spending for computer equipment and leasehold improvements.

Interest Expense

Interest expense increased to $1.5 million for 2003 from $.4 million for 2002. Interest expense increased due to the amortization of loan fee expense associated with our credit facility, as well as the payment of interest

on amounts borrowed under that facility. Interest expense was reduced by our repayment of a mortgage note in the second quarter of 2003.

Provision for Income Taxes

Income taxes totaled $23.9 million in 2003, resulting in an effective tax rate of 36.0%, as compared to $17.9 million in 2002, resulting in an effective tax rate of 37.0%. The lower 2003 tax rate was due to: (i) our Washington health plan, which does not pay state income taxes, generating a greater percentage of our total earnings; and (ii) our receiving $1.6 million of California Economic Development Tax Credits (Credits) in 2003 as compared to our receiving $.4 million in 2002. Approximately $1.0 million of the 2003 Credits relate to prior years that are being recovered through amended state tax filings. The table below includes a breakdown of the total 2003 Credits, net of recovery fees paid to consultants (included in Salary, General and Administrative expenses):

	Reduced Income Taxes	Recovery Fees	Net Income	Diluted Earnings Per Share
2003	$ 585	$ 107	$ 478	$ .02
Prior years	1,034	189	845	04
Total 2003 Credits	$ 1,619	$ 296	$ 1,323	$ .06

The prior year credit recognized in 2003, net of recovery fees, of $845 ($.04 per diluted share) was accounted for as a change in estimate.

Acquisitions

Effective June 1, 2004, we completed our acquisition of the Healthy Options (Medicaid) and Basic Health Plan contracts of Premera Blue Cross, adding approximately 56,000 members. We paid to Premera $18 million for both contracts in addition to assuming an estimated $0.4 million in medical related liabilities. The transaction was funded with cash internally generated by our Washington HMO.

On July 1, 2004, we closed on our acquisition of Health Care Horizons, Inc., or HCH, the parent company of Cimarron Health Plan, Inc. (now Molina Healthcare of New Mexico, Inc.), a New Mexico corporation. Total consideration for the acquisition, including direct transaction costs was $71.8 million. At the close of the acquisition, we extinguished approximately $5.8 million of outstanding HCH bank debt. We funded the acquisition with proceeds from our initial and secondary public offerings.

Prior to the closing of the HCH acquisition, we announced a definitive agreement had been reached to transfer the commercial membership acquired in the HCH purchase to Lovelace Sandia Health System, Inc., or Lovelace. Effective August 1, 2004, the transfer was completed. We received a total of $18.0 million (net of approximately $0.3 million in direct transactions costs) in connection with the transfer. We also entered into a transition services agreement with Lovelace to provide commercial claims processing, customer and provider call handling, and billing and treasury services through the date the commercial contracts are expected to be fully transitioned to Lovelace.

On October 1, 2004, we transitioned approximately 73,000 members from the Wellness Plan of Michigan into our Michigan HMO. Total consideration paid in connection with the transition of these members was approximately $18.8 million (including direct acquisition costs).

On November 22, 2004, our California HMO and Sharp Health Plan, or Sharp, entered into a definitive Asset Purchase Agreement to transfer Sharp's Medi-Cal (Medicaid) and Healthy Families Program (SCHIP)

contracts to our California HMO. As of March 4, 2005, the proposed transfer had been approved by each of the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. The transaction would add approximately 70,000 members to our California HMO's current membership. We anticipate paying approximately $25 million for the transfer of these contracts, subject to possible adjustment and an earn-out provision. As part of the transaction, Sharp will assign the bulk of its provider network to our California HMO.

On December 10, 2004, our California HMO, and Universal Care, Inc., a California corporation, entered into a definitive Asset Purchase Agreement to transfer Universal's Medi-Cal and Healthy Families contracts to our California HMO. As of March 4, 2005, the proposed transfer had been approved by each of the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. The transaction would add approximately 17,000 members to our California HMO's current membership. We anticipate paying approximately $6.2 million for the transfer of these contracts, subject to possible adjustment. As part of the transaction, Universal will assign the bulk of its provider network related to its Medi-Cal and Healthy Families members to our California HMO.

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, SG&A expenses and acquisitions. We generally receive premium revenue in advance of payment of claims for related health care services, with the exception of our Utah HMO.

In July 2003, we completed the initial public offering of our common stock. We sold 7,590,000 shares, generating net proceeds of approximately $119.6 million after deducting approximately $3.9 million in fees and expenses and $9.3 million in the underwriters' discount. In March 2004, we completed a public offering of our common stock. We sold 1,800,000 shares, generating net proceeds of approximately $47.3 million after deducting approximately $0.6 million in fees and expenses and $2.5 million in the underwriters' discount.

Our offerings of common stock in July 2003 and March 2004, respectively, have substantially enhanced our liquidity. Additionally, because we generally receive premium revenue in advance of payment for the related medical care costs (with the exception of our Utah HMO), our cash has increased during periods when we experienced enrollment growth. Our ability to support the increase in membership with existing infrastructure also allows us to retain a larger portion of the additional premium revenue as profit.

At December 31, 2004, we had working capital of $202.2 million as compared to $182.2 million at December 31, 2003. At December 31, 2004 and December 31, 2003, cash and cash equivalents were $228.1 million and $141.9 million, respectively. At December 31, 2004 and December 31, 2003, our investments were $88.5 million and $98.8 million, respectively.

Our subsidiaries are required to maintain minimum capital prescribed by the various jurisdictions in which we operate. As of December 31, 2004, 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.

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 with maturities of up to 12 months.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements. As of December 31, 2004, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. As of December 31, 2004, our investments consisted solely of investment grade debt securities (all of which are classified as current assets) with a maximum maturity of five years and an average duration of two years. Two professional portfolio managers operating under documented investment guidelines manage our investments. 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 with maturities of up to 12 months.

The average annualized portfolio yield for the years ended December 31, 2004, 2003, and 2002 was approximately 1.4%, 1.1%, and 1.7%, respectively.

Net cash provided by operations was $91.0 million for 2004 and $45.6 million for 2003. The increase in net cash provided by operations for 2004 when compared to 2003 was due to the following factors:

- increased net income ($13.3 million higher in 2004);
- increased depreciation and amortization expense ($2.5 million higher in 2004);
- increased medical claims and benefits payable (a source of $23.1 million in 2004 compared to a source of $14.7 million in 2003;
- changes in accounts receivable balances, which were a use of $3.6 million in 2004 compared to a use of $24.1 million in 2003);
- changes in miscellaneous working capital accounts (a source of $6.9 million in 2004 compared to a source of $6.0 million in 2003).

Credit Facility

We entered into a credit agreement dated as of March 19, 2003, under which a syndicate of lenders provided a $75.0 million senior secured credit facility. Interest on any amount outstanding under the facility is payable monthly at a rate per annum of: (a) LIBOR plus a margin ranging from 200 to 250 basis points or (b) the higher of (i) Bank of America prime or (ii) the federal funds rate plus 0.50%, plus a margin ranging from 100 to 150 basis points. All borrowings under the credit facility are due and payable in full by March 20, 2006. The credit facility is secured by substantially all of our parent company's real and personal property and the real and personal property of one of our Utah subsidiaries and, subject to certain limitations, all shares of our Washington HMO subsidiary, our Michigan HMO subsidiary, our New Mexico HMO subsidiary, and our Utah HMO subsidiary.

The terms of the credit agreement contain various covenants that place restrictions on our and/or our subsidiaries' ability to incur debt, pay dividends, create liens, make investments, optionally repay, redeem or repurchase our securities, and enter into mergers, dispositions, and transactions with affiliates. The credit agreement also requires us to meet various financial covenants, including a minimum fixed-charge coverage requirement, a maximum consolidated leverage ratio, a minimum consolidated net worth requirement, a capital expenditure limit, and individual subsidiary risk based capital levels. At December 31, 2004, we were in compliance with all of these covenants.

At December 31, 2004, no amounts were outstanding under the credit facility.

We are currently in the process of amending and restating our credit facility to increase the maximum amount that can be borrowed under the facility to $180 million, and to make certain other revisions. We anticipate that this amendment and restatement will be completed in the first half of March 2005.

Regulatory Capital and Dividend Restrictions

At December 31, 2004, our principal operations are conducted through the five HMOs operating in California, Washington, Michigan, Utah, and New Mexico. 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 restrict the timing, payment, and amount of dividends and other distributions that may be paid to their 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 $130.0 million at December 31, 2004, and $72.0 million at December 31, 2003.

The National Association of Insurance Commissioners has 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 rules. These HMO rules, which may vary from state to state, have been adopted in Washington, Michigan, Utah, and New Mexico. California has not adopted risk-based capital requirements for HMOs and has not formally given notice of its intention to do so. The National Association of Insurance Commissioners' HMO rules, if adopted by California, may increase the minimum capital required for that state.

As of December 31, 2004, our HMOs had aggregate statutory capital and surplus of approximately $157.8 million, compared with the required minimum aggregate statutory capital and surplus of approximately $85.9 million. All of our HMOs were in compliance with the minimum capital requirements.

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 independent 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 estimates are adequate, 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 customers, 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.

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 a date subsequent to that month of service. Completion factors are based upon historical payment patterns. The following table reflects the change in our estimate of claims liability as of December 31, 2004 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding that date by the percentages indicated. Our Utah HMO is excluded from these calculations, as the majority of the Utah business is conducted under a cost reimbursement contract. Amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ 13,077
(2)%	8,718
(1)%	4,359
1%	(4,359)
2%	(8,718)
3%	(13,077)

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 delay inherent between the patient/physician encounter and the actual submission of a claim for payment. For these months of service we estimate our claims liability based upon trended per member per month 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 December 31, 2004 that would have resulted had we altered our trend factors by the percentages indicated. Our Utah HMO is excluded from these calculations, as the majority of the Utah business is conducted under a cost reimbursement contract. Amounts are in thousands.

Increase (Decrease) in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ (7,728)
(2)%	(5,152)
(1)%	(2,576)
1%	2,576
2%	5,152
3%	7,728

Assuming a hypothetical 1% change in both completion factors and per member per month cost estimates from those used in our calculation of IBNR at December 31, 2004, net income for the year ended December 31, 2004 would increase or decrease by approximately $1.1 million, or $.04 per diluted share, net of tax.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2004, our lease obligations for the next five years and thereafter are as follows: $6.9 million in 2005, $6.6 million in 2006, $5.9 million in 2007, $5.6 million in 2008, $4.8 million in 2009, and an aggregate of $10.0 million thereafter.

We lease certain equipment at our New Mexico HMO under capital leases. As of December 31, 2004, our lease obligations for the next five years and thereafter are as follows: $0.2 million in 2005, $0.2 million in 2006, $0.2 million in 2007, $0.1 million in 2008, and none thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in the “Commitments and

Contingencies" section of our consolidated financial statements appearing elsewhere in this report and the notes thereto. We have in the past made certain advances and loans to related parties, which are discussed in the consolidated financial statements appearing elsewhere in this report and the notes thereto.

Contractual Obligations

In the table below, we set forth our contractual obligations as of December 31, 2004. Some of the figures we include in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	2005	2006 – 2007	2008 – 2009	2010 and Beyond
Operating lease obligations	$6,891	$ 12,522	$ 10,418	$ 9,990
Capital lease obligations	183	366	107	—
Purchase commitments	2,305	1,986	30	—
Mortgage note obligation	82	179	179	1,520
Total contractual obligations	$9,461	$ 15,053	$ 10,734	$ 11,510

RISK FACTORS

In addition to the factors discussed elsewhere in this report, the following are some of the important factors that could cause our actual results to differ materially from those projected in any forward-looking statements. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties, including those not presently known to us or that we currently deem immaterial, also may result in decreased revenues, increased expenses, or other events which could result in a decline in the price of our common stock.

Risks Related To Our Business

Reductions in Medicaid funding could substantially reduce our profitability.

Substantially all of our revenues come from state Medicaid premiums. The premium rates paid by each state to health plans like ours differ depending on a combination of factors, such as upper payment limits established by the federal and state governments, a member's health status, age, gender, county or region, benefit mix, and member eligibility categories. Future Medicaid premium rate levels may be affected by continued government efforts to contain medical costs, or federal and state budgetary constraints. Changes in Medicaid funding could, for example, reduce the number of persons enrolled in or eligible for Medicaid, reduce the amount of reimbursement or payment levels by the federal or state governments or increase our administrative or health benefit costs. Additionally, changes could eliminate coverage for certain benefits such as our pharmacy, behavioral health, vision, or other benefits. In some cases, changes in funding could be made retroactive. The federal government and all of the states in which we operate are presently considering proposals and legislation that would implement certain Medicaid reforms or redesigns, reduce reimbursement or payment levels, or reduce the number of persons eligible for Medicaid. Reductions in Medicaid payments at either the federal or state level could reduce our profitability if we are unable to reduce our expenses.

If our government contracts or our subcontracts with government contractors are not renewed or are terminated, our business will suffer.

All of our contracts are terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are subject to cancellation by the state in the event of unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. In addition, most contracts are terminable without cause. Most contracts are for a specified period and are subject to non-renewal. Our other contracts are also eligible for termination or renewal through annual competitive bids. We may face increased competition as other plans attempt to enter our markets through the contracting process. If we are unable to renew, successfully rebid, or compete for any of our government contracts, or if any of our contracts are terminated, our business will suffer.

If we are unable to effectively manage medical costs, our profitability could be reduced.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage medical costs. Historically, our medical care costs as a percentage of premium and other operating revenue have fluctuated. Relatively small changes in these medical care ratios can create significant changes in our financial results. Changes in health care laws, regulations and practices, level of use of health care services, hospital costs, pharmaceutical costs, major epidemics, terrorism or bioterrorism, new medical technologies, and other external factors, including general economic conditions such as inflation levels, could reduce our ability to predict and effectively control the costs of providing health care services. Although we have been able to manage medical care costs through a variety of techniques, including various payment methods to primary care physicians and other providers, advance approval for hospital services and referral requirements, medical management and quality management programs, our information systems, and reinsurance arrangements, we may not be able to continue to effectively manage medical care costs in the future. If our medical care costs increase, our profits could be reduced or we may not remain profitable.

A failure to accurately estimate incurred but not reported medical care costs may hamper our operations.

Our medical care costs include estimates of claims incurred but not reported. We, together with our independent actuaries, estimate our medical claims liabilities using actuarial methods based on 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 continually reviewed and updated, and adjustments, if necessary, are reflected in the period known. While our estimates of claims incurred but not reported have been adequate in the past, they may be inadequate in the future, which would negatively affect our results of operations. Further, our inability to accurately estimate claims incurred but not reported may also affect our ability to take timely corrective actions, further exacerbating the extent of the negative impact on our results. If we estimate claims incurred but not reported too conservatively, our profits may be understated, which could result in inaccurate disclosure to the public in our periodic reports.

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than stockholders. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations along with the terms of our government contracts regulate how we do business, what services we offer, and how we interact with members and the public. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations could reduce our profitability by:

- imposing additional capital requirements,
- increasing our liability,
- increasing our administrative and other costs,
- increasing or decreasing mandated benefits,
- forcing us to restructure our relationships with providers, or
- requiring us to implement additional or different programs and systems.

For example, Congress enacted the Health Insurance Portability and Accountability Act of 1996 which mandates that health plans enhance privacy protections for member protected health information. This requires health plans to add, at significant cost, new administrative, information, and security systems to prevent inappropriate release of protected member health information. The requirements for compliance with this law are uncertain and will continue to affect our profitability. The regulations enacting this law also establish significant criminal penalties and civil sanctions for non-compliance, including fines for violations of the regulations by our business associates. Individual states periodically consider adding operational requirements applicable to health plans, often without identifying funding for these requirements. California recently required all health plans to make available to members independent medical review of their claims. This requirement is costly to implement and could affect our profitability.

We are subject to various routine and non-routine governmental reviews, audits, and investigation. Violation of the laws governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, and exclusion from participation in government sponsored health programs, including Medicaid and SCHIP. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue.

Our business depends on our information systems, and our inability to effectively integrate, manage, and keep secure our information systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, monitoring utilization and other cost factors, supporting our health care management techniques, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to produce timely and accurate reports could be adversely affected. In addition, our information system software is leased from a third party. If the owner of the software were to become insolvent and fail to support the software, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and client data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses theoretically could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if they are not prevented.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of Medicaid contract rights and other health plans have accounted for a significant amount of our growth. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that acquisitions similar in nature to those we have historically executed will be important to our future growth strategy. Many of the other potential purchasers of these assets have greater financial resources than we have. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with the existing business. This may include the integration of:

- additional employees who are not familiar with our operations,
- new provider networks, which may operate on terms different from our existing networks,
- additional members, who may decide to transfer to other health care providers or health plans,

- disparate information, claims processing, and record keeping systems, and
- accounting policies, including those which require judgmental and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. For example, the previously announced agreements to transfer to the company the Medi-Cal (Medicaid) and Healthy Families Program (California's SCHIP) contracts of both Sharp Health Plan and Universal Care in San Diego County require four separate governmental agency approvals. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we will be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of the state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or to comply with these regulatory requirements for an acquisition in a timely manner, or at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced or to sustain our pattern of growth.

Ineffective management of our growth may negatively affect our results of operations, financial condition, and business.

Depending on acquisition and other opportunities, we expect to continue to grow our membership and to expand into other markets. In 1998, we had total revenue of $135.9 million. In 2004, we had total revenue of $1.175 billion. Continued rapid growth could place a significant strain on our management and on other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is currently subject to significant changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by financial resources available to a health plan. Many other organizations with which we compete have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership.

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions and declare dividends.

We have a credit facility that imposes various restrictions and covenants, including prescribed debt coverage ratios, net worth requirements, and acquisition limitations, that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends without lender approval. Our growth strategy may be negatively impacted by our inability to act with complete flexibility.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our President and Chief Executive Officer and our Executive Vice Presidents, some of whom have entered into employment agreements with us. These employment

agreements may not provide sufficient incentives for those employees to continue their employment with us. While we believe that we could find replacements, the loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel which could negatively impact our operations.

Claims relating to medical malpractice and other litigation could cause us to incur significant expenses.

Our providers involved in medical care decisions may be exposed to the risk of medical malpractice claims. Providers at the primary care clinics we operate in California are employees of our California subsidiary. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our subsidiary may experience increased exposure to liability for acts or omissions by our employees and for acts or injuries occurring on our premises. We maintain errors and omissions insurance in the amount of $5 million per occurrence and in aggregate for each policy year, medical malpractice insurance for our clinics in the amount of $1 million per occurrence, and an annual aggregate limit of $3 million, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

In addition, claimants often sue managed care organizations for improper denials or delay of care. Also, Congress, as well as several states, are considering legislation that would permit managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. If this or similar legislation were enacted, claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

The results of our operations could be negatively impacted by both upturns and downturns in general economic conditions.

The number of persons eligible to receive Medicaid benefits has historically increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. However, during such economic downturns, state and federal budgets could decrease, causing states to attempt to cut health care programs, benefits, and rates. If federal or state funding were decreased while our membership was increasing, our results of operations would be negatively affected. Conversely, the number of persons eligible to receive Medicaid benefits may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels and profitability to decrease, which could lead to decreases in our operating income and stock price.

If state regulators do not approve payments of dividends and distributions by our affiliates to us, it may negatively affect our business strategy.

We principally operate through our health plan subsidiaries. These subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. In Michigan, Utah, Washington, and New Mexico, our health plans must give thirty days advance notice and the opportunity to disapprove "extraordinary" dividends to the respective

state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2004, 2003, and 2002 without approval of the regulatory authorities were approximately $27.9 million, $29.0 million, and $28.9 million, respectively, assuming no dividends had been paid during the respective calendar years. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments on amounts drawn from our credit facility.

Unforeseen changes in regulations or pharmaceutical market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our HMOs to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our financial condition and results of operations.

Risks Associated With Our Common Stock

Our common stock has been publicly traded only since July 2003, and the price of our common stock has fluctuated substantially.

Our common stock has been traded on a public market for approximately eighteen months. Since our initial public offering in July 2003, the closing sales price of our common stock has ranged from a low of $20.15 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

- state and federal budget decreases,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding eligibility,
- changes in government payment levels,
- changes in state mandatory programs,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies,
- the termination of our Medicaid or SCHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change, and
- general economic conditions, including inflation and unemployment rates.

In addition, the stock market in general has been highly volatile recently. During this period of market volatility, the stocks of health care companies also have been highly volatile and have recorded lows well below their historical highs. Our stock may not trade at the same levels as the stock of other health care companies and the market in general may not sustain its current prices. Also, if the trading market for our stock does not continue to develop, securities analysts may not initiate or maintain research coverage of our company and our shares, and this could further depress the market for our shares.

Our stockholders will experience dilution with the future exercise of stock options.

As of December 31, 2004, we had outstanding options to purchase 694,452 shares of our common stock, of which 417,352 were exercisable. From time to time, we may issue additional options to employees and non-employee directors pursuant to our equity incentive plans. These options generally vest commencing one year from the date of grant and continue vesting over a three year period. Once these options vest, our stockholders will experience further dilution as these stock options are exercised by their holders.

Future sales, or the availability for sale, of our common stock may cause our stock price to decline.

Sales of substantial amounts of our common stock in the public market, or the perception that such sales could occur, could adversely affect the market price of our common stock and could materially impair our future ability to raise capital through offerings of our common stock.

Our directors and officers and members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Our executive officers and directors, in the aggregate, beneficially own approximately 22.4% of our capital stock. Members of the Molina family (some of whom are also officers or directors), in the aggregate, beneficially own approximately 58.0% of our capital stock, either directly or in trusts of which members of the Molina family are beneficiaries. In some cases, members of the Molina family are trustees of the trusts. As a result, Molina family members, acting themselves or together with our officers and directors, will have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of substantially all of our assets. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of ownership in our company could delay, defer, or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of our controlling stockholders may be different from those of our company or our other stockholders, and our controlling stockholders may vote their common stock in a manner that may adversely affect our other stockholders.

It may be difficult for a third party to acquire our company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,

- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Our forecasts and other forward-looking statements are based on a variety of assumptions that are subject to significant uncertainties. Our performance may not be consistent with these forecasts and forward-looking statements.

From time to time in press releases and otherwise, we may publish forecasts or other forward-looking statements regarding our future results, including estimated revenues, net earnings, and other operating and financial metrics. Any forecast of our future performance reflects various assumptions. These assumptions are subject to significant uncertainties, and as a matter of course, any number of them may prove to be incorrect. Further, the achievement of any forecast depends on numerous risks and other factors, including those described in this Annual Report on Form 10-K, many of which are beyond our control. As a result, we cannot assure that our performance will be consistent with any management forecasts or that the variation from such forecasts will not be material and adverse. You are cautioned not to base your entire analysis of our business and prospects upon isolated predictions, but instead are encouraged to utilize the entire publicly available mix of historical and forward-looking information, as well as other available information affecting us and our services, when evaluating our prospective results of operations.

Item 7A. *Quantitative and Qualitative Disclosures About Market Risk*

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments which potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments.

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, 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. Professional portfolio managers operating under documented investment guidelines manage our investments. Restricted investments are invested principally in certificates of deposit. 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 December 31, 2004, we had cash and cash equivalents of $228.1 million, investments of $88.5 million, and restricted investments of $10.8 million. The cash equivalents consist of highly liquid securities with original maturities of up to three months that are readily convertible into known amounts of cash. Our investments (all of which are classified as current assets) consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two 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.

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.

While we currently believe our strategies to mitigate health care cost inflation will continue to 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.

MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

INDEX TO FINANCIAL STATEMENTS

MOLINA HEALTHCARE, INC.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. and subsidiaries (the company) as of December 31, 2004 and 2003, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2004. These consolidated financial statements are the responsibility of the company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. and subsidiaries at December 31, 2004 and 2003, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2004, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2004, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 25, 2005, expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 25, 2005

MOLINA HEALTHCARE, INC.

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

	December 31	
	2004	2003
ASSETS		
Current assets:		
Cash and cash equivalents	$228,071	$141,850
Investments	88,530	98,822
Receivables	65,430	53,689
Deferred income taxes	3,981	2,442
Prepaid and other current assets	8,306	5,254
Total current assets	394,318	302,057
Property and equipment, net	25,826	18,380
Intangible assets, net	36,749	8,443
Goodwill	61,978	3,841
Restricted investments	10,847	2,000
Deferred income taxes	—	1,996
Advances to related parties and other assets	4,141	7,868
Total assets	$533,859	$344,585
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$160,210	$105,540
Accounts payable and accrued liabilities	22,966	11,419
Net liability for termination of commercial operations	1,676	—
Income taxes payable	7,110	2,882
Current maturities of long-term debt	171	—
Total current liabilities	192,133	119,841
Long-term debt, less current maturities	1,723	—
Deferred income taxes	5,315	—
Other long-term liabilities	4,066	3,422
Total liabilities	203,237	123,263
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 27,602,443 shares at December 31, 2004 and 25,373,785 shares at December 31, 2003	28	25
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	157,666	103,854
Accumulated other comprehensive income (loss)	(234)	54
Retained earnings	193,552	137,779
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	330,622	221,322
Total liabilities and stockholders' equity	$533,859	$344,585

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME
(dollars in thousands, except per share data)

	Year ended December 31		
	2004	2003	2002
Revenue:			
Premium revenue	$ 1,166,870	$ 789,536	$ 639,295
Other operating revenue	4,168	2,247	2,884
Total premium and other operating revenue	1,171,038	791,783	642,179
Investment income	4,230	1,761	1,982
Total revenue	1,175,268	793,544	644,161
Expenses:			
Medical care costs:			
Medical services	222,168	212,111	177,584
Hospital and specialty services	643,074	374,076	296,347
Pharmacy	119,444	71,734	56,087
Total medical care costs	984,686	657,921	530,018
Salary, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	94,150	61,543	61,227
Depreciation and amortization	8,869	6,333	4,112
Total expenses	1,087,705	725,797	595,357
Operating income	87,563	67,747	48,804
Other income (expense):			
Interest expense	(1,049)	(1,452)	(438)
Other, net	1,171	118	33
Total other income (expense)	122	(1,334)	(405)
Income before income taxes	87,685	66,413	48,399
Provision for income taxes	31,912	23,896	17,891
Net income	$ 55,773	$ 42,517	$ 30,508
Net income per share:			
Basic	$ 2.07	$ 1.91	$ 1.53
Diluted	$ 2.04	$ 1.88	$ 1.48
Weighted average shares outstanding:			
Basic	26,965,000	22,224,000	20,000,000
Diluted	27,342,000	22,629,000	20,609,000

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(dollars in thousands)

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
Balance at January 1, 2002	20,000,000	$ 5	$ —	$ —	$ 64,754	$ —	$ 64,759
Comprehensive income:							
Net income	—	—	—	—	30,508	—	30,508
Balance at December 31, 2002	20,000,000	5	—	—	95,262	—	95,267
Comprehensive income:							
Net income	—	—	—	—	42,517	—	42,517
Other comprehensive income, net of tax:							
Change in unrealized gain on investments	—	—	—	54	—	—	54
Total comprehensive income	—	—	—	54	42,517	—	42,571
Purchase of treasury stock	(1,201,174)	—	—	—	—	(20,390)	(20,390)
Issuance of shares	7,590,000	21	119,562	—	—	—	119,583
Repurchase and retirement of shares	(1,120,571)	(1)	(19,609)	—	—	—	(19,610)
Reclassification of accrued stock compensation expense to additional in paid-in capital	—	—	2,415	—	—	—	2,415
Stock options exercised and employee stock purchases	105,530	—	1,264	—	—	—	1,264
Tax benefit for exercise of employee stock options	—	—	222	—	—	—	222
Balance at December 31, 2003	25,373,785	25	103,854	54	137,779	(20,390)	221,322
Comprehensive income:							
Net income	—	—	—	—	55,773	—	55,773
Other comprehensive income (loss), net of tax:							
Change in unrealized gain (loss) on investments	—	—	—	(288)	—	—	(288)
Total comprehensive income	—	—	—	(288)	55,773	—	55,485
Issuance of shares	1,800,000	2	47,280	—	—	—	47,282
Stock options exercised, employee stock grants and employee stock purchases	428,658	1	2,678	—	—	—	2,679
Tax benefit for exercise of employee stock options	—	—	3,854	—	—	—	3,854
Balance at December 31, 2004	27,602,443	$ 28	$ 157,666	$ (234)	$ 193,552	$ (20,390)	$ 330,622

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

	Year ended December 31		
	2004	2003	2002
Operating activities			
Net income	$ 55,773	$ 42,517	$ 30,508
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	8,869	6,333	4,112
Amortization of capitalized credit facility fee	628	525	—
Deferred income taxes	2,175	(101)	(1,332)
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	3,854	222	—
Loss on disposal of property and equipment	—	—	38
Stock-based compensation	179	1,236	860
Changes in operating assets and liabilities, net of effects of acquisitions:			
Receivables	(3,641)	(24,098)	(8,513)
Prepaid and other current assets	(2,049)	1,057	(2,838)
Medical claims and benefits payable	23,121	14,729	26,711
Deferred revenue	(687)	—	—
Accounts payable and accrued liabilities	5,196	(655)	1,171
Income taxes payable and receivable	(2,369)	3,786	(4,991)
Net cash provided by operating activities	91,049	45,551	45,726
Investing activities			
Purchase of equipment	(10,765)	(8,352)	(6,206)
Purchases of investments	(440,208)	(196,762)	—
Sales and maturities of investments	450,039	98,027	—
Increase in restricted cash	(1,062)	—	—
Other long-term liabilities	644	1,137	234
Advances to related parties and other assets	3,099	(3,727)	97
Cash paid in purchase transactions, net of cash acquired and received in divestiture transaction	(51,766)	(8,934)	(3,250)
Net cash used in investing activities	(50,019)	(118,611)	(9,125)
Financing activities			
Issuance of common stock	47,282	119,583	—
Payment of credit facility fees	—	(1,887)	—
Borrowings under credit facility	—	8,500	—
Repayments of debt acquired in acquisition	(5,819)	—	—
Repayments of amounts borrowed under credit facility	—	(8,500)	—
Issuance (repayment) of mortgage note	1,302	(3,350)	—
Principal payments on note payable	—	—	(51)
Principal payments on capital lease obligations	(74)	—	—
Purchase and retirement of common stock	—	(19,610)	—
Proceeds from employee stock grants, exercise of stock options and employee stock purchases	2,500	1,264	—
Purchase of treasury stock	—	(20,390)	—
Net cash provided by (used in) financing activities	45,191	75,610	(51)
Net increase in cash and cash equivalents	86,221	2,550	36,550
Cash and cash equivalents at beginning of year	141,850	139,300	102,750
Cash and cash equivalents at end of year	$ 228,071	$ 141,850	$139,300
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 25,385	$ 19,989	$ 24,215
Interest	$ 416	$ 631	$ 352
Schedule of non-cash investing and financing activities:			
Reclassification of accrued stock compensation expense to additional paid-in capital	$ —	$ 2,415	$ —
Change in unrealized gain (loss) on investments	$ (461)	$ 87	—
Deferred income taxes	173	(33)	—
Net unrealized gain (loss) on investments	$ (288)	$ 54	$ —
Details of acquisitions:			
Fair value of assets acquired, net of assets sold	$ 165,651	$ 8,934	$ 3,250
Less cash acquired in purchase and divestiture transaction	(56,770)	—	—
Liabilities assumed in purchase and divestiture transaction	(57,115)	—	—
Cash paid in purchase transactions, net of cash acquired and cash received in divestiture transaction	$ 51,766	$ 8,934	$ 3,250

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(dollars in thousands, except per share data)
December 31, 2004

1. The Reporting Entity

Molina Healthcare, Inc. 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), Utah (Utah HMO), Washington (Washington HMO), Michigan (Michigan HMO) and New Mexico (New Mexico HMO). On July 31, 2003, the California HMO transferred ownership of the Michigan HMO to us by dividend, causing the Michigan HMO to become our direct, wholly-owned subsidiary. Another subsidiary, Molina Healthcare of Indiana, Inc. (Indiana HMO) was licensed as an HMO on December 15, 2004 but had not yet begun operation as of December 31, 2004. We have established subsidiaries in other states where we are exploring the possibility of obtaining an HMO license.

The consolidated financial statements and notes give effect to a 40-for-1 stock split of our outstanding common stock and re-capitalization as a result of the share exchange in the re-incorporation merger which occurred on June 26, 2003 (see Note 11—Restatement of Capital Accounts).

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority-owned subsidiaries. All significant inter-company transactions and balances have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include determination of allowances for uncollectible accounts, settlements under risks/savings sharing programs, impairment of long-lived and intangible assets, medical claims and accruals, professional and general liability claims, reserves for potential absorption of claims unpaid by insolvent providers, reserves for the outcome of litigation and valuation allowances for deferred tax assets.

Premium Revenue

Premium revenue is primarily derived from Medi-Cal/Medicaid programs and other programs for low-income individuals. Premium revenue includes per member per month fees received for providing medical services, fee for service reimbursement for delivery of newborns on a per case basis (birth income) and (in Utah) reimbursement of health care expenditures plus an administrative fee. Prepaid health care premiums are reported as revenue in the month in which enrollees are entitled to receive health care. A portion of the premiums is subject to possible retroactive adjustments which have not been significant, although there can be no certainty

that such adjustments will not be significant in the future. Birth income is recorded during the month when services are rendered and accounted for 7% or less of total premium revenue during each of the three years in the period ended December 31, 2004.

Effective July 1, 2002, the state of Utah ceased paying us on a per member per month (risk) basis and entered into an agreement with us that 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 health plan bills the state of Utah monthly for actual paid health care claims plus administrative fees.

Other Operating Revenue

Other operating revenue for the year ended December 31, 2004 includes $2,100 recorded for estimated savings sharing income recognized by our Utah HMO during 2004. The estimated savings sharing is based upon claims experience for the period of July 1, 2003 through December 31, 2004 (see Receivables). Other operating revenue for the year ended December 31, 2003 includes $734 of savings sharing income earned by our Michigan HMO. Our Michigan HMO's contract with the state no longer contains risk sharing provisions.

Medical Care Costs

We arrange to provide comprehensive medical care to our members through our clinics and a network of contracted hospitals, physician groups and other health care providers. Medical care costs represent cost of health care services, such as physician salaries at our clinics and fees to contracted providers under capitation and fee-for-service arrangements.

Under capitation contracts, we pay a fixed per member per month payment to the provider without regard to the frequency, extent or nature of the medical services actually furnished. Under capitated contracts we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management and other criteria. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided at discounted payment rates. Expenses related to both capitation and fee for service programs are recorded in the period in which the related services are dispensed or the member is entitled to service.

Medical claims and benefits payable include claims reported as of the balance sheet date and estimated costs of claims for services that have been rendered as of the balance sheet date but have not yet been reported to us. Such estimates are developed using actuarial methods and are based on many variables, including utilization of health care services, historical payment patterns, cost trends, product mix, seasonality, changes in membership and other factors. We include loss adjustment expenses in the recorded claims liability. We continually review and update the estimation methods and the resulting reserves. 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 not come to light until a substantial period of time has passed following the contract implementation, leading to potential misstatement of some costs in the period in which they are first recorded. Any adjustments to reserves are reflected in current operations.

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material as the cost is not significant and the likelihood that coverage will be applicable is low.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The following table shows the components of the change in medical claims and benefits payable for each of the following periods:

	Year ended December 31		
	2004	2003	2002
Balances as of January 1	$105,540	$ 90,811	$ 64,100
Components of medical care costs related to:			
Current year	990,007	672,881	534,349
Prior years	(5,321)	(14,960)	(4,331)
Total medical care costs	984,686	657,921	530,018
Payments for medical care costs related to:			
Current year	839,663	572,845	452,712
Prior years	90,353	70,347	50,595
Total paid	930,016	643,192	503,307
Balances as of December 31	$160,210	$105,540	$ 90,811

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was required as of December 31, 2004 or 2003.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Investments

We account for our investments in marketable securities in accordance with Statement of Financial Accounting Standards (SFAS) No. 115, *Accounting for Certain Investments in Debt and Equity Securities.* Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method. Fair values of securities are based on quoted prices in active markets.

Except for restricted investments, marketable securities are designated as available-for-sale and are carried at fair value. Unrealized gains or losses, if any, net of applicable income taxes, are recorded in stockholders' equity as other comprehensive income. Since these securities may be readily liquidated, they are classified as current assets without regard to the securities' contractual maturity dates.

Our investments consisted of the following:

	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
	December 31, 2004			
U.S. Treasury and agency securities	$ 49,681	$ 10	$ 368	$ 49,323
Municipal securities	10,201	475	5	10,671
Corporate bonds	29,022	9	495	28,536
Total investment securities	$ 88,904	$ 494	$ 868	$ 88,530
	December 31, 2003			
U.S. Treasury and agency securities	$ 35,989	$ 58	$ 11	$ 36,036
Municipal securities	47,948	26	1	47,973
Corporate bonds	14,798	16	1	14,813
Total investment securities	$ 98,735	$ 100	$ 13	$ 98,822

The contractual maturities of our investments as of December 31, 2004 are summarized below.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 32,570	$ 32,561
Due one year through five years	49,102	48,829
Due after one year through five years	7,232	7,140
Total debt securities	$ 88,904	$ 88,530

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Net losses on the sale of available-for-sale securities in 2004 were $19. In 2003, net gains on sales of available-for -sale securities were $1.

Unrealized losses at December 31, 2004 and 2003 have been determined to be temporary in nature. The decline in market value for these securities is the result of rising interest rates rather than a deterioration of the

credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be immaterial. Also, the disclosures required under EITF 03-1, "The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments," have not been included because our unrealized losses are immaterial at December 31, 2004.

In September, 2004, the FASB issued FASB Staff Position, or FSP, Emerging Issues Task Force, or EITF, Issue 03-1-1 Effective Date of Paragraphs 10-20 of EITF Issue No. 03-01, *The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments*, which delayed the effective date for paragraphs 10-20 of EITF Issue No. 03-01. Paragraphs 10-20 provide guidance for assessing impairment losses on debt and equity investments. The delay does not suspend the requirement to recognize other-than-temporary impairments as required by existing literature. In addition, the FASB staff issued a proposed FSP EITF Issue No. 03-1-a, Implementation Guidance for the Application of Paragraph 16 of EITF Issue No. 03-01, *The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments*. The proposed FSP would provide implementation guidance with respect to debt securities that are impaired solely due to interest rates and/or sector spreads and analyzed for other-than-temporary impairment under EITF Issue No. 03-01. The delay of the effective date for paragraphs 10-20 of EITF 03-01 will be superceded with the final issuance of EITF Issue No. 03-1-a. We will evaluate the effect, if any, of the EITF Issue No. 03-1-a when final guidance is released.

Receivables

Receivables consist primarily of amounts due from the various states in which we operate. All receivables are subject to potential retroactive adjustment by the various states in which we operate. As the amounts of all receivables are readily determinable and our creditors are state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable by operating subsidiary are comprised of the following:

	December 31,	
	2004	2003
California HMO	$23,304	$22,082
Utah HMO	29,292	26,465
Washington HMO	6,669	2,997
Other HMOs	6,165	2,145
Total receivables	$65,430	$53,689

Substantially all receivables due our California HMO at December 31, 2004 and 2003 were collected in January of 2005 and 2004, respectively.

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 health plan 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 (Other Operating Revenue); 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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Restricted Investments

Pursuant to the regulations governing our subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities as follows:

	December 31	
	2004	2003
California	$ 300	$ 300
Utah	550	550
Michigan	1,000	1,000
New Mexico	7,847	—
Indiana	500	—
Washington	150	150
Other	500	—
Total	$10,847	$2,000

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost. The use of these funds is limited to specific purposes as required by each state.

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Leasehold improvements are amortized over the term of the lease or five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years.

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights) are amortized on a straight-line basis over the expected period to be benefited. Effective January 1, 2002, we ceased amortization of goodwill in accordance with the provisions of SFAS No. 142, *Goodwill and Other Intangible Assets*. Prior to that date, we amortized goodwill over periods not exceeding 15 years. We performed the required impairment tests of goodwill and indefinite lived intangible assets in 2004, 2003 and 2002 and no impairment was identified in these periods.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the present value of the expected cash flows associated with that asset. In such circumstances the asset is said to be impaired. We review material long-lived assets for impairment on an annual basis, as well as when events or changes in business conditions suggest potential impairment. Impaired assets are written down to fair value. We have determined that no long-lived assets are impaired at December 31, 2004 and 2003.

Income Taxes

We account for income taxes based on SFAS No. 109, *Accounting for Income Taxes*. SFAS No. 109 is an asset and liability approach that requires the recognition of deferred tax assets and liabilities for the expected

future tax consequences of events that have been recognized in our financial statements or tax returns. Measurement of the deferred items is based on enacted tax laws. Valuation allowances are established, when necessary, to reduce future income tax assets to the amount expected to be realized.

Taxes Based on Premiums

Our Washington, Michigan and New Mexico (beginning July 1, 2004) HMOs are assessed a tax based upon premium revenue collected. Our Consolidated Statements of Income do not include New Mexico premium taxes prior to July 1, 2004 (the effective date of New Mexico HMO acquisition). Premium tax expense totaled $24,333 $9,194 and $4,997 in 2004, 2003, and 2002, respectively, and is included in salary, general and administrative expenses.

Professional Liability Insurance

We carry medical malpractice insurance for health care services rendered through our clinics in California. Through December 31, 2003, claims-made coverage under this insurance was $5,000 per occurrence with an annual aggregate limit of $10,000. Subsequent to December 31, 2003, claims-made coverage under this insurance is $1,000 per occurrence with an annual aggregate limit of $3,000. We also carry claims-made managed care professional liability insurance for our HMO operations. This insurance is subject to a coverage limit of $5,000 per occurrence and in aggregate for each policy year.

Stock-Based Compensation

At December 31, 2004, we had two stock-based employee compensation plans, which are described more fully in Note 11. We account for the plans 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 and is measured as the excess of the market price of our 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*.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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

	Year ended December 31		
	2004	2003	2002
Net income, as reported	$55,773	$42,517	$30,508
Reconciling items (net of related tax effects):			
Add: Stock-based employee compensation expense determined under the intrinsic-value based method for stock option awards	—	773	542
Reduction in stock option settlements charge (see Note 9)	—	—	4,913
Deduct: Stock-based employee compensation expense determined under the fair-value based method for stock option and employee stock purchase plan awards	(976)	(1,693)	(620)
Net adjustment	(976)	(920)	4,835
Net income, as adjusted	$54,797	$41,597	35,343
Earnings per share:			
Basic—as reported	$ 2.07	$ 1.91	$ 1.53
Basic—as adjusted	$ 2.03	$ 1.87	$ 1.77
Diluted—as reported	$ 2.04	$ 1.88	$ 1.48
Diluted—as adjusted	$ 2.00	$ 1.84	$ 1.72

The following table illustrates the components of our stock-based compensation expense (net of tax) as reported in the Consolidated Statements of Income:

	Year ended December 31		
	2004	2003	2002
Stock options	$—	$773	$542
Stock grants	112	—	—
Total stock-based compensation expense	$112	$773	$542

The recognition and measurement of stock grants is the same under APB Opinion No. 25 and SFAS No. 123. 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, as reported amounts in the pro forma net income table above.

In December 2004, the FASB issued SFAS No. 123R, “Share-Based Payment”. SFAS No. 123R is a revision of SFAS No. 123, “Accounting for Stock Based Compensation”, 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 the cost of employee services received in exchange for awards of equity instruments, based on the grant date fair value of those awards, in the financial statements. The effective date of SFAS 123R is the first reporting period beginning after June 15, 2005, which is third quarter 2005 for calendar year companies, 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 also permits entities to restate financial statements of previous periods based on proforma disclosures made in accordance with SFAS 123.

We currently utilize the Black-Scholes standard option pricing model to measure the fair value of stock options granted to employees. While SFAS 123R permits us to continue to use such a model, the standard also permits the use of a "lattice" model. We have not yet determined which model we will use to measure the fair value of employee stock options upon the adoption of SFAS 123R.

SFAS 123R also requires that the benefits associated with the tax deductions in excess of recognized compensation cost be reported as a financing cash flow, rather than as an operating cash flow as required under current literature. This requirement will reduce net operating cash flows and increase net financing cash flows in periods after the effective date. These future amounts cannot be estimated, because they depend on, among other things, when employees exercise stock options. However, the amounts of operating cash flows recognized in prior periods for such excess tax deductions, as shown in our Consolidated Statement of Cash Flows were $3,854 and $222, for 2004 and 2003, respectively. No such amounts were recognized in 2002.

We currently expect to adopt SFAS 123R effective July 1, 2005; however, we have not yet determined which of the aforementioned adoption methods we will use. Subject to a complete review of the requirements of SFAS 123R, based on stock options granted to employees through December 31, 2004, as well as stock options expected to be granted and shares expected to be issued under our Employee Stock Purchase Plan during 2005, we expect that the adoption of SFAS 123R on July 1, 2005, would reduce both third quarter 2005 and fourth quarter 2005 net earnings by approximately $436 ($0.02 per diluted share) each. See Note 12 for further information on our stock-based compensation plans.

Earnings Per Share

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

	Year ended December 31		
	2004	2003	2002
Shares outstanding at the beginning of the year	25,374,000	20,000,000	20,000,000
Weighted-average number of shares issued	1,591,000	3,806,000	—
Weighted-average number of shares acquired	—	(1,582,000)	—
Denominator for basic earnings per share	26,965,000	22,224,000	20,000,000
Dilutive effect of employee stock options and stock grants (1)	377,000	405,000	609,000
Denominator for diluted earnings per share	27,342,000	22,629,000	20,609,000

(1) All options to purchase common shares were included in the calculation of diluted earnings per share because their exercise prices were at or below the average fair value of the common shares for each of the periods presented.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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. The CADRE Funds are a series of funds managed by the CADRE Institutional Investors Trust (Trust), a Delaware business trust registered as an open-end management investment fund

Our investments (all of which are classified as current assets) and a portion of our cash equivalents are managed by two professional portfolio managers operating under documented investment guidelines. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years.

Restricted investments are invested principally in certificates of deposit and treasury securities.

Concentration of credit risk with respect to receivables is limited as the payors consist principally of state governments.

Fair Value of Financial Instruments

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, notes payable and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization. The carrying value of advances to related parties and all long-term obligations approximates their fair value based on borrowing rates currently available to the company for instruments with similar terms and remaining maturities.

Risks and Uncertainties

Our profitability depends in large part on accurately predicting and effectively managing medical care costs. We continually review our premium and benefit structure so that it reflects our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations or cash flows.

At December 31, 2004 we operated in five states, in some instances as a direct contractor with the state, and in others as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Segment Information

We present segment information externally in the same manner used by management to make operating decisions and assess performance. Each of our subsidiaries arranges for the provision of health care services to

Medicaid and similar members in return for compensation from state agencies. They share similar characteristics in the membership they serve, the nature of services provided and the method by which medical care is rendered. The subsidiaries are also subject to similar regulatory environment and long-term economic prospects. As such, we have one reportable segment.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

3. Acquisitions

New Mexico HMO

On July 1, 2004, we acquired the capital stock of Health Care Horizons, Inc. ("HCH"), which is the parent company of New Mexico-based Cimarron Health Plan, Inc., for approximately $69,000, in addition to the assumption of approximately $5,800 of bank debt. The purchase price also included "Other Purchase Related Costs" consisting of (i) $1,440 in change of control payments to certain members of HCH management based upon executive employment agreements in effect at the HCH purchase date, (ii) $660 of direct transaction costs, and (iii) $660 representing the after-tax proceeds realized by HCH upon the sale of certain warrants to purchase the common stock of an unaffiliated entity. Effective as of August 1, 2004, we changed the name of Cimarron Health Plan, Inc. to Molina Healthcare of New Mexico, Inc. We acquired HCH in order to diversify our operations by expanding into another state.

Cimarron Health Plan served both Medicaid and commercial members. The operation of a commercial HMO is inconsistent with our objective 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. Accordingly, we entered into the negotiations to acquire HCH with the intent of divesting ourselves of the commercial membership upon consummation of the transaction. Our intent was to either transfer the commercial membership to another health plan or to allow each commercial membership contract to lapse upon its next renewal date.

Prior to the closing of the HCH acquisition, we announced a definitive agreement had been reached to transfer the commercial membership acquired in the HCH purchase to Lovelace Sandia Health System, Inc. ("Lovelace"). Effective August 1, 2004, the transfer was completed. We received a total of $17,994 (net of approximately $265 in direct transactions costs) in connection with the transfer. We also entered into a transition services agreement with Lovelace to provide commercial claims processing, customer and provider call handling, and billing and treasury services through the date the commercial contracts are expected to be fully transitioned to Lovelace.

The HCH purchase has been accounted for under the purchase method of accounting. Accordingly, the consideration paid has been allocated to the assets acquired and liabilities assumed based on their estimated fair values. The excess of such consideration paid over the estimated fair value of the assets and liabilities has been allocated to certain identifiable intangible assets (included in the table below) and goodwill. The goodwill has been reduced by the consideration received for the commercial membership assets transferred to Lovelace, and further adjusted for the net cash inflows of the commercial operations for the one-month period ended July 31, 2004, or $260, the estimated cash outflows of the transition services agreement and other actions taken in connection with the termination of the commercial line of business, or $2,900, and a tax liability resulting from a gain on transfer of $5,279.

We established a reserve to record our net liability incurred in regard to the termination of the commercial health plan operations of HCH and Cimarron Health Plan. That reserve was calculated to be $2,900 representing

the estimated cash outflows for the termination of commercial operations and transition services agreement, offset by $260, the net cash inflows of the commercial operations for the one-month period ended July 31, 2004. A summary of activity for this reserve for the period July 1, 2004 follows:

Net liability for termination of commercial operations at July 1, 2004	$ 2,640
Revenue earned on transition services agreement	1,116
Expenses incurred in providing transition services	(2,080)
Net liability for termination of commercial operations at December 31, 2004	$ 1,676

The following is an analysis of goodwill and intangible assets recognized in connection with the HCH transactions:

Purchase price consideration	$ 69,000
Other purchase related costs	2,760
Total purchase consideration	71,760
Less net assets acquired	(18,990)
Less net consideration received for transfer of commercial membership	(17,994)
Add net liability assumed in transition services agreement and one-month of commercial operations, net of tax at 37.5%	1,650
Add back tax liability arising from sale of commercial membership	5,279
Add back goodwill included in net assets acquired	7,321
Acquisition cost in excess of net assets acquired	$ 49,026

Allocation of acquisition cost in excess of net assets acquired (including effect of the Lovelace divestiture transaction) is as follows:

Allocation to identifiable intangible assets		
Contract rights		$ 11,900
Medicaid medical provider network		850
Trade name		2,400
Allocation to other than identifiable intangible assets		
Goodwill before deferred tax adjustment	$33,876	
Less HCH goodwill	(7,321)	
	26,555	
Increase in deferred tax liability due to step up in identifiable intangible assets	4,284	
Increase in non-deductible goodwill		30,839
Adjustment to goodwill and intangible assets (including effect of Divestiture Transaction that reduced acquired goodwill by $11,421)		$ 45,989

Subsequent to the effectiveness of the HCH purchase, we paid approximately $5,800 to retire all of HCH’s outstanding bank debt.

The Medicaid contract rights and the Medicaid medical provider network will be amortized on a straight-line basis over ninety-six months. The trade name will not be amortized as it is an indefinite lived asset and will be subject to an annual impairment test.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

We retained the tangible assets and liabilities associated with the commercial business at August 1, 2004 (consisting of $4,812 of premiums receivable and $9,895 of medical claims payable).

The following summarizes our preliminary estimate of net assets acquired at the date of acquisition (includes effect of the Lovelace divestiture transaction):

Current assets	$ 65,873
Property and equipment	1,507
Goodwill and intangible assets	53,310
Restricted investments	7,785
Current liabilities	(51,447)
Long-term debt	(4,792)
Other long-term liabilities	(476)
	$ 71,760

The unaudited pro forma financial information presented below assumes that the acquisition of HCH had occurred as of the beginning of each respective period. The pro forma information includes the results of operations for HCH for the periods prior to its acquisition, adjusted for the transfer of commercial operations to Lovelace, reduction in investment income assuming cash payment for purchase consideration, amortization of intangible assets with definite useful lives and the related income tax effects. The pro forma financial information is presented for informational purposes only and may not be indicative of the results of operations had HCH been a wholly-owned subsidiary during the years ended December 31, 2004 and 2003, nor is it necessarily indicative of future results of operations.

	Year ended December 31,	
	2004	2003
	(Unaudited)	
Pro forma revenues	$ 1,301,304	$ 1,022,149
Pro forma net income	$ 55,667	$ 38,477
Pro forma earnings per share:		
Basic	$ 2.06	$ 1.73
Diluted	$ 2.04	$ 1.70

Michigan HMO

On October 1, 2004, we transitioned approximately 73,000 members from the Wellness Plan of Michigan into the Michigan HMO. Total consideration paid in connection with the transition of these members was approximately $18,777 (including direct acquisition costs). Of the cost of the acquisition, $4,500 was assigned to identifiable intangible assets (contract rights) to be amortized over sixty months, while $14,277 was recorded as non-deductible goodwill. We transitioned these members into our Michigan HMO to take advantage of the operational efficiencies arising from a larger membership base and to enter new counties in the state, particularly the Detroit Metropolitan area.

Under the terms of an agreement with another health plan, approximately 9,400 members were transferred to the Michigan HMO on August 1, 2003. Effective October 1, 2003, approximately 32,000 members were transferred to the Michigan HMO under the terms of an agreement with yet another health plan. Total costs associated with these two transactions were $8,934. In both instances the entire cost of the transactions was recorded as an identifiable intangible asset (contract rights) and is being amortized over sixty months. We transitioned these members into our Michigan HMO to take advantage of the operational efficiencies arising from a larger membership base.

Washington HMO

Effective June 1, 2004, we completed our acquisition of the Healthy Options (Medicaid) and Basic Health Plan contracts of Premera Blue Cross, adding approximately 56,000 members to the Washington HMO. We paid to Premera $18,000 for both contracts in addition to assuming an estimated $400 in medical related liabilities. Of the $18,400 cost of the acquisition, $12,700 was assigned to identifiable intangible assets (contract rights) to be amortized over seventy-two months, while $5,700 was recorded as non-deductible goodwill. We added theses members into our Washington HMO to take advantage of the operational efficiencies arising from a larger membership base.

On July 1, 2002, the Washington HMO paid $3,250 to another health plan for the assignment of a Medicaid contract. The assigned contract had a remaining term of six months on the acquisition date and was subsequently renewed for an additional one-year period as anticipated by us at the time of acquisition. The assignment was accounted for as a purchase transaction and the purchase price was allocated to an identifiable intangible asset (contract rights) to be amortized over eighteen months. We added theses members into our Washington HMO to take advantage of the operational efficiencies arising from a larger membership base.

California HMO (pending acquisitions)

On November 22, 2004, our California HMO and Sharp Health Plan, or Sharp, entered into a definitive Asset Purchase Agreement to transfer Sharp's Medi-Cal (Medicaid) and Healthy Families Program (SCHIP) contracts to our California HMO. As of March 4, 2005, the proposed transfer had been approved by each of the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. The transaction would add approximately 70,000 members to our California HMO's current membership.

We anticipate paying approximately $25 million for the transfer of these contracts, subject to possible adjustment and an earn-out provision. As part of the transaction, Sharp will assign the bulk of its provider network to our California HMO.

On December 10, 2004, our California HMO, and Universal Care, Inc., a California corporation, entered into a definitive Asset Purchase Agreement to transfer Universal's Medi-Cal and Healthy Families contracts to our California HMO. As of March 4, 2005, the proposed transfer had been approved by each of the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. The transaction would add approximately 17,000 members to our California HMO's current membership.

We anticipate paying approximately $6.2 million for the transfer of these contracts, subject to possible adjustment. As part of the transaction, Universal will assign the bulk of its provider network related to its Medi-Cal and Healthy Families members to our California HMO.

4. Goodwill and Intangible Assets

Under SFAS No. 142, *Goodwill and Other Intangible Assets*, goodwill and indefinite lived assets are no longer amortized, but are subject to impairment tests on an annual basis or more frequently if impairment indicators exist. Under the guidance of SFAS No. 142, we used a discounted cash flow methodology to assess the fair values of our reporting units at December 31, 2004 and 2003. If book equity values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite lived asset balance. Based on the results of our impairment testing, no adjustments were required.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Other intangible assets are being amortized over their useful lives ranging from 5 to 8 years. As part of the implementation SFAS No. 142, we reassessed the remaining useful lives of the other intangible assets. Amortization on intangible assets recognized for the years ending December 31, 2004, 2003, and 2002 was $4,043, and $2,701, and $1,968, respectively. We estimate our intangible asset amortization will be $6,397 in 2005, 2006, and 2007, $5,906 in 2008 and $4,385 in 2009. The following table sets forth balances of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(Amounts in thousands)	
Intangible assets:			
Contract rights	$42,345	$ 8,793	$ 33,552
Provider network	850	53	797
Trade name	2,400	—	2,400
Balance at December 31, 2004	$45,595	$ 8,846	$ 36,749
Intangible assets:			
Contract rights	$13,244	$ 4,801	$ 8,443
Balance at December 31, 2003	$13,244	$ 4,801	$ 8,443

The changes in the carrying amount of goodwill are as follows:

Balance as of January 1 and December 31, 2003	$ 3,841
Goodwill acquired during 2004	58,137
Balance at December 31, 2004	$61,978

5. Property and Equipment

A summary of property and equipment is as follows:

	December 31	
	2004	2003
Land	$ 3,000	$ 3,000
Building and improvements	13,735	10,493
Furniture, equipment and automobiles	17,643	11,469
Capitalized computer software costs	5,868	3,087
	40,246	28,049
Less accumulated depreciation and amortization	(14,420)	(9,669)
Property and equipment, net	$ 25,826	$18,380

Depreciation expense recognized for the years ending December 31, 2004, 2003, and 2002 was $4,826, $3,632, and $2,144, respectively.

6. Related Party Transactions

We lease two medical clinics from the Molina Family Trust. These leases have five five-year renewal options. In May 2001, we entered into a similar agreement with the Molina Siblings Trust for the lease of another medical clinic, which we also use as a backup data center. In December 2004, we purchased this clinic from the

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Molina Siblings Trust for $1,850. Rental expense for these leases totaled $367, $383, and $390 for the years ended December 31, 2004, 2003, and 2002, respectively. At December 31, 2004, minimum future lease payments for the two remaining leased clinics amount to $23 in 2005 and nothing thereafter.

We were a party to Collateral Assignment Split-Dollar Insurance Agreements with the Molina Siblings Trust. We agreed to make premium payments towards the life insurance policies held by the Molina Siblings Trust on the life of Mary R. Molina, a former employee and director and a current shareholder, in exchange for services from Mrs. Molina. We were not an insured under the policies, but were entitled to receive repayment of all premium advances from the Molina Siblings Trust upon the earlier of Mrs. Molina's death or cancellation of the policies. Advances through December 31, 2003 of $3,349 were discounted based on the insured's remaining actuarial life, using discount rates commensurate with instruments of similar terms or risk characteristics (4%). Such receivables were secured by the cash surrender values of the policies. The discounted receivable of $2,188 was included in advances to related parties and other assets.

On March 2, 2004, the Collateral Assignment Split-Dollar Insurance Agreements were terminated when the Molina Siblings Trust repaid to us the advances. Upon such termination, we recognized a pretax gain of $1,161. The gain of $1,161 represented the recovery of the discounts previously recorded and was recorded as Other Income in the Consolidated Statements of Income.

We received technology services from companies owned by non-employee members of the Molina family during 2002. Such services received during the year ended December 31, 2002 totaled $86.

7. Long-Term Debt

We entered into a credit agreement dated as of March 19, 2003, under which a syndicate of lenders provided a $75,000 senior secured credit facility. Interest on any amount outstanding under the facility is payable monthly at a rate per annum of: (a) LIBOR plus a margin ranging from 200 to 250 basis points or (b) the higher of (i) Bank of America prime or (ii) the federal funds rate plus 0.50%, plus a margin ranging from 100 to 150 basis points. All borrowings under the credit facility are due and payable in full by March 20, 2006. The credit facility is secured by substantially all of our parent company's real and personal property and all shares of our Washington HMO subsidiary, our Michigan HMO subsidiary, our New Mexico HMO subsidiary, and our Utah HMO subsidiary.

The terms of the credit agreement contain various covenants that place restrictions on our and/or our subsidiaries' ability to incur debt, pay dividends, create liens, make investments, optionally repay, redeem or repurchase our securities, and enter into mergers, dispositions, and transactions with affiliates. The credit agreement also requires us to meet various financial covenants, including a minimum fixed-charge coverage requirement, a maximum consolidated leverage ratio, a minimum consolidated net worth requirement, a capital expenditure limit, and individual subsidiary risk based capital levels. At December 31, 2004, we were in compliance with all of these covenants.

In April 2003, we paid off a mortgage note incurred in connection with the purchase of our corporate office building with a payment of approximately $3,350. During the first six months of 2003, we borrowed a total of $8,500 under our credit facility. In July 2003 we repaid the entire $8,500 owed on the credit facility with a portion of the proceeds from our initial public offering of common stock (see Note 12. Stock Transactions).

At December 31, 2004 and 2003, no amounts were outstanding under the credit facility.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

In December 2004, we issued a mortgage note in the amount of $1,302 in connection with the purchase of a medical clinic from a related party (see Note 5. Related Party Transactions). The note bears a variable interest rate of LIBOR (six month London Interbank Offered Rates) added to a margin of 2.75% subject to change no more often than monthly; the initial interest rate applicable to the first payment is 5.5%. The terms of the note specify 119 regular equal payments of $7 per month and one irregular last payment. The first payment is due February 1, 2005, with the final payment on January 1, 2015. Principal payment obligations under this mortgage note are:

Year ending December 31	
2005	$ 18
2006	19
2007	20
2008	22
2009	23
Thereafter	1,200
	$1,302

We also lease certain equipment under a capital lease expiring in 2008. Future payments under this obligation are as follows:

Year ending December 31	
2005	$183
2006	183
2007	183
2008	107
Total minimum lease payments	656
Less amount representing interest	64
Present value of minimum lease payments	592
Less current portion	153
Long-term portion	$439

Equipment held under capital lease at December 31, 2004 has a cost of $790 and related accumulated amortization of $277. Amortization of this equipment is included in depreciation expense.

8. Income Taxes

The provision for income taxes is as follows:

	Year ended December 31		
	2004	2003	2002
Current:			
Federal	$28,635	$22,695	$17,387
State	1,102	1,302	1,836
Total current	29,737	23,997	19,223
Deferred:			
Federal	1,822	14	(1,235)
State	353	(115)	(97)
Total deferred	2,175	(101)	(1,332)
Total provision for income taxes	$31,912	$23,896	$17,891

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

A reconciliation of the effective income tax rate to the statutory federal income tax rate is as follows:

	Year ended December 31		
	2004	2003	2002
Taxes on income at statutory federal tax rate	$30,691	$23,245	$16,940
State income taxes, net of federal benefit	946	771	1,130
Other	275	(120)	12
Change in valuation allowance	—	—	(191)
Reported income tax expense	$31,912	$23,896	$17,891

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. Tax assessments related to these audits may not arise until several years after tax returns have been filed. Although predicting the outcome of such tax assessments involves uncertainty, we believe that the recorded tax liabilities appropriately account for our analysis of probable outcomes, including interest and other potential obligations. Our tax liabilities are adjusted in light of changing facts and circumstances, such as the progress of audits, case law and emerging legislation and such adjustments are included in the effective tax rate.

The components of net deferred income tax assets and liabilities are as follows:

	December 31	
	2004	2003
Accrued expenses	$ 1,005	$1,565
Reserve liabilities	1,442	—
State taxes	887	885
Shared risk	—	—
Other, net	647	(8)
Deferred tax asset—current	3,981	2,442
Net operating losses	277	272
Depreciation and amortization	(6,898)	(389)
Deferred compensation	965	1,655
Other accrued medical costs	90	97
Other, net	251	361
Deferred tax (liability) asset—long term	(5,315)	1,996
Net deferred income tax (liabilities) assets	$(1,334)	$4,438

During 2004 and 2003, we pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California Economic Development Tax Credits (Credits). Our tax expense was reduced by approximately $900 and $1,000 for the years ended December 31, 2004 and 2003, respectively, by out-of-year Credits. Consulting fees incurred in connection with the Credits, were recorded as Salary, General and Administrative Expenses.

9. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and clerical employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the

maximum allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $1,387, $1,120, and $1,007 in the years ended December 31, 2004, 2003, and 2002, respectively.

10. Commitments and Contingencies

Leases

We lease office space, clinics, equipment and automobiles, under agreements that expire at various dates through 2012. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases (including related parties) consist of the following approximate amounts:

Year ending December 31	
2005	$ 6,891
2006	6,614
2007	5,908
2008	5,604
2009	4,814
Thereafter	9,990
Total minimum lease payments	$39,821

Rental expense related to these leases totaled $7,416, $5,771, and $4,930 for the years ended December 31, 2004, 2003, and 2002, respectively.

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. Additionally, 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 to disputes with medical providers which may seek additional monetary compensation.

In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital (“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 the California HMO intends 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.

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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Provider Claims

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. Much of the amount claimed by the Department of Health involves issues of contract compliance, interpretation and intent. We are evaluating the Department of Health claims and are unable at this time to 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.

Employment Agreements

Agreements

During 2001 and 2002, we entered into employment agreements with five executives with initial terms of one to three years, subject to automatic one-year extensions thereafter. The agreements currently provide for annual base salaries of $1,955 in the aggregate plus a Target Bonus, as defined. In most cases, should the executive be terminated without cause or resign for good reason before a Change of Control, as defined, we will pay one year's base salaries and Target Bonus for the year of termination, in addition to full vesting of 401(k) employer contributions and stock options, and continued health and welfare benefits for the earlier of 18 months or the date the executive receives substantially similar benefits from another employer. If any of the executives are terminated for cause, no further payments are due under the contracts.

In most cases, if termination occurs within two years following a Change of Control, the employees will receive two times their base salaries and Target Bonus for the year of termination in addition to full vesting of 401(k) employer contributions and stock options and continued health and welfare benefits for the earlier of three years or the date the executive receives substantially similar benefits from another employer.

Executives who receive severance benefits, whether or not in connection with a Change of Control, will also receive all accrued benefits for prior service including a pro rata Target Bonus for the year of termination.

Stock Option Settlements

One of our executives changed responsibilities and entered into a new employment agreement on January 1, 2005. We also amended the executive's stock option grant to immediately vest 30,000 stock options previously granted on February 10, 2004. The benefit to the executive resulting from the remeasurement of the stock option award was $632, representing the award's intrinsic value at the date of modification in excess of the award's original intrinsic value. This amount, or some portion thereof, will only be recognized in the consolidated statement of income if the executive employee leaves our company prior to the completion of the 3-year vesting period under the original agreement.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 640,000 shares of common stock and the related Put Option held by an executive through a cash payment of $7,660. The cash payment was determined based on the negotiated fair value per share in excess of the exercise price of the 640,000 shares as if the options were exercised and the shares repurchased. The cash settlement resulted in a compensation charge of $6,880 in the fourth quarter of 2002.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 95,200 shares of common stock held by another executive through a cash payment of $1,023. The cash payment was determined

based on the negotiated fair value per share in excess of exercise price of the 95,200 shares as if the options were exercised and the shares repurchased. The cash settlement resulted in a 2002 fourth quarter compensation charge of $916.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our HMO subsidiaries operating in California, Washington, Michigan, New Mexico, and Utah. 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 $130,000 at December 31, 2004 and $72,000 at December 31, 2003. 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, Michigan, New Mexico, and Utah have adopted these rules, which may vary from state to state. California has not yet adopted NAIC risk-based capital requirements for HMOs and has not formally given notice of its intention to do so. Such requirements, if adopted by California, may increase the minimum capital required for that state.

As of December 31, 2004, our HMOs had aggregate statutory capital and surplus of approximately $157,800, compared with the required minimum aggregate statutory capital and surplus of approximately $85,900. All of our HMOs were in compliance with the minimum capital requirements. We have the ability and commitment to provide additional capital to each of our HMOs when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

11. Restatement of Capital Accounts

Our stockholders voted on July 31, 2002, to approve a re-incorporation merger whereby our company merged with and reincorporated into a newly formed Delaware corporation as the surviving corporation. The re-incorporation merger took effect on June 26, 2003, and these financial statements reflect the effect of a 40-for-1 split of our outstanding common stock as a result of the share exchange in the re-incorporation merger.

Our Certificate of Incorporation provides for 80,000,000 shares of authorized common stock, par value $0.001 and 20,000,000 shares of authorized preferred stock, par value $0.001. Our board of directors may designate the rights, preferences, and privileges of each series of preferred stock at a future date. Such rights, preferences, and privileges may include dividend and liquidation preferences and redemption and voting rights.

12. Stock Plans

In 2002, we adopted the 2002 Equity Incentive Plan (2002 Plan), which provides for the granting of stock options, restricted stock, performance shares, and stock bonus awards to the company’s officers, employees, directors, consultants, advisors, and other service providers. The 2002 Plan was effective upon the effectiveness of our initial public offering of common stock in July of 2003. The 2002 Plan originally allowed for the issuance of 1,600,000 shares of common stock, of which up to 600,000 shares may be issued as restricted stock. Beginning January 1, 2004, and each year thereafter, shares eligible for issuance will automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors provides for a smaller increase. Awards were first made under the 2002 Plan during 2004. During the year ended December 31, 2004, we issued options to purchase 302,200 shares (of which 5,100 were subsequently

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

forfeited) at an estimated fair value of $3,960. Also during the year ended December 31, 2004, we awarded stock grants for 51,000 shares with a fair value at the date of grant of $1,908, recognizing $179 in compensation expense.

Through July 2, 2003, we made periodic grants of stock options to key employees and non-employee directors under the 2000 Omnibus Stock and Incentive Plan (the 2000 Plan) and prior grants. Pursuant to the 2000 Plan, we were able to grant qualified and non-qualified options for common stock, stock appreciation rights, restricted and unrestricted stock and performance units (collectively, the awards) to officers and key employees based on performance. The 2000 Plan limited the number of shares that could be granted in one year to 10% of the outstanding common shares at the inception of the year. Exercise price, vesting periods and option terms were determined by the board of directors. During the year ended December 31, 2003, we issued options to purchase 70,000 shares of our common stock with an estimated fair value of $374. All such options were issued prior to July 2, 2003. All options granted through July 2, 2003 vested upon the completion of our initial public offering of common stock in July of 2003. No options were issued during the year ended December 31, 2002. Further grants under the 2000 Plan have been frozen.

In July 2002, we adopted the 2002 Employee Stock Purchase Plan (Purchase Plan) which provides for the issuance of up to 600,000 common shares. The Purchase Plan was effective upon the effectiveness of our initial public offering of common stock in July of 2003. Beginning January 1, 2004, and each year thereafter, shares eligible for issuance will automatically increase by the lesser of 6,000 shares or 1% of total outstanding capital stock on a fully diluted basis. During each six-month offering period, eligible employees may purchase common shares at 85% of their fair market value through payroll deductions. Each eligible employee is limited to a maximum purchase of $25 (as measured by the fair value of the stock acquired) per year. During the year ended December 31, 2004, 37,050 shares were issued pursuant to the Purchase Plan. During the year ended December 31, 2003, 80,130 shares were issued pursuant to the Purchase Plan.

For the year ended December 31, 2004, we made stocks grants comprising 51,000 shares of common stock as employee compensation. Restrictions on these shares will expire and related charges are being amortized as earned over the vesting period of up to three years. We issued 390,608 and 25,400 common shares during the years ended December 31, 2004 and 2003, respectively, pursuant to the exercise of stock options. No common shares were issued pursuant to the exercise of stock options during 2002.

Through July 2, 2003, 632,840 of outstanding options were granted with exercise prices below fair value. Upon the effectiveness of our initial public offering of common stock in July 2003, all outstanding options vested immediately and all deferred stock-based compensation was expensed immediately. Additionally, the liability for stock-based compensation expense was reclassified to paid-in-capital. Compensation expense recognized in the consolidated statements of income in connection with these options was $1,236 and $860 for the years ended December 31, 2003 and 2002, respectively.

Pro forma information regarding net income (loss) and earnings (loss) per share, as presented in Note 2, “Significant Accounting Policies,” is required by SFAS No. 123, as amended by SFAS No. 148, and has been determined as if we had accounted for our employee stock options under the fair value method of that Statement upon its initial effective date. The fair value for these options was estimated at the date of grant using a minimum value option-pricing model for grants made prior to our initial public offering in July 2003 and a Black-Scholes option-pricing model for grants made subsequent to our initial public offering with the following weighted-average assumptions: a risk-free interest rate of 4.15% in 2004 and 3.78% in 2003; expected stock process volatility of 51.2% in 2004 (volatility is not applicable in 2003 as no grants were made that were subject to the Black-Scholes option-pricing model); dividend yield of 0% and expected option lives of 60 months. Assumptions for 2002 were not provided since no options were granted.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The Minimum Value option-pricing model used prior to the effectiveness of our initial public offering was developed for use in estimating the fair value of traded options and warrants which have no vesting restrictions and are fully transferable. In addition, option valuation models require the input of highly-subjective assumptions, including the expected stock price volatility. Because our employee stock options have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

Stock option activity and related information is as follows:

	Year ended December 31					
	2004		2003		2002	
	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
Outstanding at beginning of year	797,200	$ 4.77	758,360	$ 3.57	1,498,600	$ 2.28
Granted	302,200	26.80	70,000	16.98	—	—
Exercised	390,608	4.00	25,400	2.83	—	—
Forfeited(a)	14,340	11.91	5,760	4.50	740,240	1.11
Outstanding at end of year	694,452	14.64	797,200	4.77	758,360	3.57
Exercisable at end of year	417,352	6.59	797,200	4.77	416,680	2.87
Weighted average per option fair value of options granted during the year		13.10		5.35		—

(a) Includes options to purchase 735,200 shares which were canceled in 2002 in exchange for payments of $8,683 to the option holders (see Note 9—Commitments and Contingencies).

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31 2004	Weighted Average Remaining Contractual Life (Number of Months)	Weighted Average Exercise Price	Number Exercisable at December 31 2004	Weighted Average Exercise Price
$2.00 – 4.50	333,352	70	$ 3.33	333,352	$ 3.33
16.98 – 29.17	328,100	107	23.71	80,000	18.65
37.47 – 48.38	33,000	116	38.67	4,000	37.47
2.00 – 48.38	694,452	90	14.64	417,352	6.59

13. Stock Transactions

Stock Repurchases

In January and February 2003, we redeemed 1,201,174 shares of common stock from certain stockholders for cash payments of $20,390 ($16.98 per share). The redeemed shares were recorded as treasury stock. The redemptions were made from available cash reserves.

In July 2003, we repurchased a total of 1,120,571 shares of common stock from two stockholders for $17.50 per share or an aggregate purchase price of $19,610. We purchased 912,806 of these shares from the MRM GRAT 301/2 and 207,765 shares from the Mary R. Molina Living Trust. All of these shares were subsequently retired.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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 the underwriters' discount.

In July 2003, we completed an initial public offering of our common stock. We sold 7,590,000 shares, generating net proceeds of approximately $119,600 after deducting approximately $3,900 in fees, costs and expenses and $9,300 in underwriters' discount.

14. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2004 and 2003.

	For the quarter ended			
	March 31, 2004	June 30, 2004	September 30, 2004	December 31, 2004
Premium and other operating revenue	$219,163	$248,146	$ 329,727	$ 374,002
Operating income	16,752	19,434	25,089	26,288
Income before income taxes	17,659	19,157	24,810	26,059
Net income	11,098	11,950	16,439	16,286
Net income per share:				
Basic	$ 0.44	$ 0.44	$ 0.60	$ 0.59
Diluted	$ 0.43	$ 0.43	$ 0.59	$ 0.58

	For the quarter ended			
	March 31, 2003	June 30, 2003	September 30, 2003	December 31, 2003
Premium and other operating revenue	$191,768	$194,660	$ 197,053	$ 208,302
Operating income	13,349	17,594	17,593	19,211
Income before income taxes	13,275	16,990	17,227	18,921
Net income	7,980	10,947	11,724	11,866
Net income per share:				
Basic	$ 0.41	$ 0.58	$ 0.46	$ 0.47
Diluted	$ 0.40	$ 0.57	$ 0.46	$ 0.46

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

15. Condensed Financial Information of Registrant

Following are the condensed balance sheets of the Registrant as of December 31, 2004 and 2003, and the statements of income and cash flows for each of the three years in the period ended December 31, 2004.

Condensed Balance Sheets

	December 31	
	2004	2003
Assets		
Current assets:		
Cash and cash equivalents	$ 4,250	$ 11,868
Investments	50,143	84,733
Deferred income taxes	617	414
Due from affiliates	7,794	9,506
Income tax receivable	160	—
Prepaid and other current assets	5,806	3,714
Total current assets	68,770	110,235
Property and equipment, net	15,441	9,693
Investment in subsidiaries	252,737	101,841
Deferred income taxes	—	325
Advances to related parties and other assets	3,661	5,977
Total assets	$340,609	$228,071
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 4,758	$ 3,146
Current maturities of long-term debt	18	—
Income taxes payable	—	1,565
Total current liabilities	4,776	4,711
Deferred income taxes, long-term	952	—
Long-term debt, less current maturities	1,284	—
Other long-term liabilities	2,975	2,038
Total liabilities	9,987	6,749
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: - 27,602,443 shares at December 31, 2004 and 25,373,785 shares at December 31, 2003	28	25
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	157,666	103,854
Accumulated other comprehensive income, net of tax	(234)	54
Retained earnings	193,552	137,779
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	330,622	221,322
Total liabilities and stockholders' equity	$340,609	$228,071

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Condensed Statements of Income

	Year ended December 31,		
	2004	2003	2002
Revenue:			
Management fees	$52,039	$41,685	$42,553
Other operating revenue	134	—	—
Investment income	1,753	788	179
Total revenue	53,926	42,473	42,732
Expenses:			
Medical care costs	12,063	9,124	7,034
Salary, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	32,569	24,538	29,834
Depreciation and amortization	3,681	2,669	1,095
Total expenses	48,313	36,331	37,963
Operating income	5,613	6,142	4,769
Other income (expense):			
Interest expense	(1,013)	(1,110)	(140)
Other, net	544	—	88
Total other expense	(469)	(1,110)	(52)
Income before income taxes and equity in net income of subsidiaries	5,144	5,032	4,717
Provision for income taxes	931	1,542	2,001
Net income before equity in net income of subsidiaries	4,213	3,490	2,716
Equity in net income of subsidiaries	51,560	39,027	27,792
Net income	$55,773	$42,517	$30,508

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Condensed Statements of Cash Flows

	Year ended December 31		
	2004	2003	2002
Operating activities			
Cash provided by operating activities	$ 11,492	$ 5,609	$ 2,969
Investing activities			
Net dividends from and capital contributions to subsidiaries	(21,694)	2,743	26,350
Purchases of investments	(383,246)	(182,673)	—
Sales and maturities of investments	417,681	98,027	—
Cash paid in purchase transactions	(76,403)	—	—
Purchases of equipment	(9,429)	(7,182)	(4,024)
Changes in amounts due to and due from affiliates	272	(9,249)	(1,584)
Change in other assets and liabilities	2,625	(1,964)	572
Net cash provided by (used in) investing activities	(70,194)	(100,298)	21,314
Financing activities			
Issuance of common stock	47,282	119,583	—
Issuance of mortgage note	1,302	—	—
Payment of credit facility fees	—	(1,887)	—
Borrowings under credit facility	—	8,500	—
Repayments under facility	—	(8,500)	—
Purchase and retirement of common stock	—	(19,610)	—
Proceeds from exercise of stock options and employee stock purchases	2,500	1,264	—
Cash dividends declared	—	(20,390)	—
Net cash provided by financing activities	51,084	78,960	—
Net (decrease) increase in cash and cash equivalents	(7,618)	(15,729)	24,283
Cash and cash equivalents at beginning of year	11,868	27,597	3,314
Cash and cash equivalents at end of year	$ 4,250	$ 11,868	$27,597

Notes to Condensed Financial Information of Registrant

Note A—Basis of Presentation

Molina Healthcare, Inc. (Registrant) was incorporated on May 26, 1999. Prior to that date, Molina Healthcare of California (formerly Molina Medical Centers, Inc.) operated as a California HMO and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In 2000, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The Registrant's share of net income (loss) of its unconsolidated subsidiaries is included in consolidated net income using the equity method.

The parent company-only financial statements should be read in conjunction with the consolidated financial statements and accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Note B—Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2004, 2003, and 2002 for these services totaled $52,039, $41,685, and $42,553, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. NOL benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C—Capital Contribution and Dividends

During 2004, 2003, and 2002, the Registrant received dividends from its subsidiaries totaling $4,850, $12,200, and $31,000, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2004, 2003, and 2002, the Registrant made capital contributions to certain subsidiaries totaling $26,544, $9,457, and $4,650 respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D—Related Party Transactions

The Registrant was a party to Collateral Assignment Split-Dollar Insurance Agreements with the Molina Siblings Trust (Trust). The Registrant and a subsidiary agreed to make premium payments towards the life insurance policies held by the Trust on the life of Mary R. Molina, a former employee and director and a current shareholder, in exchange for services from Mrs. Molina. The Registrant and its subsidiary were not an insured under the policies, but were entitled to receive repayment of all premium advances from the Trust upon the earlier of Mrs. Molina's death or cancellation of the policies.

On March 2, 2004, the Collateral Assignment Split-Dollar Insurance Agreements were terminated by the early repayment of the advances to the Trust. Upon such termination, the Registrant and its subsidiary recognized a combined pretax gain of $1,161, of which $551 was recognized by the Registrant. The gain of $551 represented the recovery of the discounts previously recorded and was recorded as Other Income in the Condensed Statements of Income of the Registrant.

In December 2004 we issued a mortgage note in the amount of $1,302 in connection with the purchase of a medical clinic from a related party, the Molina Siblings Trust. This facility also serves as our backup data center. Total purchase price for the facility was $1,850.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) under the Securities Exchange Act of 1934. Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "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")). Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submits 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.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting during the three months ended December 31, 2004 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting: Our management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) under the Securities Exchange Act of 1934. Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. Our management assessed the effectiveness of our internal control over financial reporting as of December 31, 2004. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control—Integrated Framework.*

Our management's evaluation did not include an assessment of the effectiveness of internal control over financial reporting at Health Care Horizons, Inc., which was acquired on July 1, 2004. The assets and net assets of Health Care Horizons, Inc, at December 31, 2004 were approximately $126.5 million and $81.2 million, respectively. Total revenue and net income of Health Care Horizons, Inc. included in our consolidated results of operations for the year ended December 31, 2004 were approximately $129.1 million and $3.4 million respectively. Our management has not had sufficient time to make an assessment of this subsidiary's internal control over financial reporting.

Based on our assessment, we believe that, as of December 31, 2004, the company's internal control over financial reporting is effective based on the COSO criteria.

Management's assessment of the effectiveness of internal control over financial reporting as of December 31, 2004, has been audited by Ernst & Young LLP; the independent registered public accounting firm who also audited the company's consolidated financial statements. Ernst & Young LLP's attestation report on management's assessment of the company's internal control over financial reporting appears on the page immediately following.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM OVER FINANCIAL REPORTING

The Board of Directors and Stockholders
Molina Healthcare, Inc.

We have audited management's assessment, included in the accompanying Management's Report on Internal Control over Financial Reporting that Molina Healthcare, Inc. and subsidiaries (the company) maintained effective internal control over financial reporting as of December 31, 2004, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management's assessment and an opinion on the effectiveness of the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, evaluating management's assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed 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. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Health Care Horizons, Inc. (acquired on July 1, 2004), which is included in the 2004 consolidated financial statements of Molina Healthcare, Inc. and constituted $126.5 million and $81.2 million of total and net assets, respectively, as of December 31, 2004 and $129.1 million and $3.4 million of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of the company also did not include an evaluation of the internal control over financial reporting of Health Care Horizons, Inc.

In our opinion, management's assessment that the company maintained effective internal control over financial reporting as of December 31, 2004, is fairly stated, in all material respects, based on the COSO criteria. Also, in our opinion, the company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2004, based on the COSO criteria**.**

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. and subsidiaries as of December 31, 2004 and 2003, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2004 of Molina Healthcare, Inc. and our report dated February 25, 2005 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 25, 2005

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors and Executive Officers of the Company***

The information required by this Item with respect to our executive officers is set forth in Part I of this report. The other information required under this Item is incorporated by reference from our definitive proxy statement for the 2005 Annual Meeting of Stockholders under the captions “Election of Directors,” “The Board of Directors and its Committees” and “Section 16(a) Beneficial Ownership Reporting Compliance.”

We have adopted a code of ethics that applies to our chief executive officer, chief financial officer and controller. The code of ethics is posted on our website at *www.molinahealthcare.com*. Any amendments to, or waivers of, this code of ethics will be disclosed on our website promptly following the date of such amendment or waiver.

Item 11. ***Executive Compensation***

The information required under this Item is incorporated by reference from our definitive proxy statement for the 2005 Annual Meeting of Stockholders under the caption “Executive Compensation.”

Item 12. ***Security Ownership of Certain Beneficial Owners and Management***

The information required under this Item is incorporated by reference from our definitive proxy statement for the 2005 Annual Meeting of Stockholders under the caption “Security Ownership of Certain Beneficial Owners and Management.”

Item 13. ***Certain Relationships and Related Transactions***

The information required under this Item is incorporated by reference from our definitive proxy statement for the 2005 Annual Meeting of Stockholders under the captions “Related Party Transactions” and “Compensation Committee Interlocks and Insider Participation.”

Item 14. ***Principal Accounting Fees and Services***

The information required under this Item is incorporated by reference from our definitive proxy statement for the 2005 Annual Meeting of Stockholders under the caption “Disclosure of Auditor Fees.”

PART IV

Item 15. ***Exhibits, Financial Statement Schedules***

(a) The consolidated financial statements, financial statement schedule and exhibits listed below are filed as part of this report.

(1) The company's consolidated financial statements, the notes thereto and the report of the Registered Public Accounting Firm are on pages 38 through 71 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm
Consolidated Balance Sheets—At December 31, 2004 and 2003
Consolidated Statements of Operations—Years ended December 31, 2004, 2003, and 2002
Consolidated Statements of Shareholders' Equity—Years ended December 31, 2004, 2003, and 2002
Consolidated Statements of Cash Flows—Years ended December 31, 2004, 2003, and 2002
Notes to Consolidated Financial Statements

(2) Exhibits

Referenceis made to the Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 8th day of March, 2005.

MOLINA HEALTHCARE, INC.

By: /s/ JOSEPH M. MOLINA, M.D

Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ JOSEPH M. MOLINA, M.D **Joseph M. Molina, M.D.**	Director, Chairman of the Board, Chief Executive Officer and President (Principal Executive Officer)	March 8, 2005
/s/ JOHN C. MOLINA, J.D. **John C. Molina, J.D.**	Director, Executive Vice President, Financial Affairs, Chief Financial Officer and Treasurer (Principal Financial Officer)	March 8, 2005
/s/ JOSEPH W. WHITE, CPA **Joseph W. White, CPA**	Vice President, Accounting (Principal Accounting Officer)	March 8, 2005
/s/ GEORGE S. GOLDSTEIN, PH.D. **George S. Goldstein, Ph.D.**	Director Executive Vice President, Public Policy	March 8, 2005
/s/ CHARLES Z. FEDAK, CPA **Charles Z. Fedak, CPA**	Director	March 8, 2005
/s/ SALLY K. RICHARDSON **Sally K. Richardson**	Director	March 8, 2005
/s/ RONNA ROMNEY **Ronna Romney**	Director	March 8, 2005
/s/ FRANK E. MURRAY, M.D. **Frank E. Murray, M.D.**	Director	March 8, 2005

INDEX TO EXHIBITS

Exhibit Number	Description of Exhibit
3.1	Certificate of Incorporation (incorporated by reference to Exhibit 3.2 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
3.2	Amended and Restated Bylaws (incorporated by reference to Exhibit 3.4 to registrant's Current Report on Form 8-K, filed September 23, 2003 (Number 1-31719)).
3.3	Form of share certificate for common stock (incorporated by reference to Exhibit 3.5 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.1	Medi-Cal Agreement between Molina Medical Centers and the California Department of Health Services dated April 2, 1996, as amended (incorporated by reference to Exhibit 10.1 to registrant's Registration Statement on Form S-1 (Number 333-102268)).
10.2*	Health Services Agreement between Foundation Health, and Molina Medical Centers dated February 1, 1996, as amended (incorporated by reference to Exhibit 10.2 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.3	Contract Between Molina Healthcare of Michigan, Inc. and the State of Michigan effective October 1, 2000, as amended (incorporated by reference to Exhibit 10.3 to registrant's Registration Statement on Form S-1 (Number 333-102268)).
10.4*	HMO Contract between American Family Care and the Utah Department of Health effective July 1, 1999, as amended (incorporated by reference to Exhibit 10.4 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.5*	Memorandum of Understanding between Molina Healthcare of Utah, Inc. and the Utah Department of Public Health effective July 1, 2002 (incorporated by reference to Exhibit 10.5 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.6	2003-2005 Contract for Healthy Options and State Children's Health Insurance Plan between Molina Healthcare of Washington, Inc. and the State of Washington Department of Social and Health Services effective January 1, 2002, as amended (incorporated by reference to Exhibit 10.6 to registrant's Annual Report on Form 10-K for the year ended December 31, 2003)).
10.7	Employment Agreement with J. Mario Molina, M.D. dated January 2, 2002 (incorporated by reference to Exhibit 10.7 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.8	Employment Agreement with John C. Molina, J.D. dated January 1, 2002 (incorporated by reference to Exhibit 10.8 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.9	Employment Agreement with Mark L. Andrews, Esq. dated December 1, 2001 (incorporated by reference to Exhibit 10.9 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.10	Employment Agreement with George S. Goldstein, PhD. dated July 30, 1999 (incorporated by reference to Exhibit 10.10 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.11	Employment Agreement with M. Martha Bernadett, M.D. dated January 1, 2002 (incorporated by reference to Exhibit 10.11 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).

Exhibit Number	Description of Exhibit
10.12	2000 Omnibus Stock and Incentive Plan (incorporated by reference to Exhibit 10.12 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.13	2002 Equity Incentive Plan (incorporated by reference to Exhibit 10.13 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.14	2002 Employee Stock Purchase Plan (incorporated by reference to Exhibit 10.14 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.15	Credit Agreement dated as of March 19, 2003 (incorporated by reference to Exhibit 10.15 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.16*	Amendment to Health Services Agreement effective October 1, 2002 between Foundation Health and Molina Medical Centers dated February 1, 1996, as amended (incorporated by reference to Exhibit 10.18 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.17*	Amendment to Health Services Agreement effective October 1, 2002 between Foundation Health and Molina Medical Centers dated February 1, 1996, as amended (incorporated by reference to Exhibit 10.19 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.18	Amendment to Health Services Agreement effective October 28, 2003 between Foundation Health and Molina Medical Centers dated February 1, 1996, as amended (incorporated by reference to Exhibit 10.18 to registrant's Annual Report on Form 10-K for the year ended December 31, 2003)).
10.19	Medicaid Managed Care Services Agreement between Molina Healthcare of New Mexico, Inc. and the State of New Mexico Human Services Department, as amended.
21.1	List of Subsidiaries.
23.1	Consent of Registered Independent Public Accounting Firm.
31.1	Section 302 Certification of Chief Executive Officer.
31.2	Section 302 Certification of Chief Financial Officer.
32.1	Certificate 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	Certificate 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.

* Portions of this Exhibit are subject to an order granting confidential treatment by the Securities and Exchange Commission pursuant to Rule 406 promulgated under the Securities Act of 1933, as amended.

Exhibit 10.19

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 Cimarron Health Plan of Albuquerque, New Mexico, ("CONTRACTOR"), specifies the terms and conditions under which the CONTRACTOR shall provide Medicaid managed care services for HSD's Medical Assistance Division ("MAD").

The term of this Agreement shall be from July 1, 2001 and shall expire June 30, 2003, unless amended, or terminated pursuant to its terms. Pursuant to the Request for Proposals ("RFP"), HSD and the CONTRACTOR mutually may extend this Agreement for two additional one-year terms, or a single additional two-year term. In no circumstance shall the Agreement exceed a total of four 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' Health Care Financing Administration ("HCFA"). The New Mexico Attorney General's Office must also review this agreement for legal form and sufficiency.

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 NMAC 5.2 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 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 Questions and HSD Answers; and HSD 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, concerning Medicaid services, managed care organizations, 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; to this effect, the CONTRACTOR is put on notice that regulations have been promulgated by the federal government implementing the Balanced Budget Act. The effective date of these regulations has been delayed until June 18, 2001, with the possibility of another extension. However, the CONTRACTOR and its subcontractors shall comply with these regulations, if not repealed, as of their effective date.

(7) The HSD's 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 concerning State Children's Health Insurance Program ("SCHIP").

1.3 HSD is responsible for administering New Mexico's Medicaid program. Due to increasing budgetary constraints, HSD shall require that most Medicaid recipients enroll with managed care organizations ("MCOs"). HSD plans to execute agreements with managed care organizations which meet the requirements specified under the terms of this Agreement and the RFP.

1.4 HSD shall award risk-based contracts to the CONTRACTORS with statutory authority to enter into capitated agreements, assume risk and that 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, 2001. "Active pursuit" is defined as having applied for accreditation.

NOW, THEREFORE, in consideration of the mutual promises contained herein, HSD 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 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; those adults who are in the custody of the State; those 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.

i. The CONTRACTOR shall 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. The CONTRACTOR shall 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. The CONTRACTOR shall maintain and comply with written policies and procedures regarding members' and/or legal guardians' right to select a primary care provider.

iv. The CONTRACTOR shall perform an initial assessment of member's health care needs within 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 in 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. The CONTRACTOR shall provide potential and enrolled members with a directory to include MCO addresses and telephone numbers, (and primary care and specialty provider lists and relevant phone numbers) and the identity, location, phone number and qualifications to include area of specialty, board certification and any areas of special expertise that would be helpful to individuals deciding to enroll with the CONTRACTOR, for each primary care and specialty provider. At the option of the CONTRACTOR, the directory may be limited to primary care and self-refer providers.

vi. The CONTRACTOR shall provide potential and enrolled members 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.

vii. The CONTRACTOR'S written policies and procedures shall be made available upon request to members and their representatives for review during normal business hours.

B. Member Education

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

C. Initial Information

The education of the member is initiated when the member becomes eligible for Medicaid. HSD 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 provides specific information about services included in the benefit packages, MCOs from which the member can choose, and enrollment of the member(s).

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. The CONTRACTOR shall provide periodic updates to the handbook as needed explaining changes in all policies and procedures that affect the member.

iii. The CONTRACTOR shall send a provider directory and member handbook to enrollees or potential enrollees requesting a copy and as requested by HSD. The CONTRACTOR shall direct a person requesting a member handbook or a provider directory to an internet

site. However, a specific request for a printed document shall be met. The CONTRACTOR shall provide a one page, two-sided summary of its benefits which may be distributed by HSD at its discretion.

iv. Member handbooks shall be made available in formats other than written English, (e.g. Braille), if in the CONTRACTOR'S or HSD's determination five percent of the CONTRACTOR'S Salud! members are conversant only in those other languages or formats. In addition, such language used shall be prepared in a manner which is clear and understandable to an individual who has completed no more than the sixth grade. The handbook shall include:

a) Limitations to the receipt of care from non-participating providers;

b) Coordination of care by PCPs;

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

d) Services for which prior authorization or a referral is required, and the method of obtaining both;

e) The provider list, including phone numbers, addresses and type of service designations which need not physically be a part of the handbook;

f) Notice to members on both the internal and HSD grievance and appeal processes;

g) Information on how to obtain services;

h) The members' rights and responsibilities;

i) Information on obtaining care in emergency or urgent conditions;

(j) The CONTRACTOR'S operating rules as required by NCQA;

(k) Information on accessing behavioral health or other specialty services, including but not limited to EPSDT, and family planning services, including a discussion of member's rights to self refer to in-plan and out-of-plan family planning providers;

(l) Information on the member's right to terminate enrollment and the process for voluntarily disenrolling from the plan; and

(m) Other information determined by the State to be essential during the member's initial contact with the CONTRACTOR.

F. 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.

G. Maintenance of Toll-Free Line

The CONTRACTOR shall maintain one or more toll-free telephone line(s) which is 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.

H. Member Notification

i. The CONTRACTOR shall adopt written policies and procedures to

require prompt notification of abnormal results of diagnostic laboratory, diagnostic imaging, and other testing and, if clinically indicated, to notify the member of a scheduled follow-up visit. 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. This shall be documented in the member's records maintained by the CONTRACTOR.

I. Benefit Information

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

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; and

d) The following information regarding the member's rights of access to, and coverage of, emergency services, both inside and outside of the CONTRACTOR'S network:

1. That both in-network and out-of-network emergency services are a covered benefit;

2. That emergency services are defined as covered inpatient and outpatient services furnished by a qualified Medicaid provider that are necessary to evaluate or stabilize an emergency condition;

3. That an emergency condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the individual's health (or with respect to a

pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part;

4. That the CONTRACTOR shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard (defined in (3) above), turned out to be non-emergency in nature; and

5. That the CONTRACTOR does not require prior authorization for emergency services rendered in or out of network with all emergency services reimbursed at the in network rate.

ii. The CONTRACTOR shall provide each member with written information in English or Spanish, as appropriate, that instructs members about how to obtain primary and specialty care, including:

a) A list of providers, by provider type and specialty, 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, point-of-entry behavioral health providers, urgent and emergency care providers, IHS and other Native American providers, and pharmacies. Upon request, the CONTRACTOR shall provide information on the participation status of any provider;

b) The means for obtaining more information about providers who participate in the MCO;

c) The means for obtaining primary care services;

d) The means for obtaining specialty care, behavioral health services and hospital services;

e) The means for obtaining care after normal office hours;

f) The means for obtaining emergency care, including the CONTRACTOR'S policy on when to directly access emergency care or use 911 services;

g) The means for obtaining care and coverage when out of the CONTRACTOR'S service area;

h) The means by which the CONTRACTOR shall notify members affected by the termination or change in any benefit, service or service delivery office/site.

iii. The CONTRACTOR shall provide each member and/or legal guardian with written policies and procedures in English and Spanish and procedures concerning:

a) Its policy on freedom of provider choice;

b) Changing assigned providers, if applicable;

c) Accessing the toll-free phone lines;

d) Filing a grievance and/or appeal;

e) The procedure for appealing a decision that adversely affects the member's coverage, benefits, or other relationship with the CONTRACTOR; and

f) All other policies and procedures regarding member rights and responsibilities.

iv. The CONTRACTOR shall provide affected members and/or legal guardians with updated information within 30 days of any material change.

J. Member Identification Card

The CONTRACTOR shall issue a member identification card within thirty (30) days of enrollment to each member. The card shall be substantially the same as the card issued to commercial enrollees. The card may not contain information which identifies the member as a Medicaid recipient, other than designations which are commonly used by the CONTRACTOR to identify for providers the members' benefits, or copayments, such as group or plan numbers.

K. Members' Patient Bill of Rights and Responsibilities

The CONTRACTOR shall be required to comply with the MAD regulation on Patient Bill of Rights. The CONTRACTOR shall provide each member with written information, in English or Spanish, as appropriate, found in the MAD patient Bill of Rights pursuant to MAD 606.7.6 and 606.1.2.3.

i. Members and/or legal guardians have a right to obtain equitable treatment, with respect and recognition of the member's dignity and need for privacy.

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

a) 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 treatment plan. The policy shall contain procedures for obtaining informed consent.

b) The policy shall ensure that legally determined surrogate decision makers shall be involved, as appropriate, to facilitate care decisions.

iii. 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.

iv. 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.

v. Members have a right to formulate advance directives consistent with Federal and State laws and regulations.

vi. Members have a right to have access to their medical records in accordance with the applicable Federal and State laws and regulations.

vii. 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.

viii. 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.

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

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

L. Consumer Advisory Board

i. The CONTRACTOR shall establish a Consumer Advisory Board representing both physical and behavioral 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 in the state's regions. 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 upon request.

iv. The Consumer Advisory Board shall advise HSD in writing ten (10) days in advance of all meetings to be held. HSD 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.

M. Standards for Utilization Management (UM)

i. The CONTRACTOR'S Utilization Management (UM) Program shall properly manage the use of limited resources, maximize the effectiveness of care by evaluating clinical appropriateness, and authorize the type and volume of services through fair, consistent and culturally competent decision making to assure equitable access to care and to a successful link between care and outcomes;

ii. The CONTRACTOR shall define in writing the UM program structure and accountability mechanisms;

iii. The CONTRACTOR senior management and the CONTRACTOR Medical Director or the CONTRACTOR'S Internal Quality Management and Improvement ("QI") program shall annually evaluate and approve or revise the UM program;

iv. The CONTRACTOR shall define all services which require prior authorization;

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

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

vii. The CONTRACTOR shall comply with NCQA Standards for Utilization Management and follow NCQA timeliness standards for routine, urgent and emergent situations. The decision-making timeframes should accommodate the clinical urgency of the situation and not delay the provision of services to members for lengthy periods of time;

viii. The CONTRACTOR shall approve or deny services for routine/nonurgent, urgent care requests within the timeframes stated in regulation. These required timeframes are not to be affected by "pend" decision;

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

x. The CONTRACTOR shall ensure that UM functions are appropriately implemented, monitored and professionally managed;

xi. The CONTRACTOR shall submit quarterly to HSD in a format to be determined by HSD after consultation with the CONTRACTOR, a job description and the qualifications of each individual behavioral health UM staff who makes behavioral health determinations; and

xii. The CONTRACTOR shall provide to HSD ad hoc reports about service utilization upon request by HSD.

N. Denials

i. The CONTRACTOR shall clearly document in English or Spanish, as appropriate, on a form agreed to by HSD, and communicate in writing the reasons for each denial. 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. The CONTRACTOR shall provide in writing the reason for a denial of service coverage to the requesting practitioner and the affected member. There shall be 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 notice of appeal.

iii. The CONTRACTOR shall recognize that a utilization review decision resulting from a Fair Hearing conducted by the designated HSD official is final and shall be honored by the CONTRACTOR, unless the CONTRACTOR successfully appeals the Fair Hearing decision in a court of competent jurisdiction.

iv. The CONTRACTOR shall 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.

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

(2) Standards for Internal Quality Management and Improvement

A. The CONTRACTOR shall have Quality Improvement (QI) Programs based on a model of continuous quality improvement. The QI programs shall encompass physical, mental and behavioral 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.

B. The CONTRACTOR shall produce and deliver to HSD 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 and to include:

i. Objectives, scope, and planned projects or activities for the year;

ii. Planned monitoring of previously identified issues, including tracking of issues over time; and

iii. Planned evaluation of the QI program.

C. The CONTRACTOR shall designate a physician and a behavioral health care practitioner with primary responsibility for the implementation of the QI program.

D. The CONTRACTOR shall establish a committee to oversee and implement QI requirements and such requirements shall address:

i. QI Program and Policy;

ii. QI Committee and Policy;

iii. Annual QI Workplan and Evaluation;

iv. Confidentiality Policy and Procedures;

v. Medical Records Documentation Policy and Procedures;

vi. Policy and Procedures for working with high need members;

vii. Member Satisfaction Surveys;

viii. Disease Management Protocols and Procedures; and

ix. Policy and Procedures for Continuity and Coordination of Care.

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

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

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

ii. The CONTRACTOR shall 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. The CONTRACTOR shall 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. The CONTRACTOR shall have a process for exchanging information throughout the CONTRACTOR'S organization;

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

vi. The CONTRACTOR shall have disease management protocols and procedures;

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

viii. The CONTRACTOR shall have written policies and procedures for conducting member and provider surveys;

ix. The CONTRACTOR shall have written policies and procedures for continuity and coordination of care; and

x. The CONTRACTOR shall 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.

G. QI Projects and Reviews

The CONTRACTOR shall:

i. Be responsible to demonstrate to HSD 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 document appropriate action.

ii. 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 which represents at least ten percent of a CONTRACTOR'S enrollment.

H. Continuous Quality Improvement

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.

I. 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. 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.

J. Delegation

HSD 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 for the SALUD! program;

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 utilization management criteria when utilization management is delegated;

v. Include in its agreement with the delegate whether the CONTRACTOR or the delegate shall oversee the performance of the subdelegate to ensure that there is a mutually agreed document in place for any subdelegated 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 a list of all delegates to HSD;

viii. Ensure that it notifies HSD of any proposed new agreement for delegation at least thirty (30) calendar days prior to the proposed beginning date of the Agreement or any material changes to existing Agreements; and

ix. Not delegate quality oversight, utilization management, prevention, education, outreach, grievance, internal hearings, appeals, data collection, or claims payment for behavioral health services.

K. Clinical Performance

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

L. Member Satisfaction Survey

As part of its QI Program, the CONTRACTOR shall conduct at least one annual survey of member satisfaction with the CONTRACTOR, 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 his/her primary care provider (PCP) and all members who have voluntarily disenrolled from the CONTRACTOR. The member survey shall address member receipt of educational materials, and use and usability of the provided education materials. The CONTRACTOR'S survey shall address the satisfaction of members with serious/chronic care conditions. 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.

ii. Disseminate results of the member satisfaction survey to practitioners, providers, HSD and members.

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

iv. Follow NCQA guidelines for the conduct of Provider Satisfaction surveys; cooperate with HSD in conducting provider satisfaction survey, including making available a current, unduplicated provider file(s) available to HSD or its EQRO upon request; conduct a provider satisfaction survey, at least annually, of all in-network providers; and report information from this survey to HSD annually; and, include the results in the QI/QM Effectiveness Evaluation into the QI/QM plan for the upcoming contract year. (HSD will work towards reducing the administrative burden of this requirement on providers by combining surveys or conducting one survey. However, until such is accomplished, the CONTRACTOR must comply with this requirement as stated.)

M. External Quality Review

i. HSD shall retain the services of an external quality review organization 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's quality standards as set forth in MAD Policy Section 606.7. HSD shall also contract with an external review organization to audit a statistically valid sample of the CONTRACTOR behavioral 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.

ii. The CONTRACTOR shall participate in various other tasks identified by HSD that shall enable HSD to gauge performance in a variety of areas, i.e., care coordination, treatment of special populations and behavioral health care delivery.

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

iv. The external quality review organization retained by HSD shall not be a competitor of the CONTRACTOR.

N. Publication

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

(3) Performance Indicators

A. Performance Improvement Projects (PIPs) are one of the tools that HSD has chosen to use to measure a CONTRACTOR'S ability to identify problematic areas within its operations and take actions which shall improve its performance

in those focus areas. Examples of these include but, are not limited to, administrative functions (telephone response rates), utilization management (timeliness of Prior Authorizations), access to care, preventive care (improvement of EPSDT screening rates), and care coordination.

B. The CONTRACTOR shall:

i. Participate in six (6) PIPs per year chosen by HSD in consultation with the CONTRACTOR. Three (3) PIPs shall relate to behavioral health;

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

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 of the ongoing effectiveness of named interventions.

C. Critical Indicators Report

The CONTRACTOR shall:

i. Track, analyze, and report to HSD monthly, certain indicators identified specific to behavioral or physical health that shall enable HSD 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 monthly;

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 EPSDT screens, high infant mortality or an increase in suicides or suicide attempts.

(4) Standards for Access

A. The CONTRACTOR shall ensure the Salud! member caseload of any PCP does not exceed fifteen hundred (1,500) enrollees.

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

C. The CONTRACTOR shall meet time and distance standards for PCPs and pharmacies as determined by HSD or as described in MAD Policy 606.7.9.3. The CONTRACTOR shall have systems to track and report this data and such data shall be available to HSD upon request.

D. The CONTRACTOR shall meet provider appointment and pharmacy in-person prescription fill time standards as described in MAD Policy 606.7.9.4; 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 24 hours, when needed on an urgent basis. All new, customized, made-to-measure equipment shall be delivered within 150 days of the request date. All repairs or modifications shall be delivered within 60 days of the request date.

E. The CONTRACTOR shall provide Geo-Access or equivalent reports quarterly to HSD on the CONTRACTOR'S network capacity of behavioral health providers and facilities.

i. 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;

g) Allow the member to self refer for behavioral health and substance abuse services, family planning, vision and dental services without approval from a PCP; and

h) Allow a newly enrolled woman in her third trimester of pregnancy to continue to see her established obstetrical provider.

i) Have CPR certified drivers to transport members whose clinical needs dictate.

F. Emergency Conditions

The CONTRACTOR shall:

i. Provide services for emergency and urgent conditions, including emergency transportation anywhere within the United States;

ii. Ensure that there is no clinically significant delay caused by the CONTRACTOR utilization control measures; and

iii. Ensure that members have access to the nearest appropriately designated Trauma Center according to established emergency Medical Services triage and transportation protocols.

G. Non-Emergency Access Standards

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

i. For routine, symptomatic, recipient-initiated, outpatient appointments for primary preventive medical care the request-to-appointment time shall be no greater than 30 days, unless the member requests a later time.

ii. For routine, symptomatic, recipient-initiated, outpatient appointments for non-urgent primary medical care, the request-to-appointment time shall be no greater than 14 days, unless the member requests a later time.

iii. For non-urgent behavioral health care, the request-to-appointment time shall be no greater than 14 days, unless the member requests a later time.

iv. Primary medical, including behavioral health, and dental care outpatient appointments for urgent conditions shall be available within 24 hours.

v. For specialty outpatient referral and/or consultation appointments, including behavioral health, the request-to-appointment time shall be consistent with the clinical urgency but no greater than 21 days, unless the member requests a later time.

vi. For outpatient scheduled appointments the time the member is seen shall not be more than 30 minutes after the scheduled time unless the member is late.

vii. 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 14 days unless the member requests a later time.

viii. For urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing, appointments availability shall be consistent with the clinical urgency but no greater than 48 hours.

ix. The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

H. The CONTRACTOR shall ensure that PCP and pharmacy availability meet

specified geographic access standards based on the county of residence: 90% of members residing in urban counties shall travel no longer than 30 miles to receive pharmacy and PCP availability; 90% of members residing in rural counties shall travel no longer than 45 miles to receive pharmacy and PCP availability; and 90% of members residing in frontier counties shall travel no longer than 60 miles to receive pharmacy and PCP availability. The CONTRACTOR shall ensure that members have access to pharmacy availability within 24 hours of discharge from a hospital, urgent care facility or emergency room.

(5) 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 including referrals to the following providers: 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

(6) General Care Coordination Requirements

A. The CONTRACTOR shall:

i. Provide statewide care coordination, either directly or through subcontractors, for SALUD! Members with multiple and complex special physical, mental and behavioral health care needs.

ii. Provide as part of their care coordination program, the six targeted case management programs included in the SALUD! Benefit package, on a statewide basis, and be held accountable for delivering these services according to MAD policy.

iii. Develop and implement written policies and procedures, approved by HSD, which govern how members with multiple and complex special physical, mental and behavioral health care needs shall be identified.

iv. Develop and implement written policies and procedures, approved by HSD, governing how care coordination shall be provided for members. These shall address the development of member's individual treatment

plan, based on a comprehensive assessment of the goals, capacities and medical condition of the member, and the needs and goals of the family; and criteria for evaluating a member's response to care and revising the plan, as indicated. A member and family shall be involved in the development of the treatment plan, as appropriate. A member or family shall have a right to refuse care coordination or case management.

v. Develop and implement policies and procedures which define care coordination, including the targeted case management programs, according to MAD policy on each; specify that care coordinators/case managers shall meet with members on a regular, face-to-face basis, as is indicated. Telephonic contacts alone do not meet the requirements of the six specific case management programs, or of care coordination services.

vi. Specify how care coordination shall be supported by an internal information system.

vii. Develop and implement policy and procedures to establish working relationships between care coordinators and providers.

viii. Continue to work with the Medicaid in the Schools (MITS) program providers to identify and coordinate with the child's SALUD! primary care provider (PCP).

B. Specific Coordination Requirements

i. Initial Written Referral Report. 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 behavioral health provider within seven (7) calendar days after the screening and evaluation visit.

ii. Ongoing Reporting. While the member is receiving services from a behavioral health provider, the behavioral health provider shall keep the member's PCP informed of drug therapy; laboratory and radiology results; sentinel events such as hospitalization, emergencies, incarceration, discharge from a psychiatric hospital or from behavioral health services; and transitions in level of care. The PCP shall keep the behavioral health provider informed of drug therapy; laboratory and radiology results; medical consultations; and sentinel events such as hospitalization and emergencies.

iii. Behavioral Health Referral Policies and Procedures. The CONTRACTOR shall develop and implement written policies and procedures that allow members access to behavioral health services without first going through the PCP. These policies and procedures shall accord timely access to behavioral health services. The CONTRACTOR shall notify members of their rights to access behavioral health services without a referral. The CONTRACTOR shall notify members of their rights to access behavioral health services without a referral.

iv. Psychiatric Consultation. A psychiatrist shall be available to the PCP to assist with pharmacotherapy and diagnostic evaluations.

v. 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.

vi. 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, necessary services are provided and are not duplicative. HSD shall monitor utilization to ensure that the CONTRACTOR provides to members who are waiver participants all benefits included in the CONTRACTOR benefit package.

vii. 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 to the following sections of the New Mexico Children's Code: Section 32A-2-21 (Disposition of a mentally disordered or developmentally disabled child in a delinquency proceeding); Section 32A-3A-5 (Plan for family services/ family needs assessment and referral); Section 32A-3B-17 (Disposition of developmentally disabled or mentally disordered child in a proceeding under the Family in Need of Services Act); Section 32A-4-3 (Duty to report child abuse and child neglect and penalty); Section 32A-4-14 (Change in placement); Section 32A-4-23 (Disposition of a mentally disordered or developmentally disabled child in a proceeding under the Abuse and Neglect Act.); and Article 6, Children's Mental Health and Developmental Disabilities. 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 treatment plan, including decisions regarding the provision of services for the member. The CONTRACTOR shall designate a single contact point for these cases.

viii. 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.

(7) 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.

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

CONTRACTOR shall offer freedom of choice to members in making a PCP selection. 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. The CONTRACTOR shall assign a PCP based on factors such as patient age, residence, and if known, current provider relationships.

B. 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. Any change in PCP shall be effective as of the first of the month following the month in which the request was received.

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

i. 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;

ii. A member's PCP ceases to participate in the CONTRACTOR'S network;

iii. 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

iv. A member has initiated legal actions against the PCP.

D. 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.

E. PCP Lock In. HSD 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 approved by HSD 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 shall be notified of all lock in removals.

2.2 **ENROLLMENT**

(1) Maximum Medicaid Enrollment

HSD 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 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 capacity for statewide Medicaid enrollment. Subsequent to the establishment of this limit, if the CONTRACTOR wishes to change its maximum enrollment level, the CONTRACTOR shall notify HSD in writing ninety (90) days prior to the desired effective date of the change. HSD 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 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 HCFA 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.

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 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. Members eligible for both Medicaid and Medicare, i.e. dual eligibles;

ii. Institutionalized members i.e., those residing for greater than thirty (30) days in nursing facilities;

iii. Members residing in intermediate care facilities for the mentally retarded;

iv. Members participating in the Health Insurance Premium (HIPP) Program;

v. Children and adolescents in out-of-state foster care or adoption placement; and

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

(4) HSD Exemptions

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

(5) Special Situations

A. Newborn Enrollment

Newborns are automatically eligible for a period of one (1) year 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 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. Instead, HSD shall pay the appropriate provider(s), on a fee-for-service basis, all provider-submitted claims related to a member who is hospitalized in a general acute care, rehabilitation or freestanding psychiatric hospital at the time such member enrolls with the CONTRACTOR, until such time as the member is discharged from the hospital.

C. Members in Placement in Residential Treatment Centers.

If a child or adolescent becomes Medicaid eligible while residing in an accredited or non-accredited residential treatment center, they shall be immediately eligible for enrollment.

D. Members in Treatment Foster Care Placements.

If a child or adolescent was residing in a treatment foster care placement at the time managed care enrollment began, they shall be exempt from enrolling in an MCO until they are discharged from treatment foster care.

E. Native Americans

i. Native Americans shall have the option to participate in managed care and be enrolled with the CONTRACTOR to receive medical care through Indian Health Services (IHS), tribal provider, and/or other non-Native American provider, or to not participate in managed care and continue to receive medical care. If a Native American member voluntarily chooses to enroll with the CONTRACTOR, the enrollment process is initiated.

ii. The CONTRACTOR shall make good faith efforts to contract with the appropriate urban Indian clinics tribally owned health centers, and IHS facilities for the provision of medically necessary services.

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

iv. The CONTRACTOR shall ensure adequate medical transportation for Native American members residing in rural and remote areas.

v. The CONTRACTOR shall ensure that culturally appropriate materials are reasonably available to Native Americans.

F. Members Placed in Nursing Facilities:

A member 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.

G. 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 MCOs during the first eighty five (85) 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 an MCO 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 shall assign the new member to an MCO.

B. Begin Date of Enrollment

Enrollment generally shall begin the first day of the first full month following selection or assignment. If the selection or assignment is made after the 25th day of the month and before the first full day of the next month, the enrollment shall begin on the first day of the second full month after the selection or assignment.

C. Member Switch

A current CONTRACTOR member has the opportunity to change MCOs during the first eighty-five (85) days of a twelve (12) month period. HSD shall notify the CONTRACTOR members of their opportunity to select a new CONTRACTOR provider. A member is limited to one eighty-five 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 lock-in period expires before being permitted to switch CONTRACTORS.

D. Mass Transfer Process

The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO 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

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

ii. The CONTRACTOR shall 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 treatment plans are revised as necessary;

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

iv. The CONTRACTOR shall honor all prior approvals granted by HSD through its CONTRACTOR for the first thirty 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. The CONTRACTOR shall adhere to the New Mexico Children's Code NMSA 1978 §32A-3B-9 relating to notification of the child's guardian ad litem, parent, guardian or legal custodian 10 days prior to a change in placement for members currently receiving behavioral health services requiring a level of care determination, unless an emergency situation requires moving the child prior to sending notice;

vi. The current CONTRACTOR shall reimburse the providers and facilities approved by HSD, if a donor organ becomes available during the first thirty days of enrollment and transplant services have been prior approved by HSD;

vii. The CONTRACTOR shall fill prescriptions for drug refills for the first thirty days or until the CONTRACTOR has made other arrangements, for newly enrolled managed care members;

viii. The CONTRACTOR shall pay for DME costing $2000 or more, approved by the CONTRACTOR but delivered after disenrollment;

ix. The CONTRACTOR shall 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;

x. The CONTRACTOR is responsible for payment of all inpatient services until discharge from the hospital or transfer to a different level of care, if the member is hospitalized at the time of exemption or switch enrollment;

xi. The CONTRACTOR is responsible for payment until disenrollment, if an enrollment member is placed in a nursing facility or intermediate care facility for the mentally retarded as a long term or permanent placement; and

xii. The CONTRACTOR shall ensure the transition of care requirements outlined above can be met with both individual and mass enrollment into and out of their organization.

(7) Member Disenrollment

A. CONTRACTOR Requests for Disenrollment

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. The request and supporting documentation shall meet requirements specified by HSD. 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. Conditions that may permit lock-out or disenrollment are:

i. The CONTRACTOR demonstrates that it has made a good faith effort to accommodate the member but such efforts have been unsuccessful;

ii. 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;

iii. The CONTRACTOR has offered to the member in writing the opportunity to utilize the grievance procedures;

iv. The CONTRACTOR shall not terminate enrollment because of an adverse change in the member's health. The CONTRACTOR shall provide adequate documentation that terminations are proper and not due to an adverse change in the member's health; and

v. The CONTRACTOR has received threats or attempts of intimidation from the member to the CONTRACTORS, providers or its own staff.

B. Member Initiated Disenrollment

A Medicaid member who is required to participate in managed care may request to be disenrolled from the CONTRACTOR "for cause" at anytime, even during a lock-in period. This request shall be submitted in writing to HSD for review. HSD shall complete the review and furnish a written decision to the member and the CONTRACTOR in a timely manner. Members who voluntarily enroll may choose to disenroll at any time.

C. HSD Initiated Disenrollment

HSD may initiate disenrollment in three circumstances:

i. If a member loses Medicaid eligibility;

ii. If the member is re-categorized into a Medicaid coverage category not included in the managed care initiative; or

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

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 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.

(1) Required Policies and Procedures

A. The CONTRACTOR shall maintain written policies and procedures on provider recruitment and termination of provider participation with the CONTRACTOR. HSD 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. The CONTRACTOR shall 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. The CONTRACTOR shall annually develop and implement a training plan to educate providers and their staff on selected managed care or the CONTRACTOR processes and procedures. The plan shall be submitted to HSD for review and approval on or before July of each year.

(2) General Information Submitted to HSD

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 on a monthly basis and include a clear delineation of all additions and terminations that have occurred the prior month. The CONTRACTOR shall report quarterly the capacity of each contracted behavioral health provider to take new Medicaid clients and to serve current clients. The CONTRACTOR'S contracts with providers must include language stating that the MCO contractors 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. The CONTRACTOR shall provide twenty-four (24) hour, seven (7) day a week access; and 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, ensuring that the member receives appropriate prevention services for their age group.

B. The CONTRACTORS are prohibited from excluding providers as primary care providers based on the proportion of high-risk patients in their caseloads.

C. The CONTRACTOR shall have a formal process for provider education regarding SALUD!, the conditions of participation in the network and the provider's responsibilities to the CONTRACTOR and its members. HSD 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 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 CONRACTOR 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) Provider to Member Ratios and Access Requirements

The CONTRACTOR shall ensure that member caseload of any PCP in its network does not exceed fifteen hundred (1,500) of its members. Exceptions to this limit may be made with the consent of HSD. 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.

(8) Geographic Access Requirements

The minimum number of primary care providers from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier as defined. Urban counties are: Bernalillo, Los Alamos, Santa Fe, and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel, and Cibola. Rural counties are those which are not listed as urban or frontier. The standards are as follows: 90 percent of urban residents shall travel no longer than 30 miles to see a PCP; 90 percent of rural residents shall travel no longer than 45 miles to see a PCP; and 90 percent of frontier residents shall travel no longer than 60 miles to see a PCP.

(9) 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. Current federal regulations {SSA 1902(a)(13)(E)} specify that states shall guarantee access to FQHCs and 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.

(10) University of New Mexico Health Sciences Center

The CONTRACTOR shall contract with the University of New Mexico Health Sciences Center for specialty services provided by Carrie Tingley Hospital and the University of New Mexico Hospital including transplants, neonatal, burn and trauma, level I trauma center, and other specialized pediatric services, not otherwise available, provided that in the event the CONTRACTOR and University of New Mexico Health Sciences Center cannot reach agreement as to reimbursement for services that the CONTRACTOR shall agree to pay Medicaid fee-for-service rates for the services in question.

(11) Local Department of Health Offices

A. The CONTRACTOR shall contract with public health providers for services as described in Section MAD-606.A.6., BENEFITS PACKAGE, 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.

(12) 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, and asthma and pulmonary.

(13) 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.

(14) School-Based Providers

The CONTRACTOR shall participate in the School Based Health Clinic Project.

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

A. The CONTRACTOR shall allow members who are Native American to seek care from any IHS, Tribal Provider or Urban Indian Program 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 or Urban Indian Providers, and network providers due to their status as Native Americans.

C. The CONTRACTOR shall track IHS 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.

(16) 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. 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 a participating or non-participating provider. 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 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 devises/supplies;

ix. Tubal legations;

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 initiated obligation to reimburse non-participating family planning providers for non-emergent services outside the scope of these defined services.

(17) Behavioral Health Care

A. The CONTRACTOR shall:

i. Deliver all behavioral health services through direct contracts with individual behavioral health provider groups. All administrative functions associated with behavioral health shall be retained and integrated within the CONTRACTOR;

ii. Minimize the administrative costs associated with the delivery of behavioral health care;

iii. Build a statewide behavioral health provider network that ensures access to all levels of behavioral health services, across a continuum from the most to the least restrictive setting. The network shall be sufficient to ensure that the standards in MAD Policy 606 for access to care providers who want to refer members for behavioral health care and vice versa;

iv. Develop and implement written policies and procedures for members on how to access behavioral health services without a referral along with written policies and procedures for primary care and other specialty care providers who want to refer members for behavioral health care and vice versa;

v. Develop and implement written policies and procedures for co-ordination of physical and behavioral health services, monitoring its implementation;

vi. Develop and distribute a provider manual, which includes a specific section on behavioral health; and

vii. Develop procedures for communicating regularly with behavioral health providers on issues related to provision of services.

B. Behavioral Health Clinical Practice Guidelines and Utilization Management

i. The CONTRACTOR shall develop and implement written behavioral health clinical practice guidelines for major behavioral health diagnoses for children, youth and adult populations. These guidelines shall be based upon the MAD regulation definition of medical necessity, professionally accepted standards of practice, and national guidelines, and with input from the CONTRACTOR'S practitioners. Behavioral health clinical practice guidelines and utilization management criteria shall be applied consistently across the state.

ii. The CONTRACTOR shall provide care coordination for members with multiple and complex special physical, mental, neurobiological, emotional and/or behavioral health care needs on an as needed basis, depending upon the clinical profile of the patient. The CONTRACTOR shall have written policies and procedures, approved by HSD, which govern how members with these multiple and complex needs will be identified and how these specific care coordination services will be provided.

iii. The CONTRACTOR shall reevaluate the behavioral health clinical practice guidelines at least every two years, with input from the CONTRACTOR'S clinical providers. Any updates should be communicated to providers.

iv. The CONTRACTOR shall ensure the continuity and coordination of a member's medical and behavioral health care among practitioners treating the same member.

v. The CONTRACTOR shall affect a smooth transition in situations when a network provider leaves the network.

vi. The CONTRACTOR shall collect and report longitudinal data, on a quarterly basis for two (2) years, for all Medicaid SALUD! children and youth to age 21 accessing treatment foster care (TCI I and II); residential treatment centers (RTCs) and inpatient psychiatric hospitalization. This data shall track individual members, including the child or adolescent's actual length of stay and disposition after discharge for data elements that are mutually agreed to in writing by HSD and the CONTRACTOR. The data shall be analyzed by the CONTRACTOR and used to evaluate the appropriateness of care and to identify any trends, including, but not limited to, premature discharges, as evidenced by readmissions to either TFC, RTC and/or inpatient psychiatric hospitalization.

vii. The CONTRACTOR shall collect and report on a quarterly basis key variables of program performance related to behavioral health services. Key variables will be determined in consultation with the CONTRACTOR and stakeholders.

C. Behavioral Health Care Coordination

The CONTRACTOR shall provide care coordination for members with multiple and complex special physical, mental, neurobiological, emotional and/or behavioral health care needs on an as needed basis, depending upon the clinical profile of the member. The CONTRACTOR shall have written policies and procedures, approved by HSD, which govern how members with these multiple and complex needs shall be identified and how these specific care coordination services shall be provided.

(18) Standards For Provider Credentialing and Recredentialing

A. Individual Providers

At the time of credentialing, the CONTRACTOR shall comply with all requirements in the MAD Policy Manual, which include the requirement to verify from primary sources that at a minimum the provider has:

i. A current valid license to practice;

ii. Clinical privileges in good standing at the institution designated by the practitioner as the primary admitting facility, if applicable;

iii. A valid DEA or CDS certificate, if applicable;

iv. Graduation from an accredited professional school/program and/or highest training program applicable to the academic or professional degree, discipline, and licensure of the practitioner;

v. Board certification if the practitioner states that he/she is board certified in a specialty on the application;

vi. Current, adequate malpractice insurance, in accordance with the CONTRACTOR'S requirements, if applicable;

vii. 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

viii. Not been barred from participation based on existing Medicare or Medicaid sanctions.

(19) Organizational Providers

A. The CONTRACTOR shall 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; free-standing surgical centers; ambulatory psychiatric and addiction disorder residential treatment centers, clinics, and other facilities; 24-hour programs included in the continuum of behavioral care, such as behavioral units of general hospitals; and freestanding psychiatric hospitals.

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

C. The CONTRACTOR shall confirm that the provider has been reviewed and approved by an accrediting body (Accredited Residential Treatment Centers

shall be accredited by the JCAHO, and other behavioral care providers shall be accredited by the Council on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA) for child/adolescent providers); or

D. The CONTRACTOR shall develop and implement standards of participation that demonstrates 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.

(20) Recredentialing

The CONTRACTOR shall formally recredential its network providers at least every two years.

(21) Primary Source Verification

A. HSD 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 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 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.

C. The CONTRACTOR shall maintain relatively low administrative expenses and reduce administrative burden and use current technology to minimize administrative burdens for subcontracted and provider staff.

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. 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 asset forth in MAD Program Manual section MAD-721, HOSPITAL SERVICES. The CONTRACTOR shall comply with the maternity length of stay in the Health Insurance and Portability 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 MAD-764, TRANSPLANT SERVICES, Section MAD-765, 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 MAD-721.61, OUTPATIENT COVERED SERVICES.

(4) Case Management Services

The benefit package includes case management services as set forth in the MAD Program Manual Sections MAD 771-772, MAD 774- 775, and MAD-744, including, Case Management Services for Adults With Developmental Disabilities as set forth in the MAD Program Manual Section MAD-771, CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES; Case Management Services for Pregnant Women and Their Infants as set forth in MAD Program Manual Section MAD-772, CASE MANAGEMENT SERVICES FOR PREGNANT

WOMEN AND THEIR INFANTS; Case Management Services for Traumatically Brain Injured Adults set forth in the MAD Program Manual Section MAD-774, CASE MANAGED SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS. Case management services for children up to the age of three (3) as set forth in MAD Program Manual Section MAD-775, CASE MANAGEMENT SERVICES FOR CHILDREN UP TO AGE THREE; Case Management Services for The Medically at Risk as set forth in MAD Program Manual Section MAD-744, EPSDT CASE MANAGEMENT. 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 services meeting the definition of emergency services. Emergency Services shall be provided in accordance with MAD-606.A.7. QUALITY MANAGEMENT.

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 (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 services which are medically necessary until the clinical emergency is stabilized. This includes all treatment that may be necessary to assure, within reasonable medical probability, that 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.

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 HSD 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 MAD-711, MEDICAL SERVICES PROVIDERS; Section MAD-718.1, MIDWIFE SERVICES; Section MAD-718.2, PODIATRY SERVICES; Section MAD-712, RURAL HEALTH CLINIC SERVICES; and Section MAD-713, 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 MAD-751, LABORATORY SERVICES.

(8) Diagnostic Imagining and Therapeutic Radiology Services

The benefit package includes medically necessary diagnostic imaging and radiology services as set forth in MAD Program Manual Section 752, DIAGNOSTIC IMAGINING 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 MAD-714, ANESTHESIA SERVICES.

(10) Vision Services

The benefit package includes vision services as set forth in MAD Program Manual Section MAD-715, VISION CARE SERVICES.

(11) Audiology Services

The benefit package includes audiology services as set forth in MAD Program Manual Section MAD-755, HEARING AIDS AND RELATED EVALUATION.

(12) Dental Services

The benefit package includes dental services as set forth in MAD Program Manual Section MAD-716, DENTAL SERVICES.

(13) Dialysis Services

The benefit package includes medically necessary dialysis services as set forth in MAD Program Manual Section MAD-761, 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 MAD MAD-753 PHARMACY SERVICES. The CONTRACTOR formulary 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 formulary shall follow the HCFA special guidelines relating to drugs used to treat HIV infection; (v) The formulary shall include coverage of certain 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 formulary shall be made for an individual member.

B. Drug Utilization Review Program

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

(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 MAD-754, 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 MAD-740, 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 MAD-746.3, 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. 42 CFR Section 440.167, MAD 746.5.

C. Tot-to-Teen Health Checks

The CONTRACTOR shall adhere to the periodicity schedule and 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 with special emphasis on the behavioral health needs of the members; (v) Processes to document, measure, and assure 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) Services Provided in Schools

The benefit package includes services provided in schools excluding those specified in the Individual Education Plan (IEP) or the Individualized Family Services Plan (IFSP) as set forth in the MAD Program Manual Section MAD-747, SCHOOL-BASED SERVICES FOR RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE.

(18) Nutritional Services

The benefit package includes nutritional services furnished to pregnant women and children as set forth in MAD Program Manual Section MAD-758, NUTRITIONAL SERVICES.

(19) Home Health Services

The benefit package includes home health services as set forth in MAD Program Manual Section MAD-768, 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.

(20) Hospice Services

The benefit package includes hospice services as set forth in MAD Program Manual Section MAD- 763, HOSPICE CARE SERVICES.

(21) Ambulatory Surgical Services

The benefit package includes surgical services rendered in an ambulatory surgical center setting as set forth in MAD Program Manual Section MAD-759, AMBULATORY SURGICAL CENTER SERVICES.

(22) 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 MAD-767, REHABILITATION SERVICES and licensed speech and language pathology services furnished under the EPSDT program as set forth in MAD Program Manual Section MAD-746.4, 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.

(23) Reproductive Health Services

The benefit package includes reproductive health services as set forth in MAD Program Manual Section MAD-762, 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.

(24) 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 MAD-766, PREGNANCY TERMINATION PROCEDURES.

(25) Transportation Services

The benefit package includes transportation service 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 as set forth in MAD Program Manual Section MAD-756, TRANSPORTATION SERVICES. Pursuant to NMSA 1978 Section 65-2-97.F and applicable rules and interpretations of these laws 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.

(26) Prosthetics and Orthotics

The benefit package includes prosthetic and orthotic services as set forth in the MAD Program Manual Section MAD-757, PROSTHETICS AND ORTHOTICS.

(27) Behavioral Health Services Included in the Benefit Package for Adults and Children

A. Inpatient Hospital Services

The benefit package includes inpatient hospital psychiatric services provided in general hospital units and/or PPS-Exempt Units in a general hospital as set forth in the MAD Program Manual Section MAD-721, HOSPITAL SERVICES,

B. Hospital Outpatient Services

The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt units of general hospitals as set forth in the MAD Program Manual Section MAD-722, OUTPATIENT PSYCHIATRIC SERVICES AND PARTIAL HOSPITALIZATION.

C. Outpatient Health Care Professional Services

The benefit package includes outpatient health care services as set forth in the MAD Program Manual Section MAD-717, PSYCHIATRIC AND PSYCHOLOGICAL SERVICES and MAD-746.2 LICENSED MASTERS LEVEL INDEPENDENT SOCIAL WORKER.

(28) Behavioral Health Services Included only in the Benefit Package for Children

A. The benefit package includes prevention, screening, diagnostics, ameliorative services, and other medically necessary behavioral health care and substance abuse treatment or services for Medicaid members under twenty-one (21) years of age whose need for behavioral health services is identified during an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screen.

B. All behavioral health care services shall be provided in accordance with the New Mexico Children's Code. The services include:

i. Inpatient Hospitalization in Free Standing Psychiatric Hospitals: The benefit package includes inpatient services in free standing psychiatric hospitals as set forth in the MAD Program Manual Section MAD-742.1, INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS.

ii. Accredited Residential Treatment Center Services: The benefit package includes accredited residential treatment services as set forth in the MAD Program Manual Section MAD-742.2, ACCREDITED RESIDENTIAL TREATMENT CENTER SERVICES.

iii. Non-Accredited Residential Treatment Centers: The benefit package includes residential treatment services as set forth in the MAD Program Manual Section MAD-742.3, NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES.

iv. Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospital: The benefit package includes outpatient and partial hospitalization services provided in freestanding psychiatric hospitals as set forth in the MAD Program Manual Section MAD-742.4 OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS.

v. Day Treatment Services: The benefit package includes day treatment services as set forth in the MAD Program Manual Section MAD-745.3, DAY TREATMENT SERVICES.

vi. Behavior Management Skills Development Services (BMSDS): The benefit package includes behavior management services as set forth in the MAD Program Manual Section MAD-745.2, BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES.

vii. School-Based Services: The benefit package includes counseling, evaluation, and therapy furnished in a school-based setting but not specified in the Individual Education Plan (IEP) or the Individualized Family Services Plan (IFSP) as set forth in the MAD Program Manual Section MAD-747, SCHOOL-BASED SERVICES FOR RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE.

viii. Case Management Services for The Medically at Risk: Case management services for individuals who are under twenty-one (21) who are medically at risk as set forth in MAD Program Manual Section MAD-744, EPSDT CASE MANAGEMENT.

ix. Treatment Foster Care Services: Treatment Foster Care services as set forth in MAD Program Manual Section MAD-745.1, TREATMENT FOSTER CARE.

(29) Behavioral Health Services Included only in the Benefit Package for Adults

A. Psychosocial Rehabilitation

The benefit package includes psychosocial rehabilitation services as set forth in the MAD Program Manual Section MAD-737, MENTAL HEALTH REHABILITATION.

B. Case Management Services for the Chronically Mentally Ill

The benefit package includes case management services as set forth in the MAD Program Manual Section MAD-773, CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL.

(30) 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).

(31) Advance Directives

A. The CONTRACTOR shall implement written policies and procedures with respect to advance directives that address the following requirements:

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

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

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

iv. The CONTRACTOR shall ensure compliance with requirements of Federal and State laws respecting advance directives; and

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

(32) 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, Section 765, EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES, TECHNOLOGIES OR THERAPIES.

(33) 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, 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 aged 50-69 years who are not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination.

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 18 years of age, and every three years thereafter until reaching 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 frequency shall be at least annual.

c) Screening for Colorectal Cancer. All members aged 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. All enrolled men aged 35-65 years and women aged 45-65 years 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. All members aged 9-15 months (ideally 12 months) shall receive a blood lead measurement at least once.

h) Screening for Diabetes. All 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. All 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. All members aged 3-4 years shall be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

l) Screening for Hearing Impairment. All members aged 50 and beyond shall be routinely screened for hearing impairment by questioning them about their hearing.

m) Screening for Problem Drinking and Substance Abuse. All 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. All 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 counsel and offer testing for HIV.

o) Newborn Screening. At a minimum, all 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 21 years of age to ensure the delivery of the Federally mandated Early and Periodic Screening, Diagnostic, and Treatment (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 MAD-740.

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) Prediagnostic 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 which 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 SALUD! members.

(2) The CONTRACTOR shall phase-in the cultural competency plan over the first two years of the contract according to the following process:

A. Year 1, and no later than July 1, 2002

The CONTRACTOR shall:

i. Develop a Cultural Competency Plan that describes how the CONTRACTOR shall ensure that services provided are culturally competent.

ii. 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.

iii. Target cultural competency training to primary care providers, care coordinators/case mangers, home health care staff and licensed masters and doctoral level mental health and substance abuse professionals.

iv. 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.

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

B. Year 2, and no later than July 1, 2003

The CONTRACTOR shall:

i. Incorporate cultural competence into treatment planning, utilization management and quality improvement.

ii. Identify resources and interventions for high risk health conditions found in certain cultural groups.

iii. Develop and incorporate contract language specific to cultural competency requirements for inclusion in contracts between the CONTRACTOR and providers and subcontractors.

2.6 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

(1) General Requirements

CSHCN applies to individuals, under 21 years of age, who have or are at an increased risk for a chronic physical, developmental, or behavioral or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally. The guiding principle for this definition is that the children shall be at individual risk and have a functional need. The primary purpose of the definition is to identify CSHCN 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 discharging them when special services are no longer needed.

A. CONTRACTOR Requirements:

i. The CONTRACTOR shall include in its member services handbook a description of providers and programs available to children with special health care needs.

ii. The CONTRACTOR shall identify from among its members children with special health care needs, using the proposed definition and criteria for identification.

B. Criteria that the CONTRACTOR shall use in identifying CSHCN, include:

i. Children who are eligible for SSI as disabled under Title XVI;

ii. Children identified in the DOH Title V Children's Medical Services program;

iii. Children participating in the Home and Community Based Waivers;

iv. Children receiving foster care or adoption assistance support through Title IV-E;

v. Other children in foster care or out-of-home placement; and

vi. Children who are described in the Individuals with Disabilities Education Act; and other children who, by merit of a clinical assessment, should be included.

C. SALUD! Enrollment for CSHCN

The CONTRACTOR shall 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) Parent/Child Information and Education

A. The CONTRACTOR shall develop and distribute, as appropriate, information and materials specific to the needs of CSHCN members and their caregivers. This includes information, such as a list of items and services that are in SALUD! and those that are carved out, how to plan for and arrange transportation, how to access behavioral health care without going through the PCP, how the parent or legal guardian should present a child for care in an emergency room unfamiliar with the child's special health care needs, and the

availability of a care coordinator. This information could be included in a special member handbook on CSHCN or in an insert to the member handbook.

B. The CONTRACTOR shall make available health education programs to assist the child's caregiver(s) in understanding CSHCN and how to cope with the day-to-day stress of caring the child.

C. The CONTRACTOR shall provide a list of key CONTRACTOR CSHCN resource people and their phone numbers.

D. The CONTRACTOR shall designate a single entity that a parent or provider can call for information during the enrollment process and after becoming a member.

(3) Choice of Specialist as Primary Care Provider (PCP)

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 CSHCN

The CONTRACTOR shall have enough specialty providers to ensure timely access to necessary specialty care, consistent with SALUD! access appointment standards for clinical urgency.

(5) Transportation

A. The CONTRACTOR shall have written policies and procedures in place to ensure that the appropriate level of transportation is arranged based on the member's clinical condition.

B. The CONTRACTOR shall have past member and service data available at the time services are requested to expedite appropriate arrangements.

C. The CONTRACTOR shall ensure that CPR-certified drivers transport CSHCN whose clinical need dictates.

D. The CONTRACTOR shall have written policies and procedures to ensure that transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers.

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

F. The CONTRACTOR shall 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.

G. The CONTRACTOR shall distribute clear and detailed written information to CSHCN and their families on how to obtain transportation services and also make this information available to network providers.

(6) Care Coordination for CSHCN

A. The CONTRACTOR shall have written policies and procedures for identifying CSHCN who could benefit from care coordination and ensuring that those children have access to care coordination.

B. The CONTRACTOR shall have written policies and procedures for accessing care coordination.

C. The CONTRACTOR shall have written policies and procedures for the development, implementation and periodic evaluation of a child's treatment plan. These policies and procedures shall address the involvement of parent(s) and legal guardians, as well as the child, in decisions about the child's care and development and implementation of the treatment plan. The caregivers of CSHCN and the children themselves, where indicated, shall be full participants in setting and achieving their own goals related to the child's health.

D. The CONTRACTOR shall have written policies and procedures for educating parent(s), legal guardians and children that care coordination is available and when it may be appropriate to their needs.

E. The CONTRACTOR shall have written policies and procedures for educating providers about the availability of care coordination, its value as a resource in caring for the child, and how to access it.

(7) Emergency, Inpatient and Outpatient Ambulatory Surgery Hospital Requirements for CSHCN

A. The CONTRACTOR shall develop and implement written policies and procedures for educating caregivers of CSHCN with complicated clinical histories on how to utilize emergency room care, including what clinical history to present when emergency care or inpatient admission are needed for their child.

B. The CONTRACTOR shall develop and implement written policies and procedures governing how coordination with the PCP and hospitalists shall occur when a child with a special health care need is hospitalized.

C. The CONTRACTOR shall develop and implement written policies and procedures to ensure that the ER physician has access to the child's medical history.

D. The CONTRACTOR shall 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 members having outpatient or ambulatory surgical procedures performed.

(8) Rehabilitation Therapy Services (Physical, Occupational, Speech Therapy) for CSHCN

A. The CONTRACTOR shall develop and implement therapy clinical practice guidelines specific to the chronic or long term conditions of their CSHCN population, including the use of a home therapy program and involvement of a caretaker in the treatment plan, and based on Medicaid managed care policy on medical necessity.

B. The CONTRACTOR shall 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. The CONTRACTOR shall involve families of members, physicians and therapy providers to identify issues that should be addressed in developing the new criteria.

D. The CONTRACTOR shall 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

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

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

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

(10) Clinical Practice Guidelines for Provision of Care to CSHCN

The CONTRACTOR shall develop clinical practice guidelines, practice parameters and/or other specific criteria that consider the needs of CSHCN and provide guidance in the provision of acute and chronic medical and behavioral 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 CSHCN

The CONTRACTOR shall develop written policies and procedures to exclude from prior authorization any item or service enumerated in the child's treatment plan, 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 treatment plan, as indicated.

(12) Consumer Surveys Specific to CSHCN

The CONTRACTOR shall add questions about children with special health care needs to their HEDIS CAHPS 2.04 survey.

(13) CSHCN Performance Improvement Project

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

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 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 on a permanent basis as set forth in MAD Program Manual Section MAD-731, NURSING FACILITIES, and MAD-723, SWING BED HOSPITAL SERVICES.

B. Services provided in intermediate care facilities for the mentally retarded as set forth in MAD Program Manual Section MAD-732, 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, HOME AND COMMUNITY-BASED SERVICES WAIVERS;

D. Emergency services to undocumented aliens as set forth in MAD Program Manual Section MAD-769, EMERGENCY SERVICES FOR UNDOCUMENTED ALIENS;

E. Experimental or investigational procedures, technologies or non-drug therapies as set forth in MAD Program Manual Section MAD-765, EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES, TECHNOLOGIES OR NON-DRUG THERAPIES;

F. Special Rehabilitation Services at set forth in MAD Program Manual Section MAD-743, 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 MAD-744, EPSDT CASE MANAGEMENT;

H. Case management provided by the Children Youth and Families Department as detailed in the Medical Assistance Manual Section MAD-776, ADULT PROTECTIVE SERVICES CASE MANAGEMENT.

I. Case management provided by Children, Youth and Families Department as detailed in the Medical Assistance Manual Section MAD-778, CASE MANAGEMENT SERVICES FOR CHILDREN PROVIDED BY JUVENILE PROBATION AND PAROLE OFFICERS.

J. Services provided in the schools and specified in the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), as detailed in the medical assistance manual Section MAD 747, 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 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, unless the enhanced benefits offered by the CONTRACTOR do not generate claim or encounter data.

2.9 **GRIEVANCE**

The member, guardian of the member for minors, or representative of the member has the right to file a grievance if he/she is dissatisfied with the services rendered by the CONTRACTOR. This includes but is not limited to dissatisfaction with direct service provider(s), appropriateness of services rendered, timeliness of services rendered, availability of services, delivery of services, prescription of services, denial, reduction, and/or termination of services, disenrollment, or any other performance that is considered unsatisfactory. A participating provider also has the right to file a grievance with the CONTRACTOR if the provider is dissatisfied with the CONTRACTOR'S decision to terminate, suspend, reduce, or not provide services to a member. The CONTRACTOR shall implement written policies and procedures describing how the member and provider register a grievance with the CONTRACTOR and how the CONTRACTOR resolves a given type of grievance.

(1) CONTRACTOR Grievance Hearing Policies and Procedures

A. The CONTRACTOR shall establish and implement written policies and procedures for resolution of grievances, including internal CONTRACTOR hearings which shall include at minimum:

i. The procedures for notifying members of the right to file a grievance and to request a hearing using the CONTRACTOR'S hearing process and provide members written notice of adverse actions as described in the Medical Assistance Division Program Manual;

ii. The name of specific individual(s) designated as the MCO Medicaid member grievance coordinator with the authority to administer the policies and procedures for grievance resolution, to review patterns/trends in grievances and to initiate corrective action;

iii. The policies and procedures for a toll-free telephone line for members to register a grievance with the CONTRACTOR;

iv. The specific policies and procedures detailing how a thorough investigation of the grievance, using applicable statutory, regulatory, and contractual provisions, is conducted; The CONTRACTOR shall have physician involvement in reviewing medically-related grievances. The CONTRACTOR shall offer to meet with the member during the formal grievance process;

v. The investigation and final CONTRACTOR decision for grievances filed by Medicaid members and providers shall be completed within thirty (30) calendar days of the receipt of the grievance with a report in writing stating the resolution of the grievance to HSD, the grievant, and involved parties. The CONTRACTOR shall implement policies and procedures for an expedited or emergency alternative appeal process for quality of care and level of care/placement issues, and for cases where the health and/or welfare of the member is immediately at risk; The expedited or emergency process shall result in a timely resolution such that a reasonable person would believe that a prevailing member would be able to realize the full benefit of a decision in his or her favor;

vi. The procedures for maintaining a file of all grievances that contain sufficient information to identify the grievance, the date the grievance was received, the nature of the grievance, notice to the grievant of receipt of a grievance, all correspondence between affected parties, the date the grievance is resolved, the means of grievance resolution, and notices of final decision to affected parties and all other pertinent information. Documentation regarding the grievance shall be made available to the grievant, if requested;

vii. Specific policies and procedures detailing how confidential information gathered or learned during the investigation or resolution of a grievance is to be maintained, including the confidentiality of the member's status as a Medicaid member and status as a grievant; and

viii. A statement that the member shall not be subject to retaliation for filing a grievance.

(2) Accessibility of Grievance Files

All grievance files shall be maintained in a secure, designated area and be accessible to HSD upon request, for review. Grievance files shall be retained for six (6) years following the final decision, HSD or judicial appeal, or closure of a grievance case file.

(3) Information Distribution

The CONTRACTOR shall have the following responsibilities with regard to the distribution of information:

A. Member Notice With Initial Enrollment

Upon enrollment, the CONTRACTOR shall provide members, at no cost, with a member information sheet or handbook which provides information on how they and/or their representative(s) can file a grievance and about the grievance resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with HSD Hearings Bureau, without first utilizing the CONTRACTOR'S grievance process, in those instances in which Medicaid benefits are terminated, suspended, reduced or

not-provided. The information shall meet the standards for communication specified in Section MAD-606.7, QUALITY MANAGEMENT, Standards for Member Communication.

B. The CONTRACTOR may not establish time limits of less than one year from the date of occurrence for the member to file a formal grievance.

i. Method of Obtaining Hearing and the Right to Representation: The information shall include the method by which a hearing may be obtained and the right to self-representation or the use of a spokesperson or legal counsel.

ii. Non-Disclosure of Information. The member information shall include a statement that information about the grievance is not disclosed without the member's permission unless disclosure is required by law.

iii. Non-Retaliation. The information shall include a statement which verifies that the member shall not be subjected to retaliation for filing a grievance.

(4) Provider Receipt of Grievance Policies and Procedures

The CONTRACTOR shall provide a copy of its policies and procedures for grievance resolution to all service providers in the CONTRACTOR network.

(5) Acknowledgment When Grievance Filed

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.

(6) Notice to Member or Provider of Final Decision

The CONTRACTOR shall mail a copy of its final written decision to HSD, the member or provider to the address on file and all those parties affected by the decision. The final decision shall include and describe at least the following:

A. The nature of the grievance;

B. A statement of the action the CONTRACTOR intends to take;

C. A statement describing the reasons for the CONTRACTOR'S action;

D. Specific references and citations to applicable Medicaid and the CONTRACTOR'S policies and procedures, if any, that support the action;

E. The member's right to request an administrative hearing, if not already requested, to appeal the CONTRACTOR'S decision to the HSD Hearings Bureau within thirty (30) calendar days of the final CONTRACTOR'S decision to terminate, suspend, reduce, or not provide a benefit to the member; and

F. The statement that the member's request for an administrative hearing which is received by HSD within ten (10) calendar days of the CONTRACTOR'S final decision stays the enforcement of the CONTRACTOR'S decision to discontinue services currently provided, but does not require the CONTRACTOR to initiate any treatment or services or to increase the level of any current treatment or services.

(7) Notice to HSD

If a request for an administrative hearing to appeal the CONTRACTOR'S final decision is received, an official record of the grievance and copy of the final CONTRACTOR'S decision shall be provided to the HSD Hearings Bureau by the CONTRACTOR within five (5) working days of HSD's request for such information.

(8) Administrative Hearings

Members may file a request for an administrative hearing through the HSD Hearings Bureau without first availing themselves of the CONTRACTOR'S grievance process when the final decision rendered by the CONTRACTOR is to terminate, suspend, reduce, or not-provide benefit(s) to a member.

(9) Quarterly Reports

The CONTRACTOR shall provide a quarterly report to HSD of all grievances received from or about Medicaid members, by the CONTRACTOR or its subcontractors. The report shall include patient details according to the format in Guidance Memo #62.

(10) Hearing Report

The CONTRACTOR shall provide a monthly report of all internal CONTRACTOR hearings filed and their disposition.

2.10 **FIDUCIARY RESPONSIBILITIES**

(1) Solvency Requirements and Risk Protections

A CONTRACTOR that contracts with HSD 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 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, at no cost to HSD, in a reasonable time from the date of request or as specified herein.

(2) Reinsurance

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 such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance.

(3) Third Party Liability

The CONTRACTOR is responsible for identification of other third party coverage of members and coordination of benefits with applicable third parties. The CONTRACTOR shall inform HSD of any member who has other health care coverage. The CONTRACTOR shall provide documentation to HSD enabling HSD to pursue its rights under State and Federal law. Documentation includes payment information on enrolled members as requested by HSD, 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 includes a quarterly listing of potential accident and personal injury cases to be pursued by HSD that are known to the CONTRACTOR. The CONTRACTOR and HSD 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 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 is 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, audit and accounting standards.

B. Per Member Cash Reserve

The CONTRACTOR shall maintain three (3) percent of the monthly capitated payments per member with an independent trustee during each month of the first year of the Agreement. The CONTRACTOR shall maintain this cash reserve for the duration of the Agreement. HSD 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.

(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 or its designee, and provide all financial records required by HSD or its designee so that they may inspect and audit the CONTRACTOR'S financial records at least annually or at HSD's discretion.

(8) Timely Payments

A. The CONTRACTOR shall make timely payments to both its contracted and non-contracted providers. 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. The CONTRACTOR shall pay 90 percent of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities within 30 days of date of receipt, and shall pay 99 percent of all such clean claims within 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; it includes a claim with errors originating in the states' system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; or has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan within thirty days of the date of receipt if submitted electronically or forty-five days if submitted manually.

(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, and;

iv. Reinsurance.

v. Automobile insurance to the extent applicable to CONTRACTOR'S operations.

B. The CONTRACTOR shall provide HSD 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 such written documentation as is necessary to show the existence of this protection, which may include policies and procedures of reinsurance.

2.11 **FRAUD AND ABUSE**

(1) The CONTRACTOR shall have written policies and procedures to address prevention, detection, preliminary investigation, reporting of potential and actual Medicaid fraud and abuse;

(2) The CONTRACTOR shall 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) The CONTRACTOR shall 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) The CONTRACTOR shall cooperate with the Medicaid Fraud Control Unit (MFCU) and other investigatory agencies as mutually agreed to by the parties in writing;

(5) The CONTRACTOR shall have systems that can monitor service utilization and encounters for fraud and abuse;

(6) The CONTRACTOR shall immediately report to HSD 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 as defined by the CONTRACTOR in consultation with HSD and the Medicaid Fraud Control Unit (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) The CONTRACTOR shall 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.

2.12 **REPORTING**

The CONTRACTOR shall provide to HSD managerial, financial, and utilization and quality reports. The content, format, and schedule for submission shall be determined by HSD in advance for the financial reporting period and shall conform to reasonable industry, and/or HCFA standards. HSD may also require the CONTRACTOR to submit non-routine ad hoc reports, provided that HSD 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 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 defined standards; and

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.

E. Possibility for Change. HSD 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 by HSD.

(2) Monitoring of Grievance Resolution

The CONTRACTOR shall submit a Quarterly Grievance Report to HSD 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 shall include an audited schedule of Salud! revenues and expenses including a breakout of the Salud! behavioral health revenue and expenses. The result of the CONTRACTOR'S annual audit and related management letters shall be submitted no later than one hundred 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 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 system of accounting. The accounting system shall clearly document all financial transactions between the CONTRACTOR and its subcontractors, and the CONTRACTOR and HSD. 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 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 access to its facilities.

D. The CONTRACTOR and its subcontractors shall retain all records and reports relating to agreements with HSD for a minimum of six (6) years from the date of final payment. In cases involving incomplete audits and/or unresolved audit findings, administrative sanctions, or litigation, the minimum six (6) year retention period shall begin when such actions are resolved.

E. The CONTRACTOR shall submit records involving any business restructuring when changes in ownership interest of 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 5% or more. These records shall be provided no later than sixty (60) days following the change of ownership.

F. The following table gives an overview of the reporting requirements the HSD has established to monitor and examine CONTRACTOR for solvency and compliance with Federal requirements for financial stability. These requirements shall enable HSD or its designee to determine if changes have occurred which affect an MCO and 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 MCO net worth or other financial condition.

G. Behavioral Health Reporting

(1) Submit monthly behavioral health UM reports to HSD, in a format to be determined by HSD after consultation with the CONTRACTOR. These monthly reports will include the following categories: total number of UM reductions of care, total number of terminations of care, the total of clinical denials of care and total number of administrative denials for all prior approved behavioral health services;

(2) Submit a monthly behavioral health utilization report to HSD, in a format to be determined by HSD after consultation with the CONTRACTOR,

identifying the actual Medicaid clients impacted by any of the reporting elements above, including each client's name, social security number, date of request, date of UM determinations, service requested, and final UM determination.

(3) The CONTRACTOR shall collect and report on a quarterly basis key variables of program performance related to behavioral health services. Key variables will be determined in consultation with the CONTRACTOR and stakeholders.

H. Financial Reporting Requirements:

Definition	Frequency	Objective	Due Date
Calendar year Independently Audited Financial Statements	Annual	Examine for Solvency and HCFA Compliance	June 1
CalendarYear Medicaid Specific Behavioral Health Schedule of Revenue and Expenses	Annual	Examine for Solvency and HCFA Compliance	June 1
Calendar Year Medicaid Specific Audited Schedule of Revenue and Expenses	Annual	Examine for Solvency and HCFA 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 HCFA Compliance	45 days from end of Quarter, March 1 for Annual Statement

Claims Aging	Quarterly	Examine for Solvency and HCFA Compliance	30 days from end of Qtr
Expenditure by Category of Services for hospital, pharmacy, behavioral health, physician, dental, transportation and other	Quarterly	Determine Cost Efficiency	30 days from end of Qtr
Expenditure of services to FQHC's.	Quarterly	Enable HSD to make wraparound payments to FQHC's	30 days from end of Qtr
Expenditures of services to RHC's	Quarterly	Enable HSD to make wraparound payments to RHC's	30 days from end of Qtr
Expenditures specifically made to IHS, tribal 638 and urban Indian providers.	Quarterly	Enable HSD to reconcile the payments made by the CONTRACTOR to IHS, tribal 638, and urban Indian providers against the supplemental capitation payments made by HSD to the CONTRACTOR	30 days from end of Qtr
Analysis of Benefit Coordination savings of MCO by rate cell	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 HCFA Compliance	Initially and upon renewal

Analysis of Stop-loss protection with Detail of Panel Composition	Quarterly and Annually	Examine for Solvency, Rate Payment, and HCFA Compliance Including Rules Regarding Physician Incentives	30 days from end of Qtr
Reinsurance Policy	Annual	Assess Solvency and HCFA Compliance	Initially and upon renewal
Cash Reserve Statement	Quarterly	Examine for Solvency and HCFA Compliance	30 days from end of Qtr

(4) Automated Reporting

A. The CONTRACTOR is required to submit data to HSD. HSD 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 any inconsistencies immediately upon discovery. If any unreported inconsistencies are subsequently discovered, the CONTRACTOR shall make the necessary adjustments at its own expense.

C. HSD, in conjunction with its fiscal agent, intends to implement electronic data interchange standards for transactions related to managed health care. The CONTRACTOR shall work with HSD to develop the technical components of such an interface.

(5) Encounters

HSD 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. HSD 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 in accordance with the following:

A. Encounter Submission Media

The CONTRACTOR shall provide encounter data to HSD 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 within 90 days of the date of service or discharge, regardless of whether the encounter is from a subcontractor or subcapitated arrangement. Encounters which do not clear edit checks shall be returned to the CONTRACTOR for correction and resubmission. The CONTRACTOR shall correct and resubmit the encounter data to HSD.

C. Encounter Data Elements

Encounter data elements are based on the Medicaid-Medicare Common Data Initiative (McData Set) which is a minimum core data set for states and MCOs developed by HCFA and HSD for use in managed care. HSD may increase or reduce or make mandatory or optional, data elements as it deems necessary.

D. Encounter Data Formats

The CONTRACTOR shall submit encounter data to HSD using the following formats:

i. HCFA 1500 Encounter Format - This format is used to report individual medical services such as physician visits, nursing visits, surgical procedures, anesthesia services, laboratory test, radiology services, home and community based services, therapy procedures, durable medical equipment, supplies and transportation services. Services shall be reported through the use of HCFA Common Procedure Coding System (HCPCS) codes (level 1, 2, or 3).

ii. UB92 Encounter Format - This encounter format is primarily used to report facility services such as inpatient or outpatient hospital, dialysis, and institutional services.

iii. New Mexico Drug Form Encounter Format - This format is used to report pharmacy items provided to enrolled Medicaid Managed Care members.

iv. ADA Dental Claim Encounter Format - This encounter format is used to report dental services provided to enrolled Medicaid Managed Care members.

v. Turn Around Document (TAD) - This encounter format is used to report long term care and residential care stays.

(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 along with the HEDIS data submission tool. The HEDIS compliance audit will be at the expense of the CONTRACTOR.

(8) MHSIP

The CONTRACTOR shall report MHSIP data annually to HSD; utilize a standardized format for data submission, designed by HSD in consultation with the CONTRACTOR; pull a statistically valid sample from which to collect MHSIP data; and train its staff in the collection and reporting of MHSIP data and in survey conduct.

(9) Health Management Systems Reports

The CONTRACTOR shall identify the number of adult Severely Disabled Mentally Ill (SDMI) and Severely Emotionally Disturbed Children (SED) and Chronic Substance Abuse (CSA) members served and report the following adverse events involving SDMI, SED, and CSA members to the HSD on a quarterly basis: suicides, other deaths, attempted suicides, involuntary hospitalizations, detentions for protective custody, and detention for alleged criminal activity.

(10) Provider Network Reports

The CONTRACTOR shall notify HSD within five (5) working days of any unexpected changes to the composition of its provider network that negatively affects 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 in writing when the CONTRACTOR knows of the anticipated change or within thirty (30) calendar days, whichever comes first. The notice submitted to HSD 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 SALUD! Program by June 1, 2001. The CONTRACTOR'S MIS shall the following requirements.

(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. Conduct automated claims processing;

C. Estimate the number of records to be received from providers and subcontractors, monitor, and transmit electronic encounter data to HSD according to encounter data submission standards;

D. Transmit data electronically over a Bulletin Board System and via internet;

E. Disseminate enrollment information to providers within five (5) business days of receipt of the information;

F. Maintain a website for dispersing information to providers and members, and be able to receive comments electronically;

G. Have the systems capability to receive data elements associated with identifying members who are receiving ongoing services under fee-for-service Medicaid or from another CONTRACTOR;

H. Have systems capability to transmit to HSD or another CONTRACTOR data elements associated with their members who have been receiving ongoing services within their organization; and

I. 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 on a monthly basis, no later than the 28th day of each month, to include all contracted providers, non-contracted providers who have provided service to date, providers who have applied for contract and are pending, providers whose application has been denied, and providers who have been terminated from contract. The file is a general replacement file each month with no deletions from the file until 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 for that provider or not;

C. Providing a complete and accurate designation of each provider according to the data elements and definitions included in the SALUD! Systems Manual; 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 National Standard Formats for electronic claims submission. In the event that final HIPAA regulations change any formats or data required on the standardized formats, the CONTRACTORS shall be required to adapt their systems accordingly;

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 in a joint committee for standardizing coding where national coding systems do not apply;

G. Accepting from providers and subcontractors national standard codes and, where these codes don't apply, acceptance of state-assigned codes that have been approved by the HSD joint committee for standardization;

H. Editing claims to ensure providers licensed to render the services being billed are submitting services, that services are appropriate in scope and amount, and that enrollees are eligible to receive the service; and

I. Developing and maintaining an electronic billing system for all providers submitting bills directly to the CONTRACTOR within six months of the inception of the Agreement. Require all subcontractor benefit managers to meet the same deadline.

(5) Member Information Requirements: The CONTRACTOR'S member information requirements shall include, but not be limited to:

A. Accepting, maintaining and transmitting member information:

B. Monitoring newborns to ensure minimal lapse in time between the infant's birth and their determination of Medicaid eligibility. The CONTRACTOR shall submit electronic claims for newborn capitations until the MMIS is capable of

issuing the capitations automatically. The anticipated date for this capability is October 1, 2001, after which the CONTRACTOR shall only be responsible for submitting capitation claims in unusual circumstances, such as to correct a previously unidentified problem. Retroactive capitations shall only be issued for the first three months of life, during which time the mother's MCO shall cover the services of the newborn. After the time, if that newborn has not appeared on a roster for the CONTRACTOR, the CONTRACTOR shall not be responsible for the continuing health care for the child. However, the parent or guardian may choose a different MCO for the newborn as early as the second month of life. In such a case, the MCO of the mother is only entitled to the capitation for the birth month;

C. Generating member information to providers within five (5) business days of receipt of the enrollment roster from HSD;

D. Using all four occurrences of the Medicaid member ID number sent to the CONTRACTOR on the enrollment roster to ensure the CONTRACTOR can differentiate between a change in an existing client's Medicaid member ID number and a new client. These numbers needs to be available to staff to be used as a cross reference when providers or others submit a number other than the number maintained by the CONTRACTOR as the primary number and as a means to update the member's ID number when eligibility changes necessitate a change to the number;

E. Maintaining a special medical status identifier on their system's database consistent with HSD'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 or verifying member eligibility;

F. Meeting federal HCFA standards for release of member information (applies to subcontractors as well). Standards are specified in the SALUD! Systems Manual and at 42 CFR 431.306(b);

G. Track 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,

I. Providing automated access to providers regarding member eligibility and PCP assignment;

J. Making member enrollment and PCP assignment information available for electronic verification systems, including swipe card systems; and

K. Providing daily electronic transmission to HSD of member enrollment and PCP assignment.

(6) Encounter and Provider Network Reporting Requirements: The CONTRACTOR has a responsibility for the following Encounter and Provider Network File Submission and Reporting capabilities to include, but not be limited to:

A. Submitting to HSD encounters, according to the specifications included in the SALUD! Systems Manual, within 90 days of the date of service or discharge, regardless of whether the encounter is from a subcontractor or subcapitated arrangement;

B. Submitting encounter files that have an error rate of no more than five percent;

C. Submitting corrections to any encounters that are rejected by HSD as exceeding by HSD the five percent error threshold within 30 days of the rejection;

D. Submitting adjustments/voids to encounters that have previously been accepted by HSD within 30 days of the adjustment or void of claim;

E. Including written contractual requirements for subcontractors or providers that pay their own claims to submit encounters to the CONTRACTOR on a timely basis to ensure that the CONTRACTOR can submit encounters to HSD within 90 days of the date of service or discharge;

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 to assure timeliness of submissions, resubmissions and corrections and completeness of data. The CONTRACTORS shall be required to report the status of their encounter data submissions overall on a form developed by HSD;

H. Having a formal monitoring and reporting system to reconcile submissions and resubmissions of encounter data between the CONTRACTORS and their subcontractors or providers who pay their own claims to assure timeliness and completeness of their submission of encounter data to the CONTRACTORS;

I. 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 HCFA guidelines is included in the SALUD! Systems Manual;

J. Complying with HCFA standards for electronic transmission, security, and privacy, as may be required by HIPAA (also applies to subcontractors); and

K. Reporting all data noted as "required" in the encounter formats provided in the Systems Manual.

ARTICLE 3 - LIMITATION OF COST

The total amount payable by HSD to all CONTRACTORS executing Agreements with HSD to perform services shall be less than the upper payment limit established under the terms of the 1915(b) waiver for Medicaid managed care. 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 Section 447.361 and 447.362. In no event shall HSD pay twice for the provision of services.

ARTICLE 4 - HSD RESPONSIBILITY

4.1 HSD shall:

(1) Establish and maintain Medicaid eligibility information and transfer eligibility information to assure 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.

(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 in 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 assure compliance with all applicable State and Federal laws and regulations.

(16) Monitor encounter data submitted by the CONTRACTOR and shall 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, as necessary, to encourage health care providers paid by HSD to enter into contracts with the CONTRACTOR at the applicable Medicaid reimbursement rate for the provider, absent other negotiated arrangements. 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.

4.2 HSD and/or its fiscal agent shall implement electronic data interchange standards for transactions related to managed health care.

4.3 Performance by the CONTRACTOR shall not be contingent upon time availability of HSD 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 personnel shall be granted as freely as possible. However, the competency/sufficiency of HSD staff shall not be 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 to perform its specific responsibilities under the Agreement, the CONTRACTOR'S performance shall be excused or delayed, as appropriate. The CONTRACTOR shall provide HSD 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 has failed to meet, as well as the reason HSD's failure impacts the CONTRACTOR'S ability to meet its performance obligations under the Agreement.

ARTICLE 5 - COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE

5.1 Subject to Article 8, ENFORCEMENT, HSD shall pay the monthly rates shown below, for each member, in full consideration of all the work to be performed by the CONTRACTOR

under this Agreement. The monthly rate for each member is based on the age, gender, and eligibility category of the member. 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 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 monthly rate set forth below shall be subject to renegotiation during the Agreement if HSD determines that it is necessary due to change in Federal or State law or in the appropriations made available for these tasks as set forth in Article 14, Appropriations, and Article 12, Contract Modification.

5.3 Payment for Services

(1) HSD 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 a combination of the age, gender and eligibility category of the member. The combinations are grouped into twenty-nine (29) 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) HSD shall pay each CONTRACTOR an additional payment for each Native American identified in HSD's system. This additional payment is to be used to cover medical costs of Native Americans provided at Indian Health Service; tribal 638 and defined urban Indian providers. The Native American payment amount is established by HSD and is fully reimbursed to the CONTRACTOR. The supplemental payment amounts are subject to revision based upon an actuarial review. These payments are cost neutral to the CONTRACTOR. Any payment made beyond the amount of the supplemental capitation shall be reimbursed by HSD. Any payment made by HSD that is not expended shall be recouped from the CONTRACTOR.

(3) 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 members liability for copayments 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 copayment obligations.

5.4 Payment on Risk Basis

The CONTRACTOR is at risk of incurring losses if its expenses for providing the managed care benefit package exceeds its capitation payment. HSD 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 shall remain in effect as referenced in Attachments A and B for the first twenty-four (24) months for the effective date of this Agreement. Capitation rates may be reviewed if this Agreement is extended with the CONTRACTOR pursuant to this Agreement. Upon mutual Agreement of the CONTRACTOR and HSD, the capitation rates may be adjusted based on factors such as changes in the scope of work, a Native American MCO is established or a Navajo Medicaid Agency created, HCFA requires a modification of the state's waiver or 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 modified pursuant to Articles 12 (Contract Modification) and 37 (Amendments) of this agreement.

(2) HSD shall compensate the CONTRACTOR for work performed under this Agreement at the following rates shown on Attachments A and B.

(3) The CONTRACTOR shall obtain reinsurance for coverage of members as required by this Agreement. However, the CONTRACTOR remains ultimately liable to HSD 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 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, the CONTRACTOR shall submit a payment request to HSD for the newborn member. HSD shall pay the CONTRACTOR the monthly rate for the newborn after receipt and verification of the claim by HSD.

(3) HSD 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 paid the CONTRACTOR for the member's care under the terms of this Agreement.

(4) HSD shall recoup payments for members who are incorrectly enrolled with more than one CONTRACTOR; payments made for members who die prior to the enrollment month for which payment was made; and/or payments for members whom HSD later determines were not eligible for Medicaid during the enrollment month for which payment was made. Notwithstanding the foregoing, HSD shall not have the right to recoup a payment made to the CONTRACTOR if either the CONTRACTOR (and/or its subcontractors) provided any health care services to the member during the relevant period of time or more than twenty-four months have elapsed since the payments were made.

(5) With the exception of newborns born while the mother is an enrolled member, HSD 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 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, 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 subacute 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 MCO.

(8) On a periodic basis, HSD 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. Attempt to recover any third-party resources available to Medicaid recipients (42 C.F.R. 433 Subpart D) and shall make all records pertaining to Third Party Collections (TPL) for members available to HSD for audit and review. HSD shall have the right to claim any TPL collections generated by these activities.

C. Notify HSD 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.

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. Members shall not be charged 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.

F. Payments provided for under this Agreement shall be denied for new members when, and for so long as, payment for those members is denied under 42 CFR Section 434.67(e).

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 100 percent 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 100 percent 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 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 (OMB), or 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.

5.8 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 (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 services which are medically necessary until the clinical emergency is stabilized. This includes all treatment that may be necessary to assure, within reasonable medical probability, that 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 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 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.

ARTICLE 6 - CONTRACT ADMINISTRATOR

The Contract Administrator is, and his/her successor shall be, designated by the Secretary of HSD. HSD 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 to represent HSD in all matters related to this Agreement except those reserved to other HSD 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 in its proposal.

7.2 Replacement of any CONTRACTOR personnel shall be with personnel of equal ability, experience, and qualifications.

7.3 HSD 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, meeting the needs of Medicaid members or the needs of HSD 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.

7.5 The CONTRACTOR shall submit to HSD on a quarterly basis a brief job description and the qualifications of each individual behavioral health UM staff.

ARTICLE 8 - ENFORCEMENT

8.1 HSD 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 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 failed to comply with any applicable law, regulation, term of this Agreement, policy, standard, rule, or for other good cause, the Secretary of HSD may impose any or all of the following in accordance with applicable law:

A. Plans of Correction. The CONTRACTOR shall be required to provide to HSD, within fourteen (14) days, a plan of correction to remedy any defect in its performance.

B. Directed Plans of Correction. The CONTRACTOR shall be required to provide to HSD, within fourteen (14) days, a plan of correction as directed by HSD.

C. Civil or administrative monetary penalties may be imposed to the extent authorized by federal or state law.

i. HSD 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 shall impose liquidated damages consistent with letter J of this Article.

iii. A monetary penalty, depending upon the severity of the infraction. Penalty assessments shall range, up to five (5) percent of the CONTRACTOR'S Medicaid capitation payment in the month in which the penalty is assessed.

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. All other administrative, contractual or legal remedies available to HSD shall be employed in the event that the CONTRACTOR violates or breaches the terms of the Agreement.

D. Adjustment of Automated Assignment Formula: HSD 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 may suspend new enrollment to the CONTRACTOR.

F. Appointment of a State Monitor: Should HSD 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 may deny payment for all members or deny payment for new members.

H. Rescission: HSD may rescind marketing consent.

I. Actual Damages: HSD may assess to the CONTRACTOR actual damages to HSD or its members resulting from the CONTRACTOR'S non-performance of its obligations.

J. Liquidated Damages: HSD 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. The State may withhold payment to the CONTRACTOR for liquidated damages until such damages are paid in full.

K. Removal: HSD may remove members with third party coverage from enrollment with the CONTRACTOR.

L. Temporary Management: HSD may appoint temporary management to oversee the operations of the CONTRACTOR upon a finding by the Secretary of HSD that there is continued egregious behavior by the CONTRACTOR, there is a substantial risk to the health of the members, or to assure the health of the CONTRACTOR'S members while there is an orderly termination or reorganization of the CONTRACTOR'S organization or improvements are made to remedy the identified violations. The Secretary of HSD shall not allow the removal of the temporary management until it determines that the CONTRACTOR has the capability to ensure that the violation shall not reoccur. The CONTRACTOR does not have the right to a predetermination hearing prior to the appointment of temporary management.

M. Terminate Enrollment: HSD may permit members enrolled with the CONTRACTOR to terminate enrollment without cause and notify such members of the right to terminate enrollment.

N. Impose Penalty: HSD 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 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, provide any services that have been denied or take steps to provide or arrange for the provision of any services that it has agreed or is otherwise obligated to make available.

P. Suspension: HSD may suspend the Agreement.

Q. Termination: HSD may terminate the Agreement.

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 may also deny payment if HSD learns that a CONTRACTOR:

A. 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 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 shall notify the Secretary of Health and Human Services of noncompliance with subparagraph A above. HSD 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 and Congress a written statement describing the compelling reasons that exist for renewing and extending the Agreement.

(4) This section is subject to the "nonexclusively of remedy" language.

8.3 Notice and Cure

HSD shall provide reasonable written notice of its decision to impose sanctions on the CONTRACTOR and, as HSD 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 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 under the provisions of this Agreement or of applicable law or regulations.

8.5 CONTRACTOR'S Incentive Requirements

HSD shall provide incentives to the CONTRACTOR'S that receive 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 by automatically assigning in greater number to the CONTRACTOR determined by HSD 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 and the CONTRACTOR upon such terms and conditions as they may agree;

(2) By HSD for convenience, upon not less than one hundred 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 subacute or skilled nursing care, whichever occurs first. In the event that HSD 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 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 subacute or skilled nursing care, whichever occurs first;

(4) By HSD for cause upon failure of the CONTRACTOR to materially comply with the terms and conditions of this Agreement. HSD 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 may serve written notice stating the date of termination and work stoppage arrangements;

(5) By HSD, if required by modification, change, or interpretation in State or Federal law or HCFA 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's decision as to whether sufficient funds are available shall be accepted by the CONTRACTOR and shall be final;

(6) By HSD, 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, 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, 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, in the event it determines that the health or welfare of Medicaid members are in jeopardy should the Agreement continue. For purposes of this paragraph, termination of the Agreement requires a finding by HSD that a substantial number of members face the threat of immediate and serious harm;

(10) By HSD, 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 in the event a petition for bankruptcy is filed by or against the CONTRACTOR;

(12) By HSD if the CONTRACTOR fails substantially to provide medically necessary items and services that are required under this Agreement;

(13) By HSD, 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 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, if the CONTRACTOR intentionally misrepresents or falsifies information that is furnished to the Secretary of Health and Human Services, HSD or Medicaid members, potential members or health care providers under the Social Security Act or pursuant to this Agreement;

(15) By HSD, 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 fails to pay any amount due the CONTRACTOR hereunder within thirty (30) days of the date such payments are due; and

(17) By the CONTRACTOR, on sixty (60) days written notice with cause, or one hundred eighty (180) days written notice without cause.

9.2. If HSD terminates this Agreement pursuant to this Article and unless otherwise specified in this Article, HSD shall provide the CONTRACTOR written notice of such termination at least sixty (60) days prior to the effective date of the termination, unless HSD itself receives less than sixty (60) days notice, in which case HSD shall provide the CONTRACTOR with as much notice as possible, but in no event less than sixty (60) days notice. If HSD 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 has reduced to writing and delivered to the CONTRACTOR notice of termination, the effective date, and reasons therefor, if any, HSD, in addition to other rights provided in this Agreement, may require the CONTRACTOR to transfer, deliver, and/or make readily available to HSD, property in which HSD has a financial interest. Prior to invoking the provisions of this paragraph, HSD shall identify that property in which it has a financial interest, provided that, subject to HSD's recoupment rights herein, property acquired with capitation or other payments made for members properly enrolled shall not be considered property in which HSD has a financial interest.

10.2 In the event this Agreement is terminated by HSD, 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.

(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 may direct for orderly completion and transition.

(3) Agree that HSD 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's negligence, wrongful act, or breach of the Agreement.

(4) Take such action as HSD 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 programs.

(6) Allow HSD, 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.

ARTICLE 11 - RIGHTS UPON TERMINATION OR EXPIRATION

11.1 Upon termination or expiration of this Agreement, the CONTRACTOR shall, upon request of HSD, make available to HSD, or to a person authorized by HSD, all records and equipment which are the property of HSD.

11.2 Upon termination or expiration, HSD shall pay the CONTRACTOR all amounts due for service through the effective date of such termination. HSD may deduct from amounts otherwise payable to the CONTRACTOR monies determined to be due HSD from the CONTRACTOR. Any amounts in dispute at the time of termination shall be placed by HSD in an interest-bearing escrow account with an escrow agent mutually agreed to by HSD and the CONTRACTOR.

11.3 In the event that HSD terminates the Agreement for cause in full or in part, HSD may procure services similar to those terminated and the CONTRACTOR shall be liable to HSD 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 for administrative costs incurred by HSD in procuring such similar services. The rights and remedies of HSD 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 of any outstanding claims for which HSD 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. 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 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 care in progress, whether or not those members are hospitalized or in long-term treatment.

11.7 The CONTRACTOR shall be responsible to HSD for liquidated damages arising out of CONTRACTOR'S breach of this Agreement.

11.8 In the event HSD proves that the CONTRACTOR'S course of performance has resulted in reductions in HSD's receipt of federal program funds, as a Federal sanction, the CONTRACTOR shall remit to HSD, as liquidated damages, such funds as are necessary to make HSD 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 manages its Medicaid program, this Agreement shall be subject to substantial modification by amendment. Such election shall be effected by HSD sending written notice to the CONTRACTOR. HSD'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 37, Amendment. In addition, in the event that approval of HSD'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 HCFA in granting the waiver, shall be negotiated and mutually agreed to between HSD and the CONTRACTOR. The results of the negotiations shall be placed in writing in compliance with Article 37, (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, who after investigation may direct the CONTRACTOR not to incorporate such components. If HSD shall not object, and after the CONTRACTOR obtains written consent of the party owning the same, and furnishing a copy to HSD, 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 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, Health and Human Services (HHS)/Health Care Financing Authorities (HCFA), or the U.S. Congress for the performance of this Agreement. If sufficient appropriations and authorizations are not made by either the Legislature, HHS/HCFA or the Congress, this Agreement shall be subject to termination or amendment. HSD'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 pursuant to this Section 14.1 shall be in writing and signed by the parties in accordance with Article 37 (Amendments) of this Agreement.

14.2 To the extent Health Care Finance Administration, legislation or Congressional action impact the amount of appropriation available for performance under this Contract, HSD has the right to amend the Scope of Work, in its discretion, which shall be effected by HSD sending written notice to the CONTRACTOR.

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 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, various applicable documents shall be referred to for the purpose of clarification or for additional detail in the order of priority and significance, specified below:

15.2.1 Amendments to the Agreement in reverse chronological order followed by;

15.2.2 The Agreement, including items incorporated by reference in Paragraph 1.2, followed by:

15.2.3 The CONTRACTOR'S Best and Final Offer followed by;

15.2.4 The Request for Proposal, including attachments thereto and HSD's written responses to written questions and HSD'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

(1) Any dispute concerning sanctions imposed under this Agreement shall be reported in writing to the MAD Director within fifteen (15) days of the date the reporting party received notice of the sanction. 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 Secretary of the HSD 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 Secretary of the HSD 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 the 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 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, its officers or employees nor the State of New Mexico to any obligation not expressly authorized herein unless HSD 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. HSD 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 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 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 MCO function. The CONTRACTOR remains legally responsible to HSD for all work performed by any subcontractor. The CONTRACTOR shall submit to HSD 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 prior to execution by any subcontractor.

(2) HSD 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 prior notice with regard to its intent to subcontract certain significant contract requirements as specified herein or in writing by HSD including, but not limited to, credentialing, utilization review, and claims processing. HSD 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 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 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 434.70(a)(3) to allow HSD to determine whether the incentive plans meet the requirements of 42 CFR 417.479(d) through (g). The CONTRACTOR shall

provide capitation data required by 42 CFR 479(h)(1)(iv) for the previous calendar year to HSD 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 the HSD 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 MCO 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 for the SALUD! 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 utilization management criteria when utilization management 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 a fully executed original of all subcontracts which are accessible to HSD 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 and 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 six (6) year period and shall make all enrollee medical records available for the purpose of quality review conducted by HSD or is 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 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. The subcontractor shall accept payment from the CONTRACTOR as payment for any services included in the benefit package, and cannot request payment from HSD for services performed under the subcontract;

xi. If the subcontract includes primary care, provisions for compliance with PCP requirements delineated in the primary MCO contract apply;

xii. The subcontractor shall comply with all applicable State and Federal statutes, laws, rules, and regulations;

xiii. Subcontracts shall include provision for termination for any violation of applicable HSD, State or Federal requirements;

xiv. The subcontract 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. The subcontract 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. The subcontract 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.

xvii. The subcontract for pharmacy providers shall include a payment provision consistent with 1978 NMSA § 27-2-16B unless the subcontractor provides a voluntary waiver to any rights under 1978 NMSA §27-2-16B or the CONTRACTOR is notified by HSD that the provisions of Section 27-2-16B do not apply to the CONTRACTOR'S subcontract with the Pharmacies.

ARTICLE 20 - RELEASE

20.1 Upon final payment of the amounts due under this Agreement, the CONTRACTOR shall release HSD, 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 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 for such obligations. Any payments by HSD to the CONTRACTOR shall be subject to any appropriate recoupment by HSD.

20.3 Notice of any post-termination audit or investigation of complaint by HSD shall be provided to the CONTRACTOR, and such audit or investigation shall be initiated in accordance with HCFA requirements. HSD shall notify the CONTRACTOR of any claim or demand within 30 days after completion of the audit or investigation or as otherwise authorized by HCFA. Any payments by HSD to the CONTRACTOR shall be subject to any appropriate recoupment by HSD 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 six (6) years after a pending audit is completed and resolved, whichever is later, HSD 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, the Department of Finance and Administration, the State Auditor and/or any authorized State or Federal entity and shall be retained for six (6) years. Payment under this Agreement shall not foreclose the right of HSD 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, State, and Federal reporting or monitoring requirements for six (6) years after the contract is terminated under any provisions of Article 11 of this Agreement or six (6) years after any pending audit is completed and resolved, whichever is later. These records shall be subject to inspection by HSD, 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 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 in a manner on paper and/or in electronic format that is timely, legible, current, set forth, and organized, and 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 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 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'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. However, nothing in this Agreement shall require the CONTRACTOR to provide HSD 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, 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 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 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 subcontractors activities. The CONTRACTOR shall be given 10 working days to respond to any findings of an audit before HSD 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, 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 against any and all liability, loss, damage, costs or expenses which HSD 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 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, or any of its officers, employees, or agents.

22.3 The CONTRACTOR shall agree to indemnify and hold harmless HSD, 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 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 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 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 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, 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 MAD population required to make co-payments under Medical Assistance Division policy. In no case, shall the State, HSD 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.

ARTICLE 23 - LIABILITY

23.1 The CONTRACTOR shall be wholly at risk for all covered services. No additional payment shall be made by HSD, nor shall any payment be collected from an enrollee, except for co-payments authorized by HSD 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 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 finds that the CONTRACTOR is not in compliance with this requirement at any time during the term of this Agreement, HSD 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 is the property of HSD and shall be turned over to HSD 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 (or benefits to others) to be issued in error, the CONTRACTOR shall reimburse the State within thirty (30) days of written notice of such error for the full amount of the payment. Interest shall accrue at the statutory rate upon 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.

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 shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at members before use. Examples include written materials, billboards, and radio, television advertisements and websites.

(1) The CONTRACTOR shall provide a copy of the CONTRACTOR'S member handbook to enrollees or potential enrollees requesting a copy and as requested by HSD.

(2) The CONTRACTOR shall send a provider directory to any person requesting a copy;

(3) The CONTRACTOR shall provide a one page, two-sided summary of its benefits which may be distributed by HSD at its discretion; and

(4) The CONTRACTOR shall maintain policies and procedures governing the development and distribution of marketing materials for members.

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 MAD 606.4.8, MEDICAID MANAGED CARE MARKETING GUIDELINES.

(2) All marketing and/or outreach materials produced by the CONTRACTOR under the Medicaid managed care 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 (verbal, 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 MCO;

B. Designing a marketing or outreach plan which discourages or encourages MCO 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 MCO 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; and

H. Conducting any other marketing activity prohibited by HSD 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 timely take corrective actions. HSD 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 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, member handbooks.

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 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 their knowledge and belief, that:

(1) No Federal 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 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 Federal 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 subrecipients 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 section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $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 Project Manager 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 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 - CONFIDENTIALITY

32.1 Any confidential information, as defined in State or Federal law, code, rules or regulations or otherwise applicable by the Code of Ethics, regarding HSD's recipients or providers given to or developed by the CONTRACTOR and its subcontractors shall not be made available to any individual or organization by the CONTRACTOR and its subcontractors without the prior written approval of HSD.

32.2 The CONTRACTOR shall (1) notify HSD promptly of any unauthorized possession, use, knowledge, or attempt thereof, of HSD's data files or other confidential information; and (2) promptly furnish HSD full details of the unauthorized possession, use of knowledge or attempt thereof, and assist investigating or preventing the recurrence thereof.

32.3 In order to protect the confidentiality of member information and records:

(1) The CONTRACTOR shall adopt and implement written confidentiality policies and procedures which conform to Federal and State laws and regulations.

(2) The CONTRACTOR'S contracts with practitioners and other providers shall explicitly state expectations about the confidentiality of member information and records.

(3) The CONTRACTOR shall afford members and/or legal guardians the opportunity to approve or deny the release of identifiable personal information by the CONTRACTOR to a person or agency outside of the CONTRACTOR, except to duly authorized subcontractors, providers or review organizations, or when such release is required by law, State regulation, or quality standards.

(4) When release of information is made in response to a court order, the CONTRACTOR shall notify the member and/or legal guardian of such action in a timely manner.

(5) The CONTRACTOR shall have specific written policies and procedures that direct how confidential information gathered or learned during the investigation or resolution of a grievance is maintained, including the confidentiality of the member's status as a grievant.

32.4 The CONTRACTOR shall comply with HSD's requests for records and documents as necessary to verify the CONTRACTOR is meeting its duties and obligations under this Agreement, or for data reporting legally required of HSD. Except as otherwise required by law, HSD may not request from the CONTRACTOR records and documents that go beyond ensuring that the CONTRACTOR is meeting its duties under this Agreement, including, where appropriate, records and documents that are protected by any law, including, but not limited to, laws protecting proprietary information as a trade secret, confidentiality laws, and any and all applicable legal privileges (including, but not limited to, attorney/client, physician/patient, and quality assurance and peer review).

ARTICLE 33 - COOPERATION WITH MEDICAID FRAUD CONTROL UNIT

33.1 The CONTRACTOR shall immediately report to the New Mexico State Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office and HSD any reasonable suspicion or knowledge of fraud and/or abuse, including but not limited to the false or fraudulent filings of claims and/or the acceptance of or failure to return monies allowed or paid on claims known to be false or fraudulent. Where required by law, the reporting entity shall not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the MFCU.

33.2 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 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.

33.3 The CONTRACTOR shall disclose to HSD, 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 Salud! program and persons related to the CONTRACTOR convicted of criminal activity related to Medicaid, Medicare, or the federal Title XX programs.

33.4 Any actual or potential conflict of interest within the CONTRACTOR'S Salud! 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 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 in a capacity relating to Medicaid or the Salud! program or any other party with direct responsibility for this Agreement.

33.5 Any recoupment received from the CONTRACTOR by HSD 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.

33.6 Upon request to the CONTRACTOR, the MFCU shall be provided with copies of all grievances and resolutions affecting Medicaid members.

33.7 Should the CONTRACTOR know about or become aware of any investigation being conducted by the MFCU or HSD, the CONTRACTOR, and its representatives, agents and employees, shall maintain the confidentiality of this information.

33.8 The CONTRACTOR shall have in place and enforce policies and procedures to educate Medicaid members of the existence of, and role of, the MFCU.

33.9 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.

33.10 All documents submitted by the CONTRACTOR to HSD, 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 34 - WAIVERS

34.1 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.

34.2 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 35 - 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, shall be willing to become a network provider for any managed care organization that contracts with HSD for Medicaid managed care services, to be reimbursed by such MCO 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 36 - NOTICE

36.1 A notice shall be deemed duly given upon delivery, if delivered by hand, or three 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.

36.2 All notices required to be given to HSD under this Agreement shall be sent to the HSD Contract Administrator or his/her designee at:

Contract Administrator
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348

36.3 All notices required to be given to the CONTRACTOR under this Agreement shall be sent to:

Garrey Carruthers, President and CEO
Cimarron Health Plan
7801 Academy NE, Building 2, Suite 202
Albuquerque, NM 87109

ARTICLE 37 - 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 38 - HEADINGS NOT CONTROLLING

Headings used in this Agreement are for reference purposes only and shall not be deemed a part of the Agreement.

ARTICLE 39 – STATE CHILDREN HEALTH INSURANCE PROGRAM (SCHIP)

39.1 The CONTRACTOR shall enroll as members children who are participants in SCHIP under Title XXI of the Social Security Act. SCHIP enrollees are entitled to all of the benefits provided under this Agreement and any Amendments thereto except that the CONTRACTOR may enforce, against participants of SCHIP only, any cost sharing requirements approved by HSD.

39.2 The CONTRACTOR may enforce, against participants of the SCHIP only, any cost sharing requirements approved by HCFA. All other terms and conditions of the Agreement and this Amendment shall apply to SCHIP participants, as they do to Title XIX Medicaid recipients.

ARTICLE 40 - 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 41 – 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, 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:

Robin Dozier Otten, Deputy Secretary
Human Services Department

Approved as to Form and Legal sufficiency:

By: _____ Date:

Rumaldo Armijo, General Counsel
Human Services Department

OFFICE OF THE ATTORNEY GENERAL

Approved as to Form and Legal sufficiency:

By: _____ Date:

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:

AGREEMENT NO. PSC _____
Between the State of New Mexico Human Services Department
And Cimarron Health Plan

Amendment No. 1 ("Amendment") is entered into by and between the New Mexico Human Services Department (hereinafter referred to "HSD") and Cimarron Health Plan (hereinafter referred to as "CONTRACTOR" OR "MCO").

WHEREAS, the parties have previously entered into Agreement PSC _____ Approved by the Department of Finance and Administration (DFA) on July 1, 2001 (the "Agreement") and

WHEREAS, Article 37 of the Agreement allows for amendment of the Agreement; and

WHEREAS, the parties have determined that the term of the Agreement should be extended for an additional year.

WHEREAS, the Balanced Budget Act of 1997 requires certain changes to the Agreement; and

WHEREAS, based on the parties' experience since implementation of the Agreement, the parties have agreed to certain changes in the Agreement beneficial to the Agreement's goals;

NOW THEREFORE, the parties do amend the Agreement as follows:

1. All terms, definitions and conditions stated in the Agreement and not modified by this Amendment shall remain in full force and effect. This Amendment shall become effective July 1, 2003, provided it has been approved by the Department of Finance and Administration, and the U.S. Department of Health and Human Services, Center for Medicare/Medicaid Services (CMS). Any reference to CMS in this document is a reference to the agency formerly known as Health Care Financing Administration (HCFA);

2. This Agreement is extended to expire at midnight June 30, 2004.

3. In the event of a conflict between, on the one hand, the Agreement as amended herein, and on the other hand, the regulations promulgated by the Code of Federal Regulations (CFR) for Managed Care Organizations (MCOs) and the Human Services Department, the federal and state regulations will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment No. 1 as of the date of execution by the State Contracts Officer, below.

Article 1 (RECITALS), Section 1.2.(6). is amended to read as follows:

1.2.(6). All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico ("State"), and HSD, concerning Medicaid services, managed care organizations, 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.

Article 1 (RECITALS), Section 1.7. is added to read as follows:

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.

Article 1 (RECITALS), Section 1.8. is added to read as follows:

1.8 HSD may, in the administration of this contract, seek input on health care related issues from any advisory group or steering committee.

Article 2 (SCOPE OF WORK) Section 2.1.(1).A.v. is amended to read as follows:

2.1.(1).A.v. The CONTRACTOR shall 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 to 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 a manner and format that may be easily understood. At the option of the CONTRACTOR, the directory may be limited to primary care and self-refer providers.

Article 2 (SCOPE OF WORK) Section 2.1.(1).A.vi. is amended to read as follows:

2.1.(1).A.vi. The CONTRACTOR shall 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 may be easily understood.

Article 2 (SCOPE OF WORK), Section 2.1.(1).D. is amended to read as follows:

2.1.(1).D. MCO Enrollment Information

Once a member is determined to be an MCO mandatory member, HSD 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 to the CONTRACTOR at the time of enrollment in the MCO of each Medicaid member.

Article 2 (SCOPE OF WORK) Section 2.1.(1).E.ii. is amended to read as follows:

2.1.(1).E.ii. The CONTRACTOR is responsible for providing members with a member handbook and provider directory within a reasonable time after the CONTRACTOR is notified by HSD 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.

Article 2 (SCOPE OF WORK) Section 2.1.(1).E.iii. is amended to read as follows:

2.1.(1).E.iii. The CONTRACTOR shall send a provider directory and member handbook to members or potential members requesting a copy and as requested by HSD. The CONTRACTOR may direct a person requesting a member handbook or a provider directory to an internet site. However, a specific request for a printed document shall be met. The CONTRACTOR shall provide a one page, two-sided summary of its benefits which may be distributed by HSD at its discretion. The CONTRACTOR must notify all members at least once per year of their right to request and obtain this information.

Article 2 (SCOPE OF WORK) Section 2.1.(1).E.iv.a.b.c. are amended to read as follows:

2.1.(1).E.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's determination there is a prevalent population of the CONTRACTOR'S Salud! members that 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. These oral interpretations must be available in all non-English languages, not just those that are determined to be prevalent by the CONTRACTOR and HSD. The CONTRACTOR must notify potential members and members that oral interpretation is available in any language and that written information is available in prevalent languages and how to access this information.

(1) The format for the written material 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.

(2) All potential members upon request and enrolled members must be notified how to access these formats.

(3) The handbook shall include:

a) Limitations to the receipt of care from non-participating providers;

b) Coordination of care by PCPs;

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

d) Services for which prior authorization or a referral is required, and the method of obtaining both;

e) The provider directory, which need not physically be part of the handbook. This provider directory shall include the names, locations, telephone numbers of, and non- English languages spoken by current contracted providers in the member's service area, including the identification of providers who are not accepting new patients. At a minimum, this information shall include Primary Care Providers (PCPs), self referral specialists, and hospitals.

f) Any restrictions on the member's freedom of choice among network providers;

g) Notice to members on both the CONTRACTOR'S internal grievance and appeal processes and HSD's fair hearing process;

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

i) The member's rights, protections, and responsibilities;

j) Information on obtaining care in emergency or urgent conditions;

k) Information on accessing behavioral health or other 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. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

l) Information on the member's rights to terminate enrollment and the process for voluntarily disenrolling from the plan;

m) Other information determined by HSD to be essential during the member's initial contact with the CONTRACTOR;

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

o) Information regarding advanced directives.

p) Information on cost sharing if any;

q) Additional information upon request, including information on how to obtain the CONTRACTOR'S structure and operation and physician incentive plans.

Article 2 (SCOPE OF WORK), Section 2.1.(1).F.iii. is added to read as follows:

2.1.(1).F.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.

Article 2 (SCOPE OF WORK) Section 2.1.(1).I.i.d). is amended to read as follows:

2.1.(1).I.i.d) The following information regarding the member's rights of access to and coverage of emergency services shall include:

1. The fact that the member has a right to use any hospital or other setting for emergency care;
2. What constitutes emergency medical condition, emergency services, and post stabilization services;
3. That an emergency condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the individual's health (or with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part;
4. That post stabilization care covers services related to an emergency medical condition, that are provided after the member is stabilized in order to maintain the stabilized condition or, to improve or resolve the member's condition;
5. The fact that prior authorization is not required for emergency services in or out of the network with all emergency services reimbursed at least at the Medicaid network rate and that the CONTRACTOR shall not retroactively deny a claim for an emergency screening examination because the condition, which

appeared to be an emergency medical condition under the prudent layperson standard (defined above), turned out to be non-emergency in nature;

6. The locations of any emergency settings and other locations at which providers and hospital furnish emergency services and post stabilization services furnished under the contract.

Article 2 (SCOPE OF WORK) Section 2.1.(1).I.iv. is amended to read as follows:

2.1.(1).I.iv. The CONTRACTOR shall provide affected members and/or legal guardians with written updated information within 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 days after receipt or issuance of termination notice to each who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

Article 2 (SCOPE OF WORK) Section 2.1.(1).K. is amended to read as follows:

2.1.(1).K. The CONTRACTOR shall be required to comply with the MAD regulation 8.305.8.15. on Patient Bill of Rights. The CONTRACTOR shall provide each member with written information, in English or prevalent language, as appropriate, found in the MAD patient Bill of Rights pursuant to MAD 8.305.8.15.

Article 2 (SCOPE OF WORK), Section 2.1.(1).K.ii.a is amended to read as follows:

2.1.(1).K.ii.a 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.

Article 2 (SCOPE OF WORK), Section 2.1.(1).K.xi. is added to read as follows:

2.1.(1).K.xi. 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.

Article 2 (SCOPE OF WORK) Section 2.1.(1).L.ii. is amended to read as follows:

2.1.(1).L.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.

Article 2 (SCOPE OF WORK), Section 2.1.(1).M.vii is amended to read as follows:

2.1.(1).M.vii. The CONTRACTOR shall comply with NCQA standards for Utilization Management and follow NCQA timeliness standards for routine, urgent and emergent situations. The decision-making timeframes should accommodate the clinical urgency of the situation and not delay the provision of services to member for lengthy periods of time. These required timeframes are not to be affected by "pend" decisions. A possible extension of up to 14 additional calendar days may apply if:

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

(ii) the CONTRACTOR justifies to HSD a need for additional information and demonstrates how the extension is in the member's interest.

Article 2 (SCOPE OF WORK), Section 2.1.(1).N. is added to read as follows:

A. Coverage and authorization of services.

The CONTRACTOR shall do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the CONTRACTOR is required to offer.

(2) Require that the services identified in paragraph (1) of this section 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.

(3) The CONTRACTOR:

(i) shall 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.

(ii) may 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;

(iii) may place appropriate limits on a service –

(a) on the basis of criteria applied under HSD, such as medical necessity; or

(b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (A)(3)(i) of this section; and

(4) The CONTRACTOR shall specify what constitutes "medically necessary services" in a manner that:

(i) Is no more restrictive than that used by HSD as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the CONTRACTOR is responsible for covering services related to the following:

(a) the prevention, diagnosis, and treatment of health impairments;

(b) the ability to achieve age-appropriate growth and development;

(c) the ability to attain, maintain, or regain functional capacity.

(B) Authorization of Services

For the processing of requests for initial and continuing authorizations of services, the CONTRACTOR must:

(1) Require that its subcontractors have in place, and follow, written policies and procedures;

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

(3) Consult with the requesting provider when appropriate; and

(4) 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.

(C) 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 requirement of 42 CFR Section 438.404, except that the notice to the provider need not be in writing.

D. Compensation for utilization management 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.

Article 2 (SCOPE OF WORK), Section 2.1.(1).N. (Denials) is changed to Section 2.1.(1).O.

Article 2 (SCOPE OF WORK), Section 2.1.(2).F.viii. is amended to read as follows:

2.1.(2).F.viii. The CONTRACTOR shall have written policies and procedures for conducting member surveys.

Article 2 (SCOPE OF WORK) Section 2.1.(2).G.ii. is amended to read as follows:

2.1.(2).G.ii. 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 which represents at least five percent of a CONTRACTOR'S enrollment.

Article 2 (SCOPE OF WORK), Section 2.1.(2).J.x. is added to read as follows:

2.1.(2).J.x. Ensure the delegate takes corrective action if the CONTRACTOR identifies deficiencies.

Article 2 (SCOPE OF WORK), Section 2.1.(2).J.xi. is added to read as follows:

2.1.(2).J.xi. Revoke delegation or impose other sanctions if the delegate's performance is inadequate, in accordance with CONTRACTOR'S policy and procedures.

Article 2 (SCOPE OF WORK), Section 2.1.(2).L.iv. is amended to read as follows:

2.1.(2).L.iv. Follow NCQA guidelines for the conduct of provider satisfaction surveys; cooperate with HSD in conducting provider satisfaction survey, including making available a current, unduplicated provider file(s) available to HSD or its EQRO upon request;

Article 2 (SCOPE OF WORK) Section 2.1.(2).M.i. is amended to read as follows:

2.1.(2).M.i. HSD shall retain the services of an external quality review organization 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's quality standards as set forth in MAD Policy Section 8.305.8. HSD shall also contract with an external review organization to audit a statistically valid sample of the CONTRACTOR behavioral 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.

Article 2 (SCOPE OF WORK) Section 2.1.(3). is amended to read as follows:

2.1.(3). Disease Management Indicators

A. Disease Management Programs and Performance Improvement Projects are two of the tools that HSD has chosen to use to measure a CONTRACTOR'S ability to identify problematic areas within its operations and take actions which shall improve its performance in those focus areas. Examples of these include but, are not limited to, administrative functions (telephone response rates), utilization management (timeliness of prior authorizations), access to care, preventive care (improvement of EPSDT screening rates), and care coordination.

B. The CONTRACTOR shall:

i. Participate in disease management programs/performance improvement projects annually. HSD will coordinate with CONTRACTOR to select programs that meet the NCQA requirements. Fifty percent of the disease management programs/performance improvement projects shall relate to behavioral health;

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

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 of the ongoing effectiveness of named interventions.

Article 2 (SCOPE OF WORK) Section 2.1.(3).C.i. and ii. is amended to read as follows:

2.1.(3).C.i. Track, analyze, and report to HSD quarterly, certain indicators identified specific to behavioral or physical health that shall enable HSD to determine potential problems areas within quality of care, access, or service delivery;

2.1.(3).C.ii. Collect the requested data quarterly, perform analysis on the data for the purpose of determining completeness and validity, and report results to HSD quarterly;

Article 2 (SCOPE OF WORK), Section 2.1.(3).D. is added to read as follows:

2.1.(3).D. PHYSICAL AND BEHAVIORAL HEALTH PERFORMANCE MEASURES FOR FY 2004 MCO CONTRACTS.

A. Managed Care Performance Measures:

For capitation payments made on or after June 25, 2003, HSD shall withhold one-half of one (0.5) percent of the CONTRACTOR'S payments. The withhold funds shall be released to the CONTRACTOR no sooner than July 1st and no later than July 31st of 2004 only if, in the judgment of HSD, performance targets in the contract are achieved. Withhold funds shall be released to the CONTRACTOR based on the following scoring system for each of the ten performance measures listed below:

1. Dental Access to Care shall be worth 10 points;
2. Child Access to PCP shall be worth 10 points;
3. Diabetes Care shall be worth 10 points;
4. Consumer/Family Based Services shall be worth 15 points;
5. RTC Readmissions shall be worth 10 points;
6. Behavioral Health Discharge Follow-up after 7 days shall be worth 5 points;
7. Behavioral Health Discharge Follow-up after 30 days shall be worth 5 points;
8. Provider Payment Timeliness shall be worth 15 points;
9. Customer Support Services shall be worth 10 points; and
10. Encounter Data Reporting shall be worth 10 points.

The percentage of the CONTRACTOR'S withhold funds to be released shall be calculated by summing all earned points, dividing the sum by 100, and converting to a percentage. No partial whole number of points will be

assigned if the CONTRACTOR fails to completely meet performance measures described in one through ten above. Points assigned for the performance measures will be all or none (e.g. 15 points or 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 by CONTRACTOR, provided that HSD shall have the right to audit and validate the information or results as reported by CONTRACTOR.

For the current contract amendment the CONTRACTOR shall submit HEDIS scores for calendar year 2003 according to the required HEDIS submission schedule for evaluation under this performance measurement section.

B. Performance Measures Requirements:

The ten performance measures shall be evaluated using the following criteria:

1. DENTAL ACCESS TO CARE:

The CONTRACTOR'S members between the ages of four and twenty-one who were continuously enrolled with the CONTRACTOR during the measurement period will have a dental visit during the measurement year, as evidenced by a minimum HEDIS score of 44.00.

2. CHILD ACCESS TO PCP:

The CONTRACTOR'S members between the age of twelve months through twenty-four months who are continuously enrolled with the CONTRACTOR during the measurement period, will have a visit with a pediatrician, family physician, or other CONTRACTOR'S primary care provider during the measurement year, as evidenced by a minimum HEDIS score of 96.00.

3. DIABETES CARE, HbA1c:

Diabetic members who are continuously enrolled with the CONTRACTOR during the measurement period will have a glycohemoglobin (HbA1c) blood test during the measurement year, as evidenced by a minimum HEDIS score of 73.72.

4. CONSUMER/FAMILY BASED SERVICES:

At least one-half of one (0.5) percent of the Salud! behavioral health expenditures for FY 04 will be expended for non-profit family and/or member controlled/operated organizations. These organizations shall be member-centered and recovery-driven. These organizations shall develop and direct activities that provide support, education and access to services to consumers and families. HSD shall provide the reporting format to the CONTRACTOR. The CONTRACTOR shall report to HSD on a quarterly basis.

For all three CONTRACTORS the total minimum expenditure will be $434,166.00 (0.5% of $86,833,000.00).

Cimarron's minimum expenditure will be $117,225.00.

5. RTC RE-ADMISSIONS:

Nineteen percent or less of the CONTRACTOR'S members who are discharged from a residential treatment center (RTC) will be readmitted to the same level of care or a higher level of care within thirty days of discharge from the RTC.

6. BEHAVIORAL HEALTH DISCHARGE FOLLOW-UP:

The CONTRACTOR'S members who are discharged from an acute psychiatric hospital setting will receive follow-up care within seven days of discharge as evidenced by a minimum HEDIS score of 34.56.

7. BEHAVIORAL HEALTH DISCHARGE FOLLOW-UP:

The CONTRACTOR'S members who are discharged from an acute psychiatric hospital setting will receive follow-up care within thirty days of discharge as evidenced by a minimum HEDIS score of 57.25.

8. PROVIDER PAYMENT TIMELINESS:

The CONTRACTOR shall pay ninety percent of all clean claims for physical and behavioral health within thirty days and ninety-nine percent of all physical and behavioral health clean claims within ninety days.

9. CUSTOMER SUPPORT SERVICES:

a. Ninety percent of the CONTRACTOR'S member services calls shall be answered within thirty seconds or less based on the reported average.

b. The CONTRACTOR shall conduct a Consumer Advisory Board meeting on a quarterly basis.

10. ENCOUNTER DATA REPORTING:

The CONTRACTOR shall submit 100 percent of all required encounter data on a timely basis for submissions and necessary re-submissions as set forth in the contract, 2.12.(5).B. The submissions and required re-submissions shall have an error rate of five percent or less for at least seventy-five percent of the files.

C. Retention and Release of Withhold Funds:

1. The retention of funds withheld shall be accomplished as follows:

A. The CONTRACTOR shall place all funds to be withheld by HSD, under part A. (Managed Care Performance Measures) of this section, in a separate account and shall provide to HSD 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.

2. The release of the funds withheld shall be made as follows:

A. The funds in the withheld funds account shall be released for use by the CONTRACTOR only after HSD has submitted in writing that, in HSD's judgment, the performance targets in the contract have been achieved for the period of time specified in the contract. HSD shall provide written confirmation no sooner than July 1st and no later than July 31st of 2004.

3. The release of funds withheld shall be calculated as follows:

A. The difference between the total FY 2004 capitation payments to the CONTRACTOR as of June 30, 2004 divided by 0.995 (99.5 percent) and the total FY 2004 capitation payments to the MCO as of June 30, 2004.

B. The difference calculated shall be multiplied by the percentage determined in Section A., Managed Care Withhold, above.

D. 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 the average of the two HEDIS 2004 Use of Services measurements.

A. 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:

1. HEDIS WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEAR OF LIFE.

As annually reported to HSD, the percentage of members who were three, four, five, or six years old during the measurement year, who were continuously enrolled with the CONTRACTOR during the measurement year, and who received at least one primary care provider visit.

a. For this measurement, the CONTRACTOR shall determine continuous enrollment for a member pursuant to the HEDIS technical specifications.

b. The CONTRACTOR shall determine a primary care provider visit pursuant to the HEDIS technical specifications for administrative or hybrid methods.

2. HEDIS ADOLESCENT WELL-CHILD VISIT.

As annually reported to HSD, the year's percentage of members who were twelve through twenty-one years old during the measurement year, who were continuously enrolled with the CONTRACTOR during the measurement year, and who received at least one primary care provider visit.

a. For this measurement, the CONTRACTOR shall determine continuous enrollment for a member pursuant to the HEDIS technical specifications.

b. The CONTRACTOR shall determine a primary care provider visit pursuant to the HEDIS technical specifications for administrative or hybrid methods.

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

B. Challenge Pool Payments

1. A CONTRACTOR that earns all withhold funds described in Section A shall not be eligible for any Challenge Pool payment.

2. The CONTRACTOR with the highest overall average of two HEDIS 2004 measurements during the measurement year will have released an amount that does not exceed one hundred percent of the funds withheld from the CONTRACTOR.

3. All other CONTRACTORS will have returned a percentage of their withheld 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 withheld funds that were not earned under Section A.

E. 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:

1. CERVICAL CANCER SCREENING:

Female members aged twenty-one to sixty-four 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.

2. DISTRIBUTION OF BEHAVIORAL HEALTH PROVIDERS:

As demonstrated by a quarterly geo-access report, ninety percent of CONTRACTOR members in urban areas will have access to a licensed behavioral health provider within thirty miles. Ninety percent of CONTRACTOR members in rural areas will have access to a licensed behavioral health provider within sixty miles. Ninety percent of CONTRACTOR members in frontier areas will have access to a licensed behavioral health provider within ninety miles. The behavioral health provider must be in active practice. Telemedicine and circuit-riders can be utilized to fulfill this requirement. Compliance shall be averaged over a six-month measurement period.

3. BEHAVIORAL HEALTH PENETRATION RATE:

The penetration rates for the following populations shall be determined according to HEDIS methodology, using appropriate encounter data:

a. CONTRACTOR members up to the age of twenty-one who are continuously enrolled during the measurement year, there will be a behavioral health penetration rate of at least 7.7 percent.

b. CONTRACTOR members ages nineteen through twenty who are continuous enrolled during the measurement year, there will be a behavioral health penetration rate of at least 10.5 percent.

4. COMMUNITY BASED BEHAVIORAL HEALTH SERVICES:

The CONTRACTOR shall increase its expenditures on the following community based services by a total of ten percent:

Assertive Community Treatment (ACT);

Behavior Management Services (BMS);

Case Management for children and adults (CM);

Non-Emergency Room Crisis Services;

Home Based Services;

Intensive Outpatient Services (IOP);

Psychosocial Rehabilitation Services (PSR);

Respite Services for children/adolescents and adults;

Shelter Care Services for children/adolescents;

Transitional Living Services for children/adolescents and adults;

Day Treatment Program (DTP); and

Multi-Systemic Therapy (MST).

HSD shall provide a reporting format to the CONTRACTOR. The CONTRACTOR shall report to HSD on a quarterly basis using this format.

Article 2 (SCOPE OF WORK) Section 2.1.(4).C. is amended to read as follows:

2.1.(4).C. The CONTRACTOR shall meet time and distance standards for PCPs and pharmacies as determined by HSD 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 upon request.

Article 2 (SCOPE OF WORK) Section 2.1.(4).D. is amended to read as follows:

2.1.(4).D. The CONTRACTOR shall meet provider appointment and pharmacy in-person prescription fill time standards as described in MAD Policy 8.305.8.18; 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 24 hours, when needed on an urgent basis. All new, customized, made-to-measure equipment shall be delivered within 150 days of the request date. All repairs or modifications shall be delivered within 60 days of the request date.

Article 2 (SCOPE OF WORK) Section 2.1.(4).E.i. is amended to read as follows:

2.1.(4).E.i. 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;

g) Have CPR certified drivers to transport members whose clinical needs dictate.

Article 2 (SCOPE OF WORK), Section 2.1.(4).I is added to read as follows:

2.1.(4).I 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 mechanisms to ensure compliance by providers; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply.

Article 2 (SCOPE OF WORK), Section 2.1.(6).A.iii is amended to read as follows:

2.1.(6).A.iii Develop and implement written policies and procedures, which govern how members with multiple and complex special physical, and behavioral health care needs shall be identified.

Article 2 (SCOPE OF WORK), Section 2.1.(6).A.iv. is amended to read as follows:

2.1.(6).A.iv Develop and implement written policies and procedures, governing how care coordination shall be provided for members with special health care needs. A member or family shall have a right to refuse care coordination or case management.

Article 2 (SCOPE OF WORK), Section 2.1.(6).B.vii is amended to read as follows:

2.1.(6).B.vii 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.

Article 2 (SCOPE OF WORK) Section 2.1.(7).B. is amended to read as follows:

2.1.(7).B. 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.

Article 2 (SCOPE OF WORK) Section 2.2.(3).A.iv. is amended to read as follows:

2.2.(3.).A. HSD 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:

iv. Members participating in the Health Insurance Premium (HIPP) Program or the Breast and Cervical Cancer (BCC) Medicaid Program.

Article 2 (SCOPE OF WORK) Section 2.2.(5).B. is amended to read as follows:

2.2.(5).B. Hospitalized Members

A member who is hospitalized in a general acute-care, rehabilitation or freestanding psychiatric 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 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, rehabilitation or freestanding psychiatric hospital at the time such member enrolls with the CONTRACTOR, until such time as the member is discharged from the hospital.

Article 2 (SCOPE OF WORK) Section 2.2.(5).C. is amended to read as follows:

2.2.(5).C. Members in Placement in Residential Treatment Centers

If a child or adolescent becomes Medicaid eligible or enrolls with the CONTRACTOR while residing in an accredited or non-accredited residential treatment center, he or she shall be immediately eligible for enrollment and the CONTRACTOR shall assume financial responsibility for the member as of the effective date of enrollment.

Article 2 (SCOPE OF WORK) Section 2.2.(5).D. is amended to read as follows:

2.2.(5).D. Members in Treatment Foster Care Placements

If a child or adolescent was residing in a treatment foster care placement at the time managed care enrollment began, they shall be exempt from enrolling in an MCO until he or she is discharged from treatment foster care.

Article 2 (SCOPE OF WORK), Section 2.2.(6). is amended to read as follows:

2.2.(6). Enrollment Process for Members

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

Article 2 (SCOPE OF WORK), Section 2.2.(6).C. is amended to read as follows:

2..2.(6).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 shall notify the CONTRACTOR 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.

Article 2 (SCOPE OF WORK), Section 2.2.(6).E.ii. is amended to read as follows:

2.2.(6).E.ii The CONTRACTOR shall 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;

Article 2 (SCOPE OF WORK) Section 2.2.(6).E.x. is amended to read as follows:

2.2.(6).E.x. The CONTRACTOR is responsible for payment of all inpatient services provided by a general acute-care, rehabilitation or freestanding psychiatric 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;

Article 2 (SCOPE OF WORK) Section 2.2.(6).E.xi. is amended to read as follows:

2.2.(6).E.xi. The CONTRACTOR is responsible for payment until disenrollment or switch enrollment, if an enrolled member is placed in a residential treatment center or treatment foster care, or is admitted to a nursing facility or intermediate care facility for the mentally retarded as a long term or permanent placement; and

Article 2 (SCOPE OF WORK), Section 2.2.(7).A.iv. is amended to read as follows:

2..2.(7).A.iv. 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;

Article 2 (SCOPE OF WORK), Section 2.2.(7).B. is amended to read as follows:

2..2.(7).B. Member Initiated Disenrollment

1. A member who is required to participate in managed care may request to be disenrolled from the CONTRACTOR "for cause" at anytime, even during a lock-in period. The following are causes for disenrollment:
   - i. The member moves out of the Contractor's service area.
   - ii. The CONTRACTOR does not, because of moral or religious objections, cover the service the member seeks.
   - iii. The member needs related services (for example, a caesarian section and a tubal ligation) to be performed at the same time and 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.
   - iv. 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.
2. This request shall be submitted in writing to HSD for review. HSD 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 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.

Article 2 (SCOPE OF WORK) Section 2.2.(7).D. is added to read as follows:

2.2.(7).D Retroactive Reenrollment

A member who is no longer enrolled with the CONTRACTOR, whether in error or otherwise, shall not be retroactively reenrolled by the CONTRACTOR unless HSD submits its request for re-enrollment to the CONTRACTOR within 30 days of the date the CONTRACTOR received enrollment data from HSD indicating that the member was no longer enrolled with the CONTRACTOR or eligible for Medicaid Managed Care provided however that nothing in this section shall restrict the appropriate enrollment of newborns in accordance with the provision of 2.2.(5).A. The CONTRACTOR may not be obligated to accept retroactive reenrollment.

Article 2 (SCOPE OF WORK), Section 2.3, is amended to read as follows:

2.3 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, and 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. 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.

Article 2 (SCOPE OF WORK), Section 2.3(1).C is added to read as follows:

2.3.(1).C. The CONTRACTOR, in establishing and maintaining the network of appropriate providers, shall consider its:

i. Anticipated Medicaid 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.

Article 2 (SCOPE OF WORK), Section 2.3.(1).D. is added to read as follows:

2.3.(1).D The CONTRACTOR shall 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.

Article 2 (SCOPE OF WORK) Section 2.3.(11).A. is amended to read as follows:

2.3.(11).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.

Article 2 (SCOPE OF WORK), Section 2.3.(16).B is amended to read as follows:

2.3.(16).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 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 a participating or non-participating provider. Unless otherwise negotiated, the CONTRACTOR shall reimburse providers of family planning services at the Medicaid rate.

Article 2 (SCOPE OF WORK) Section 2.3.(17).A.iii. is amended to read as follows:

2.3.(17).A.iii. Build a statewide behavioral health provider network that ensures access to all levels of behavioral health services, across a continuum from the most to the least restrictive setting. The network shall be sufficient to ensure that the standards in MAD Policy 8.305 for access to care providers who want to refer members for behavioral health care and vice versa;

Article 2 (SCOPE OF WORK), Section 2.3.(17).B.ii. is amended to read as follows:

2.3.(17).B.ii The CONTRACTOR shall provide care coordination for members with multiple and complex special physical, mental, neurobiological, emotional and/or behavioral health care needs on an as needed basis, depending upon the clinical profile of the member. The CONTRACTOR shall have written policies and procedures, which govern how members with these multiple and complex needs shall be identified and how these specific care coordination services shall be provided.

Article 2 (SCOPE OF WORK), Section2.3.(17).C is amended to read as follows:

2.3.(17).C The CONTRACTOR shall provide care coordination for members with multiple and complex special physical, mental, neurobiological, emotional and/or behavioral health care needs on an as needed basis, depending upon the clinical profile of the member. The CONTRACTOR shall have written policies and procedures, which govern how members with these multiple and complex needs shall be identified and how these specific care coordination services shall be provided.

Article 2 (SCOPE OF WORK) Section 2.3.(20). is amended to read as follows:

2.3.(20) Recredentialing

The CONTRACTOR shall formally recredential its network providers at least every three years.

Article 2 (SCOPE OF WORK) Section 2.4.(1). is amended to read as follows:

2.4.(1). Inpatient Hospital Services

The benefit package includes hospital inpatient acute care, procedures, and services asset forth in MAD Program Manual section MAD-721, HOSPITAL SERIVCES. The CONTRACTOR shall comply with the maternity length of stay in the Health Insurance Portability and Accounting 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.

Article 2, (SCOPE OF WORK), Section 2.4.(5).A. is amended to read as follows:

2.4.(5).A. The benefit package includes emergency and poststabilization care services. Emergency services are covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency condition. An emergency condition shall meet the definition of emergency as per NMAC 8.305.1.7.V. Emergency services shall be provided in accordance with NMAC 8.305.7.11F. Poststabilization 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.

Article 2, (SCOPE OF WORK), Section 2.4.(5).B.iii. is amended to read as follows:

2.4.(5).B.iii. The CONTRACTOR is required to pay for all emergency and poststabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

Article 2 (SCOPE OF WORK), Section 2.4.(23). is amended to read as follows:

2.4.(23). Reproductive Health Services

The benefit package includes reproductive health services as set forth in MAD Program Policy, Section 762, 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 is in addition to the member's designated source of primary care if that source is not a women's health specialist.

Article 2 (SCOPE OF WORK) Section 2.4.(28) is amended to read as follows:

2.4.(28).A. The benefit package includes prevention, screening, diagnostics, ameliorative services, and other medically necessary behavioral health care and substance abuse treatment or services for Medicaid members under twenty-one (21) years of age whose need for behavioral health services is identified during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screen.

Article 2 (SCOPE OF WORK), Section 2.4.(31).A. is amended to add as follows:

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

Article 2 (SCOPE OF WORK), Section 2.5.(1). is amended to read as follows:

2.5.(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 SALUD! members. The CONTRACTOR shall participate with the State'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.

Article 2 (SCOPE OF WORK), Section 2.5.(2).B.i is amended to read as follows:

2.5.(2).B.i Incorporate cultural competence into utilization management, quality improvement and planning for the course of treatment.

Article 2 (SCOPE OF WORK), Section 2.6 is amended in its entirety to read as follows:

2.6. INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS

2.6.(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.

2.6.(1).A. CONTRACTOR Requirements:

i. The CONTRACTOR shall produce a special handbook or create an insert to include in its member services handbook a description of providers and programs available to individuals with special health care needs.

ii. The CONTRACTOR shall identify from among its members individuals with special health care needs, using the criteria for identification and information provided by the state to the MCO.

2.6.(1).B. The CONTRACTOR shall work with HSD to develop and implement written policies and procedures which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The CONTRACTOR shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify individuals with special health care needs.

2.6.(1).C.	SALUD! Enrollment for Individuals with Special Health Care Needs
	The CONTRACTOR shall 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.
2.6.(2)	Information and Education for Individuals with Special Health Care Needs
2.6.(2)A.	The CONTRACTOR shall develop and distribute, as appropriate, information and materials specific to the needs of individuals with special health care needs, and, in the case of children with special health care needs, their caregivers. This includes information, such as a list of items and services that are in the SALUD! benefit package and those that are carved out, how to plan for and arrange transportation, how to access behavioral health care without going through the PCP, how to present for care in an emergency room unfamiliar with the individual's special health care needs, and the availability of a care coordinator. This information could be included in a special member handbook on individuals with special needs or in an insert to the member handbook.
2.6.(2).B.	The CONTRACTOR shall make available health education programs to assist individuals with special health care needs, 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.
2.6.(2).C.	The CONTRACTOR shall provide a list of key CONTRACTOR resource people and their phone numbers.
2.6.(2).D.	The CONTRACTOR shall designate a single entity that can be called for information during the enrollment process and after becoming a member.
2.6.(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.
2.6.(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.

2.6.(5)	Transportation for Individuals with Special Health Care Needs
2.6.(5).A.	The CONTRACTOR shall have written policies and procedures in place to ensure that the appropriate level of transportation is arranged based on the individual's clinical condition.
2.6.(5).B.	The CONTRACTOR shall have past member and service data available at the time services are requested to expedite appropriate arrangements.
2.6.(5).C.	The CONTRACTOR shall ensure that CPR-certified drivers transport individuals with special health care needs whose clinical need dictates.
2.6.(5).D	The CONTRACTOR shall have written policies and procedures to ensure that transportation mode is clinically appropriate, including access to non-emergency ground ambulance carriers.
2.6.(5).E.	The CONTRACTOR shall 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.
2.6.(5).F.	The CONTRACTOR shall 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.
2.6.(5).G.	The CONTRACTOR shall distribute clear and detailed written information to individuals with special health care needs and, if needed, their caregivers on how to obtain transportation services and also make this information available to network providers.
2.6.(6)	Care Coordination for Individuals with Special Needs
2.6.(6).A.	The CONTRACTOR shall 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 Individuals with Special Health Care Needs. The CONTRACTOR will provide HSD with the applicable policy and procedure describing the targeting and stratification process.
2.6.(6).B.	The CONTRACTOR shall have written policies and procedures for accessing the need for care coordination.
2.6.(6).C.	The CONTRACTOR shall have written policies and procedures for educating individuals with special health care needs 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.
2.6.(6).D.	The CONTRACTOR shall have written policies and procedures for educating providers about the availability of care coordination, its value as a resource in caring for individuals with special health care needs, and how to access it.
2.6.(7).	Emergency, Inpatient and Outpatient Ambulatory Surgery Hospital Requirements for Individuals with Special Health Care Needs
2.6.(7).A.	The CONTRACTOR shall develop and implement written policies and procedures for educating individuals with special care needs, and with complicated clinical histories, and their caregivers, on how to utilize emergency room care, including what clinical history to present when emergency care or inpatient admission are needed.
2.6.(7).B	The CONTRACTOR shall develop and implement written policies and procedures governing how coordination with the PCP and hospitalists shall occur when an individual with a special health care need is hospitalized.
2.6.(7).C	The CONTRACTOR shall develop and implement written policies and procedures to ensure that the ER physician has access to the individual's medical history.
2.6.(7).D.	The CONTRACTOR shall 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.
2.6.(8)	Rehabilitation Therapy Services (Physical, Occupational, Speech Therapy) for Individuals with Special Health Care Needs
2.6.(8).A.	The CONTRACTOR shall develop and implement therapy clinical practice guidelines specific to the chronic or long term conditions of their individuals with special health care needs population, based on Medicaid managed care policy on medical necessity.
2.6.(8).B.	The CONTRACTOR shall 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.

2.6.(8).C. The CONTRACTOR shall involve families of members, physicians and therapy providers to identify issues that should be addressed in developing the new criteria.

2.6.(8).D. The CONTRACTOR shall 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.

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

2.6.(9).A. Subject to any requirements to procure a physician’s order to provide supplies to members, the CONTRACTOR shall develop and implement a process to permit members utilizing supplies on an ongoing basis to submit a list of supplies monthly. 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.

2.6.(9).B. The CONTRACTOR shall develop and implement a system for monitoring compliance with standards for DME and medical supplies, and instituting corrective action, if the provider is out of compliance.

2.6.(9).C. The CONTRACTOR shall have an emergency response plan for DME and medical supplies needed on an emergent basis.

2.6.(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 individuals with special health care needs and provide guidance in the provision of acute and chronic medical and behavioral health care services to this population. The guidelines should be professionally accepted standards of practice and national guidelines.

2.6.(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.

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

The CONTRACTOR shall add questions about individuals with special health care needs to the most current HEDIS CAHPS survey.

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

The CONTRACTOR shall perform a performance improvement project specific to individuals with special health care needs.

Article 2 (SCOPE OF WORK), Section 2.9 is amended in its entirety to read as follows:

2.9 GRIEVANCE SYSTEM

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 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.

General Requirements for Grievance & Appeals

1. The CONTRACTOR shall 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.

2. The CONTRACTOR shall 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.

3. The CONTRACTOR shall 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.

4. The CONTRACTOR shall 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.

5. The CONTRACTOR shall 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:

   a) An appeal of a CONTRACTOR denial that is based on lack of medical necessity;

   b) A CONTRACTOR denial that is upheld in an expedited resolution;

   c) A grievance or appeal that involves clinical issues.

6. Upon enrollment, the CONTRACTOR shall provide members, 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 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 policy 8.305.8.15.(13).

7. The CONTRACTOR must ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or a provider that supports a member's grievance and/or appeal.

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.

1. A member may file a grievance either orally or in writing with the CONTRACTOR within 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.

2. 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.

3. 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.

4. The CONTRACTOR may request an extension from HSD of up to fourteen (14) calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD 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.

5. 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:

   (a) all information considered in investigating the grievance;

   (b) findings and conclusions based on the investigation; and

   (c) the disposition of the grievance.

APPEALS

An appeal is a request for review by the CONTRACTOR of a CONTRACTOR action.

1. A member may file an appeal of a CONTRACTOR action within 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.

   An "action" is defined as:

   (a) the denial or limited authorization of a requested service, including the type or level of service;

(b) the reduction, suspension, or termination of a previously authorized service;

(c) the denial, in whole or in part, of payment for a service;

(d) the failure of the CONTRACTOR to provide services in a timely manner, as defined by HSD; or

(e) the failure of the CONTRACTOR to complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

2. 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.

3. 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.

4. The CONTRACTOR has thirty (30) calendar days from the date the oral or written appeal is received by the CONTRACTOR to resolve the appeal.

5. The CONTRACTOR may extend the thirty (30) day timeframe by 14 calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD 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.

6. 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.

7. 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.

8. 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.

a. The written notice of the appeal resolution must include but not be limited to the following information:

(i) the result(s) of the appeal resolution; and

(ii) the date it was completed.

b. 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:

(i) the right to request an HSD fair hearing and how to do so;

(ii) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(iii) that the member may be held liable for the cost of those benefits if the hearing decision upholds the CONTRACTOR'S action.

9. The CONTRACTOR may continue benefits while the appeal and/or the HSD fair hearing process is pending.

a. The CONTRACTOR shall continue the member's benefits if all of the following are met:

(i) The member or the provider files a timely appeal of the CONTRACTOR action (within 10 days of the date the CONTRACTOR mails the notice of action);

(ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(iii) The services were ordered by an authorized provider;

(iv) The time period covered by the original authorization has not expired; and

(v) The member requests extension of the benefits.

b. The CONTRACTOR shall provide benefits until one of the following occurs:

(i) The member withdraws the appeal;

(ii) Ten 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;

(iii) An HSD Administrative Law Judge issues a hearing decision adverse to the member;

(iv) The time period or service limits of a previously authorized service has expired.

c. 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).

d. If the CONTRACTOR or the HSD Administrative Law Judge 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.

e. If the CONTRACTOR or the HSD Administrative Law Judge 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.

EXPEDITED RESOLUTION OF APPEALS

An expedited resolution of an appeal is an expedited review by the CONTRACTOR of a CONTRACTOR action.

1. 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; and
   (iv) the CONTRACTOR'S independent determination.
2. The CONTRACTOR shall ensure that the expedited review process is convenient and efficient for the member.
3. The CONTRACTOR shall resolve the appeal within three (3) working days of receipt of the request for an expedited appeal.
4. The CONTRACTOR may extend the timeframe by up to 14 calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD 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 oral notification and follow-up within two (2) days.
5. 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.

6. 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.

7. The CONTRACTOR shall inform the member of the limited time available to present evidence and allegations in fact or law.

8. 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 30-day period begins on the date the CONTRACTOR received the request; and

   (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;

   (iii) inform the member in the written notice of the right to file a grievance if the member is dissatisfied with the CONTRACTOR'S decision to deny an expedited resolution.

9. The CONTRACTOR shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

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 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.

OTHER RELATED CONTRACTOR PROCESSES

1. Notice of CONTRACTOR Action (this also applies to Article 2 Section 2.1.(1).N. ii., Denials in the current contract and renumbered in this Amendment as Section 2.1.(1).O.ii.)

   a. The CONTRACTOR shall mail a notice of action to the member or provider and all those parties affected by the decision within 10 days of the date of an action. 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 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;

(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.

2. 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.

3. Grievance and/or Appeal Files

a. All grievance and/or appeal files shall be maintained in a secure, designated area and be accessible to HSD upon request, for review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the CONTRACTOR, HSD, an Administrative Law Judge, judicial appeal, or closure of a file, whichever occurs later.

b. 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.

c. Documentation regarding the grievance shall be made available to the member, if requested.

4. 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 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).

Section 2 (SCOPE OF WORK), Section 2.10.(2). is amended to read as follows:

2.10.(2). 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 such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance. Information provided to HSD on the CONTRACTOR's reinsurance must be computed on an actuarially sound basis.

Article 2 (SCOPE OF WORK) Section 2.10.(6).B. is amended to read as follows:

2.10.(6).B. Per Member Cash Reserve

The CONTRACTOR shall maintain three (3) percent 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 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 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.

Article 2 (SCOPE OF WORK) Section 2.10.(8).A. is amended to read as follows:

2.10.(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 90 percent of all clean claims from practitioners who are in individual or group practice or

who practice in shared health facilities within 30 days of date of receipt, and shall pay 99 percent of all such clean claims within 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. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, or one that is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; or one that has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan within thirty days of the date of receipt if submitted electronically or forty-five days if submitted manually.

iii. Consistent with the requirements of MAD Reg. 8.305.11.9.B(1), which applies to clean claims submitted electronically, and NMSA Section59A-2-9.2, the CONTRACTOR shall pay interest at the rate of one and one-half percent a month on:

(1) the amount of a clean claim electronically submitted by a contracted provider and not paid within thirty days of the date of receipt; and

(2) the amount of a clean claim manually submitted by a contracted provider and not paid within forty-five days of the date of receipt.

(3) Interest payments shall accrue and begin on the 31st day for electronic submissions and the 46th day for hard copy.

Article 2 (FIDUCIARY RESPONSIBILITIES), Section 2.10.(11) is added to read as follows:

2.10.(11) Special Contract Provisions As required by 42 CFR 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.

Article 2 (SCOPE OF WORK) Section 2.12.(4).A., B. and C is amended to read as follows:

2.12.(4).A. The CONTRACTOR is required to submit data to HSD. Subject to the provisions of Section 4.2 of this Agreement, HSD shall define the format and data elements after having consulted with the CONTRACTOR on the definition of these elements.

2.12.(4).B. The CONTRACTOR is responsible for identifying and reporting to HSD immediately upon discovery any inconsistencies in its automated reporting, CONTRACTOR shall make necessary adjustments to its reports at its own expense.

2.12.(4).C. HSD, 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 to develop the technical components of such an interface.

Article 2 (SCOPE OF WORK) Section 2.12.(5).B. is amended to read as follows:

2.12.(5).B. Encounter Submission Time Frames

The CONTRACTOR shall submit encounters to HSD within 120 days of the date of service or discharge, regardless of whether the encounter is from a subcontractor or subcapitated arrangement. 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.

Article 2 (SCOPE OF WORK) Section 2.12.(5).C is amended to read as follows:

2.12.(5).C. Encounter Data Elements

Encounter data elements are based on the Medicaid-Medicare Common Data Initiative (McData Set) which is a minimum core data set for states and MCOs developed by CMS and HSD for use in managed care. Subject to the provisions of Section 4.2 of this Agreement, HSD may increase or reduce or make mandatory or optional, data elements as it deems necessary.

Article 2 (SCOPE OF WORK) Section 2.13.(6).A. is amended to read as follows:

2.13.(6).A. Submitting to HSD encounters, according to the specifications included in the SALUD! Systems Manual, within 120 days of the date of service or discharge, regardless of whether the encounter is from a subcontractor or subcapitated arrangement;

Article 2 (SCOPE OF WORK) Section 2.13.(6).E. is amended to read as follows:

2.13.(6).E. Including written contractual requirements for subcontractors or providers that pay their own claims to submit encounters to the CONTRACTOR on a timely basis to ensure that the CONTRACTOR can submit encounters to HSD within 120 days of the date of service or discharge;

Article 2 (SCOPE OF WORK), Section 2.14 is added to read:

2.14 CARE COORDINATION

(1) General Requirements

Care coordination is defined as a service that assists clients with special health care needs. Care coordination is provided on an as needed basis. Care coordination is member-centered, family-focused (when appropriate), culturally competent and strength-based service. Care coordination helps to ensure that the medical and behavioral health needs of the Salud! population are identified and related services are provided and coordinated with the individual member and family as appropriate. Care coordination operates within the MCO by means of a dedicated care coordination staff functioning independently but is structurally linked to the other MCO 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 health conditions exist, the care shall be coordinated between both physical and behavioral health staff, and the responsibility for the care coordination shall be based upon what is in the best interest of the member.

(2) Primary Elements of Care Coordination

The CONTRACTOR shall use the following primary elements for care coordination:

A. Identify proactively the eligible populations;

B. Identify proactively the needs of the eligible population;

C. Designate an individual who has primary responsibility for coordinating health services and serves as the single point of contact for the member;

D. Inform the member regarding the care coordinator’s name and how to contact him/her;

E. Ensure 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.

F. Ensure the provision of necessary services and actively assist members and providers in obtaining such services;

G. Ensure appropriate coordination between physical and behavioral health services and non-Salud! services;

H. Coordinate with designated case managers and/or medical/behavioral health service providers;

I. Monitor progress of the members to ensure that services are received and assist in resolving identified problems;

J. Be responsible for linking individuals to case management when needed if a local case manager/designated provider is not available.

Article 3 (LIMITATION OF COST) is amended to read as follows:

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. Section 447.361 and 447.362. In no event shall HSD pay twice for the provision of services.

Article 4 (HSD RESPONSIBILITY) Section 4.1.(18). is amended to read as follows:

4.1.(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 to enter into contracts with the CONTRACTOR at the applicable Medicaid reimbursement rate for the provider, absent other negotiated arrangements, and take all available measures to have any Medicaid participating provider who is not contracted with the CONTRACTOR accept the applicable Medicaid reimbursement as payment in full for covered services provided in an emergency to a member who is enrolled with the CONTRACTOR. The applicable Medicaid reimbursement rate is defined to exclude disproportionate share and medical education payments.

Article 4 (HSD RESPONSIBILITY) Section 4.1.(20). is added to read as follows:

4.1.(20). Ensure that no requirement or specification established or provided by HSD under this section conflicts with requirements or specifications established pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated thereunder. All requirements and specifications established or provided by HSD under this section shall comply with the requirements of Section 4.2 of this Agreement.

Article 4 (HSD RESPONSIBILITY) Section 4.1.(21). is added to read as follows:

4.1.(21). Cooperate with CONTRACTOR in CONTRACTOR'S efforts to achieve compliance with HIPAA requirements.

Article 4 (HSD RESPONSIBILITY) Section 4.2. is amended to read as follows:

4.2.(1). HSD and/or its fiscal agent shall implement electronic data standards for transactions related to managed health care. In the event HSD and/or any of its agents are unable to accept standard transactions on or after October 1, 2003, the CONTRACTOR and HSD shall address any additional costs associated with such an event through an amendment to this contract.

4.2.(2). In the event that HSD 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 37.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE), Section 5.1 is amended to read as follows:

5.1 HSD 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 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.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.2. is amended to read as follows:

5.2 The monthly rates set forth in Attachments A and B shall be subject to renegotiation during the Agreement if HSD determines that it is necessary due to change in Federal or State law or in the appropriations made available for these tasks as set forth in Article 14, Appropriations, and Article 12, Contract Modification. Rates shall in all events be actuarially sound. In addition, in the event that HSD implements a significant or material program change under this or any other provision of this Agreement, such change including but not limited to the rates paid hereunder and the costs associated with the change, shall be adjusted appropriately pursuant to a mutually agreeable amendment to this Agreement in accordance with the provisions of Article 37.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE), Section 5.3.(1). is amended to read as follows:

5.3.(1). HSD 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.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE), Section 5.3.(4). is added to read as follows:

5.3.(4). 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 Strategies (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, the State's offer of all capitation rates referred to in the attached Schedule of this contract is contingent on both certification by the State'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, the State reserves the right to renegotiate these rates. The state's decision to renegotiate the rates under the circumstances described above is binding on the CONTRACTOR.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.5.(1) is amended to read as follows:

5.5.(1). The capitation rates shall remain in effect as referenced in Attachments A and B for the first twenty-four (24) months following the effective date of the original Agreement and thereafter the capitation rates shall be effective for twelve (12) months. Capitation rates may be reviewed if this Agreement is extended with the CONTRACTOR pursuant to this Agreement. Upon mutual agreement of the CONTRACTOR and HSD, the capitation rates may be adjusted based on factors such as changes in the scope of work, a Native American MCO is established or a Navajo Medicaid Agency created, CMS requires a modification of the state's waiver or 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 37 (Amendments) of this Agreement.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.6.(4) is amended to read as follows:

5.6.(4). HSD shall have the discretion to recoup payments 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 later determines were not eligible for Medicaid during the enrollment month for which payment was made. Notwithstanding the foregoing, in the absence of fraud on the part of CONTRACTOR, HSD shall not have the right to recoup any payment made to the CONTRACTOR if either the CONTRACTOR (and/or its subcontractors) provided any health care services to the member during the relevant period of time or more than twenty-four months have elapsed since the payments were made unless HSD is required by a federal agency to go beyond the twenty-four month period. To allow for claim submission lags, HSD will not request a payment recoupment until 120 days has elapsed from the date of which the enrollment error was made. Any process that automates the recoupment procedures will be mutually agreed upon in advance by HSD and the CONTRACTOR and documented in writing. The CONTRACTOR has the right to dispute any recoupment requests in accordance with Article 15 (DISPUTES).

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE), Section 5.6.(8). is amended to read as follows:

5.6.(8). On a periodic basis, HSD shall provide the CONTRACTOR with coordination of benefits and third party liability information for enrolled members. The CONTRACTOR shall:

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE), Section 5.6.(8).B is amended to read as follows:

5.6.(8).B. Have the sole right of subrogation, and to recovery of and/or to attempt to recover any third-party resources available to Medicaid members but shall make records pertaining to Third Party Collections (TPL) for members available to HSD for audit and review.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE), Section 5.8.(3) is amended to read as follows:

5.8.(3). The CONTRACTOR is required to pay for all emergency and poststabilization 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.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE), Section 5.9 is added to read as follows:

5.9. The CONTRACTOR shall accept the capitation rate paid each month by the HSD 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 and related 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 and related services of the Agreement, the HSD will withhold an amount so that the CONTRACTOR'S ratio for service expenditures are eighty-five percent (85%). The HSD 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 and related services required under the contract utilizing reported information and the Department of Insurance Reports. Administrative costs and other financial information will be monitored on a regular basis by the HSD.

Members shall be entitled to receive all covered services for the entire period for which payment has been made by the HSD. 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 8 (ENFORCEMENT) Section 8.1.(2).B. is amended to read as follows:

8.1.(2).B. Directed Plans of Correction. The CONTRACTOR shall be required to provide to HSD, within fourteen (14) days, a response to the directed plan of correction as directed by HSD.

Article 8 (ENFORCEMENT), Section 8.1.(2).C.iii is amended to read as follows:

8.1.(2).C.iii. The limit on, or specific amount of, civil monetary penalties that HSD 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 $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 $100,000 for each of the following determinations: discrimination; or misrepresentation or false statements to HSD or CMS.

c. A maximum of $15,000 for each member HSD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice. This is subject to an overall limit of $100,000 under (b.) above.

d. A maximum of $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 will deduct from the penalty the amount of overcharge and return it to the affected member(s).

Article 8. (ENFORCEMENT), Section 8.1.(2).L. is amended to read as follows:

8.1.(2).L. Temporary Management

1. Optional imposition of sanction. HSD may impose temporary management to oversee the operations of the CONTRACTOR upon a finding by the Secretary of HSD 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 members 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.
2. 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.
3. Required imposition of sanction. HSD 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, Section 1396b (m) or 1396u-2 or 42 CFR 438, Subpart I (Sanctions).
4. Hearing. HSD shall not delay imposition of temporary management to provide a hearing before imposing this sanction.
5. Duration of Sanction. HSD shall not terminate temporary management until it determines that the CONTRACTOR can ensure that the sanctioned behavior will not recur.

Article 8. (ENFORCEMENT), Section 8.1.(2).M. is amended to read as follows:

8.1.(2).M. Terminate Enrollment

HSD 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.

Article 8. (ENFORCEMENT), Section 8.1.(2).O. is amended to read as follows:

8.1.(2).O. Intermediate Sanctions

1. Basis for imposition of Sanctions: HSD will impose the foregoing sanctions if HSD 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, 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) misrepresents or falsifies information that it furnishes to HSD or CMS;
   - (e) 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 or that contain false or materially misleading information; or
   - (h) fails to perform in any other contract areas.
2. HSD’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.

3. HSD 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.

4. Intermediate Sanctions: The Secretary of HSD or designee will 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 of their right to disenroll);

(d) suspending all new enrollment, including default enrollment after the effective date of sanction;

(e) suspending of payment for members enrolled after the effective date of the sanction until HSD or CMS is satisfied that the reason for imposing the sanction no longer exists and is not likely to recur.

Article 8 (ENFORCEMENT) 8.1. (2).Q. is amended to read as follows:

8.1.(2).Q. The Secretary of HSD 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 determines that the CONTRACTOR has failed to do either of the following:

1. Carry out the substantive terms of its contract; or

2. Meet applicable requirements in Sections 1932, 1903 (m), and 1905 of the Social Security Act.

Article 8 (ENFORCEMENT) 8.1. (2).R. is added to read as follows:

8.1.(2).R. Notice of sanction: Except as provided in this Article regarding Temporary Management, before imposing any of the intermediate sanctions specified, HSD must give the CONTRACTOR timely written notice that explains the basis and nature of the sanction and any other due process protections that HSD elects to provide.

a. Pre-termination hearing: Before terminating the contract, HSD must provide the CONTRACTOR a pre-termination hearing, which consist of the following procedures:

1. HSD shall give the CONTRACTOR written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing.

2. After the hearing, HSD 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.

3. 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.

4. The pre-termination hearing procedures shall proceed according to Section 15.3 (Dispute Procedures) of the Agreement.

b. HSD 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 30 days after HSD imposes or lifts a sanction; and must specify the affected CONTRACTOR, the kind of sanction, and the reason for HSD's decision to impose or lift the sanction.

Article 8 (ENFORCEMENT) Section 8.3 is amended to read as follows:

8.3. Notice and Cure

HSD shall provide reasonable written notice of its decision to impose sanctions on the CONTRACTOR and, as HSD 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 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.

Article 9 (TERMINATION) Section 9.1.(17) is amended to read as follows:

9.1.(17). By the CONTRACTOR, on at least sixty (60) days prior written notice in the event that HSD is unable to make future payments of undisputed capitation payments due to a lack of a state budget or legislative appropriation;

Article 9 (TERMINATION) Section 9.1.(18). is added to read as follows:

9.1.(18). By either party, upon 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; and

Article 9 (TERMINATION) Section 9.1.(19). is renumbered to read as follows:

9.1.(19). By the CONTRACTOR on sixty (60) days prior written notice with cause, or one hundred eighty (180) days written notice without cause.

Article 10 (TERMINATION AGREEMENT), Section 10.3 is added to read as follows:

10.3. Dispute Procedure Involving Contract Termination Proceedings. In the event HSD seeks to terminate this Agreement with the CONTRACTOR, the CONTRACTOR may appeal the termination directly to the HSD Secretary within ten (10) days of receiving HSD's termination notice.

(1) The HSD 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 Secretary will conduct a formal hearing on the contract termination issues raised by the CONTRACTOR.

(3) The CONTRACTOR and 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 MAD, or its successor.

(5) The hearing shall be recorded by a court reporter paid for equally by HSD and the CONTRACTOR. Copies of transcripts of the hearing shall be paid by the party requesting the copy.

(6) The court reporter shall swear witnesses under oath.

(7) The HSD 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 Secretary may, but is not required, to allow opening statements from the parties before taking evidence.

(9) The HSD Secretary may, but it not required, to request written findings of fact, conclusions of law and closing argument or any combination thereof. Or, the Secretary may, but is not required, to allow only oral closing argument.

(10) The HSD 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) MAD, or its successor, and the CONTRACTOR may be represented by counsel or another representative of choice at the hearing. The legal or other representative 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.

(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 MAD director.

Article 14 (APPROPRIATIONS) Section 14.1 is amended to read as follows:

14.1 The terms of this Agreement are contingent upon sufficient appropriations or authorizations being made by either the Legislature of New Mexico, 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'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 effected pursuant to this Section 14.1 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 37 (Amendments) of this Agreement and any other applicable state or federal rules, regulations or statutes.

Article 14 (APPROPRIATIONS) Section 14.2 is amended to read as follows:

14.2 To the extent CMS, legislation or congressional action impacts the amount of appropriation available for performance under this contract, HSD has the right to amend the Scope of Work, in its discretion, which shall be effected by HSD sending written notice to the CONTRACTOR. Any changes to the Scope of Work and compensation to CONTRACTOR effected pursuant to this Section 14.2 shall be negotiated, reduced to writing and signed by the parties in accordance with Article 37 (Amendments) of this Agreement and any other applicable state or federal rules, regulations or statutes.

Article 15 (DISPUTES), Section 15.3.(1). is amended to read as follows:

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 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 Secretary a written appeal of the decision of the Director.

Article 26 (ERRONEOUS ISSUANCE OF PAYMENT OR BENEFITS) is amended to read as follows:

In the event of an error which causes payment(s) to the CONTRACTOR to be issued by HSD, 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 (30^{th}) day following the notice.

Article 27 (EXCUSABLE DELAYS) is amended to read as follows:

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, in writing, of its intent to suspend performance and HSD 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 provided that the CONTRACTOR notifies HSD in writing of its intent to suspend performance and HSD is unable to remedy the monetary shortfall within 45 days.

Article 28 (MARKETING), Section 28.2. is amended in its entirety to read as follows:

28.2 HSD 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; and

(3) The CONTRACTOR shall specify the methods by which the entity assures HSD that marketing materials are accurate and do not mislead, confuse, or defraud the members or HSD. 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 in the MCO in order to obtain benefits or in order not to lose benefits; or

(b) The MCO is endorsed by CMS, the Federal or State Government, or similar entity.

Article 28 (MARKETING) Section 28.3.(1). is amended to read as follows:

28.3.(1). Marketing and/or outreach materials shall meet requirements for all communication with Medicaid members, as set forth in Section MAD 8.305.5.16, MEDICAID MANAGED CARE MARKETING GUIDELINES.

Article 28 (MARKETING), Section 28.4.(1).G. is amended to read as follows:

28.4.(1).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 MCO with a potential member for the purpose of marketing. Marketing means any communication from an MCO 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 MCO’s Medicaid product, or either not to enroll in, or to disenroll from, another MCO’s Medicaid product. The CONTRACTOR may send informational material regarding their benefit package to potential members.

Article 28 (MARKETING), Section 28.8. is amended to read as follows:

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, member handbooks. HSD shall not approve health education materials.

Article 32 (CONFIDENTIALITY), Section 32.1 is amended to read as follows:

32.1 Any confidential information, as defined in State or Federal law, code, rules or regulations or otherwise applicable by the Code of Ethics, regarding HSD’s

members or providers given to or developed by the CONTRACTOR and its subcontractors shall not be made available to any individual or organization by the CONTRACTOR and its subcontractors without the prior written approval of HSD. Specifically the CONTRACTOR shall ensure that medical records and any other health and enrollment information that identifies a particular member, that the CONTRACTOR uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

Article 32 (CONFIDENTIALITY) Section 32.5. is added to read as follows:

32.5 The CONTRACTOR and HSD shall each comply with all requirements established under HIPAA regarding the privacy of individually identifiable health information and notices.

Article 33 (COOPERATION WITH MEDICAID FRAUD CONTROL UNIT) Section 33.1. is amended to read as follows:

33.1 The CONTRACTOR shall make an initial report to HSD within five working days when, in 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 the HSD and submit any applicable evidence in support of its findings. If HSD decides to refer the matter to the New Mexico State Medicaid Fraud Control Unit of the Attorney General's Office (MFCU), HSD 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.

CONTRACTOR

By: _____ **Date:** _____

Title: _____

STATE OF NEW MEXICO

By: _____ **Date:** _____

Secretary
Human Services Department

Approved as to Form and Legal sufficiency:

By: _____ **Date:** _____

General Counsel
Human Services Department

OFFICE OF THE ATTORNEY GENERAL

By: _____ **Date:** _____

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:** _____

DEPARTMENT OF FINANCE AND ADMINISTRATION

By: _____ **Date:** _____

State Contracts Officer

AGREEMENT NO. PSC 02-05
Between the State of New Mexico Human Services Department
And Cimarron Health Plan

Amendment No. 2 ("Amendment") is entered into by and between the New Mexico Human Services Department (hereinafter referred to "HSD") and **Cimarron Health Plan** (hereinafter referred to as "CONTRACTOR" OR "MCO").

WHEREAS, the parties have previously entered into Agreement PSC 02-05 Approved by the Department of Finance and Administration (DFA) on July 1, 2001 (the "Agreement") and

WHEREAS, Article 37 of the Agreement allows for amendment of the Agreement; and

WHEREAS, the parties have determined that the term of the Agreement should be extended for an additional year.

WHEREAS, the Balanced Budget Act of 1997 requires certain changes to the Agreement; and

WHEREAS, based on the parties' experience since implementation of the Agreement, the parties have agreed to certain changes in the Agreement beneficial to the Agreement's goals;

NOW THEREFORE, the parties do amend the Agreement as follows:

1. All terms, definitions and conditions stated in the Agreement and not modified by this Amendment shall remain in full force and effect. This Amendment shall become effective July 1, 2004, provided it has been approved by the Department of Finance and Administration, and the U.S. Department of Health and Human Services, Center for Medicare/Medicaid Services (CMS). Any reference to CMS in this document is a reference to the agency formerly known as Health Care Financing Administration (HCFA);
2. This Agreement is extended to expire at midnight June 30, 2005.
3. In the event of a conflict between, on one hand, the Agreement is amended herein, and on the other hand, the regulations promulgated by the Code of Federal Regulations (CFR) for managed care organizations (MCOs) and the Human Services Department, the federal and state regulations will prevail. This agreement will take precedence when delays in the promulgation of regulations present operational barriers in the performance of this contract.

IN WITNESS WHEREOF, the parties have executed this Amendment No. 2 as of the date of execution by the State Contracts Officer, below.

Article 1 (RECITALS), Section 1.7 is amended to read as follows:

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 for any new contract requirements.

Article 1 (RECITALS), Section 1.8 is amended to read as follows:

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

Article 2 (SCOPE OF WORK) Section 2.1.(1).I.i.d.3. is amended to read as follows:

2.1.(1).I.i.d.3. That an emergency condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such as that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the individual's health (or with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part. 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.

Article 2 (SCOPE OF WORK) Section 2.1.(1).I.ii. is amended to read as follows:

2.1.(1).I.ii. The CONTRACTOR shall provide, in English, Spanish and any other prevalent languages identified by the CONTRACTOR as being five percent or more of the CONTRACTOR's Salud! members who are conversant only in those other languages and formats, each member and/or legal guardian with written information about benefits including:

Article 2 (SCOPE OF WORK) Section 2.1.(1).J. is amended to read as follows:

2.1.(1).J. Member Identification Card

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

Article 2 (SCOPE OF WORK) Section 2.1.(1).M.vii. is amended to read as follows:

2.1.(1).M.vii. The CONTRACTOR shall comply with NCQA standards for Utilization Management and follow NCQA timeliness standards for urgent and emergent situations. NCQA standards shall be superseded by BBA requirements. The decision-making timeframes should accommodate the clinical urgency of the situation and not delay the provision of services to members for lengthy periods of time. These required timeframes are not affected by "pend" decisions. A possible extension of up to 14 additional calendar days may apply if:

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

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

Article 2 (SCOPE OF WORK) Section 2.1.(1).N.A.(4).(ii). is amended to read as follows:

2.1.(1).N.A.(4).(ii). Addresses the extent to which the CONTRACTOR is responsible for covering services related to the following:

(a) the prevention, diagnosis, and treatment of health impairments; and

(b) the ability to attain, maintain, or regain functional capacity.

Article 2 (SCOPE OF WORK) Section 2.1.(3). is amended to read as follows:

2.1.(3). A**.** Disease Management Programs and Performance Measures are two of the tools that HSD has chosen to use to measure a CONTRACTOR'S ability to identify problematic areas within its operations and take actions which shall improve its performance in those focus areas. Examples of these include but are not limited to, administrative functions (telephone response rates), utilization management (timeliness of prior authorizations), access to care, preventive care (improvement of EPSDT screening rates), and care coordination.

B. The Contractor shall:

i. Participate in disease management programs/performance

measures projects annually. HSD will coordinate with CONTRACTOR to select programs that meet the NCQA requirements. Fifty percent of the disease management programs/performance measures projects shall relate to behavioral health;

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

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..

Article 2 (SCOPE OF WORK) Section 2.1.(3).D.A. is amended to read as follows:

2.1.(3).D. PHYSICAL AND BEHAVIORAL HEALTH PERFORMANCE MEASURES FOR FY 2005 MCO CONTRACTS.

A. Managed Care Performance Measures:

For capitation payments made on or after June 25, 2004, the CONTRACTOR shall withhold one-half of one (0.5) percent of HSD's payments and hold such funds on HSD's behalf. The withhold funds shall be released to the CONTRACTOR no sooner than July 1st and no later than October 31st of 2005 only if, in the judgment of HSD, performance targets in the contract are achieved. Withhold funds shall be released to the CONTRACTOR based on the following scoring system for each of the ten performance measures listed below:

1. Dental Access to Care shall be worth 5 points;
2. Child Access to PCP shall be worth 5 points;
3. Diabetes Care shall be worth 5 points;
4. Consumer/Family Based Services shall be worth 15 points;
5. RTC Readmissions shall be worth 10 points;
6. Behavioral Health Discharge Follow-up after 7 days shall be worth 5 points;
7. Behavioral Health Discharge Follow-up after 30 days shall be worth 5 points;

8. Provider Payment Timeliness shall be worth 15 points;

9. Customer Support Services shall be worth 5 points; and

10. Encounter Data Reporting shall be worth 10 points.

11. Reports #30 and #31 shall be worth 20 points.

The percentage of the CONTRACTOR'S withhold funds to be released shall be calculated by summing all earned points, dividing the sum by 100, and converting to a percentage. No partial whole number of points will be assigned if the CONTRACTOR fails to completely meet performance measures described in one through ten above. Points assigned for the performance measures will be all or none (e.g. 15 points or 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 by CONTRACTOR, provided that HSD shall have the right to audit and validate the information or results as reported by CONTRACTOR.

For the current contract amendment the CONTRACTOR shall submit HEDIS scores for calendar year 2004 according to the required HEDIS submission schedule for evaluation under this performance measurement section.

2.1.(3).D.B.11. The CONTRACTOR shall achieve and maintain compliance with all format and content changes required by HSD for reports #30 and #31. HSD will finalize the descriptions of the categories of services by July 15, 2004. By August 30, 2004 the data in reports #30 and #31 will be within three percent of the health care expenses on the quarterly financial statements (Report 26A). On an annual basis reports #30 and #31 shall be within three percent of the annual audited financial statements.

Article 2 (SCOPE OF WORK) Section 2.1.(3).D.B.5. is amended to read as follows:

2.1.(3).D.B.5. RTC RE-ADMISSIONS:

Nineteen percent or less of the CONTRACTOR'S members who are discharged from a residential treatment center (RTC) to a lower lever of care will be re-admitted to the same level of care or a higher level of care within 30 days of discharge from the RTC.

Article 2 (SCOPE OF WORK) Section 2.1.(3).D.C.1.A. is amended to read as follows:

2.1.(3).D.C.1.A. The CONTRACTOR shall place all funds under part A. (Managed Care Performance Measures) of this section, in a separate account and shall provide to HSD 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.

Article 2 (SCOPE OF WORK) Section 2.1.(3).D.C.2.A. is amended to read as follows:

2.1.(3).D.C.2.A. The funds in the withheld funds account shall be released for use by the CONTRACTOR only after HSD has submitted in writing that, in HSD's judgment, the performance targets in the contract have been achieved for the period of time specified in the contract. HSD shall provide written confirmation no sooner than July 1, 2005 and no later than October 31, 2005 or within thirty (30) days of verification, whichever comes first.

Article 2 (SCOPE OF WORK) Section 2.1.(3).D.C.3.A. is amended to read as follows:

2.1.(3).D.C.3.A. The difference between the total FY 2005 capitation payments to the CONTRACTOR as of June 30, 2005 divided by 0.995 (99.5 percent) and the total FY 2005 capitation payments to MCO as of June 30, 2005.

Article 2 (SCOPE OF WORK) Section 2.1.(3).E.4. is amended to read as follows:

2.1.(3).E.4. COMMUNITY BASED BEHAVIORAL HEALTH SERVICES:

The CONTRACTOR shall increase its expenditures on the following community based services by a total of five percent of FY04 expenditures for those services identified as community based services:

Assertive Community Treatment (ACT);
Behavior Management Services (BMS);
Case Management for children and adults (CM);
Non-Emergency Room Crisis Services;
Home Based Services;
Intensive Outpatient Services (IOP);
Psychosocial Rehabilitation Services (PSR);
Respite Services for children/adolescents and adults;
Shelter Care Services for children/adolescents;
Transitional Living Services for children/adolescents and adults;
Day Treatment Program (DTP); and
Multi-Systemic Therapy (MST).

HSD shall provide a reporting format to the CONTRACTOR. The CONTRACTOR shall report to HSD on a quarterly basis using this format.

Article 2 (SCOPE OF WORK) Section 2.1.(4).A. is amended to read as follows:

2.1.(4).A. The CONTRACTOR shall ensure the Salud! member caseload of any PCP does not exceed fifteen hundred (1,500) enrollees of the CONTRACTOR.

Article 2 (SCOPE OF WORK) Section 2.1.(4).E.i. is amended to read as follows:

2.1.(4).E.i. The CONTRACTOR shall provide Geo-Access or equivalent reports quarterly to HSD on the CONTRACTOR'S network capacity of behavior health providers and facilities.

Article 2 (SCOPE OF WORK) Section 2.1.(6).A.viii. is amended to read as follows:

2.1.(6).A.viii. Continue to work with the School Based Health Services providers to identify and coordinate with the child's SALUD! primary care provider (PCP).

Article 2 (SCOPE OF WORK) Section 2.1.(6).B.i. is amended to read as follows:

2.1.(6).B.i. Initial Written Referral Report. 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 behavioral health provider within seven (7) calendar days after the screening and evaluation visit unless the member does not agree to release this information.

Article 2 (SCOPE OF WORK) Section 2.1.(6).B.ii. is amended to read as follows:

2.1.(6).B.ii. Ongoing Reporting. While the member is receiving services from a behavioral health provider, the behavioral health provider, with the member's consent, shall keep the member's PCP informed of drug therapy; laboratory and radiology results; sentinel events such as hospitalization, emergencies, incarceration, discharge from a psychiatric hospital or from behavioral health services; and transitions in level of care. The PCP, with the member's consent, shall keep the behavioral health provider informed of drug therapy; laboratory and radiology results; medical consultations; and sentinel events such as hospitalization and emergencies.

Article 2 (SCOPE OF WORK) Section 2.1.(6).B.vii. is amended to read as follows:

2.1.(6).B.vii. 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 and CYFD.

Article 2 (SCOPE OF WORK) Section 2.2.(3).A. is amended to read as follows:

2.2.(3).A. Eligibility

HSD 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 i.e., 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.

Article 2 (SCOPE OF WORK) Section 2.2.(5).A. is amended to read as follows:

2.2.(5).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.

Article 2 (SCOPE OF WORK) Section 2.2.(5).D. is amended to read as follows:

2.2.(5).D. Members in Treatment Foster Care Placements

If a child or adolescent was residing in a treatment foster care placement at the time managed care enrollment began in 1997, they shall be exempt from enrolling in an MCO until he or she is discharged from treatment foster care.

Article 2 (SCOPE OF WORK) Section 2.2.(5).E.i. is amended to read as follows:

2.2.(5).E.i. Native Americans shall have the option to participate in:

a. managed care and be enrolled with the CONTRACTOR to receive medical care through Indian Health Service (IHS), tribal providers, and/or other in-network providers, or

b. Primary Care Case Management with the Indian Health Service.

Article 2 (SCOPE OF WORK) Section 2.2.(5).H. is added to read as follows:

2.2.(5).H. Members with Dual-Eligibility (Medicare and Medicaid)

The benefit package for members with dual-eligibility will be limited to Medicaid benefits that are not covered by Medicare, including, but not limited to: transportation, vision, pharmacy, and dental.

Article 2 (SCOPE OF WORK) Section 2.2.(5).I. is added to read as follows:

2.2.(5).I. Medicaid Eligible Participants Receiving Personal Care Option Services

The CONTRACTOR shall be responsible for PCO assessments including service plans and utilization review for their members. The CONTRACTOR shall also be responsible for the assessments with service plans and utilizations review of other Medicaid clients as requested by HSD. If any of these utilization review decisions result in an HSD Fair Hearing, the CONTRACTOR shall be responsible for the Summary of Evidence and for attending the hearing.

Article 2 (SCOPE OF WORK) Section 2.2.(5).J. is added to read as follows:

2.2.(5).J. Native American enrollees who are not in Long Term Care Facilities and/or are not enrolled in Salud! may be assigned to the CONTRACTOR to receive transportation and pharmacy benefits through the CONTRACTOR.

Article 2 (SCOPE OF WORK) Section 2.3.(7). is amended to read as follows:

2.3.(7). Provider to Member Ratios and Access Requirements

The CONTRACTOR shall ensure that member caseload of any PCP in its network does not exceed fifteen hundred (1,500) of its Salud! members. Exceptions to this limit may be made with the consent of HSD. 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.

Article 2 (SCOPE OF WORK) Section 2.3.(17).A.i. is amended to read as follows:

2.3.(17).A.i. Deliver all behavioral health services through direct contacts with individual behavioral health providers or provider groups. All administrative functions associated with behavioral health shall be retained and integrated within the CONTRACTOR;

Article 2 (SCOPE OF WORK) Section 2.3.(17).D. is added to read as follows:

2.3.(17).D. If or when the time comes that the CONTRACTOR is no longer capitated by HSD to provide behavioral health medically necessary services to its members, the CONTRACTOR shall honor and ensure that all remaining contractually required behavioral health reports, performance and tracking measures are submitted in a timely manner and as required by HSD. The CONTRACTOR will accept financial liability for all medically necessary behavioral health services provided while under the capitation and will be responsible for coordinating the successful transition of services required by the member.

Article 2 (SCOPE OF WORK) Section 2.4.(28).B.vii. is amended to read as follows:

2.4.(28).B.vii. School-Based Services:

The benefit package includes counseling, evaluation and therapy furnished in a school-based setting as part of the pilot project, entitled “Linking School-Based Health Centers with Salud!” as referenced in 8.305.615.B, 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.

Article 2 (SCOPE OF WORK) Section 2.9. is amended to read as follows:

2.9 GRIEVANCE SYSTEM

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 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 directly as described in 8.352.2 NMAC, *Fair Hearings*, if the MCO member believes the MCO 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.

General Requirements for Grievance & Appeals

1. The CONTRACTOR shall 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.
2. The CONTRACTOR shall 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.
3. The CONTRACTOR shall 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.
4. The CONTRACTOR shall 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.

5. The CONTRACTOR shall 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:

   a) An appeal of a CONTRACTOR denial that is based on lack of medical necessity;

   b) A CONTRACTOR denial that is upheld in an expedited resolution;

   c) A grievance or appeal that involves clinical issues.

6. Upon enrollment, the CONTRACTOR shall provide members, 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 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 policy 8.305.8.15.(13).

7. The CONTRACTOR must ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or a provider that supports a member's grievance and/or appeal.

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.

1. A member may file a grievance either orally or in writing with the CONTRACTOR within 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.

2. 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.

3. 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.

4. The CONTRACTOR may request an extension from HSD of up to fourteen (14) calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD 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.

5. 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:

   (a) all information considered in investigating the grievance;

   (b) findings and conclusions based on the investigation; and

   (c) the disposition of the grievance.

APPEALS

An appeal is a request for review by the CONTRACTOR of a CONTRACTOR action.

1. An "action" is defined as:

   a. the denial or limited authorization of a requested service, including the type or level of service;

   b. the reduction, suspension, or termination of a previously authorized service;

   c. the denial, in whole or in part, of payment for a service;

   c. the failure of the CONTRACTOR to provide services in a timely manner, as defined by HSD; or

   d. the failure of the CONTRACTOR to complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

2. Notice of CONTRACTOR Action (this also applies to Article 2 Section 2.1.(1).N. ii., Denials in the current contract and renumbered in this Amendment as Section 2.1.(1).O.ii.)

   a. The CONTRACTOR shall mail a notice of action to the member or provider and all those parties affected by the decision within 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 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;

(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.

3. A member may file an appeal of a CONTRACTOR action within 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.

4. The CONTRACTOR has thirty (30) calendar days from the date the oral or written appeal is received by the CONTRACTOR to resolve the appeal.

5. 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.

6. 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.

7. The CONTRACTOR may extend the thirty (30) day timeframe by 14 calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD 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.

8. 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.

9. 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.

10. 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.

    a. The written notice of the appeal resolution must include but not be limited to the following information:

        (i) the result(s) of the appeal resolution; and

        (ii) the date it was completed.

    b. 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:

        (i) the right to request an HSD fair hearing and how to do so;

        (ii) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

        (iii) that the member may be held liable for the cost of those benefits if the hearing decision upholds the CONTRACTOR'S action.

11. The CONTRACTOR may continue benefits while the appeal and/or the HSD fair hearing process is pending.

    a. The CONTRACTOR shall continue the member's benefits if all of the following are met:

        (i) The member or the provider files a timely appeal of the CONTRACTOR action (within 10 days of the date the CONTRACTOR mails the notice of action);

        (ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

        (iii) The services were ordered by an authorized provider;

(iv) The time period covered by the original authorization has not expired; and

(v) The member requests extension of the benefits.

b. The CONTRACTOR shall provide benefits until one of the following occurs:

(i) The member withdraws the appeal;

(ii) Ten 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;

(iii) HSD issues a hearing decision adverse to the member;

(iv) The time period or service limits of a previously authorized service has expired.

c. 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).

d. If the CONTRACTOR or HSD 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.

e. If the CONTRACTOR or HSD 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.

EXPEDITED RESOLUTION OF APPEALS

An expedited resolution of an appeal is an expedited review by the CONTRACTOR of a CONTRACTOR action.

1. 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.

2. The CONTRACTOR shall ensure that the expedited review process is convenient and efficient for the member.

3. 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.

4. The CONTRACTOR may extend the timeframe by up to 14 calendar days if the member requests the extension, or the CONTRACTOR demonstrates to HSD 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.

5. 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.

6. 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.

7. The CONTRACTOR shall inform the member of the limited time available to present evidence and allegations in fact or law.

8. 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 30-day period begins on the date the CONTRACTOR received the request; and

   (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;

   (iii) inform the member in the written notice of the right to file a grievance if the member is dissatisfied with the CONTRACTOR'S decision to deny an expedited resolution.

9. The CONTRACTOR shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

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 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.

OTHER RELATED CONTRACTOR PROCESSES

1. 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.

2. Grievance and/or Appeal Files

   a. All grievance and/or appeal files shall be maintained in a secure, designated area and be accessible to HSD upon request, for review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the CONTRACTOR, HSD, an Administrative Law Judge, judicial appeal, or closure of a file, whichever occurs later.

   b. 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.

   c. Documentation regarding the grievance shall be made available to the member, if requested.

4. REPORTING

   a. The CONTRACTOR shall provide information requested or required by the Centers for Medicare and Medicaid Services.

   e. The CONTRACTOR shall provide a quarterly report to HSD 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).

5. 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 with the CONTRACTOR regarding utilization management decisions and/or provider payment issues. Grievances shall be resolved within 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 NMAC 8.205.12.13 for special rules for certain expedited service authorizations.

Article 2 (SCOPE OF WORK) Section 2.10.(2) is amended to read as follows:

2.10.(2) Reinsurance

The CONTRACTOR shall have and maintain adequate protections against financial loss due to outlier (catastrophic) cases. The CONTRACTOR shall submit to HSD such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance. Information provided to HSD on the CONTRACTOR's reinsurance must be computed on an actuarially sound basis.

Article 2 (SCOPE OF WORK) Section 2.10.(3) is amended to read as follows:

2.10.(3). Third Party Liability

The CONTRACTOR is responsible for identification of other third party coverage of members and coordination of benefits with applicable third parties. The CONTRACTOR shall inform HSD of any member who has other health care coverage. The CONTRACTOR shall provide documentation to HSD enabling HSD to pursue its rights under State and Federal law. Documentation includes payment information on enrolled members as requested by HSD, 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, includes a quarterly listing of potential accident and personal injury cases that are known to the CONTRACTOR. The CONTRACTOR and HSD 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 retains the right to make a final determination of the reporting format.

Article 2 (SCOPE OF WORK) Section 2.10.(6).B. is amended to read as follows:

2.10.(6).B. Per Member Cash Reserve

The CONTRACTOR shall maintain three (3) percent 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 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 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, with HSD approval and consistent with DOI regulations and guidelines, for investment with cash reserve accounts.

Article 2 (SCOPE OF WORK) Section 2.12.(3).E. is amended to read as follows:

2.12.(3).E. The CONTRACTOR is mandated to notify HSD 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.

The CONTRACTOR shall submit records involving any business restructuring when changes in ownership interest of 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 5% or more. These records shall be provided no later than sixty (60) days following the change of ownership.

Article 2 (SCOPE OF WORK) Section 2.12.(5).C. is amended to read as follows:

2.12.(5).C. Encounter Data Elements

Encounter data elements are based on the Medicaid-Medicare Common Data Initiative (McData Set), which is a minimum core data set for states and MCOs developed by CMS and HSD for use in managed care. Subject to the provisions of Section 4.2 of this Agreement, HSD 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. The transition to HIPAA codes and requirements does not relieve the CONTRACTOR of timely submission of encounter data.

Article 2 (SCOPE OF WORK) Section 2.12.(5).D. is amended to read as follows:

2.12.(5).D. Encounter Data Formats

The CONTRACTOR shall submit encounter data to HSD using the 837 and NCPDP formats.

Article 2 (SCOPE OF WORK) Section 2.13.(3).B. is amended to read as follows:

2.13.(3).B. Transmitting a Provider Network File to HSD on a monthly basis, no later than the 28th day of each month, 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 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 for that provider or not;

Article 4 (HSD RESPONSIBILITY) Section 4.1.(18). is amended to read as follows:

4.1.(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 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.

Article 4 (HSD RESPONSIBILITY) Section 4.1.(21) is amended to read as follows:

4.1.(21). Cooperate with CONTRACTOR in 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.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.2 is amended to read as follows:

5.2 The PARTIES to this contract understand and agree that the compensation and payment reimbursement for managed care is dependant 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 during the term of this contract:

In the event that HSD initiates a programmatic change effecting compensation and payment reimbursement for managed care during the term of this contract HSD 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 or benefit modification, the CONTRACTOR may request 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. 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 37.

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, then the change shall be implemented and become effective under Article 37 of this contract.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.6. is amended to read as follows:

5.6 Procedures

(1) HSD 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, the CONTRACTOR shall submit a payment request to HSD for the newborn member. HSD shall pay the CONTRACTOR the monthly rate for the newborn after receipt and verification of the claim by HSD.

(3) HSD 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 paid the CONTRACTOR for the member’s care under the terms of this Agreement.

(4) HSD shall have the discretion to recoup payments 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 later determines were not eligible for Medicaid during the enrollment month for which payment was made. Notwithstanding the foregoing, in the absence of fraud on the part of CONTRACTOR, HSD shall not have the right to recoup any payment made to the CONTRACTOR if either the CONTRACTOR (and/or its subcontractors) provided any health care services to the member during two months or more than twenty-four months have elapsed since the payments were made unless HSD is required by a federal agency to go beyond the twenty-four month period. To allow for claim submission lags, HSD will not request a payment recoupment until 120 days has elapsed from the date of 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, the CONTRACTOR shall reimburse HSD 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 (30) day following the notice. Any process that automates the recoupment procedures will be mutually agreed upon in advance by HSD 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 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, 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 MCO.

(8) On a periodic basis, HSD 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, and to recovery of and/or to attempt to recover any third-party resources available to Medicaid members but shall make records pertaining to Third Party Collections (TPL) for members available to HSD for audit and review.

C. Notify HSD as set forth below when the CONTRACTOR learns (not identified in enrollment roster) that a member has TPL for medical are:

i. Within fifteen (15) working days when a member is verified as having dual coverage under its managed care organization.

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. Members shall not be charged 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.

F. Payments provided for under this Agreement shall be denied for new members when, and for so long as, payment for those members is denied under 42 CFR Section 434.67(e).

(9) In those instances where a duplicate payment is identified either by the CONTRACTOR or HSD, HSD retains the ability to recoup these payments within time periods allowed by law.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.7.(5) is added to read as follows:

5.7.(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 that they have provided services to a newborn who has not been included on their roster. HSD 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.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.7.(6) is added to read as follows:

5.7.(6). Personal Care Option Assessment/Utilization Review Management Services

Payment for PCO services provided by the CONTRACTOR to manage PCO through assessment and utilization review shall be paid to the CONTRACTOR on a Fee-for-Service basis. The CONTRACTOR shall be responsible for their member PCO participant assessments including service plans and utilization review. The CONTRACTOR shall also be responsible for the assessments with service plans and utilizations review of other Medicaid clients as requested by HSD. If any of these utilization review decisions result in an HSD Fair Hearing, the CONTRACTOR shall be responsible for the Summary of Evidence and for attending the hearing.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.7.(7) is added to read as follows:

5.7.(7). Native Americans

The CONTRACTOR shall be paid a negotiated rate to provide the transportation and pharmacy benefits to Native American enrollees not currently in Long Term Care services.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.7.(8) is added to read as follows:

5.7.(8) Members with Dual-Eligibility (Medicare and Medicaid)

The CONTRACTOR shall be paid a negotiated rate to provide benefits for members with dual-eligibility. Such benefits may be limited to Medicaid benefits that are not covered by Medicare, including, but not limited to: transportation, vision, pharmacy, and dental.

Article 5 (COMPENSATION & PAYMENT REIMBURSEMENT FOR MANAGED CARE) Section 5.9 is amended to read as follows:

5.9. The CONTRACTOR shall accept the capitation rate paid each month by the HSD 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 and behavioral 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 and behavioral health services of the Agreement, HSD will withhold an amount so that the CONTRACTOR'S ratio for service expenditures are eighty-five percent (85%). HSD 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 and behavioral health services required under the contract utilizing reported information and the Department of Insurance Reports. Administrative costs, to be no higher that fifteen (15) percent, and other financial information will be monitored on a regular basis by HSD.

Members shall be entitled to receive all covered services for the entire period for which payment has been made by HSD. 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 (ENFORCEMENT) Section 8.1.(2).O.1 is amended to read as follows:

8.1.(2).O.1 Intermediate Sanctions

1. Basis for imposition of Sanctions: HSD will impose the foregoing sanctions if HSD 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, 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 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 or that contain false or materially misleading information; or

(h) fails to perform in any other contract areas.

Article 36 (NOTICE) Section 36.3 is amended to read as follows:

Gerald Landgraf, President and CEO
Cimarron Health Plan
8801 Horizon Boulevard NE
Albuquerque, NM 87113

CONTRACTOR

By: _____ **Date:** _____

Title: _____

STATE OF NEW MEXICO

By: _____ **Date:** _____

Secretary
Human Services Department

Approved as to Form and Legal sufficiency:

By: _____ **Date:** _____

General Counsel
Human Services Department

OFFICE OF THE ATTORNEY GENERAL

By: _____ **Date:** _____

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:** _____

DEPARTMENT OF FINANCE AND ADMINISTRATION

By: _____ **Date:** _____

State Contracts Officer

Exhibit 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Healthcare of California	California
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Utah, Inc.	Utah
Health Care Horizons, Inc.	Michigan
Molina Healthcare of New Mexico, Inc. (indirect)	New Mexico
Molina Healthcare of Indiana, Inc.	Indiana
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Georgia, Inc.	Georgia

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the Registration Statement (Form S-8) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan and 2002 Employee Stock Purchase Plan, of our reports dated February 25, 2005, with respect to the consolidated financial statements of Molina Healthcare, Inc., Molina Healthcare Inc.'s management assessment of the effectiveness of internal control over financial reporting, and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in the Annual Report (Form 10-K) for the year ended December 31, 2004.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 3, 2005

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, J. Mario Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2004 of Molina Healthcare, Inc.;
2. Based on my knowledge, this 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 this report;
3. Based on my knowledge, the financial statements, and other financial information included in this 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 this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) 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 this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (d) Disclosed in this 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 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.

March 8, 2005

Date

/s/ JOSEPH M. MOLINA

Joseph M. Molina
Chief Executive Officer and President

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2004, of Molina Healthcare, Inc.;
2. Based on my knowledge, this 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 this report;
3. Based on my knowledge, the financial statements, and other financial information included in this 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 this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) 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 this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (d) Disclosed in this 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 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.

March 8, 2005

Date

/s/ JOHN C. MOLINA

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 annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2004 as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario 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.

March 8, 2005

/s/ JOSEPH M. MOLINA

Joseph M. Molina, M.D.
Chief Executive Officer and President

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

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 annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2004 as filed with the Securities and Exchange Commission (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.

March 8, 2005

/s/ JOHN C. MOLINA

John C. Molina, J.D.
Executive Vice President, Financial Affairs
Chief Financial Officer and Treasurer

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.